## CARES Act Provider Relief Fund
### Basis, Formulas, and What the Funds Are To Be Used For

<table>
<thead>
<tr>
<th>Specific Tranche/Distribution</th>
<th>Basis and Formula(s)</th>
<th>Funds To Be Used For…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Distribution</strong></td>
<td><strong>$50 Billion</strong></td>
<td><strong>To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.</strong></td>
</tr>
</tbody>
</table>
| **$30 Billion Tranche**       | **Basis:** Automatic based on provider’s share of Medicare fee-for-service reimbursements in 2019  
**Formula to Determine Allocation:**  
Payment Allocation per Provider =  
(Provider’s 2019 Medicare Fee-For-Service Payments / $453 Billion) x $30 Billion | **“Health care related expenses attributable to coronavirus” is a “broad term that may cover a range of items and services,” including:**  
i. supplies used to provide healthcare services for possible or actual COVID-19 patients;  
ii. equipment used to provide healthcare services for possible or actual COVID-19 patients;  
iii. workforce training;  
iv. developing and staffing emergency operation centers;  
v. reporting COVID-19 test results to federal, state, or local governments;  
vii. acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery. |
| **CARES Act Provider Relief Fund Payment Attestation Portal** | **Basis:** Based on CMS cost reports or incurred losses  
**Formula to Determine Allocation:**  
Payment Allocation per Provider =  
((Most Recent Tax Year Annual Gross Receipts x $50 Billion) / $2.5 Trillion) – Initial General Distribution Payment to Provider | **“Lost revenues that are attributable to coronavirus” means any revenue that a healthcare provider lost due to coronavirus.**  
i. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care.  
ii. 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.”  
iii. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover: (i) Employee or contractor payroll; (ii) Employee health insurance; (iii) Rent or mortgage payments; (iv) Equipment lease payments; and/or (v) Electronic health record licensing fees. |
| **$20 Billion Tranche**       | **Basis:** Distributed April 10 ($26 billion) and April 17 ($4 billion)  
**CARES Act Provider Relief Fund Payment Attestation Portal** | **90-day attestation period from date payment is received  
If payment is retained without the recipient attesting or contacting HHS regarding remittance of the funds within 90 days, the recipient is deemed to have accepted the Terms and Conditions (Ts&Cs)** |
| **General Distribution**      | **Payment Attestation Portal** | **90-day attestation period from date payment is received  
If payment is retained without the recipient attesting or contacting HHS regarding remittance of the funds within 90 days, the recipient is deemed to have accepted the Terms and Conditions (Ts&Cs)** |
| **$50 Billion**               | **General Distribution Portal** | **Documentation to apply for additional funds under this tranche was due to this portal by June 3, 2020  
Each provider that receives payment from this tranche must attest to Ts&Cs within 90 days using the CARES Act Attestation Portal** |

- Distributions ($9.1 billion) and portal access began April 24  
- After April 24, $10.9 billion became available and as of May 27, $2.5 billion has been distributed
## Targeted Allocations

**High-Impact Distribution**

- **Fund**: $12 billion
- **Basis**: Hospitals with 100 or more COVID-19 admissions between January 1 and April 10 based on information submitted to HHS
- **Formulas to Determine Allocation**:
  - $10 Billion to 395 High-Impact Hospitals
    - Payment Allocation per Hospital = Number of COVID-19 Admissions (must be more than 100) x $76,975
  - $2 Billion to 395 High-Impact Hospitals with Medicare Disproportionate Share
    - Additional Payment Allocation per Hospital = $2 Billion x (Hospital Medicare Funding / Sum of Medicare Funding for 395 Hospitals)
- **Rural Distribution**
  - **Fund**: $10 billion
  - **Basis**: Rural providers, including rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural areas, based on operating expenses and type of facility
  - **Formulas to Determine Allocation**:
    - Rural Acute Care Hospitals and Critical Access Hospitals
      - Payment Allocation per Hospital = Graduated Base Payment* + 1.97% of the Hospital’s Operating Expenses
      - *Base payments ranged between $1 million to $3 million
    - Independent Rural Health Clinics (RHC)
      - Payment Allocation per Independent RHC = $100,000 per clinic site + 3.6% of the RHC’s Operating Expenses
    - Community Health Centers (CHC)
      - Payment Allocation per CHC = $100,000 per rural clinic site

