CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

CARES Act Provider Relief Fund

Updated January 20, 2022

Below is an overview of funding opportunities available to hospitals and health systems as part of the Provider Relief Fund, which was established by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and further funded by subsequent legislation. Under the CARES Act, $100 billion in total funds was made available to hospitals, health systems, and other providers. The Paycheck Protection Program and Health Care Enhancement and Consolidated Appropriations Acts increased the funds available by an additional $75 billion and $3 billion, for a total of $178 billion in the Provider Relief Fund. Additionally, similar to the Provider Relief Fund, the American Rescue Plan allocated $8.5 billion to rural providers to cover expenses and lost revenue related to COVID-19.

These are payments, not loans, and do not need to be repaid so long as the specific distribution terms and conditions are met. In addition, CHA has also prepared a federal funding infographic showing specific legislation, amount of funding allocated for health care providers, what the funding covers, and more.

Eligible Providers

The CARES Act defines eligible providers as public entities, Medicare- or Medicaid-enrolled suppliers and providers, and other nonprofit and for-profit entities specified by the Secretary of the Department of Health and Human Services (HHS).

Eligible COVID-19-Related Expenses

Expenses that are paid for with General and Targeted Provider Relief Fund payments must be used to prevent, prepare for, and respond to coronavirus, are unreimbursed by other sources and that other sources are not obligated to reimburse[1]. Recipients that received between $10,001 and $499,999 in aggregated Provider Relief Fund payments during each Payment Received Period are required to report on the use of Provider Relief Funds in two categories – general and administrative expenses, and health care-related expenses.

Recipients that received $500,000 or more in aggregated payments during each Payment Received Period are required to report on the use of Provider Relief Funds by expense-type sub-category within general and administrative and health care-related expenses. See Appendix I for a table of additional detail by sub-category.

Eligible Lost Revenue Related to COVID-19

Provider Relief Funds[2] not fully expended on health care-related expenses attributable to coronavirus may be

[1] Examples of other sources include payments from health insurance, other funds received from the Federal Emergency Management Agency, the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, and the Small Business Administration (SBA) and Department of Treasury's Paycheck Protection Program (PPP).

[2] Excluding SNF and Nursing Home Infection Control Distribution payments

applied to patient care lost revenues. Recipients may choose to apply payments toward lost revenues using one of three reporting options:

1) *Actual Revenue*: The difference between actual patient care revenues
2) *Budgeted Revenue*: The difference between budgeted[3] and actual patient care revenues
3) *Other Reasonable Method*[4]: Calculated by any reasonable method of estimating revenues

Reporting Requirements

A reporting entity must report when it has received over $10,000 in aggregated Provider Relief Fund payments during a single Payment Received Period. HHS has published a notice with additional details on reporting requirements, which includes the categories and definitions of data elements that recipients must submit for each reporting period. The reporting requirements apply for all distributions except the Rural Health Clinic Testing distributions which has separate reporting requirements. The reporting requirements also do not apply to reimbursement from the Health Resources and Services Administration (HRSA) Uninsured Program.

As shown in the table below, recipients have at least 12 months from the date they receive a payment to expend the funds.

Period	Payment Received Period	Deadline to Use Funds	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	June 30, 2021	July 1, 2021 to September 30, 2021*
Period 2	July 1, 2020 to December 31, 2020	December 31, 2021	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	June 30, 2022	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	December 31, 2022	January 1, 2023 to March 31, 2023

*HRSA provided an additional "grace period" for Period 1 that extended to November 30, 2021.

Once the deadline to use funds expires, recipients will have 90 days to report on their use of funds. Recipients must register for and report their use of funds via the Provider Relief Fund Reporting Portal. HHS provides supporting worksheets and additional resources to assist recipients with completion of reports. In addition, recipients who are using a portion of their funds for lost revenues are required to upload supporting documentation when reporting on their calculation of lost revenues. The documentation required is dependent upon which method of calculating lost revenues providers select. HHS has published a list of frequently asked questions that addresses questions related to reporting.

Distribution of Funds

As of January 2022, HHS has made four rounds of general distributions to providers and several targeted distributions. Each distribution has specific terms and conditions that providers were required to agree to when attesting to receipt of the funds.

General Distribution Funding

[3] Reporting entities may use budgeted revenues if the budget(s) and associated documents covering calendar year 2020 were established and approved on or before March 26, 2020.
[4] Recipients seeking to use an alternate methodology face an increased likelihood of an audit by HRSA.

