

MEMORANDUM

To: ACI Alliance
From: Legislative Practice Group
Date: March 31, 2020
Re: **Summary of the Coronavirus Aid, Relief, and Economic Security (CARES) Act**

Congress and the Trump Administration have taken several key steps to address the expanding public health crisis caused by the coronavirus, officially known as COVID-19, while at the same time trying to staunch the negative repercussions currently affecting the nation's employment and financial markets. To stay up to date on the latest news and insights from the Powers Law Firm, please visit our COVID-19 resource page: <https://www.powerslaw.com/covid-19/>.

On March 6, 2020, the President signed an emergency supplemental appropriations bill, marking the first major effort to address the coronavirus pandemic. The full text of the Coronavirus Preparedness and Response Supplemental Appropriations Act can be found [here](#), and our memorandum summarizing the major provisions can be found [here](#). This "Coronavirus 1.0" package includes more than \$8 billion in emergency funding for federal agencies, state and local governments, and community health centers to fund the pandemic response, as well as a series of provisions to expand access to telehealth for Medicare patients. On March 18, the second package (the Families First Coronavirus Response Act) was signed into law. The full text of the legislation can be found [here](#), and our memorandum analyzing the bill can be found [here](#).

On March 25, the Senate unanimously approved a third measure, encompassing \$2.2 trillion in emergency relief to address the crisis and bolster the economy. The Coronavirus Aid, Relief, and Economic Security (CARES) Act was passed by voice vote in the House on March 27 and was signed by the President soon thereafter. The following is a summary of key legislative provisions in this third emergency bill, focusing on the impact for the health care sector. A separate memorandum summarizing Titles I and II of the CARES Act, including the \$349 billion Paycheck Protection Act, direct rebates to American families, and a massive small business loan program can be found [here](#). The full text of the CARES legislation can be found [here](#).

The Coronavirus Aid, Relief, and Economic Security (CARES) Act

I. Health Care Provisions

The CARES Act includes significant provisions to enhance and support the health care system in response to COVID-19, which will impact almost all sectors in the health care industry.

Access to Health Care for COVID-19 Patients

- *Private Insurance Coverage* - Section 3201 requires group health plans and health insurance issuers offering group or individual health insurance to cover (without imposing cost-sharing, prior authorization, or other medical management requirements) certain *in vitro* diagnostic tests for COVID-19, as well as the administration of such tests if furnished during any portion of the public health emergency period.
 - Section 3203 requires health plans and issuers to cover (without cost-sharing) any “qualifying coronavirus preventive services,” such as vaccines, within 15 days after the date such services are recommended by the U.S. Preventive Services Task Force or the Advisory Committee on Immunization Practices.
- *Medicare Coverage* - Section 3713 requires Medicare Part B (as well as Medicare Advantage plans) to cover COVID-19 vaccines and their administration without any beneficiary cost-sharing.
- *Medicaid Coverage* - Section 3717 clarifies that Medicaid covers COVID-19 *in vitro* diagnostic products even if the products have not been approved, cleared, or authorized under certain sections of the Federal Food, Drug, and Cosmetic Act.
- *Payment of COVID-19 Testing* - Section 3202 requires each provider of a COVID-19 diagnostic test to publish the cash price for such a test on the provider’s public website. Failure to do so may result in civil monetary penalties.
 - This section also requires health plans and issuers providing coverage of COVID-19 testing to reimburse the provider of the diagnostic testing by paying either:
 - The negotiated rate in effect before the public health emergency was declared, or
 - If the health plan or issuer does not have a negotiated rate with such provider, (1) the cash price posted by the provider on their website, or (2) a rate negotiated between the plan/issuer and the provider that is less than the posted cash price.
- *Public Health Funding* - Section 3211 provides \$1.32 billion in supplemental awards for fiscal year 2020 to health centers designated under Section 330 of the Public Health Service Act (PHSA) for the prevention, diagnosis, and treatment of COVID-19. It is unclear whether these funds will be available for Federally Qualified Health Center Look-Alikes.
- *Rural Funding* - Section 3213 authorizes the appropriation of \$79.5 million in grants for each of fiscal years 2021 through 2025 for the Health Resources and Services Administration’s (HRSA) rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs.

