

May 8, 2020

Details on HHS' Distribution of Emergency Funds to Hospitals with High COVID-19 Admissions and Rural Providers

The Department of Health and Human Services (HHS) this week distributed \$22 billion from the Public Health and Social Services Emergency Fund to hospitals with high numbers of COVID-19 admissions, as well as rural hospitals and clinics. Specifically, \$12 billion was allocated to hospitals with at least 100 COVID-19 inpatient admissions through April 10, 2020. Another \$10 billion went to all critical access hospitals (CAHs), in addition to general acute-care hospitals, rural health clinics (RHCs) and community health centers (CHCs) located in rural areas. HHS has [announced](#) new details on the distribution methodologies, which are described below. Also included in the Special Bulletin, is a Terms and Conditions comparison chart for the first three tranches of payments from the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund.

High-COVID-19 Admission Methodology

Last month, HHS requested that hospitals submit information on their number of COVID-19 inpatient admissions through April 10. HHS used this information to identify those hospitals with at least 100 admissions, who accounted for over 70% of the total number of admissions reported. HHS distributed \$10 billion to these facilities, in the form of \$76,975 per admission. HHS noted that this payment is not intended to reimburse the specific cost of these admissions. Rather, the number of COVID-19 admissions was being used as a proxy for the extent to which each facility experienced lost revenue and increased expenses associated with directly treating a substantial number of COVID-19 inpatient admissions.

In addition, HHS distributed \$2 billion in additional funding to the hospitals identified above in proportion to each facility's share of Medicare Disproportionate Share funding.

Rural Distribution Methodology

Definition of Rural

HHS utilizes the following definition of rural to identify general acute-care hospitals for these targeted funds:

- All non-metro counties;
- All census tracts within a metro county that have a Rural-Urban Commuting Area (RUCA) code of 4-10;

- 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.

All CAHs received funds from this distribution regardless of their geographic location. In addition, all independent RHCs are eligible per the authorizing statute criterion of being located outside of an Urbanized Area as defined by the U.S. Census Bureau.

Payments to CAHs and Rural Hospitals

The per-hospital allocation of the rural distribution is based on total operating expenses of the hospital, calculated by the formula below:

Graduated Base payment + 1.97%¹ of the hospital's operating expenses

The base payment [increases as operating expenses increase](#), with a maximum base payment of \$3 million. The most recent, publicly available Medicare hospital cost reports were used to identify operating costs. Rural hospitals with no operating expense data receive a base payment of \$1 million.

The calculated amount for each hospital was then multiplied by 1.03253231 to determine the actual payment in order to ensure the total rural distribution equaled \$10 billion.

Payments to RHCs and CHCs in Rural Areas

- **Provider-based RHCs:** Payments for provider-based RHCs are part of the payment to the respective CAH or rural hospital – these provider-based RHCs do not receive separate payments. Operating expenses of these RHCs are considered as part of the total operating expenses of the hospital.
- **Independent RHCs:** Independent RHCs receive approximately \$100,000 as a base payment for each site and an add-on that is approximately 3.6% of the RHC's total operating expenses.
- **CHCs:** CHCs receive a flat payment rate, approximately \$100,000. Only those CHC sites located in a rural area receive payment from this distribution.

Terms and Conditions Comparison Chart

Attached is a chart comparing the Terms and Conditions for the first three tranches of payments from the CARES Provider Relief Fund – the \$30 billion general distribution, the \$20 billion general distribution and the \$10 billion targeted distribution to rural providers. While most of the Terms and Conditions are consistent, there are a few key difference flagged in the attached chart.

Further Questions

If you have questions, please contact AHA at 800-424-4301.

¹ Per the HHS website, the actual value used in the formula was 1.967728428%.