Phase 1 General Distribution: HHS allocated $46 billion[5] in general funding proportional to providers' share of 2018 net patient revenue. HHS designed its allocation methodology to provide payments to Medicare fee-for-service providers based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April 2020.

On April 10, 2020, HHS distributed the first round of general allocation funding — $30 billion — to hospitals via direct grants based on the proportion of Medicare fee-for-service revenue received by the hospital in 2019. Automatic payments were distributed to providers via Optum Bank with "HHSPAYMENT" as the payment description or via paper checks.

A second round of $16 billion[6] in general allocation funding was announced on April 22, 2020. HHS distributed the additional $16 billion automatically — based on a provider's share of 2018 net patient revenue — as part of its $46 billion overall general allocation.

Phase 2 General Distribution: HHS distributed, based on application, $5.09 billion[7] in the Phase 2 General Distribution. Eligible providers include participants in state Medicaid/CHIP programs, Medicaid managed care plans, dentists, and certain Medicare providers, including those that missed the Phase 1 General Distribution payment equal to 2% of their total patient care revenue or had a change in ownership in 2019 or 2020. Assisted living facilities were also eligible to apply. The application process closed on October 4, 2020.

Phase 3 General Distribution: HHS allocated $24.5 billion[8] in general funding for the Phase 3 distribution. Funds were allocated based on providers' applications, which were due on November 6, 2020. The application process first allocated the Phase 3 payments to providers that had not received a payment of 2% of annual operating revenue and then to providers based on actual expenses and lost revenue attributed to COVID-19. Providers received the greater of up to 88% of their reported losses (both lost revenue and health care-related expenses attributable to coronavirus incurred during the first half of 2020) or 2% of annual revenue from patient care. Some applicants did not receive an additional payment, either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they already received funds that equal or exceed reimbursement of 88% of reported losses or 2% of revenue from patient care. Payments to approximately 97,400 qualifying providers began on December 16, 2020.

Phase 3 included a reconsideration process for providers who believed their payment was not calculated correctly. Providers are not able to use this process to submit an application if they missed a deadline or revise an application that was submitted incorrectly. Applications for the Phase 3 reconsideration process were due on November 12, 2021. HRSA is processing the requests that were received by reviewing providers' original submitted applications again based on the PRF Phase 3 Payment Methodology. Given the volume of requests received and the complexity of the reviews, HRSA anticipates that review of requests will occur over an extended period of time.

[5] As of November 21, 2021, $42.82 billion has been allocated.
[6] HHS initially allocated $20 billion in the second round of the Phase 1 General Distribution but subsequently reduced that amount.
[7] HHS initially projected and announced $18 billion in the Phase 2 General Distribution funding. This allocation was later revised as HHS received less than $18 billion in actual applications for funding.
[8] As of November 12, 2021, $21.36 billion has been distributed.

Phase 4 General Distribution[9]: HRSA allocated $17 billion to the Phase 4 general distribution. Eligibility for funding was based on providers' applications, which were due on October 26, 2021. The application process included both the Phase 4 funding and the American Rescue Plan rural distribution.

Approximately 75% of Phase 4 distribution was based on COVID-19-related expenses and decreased revenues from July 1, 2020, to March 31, 2021. HRSA reimbursed a higher percentage of losses and expenses for smaller providers, as illustrated in the table below.

Size	Annual Net Patient Care Revenues	Percentage of Change in Revenues and Expenses to be Paid
Small	Less than or equal to $10M	45%
Medium	Between $10M and $100M	25%
Large	Greater than or equal to $100M	20%

The remaining 25% of Phase 4 funding was distributed as "bonus" payments based on the amount and type of services provided to Medicare, Medicaid, or CHIP patients. The methodology used was similar to the American Rescue Plan Rural Distribution (discussed below). HRSA began releasing $9 billion Phase 4 funds in December 2021. The initial release went to the 75% of applications that HRSA determined were low risk. The remaining 25% of applications are undergoing an additional "risk mitigation review." HRSA intends to complete this review and distribute remaining funds during the first quarter of 2022.

The reconsideration window for ARP Rural and Phase 4 payments will open on February 1, 2022. Providers will be able to request reconsideration of their ARP Rural and/or Phase 4 payments. Details regarding the application process will be provided by HRSA on this website by February 1, 2022.

The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meets the payment's terms and conditions. The CARES Act Provider Relief Fund Payment Attestation Portal or the Provider Relief Fund Application and Attestation Portal guides providers through the attestation process to accept or reject the funds. Not returning the payment within 90 days of receipt will be viewed as acceptance of the terms and conditions. A provider must attest for each of the Provider Relief Fund distributions received. For assistance in using these portals, please call the CARES Act provider hotline at (866) 569-3522.

