

# CARES Act Offers Relief, Support for US Healthcare Sector During COVID-19 Response

March 2020

*As the outbreak of the Coronavirus (COVID-19) affects every sector of the US economy, the US Congress and the White House came together to provide funding, supplies and regulatory relief to address the crisis. The US Senate unanimously passed the **Coronavirus Aid, Relief, and Economic Security (CARES) Act** on March 25, 2020. The US House of Representatives followed suit and passed the bill on March 27, 2020. The President signed it into law shortly after. The CARES Act represents the third stimulus bill passed by Congress in response to the COVID-19 pandemic. With \$2 trillion in allocations, it is the largest stimulus bill in US history.*

*The sweeping legislation directs \$100 billion to an emergency fund accessible by eligible healthcare providers and provides additional low-interest and small business loan support to businesses combatting the COVID-19 outbreak. Other key provisions boost Medicare and Medicaid reimbursement for COVID-19-related inpatient services and generally, expand testing and treatment coverage, and provide additional regulatory relief for rural providers.*

*This article offers an overview of the CARES Act's major federal healthcare program provisions. It is not an exhaustive summary of all the healthcare provisions in the new law, and we encourage readers to review the law to identify additional provisions that may be of interest to their organizations.*

## Helpful Resources

- [Full CARES Act Text](#)
- [McDermott Will & Emery Coronavirus Resource Center](#)

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## **EMERGENCY FUNDS AND LOAN OPPORTUNITIES**

### **Public Health Fund for Providers**

The CARES Act includes \$100 billion for the Public Health and Social Services Emergency Fund for eligible healthcare providers for healthcare-related expenses or lost revenues associated with COVID-19. Providers eligible for this fund include public entities, Medicare or Medicaid enrolled suppliers and providers, for-profit entities and nonprofit entities in the United States that provide diagnoses, testing or care for individuals with possible or actual cases of COVID-19. The law authorizes the Secretary of Health and Human Services to review applications and make determinations about who will receive funds and for what purpose on a rolling basis. The law states that providers must submit to the Secretary applications that include statements justifying the need for the funds. While providers across the country are anxious to obtain funds to assist them through the crisis, the US Department of Health and Human Services (HHS) will need to set out criteria it will use to allocate the funds.

The CARES Act also provides supplemental awards and grants to support healthcare providers. The bill provides \$1.32 billion in supplemental funding to community health centers (CHCs), and reauthorizes Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technology and strengthen rural healthcare.

Other grant opportunities included in CARES are summarized in the appendix.

### **Small Business Administration 7(a) Loans**

The CARES Act provides economic relief to small businesses through Small Business Administration (SBA) loan guarantees and subsidies. The SBA program primarily provides financial assistance to small businesses through the 7(a) loan program. The CARES Act increases the maximum 7(a) loan amount from \$5 million to \$10 million. The law also expands eligible uses of 7(a) loans to include payroll support, employee salaries, mortgage payments, insurance premiums and any other debt obligations, and makes other important changes. Under the CARES Act, entities eligible for 7(a) loans include small businesses, nonprofits and veteran organizations with fewer than 500 employees.

### **Economic Injury Disaster Loans**

The CARES Act allocates \$10 billion for emergency economic injury disaster loans (EIDLs). EIDLs are available to businesses with fewer than 500 employees in states where the governor has declared a state of emergency under the Stafford Act. These loans can be up to \$2 million and may be used by small businesses to pay off debt, payroll and other bills that can't be paid because of the disaster. The Act stipulates that, in issuing these loans, the SBA may waive any personal guarantee on loans less than \$200,000 and offer loans solely based on credit score. Loan recipients may request an advance on a loan of less than \$10,000, which the SBA must make available within three days.

### **Paycheck Protection Program**

In addition to the EIDL grants and increased SBA 7(a) loans, the CARES Act establishes a third loan program for small businesses called the Paycheck Protection Program (PPP). PPP loans are designed to help small businesses avoid closure or layoffs, and can be used to cover payroll, utilities, insurance premiums, and rent and mortgage interest payments on a facility. This program concludes on June 30, 2020, and is tailored for businesses that typically would not qualify for a loan at an average local or national bank. The loans require no collateral, credit test or personal guarantees from a business, only proof that the business was open and operational on February 15, 2020. In order to attract lenders, the government is offering a 100% guarantee on loans through the end of 2020.