## Funds To Be Used For...

- **High-Impact Distribution**
  - To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms
- **Rural Distribution**
  - To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms
- **Skilled Nursing Facilities Distribution**
  - To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms
- **Indian Health Service Distribution**
  - To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms

### Table: Targeted Allocations

<table>
<thead>
<tr>
<th>Specific Distribution</th>
<th>Basis</th>
<th>Formula to Determine Allocation</th>
<th>Funds To Be Used For...</th>
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</thead>
</table>
| High-Impact Distribution | Hospitals with 100 or more COVID-19 admissions between January 1 and April 10 based on information submitted to HHS | $10 Billion to 395 High-Impact Hospitals
  - Payment Allocation per Hospital = Number of COVID-19 Admissions (must be more than 100) x $76,975
  - $2 Billion to 395 High-Impact Hospitals with Medicare Disproportionate Share
    - Additional Payment Allocation per Hospital = $2 Billion x (Hospital Medicare Funding / Sum of Medicare Funding for 395 Hospitals) | To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms |
| Rural Distribution | Rural providers, including rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural areas, based on operating expenses and type of facility | Rural Acute Care Hospitals and Critical Access Hospitals
  - Payment Allocation per Hospital = Graduated Base Payment* + 1.97% of the Hospital’s Operating Expenses
  - *Base payments ranged between $1 million to $3 million
  - Independent Rural Health Clinics (RHC)
    - Payment Allocation per Independent RHC = $100,000 per clinic site + 3.6% of the RHC’s Operating Expenses
  - Community Health Centers (CHC)
    - Payment Allocation per CHC = $100,000 per rural clinic site | To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms |
| Skilled Nursing Facilities Distribution | Skilled nursing facilities with 6 or more certified beds, based on both a fixed basis and variable basis | Payment Allocation per Facility = Fixed Payment of $50,000 + $2,500 per Certified Bed (facilities must have 6 or more certified beds) | To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms |
| Indian Health Service Distribution | Tribal Hospitals, Clinics, and Urban Health Centers, based on operating expenses | IHS and Tribal Hospitals
  - Payment Allocation per Hospital = $2.81 Million + 3% of Total Operating Expenses
  - IHS and Tribal Clinics and Programs
    - Payment Allocation per Clinic/Program = $187,000 + 5% (Estimated Service Population x Average Cost per User)
  - IHS Urban Programs
    - Payment Allocation per Program = $181,000 + 6% (Estimated Service Population x Average Cost per User) | To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.
  - See above for definition of terms |
<table>
<thead>
<tr>
<th><strong>Medicaid and Children’s Health Insurance Program (CHIP) Distribution</strong></th>
<th><strong>Basis:</strong> Eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Distribution. Payment is dependent on provider submission of patient revenue information. <strong>Formula(s) to Determine Allocation:</strong> HHS has not yet determined the final allocation formula. <strong>Note:</strong> The payment to each provider will be at least 2 percent of reported gross revenue from patient care; the final amount each provider receives will be determined after the data is submitted, including information about the number of Medicaid patients providers serve.</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 billion (approximately)</td>
<td>To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.</td>
</tr>
<tr>
<td>Distribution announced on June 9, with corresponding portal set to launch on June 10</td>
<td>- “Medicaid Targeted Distribution Provider Relief Fund Payment Portal”</td>
</tr>
<tr>
<td>“Medicaid Targeted Distribution Provider Relief Fund Payment Portal”</td>
<td>- Providers must submit documentation reflecting annual patient revenue information to receive a distribution equal to at least 2 percent of reported gross revenues from patient care.</td>
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<tr>
<td>Documentation is due by July 3</td>
<td>90 days for attestation</td>
</tr>
<tr>
<td><strong>Safety Net Hospital Distribution</strong></td>
<td><strong>Basis:</strong> Eligible safety net hospitals serving a disproportionate number of Medicaid patients or providing large amounts of uncompensated care. Qualifying hospitals will have:</td>
</tr>
<tr>
<td>$10 billion</td>
<td>- A Medicare Disproportionate Payment Percentage (DPP) of 20.2 percent or greater;</td>
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<tr>