Enhancing the Health Care Workforce

- *Workforce Investments* - Section 3401 reauthorizes health professions workforce grant programs for fiscal years 2021 through 2025, including scholarships for disadvantaged students, loan repayments and fellowships, and educational assistance in health professions.

- *Pediatric Loan Repayment* - These programs include a reauthorization of the Pediatric Specialty Loan Repayment Program (PSLRP) at a funding level of “such sums as may be necessary” for fiscal years 2021 through 2025.
- *Innovative Models* - HHS is also authorized to make grants to develop and operate programs for developing innovative models of providing care. The U.S. Department of Health and Human Services (HHS) is directed to prioritize applicants that train residents in rural areas, including for Tribes or Tribal Organizations in such areas.
- *Workforce Development Plan* - Section 3042 directs HHS to develop a comprehensive plan for coordinating health care workforce development programs. The plan will include performance measures to evaluate programs’ impact on the health care system, identify gaps between the outcomes of existing programs and workforce needs identified by HRSA, and recommendations for addressing those gaps.
- *Physician Workforce Training* - Section 3403 reauthorizes programs for clinician training and faculty development under Title VII of the PHSA, including programs to support the workforce for geriatrics, family medicine, internal medicine, pediatrics, and other specialties.
- *Nurse Workforce Training* - Section 3404 reauthorizes programs for nurse workforce training under Title VIII of the PHSA. The bill updates existing reporting requirements to include information on how Title VIII programs perform with regards to program goals and how well HHS coordinates with other federal agencies on related programs.
 - This section also updates where Nurse Corps loan repayment beneficiaries can serve, allowing them to practice at certain private institutions, namely, nurse-managed health clinics.
- *Public Health Reserve Corps* - Section 3214 enables the creation of a United States Public Health Service Ready Reserve Corps to provide service in time of a public health or national emergency.
- *National Health Service Corps* - Section 3216 permits the Secretary of HHS to assign members of the National Health Service Corps, with the consent of such member, to a location to provide services in response to the COVID-19 public health emergency. The location must be within a reasonable distance of the site to which such members were originally assigned. The total number of hours required of such member must be the same as what was required prior to the enactment of the CARES Act.
- *Limited Provider Liability* - Section 3215 limits certain liability under Federal and State law for health care professionals providing health care services in response to the COVID-19 public health emergency on a volunteer basis, subject to certain exceptions. The protections afforded by this section preempt State law and apply to a claim for harm only if the act or omission that caused such harm occurred on or after the date of the CARES Act’s enactment.

Telehealth Services and Flexibilities

The first COVID-19 legislation allowed the Secretary of HHS to waive certain restrictions for coverage of telehealth services by allowing broadened access to telehealth under Medicare. CMS issued guidance on March 17 which, among other things, eliminated the requirement that

beneficiaries in traditional Medicare must live in rural areas in order to receive telehealth services, meaning beneficiaries in any geographic area could receive telehealth services. The guidance also allowed Medicare beneficiaries to receive telehealth services in their own homes. On the same day, the HHS Office of Inspector General announced that it would provide flexibility, under certain conditions, for health care providers to reduce or waive cost-sharing obligations for telehealth visits paid by federal health care programs. The HHS Office of Civil Rights (OCR) also announced that it will not impose certain penalties on health care providers covered by the Health Insurance Portability and Accountability Act (HIPAA) who use telehealth in ways that do not comply with existing HIPAA rules, e.g., using services such as Apple’s FaceTime or Google Hangouts to communicate with patients. For more on the first round of telehealth guidance, see our firm’s breakdown [here](#).

