ALSTON & BIRD

COVID-19 Provider Relief Fund – Distributions to Date and Upcoming Disbursements

The Provider Relief Fund (PRF) was established through the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* (enacted March 27, 2020). Pursuant to the CARES Act, $100 billion in grants will be disbursed from the Office of the Assistant Secretary for Preparedness and Response (ASPR) Public Health and Social Services Emergency Fund (PHSSEF). The *Paycheck Protection Program and Health Care Enhancement Act* (PPPHCEA) (enacted April 24, 2020), added $75 billion to the PRF, totaling $175 billion. General information on the PRF, including eligibility requirements, Terms and Conditions, and relevant attestation and data submission portals, is available here.

Overall, the distributions fall under the following categories as of June 17, 2020 (updates from the prior version are highlighted)[1]:

1. **Targeted Allocations**
    a. **Treatment for Uninsured** – portion of remaining $62.414 billion plus $1 billion[2]
    b. **COVID-19 High Impact Areas (Round 2)** – $10 billion total
    c. **Medicaid-Only** – $15 billion
    d. **Safety Net Hospitals** – $10.213 billion[3]
    e. ***COVID-19 High Impact Areas (Round 1)*** *– $12 billion total*[4]
    f. ***Rural Providers*** *– $10 billion*
    g. ***Indian Health Service (IHS)*** *– $500 million*
    h. ***Skilled Nursing Facilities (SNFs)*** *– $4.873 billion*
2. ***General Distribution to Medicare Facilities and Providers*** *– $50 billion total*[5]

On May 14, CDC released a dataset that lists each health care provider and amount of payments received and attested to from the PRF (General, High Impact, Rural Provider, and SNF distributions, totaling $76.873 billion). Through May 13, $34.09 billion has been attested to. Through May 29, $45.874 billion has been attested to. Through June 1, $48.518 billion has been attested to. Through June 3, $49.875 billion has been attested to. Through June 8, $52.611 billion has been attested to.

---

[1] Funding opportunities that are no longer available are italicized. These distributions are grayed out in the table below.
[2] The *Families First Coronavirus Response Act* (enacted March 18, 2020) appropriated $1 billion for COVID-19 testing and related visits for the uninsured. While this is separate from the PRF, HRSA, the administering agency, will distribute these funds through the same HRSA portal (here) and methodology.
[3] The Safety Net Hospital distribution state-by-state breakdown is available here (***last updated 6/11/2020***).
[4] Initially $10 billion, HHS added $2 billion that will be distributed to the eligible hospitals based on Medicare and Medicaid disproportionate share and uncompensated care payments.
[5] HHS released a CARES Act PRF Distribution Summary, available here.

Last Updated: June 17, 2020

On May 29, CDC released a dataset that lists the health care entities that have agreed to the Terms and Conditions and received reimbursement for COVID-19 testing and/or COVID-19 treatment for uninsured individuals. As of May 26, 2020, $2.08 million has been paid for treatment and $2.04 million has been paid for testing. Through June 2, $81.963 million has been paid for treatment and $10.839 million has been paid for testing.

For additional details, please view the HHS Provider Relief Fund FAQs (here) (***last updated through 6/16/2020***).

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
Uninsured (portion of remaining $62.414 billion plus $1 billion)	Every health care provider who has tested, provided testing-related visits, and provided treatment for uninsured COVID-19 patients after February 4	• Based on requested claims reimbursement • Will be reimbursed at Medicare rates (subject to available funding) • Payment disbursed via direct deposit • Qualifying COVID-19 testing and treatment services (when COVID-19 is the primary diagnosis) include: ○ Specimen collection, diagnostic, and antibody testing ○ Testing-related visits in the following settings: office, urgent care, emergency room, or via telehealth ○ Treatment[6] ○ FDA-approved vaccine (when available)	• Providers can register for this program **on April 27** (here) and begin submitting claims in May • The provider portal is available (here) • HRSA released FAQs (here) • Providers will have to: ○ Enroll as a participant ○ Check patient eligibility and benefits ○ Submit patient information ○ Submit claims ○ Attest to Terms and Conditions for Testing and Treatment