### **Loan Forgiveness**

The CARES Act establishes a forgiveness policy for all loans granted by the SBA as part of the COVID-19 response. All recipients of SBA 7(a) loans—including those granted through the PPP—are eligible for loan forgiveness equal to the amount the borrower spends in the eight weeks after the loan is originated. Loan forgiveness will not be included in income tax and can be applied to payroll costs up to \$100,000.

Employers must provide payroll information from this year and the same time last year to demonstrate that they are maintaining wages. Employers will not be penalized for rehiring employees who were recently let go.

## **MEDICARE PAYMENT**

The CARES Act attempts to alleviate some of the financial strain on hospitals, physicians and other providers through a series of Medicare payment policies that increase reimbursement and waive existing constraints.

### **Increasing Reimbursement**

The new law increases reimbursement to hospitals by providing an add-on payment for inpatient hospital discharges related to COVID-19. Under the Inpatient Prospective Payment System, a diagnostic related group (DRG) payment covers all charges associated with an inpatient stay from the time of admission to discharge. CMS assigns each DRG a weighting factor that reflects the estimated relative cost of hospital resources for the discharges assigned to that DRG compared to discharges assigned to other DRGs. During the emergency period, the new law increases the weighting factor of DRGs for patients diagnosed with COVID-19 by 20%. These patients will be identified through the use of diagnosis codes, condition codes or similar means. This provision provides direct financial relief to inpatient hospitals by increasing payments for patients diagnosed with COVID-19, whose treatment is anticipated to be more complex and resource-intensive.

### **Accelerating Payments to Providers**

The law expands the CMS accelerated payment policy in an effort to get payments to hospitals more quickly. Currently CMS has an accelerated payment policy for extraordinary circumstances that allows hospitals to receive an advance on Medicare payments if they have experienced financial difficulties due to a delay in payments or in other exceptional situations. The CARES Act makes revisions to this program, including:

- Increasing the prepayment amount from 70% to 100% (125% for critical access hospitals) of expected Medicare payments
- Increasing the length of time accelerated payments may cover from three to six months
- Delaying the start of recoupment of any overpayments from 90 to 120 days
- Extending the due date for any outstanding balances from 90 days to one year.

The CARES Act also expands the types of hospitals (including critical access, children's and cancer hospitals) that are eligible to apply for accelerated payments during the COVID-19 national emergency.

### **Temporarily Suspending Current Payment Policies that Reduce Reimbursement**

The CARES Act curtails the current 2% reduction to Medicare payment by temporarily suspending Medicare sequestration. The Budget Control Act of 2011, as amended, established that Medicare spending is subject to across the board reductions of up to 2% from 2013 through 2029. The CARES Act suspends Medicare sequestration payment reductions from May 1, 2020, through December 31, 2020. To make up for the budget savings lost during this temporary suspension, sequestration is now extended through 2030.

For the emergency period, the CARES Act also temporarily suspends the current site-neutral policy that requires certain long-term care hospital (LTCH) stays to be paid an amount based on Medicare's acute care hospital payment rates under the Inpatient Prospective Payment System or 100% of the cost of the case, whichever is lower. For the roughly 30% of LTCH stays currently subject to the site-neutral policy, this waiver will temporarily restore payments to higher LTCH Prospective Payment System rates.

Additionally, from March 6, 2020, to the end of the emergency period, the CARES Act averts price reductions to durable medical equipment by suspending revisions to the Medicare durable medical equipment payment methodology for areas other than those that are rural and noncontiguous.

## **TELEHEALTH**

### **Relieving Regulatory Burden**

The CARES Act expands the use of telehealth by easing restrictions on specific healthcare providers, changing insurance coverage and creating additional grant funding opportunities during the current public health emergency. Current telehealth laws and regulations allow Medicare to pay providers for telehealth services under certain circumstances, and the use of telehealth is limited by certain regulatory requirements. The first emergency COVID-19 supplemental (Coronavirus Preparedness and Response Supplemental Appropriations Act), signed into law March 6, 2020, lifted one of these regulatory requirements: the “originating site” rule, which requires a patient receiving the service to be physically located either in a healthcare facility or in a designated rural area. That legislation removed this restriction during the public health emergency period, allowing beneficiaries to receive telehealth services in other locations, including their homes.