- *Telehealth Waivers* - Sections 3703 – 3707 of the CARES Act further expand the Secretary’s waiver authority under Section 1135 of the Social Security Act and makes other revisions to the existing telehealth restrictions that were not addressed in the first COVID-19 package. Notably, Section 3703 removes language from Section 1135b-5(b) to allow the Secretary to waive *all* statutory requirements for telehealth services under Section 1834(m) of the Social Security Act.
 - *FQHCs and Rural Clinics* - Section 3704 allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to serve as “distant sites” and bill for telehealth services provided at the location where the practitioner is located. Prior to this, FQHCs and RHCs were only allowed to bill Medicare as an “originating site” (the facility where the patient is located). The Centers for Medicare and Medicaid Services (CMS) developed a special payment rate in which the telehealth services provided at FQHCs and RHCs during the public health emergency will be paid based on the physician fee schedule rates. Furthermore, costs associated with the provision of telehealth services will not be used to determine payment under the FQHC/RHC all-inclusive rate methodology. It is unclear whether the waiver applies to FQHC look-alikes.
 - *ESRD and Hospice* - Section 3705 allows physicians to provide periodic clinical assessments to patients with end-stage renal disease (ESRD) receiving home dialysis treatment via telehealth. Section 3706 allows a hospice physician and nurse practitioner to conduct recertification of hospice benefits via telehealth. Section 3707 encourages the Secretary to consider ways to expand the use of telecommunications, including remote patient monitoring, to care for home health patients.
- *High-Deductible Plans* - Section 3701 amends the Internal Revenue code to include an additional safe harbor provision to allow a high-deductible health plan (HDHP) with a health savings account to cover telehealth services prior to the beneficiary reaching their deductible. This applies to all HDHPs with plan years beginning on or before December 31, 2021.
- *Telehealth Resource Center* - Section 3212 authorizes \$29 million to be appropriated for each of fiscal years 2021 through 2025 for HRSA’s telehealth network and telehealth resource centers grant programs.

Post-Acute Care (PAC) Provisions

- *Physician “Extenders”* - Section 3708 allows nurse practitioners, physician assistants, and clinical nurse specialists to order home health services under the Medicare program, in order to increase access to care while keeping beneficiaries at home.
- *IRF and LTCH Waivers* - Section 3711 provides additional flexibilities and waivers to increase access to post-acute care (PAC) for Medicare beneficiaries. These include:
 - *Three Hour Rule* - Waiver of the “three hour rule” for inpatient rehabilitation facilities (IRFs). IRFs are currently required to use an “intensity of therapy” requirement for eligible admissions to IRFs, including a requirement that beneficiaries participate in at least three hours per day (or 15 hours per week) of rehabilitation therapy. This requirement is waived during the COVID-19 public health emergency, so that IRFs can accept patients even if they will not receive the required three hours.
 - *50% Rule* - Waiver of the 50 percent rule for long-term care hospitals (LTCHs). LTCHs currently undergo a payment adjustment for all discharges if fewer than 50 percent of their discharges qualify for the LTCH rate. This waiver allows LTCHs to maintain their designation even if they do not meet this threshold, during the public health emergency.
 - *Site Neutrality* - Waiver of site-neutral LTCH payments. LTCHs currently receive lower rates for certain “less intensive” patients, known as the site-neutral rate. This waiver allows LTCHs to accept as many patients as necessary at the standard LTCH rate without facing the lower rate.
 - *3-Day Rule* – CMS also [announced](#) a series of “blanket waivers” for health care facilities and providers prior to the enactment of the CARES Act. These include, among others, a waiver of the prior inpatient stay requirement to a skilled nursing facility, a waiver of bed limits for critical access hospitals, and a waiver of the 60% rule for IRF patients admitted for COVID-19 treatment.