[6] According to HRSA, treatment is defined as: office visit (including via telehealth); emergency room; inpatient; outpatient/observation; skilled nursing facility: long-term acute care; acute inpatient rehab; home health; durable medical equipment (e.g., oxygen, ventilator); emergency ambulance transportation (any type); non-emergent patient transfers via ambulance; and FDA approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay.
Services **not** covered include: services not covered by traditional Medicare; any treatment without a COVID-19 primary diagnosis (except for pregnancy when the COVID-19 code may be listed as secondary); hospice services; outpatient prescription drugs.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
COVID-19 High Impact Areas – Round 2 ($10 billion)	• Hospitals with COVID-19-positive inpatient admissions between 1/1/2020 through 6/10/2020 (specific details TBD) • Recipients of the first High Impact Area distribution are still eligible for this new distribution	• TBD (will be determined after HHS fully analyzes collective data submitted by hospitals) • Funding from the prior round will be taken into account when making payments	• Upload COVID-19-positive inpatient admissions using the CSV document via the TeleTracking portal • **Information must be submitted by 9PM ET on 6/15/2020** • Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)
Medicaid-Only Providers ($15 billion)[7]	Eligible providers must meet all of the following requirements: • Must not have received payment from the General Distribution • Must have: ○ Directly billed Medicaid for healthcare-related services from 1/1/2018-12/31/2019; or ○ Own (on the application date) an included subsidiary that has billed Medicaid for healthcare-related services from 1/1/2018-12/31/2019 • Must have: ○ Filed a federal income tax return for 2017, 2018, or 2019; or	• Providers may receive a payment equal to at least 2% of (gross revenues X percent of gross revenues from patient care) for 2017, 2018, or 2019 (as selected by the applicant) • Payments will be made to the Filing/Organizational TIN and not directly to subsidiary TINs • Payments will be disbursed on a rolling basis as information is validated (HHS may seek additional information from providers as necessary) • The majority of payments will be made through bank transfer and may require some providers to set up ACH accounts	• **The deadline to apply is 7/20/2020** • The application portal is available here • Application instructions are available here • The application form is available here • Applicants must provide: ○ Most recent federal income tax return (2017, 2018, or 2019) or a written statement explaining why it is exempt ○ Employer's Quarterly Federal Tax Return on IRS Form 941 for Q1 2020, Employer's Annual Federal Unemployment (FUTA) Tax Return on IRS Form 940, or a statement explaining why the applicant is not required to submit either form (e.g., no employees) ○ FTE Worksheet (provided by HHS)

[7] HHS is holding two webinars on the application process, one on June 23 at 2PM ET and one on June 25 at 2PM ET.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
	○ Be exempt from filing a federal income tax return and have no beneficial owner that is required to file a federal income tax return (e.g., state-owned hospital or healthcare clinic) • Must have provided patient care after 1/31/2020 • Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries • If an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee		○ If required by Field 15, the applicant's Gross Revenue Worksheet (provided by HHS) • If a provider does not have a federal tax form to submit, it must upload a statement explaining why and submit the most recent audited financial statements • Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)
Safety Net Hospitals ($10.213 billion)	Acute care facilities and children's hospitals must meet each of the following criteria, respectively. The information was extracted from CMS Hospital Cost Reports and Provider Specific Files. Acute care facilities:	• Payments will begin the week of 6/8 • Eligible hospitals will receive a minimum of $5 million and a maximum of $50 million Methodology: • HHS determined each acute care facility's bed-weighted DPP score by performing the following calculation:	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

<table>
<tr><th>Distribution</th><th>Eligible Entities</th><th>Distribution Methodology</th><th>Required Provider Action</th></tr>
<tr>
<td></td>
<td>
• A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater;
• Annual uncompensated care per bed of at least $25,000;[8] and
• Net Operating Margin of 3% or less