The first and second COVID-19 supplemental legislative packages also included restrictions on telehealth services, including a requirement that a physician have a pre-existing relationship with the beneficiary in order to be reimbursed for telehealth services. The Centers for Medicare and Medicaid Services (CMS) released telehealth guidance on March 17, 2020, announcing that it would not enforce that requirement, however. The CARES Act codifies the CMS policy, stating that a physician is not required to have that treatment relationship with the patient to be reimbursed for telehealth services for the duration of the emergency period.

### **Supporting Underserved Communities**

The CARES Act includes several provisions intended to increase access to telehealth in rural and underserved areas. In addition to the previously mentioned originating site restriction, current law includes a “distant site” requirement, which dictates where the eligible provider must be located in order to be reimbursed under Medicare. Rural health clinics and federally qualified health centers are not eligible distant sites, but the CARES Act allows them to serve as such during the public health emergency. This provision allows providers using telehealth at these facilities to be reimbursed at rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule.

The CARES Act reauthorizes and provides \$29 million per year for four years for a HRSA grant program supporting the use of telehealth technologies for services relating to mental health, at-home care, and preventive care in rural and underserved communities. The Act also fixes an access issue for beneficiaries who have a high-deductible health plan with a health savings account, by allowing coverage of telehealth services before the beneficiary meets the deductible.

All of these policies attempt to increase access to telehealth services while reducing the need for in-person visits during this public health emergency. They also give providers mechanisms to continue treating patients at a time when their typical face-to-face case load is diminished. These policies could have longer term implications, too. Stakeholders have long advocated for legislation making some of these changes—including lifting restrictions on originating and distant sites. These temporary changes could serve as a case study on telehealth’s impact on the healthcare system.

## MEDICAID

### State Medicaid Efforts to Address COVID-19

The CARES Act makes minor changes to the Medicaid statute to give state plans increased flexibility to cover certain services during the COVID-19 public health emergency.

The Act allows state Medicaid programs to pay for direct support professionals to assist disabled individuals in the hospital to reduce length of stay and free up beds. Direct support services have traditionally been reserved for home and community-based settings, but Congress recognized that the hospital may be a more appropriate setting during the public health emergency.

The CARES Act clarifies a section of the Families First Coronavirus Response Act that gives states the option to extend Medicaid eligibility to their uninsured populations for COVID-19 diagnostic testing. The CARES Act ensures that uninsured individuals can receive a COVID-19 test and related service with no cost-sharing in any state Medicaid program that elects to offer such enrollment option.

The CARES Act also gives states an additional grace period for certain requirements in Families First. For example, Families First dictates that if a state has raised its Medicaid premiums since January 1, 2020, it is ineligible to receive the 6.2% Federal Medical Assistance Percentages (FMAP) increase specified in the law. The CARES Act amends this provision to allow states 30 days from March 18, 2020, to come into compliance with the requirement and still remain eligible for the FMAP increase, as long as the state imposed the higher premium *before* Families First was enacted.

Together, these flexibilities aim to help speed up the rate of COVID-19 testing and treatment, and reduce the burden on hospitals.

## DIAGNOSTICS AND PREVENTION

### Diagnostic Tests, Vaccines and Preventive Measures for COVID-19

The CARES Act contains provisions intended to ensure rapid access to COVID-19 diagnosis and prevention services and to minimize administrative concerns for laboratories and payers. Private payers are required to cover diagnostic laboratory tests for COVID-19 and certain vaccines and preventive measures. The legislation requires that plans or issuers providing coverage of COVID-19 testing reimburse the test provider at the negotiated rate, and in the absence of the negotiated rate, the posted cash price. Providers of laboratory tests for COVID-19 are required to publish a cash price for diagnostic testing. The CARES Act imposes civil monetary penalties on diagnostic test providers that fail to post the cash price.