Medicare Payment Provisions

- *Waiver of 2% Medicare Sequester* - Section 3709 temporarily suspends the Medicare sequester – which reduces Medicare fee-for-service payments to providers by two percent – from May 1, 2020 through December 31, 2020. It also extends the Medicare sequester by one year, through fiscal year 2030.
- *Increase in DRG Payment for COVID Patients* - Section 3710 increases the weighting factor applicable to the diagnosis-related group (DRG) by 20 percent under the Medicare Inpatient Prospective Payment System in the case of a discharge of an individual diagnosed with COVID-19. The discharge of such an individual will be identified through the use of diagnosis codes, condition codes, or other such means as may be necessary. This add-on payment only applies to discharges occurring during the emergency period. The add-on payment will not be taken into account in applying budget neutrality.
- *Clinical Labs* - Section 3718 postpones the upcoming reporting period for private sector payment rates for certain clinical diagnostic laboratory tests for the establishment of

Medicare payment rates. It also prevents scheduled Medicare payment reductions for clinical diagnostic laboratory tests provided to beneficiaries in 2021.

- *Advanced and Accelerated Medicare Payments* - Section 3719 expands the Medicare hospital accelerated payment program during the COVID-19 public health emergency. On Saturday, March 28th, CMS [announced](#) the availability of advanced and accelerated Medicare payments for all Medicare providers and suppliers. See Powers' summary of the program announcement [here](#).

Medicaid Provisions

- *Home and Community-Based Services* - Section 3715 prohibits the Secretary of HHS from limiting the amount of Medicaid payment that may be made for home- and community-based services (HCBS) provided under section 1915(c), (d), or (i) of the Social Security Act or under a waiver or demonstration project under Section 1115, self-directed personal assistance services provided pursuant to a written plan of care under section 1915(j), and home- and community-based attendant services and supports under section 1915(k). It also authorizes the provision of such services in an acute care hospital if certain criteria are met.
- *Uninsured Persons* - Section 3716 clarifies the definition of who qualifies as an "uninsured individual" eligible to receive COVID-19 testing, with no cost-sharing, under a State Medicaid program that elects to offer such enrollment option. This applies to a provision expanding these options in the second COVID-19 legislative package, the Families First Coronavirus Response Act (FFCRA).
- *FMAP Increase Technical Clarification* - Section 3720 clarifies that during the 30-day period beginning on the date of enactment of the CARES Act, a State is not ineligible for the 6.2% increase in Medicaid Federal Medical Assistance Percentage (FMAP) on the basis that the State imposes a premium that exceeds the amount of such premium as of January 1, 2020.

Addressing Medical Supply Shortages

- *Medical Supply Chain Study* - Section 3101 directs the National Academies of Sciences, Engineering, and Medicine to develop a report on the security of the United States medical product supply chain. The report will include assessments of the United States' dependence on foreign-manufactured drugs and devices, potential public health or national security risks associated with the existing supply chain, and recommendations to improve the resiliency of the supply chain.
- *Strategic Stockpile* - Section 3102 requires the Strategic National Stockpile to include additional medical supplies, such as personal protective equipment (PPE) and ancillary supplies for the administration of drugs, vaccines, and diagnostic tests, such as cotton swabs used for COVID-19 tests.
- *Liability Protection for Manufacturers* - Section 3103 classifies respiratory protective devices (including face masks) as covered countermeasures under the Public Readiness and Emergency Preparedness (PREP) Act during the COVID-19 public health emergency. This

- provides permanent liability protection for manufacturers of this equipment to incentivize production and distribution.
- *Expedited Drug Review* - Section 3111 directs the Food and Drug Administration (FDA) to prioritize and expedite reviews of drug applications and any necessary inspections in order to prevent or mitigate potential drug shortages.
 - *New Drug Reporting Requirements* - Section 3112 implements new reporting requirements for drug manufacturers that face disruptions in their supply chain with regards to active pharmaceutical ingredients, during a public health emergency. Manufacturers will be required to disclose the reasons for the discontinuation or interruption, which active ingredients are involved, any alternative sources for those ingredients, whether any devices are involved in the interruption, and how long the interruption is expected to last.
 - Manufacturers are also required to maintain a “redundancy risk management plan” evaluating risks to the supply of drugs, and report on the volume of drugs manufactured.
 - The Secretary of HHS is required to report regularly to CMS on drug shortages during the emergency.
 - *New Device Reporting Requirements* - Section 3121 implements reporting requirements for medical device manufacturers that face discontinuances or interruptions in their production process. These requirements apply to manufacturers of devices that are critical to public health during an emergency, including life-supporting and life-sustaining devices and those intended for use in emergency medical care or during surgery.
 - HHS may require such reporting “during, or in advance of” a declared public health emergency, and manufacturers must report at least six months prior to an interruption or as soon as practicable.
 - HHS will share information on these shortages with providers, patient organizations, and supply chain partners, unless it is determined that disclosure would adversely affect the public health (including by potentially inciting over-purchase of products).
 - This section also allows for expedited review of applications for devices that could help mitigate or prevent expected shortages.
 - Finally, HHS will establish a device shortage list to be made publicly available, unless the Secretary determines the inclusion of certain information could be detrimental to the public health.