Children's hospitals:
• Medicare DPP of 20.2% or greater; and
• Net Operating Margin of 3.0% or less

Hospitals no longer operational or without 2018 cost report information are not eligible
</td>
<td>
Acute Care DPP Score X Number of facility beds
• HHS determined each children's hospital's bed-weighted Medicaid Only Days score by performing a similar calculation: Medicaid Only Ratio X Number of facility beds
• Each acute care facility or children's hospital's individual score was expressed as a percentage of the total sum of bed-weighted facility DPP scores and Medicaid Only ratios
• This percentage was multiplied by $10 billion

Definitions and Data Sources – Medicare Cost Report:
<table>
<tr><td>DPP</td><td>W/S E Part A Line 32, Column 1</td></tr>
<tr><td>UCC</td><td>W/S S-10, Line 30, Column 1</td></tr>
<tr><td>Hospital Beds</td><td>W/S S-3 Part I, Line 14, Column 2</td></tr>
<tr><td>Net Patient Revenue</td><td>W/S G-3, Line 3, Column 1</td></tr>
<tr><td>Total Other Income</td><td>W/S G-3, Line 25, Column 1</td></tr>
<tr><td>Total Revenue</td><td>Net Patient Revenue + Total Other Income</td></tr>
</table>
</td>
<td></td>
</tr>
</table>

[8] For example, a hospital with 100 beds would need to provide $2,500,000 in Uncompensated Care in a year to meet this requirement.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
		Net Income: W/S G-3, Line 29, Column 1 Profit Margin: Net Income / Total Revenue Medicaid-Only Days: Worksheet S-3, Part I, Column 7, Line 14, plus Line 2 and Line 32, minus the sum of Lines 5 and 6 Total Days: Worksheet S-3, Part I, Column 8, Line 14; plus Line 32; minus the sum of Lines 5 and 6; plus employee discount days reported on Line 30 Medicaid-Only Ratio: Medicaid Only Days / Total Days	
General Distribution ($50 billion)	In general • Medicare facilities and providers impacted by COVID-19	In general • All payments are made to the billing organization according to its Taxpayer ID Number (TIN)	In general • Within 90[9] days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here) • Providers who have already received payments will need to upload their most recent IRS tax filings as well as estimates of lost revenues for March and April 2020 at the "Revenue Information Portal" (here)

[9] HHS extended the deadline from 30 days to 90 days on May 22.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
			• See the Revenue Information Portal User Guide and General Distribution FAQs for additional information
	$30 billion • All facilities and providers that received Medicare FFS reimbursements in 2019	$30 billion • Based on share of total Medicare FFS payments in 2019 • Distributed via automatic payments or mail ($26 billion distributed on April 10, $4 billion on April 17)	$30 billion • Acknowledge receipt of payment and attest to Terms and Conditions (specific to the $30 billion) (here) • This step must be completed before moving on to the Revenue Information Portal
	$20 billion • It appears that all facilities and providers eligible to receive the initial $30 billion will be eligible for this distribution	$20 billion • Allocated to ensure entire $50 billion General Distribution is allocated proportional to recipients' share of 2018 net patient revenue[10] • Some providers (those with adequate cost report data) will receive automatic payments • Payments started to go out on April 24 and will continue on a weekly, rolling basis based on provider submissions and data validation	$20 billion • All providers must submit revenue information, acknowledge receipt of payment, and attest to Terms and Conditions (specific to the $20 billion) • Eligible providers may request payments and providers who received automatic payments must submit the required information through the Revenue Information Portal (here) • Revenue information must be submitted by June 3, 2020 to be eligible for this payment
COVID-19 High Impact Areas –	• 395 hospitals that provided inpatient care for 100 or	• $10 billion distributed to the eligible entities based on a fixed amount per COVID-19 inpatient admission[11]	• Within 90 days of receipt of payment, acknowledge receipt and attest to