<td>Distribution set to begin the week of June 9</td>
<td>- Average Uncompensated Care per bed of $25,000 or more;</td>
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<tr>
<td>90 days for attestation</td>
<td>- Profitability of 3 percent or less, as reported to CMS in its most recently filed Cost Report.</td>
</tr>
<tr>
<td><strong>Formula to Determine Allocation:</strong></td>
<td>HHS has not yet determined the final allocation formula.</td>
</tr>
<tr>
<td>To be used for preventing, preparing for, and responding to coronavirus. Shall only be used to reimburse for health care related expenses or lost revenues that are attributable to COVID-19.</td>
<td><strong>Note:</strong> HHS’s press release states that each recipient will receive a minimum distribution of $5 million and a maximum distribution of $50 million.</td>
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<tr>
<td><strong>Uninsured Patients – Treatment</strong></td>
<td><strong>Basis:</strong> Health care providers who have provided treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, who have registered and submitted claims for reimbursement through the <a href="#">Uninsured Portal</a>. <strong>Claims for reimbursement will be priced as follows:</strong></td>
</tr>
<tr>
<td>Undetermined Amount</td>
<td>- Reimbursement will be based on current year Medicare fee schedule rates except where otherwise noted.</td>
</tr>
<tr>
<td></td>
<td>- Reimbursement will be based on incurred date of service.</td>
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<td></td>
<td>- Publication of new codes and updates to existing codes will be made in accordance with CMS.</td>
</tr>
<tr>
<td></td>
<td>- For any new codes where a CMS published rate does not exist, claims will be held until CMS publishes corresponding reimbursement information.</td>
</tr>
<tr>
<td></td>
<td>To be used for the provision of care or treatment related to positive diagnoses of COVID-19 for individuals who do not have any health care coverage at the time the services were provided. As such, items or services where the dates of service occurred on February 4, 2020 or later, and all such items and services for which payment is sought were medically necessary for care or treatment of COVID-19 and/or its complications.</td>
</tr>
<tr>
<td>Fund</td>
<td>Amount</td>
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<tr>
<td>-----------------------------</td>
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</tbody>
</table>
| Uninsured Patients – Testing (FFCRA) | $1 billion | Health care providers who have conducted COVID-19 testing for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, who have registered and submitted claims for reimbursement through the Uninsured Portal. | ▪ Reimbursement will be based on current year Medicare fee schedule rates except where otherwise noted.  
▪ Reimbursement will be based on incurred date of service.  
▪ Publication of new codes and updates to existing codes will be made in accordance with CMS.  
▪ For any new codes where a CMS published rate does not exist, claims will be held until CMS publishes corresponding reimbursement information. | “COVID-19 Testing” means:  
An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test, that:  
▪ Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360e, 360e, 360bb–3);  
▪ The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;  
▪ Is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or  
▪ Other test that the Secretary determines appropriate in guidance. |
| Rural Health Clinic Testing | $225 million | For over 4,500 RHCs across the country to support COVID-19 testing efforts and expand access to testing in rural communities. Distributed to each RHC with a unique, active CCN listed in either the CMS Provider of Service file (March 2020) or the CMS Survey & Certification's Quality, Certification and Oversight Reports (QCOR) before May 7, 2020. | Flat amount of $50,000 each | “COVID-19 testing” means:  
▪ See above under “Uninsured Patients – Testing” for the definition.  
▪ “COVID-19 related expenses” means:  
▪ Building or construction of temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID-19 testing;  
▪ Other activities to support COVID-19 testing, including planning for implementation of a COVID-19 testing program, procuring supplies to provide testing, training providers and staff on COVID-19 testing procedures, and reporting data to HHS on COVID-19 testing activities; or  
▪ Items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of COVID-19 Testing but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product. |
| Additional Distribution for Dentists | TBD | N/A | To be used for COVID-19 testing and COVID-19 related expenses. |