Over-the-Counter Drug Reform

The CARES Act includes long-awaited reforms to the over-the-counter (OTC), or nonprescription, drug industry. These provisions have passed the House and Senate in various bills over the past few years, but have not made it into enacted legislation until now.

- *OTC Drug Oversight* - Section 3851 allows the FDA to conduct their oversight of OTC drug monographs administratively and approve changes without public notice-and-comment rulemaking, determining which drugs are recognized as safe and effective. The FDA already has this authority for prescription drugs, and the legislation standardizes the treatment of OTC drugs with prescriptions.

- The bill also includes a specific provision directing the FDA to expedite reviews of applications for innovative ingredients in sunscreen.
- The new OTC review process provides an 18-month market exclusivity period for new OTC drugs to spur innovation.
- Section 3582 states that OTC drugs that do not comply with the monograph requirements are classified as “misbranded” under FDA regulations.
- Section 3853 excludes certain OTC drugs from the new review process that have already been excluded by past FDA action.
- Section 3854 allows sponsors of OTC sunscreen ingredients currently under FDA review to choose whether to remain in the existing review process or have their product reviewed under the new OTC review pathway.
- Section 3855 requires HHS to submit an annual report to the House Energy & Commerce and Senate Health, Education, Labor, and Pensions Committees on the FDA’s process for evaluating pediatric cough and cold monograph drugs.
- Section 3856 implements technical corrections to the FDA Reauthorization Act of 2017.
- Sections 3861 and 3862 authorize a new user fee program to fund the FDA’s new review process for OTC drugs, including the hiring of new staff at FDA to oversee the process. The fees will be set at \$500,000 for a Tier 1 OTC monograph order request and \$100,000 for a Tier 2 request, and fees will be required from drug facilities as well.

Health Care “Extenders”

The CARES Act extends funding for a package of so-called “health extenders,” programs whose authorizations/funding were scheduled to lapse on May 22, 2020. The legislation extends these programs’ funding through the end of November 2020, teeing up additional debate about further extensions or permanent reauthorizations at the end of the year. Programs receiving extended funding include:

- *Medicare Program*
 - Work Geographic Index Floor (Section 3801)
 - Funding for quality measure endorsement, input, and selection (Section 3802)
 - Funding outreach and assistance for low-income programs (Section 3803). These include funding for state health insurance programs, area agencies on aging, aging and disability resource centers, and funding for Medicare’s contract with the National Center for Benefits and Outreach Enrollment.
- *Medicaid Program*
 - Money Follows the Person (MFP) demonstration program (Section 3811)
 - Spousal Impoverishment Protections program (Section 3812)
 - Community Mental Health Services demonstration program (Section 3814). The demonstration would also be expanded to two additional states chosen by HHS.
- *Human Services and Other Health Programs*
 - Sexual Risk Avoidance Education program (Section 3821)

- Personal Responsibility Education program (Section 3822)
- Health Professions Opportunity Grants program (Section 3823)
- Temporary Assistance for Needy Families (TANF) and related programs (Section 3824)
- *Public Health Provisions*
 - Community Health Centers (Section 3831)
 - National Health Service Corps (Section 3831)
 - Teaching Health Center Graduate Medical Education Program (Section 3831)
 - Special Diabetes Program for Type I Diabetes (Section 3832)
 - Special Diabetes Program for Indians (Section 3832)

DSH Facilities - Additionally, scheduled reductions in payments to Disproportionate Share Hospital (DSH) facilities are delayed until December 1, 2020 (Section 3813).