Targeted Allocations

HHS has also made the following targeted allocations:

- $20.7 billion for hospitals in COVID-19 high-impact areas[10]
- $11 billion for rural hospitals, rural health clinics (RHCs), specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas

[9] The ARP rural distribution is discussed below in the targeted allocations section.

[10] HRSA initially allocated $22 billion.

- $13.1 billion for safety net providers and $1.1 billion for children's hospitals
- $4.8 billion for skilled-nursing facilities, $4.65 billion for the Nursing Home Infection Control Distribution
- $520 million for the Indian Health Service, and an allocation for treatment of the uninsured
- $7.5 billion in American Rescue Plan for rural providers

Additional information on each targeted distribution follows:

- **COVID-19 High-Impact Areas:** On May 1, 2020, HHS announced an initial allocation to 395 hospitals that provided inpatient care for 100 or more COVID-19 patients from January 1 through April 10, 2020. Of the initial allocation, $2 billion was distributed to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments. Hospitals are paid a fixed amount per COVID-19 inpatient admission, with an additional amount that takes into account their Medicare and Medicaid disproportionate share and uncompensated care payments.

  On July 17, 2020, HHS announced an additional distribution to 1,129 hospitals in high-impact COVID-19 areas based on a formula for hospitals with over 160 COVID-19 admissions between January 1 and June 10, 2020, or one admission per day, or that experienced a disproportionate intensity of COVID-19 admissions (exceeding the average ratio of COVID-19 admissions/beds). Eligible hospitals were paid $50,000 per eligible admission. Previous high-impact payments were also taken into account when determining each hospital's payment from the second-round distribution.

- **Rural Allocations:** HHS allocated specific provider relief funds to rural hospitals, critical access hospitals, community health centers (CHCs) located in rural areas, and RHCs. Allocations were a minimum of $1 million to each hospital and $100,000 to each clinic. These providers could qualify for additional funds based on the relative proportion of operating expenses they represent across the entirety of rural health care. The minimum base payment was meant to ensure that providers without Medicare claims, such as pediatric RHCs, receive adequate support.

  HHS also allocated additional support to urban hospitals with certain rural Medicare designations, as well as others that provide care in smaller non-rural communities. These included some suburban hospitals that are not considered rural but serve rural populations and operate with smaller profit margins and limited resources than larger hospitals.

- **Safety Net Allocations:** The first distribution was announced on June 9, 2020, providing funds to 764 hospitals. Eligible hospitals received between the minimum distribution of $5 million and a maximum distribution of $50 million. HHS defined eligible safety-net hospitals as those with:
  - A Medicare disproportionate payment percentage of 20.2% or greater
  - Average uncompensated care per bed of $25,000 or more
  - Profitability of 3% or less, as reported to the Centers for Medicare & Medicaid Services in the most recently filed cost report

  On July 10, 2020, HHS announced an additional safety-net hospital funding to 227 hospitals based on expanded the criteria to qualify. The revised criteria facilitated the inclusion of certain acute care hospitals that meet a revised profitability threshold of less than 3% averaged consecutively over two or more of the last five cost reporting periods, as reported on the Medicare cost report.

- **Children's Hospital Allocation**: $1.1 billion was distributed to approximately 66 freestanding children's hospitals. To qualify, the hospital must be either be an exempt hospital from the Medicare inpatient prospective payment system or be a HRSA defined Children's Hospital Graduate Medical Education facility. Eligible hospitals will receive 2.5% of their net revenue from patient care.

- **Skilled-Nursing Facility Allocation***:* $4.8 billion was distributed to 12,864 skilled-nursing facilities (SNFs), including distinct-part nursing facilities. The funding is intended to help nursing homes address critical needs such as labor, scaling up their testing capacity, acquiring personal protective equipment, and a range of other expenses directly linked to this pandemic. HHS distributed funding to all certified SNFs with six or more certified beds on both a fixed basis and a variable basis. Each SNF received a fixed distribution of $50,000 plus a distribution of $2,500 per bed.

  HHS also distributed an additional $4.65 billion to nursing homes and skilled-nursing facilities. Approximately $2.5 billion is based on a per-facility payment of $10,000 plus a per-bed payment of $1,450. To be eligible, a facility was required to have at least six certified beds. An additional $2 billion was allocated to nursing homes and SNFs based on rates of COVID-19 infection and mortality. Additional details on the performance measures are available on the HHS website.

- **Indian Health Services:** $520 million will be distributed for Indian Health Service facilities, distributed on the basis of operating expenses.

