Provisions included in “PHASE FOUR”/CARES 2 COVID-19/The HEROES Act response package relevant to:

HEALTH CARE

As of May 12, 2020

Key Provisions

“Provider Relief Fund” Public Health and Social Services Emergency Fund (PHSSEF):

$175 billion to reimburse for health care related expenses or lost revenue attributable to the coronavirus, as well as to support testing and contact tracing to effectively monitor and suppress COVID-19, including:

- $100 billion in grants for hospital and health care providers to be reimbursed health care related expenses or lost revenue directly attributable to the public health emergency resulting from coronavirus; and
- $75 billion for testing, contact tracing, and other activities necessary to effectively monitor and suppress COVID-19.

Health Resources and Services Administration: $7.6 billion to support expanded health care services for underserved populations, including:

- $7.6 billion for Community Health Centers to expand the capacity to provide testing, triage, and care for COVID-19 and other health care services at approximately 1,000 existing health centers across the country
- $10 million to Ryan White HIV/AIDS clinics to support extended operational hours, increased staffing hours, additional equipment, and additional home delivered meals and transportation needs of clients, who disproportionately suffer from co-morbidities and underlying immunosuppression that puts them at greater risk for COVID-19 complications.

Centers for Disease Control and Prevention: $2.1 billion to support federal, state, and local public health agencies to prevent, prepare for, and respond to the coronavirus, including:

- $2 billion for State, local, Territorial, and Tribal Public Health Departments
- $130 million for public health data surveillance & analytics infrastructure modernization
National Institutes of Health: $4.745 billion to expand COVID-19-related research on the NIH campus and at academic institutions across the country and to support the shutdown and startup costs of biomedical research laboratories nationwide.

Assistant Secretary for Preparedness and Response (ASPR): $4.575 billion to respond to coronavirus, including:

- $3.5 billion for Biomedical Advanced Research and Development Authority (BARDA) for therapeutics and vaccines
- $500 million for BARDA to support U.S.-based next generation manufacturing facilities
- $500 million for BARDA to promote innovation in antibacterial research & development
- $75 million for the Office of Inspector General

Substance Abuse and Mental Health Services Administration: $3 billion to increase mental health support during this challenging time, to support substance abuse treatment, and to offer increased outreach, including:

- $1.5 billion for the Substance Abuse Prevention and Treatment Block Grant
- $1 billion for the Community Mental Health Services Block Grant
- $265 million for emergency response grants to address immediate behavioral health needs as a result of COVID-19
- Emergency mental health and substance use training and technical assistance center. Establishes a technical assistance center at the Substance Abuse and Mental Health Services Administration (SAMHSA) that will support public or nonprofit entities and public health professionals seeking to establish or expand access to mental health and substance use services associated with the COVID-19 public health emergency.

Health and Human Services Office of Inspector General: $75 million to provide necessary oversight and enforcement related to the COVID-19 pandemic.
Hospitals and Health Care Providers

- **Health Care Provider Relief Fund.** Codifies the CARES Act health care provider relief fund for the purposes of reimbursing eligible health care providers for expenses related to preventing, preparing for, and responding to COVID-19, as well as lost revenues that have resulted from the COVID-19 pandemic and appropriates an additional $100 billion into the provider relief fund and includes clear guidance to ensure that funds are distributed to providers in the most equitable and efficient way. Providers will be reimbursed on a quarterly basis for all COVID-19 related expenses and a portion of their lost revenues.

Medicare

- **Medicare hospital inpatient prospective payment system expanded outlier payment for COVID-19 patients.** Provides an outlier payment for inpatient claims for any amount over the traditional Medicare payment to cover excess costs hospitals incur for more expensive COVID-19 patients until January 31, 2021.

- **Improve the Accelerated and Advance Payment Program.** Lowers the interest rate for loans to Medicare providers made under the Accelerated and Advance Payment Program, reduces the per-claim recoupment percentage, and extends the period before repayment begins.