Under the Protecting Access to Medicare Act of 2014 (PAMA), payment rates under the Medicare Clinical Laboratory Fee Schedule (CLFS) are based on private payer-based market rates. Laboratories are required to report market data in a three-year cycle. Currently, the CLFS rates are based on private payer rates reported in 2017. Under the original schedule, laboratories were required to report private payer rates in 2020, but Congress previously delayed that to 2021. The CARES Act further delays the reporting period for an additional year, to 2022. In the interim, payment rates will continue to be based on 2017 payment rates.

PAMA requires laboratory payment rates to be set at the weighted median of private payer rates. Appreciating that historic CLFS often are higher rates than the weighted median, guardrails were put in place to limit how much the payment could be reduced each year. In 2021, when the current CLFS rate is higher than the weighted median, the rates could drop by as much as 15%. The CARES Act holds the 2021 CLFS payment rates at the 2020 level, capping the reduction at 0%. The 15% cap that was intended to be in place for 2021–2023 was delayed to 2022–2024.

Finally, the CARES Act allocates \$27 billion to fund the development and manufacturing of diagnostic, preventive and therapeutic services for COVID-19. This money may be used to fund development of countermeasures and vaccines, and to purchase vaccines, therapeutics and diagnostics. The funding prioritizes platform-based technologies with US-based manufacturing capabilities.



## **SUPPLIES**

The CARES Act includes provisions designed to strengthen the supply chain of devices, drugs and personal protective equipment—both immediately and in preparation for future epidemics.

### **Addressing Drug Shortages**

The Federal Food, Drug, and Cosmetic Act requires prescription drug manufacturers to notify the US Food and Drug Administration (FDA) if they anticipate a permanent discontinuance or temporary interruption in the supply of a life-supporting or life-sustaining drug. The CARES Act builds on this statute by requiring FDA to expedite and prioritize review of drugs that manufacturers have identified for possible shortages. The Act also requires manufacturers to submit additional information to FDA when there is an interruption in the supply chain for pharmaceuticals or medical equipment. Manufacturers must submit a contingency plan to ensure back-up supplies of life-saving and life-preserving products, and information about drug volume. In cases where the interruption is caused by missing or diminished active ingredient supply, manufacturers must share information about these ingredients with FDA. This provision represents a significant policy change, and manufacturers have long resisted the idea of sharing such information.

### **Addressing Medical Device Shortages**

As with the supply of prescription drugs, the CARES Act takes steps to ensure that providers are equipped with adequate medical devices. The Act allocates \$1 billion toward the US Department of Defense, which can use the [Defense Production Act](#) to increase the production rate of protective and medical equipment. The Defense Production Act allows the federal government to contract with private companies and provide guaranteed loans to target companies to boost production of this equipment. The government can also use “allocation authority,” which means informing firms that it has the right to purchase their products before anyone else. The Defense Production Act contains a [section](#) that authorizes the president to control the production and distribution of scarce materials deemed “essential to the national defense,” which include face masks and ventilators in the current crisis.

The CARES Act grants manufacturers of respiratory-designated protective equipment—including masks and ventilators—liability protection that extends through the time that the device is used or administered. This provision is designed to further incentivize production and distribution of shortage equipment. The CARES Act also clarifies that the Strategic National Stockpile—the nation’s largest supply of life-saving pharmaceuticals—can also stockpile medical supplies, such as the swabs necessary for COVID-19 diagnostic testing.

These provisions are designed to spur production and distribution of drugs and equipment that healthcare providers currently lack as they combat the COVID-19 outbreak. Congress also seeks to better prepare for future pandemics by clarifying the government’s powers to mitigate supply shortages, and identifying the information it needs to do so effectively.

## **EXPIRING PROGRAMS**

Many Medicare, Medicaid and public health programs are funded and authorized on a temporary, short-term basis. The programs listed below were last extended at the end of 2019 through May 22, 2020. The CARES Act further extend these programs through November 30, 2020. This date falls after the beginning of the new fiscal year and potentially during a lame duck congressional session, depending on the results of the general election. These factors might provide an opportunity for a deal on longer-term extensions and a more permanent fix to the Medicaid Disproportionate Share Hospital (DSH) cuts.

