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

	Specific Tranche/Distribution	Basis and Formula(s)	Funds To Be Used For…
Phase 1 General Distribution $50 Billion	**$30 Billion Tranche** ▪ 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)	**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	**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.** "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; vi. building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and vii. acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery. "Lost revenues that are attributable to coronavirus" means any revenue that a healthcare provider lost due to coronavirus. ▪ This may include 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." ▪ 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. ▪ Providers "may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if [providers] have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between [the] budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year."
	$20 Billion Tranche ▪ 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 General Distribution Portal ▪ Documentation to apply for additional funds under this tranche was due to the 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	**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	

	Specific Distribution	Basis/Formula	Funds To Be Used For…
Phase 2 General Distribution $18 Billion	**Distribution for Medicaid, CHIP, Medicaid Managed Care, Dental, and some Medicare Providers, and Assisted Living Facilities** $18 billion Provider Relief Fund Application and Attestation Portal ▪ Providers must submit documentation reflecting annual patient revenue information to receive a payment ▪ Applications were due by September 13 90 days for attestation	**Basis**: Eligible providers include those that participate in state Medicaid/CHIP programs or Medicaid managed care plans; dental care providers; assisted living facilities; and certain Medicare providers, including those who had a change in ownership in 2019 or 2020 or missed Phase 1 General Distribution payment equal to 2% of their annual patient care revenue. Payment is dependent on provider submission of patient revenue information **Formula to Determine Allocation**: Payment Allocation per Provider = 2% (Revenues x Percent of Revenues from Patient Care)* **Most recent tax filings (CY 2017, 2018, or 2019)*	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
Targeted Distributions $50 Billion	**High-Impact Distribution** $12 billion (first round) ▪ Distributions began May 7 to 395 hospitals (based on admissions data between January 1 and April 10) $10 billion (second round) ▪ Distributions began July 20 to more than 1,000 hospitals (based on admissions data between January 1 and June 10) 90 days for attestation (using CARES Act Attestation Portal)	**First Round** **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) **Second Round** **Basis**: Hospitals with more than 161 COVID-19 admissions between January 1 and June 10 based on information submitted to HHS **Formula to Determine Allocation**: Payment Allocation per Hospital = Number of COVID-19 Admissions x $50,000 (HHS also took into account previous High Impact Area payments for those hospitals that received initial payments from this Targeted 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 $4.9 billion ▪ Distributions began May 22 to over 13,000 certified SNFs 90 days for attestation (using CARES Act Attestation Portal)	**Basis**: Skilled nursing facilities with 6 or more certified beds, based on both a fixed basis and variable basis **Formula to Determine Allocation**: 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
	Rural Distribution $10.3 billion (approx.) ▪ Distributions began May 6 to almost 4,000 rural health care providers $1.1 billion (approx.) ▪ Distributions began July 10 to close to 500 specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas 90 days for attestation (using CARES Act Attestation Portal)	**Basis**: Rural providers, including rural acute care general hospitals and Critical Access Hospitals, Rural Health Clinics, Community Health Centers located in rural areas, Sole Community Hospitals, Medicare Dependent Hospitals, and Rural Specialty Hospitals, based on operating expenses and type of facility **Formulas to Determine Allocation**: **1. 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* **2. Rural Health Clinics (RHC)** ▪ Payment Allocation per Independent RHC = $100,000 per clinic site + 3.6% of the RHC's Operating Expenses **3. Community Health Centers (CHC)** ▪ Payment Allocation per CHC = $100,000 per rural clinic site **4. Sole Community Hospitals, Medicare Dependent Hospitals, & Rural Referral Center Hospital in Small Metro Areas** ▪ Payment Allocation per Hospital = 1% of Operating Expenses* **Minimum payment of $100,000, a supplement of $50 for each rural inpatient day, and a maximum payment of $4.5 million* ▪ Note: HHS also provided a supplemental payment of $1,000,000 for 10 isolated urban hospitals that are 40 or more miles away from another hospital open to the public. **5. Small Metro Area Hospitals without a special Medicare designation** ▪ Payment allocation per Hospital = 1% of Operating Expenses* ** Minimum payment of $100,000 and a maximum of $2 million each* **6. Rural Specialty Hospitals** ▪ Payment Allocation per Hospital = Graduated Base Payment* + 1.97% of the Hospital's Operating Expenses* ** Minimum payment of $100,000 and a maximum of $4.5 million.*	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 $500 million ▪ Distributions began May 29 to approximately 300 IHS programs 90 days for attestation (using CARES Act Attestation Portal)	**Basis**: Tribal Hospitals, Clinics, and Urban Health Centers, based on operating expenses **Formulas to Determine Allocation**: 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
	Safety Net Hospital Distribution $10.3 billion (approx.) ▪ Distributions began June 9 to safety net hospitals $3 billion (approx.) ▪ Distributions began July 10 to acute care facilities only $1.4 billion (approx.) ▪ Distributions began August 14 to 80 free-standing children's hospitals 90 days for attestation (using CARES Act Attestation Portal)	**Acute Care Facilities and Children's Hospitals 1** **Basis**: Eligible safety net hospitals serving a disproportionate number of Medicaid patients or providing large amounts of uncompensated care. Eligibility for Acute Care Facilities: ▪ A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater; ▪ Average Uncompensated Care per bed of at least $25,000; and ▪ Profit Margin of 3.0% or less, as reported to CMS in its 2018 Cost Reports Eligibility for Children's Hospitals 1: ▪ A Medicaid-Only Ratio of 20.2% or greater; and ▪ Profit Margin of 3.0% or less, as reported to CMS in its 2018 Cost Reports **Formula to Determine Allocation**: Payment Allocation per Hospital = (Hospital's Facility Score* / Cumulative Facility Scores across All Safety Net Hospitals) x $10 Billion **Facility Score = Number of facility beds x DPP for acute care facility or number of facility beds x Medicaid-only ratio for a children's hospital* **Children's Hospitals 2** **Basis**: Qualifying free-standing children's hospitals, not affiliated with larger hospital systems, must either be an exempt hospital under the CMS inpatient prospective payment system (IPPS) or be a HRSA defined Children's Hospital Graduate Medical Education facility. Note: *HHS expects most non-free-standing children's hospitals should have received financial support from their parent hospital systems as a share of General Distributions payments from the Provider Relief Fund program.* **Formula to Determine Allocation**: Payment Allocation per Hospital = 2.5% of Net Revenue from Patient Care	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