- **Imputed Rural Floor.** Requires the Centers for Medicare and Medicaid Services (CMS) to re-establish a rural floor for the Medicare hospital area wage index for hospitals in all-urban states.

Medicaid

- **FMAP increase.** Increases Federal Medical Assistance Percentage (FMAP) payments to state Medicaid programs by a total of 14 percentage points starting July 1, 2020 through June 30, 2021.

- **Temporary extension of 100 percent FMAP to Indian health providers.** Clarifies that services received through urban Indian providers are matched at 100 percent FMAP through June 30, 2021.

- **Increase DSH payments.** Temporarily increases Medicaid disproportionate share hospital (DSH) allotments by 2.5 percent.

- **Extension of existing section 1115 demonstration projects.** Authorizes states with section 1115 demonstration projects that expire on or before February 28, 2021 to extend them through December 31, 2021.

- **MFAR.** Prevents the Secretary from finalizing the Medicaid Fiscal Accountability Regulation (MFAR) until the end of the COVID-19 public health emergency.

- **Home and Community Based Services.** Increases the federal payments to state Medicaid programs by an additional 10 percentage points starting July 1, 2020 through June 30, 2021 to support activities that strengthen their home- and community-based services (HCBS) benefit.

- **Non-emergency medical transportation.** Codifies the regulatory requirement that state Medicaid programs cover non-emergency medical transportation (NEMT).
Telemedicine

- Expansion of Rural Health Care Program of FCC in Response to COVID-19. Authorizes $2 billion for a temporary expansion of the FCC’s Rural Health Care Program (RHCP) to partially subsidize their health care providers’ broadband service. Authorized subsidies would flow to all nonprofit and public hospitals, not just rural ones. Increases the broadband subsidy rate from 65 percent to 85 percent. Also uses authorized funds to expand eligibility of the RHCP to ensure mobile and temporary health care delivery sites are eligible and temporarily modifies administrative processes to ensure funding is delivered expediently.

- Ensure communications accessibility for residents of skilled nursing facilities during the COVID-19 emergency period. Ensures skilled nursing facilities provide a means for residents to conduct “televisitation” with loved ones while in-person visits are not possible during the COVID-19 public health emergency.

Skilled Nursing Facilities

- Skilled nursing facility incentive payments. Provides incentives for nursing facilities to create COVID-19-specific facilities and includes safety and quality protections for patients.

- Nursing home strike teams. Directs HHS to allocate money to the states to create strike teams to help facilities manage outbreaks when they occur.

- Infection control in nursing facilities. Requires the Secretary of HHS to provide additional assistance to facilities struggling with infection control through Medicare's Quality Improvement Organizations (QIOs).

- Nursing homes demographic data reporting. Requires HHS to collect data on COVID-19 in nursing homes and to publicly report demographic data on COVID-19 cases in nursing homes on Nursing Home Compare.

Healthcare Education and Workforce

- Public Health Workforce Loan Repayment Program. Establishes a loan repayment program to enhance recruitment and retention of state, local, tribal, and territorial public health department workforce.

- Expanding capacity for health outcomes. Authorizes grants to expand the use of technology-enabled collaborative learning and capacity building models to respond to COVID-19. To be eligible for funding under this section, health entities must have experience providing services to rural, frontier, health professional shortage areas, medically underserved populations, or Indian Tribes.

- Additional funding for Medical Reserve Corps. Authorizes additional funding for the Medical Reserve Corps (MRC), which is a national network of local volunteer units who engage their local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.

- Grants for schools of medicine in diverse and underserved areas. Authorizes grants to schools of medicine in rural, underserved, or Minority-Serving Institutions. Grants can be used to build new schools of medicine and expand, enhance, modernize, support existing schools of medicine. Funding priority is given to rural, underserved, or
Minority-Serving Institutions, including Historically Black Colleges and Universities, Hispanic-Serving Institutions, Tribal Colleges and Universities, and Asian American and Pacific Islander Serving Institutions.