[10] HHS indicated that moving to an overall revenue model should address concerns from providers in high Medicare Advantage penetration areas. The expected distribution methodology is as follows: (Gross Receipts or Sales/$2.5 Trillion) X $50 Billion = Expected Combined General Distribution

[11] Hospitals were required to submit information via an authentication portal before 3pm ET on April 25. Hospitals were required to provide: TIN; National Provider Identifier; the total number of ICU beds as of April 10, and the total number of COVID-19 positive admissions from January 1 to April 10.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
Round 1 ($12 billion)	more COVID-19 patients through April 10, 2020	○ 395 hospitals received $76,975 per COVID-19 admission • $2 billion distributed to these hospitals in proportion of each facility's share of Medicare Disproportionate Share funding • Distributions began May 7[12]	Terms and Conditions at the "Attestation Portal" (here) • Providers should update their capacity and COVID-19 census data and can use the "same method they used previously" to update this information[13]
Rural Providers ($10 billion)	• Rural acute care general hospitals • Critical Access Hospitals (CAHs) • Rural Health Clinics (RHCs) • Rural Community Health Centers (CHCs) • Must be located in in a rural location defined as: ○ All non-Metro counties ○ All Census Tracts within a Metro county that have a Rural-Urban Commuting Area (RUCA) code of 4-10	*Per Hospital Allocation = Graduated Base Payment + (1.97% X Operating Expenses)* • Graduated base payment (minimum $1 million) = (50% of first $2 million of expenses) + (40% of next $2 million) + (30% of next $2 million) + (20% of next $2 million) + (10% of next $2 million) • Provider-based RHCs (i.e., connected with rural hospitals) have allocation included with the hospital's allocation *Per Independent RHC Allocation = $100k + (3.6% X Operating Expenses)* *Per FQHC Allocation = $100k per site* Payments were multiplied by a modifier to ensure the total value of distributions equaled $10 billion.[14]	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

[12] A state and county breakdown is available here.
[13] In an FAQ modified 5/19, HHS states: *Providers should update their capacity and COVID-19 census data to ensure that HHS can make timely payments in the event that the provider becomes a high-impact provider. Providers can continue to update their information through the same method they used previously.*
[14] See the payment allocation methodology for more details.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
	○ 132 large area Census Tracts with RUCA codes 2 or 3 ○ Independent RHCs – Census Bureau definition ○ CAHs – all designated CAHs • Facilities were identified from the December 2019 CMS Provider of Services file	Distributions began May 6 based on the facility's physical address as reported to CMS and HRSA, regardless of affiliation with urban-area organizations[15]	
IHS ($500 million)	• IHS and tribal hospitals, clinics, and urban health centers • Allocations determined based on December 2019 Provider of Service Files, 1/17/2020 HCRIS, and Worksheet B PART I COL 26 of the cost report	• Payments distributed via ACH through Optum Bank to central billing office based on billing organization's TIN • **IHS and tribal hospitals:** $2.81 million base payment plus 3% of total operating expenses • **IHS and tribal clinics and programs:** $187,000 base payment plus 5% of estimated service population multiplied by average cost per user • **IHS urban programs:** $181,000 base payment plus 6% of estimated service population multiplied by average cost per user • **Estimated operating cost per person:** $3,943 (based on actual IHS spending per user from 2019 IHS Expenditures	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

[15] A state-by-state breakdown is available here (pages 5-6).

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
		Per Capita and Other Federal Health Care Expenditures Per Capita report)	
SNFs ($4.873 billion)	• All certified SNFs with six or more certified beds are eligible (more than 13,000 SNFs) • State-by-state breakdown available here	• $50,000 fixed distribution per SNF; $2,500 distribution per bed • Distributions ranged from $65,000 to $3,255,500; average distribution of approximately $315,600 per SNF • Payments distributed electronically based on banking account information associated with billing TIN (or paper check)	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

* * *