Miscellaneous Health Provisions

- *Prescription Drug Supplies* – Section 3714 requires prescription drug plans in Medicare Part D and Medicare Advantage to permit an enrollee to obtain, in a single fill or refill, up to a 90-day supply of a covered Part D drug if requested during the COVID-19 public health emergency period. Prescription drug plans may not permit a beneficiary to obtain a single fill or refill inconsistent with an applicable safety edit.
- *DME Payment Rates* - Section 3712 revises payment rates for durable medical equipment (DME) during the emergency by postponing scheduled reductions related to the competitive bidding program (CBP). Some rural areas currently face a “blended rate” for DME items under the CBP program, which is scheduled to expire at the end of 2020, which combines traditional fee schedule pricing with new, lower, competitively bid rates. After 2020, those areas are scheduled for full CBP rates. Additionally, non-rural areas that have not undergone competitive bidding now face the full, lower CBP rates. The CARES Act extends the 50-50 blended rate for rural areas through the duration of the emergency, and re-institutes a 75-25 blended rate for non-rural, non-CBP areas through the emergency and retroactively for items provided on or after March 6, 2020.
- *SUD Disclosures* - Section 3221 amends federal law and certain associated regulations (known as 42 C.F.R. Part II) governing the confidentiality and disclosure of substance use disorder (SUD) patient records to allow for disclosure and re-disclosures to covered entities, business associates, or other programs, as permitted by HIPAA regulations and after obtaining the patient’s prior written consent. The Secretary is also required to update 45 C.F.R. § 164.520 within one year of enactment of the CARES Act to require covered entities that maintain such records to provide notice of privacy practices for substance use disorder patient records.
 - This section also creates new penalties for violating the provisions of the regulations governing SUD disclosures and creates new data breach notice obligations for breaches of SUD records.
- *Protected Health Information* - Section 3224 requires the Secretary to issue guidance within 180 days of enactment regarding compliance with HIPAA regulations and all applicable

- policies when sharing protected health information (PHI) during the COVID-19 public health emergency.
- *Older Americans Act* - Sections 3222 and 3223 allow individuals participating in community services activities under the Older Americans Act to receive nutrition services by extending the participation period and extending delivery of nutrition services to seniors practicing social distancing.
 - These provisions also allow the Secretary to increase the average participation cap for eligible individuals due to the effects of the COVID-19 public health emergency.
 - *Healthy Start* - Section 3225 reauthorizes the Healthy Start program, which is operated by HRSA’s Maternal and Child Health Bureau, through fiscal year 2025. The Healthy Start program aims to reduce infant mortality rates, increase access to early pre-natal care, and remove barriers to healthcare access.
 - *Blood Supply* - Section 3226 requires the Secretary to carry out a national campaign to improve awareness and support outreach about the importance and safety of blood donations during public health emergencies.
 - *Other Transaction Authority Cap* - Section 3301 allows the Secretary to use “competitive procedures” when entering into transactions to carry out public health emergency health-related projects and prohibits these projects from being terminated when the public health emergency is declared to be over.
 - *Zoonotic Drugs* - Section 3302 amends the Federal Food, Drug, and Cosmetic Act to allow the Secretary to expedite the development and review of a new animal drug if the preliminary development and review of such drug has the potential to prevent or treat a zoonotic disease in animals that has the potential to cause serious adverse health consequences or life-threatening diseases in humans.
 - *Menstrual Products* - Section 3702 adds menstrual care products to the definition of “qualified medical expenses,” which allows these products to be paid for using health savings accounts and flexible spending accounts.