### **Delaying the Medicaid DSH Allotment Reduction**

The Affordable Care Act (ACA) reduced the amount of Medicaid DSH payments based on the expectation that expanded access to coverage included in the other portions of the law would reduce the need to reimburse hospitals for uncompensated care. As a result of shifting market dynamics and policies, however, Congress has revised and delayed those reductions in subsequent legislation. The previous

suspension delayed DSH reductions through May 22, 2020. The CARES Act further delays the cuts until December 1, 2020. The program is now set to be reduced by \$4 billion starting in fiscal year 2021 and \$8 billion in each of fiscal years 2022 through 2025.

### **Community Health Centers**

CHCs serve more than 25 million people and rely on federal discretionary funds of about \$3.6 billion annually (almost one-fifth of their total revenue) to provide services to uninsured patients, expand capacity and offer an expanded set of healthcare services, such as oral health and substance abuse disorder services. The ACA provided a significant increase in funding for CHCs through 2015, and Congress subsequently extended that funding several times.

### **Teaching Health Centers**

The HRSA operates Teaching Health Center Graduate Medical Education programs focused on increasing the primary care workforce in medically underserved communities. The program was established and funded for five years under the ACA and has been reauthorized and funded several times since then. Most of the training programs currently operating in the states are conducted in CHCs.

### **Money Follows the Person**

The Money Follows the Person program was created in 2005. The program provides states with enhanced federal matching funds for services and supports to help seniors and people with disabilities move from institutions to home-based care. Forty-four states participate in the program, which has helped more than 90,000 institutional residents transition back to their communities. The ACA expanded the program, but long-term funding expired in 2016. Since then, lawmakers have passed a series of short-term limited funding bills.

### **Special Diabetes Program**

The Bipartisan Budget Act of 1997 created two Special Diabetes Programs: the Special Diabetes Program for Indians at the Indian Health Service and the Special Statutory Funding Program for Type 1 Diabetes Research at the National Institutes of Health (NIH). These programs fund evidence-based diabetes treatment and prevention programs in local communities as well as NIH research.

### **Geographic Practice Cost Indices Work Floor**

Medicare payments to physicians are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices, that reflect how each geographic area compares to the national average. In 2003, Congress established that for three years there would be a “floor” of 1.0 on the “work” component of the formula used to determine physician payments. Congress has repeatedly extended the 1.0 floor. There are concerns that without these adjustments, physician services in rural areas in particular would be disproportionately affected by lower Medicare payments.

## **REGULATORY RELIEF**

### **Removing Burden**

The CARES Act includes provisions to reduce the regulatory burden on healthcare providers during the emergency period—and in some cases permanently. These provisions suspend or eliminate existing Medicare regulatory requirements to give providers flexibility in determining how and to whom care is delivered.

Inpatient rehabilitation facilities (IRFs) are typically required to provide Medicare patients with at least 15 hours per week of intensive therapy (or three hours per day at least five days per week) in order to be eligible for coverage. IRFs are permitted to provide fewer hours of therapy during the emergency period. This allows IRFs to accept patients who might not otherwise be eligible and provides IRFs flexibility around continued patient stays.



The CARES Act also targets regulatory relief to LTCHs. It temporarily waives the requirement that an LTCH have no more than 50% of its Medicare cases paid at the site-neutral rate to receive continued payment as an LTCH. This relief allows an LTCH to care for patients who require less intensive care during the emergency period without risking their designation as an LTCH under the Medicare program.

Congress also used the new law to implement longstanding efforts to reduce regulatory burden in the Medicare program. Consistent with the Trump Administration's previously stated priority of allowing healthcare professionals to practice at the top of their license, the CARES Act allows for payment of home health services that are certified by a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife or a physician assistant. Previously, a physician was required to certify this service. This provision will go into effect no later than six months after enactment of the Act.

## **INSURANCE COVERAGE**

The CARES Act establishes that a deductible will not apply to a COVID-19 vaccine or its administration, consistent with how Medicare treats seasonal flu vaccines. This provision is effective on the date that such a vaccine is licensed under Section 351 of the Public Health Agencies Act. Congress expects that waiving co-pays will increase the uptake in vaccinations (when available).