- **GAO study on public health workforce.** Requires the GAO to conduct a study to investigate gaps, challenges, and recommended steps for improvement associated with the Federal, State, local, Tribal, and territorial public health workforce.

**NIH on COVID Effects**

- **Longitudinal study on the impact of COVID-19 on recovered patients.** Directs NIH to carry out a study on the short- and long-term impact of COVID-19 on infected and recovered individuals.
- **Research on the mental health impact of COVID–19.** Directs the NIH’s National Institute of Mental Health to support research on the mental health consequences of COVID-19, including the impact on health care providers.

**Access to Care**

- **Medicare**
  - **Coverage of treatments for COVID–19 at no cost sharing under the Medicare Advantage program.** Establishes zero cost-sharing (out-of-pocket costs) for COVID-19 treatment under Medicare Advantage during the COVID-19 public health emergency.
  - **Hold Medicare beneficiaries harmless for specified COVID-19 treatment services furnished under Part A or Part B of the Medicare program.** Establishes zero cost-sharing (out-of-pocket costs) for COVID-19 treatment under Medicare Parts A and B during the COVID-19 public health emergency.
  - **Create a new special enrollment period for Medicare.** Creates a new special enrollment period for Medicare Parts A & B eligible individuals during the COVID-19 public health emergency.
  - **Coverage under Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug plans (MA-PDPs) without cost-sharing.** Requires coverage under Medicare PDPs and MA-PDPs without cost-sharing or Utilization Management Requirements for drugs intended to treat COVID-19 during the COVID-19 public health emergency.

- **Medicaid and Uninsured**
  - **No Medicaid cost-sharing for COVID-19 treatment.** Eliminates cost sharing for Medicaid beneficiaries for COVID-19 treatment and vaccines during the COVID-19 public health emergency.
  - **Covering the uninsured for COVID-19 treatment.** Ensures that uninsured individuals whom states opt to cover through the new Medicaid eligibility pathway will be able to receive treatment for COVID-19 without cost-sharing during the COVID-19 public health emergency.
  - **Allowance for medical assistance under Medicaid for inmates during 30-day period preceding release.** Provides Medicaid eligibility to incarcerated individuals 30 days prior to their release.
- **Private Coverage**
  - **Special enrollment period through exchanges; federal exchange outreach and Activities.** Provides for a two-month open enrollment period to allow individuals who are uninsured, for whatever reason, to enroll in coverage. Currently, Americans can only enroll in an Affordable Care Act (ACA) plan during open enrollment period, or because of a qualifying life event if they were previously insured.
  - **Ensuring access to COVID-19 prevention care.** Requires the Advisory Committee on Immunization Practices (ACIP) to meet and provide a recommendation no later than 15 days after a COVID-19 vaccine is listed under the Public Health Service Act.
  - **Coverage of COVID-19 related treatment at no cost sharing.** Requires coverage of items and services related to the treatment of COVID-19 in group and individual market health plans and waives cost-sharing requirements for consumers during the COVID-19 public health emergency.
  - **Requiring prescription drug refill notifications during emergencies.** Requires group and individual market health plans to notify consumers if their plan permits advance prescription drug refills during an emergency period.
  - **Improvement of certain notifications provided to qualified beneficiaries by group health plans in the case of qualifying events.** Improves the information provided to workers who lose their employer-sponsored coverage so that they are aware of all affordable coverage options, including coverage available under the ACA.
  - **Earlier coverage of testing for COVID-19.** Makes the requirement for free coverage of COVID-19 testing retroactive to the beginning of the COVID-19 public health emergency.
  - **Preserving health benefits for workers.** Provides approximately nine months of full premium subsidies to allow workers to maintain their employer-sponsored coverage if they are eligible for COBRA due to a layoff or reduction in hours, and for workers who have been furloughed but are still active in their employer-sponsored plan.
  - **Coverage of COVID-19 related treatment at no cost sharing for Federal Civilians.** Establishes zero cost-sharing (out-of-pocket costs) for COVID-19 treatment under the Federal Employee Health Benefit Program.