Coronavirus Aid, Relief, and Economics Security Act (“CARES Act”) Provider Relief Fund: Terms and Conditions

Category	Terms and Conditions	\$30 Billion General Distribution (April 10 to April 17, 2020)	\$20 Billion General Distribution (beginning April 24, 2020) ¹	\$10 Billion Targeted Distribution for Rural Providers (May 1, 2020)
Eligibility ²	Recipient certifies that it: <ul style="list-style-type: none"> • provides or provided after January 21, 2020 diagnoses, testing, or care for individuals with possible³ or actual cases of COVID-19; • is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; • is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and • does not currently have Medicare billing privileges revoked. 	✓	✓	✓
	Recipient certifies that it billed Medicare in 2019	✓	✓	✗
	Recipient attests to its acceptance of the Terms and Conditions. Recipient is deemed to have accepted the Terms and Conditions if it receives a payment from the Provider Relief Fund and retains that payment for at least 45 days without contacting the Department of Health and Human Services (HHS) regarding remittance of such funds. ⁴	✓	✓	✓

¹ The initial \$30 Billion General Distribution was distributed in proportion to providers’ Medicare fee for service payments in 2019. However, the remaining \$20 Billion General Distribution augments providers’ initial allocation so that the entire \$50 billion General Distribution is allocated proportionately to providers’ share of 2018 net patient revenue. See Dep’t of Health & Human Servs., *CARES Act Provider Relief Fund*, <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html#collapseOne> (last visited May 5, 2020).

² Providers that have not received funding from the \$30 Billion General Distribution as of 5:00 PM EST on Friday, April 24th are not eligible to receive additional funding from the \$20 Billion General Distribution by submitting an application through the Provider Relief Fund Application Portal. However, such providers may still be eligible for Provider Relief Fund payments through other mechanisms, including the Targeted Distributions being made from the Fund (e.g., the allocation for COVID-19 high impact areas (\$10 billion); the allocation for rural providers (\$10 billion); the allocation for Indian Health Service (\$400 million); and the allocation for treatment of the uninsured (amount not specified)). See Dep’t of Health & Human Servs., *CARES Act Provider Relief Fund General Distribution FAQs 1*, <https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf> (last visited May 7, 2020) [hereinafter “HHS, CARES ACT Provider Relief Fund General Distribution FAQs (last visited May 7, 2020)”].

³ The Department of Health and Human Services (HHS) “broadly views every patient as a possible case of COVID-19.” *Id.*

⁴ The initially published Terms and Conditions provide for deemed acceptance after 30 days. However, HHS has extended the deadline for attestations from 30 days to 45 days, per a press release published online. See Dep’t of Health & Human Servs., *HHS Extends Deadline for Attestation, Acceptance of Terms and Conditions for Provider Relief Fund Payments to 45 Days* (May 7, 2020), <https://www.hhs.gov/about/news/2020/05/07/hhs-extends-deadline-attestation-acceptance-terms-and-conditions-provider-relief-fund-payments-45-days.html>. Providers may return their General Distribution payment through the Attestation Portal. See HHS, *CARES ACT Provider Relief Fund General Distribution FAQs* (last visited May 7, 2020), *supra* note 2, at 4.

Purpose and use of Provider Relief Fund Payment (“Payment”)	Payment must be used only to prevent, prepare for, and respond to coronavirus, and for “health care related expenses or lost revenues that are attributable to coronavirus.” If a Recipient “does not anticipate having COVID-related lost revenues or increased expenses equal to or in excess of the relief payments received, they should return the funds.” ⁵	✓	✓	✓
	Payment cannot be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.	✓	✓	✓
	For all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient. ^{6,7} If a Recipient has independently contracted with another provider (e.g., anesthesiologist or laboratory), the prohibition on balance billing applies equally to any independently contracted provider that has also attested to receiving a payment from the Provider Relief Fund. ⁸	✓	✓	✓
Reporting and record keeping requirements	The Recipient must submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients. ⁹	✓	✓	✓
	The Recipient must submit general revenue data for calendar year 2018 to the Secretary when applying to receive a Payment, or within 30 days of having received a Payment.	✗	✓	✗
	If the Recipient is an entity and is receiving more than \$150,000 total in funds under the CARES Act, the Coronavirus Preparedness and Response Supplemental Appropriations Act (Pub. L. 116-123), the Families First Coronavirus Response Act (Pub. L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, the Recipient must submit a report to the Secretary and the Pandemic Response Accountability Committee within 10 days after the end of each calendar quarter. The report must contain: <ul style="list-style-type: none"> the total amount of funds received from HHS under one of the foregoing enumerated Acts; 	✓	✓	✓

⁵ HHS, CARES ACT Provider Relief Fund General Distribution FAQs (last visited May 7, 2020), *supra* note 2, at 2.

