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…
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 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	**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…
Medicaid Distribution $15 Billion (approx.)	**Medicaid & Children's Health Insurance Program (CHIP) Distribution** $15 billion (approximately) Enhanced Provider Relief Fund Payment Portal ▪ Providers must submit documentation reflecting annual patient revenue information to receive a payment ▪ Documentation is due by July 20 90 days for attestation	**Basis**: 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 **Formula(s) to Determine Allocation**: Payment Allocation per Provider = 2% (Gross Revenues x Percent of Gross Revenues from Patient Care)* **For CY 2017 or 2018 or 2019 as selected by applicant*	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 Allocations $50 Billion	**High-Impact Distribution** $12 billion ▪ Distribution began May 7 to 395 hospitals (based on admissions data between January 1 and April 10) Note: An additional distribution of $10 billion will be paid out to account for admissions through June 10 ▪ Providers needed to submit updated data to the TeleTracking portal by June 15 90 days for attestation (using CARES Act Attestation Portal)	**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) Note: HHS has not yet set the allocation methodology for the additional $10 billion distribution being paid out to account for admissions through June 10 but has stated it will take into account prior high-impact payments.	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 billion ▪ Distributions began May 6 to almost 4,000 rural providers $1 billion ▪ Distributions began July 10 to 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, 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 Note: HHS has not yet announced the formula(s) utilized for the additional $1 billion allocation. To date, they have stated in a press release that they expanded the existing payment formula to include certain special rural Medicare designation hospitals in urban areas as well as others who provide care in smaller non-rural communities—with payments ranging from $100,000 to $4,500,000 for rural designated providers and $100,000 to $2,000,000 for the other providers.	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
	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 **Formula 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 billion ▪ Distribution began June 9 $3 billion ▪ Distribution began June 10 ▪ This allocation was to safety net acute care facilities only 90 days for attestation	**Basis**: Eligible safety net hospitals serving a disproportionate number of Medicaid patients or providing large amounts of uncompensated care. Qualifying acute care facilities will have: ▪ A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater; ▪ Average Uncompensated Care per bed of at least $25,000; and ▪ Profitability of 3.0% or less, as reported to CMS in its 2018 Cost Reports. Qualified children's hospitals will have: ▪ A Medicaid-Only Ratio of 20.2% or greater; and ▪ Profitability of 3.0% or less, as reported to CMS in its 2018 Cost Reports. Using the CMS cost report, profitability was determined by calculating the sum of net patient revenue + total other income. The net income was then divided by the sum net patient revenue and total other income. **Formula to Determine Allocation**: Payment Allocation per Hospital = (Hospital's Facility Score* / Cumulative Facility Scores across All Safety Net Hospitals) x $10 Billion **Acute Care Facility Score = Number of facility beds x DPP Score* **Children's Hospital Score = Number of facility beds x Medicaid-Only Ratio* Note: Each recipient will receive a minimum distribution of $5 million and a maximum distribution of $50 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

	Dental Distribution Undetermined Amount ▪ Announced July 10 ▪ Dentists have until July 24 to apply for funding through the Enhanced Provider Relief Fund Payment Portal	**Basis**: Not yet announced. **Formula**: HHS stated that it "has not determined the methodology for the dental allocation at this time, but will share additional information in the future."	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
	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 PPPHCEA 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.