Ensuring that uninsured individuals have access to testing is also a congressional priority. Families First includes provisions to assist the uninsured with the coverage of diagnostic testing, including permitting states to extend Medicaid eligibility to their uninsured populations for COVID-19 diagnostic testing, and appropriating \$1 billion for HHS's Public Health and Social Services Emergency Fund for diagnostic testing to be administered to the uninsured. Families First defines an uninsured individual as someone who is not covered by a federal health program, a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market. The CARES Act expands the definition of an uninsured individual to include individuals whose plan does not have minimum essential coverage under the ACA requirements.

## **OTHER PROVISIONS**

### **Rural Access and Care Delivery**

The CARES Act reauthorizes and provides \$79.5 million per year for four years for three HRSA grant programs: Rural Health Care Service Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement. These programs support care coordination, chronic disease management and improving patient health outcomes for populations that tend to have less access to care and higher risk of illness in rural areas. While not specifically tied to the current public health crisis, these grant programs can help provide proper treatment for patients who may be more vulnerable to contracting COVID-19.

### **Substance Use Treatment**

Another provision in the CARES Act seeks to improve care coordination for patients with substance use disorder (SUD) treatment records. 42 CFR Part 2 (Part 2) is the legal framework that governs the confidentiality of SUD patient records created by federally assisted SUD treatment programs. Part 2 has not been modernized in almost 30 years and includes requirements such as the patient's submission of written consent prior to the disclosure of their SUD record for each time the record is shared. Some stakeholders argue that the current protections can hinder a physician's ability to effectively and appropriately treat patients. There have been efforts to align Part 2 with how patient records are treated under the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and healthcare operations. This effort must be balanced to ensure strong privacy protections around this highly sensitive health information.

The CARES Act partially addresses this issue by allowing the patient to agree to informed consent for Part 2 protected health information only once within a healthcare system. The Act also requires HHS to issue guidance clarifying what patient information may be shared during the COVID-19 public health emergency.

While this change does not fully align the treatment of Part 2 and SUD patient records with HIPAA, it represents a significant step toward that goal. HHS implementing guidance may help inform future efforts to fully align Part 2 with HIPAA.

### **Liability Protection**

The new bill provides temporary immunity from liability for volunteer healthcare professionals, as long as those health care professionals meet certain criteria. The immunity afforded by this provision is in addition to the protections afforded by the Volunteer Protection Act. However, because this provision applies only to volunteers, it likely does not apply to hospital systems or other health care providers.

## **WHAT'S MISSING**

### **Surprise Billing and Prescription Drug Pricing**

Although the CARES Act includes many health provisions, it leaves out some noteworthy policies that have been at the forefront of Congress' agenda since the beginning of 2019. The law does not address the issue of surprise medical bills, which stalled in Congress after multiple House committees proposed competing plans to resolve payment disputes between payers and providers. An alternative to the CARES Act proposed by House Democrats, the Take Responsibility for Workers and Families Act ([H.R. 6397](#)), included a section expressing the "sense of Congress" that healthcare providers should refrain from balance billing during the COVID-19 emergency, but the final text of the CARES Act includes no reference to surprise billing.

The CARES Act also does not include various bipartisan drug pricing reforms championed by Senate Finance Committee Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR). These include reforms to the catastrophic phase of the Medicare Part D benefit, a cap on drug price increases tied to inflation and monetary penalties for companies that raise their prices above the rate of inflation, and a cap on seniors' out-of-pocket costs for prescription drugs. While Senator Grassley made a last-minute public push for inclusion of these policies, it did not happen.

### **Other Provisions in the Take Responsibility Act**

Many Democratic priorities that were included in H.R. 6397 were also left out of the CARES Act. These include direct support for health plans and provisions around preserving and supporting pillars of the ACA. The CARES Act excludes a provision included in H.R. 6397 that would have prevented HHS from finalizing the [Medicaid Fiscal Accountability Regulation](#) (MFAR) until two years after the end of the public health emergency. MFAR would make changes to the way states finance their share of the Medicaid program, potentially reducing funding and limiting access to care for beneficiaries. Hospitals are widely opposed to MFAR and have called for it to be withdrawn or delayed in light of the many other burdens placed on them by the public health emergency.