⁶ HHS has clarified that the Terms and Conditions do not require the Recipient to attest to a general ban on balance billing for all patients and/or all care (because “HHS broadly views every patient as a possible case of COVID-19”). The ban on balance billing applies to “all care for a presumptive or actual case of COVID-19.” HHS defines a “presumptive case of COVID-19” as “a case where a patient’s medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.” HHS, CARES ACT Provider Relief Fund General Distribution FAQs (last visited May 7, 2020), *supra* note 2, at 3.

⁷ HHS guidance affirms that providers “can bill the patient’s insurer any amount” when providing out-of-network care to an insured, presumptive or actual COVID-19 patient, as the Terms and Conditions “do not impose any limitations on the ability of a provider to submit a claim for payment to the patient’s insurance company.” However, patients cannot be charged more than the in-network rate they would have otherwise incurred for any out-of-pocket expenses. While HHS acknowledges that providers “must know the in-network rates to be able to comply” with this statutory requirement, its guidance on this point suggests that, if a provider is unable to know the insurer’s in-network rates (e.g., because the insurer will not disclose them), the provider can ensure its compliance with the statute’s balance billing prohibition only if it does not charge any amount to the patient. *See id.* at 4 (“Most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer’s prevailing in-network rate. But if the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.”).

⁸ *Id.*

⁹ Guidance has not yet been issued with respect to such reports.

	<ul style="list-style-type: none"> the amount of funds received that were expended or obligated for reach project or activity; a detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.¹⁰ 			
	Recipient certifies that all information it provides as part of its application for the Payment, as well as all information and reports relating to the Payment that it provides in the future at the request of the Secretary or Inspector General, are true, accurate and complete, to the best of its knowledge.	✓	✓	✓
	The Recipient shall maintain appropriate records and cost documentation including, as applicable, documentation described in 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.	✓	✓	✓
Enforcement	Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of some or all of the payment. ¹¹	✓	✓	✓
Consent to disclosure	Recipient consents to the Department of Health and Human Services publicly disclosing the Payment that Recipient may receive from the Relief Fund and acknowledges that such disclosure may allow some third parties to estimate the Recipient’s gross receipts or sales, program service revenue, or other equivalent information.	✗	✓	✓
Statutory restrictions	<p>Funds cannot be used in any of the following ways:</p> <ul style="list-style-type: none"> to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II; to advocate or promote gun control; for lobbying Congress or any State or local legislative body; for abortions; for embryo research; to promote the legalization of any drug or other Schedule I controlled substance; 	✓	✓	✓

¹⁰ HHS indicates that the statutorily required reporting obligations on such providers begins for the calendar quarter ending June 30 and that the Secretary “may request additional reports prior to that date.” In addition, “HHS will provide guidance in the future about the type of documentation we expect recipients to submit.” HHS, *CARES ACT Provider Relief Fund General Distribution FAQs* (last visited May 7, 2020), *supra* note 2, at 4.

¹¹ *Id.* at 3. The guidance also states that “HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES ACT to ensure that Federal dollars are used appropriately.” *Id.*

<ul style="list-style-type: none"> • to disseminate deliberately false or misleading information; • for pornography; • for the Association of Community Organizations for Reform Now (ACORN) or any of its affiliates or subsidiaries; • to purchase sterile needles or syringes for the hypodermic injection of any illegal drug; • for propaganda; • in contravention of the Privacy Act (section 552a of title 5, United States Code) and its implementing regulations; • for confidentiality agreements that restrict employees or contractors from lawfully reporting health care fraud, waste, or abuse; • for nondisclosure agreements; • for unpaid federal tax liability; • for contracts or agreements with any corporation that was convicted of a federal criminal felony violation within the preceding 24 months; • by the National Institutes of Health, or any other Federal agency, or recipient of Federal funds on any project that entails the capture or procurement of chimpanzees obtained from the wild; 			
<p>Payments are subject to:</p> <ul style="list-style-type: none"> • the requirements of section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104); • the whistleblower protections at 48 CFR section 3.908; and • compliance with the participant protection requirement of the Office of Human Research Protection (OHRP) of for any research activities involving human subjects. 	✓	✓	✓