- **TRICARE and VA**
  - **Coverage of COVID-19 related treatment at no cost sharing in TRICARE.** Establishes zero cost-sharing (out-of-pocket costs) for COVID-19 treatment under TRICARE.
  - **Coverage of COVID-19 related treatment at no cost sharing for Veterans.** Establishes zero cost-sharing (out-of-pocket costs) for COVID-19 treatment under the Department of Veterans Affairs health plans.
  - **Streamlining payment of emergency care claims to community providers during the COVID-19 public health emergency.** Grants prior authorization for any emergency care sought by veterans at non-VA hospitals, including COVID-19-related diagnosis and treatment, and ambulance transportation.
Mental Health/SUD

Substance Abuse and Mental Health Services Administration: $3 billion to increase mental health support during this challenging time, to support substance abuse treatment, and to offer increased outreach, including:

- $1.5 billion for the Substance Abuse Prevention and Treatment Block Grant;
- $1 billion for the Community Mental Health Services Block Grant
- $100 million for services to homeless individuals
- $100 million for Project AWARE to identify students and connect them with mental health services
- $10 million for the National Child Traumatic Stress Network
- $265 million for emergency response grants to address immediate behavioral health needs as a result of COVID-19
- $25 million for the Suicide Lifeline and Disaster Distress Helpline
- Not less $150 million for tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes across a variety of programs.
- Emergency mental health and substance use training and technical assistance center. Establishes a technical assistance center at the Substance Abuse and Mental Health Services Administration (SAMHSA) that will support public or nonprofit entities and public health professionals seeking to establish or expand access to mental health and substance use services associated with the COVID-19 public health emergency.

Supply Chain Improvements

- Medical Supplies Response Coordinator. Requires the President to appoint a Medical Supplies Response Coordinator that would serve as the point of contact for the health care system, supply chain officials, and states on medical supplies, including personal protective equipment (PPE), medical devices, drugs, and vaccines. The appointee is required to have health care training and an understanding of medical supply chain logistics.

Pharma

- Reporting requirement for drug manufacturers. Requires drug manufacturers to report foreign drug manufacturing sites and to report quarterly on the volume of drugs manufactured.
- Recommendations to encourage domestic manufacturing of critical drugs. Requires National Academies of Science, Engineering, and Medicine (NASEM) to conduct a symposium of experts to discuss recommendations to encourage domestic manufacturing of critical drugs and devices of greatest priority to providing health care.
- Failure to notify of a permanent discontinuance or an interruption. Provides FDA with an enforcement mechanism to require timely notifications related to a permanent discontinuance or interruption in the manufacturing of certain drugs and the reasons for such discontinuance or interruption, as required under current law.
- Failure to develop risk management plan. Provides FDA with an enforcement mechanism to require drug manufacturers to develop a risk management plan, as required under current law.
• **National Centers of Excellence in Continuous Pharmaceutical Manufacturing.**
  Directs FDA to designate National Centers of Excellence in Continuous Pharmaceutical Manufacturing (NCEs). NCEs will work with FDA and industry to craft a national framework for the implementation of continuous manufacturing of drugs, including supporting additional research and development of this technology, workforce development, standardization, and collaborating with manufacturers to support adoption of continuous manufacturing of drugs.

**Vaccines**

• **Vaccine manufacturing and administration capacity.** Requires the Secretary of HHS to award contracts, grants, cooperative agreements, and enter into other transactions, as appropriate, to expand and enhance manufacturing capacity of vaccines and vaccine candidates to prevent the spread of COVID-19. It also requires a report on the vaccine supply necessary to stop the spread of COVID-19, the manufacturing capacity to produce vaccines, activities conducted to enhance such capacity, and plans for continued support of vaccine manufacturing and administration.