- **American Rescue Plan Rural Distribution:** On November 23, 2021, HRSA began distributing $7.5 billion in funding from the American Rescue Plan Rural Distribution. Payments were made to providers based on the amount and type of services they provide to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) patients who live in rural areas, as defined by the Federal Office of Rural Health Policy. Providers who may not be located in an area classified as rural may still receive payments if they provided care to rural patients from January 1, 2019, through September 30, 2020. Additional details on the payment methodology are available here.

Payment for Uninsured COVID-19 Testing, Treatment, and Vaccination

The U.S. Department of Health and Human Services (HHS) provides claims reimbursement to health care providers at Medicare rates for testing uninsured individuals for COVID-19, treating uninsured individuals with a COVID-19 diagnosis, and administering COVID-19 vaccines to uninsured individuals.
A separate program, the HRSA COVID-19 Coverage Assistance Fund, is available to reimburse providers for COVID-19 vaccine administration to underinsured individuals whose health plan either does not include COVID-19 vaccination as a covered benefit or covers COVID-19 vaccine administration but with cost-sharing.

- **Testing and Treatment for the Uninsured:** Every health care provider who has conducted testing or provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding. Providers must enroll in the COVID-19 Uninsured Program, which will be overseen by HRSA. Further information, including frequently asked questions and a COVID-19 Uninsured Program portal user guide, can be found on the HRSA website.

- **Vaccines for the Underinsured**: A portion of the Provider Relief Funds are also being used to reimburse health care providers for administering COVID-19 vaccines to underinsured individuals on or after December 14, 2020. Providers can request claims reimbursement and will be paid generally at Medicare rates, subject to available funding and compliance with program requirements. Providers must enroll in

the COVID-19 Coverage Assistance Fund, which will be overseen by HRSA. Further information, including frequently asked questions and a COVID-19 Uninsured Program portal user guide, can be found on the HRSA website.

CHA Recommendations

Hospitals are urged to maintain documentation of COVID-19-related expenses. For example, hospitals should consider:

- Creating a specific pay code for employees that identifies hours spent to support the command center, COVID-19 screening, and additional COVID-19-related shifts
- Using a spreadsheet to track supplies needed for purchase
- Tracking overtime associated with COVID-19 for permanent employees
- Tracking both regular and overtime hours associated with COVID-19 for unbudgeted employees
- Tracking management costs and keeping detailed timesheets of employees performing grant management and other duties related to COVID-19
- Tracking any donated resources from volunteer organizations, which may be used to offset the hospital's or health system's non-federal share

Appendix I: Expense Reporting Sub-Category for Recipients that Received More than $500,000 in Provider Relief Funds

Category	Sub-Category	Description
G&A	Mortgage/Rent	Payments related to mortgage or rent for a facility
G&A	Insurance	Premiums paid for property, malpractice, business insurance, or other insurance relevant to operations
G&A	Personnel	Workforce-related actual expenses paid to prevent, prepare for, or respond to coronavirus during the reporting period, such as

		workforce training, staffing, temporary employee or contractor payroll, overhead employees, or security personnel
G&A	Fringe Benefits	Extra benefits supplementing an employee's salary, which may include hazard pay, travel reimbursement, and employee health insurance
G&A	Lease Payments	New equipment or software leases, such as fleet cars and medical equipment that is not purchased and will be returned to the owner
G&A	Utilities/Operations	Lighting, cooling/ventilation, cleaning, or additional third-party vendor services not included in the "Personnel" sub-category
G&A	Other G&A	Expenses not captured above that are generally considered part of general and administrative expenses
Health Care	Supplies	Expenses paid for purchase of supplies (e.g., single-use or reusable patient care devices, cleaning supplies, office supplies, etc.) used to prevent, prepare for, and/or respond to coronavirus during the reporting period
Health Care	Equipment	Expenses paid for purchase of equipment, such as ventilators, refrigeration systems for COVID-19 vaccines, or updates to HVAC systems
Health Care	Information Technology	Expenses paid for IT or interoperability systems to expand or preserve coronavirus care delivery during the reporting period, such as electronic health record licensing fees, telehealth infrastructure, increased bandwidth, and teleworking to support a remote workforce
Health Care	Facilities	Expenses such as lease or purchase of permanent or temporary structures, or to retrofit facilities to accommodate revised patient treatment practices, used to prevent, prepare for, and/or respond to coronavirus during the reporting period
Health Care	Other Health Care-Related Expenses	Expenses, not previously captured above, that were paid to prevent, prepare for, and/or respond to coronavirus