II. Emergency Appropriations for Coronavirus Health Response and Agency Operations

Division B of the CARES Act includes additional supplemental appropriations to fund the COVID-19 public health emergency response. These appropriations cover nearly \$340 billion in emergency funding to federal, state, and local governments, including \$117 billion for hospitals and veterans health care, \$45 billion for the Federal Emergency Management Agency (FEMA) Disaster Relief Fund, \$16 billion for the Strategic National Stockpile, \$4.3 billion for the Centers for Disease Control and Prevention (CDC), and \$11 billion towards vaccines, therapeutics, diagnostics, and other medical needs. A comprehensive summary of the CARES Act appropriations can be found [here](#), and key provisions relevant for health care are outlined below.

- The CARES Act appropriates a total of \$127 billion to the “Public Health and Social Services Emergency Fund” to prevent, prepare for, and respond to coronavirus. \$100 billion is directed towards reimbursement for hospitals and healthcare providers for COVID-related expenses and lost revenue.

- *HRSA* - \$275 million is directed towards HRSA, \$90 million of which will be transferred to the HRSA Ryan White -HIV/AIDS Program. These funds will be used to modify existing contracts and supplement existing Ryan White Part A, B, C, and D grants and AIDS Education and Training Centers (AETC) Program grants in order to respond to COVID-19. Additional HRSA funds will go towards expanding services and capacity for rural hospitals, telehealth, and poison control centers.
- At least \$250 million is set aside to improve hospital preparedness for responding to medical events.
- *CDC* - The \$4.3 billion directed towards the CDC includes \$1.5 billion in designated funding for State and Local Preparedness Grants (adding to the \$1 billion already appropriated in the first supplemental package), \$500 million to invest in public health data surveillance and infrastructure modernization, \$500 million for global health security, and \$300 million to the Infectious Disease Fund.
- *NIH* - The National Institutes of Health (NIH) receives an additional \$945.5 million for vaccine and diagnostic research on COVID-19, with the majority of funding directed towards the National Institute of Allergy and Infectious Diseases, headed by Dr. Anthony Fauci.
- *SAMHSA* - The Substance Abuse and Mental Health Services Administration (SAMHSA) receives \$425 million, including \$250 million for mental health care services in certified community behavioral health clinics and \$100 million in flexible funding for SAMHSA emergency response grants.
- *ACL* - The Administration for Community Living (ACL) receives \$955 million for aging and disability services programs.
- *CMS* - CMS receives \$200 million for program management to respond to COVID-19, including at least \$100 million for survey and certification of healthcare facilities, especially regarding infection control in nursing homes.

III. Economic Stabilization Provisions and Coronavirus Relief Funds

The CARES Act also includes significant provisions to stabilize the economy as a result of COVID-19 and provide assistance to “severely distressed sectors,” including, in particular, air carriers. These include approximately \$500 billion to the U.S. Treasury’s Exchange Stabilization Fund to carry out direct lending to eligible businesses, states, and municipalities; credit protection during the emergency (and for 120 days after the termination of the emergency declaration); direct support to air carriers to encourage payroll maintenance; and the development of a \$150 billion Coronavirus Relief Fund. This fund will provide grants to states, territories, and tribal governments to make up for lost revenue during the crisis, allocated by population proportions. States with smaller populations will receive a minimum allotment of \$1.25 billion.

Additionally, the Department of Education (the Department) is provided new authority to waive requirements related to eligibility for schools receiving federal financial aid, and discount semesters during which students dropped out due to COVID-19 from Pell Grant eligibility. The Department is also permitted to waive loan and grant repayment for students who were forced to withdraw from school, and is provided broad waiver authority to give requested regulatory flexibility to individual

states, districts, or school systems. The CARES Act also suspends student loan payments through September 30, 2020. For a full summary of the provisions impacting higher education, please see our memorandum [here](#).

Finally, the CARES Act implements additional modifications to the emergency paid sick leave program enacted by the FFCRA. Provisions include allowing certain federal workers to be exempted from the new leave requirements, implementing caps on required leave payments per employee, and allowing laid off and rehired workers to become eligible for family leave benefits.

For further questions regarding the CARES Act or any other COVID-19 related issues, please contact any Powers professional with whom you normally work. Contact information for all professionals and practice groups can be found at <https://www.powerslaw.com/professionals/>.

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