**Devices**

• **Information to be included in list of devices determined to be in shortage.** Clarifies that the medical device identifier or national product code shall be included with any required shortage reporting, which will help facilitate identification of acceptable alternatives.

• **Device shelf life dates.** Provides authority to the Food and Drug Administration (FDA) to require manufacturers to provide the agency with information pertinent to an extension of medical device shelf life dates in cases of shortages or material slowdowns during public health emergencies.

• **Authority to destroy counterfeit devices.** Extends FDA’s administrative destruction authority to medical devices. This would allow FDA to destroy certain imported medical devices, such as counterfeit tests or masks, in instances where FDA believes such medical devices are adulterated, misbranded, or unapproved and may pose a threat to the public health as they currently do for drugs.

**Strategic National Stockpile Improvements**

• **Equipment maintenance.** Requires the Secretary of HHS to ensure that contents of the Strategic National Stockpile (SNS) are in good working order and, as necessary, conduct maintenance on contents of the stockpile.

• **Supply chain flexibility manufacturing pilot.** Improves the SNS domestic product availability by enhancing medical supply chain elasticity, improving the domestic production of PPE, and partnering with industry to refresh and replenish existing stocks of medical supplies.

• **Reimbursable transfers from Strategic National Stockpile.** Improves the SNS financial security by allowing the SNS to sell products to other Federal departments or agencies within six months of product expiration.

• **Strategic National Stockpile action reporting.** Requires the SNS to report to Congress about every request made to the SNS during the COVID-19 public health emergency and details regarding the outcomes of every request.
• **Improved, transparent processes for the Strategic National Stockpile.** Requires the SNS to develop improved, transparent processes for SNS requests and identify clear plans for future communication between the SNS and States.

• **GAO study on the feasibility and benefits of a Strategic National Stockpile user fee agreement.** Requires the Government Accountability Office (GAO) to conduct a study to investigate the public sector procurement process for single source materials from the SNS.

**Testing and Testing Infrastructure Improvements**

• **COVID–19 testing strategy.** Requires the Secretary of HHS to update the COVID-19 strategic testing plan required under the Paycheck Protection Program and Health Care Enhancement Act no later than June 15, 2020. The updated plan shall:
  o Identify the types and levels of testing necessary to monitor and contribute to the control of COVID-19 and inform any reduction in social distancing.
  o Include specific plans and benchmarks with clear timelines, regarding how to ensure sufficient availability and allocation of all testing materials and supplies, sufficient laboratory and personnel capacity, and specific guidelines to ensure adequate testing in vulnerable populations and populations at increased risk related to COVID-19, including older individuals, and rural and other underserved areas.
  o Involve testing capacity in non-health care settings in order to help expand testing availability and make testing more accessible, as well as how to implement the testing strategy in a manner that will help to reduce disparities with respect to COVID-19.

• **Centralized testing information website.** Requires the Secretary of HHS to establish and maintain a public, searchable website that lists all in vitro diagnostic and serological tests used in the United States to analyze critical specimens for detection of COVID-19 or antibodies for the virus. The website will also list relevant information about the tests, including the sensitivity and specificity of the test and the numbers of tests available.

• **Manufacturer reporting of test distribution.** Requires in vitro diagnostic test manufacturers to notify the Secretary of HHS with information regarding distribution of tests, including quantity distributed.

• **State testing report.** Requires States authorizing the development of in vitro COVID-19 tests to provide the Secretary of HHS with a weekly report identifying all authorized laboratories and providing relevant information about the laboratories, including their testing capacity, listing of all authorized tests, and providing relevant information about such tests.

• **State listing of testing sites.** Requires States receiving funding through this Act to establish a public, searchable webpage identifying and providing contact information for COVID-19 testing sites within the State.