	Nursing Home Infection Control Distribution $2.5 billion ▪ Distribution of $2.5 billion set to begin mid-August ▪ HHS has also announced the distribution of another $2 billion, which will be performance-based and is set to occur throughout the fall	**Basis**: Eligible SNFs, Medicare-certified long term care facilities, and state veterans' homes ("nursing homes") **Formula to Determine Allocation**: Payment Allocation per Facility = Fixed payment of $10,000 + $1,450 per bed (*facilities must have 6 or more certified beds*)	**To be used to reimburse costs associated with Infection Control Expenses.** "Infection Control Expenses" includes the following: ○ Costs associated with administering COVID-19 testing, which 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), 360c, 360e, 360bbb – 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. 360bbb – 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. ○ Reporting COVID-19 test results to local, state, or federal governments; ○ Hiring staff, whether employees or independent contractors, to provide patient care or administrative support; ○ Expenses incurred to improve infection control, including activities such as implementing infection control "mentorship" programs with subject matter experts or changes made to physical facilities; or ○ Providing additional services to residents, such as technology that permits residents to connect with their families if the families are not able to visit in person.

	Uninsured Patients – Treatment Undetermined Amount	**Basis**: 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 Uninsured Portal. **Claims for reimbursement will be priced as follows**: ▪ 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.	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 sough were medically necessary for care or treatment of COVID-19 and/or its complications.
	Uninsured Patients – Testing (FFCRA) $1 billion Note: The PPPHCE Act also appropriated $1 billion to reimburse providers for conducting COVID-19 testing for the uninsured.	**Basis**: 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. **Claims for reimbursement will be priced as follows**: ▪ 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.	**To be used for COVID-19 Testing and COVID-19 related expenses.** "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), 360c, 360e, 360bbb–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. 360bbb–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. "Testing-Related Items and Services" means: 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.

	Rural Health Clinic Testing $225 million Ts&Cs for this fund still state a recipient has only 45 days for attestation	**Basis**: 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. **Formula to Determine Allocation**: Flat amount of $50,000 each	**To be used for COVID-19 testing and COVID-19 related expenses.** "COVID-19 testing" ▪ 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.