### **What Comes Next?**

With these policies left out of the CARES Act, it is unclear if and when Congress will act on them. After passing the CARES Act, the Senate announced that it will adjourn until at least April 20, 2020, in an effort to protect the health of its members. The House is expected to approve CARES, and then follow suit. When Congress returns, they may turn to a fourth and fifth relief bill. It is possible that drug pricing or surprise billing policy could be included in those future packages, although it is not clear what Congress' appetite will be for including controversial policy changes in emergency relief legislation.

The next funding deadline for the extenders (November 30, 2020) could also present an opportunity to address these proposals. It has been widely assumed that if Congress were to pass surprise billing or drug pricing legislation, it would do so combined with funding the health extenders. The rationale is that the drug pricing and surprise billing proposals on the table save money, which could offset the cost of funding the extenders.

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## APPENDIX

Agency	Program	Funding Level	Description	Eligibility/Notable Specifications
<b>Department of Agriculture</b>	Distance Learning, Telemedicine (DLT), and Broadband Program	\$25 million	Supports rural communities' access to telecommunications-enabled information, audio and video equipment, as well as related advanced technologies for students, teachers and medical professionals.	Not specified.
<b>Department of Defense</b>	Defense Production Act	\$1 billion	Increases access to materials necessary for national security and pandemic recovery.	Not specified.
<b>Department of Defense</b>	Defense Health Program	\$415 million	Supports the development of vaccines, anti-virals, 24/7 lab operations and the procurement of diagnostic tests.	Not specified.
<b>Department of Health and Human Services (through ASPR)</b>	Public Health and Social Services Emergency Fund	\$100 billion	Ensures healthcare providers continue to receive the support they need for COVID-19 related expenses and lost revenue.	Eligible healthcare providers are public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities within the United States (including territories), that provide diagnoses, testing or care for individuals with possible or actual cases of COVID-19.  The Secretary will review applications on a rolling basis under the most efficient payment systems practicable to provide emergency payment. Applications should include a statement justifying the need of the provider for the payment, and the eligible provider should have a valid tax identification number.
<b>Department of Health and Human Services (through ASPR)</b>	Public Health and Social Services Emergency Fund	\$16 billion	Funds the Strategic National Stockpile to procure personal protective equipment, ventilators and other medical supplies for federal and state response efforts.	Not specified.

Agency	Program	Funding Level	Description	Eligibility/Notable Specifications
Department of Health and Human Services (through ASPR)	Public Health and Social Services Emergency Fund	\$11 billion	Supports purchasing vaccines, therapeutics, diagnostics, and other medical or preparedness needs.	Not specified.
Department of Health and Human Services (through ASPR)	Public Health and Social Services Emergency Fund	\$250 million	Supports hospital preparedness, including increasing healthcare facilities' capacity to respond to medical events.	Grants to, or cooperative agreements with, entities that are either grantees or sub-grantees of the Hospital Preparedness Program. Existing program requirements may apply.
Department of Health and Human Services (through ASPR)	Public Health and Social Services Emergency Fund	\$275 million	Expands services and capacity for rural hospitals, telehealth, poison control centers and the Ryan White HIV/AIDS program, mostly through HRSA.	No less than \$15 million shall be allocated to tribes, tribal organizations, urban Indian health organizations or health service providers to tribes.
Department of Health and Human Services	Centers for Disease Control and Prevention	\$4.3 billion	Supports public health preparedness and response, which includes funding to state and local public health responders (including reimbursement of funds used thus far in response to the coronavirus), as well as enhanced nationwide surveillance, diagnostics, laboratory support, communication campaigns to the public, guidance to physicians and healthcare workers, and global health preparedness.	<p>\$1.5 billion is set aside for grants to or cooperative agreements with states, localities, territories, tribes, tribal organizations, urban Indian health organizations or health service providers to tribes, including to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities.</p> <p>No less than \$125 million shall be allocated to tribes, tribal organizations, urban Indian health organizations or health service providers to tribes.</p> <p>No less than \$500 million shall be for global disease detection and emergency response.</p> <p>No less than \$500 million shall be for public health data surveillance and analytics infrastructure modernization.</p> <p>Funds may be used for grants for the rent, lease, purchase, acquisition, construction, alteration or renovation of non-federally owned facilities to improve preparedness and response capability at the state and local level.</p>