• **Reporting of COVID–19 testing results.** Requires every laboratory that performs or analyzes COVID-19 tests to submit daily reports to the Secretary of HHS. This information would then be required to be made available to the public in a searchable, electronic format.
• **GAO report on diagnostic tests.** Requires a GAO report on the response of laboratories, diagnostic test manufacturers, state, local, Tribal, and territorial governments, and relevant federal agencies, related to the COVID-19 epidemic with respect to the development, regulatory evaluation, and deployment of diagnostic tests.

**Public Health Data and Infrastructure**

• **Public health data system transformation.** Requires HHS to expand, enhance, and improve *public health data systems used by the Centers for Disease Control and Prevention (CDC).* This includes grants to State, local, Tribal, or territorial public health departments for the modernization of public health data systems in order to:
  - assist public health departments in assessing current data infrastructure capabilities and gaps;
  - improve secure public health data collection, transmission, exchange, maintenance, and analysis;
  - enhance the interoperability of public health data systems; to support and train related personnel;
  - support earlier disease and health condition detection; and
  - develop and disseminate related information and improved electronic case reporting.

• **Pilot program to improve laboratory infrastructure.** Authorizes grants to states and localities to improve, renovate, or modernize clinical laboratory infrastructure in order to help increase COVID-19 testing capacities.

• **Core public health infrastructure for State, local, and Tribal health departments.** Authorizes $6 billion for public health departments to expand workforce, improve laboratory systems, health information systems, disease surveillance, and contact tracing capacity to account for the unprecedented spread of COVID-19.

• **Core public health infrastructure and activities for CDC.** Authorizes $1 billion for CDC to expand and improve their core public health infrastructure and activities in order to address unmet and emerging public health needs.

**COVID-19 National Testing and Contact Tracing (CONTACT) Initiative: $75 billion**

• **National system for COVID-19 testing, contact tracing, surveillance, containment and mitigation.** Requires CDC to coordinate with State, local, Tribal, and territorial health departments to establish and implement a national evidence-based system for testing, contact tracing, surveillance, containment and mitigation of COVID-19, including offering guidance on voluntary isolation and quarantine of positive COVID-19 cases.

• **COVID-19 testing, contact tracing, surveillance, containment, and mitigation grants.** Requires CDC to award grants to State, local, Tribal, and territorial health departments to carry out evidence-based systems for testing, contact tracing, surveillance, containment and mitigation of COVID-19.
  - CDC shall provide a minimum level of funding for all State, local, Tribal, and territorial health departments, and prioritize additional funding for areas with high number of cases of COVID-19, areas with a surge in cases of COVID-19, and those proposing to serve high numbers of low-income and uninsured populations, including underserved populations.
- Funding shall be used to leverage or modernize existing systems, identify specific strategies for testing in medically underserved populations, establish culturally competent and multilingual strategies for contact tracing, hire and compensate a locally-sourced workforce, and support individuals who have been infected with or exposed to COVID-19.

- **COVID-19 testing, contact tracing, surveillance, containment, and mitigation guidance.** Requires CDC and other relevant agencies to issue guidance, provide technical assistance and information, and establish clear communication pathways for State, local, Tribal, and territorial health departments for the establishment and maintenance of their testing, contact tracing, surveillance, containment, and mitigation systems.

- **Awareness Campaign.** Provides grants for a multilingual and culturally appropriate national, science-based COVID-19 campaign, to include information related to availability of testing and promote the importance of contact tracing. Grants can be issued to public or private entities, including faith-based organizations.

- **Research and Development.** Requires CDC, in collaboration with the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), FDA, and CMS to support research and development on efficient and effective testing, contact tracing, and surveillance strategies.

- **Grants to the Local Workforce Development System and Community-based Organizations.** Authorizes grants to support the recruitment, placement, and training of individuals in COVID-19 contact tracing and related positions, with a focus on recruiting from impacted local communities and building a culturally competent workforce. This section also provides for transitional assistance and support post-employment.

