Holland & Knight

Public Health and Social Services Emergency Fund (Provider Relief Fund)
June 9, 2020

On April 22, 2020, HHS announced a new distribution methodology for the $100 billion Provider Relief Fund appropriated as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Additionally, the Paycheck Protection Program and Health Care Enhancement Act (H.R. 266), among other things, provided $75 billion in addition to the $100 billion provided under the CARES Act.

The chart below reflects actual and anticipated distributions from the $175 billion in currently appropriated funding. As of June 9, there is $97.6 billion remaining in the provider relief fund, and there has still been no distribution made to predominantly Medicaid providers.

	Funding	**Comments**
Hospitals and Physicians and Other Providers (General Fund; $50B)	First wave: $30B based on proportion of Medicare FFS Part A and B. Second wave: $20B was designed so that the two waves in combination would equal 2% of net patient service revenues for a hospital, or 2% of operating revenue for a non-hospital non-profit provider, or 2% of gross revenue for a non-hospital for-profit provider.	Some non-hospital providers who bill Medicare still have not received their second wave. If first-wave exceeded 2% net patient service revenue, no additional amount provided. Providers who don't bill Medicare (e.g., pediatricians, dentists) receive nothing from this distribution.
COVID-19 Hotspot Hospitals ($12B)	Distributed on May 7 only to hospitals that had more than 100 COVID-19 admissions as of April 10. $10 billion allocated based on approximately $77,000 per case and $2 billion based on the measurement of disproportionate share and uncompensated care.	This went to 395 hospitals. COVID-19 patients have incredibly long lengths of stay.
Reimbursement for the Uninsured (Unspecified Amount)	On April 27, HHS launched a COVID-19 Uninsured Program Portal. Providers treating uninsured COVID-19 patients on or after February 4, 2020, can register and submit claims to be reimbursed at Medicare rates. The portal may be found here.	There is a wide range of estimates as to how much funding will be consumed for these claims. KFF estimated somewhere between $10-$40 billion.
Rural Providers ($10B)	Distributed on May 6 to rural hospitals, RHCs, and CHCs. Hospitals and RHCs received a minimum base payment plus a percent of their annual expenses. This expense-based method accounted for operating costs and lost revenue incurred by rural hospitals for both inpatient and outpatient services. The base payment	Approximately 4,000 providers received funds. Here is the breakdown by state.

	accounted for RHCs with no reported Medicare claims, such as pediatric RHCs, and CHCs lacking expense data, by ensuring that all clinical, non-hospital sites received a minimum level of support no less than $100,000, with additional payment based on operating expenses.	
Indian Health Services Facilities ($500M)	Distributed on May 29 to Indian Health Service programs -- tribal hospitals, clinics, and urban health centers. Each hospital receives $2.8 million + 3% of total operating expenses. Clinics and urban programs receive a base amount + an average cost metric.	Approximately 300 IHS programs
Skilled Nursing Facilities ($4.9B)	Distributed on May 22nd -- $50,000 per facility +$2,500 per bed.	Approximately 13,000 certified SNFS.
EXPECTED: Non-Medicare Providers	Non-Medicare billers who didn't receive anything from any of the above tranches (e.g., pediatrician or dentist) have still seen nothing.	This was initially envisioned as a Medicaid based distribution; HHS has been struggling with State Medicaid program data pulls.
EXPECTED: Broader Medicaid Distribution	HHS has said this may be up to $20 Billion for various Medicaid-reliant/high uninsured providers.	See above re: data challenges.
EXPECTED: 2nd Hot Spot Tranche	The April 10 cutoff for COVID admissions did not capture facilities that did not have 100 admissions by that date or had significant new admissions after that date.	HHS is querying hospitals.
EXPECTED: 2nd General Distribution	The funding Congress provided was for "revenue losses and response costs." HHS would like to reconcile all of the above distributions with this underlying legal requirement. HHS's current thinking is to open a portal to collect loss and cost data uniformly. HHS learned that using revenue was not a simple process due to changes in ownership, mergers, problems with Taxpayer Identification Numbers (TINs), and related changes. Currently, there is little desire internally to use the percent of the revenue process again.	Some provider groups have concerns that this will take time and have recommended more straightforward metrics that would more quickly move money. It is foreseeable that providers who don't do well in the prior distributions could ultimately end up with a smaller percentage of their losses being covered when funds are exhausted. It is anticipated that, ultimately, HHS will audit total distributions to a provider as

		compared to losses/costs, and any overpayments will be recouped.

***Remaining Funds: If you assume future distributions as follows: $20B Medicaid; $10B additional hotspot; and $10B uninsured, then there is approximately $57.6B left.**

Important Resources:

- Provider Relief Fund FAQs
- CARES Act Provider Relief Fund Data
- Terms & Conditions specific to each distribution stream.
- Centers for Disease Control and Prevention (CDC) dataset of the healthcare entities who have agreed to the Terms and Conditions and received claims reimbursement for testing or treatment of uninsured COVID-19 patients.

Background:

Use of Funds: According to the CARES Act statute, payments from the Provider Relief Fund may be used to prevent, prepare for, and respond to COVID-19 domestically or internationally, for the reimbursement of necessary expenses, or for lost revenues that are attributable to COVID-19. HHS announced that it also would use a portion of the funding to reimburse providers for the costs of delivering COVID-19 care for the uninsured.

A June 2 FAQ clarifies that:

Pursuant to the Terms and Conditions, Provider Relief Fund payments should be used for one of two broad categories (1) healthcare-related expenses attributable to COVID-19, or (2) to cover costs that lost revenues attributable to the coronavirus would have covered and that are attributable to COVID-19.

"Healthcare-related expenses attributable to coronavirus" covers a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:

- Supplies used to provide health care services for possible or actual COVID-19 patients
- Equipment used to provide health care services for possible or actual COVID-19 patients
- Workforce training
- Developing and staffing emergency operation centers
- Reporting COVID-19 test results to federal, state, or local governments
- Building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide health care services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated
- Acquiring additional resources, including facilities, equipment, supplies, health care practices, staffing, and technology, to expand or preserve care delivery.

"Lost revenues that are attributable to coronavirus" means any revenue that a health care provider lost due to coronavirus (i.e., revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care). Providers can use Provider Relief Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. For example, the funds may be used for:

  - Employee or contractor payroll
  - Employee health insurance
  - Rent or mortgage payments
  - Equipment lease payments
  - Electronic health record licensing fees

Attestation: According to HHS, providers who accept funds must sign an attestation agreeing to the terms and conditions—specific to the distribution type—within 90 days of payment. There is a great deal of ambiguity around several parameters of the terms and conditions, and stakeholders are seeking clarity from HHS through additional guidance. HHS and the Office of Inspector General (OIG) will engage in significant auditing and anti-fraud work to ensure that funds are appropriately spent.

Audits/Reporting: All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the Terms and Conditions and specified in future directions issued by the Secretary. The specific reporting obligations imposed on providers receiving $150,000 or more from any Act primarily making appropriations for the coronavirus response and related activities, which is a statutory requirement, begins for the calendar quarter ending June 30.

The Secretary may request additional reports prior to that date. HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at https://www.hhs.gov/provider-relief/index.html.