Agency	Program	Funding Level	Description	Eligibility/Notable Specifications
<b>Department of Health and Human Services</b>	National Institutes of Health	\$945.5 million	Supports vaccine, therapeutic and diagnostic research to increase understanding of COVID-19, including underlying risks to cardiovascular and pulmonary conditions.	This is divided between: National Heart, Lung Blood Institute (\$103 million); National Institute of Allergy and Infectious Diseases (\$706 million); National Institute of Biomedical Imaging and Bioengineering (\$60 million); National Library of Medicine (\$10 million); National Center for Advancing Translational Sciences (\$36 million); Office of the Director (\$30 million).
<b>Department of Health and Human Services</b>	Substance Abuse and Mental Health Services Administration	\$425 million	Funds mental health and substance use disorders as a result of the COVID-19 pandemic.	This is divided between: Community Behavioral Health Clinics (\$250 million); Suicide Prevention (\$50 million); SAMHSA Emergency Response Grants (\$100 million).
<b>Department of Health and Human Services</b>	Centers for Medicare and Medicaid Services	\$200 million	Supports additional infection control surveys for facilities with populations vulnerable to severe illness from COVID-19.	No less than \$100 million shall be available for necessary expenses of the survey and certification program, prioritizing nursing home facilities in localities with community transmission of COVID-19.
<b>Federal Communications Commission</b>	N/A	\$200 million	Supports healthcare providers by providing telecommunications services, information services and devices necessary to enable the provision of telehealth services.	Not specified.
<b>Small Business Administration</b>	Disaster Loan Program	\$562 million	Funds SBA Disaster Loans.	Funds can be used for 7(a) and 7(b) loans.
<b>Small Business Administration</b>	Disaster Loan Programs	\$366 billion	Funds Small Business Administration – Business Loans Program Account, CARES Act.	\$349 billion can be used for 7(a) \$17 billion can be used for existing 7(a) (including Community Advantage), 504, or microloan product.
<b>Small Business Administration</b>	Disaster Loan Programs	\$265 million	Funds Small Business Administration—Entrepreneurial Development Programs.	Not specified.



Agency	Program	Funding Level	Description	Eligibility/Notable Specifications
<b>Small Business Administration</b>	Disaster Loan Programs	\$10 billion	Funds Small Business Administration— Emergency EIDL Grants	<p>Expands eligibility for access to economic injury disaster loans (EIDL) to include Tribal businesses, cooperatives and ESOPs with fewer than 500 employees, or any individual operating as a sole proprietor or an independent contractor during the covered period (January 31, 2020, to December 31, 2020). Private nonprofits are also eligible for both grants and EIDLs.</p> <p>Establishes that applicants shall not be required to repay advance payments, even if subsequently denied for an EIDL loan. In advance of disbursing the advance payment, the SBA must verify that the entity is an eligible applicant for an EIDL loan. This approval shall take the form of a certification under penalty of perjury by the applicant that it is eligible.</p> <p>Outlines that advance payment may be used for providing paid sick leave to employees, maintaining payroll, meeting increased costs to obtain materials, making rent or mortgage payments, and repaying obligations that cannot be met due to revenue losses.</p> <p>Adds “emergency” explicitly into other existing EIDL trigger language under Section 7(b)(2) of the Small Business Act.</p>
<b>Indian Health Services</b>	N/A	\$1 billion	Addresses critical response needs in Indian Country, along with the ability to transfer \$125 million for facility needs. Funding provides for medical and equipment supplies, mobile triage units, surveillance; medicines, purchased and referred care, transportation, backfilling	<p>Up to \$65 million is for electronic health record stabilization and support, including for planning and tribal consultation.</p> <p>No less than \$450 million shall be distributed through IHS directly operated programs and to tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act and through contracts or grants with</p>

Agency	Program	Funding Level	Description	Eligibility/Notable Specifications
			for public health service corps, and increased capacity for telehealth and other teleworking capacity.	urban Indian organizations.