### Demographic Data and Supply Reporting Related to COVID–19

- **COVID-19 Reporting Portal.** Requires the Secretary of HHS, within 15 days, to establish and maintain an online portal for health entities to track and transmit data regarding their inventory and capacity related to COVID-19. This portal will enable hospitals and long-term care facilities to report their inventory related to PPE, medical supplies (like available ventilators and beds), and facility capacity (like number of needed doctors, nurses, and lab personnel). Facilities should be required to report these figures on a biweekly basis.

- **Regular CDC reporting on COVID demographic data.** Requires the Secretary of HHS, no later than 14 days following enactment, to update and make publicly available the report on the collection of data on race, ethnicity, age, sex, and gender of individuals diagnosed with COVID-19. The updated report must include how the Secretary will provide technical assistance to State, local, and territorial health departments to improve collection and reporting of demographic data, and requirements for the report to be updated every 30 days and to identify any barriers for such health departments in collecting such data.

- **Modernization of Inequities Data**
  - Modernization of federal health inequities data. Authorizes funding to AHRQ, CDC, CMS, FDA, the Office of the National Coordinator for Health Information
Technology, and NIH to modernize their data collection methods and infrastructure in order to increase data collection related health inequities.

- **Modernization of state and local health inequities data.** Authorizes grants to state, local, and territorial health departments in order to support the modernization of data collection methods and infrastructure in order to increase data collection related health inequities.

- **Tribal funding to research health inequities, including COVID-19.** Requires the Indian Health Service (IHS), in coordination with CDC and NIH, to conduct research and field studies to improve understanding of tribal health inequities.

- **CDC field studies pertaining to specific health inequities.** Requires CDC to establish field studies to better understand health inequities that are not currently tracked by the Secretary of HHS.

- **Additional reporting to Congress on the race and ethnicity rates of COVID-19 testing, hospitalization, and mortalities.** Requires the Secretary of HHS, by August 1, to expand on the report to Congress as required by the Paycheck Protection Program and Health Care Enhancement Act describing the testing, positive diagnoses, hospitalization, intensive care admissions, mortality rates, associated with COVID–19, disaggregated by race, ethnicity, age, sex, and gender. The Secretary of HHS must also now propose evidence-based response strategies to reduce disparities related to COVID-19 and a final report in 2024.

**Food, Nutrition and Related Programs**

- **Emergency Costs for Child Nutrition Programs During COVID-19 Pandemic.** This section provides emergency funding to the school meal and child adult care food programs to help cover operational costs during COVID-19.

- **Supplemental Nutrition Assistance Program (SNAP) Provides $10 billion** to support anticipated increases in participation and to cover program cost increases related to flexibilities provided to SNAP by the Families First Coronavirus Response Act.

- **Special Supplemental Nutrition Program for Women Infants & Children (WIC)** Provides an additional $1.1 billion to provide access to nutritious foods to low-income pregnant women or mothers with young children who lose their jobs or are laid off due to the COVID-19 emergency.

- **The Emergency Food Assistance Program (TEFAP)** Includes $150 million to help local food banks meet increased demand for low-income Americans during the emergency. Including funding provided by the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), TEFAP has received a total of $1 billion.

- **Child Nutrition Programs** Includes $3 billion in additional funding to provide emergency financial relief to school meal providers and USDA’s Child and Adult Care Food Program.

**Social Services**

**Administration for Children and Families:** $10.1 billion to provide supportive and social services for families and children through programs including:

- $7 billion for Child Care and Development Block Grants;
- $1.5 billion for the Low-Income Home Energy Assistance Program (LIHEAP);
• $1.5 billion to support paying water bills for low income families
  $50 million for Family Violence Prevention and Services;
• $20 million for Child Abuse Prevention and Treatment Act (CAPTA) State Grants; and
• $20 million for Community Based-Child Abuse Prevention Grants.

**Administration for Community Living:** $100 million to provide direct services such as home delivered and prepackaged meals, and supportive services for seniors and disabled individuals, and their caregivers.