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What We Know Now: How Providers Can Access the \$100 Billion CARES Act Provider Relief Fund

The Big Picture

In recent months, the Department of Health and Human Services (HHS) has issued ongoing announcements and updates with respect to the [Provider Relief Fund](#)—that is, the now \$175 billion in direct-to-provider funding authorized by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) and Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139, known “Stimulus 3.5”). The guidance and updates that HHS has provided to date relate to the \$100 billion authorized by the CARES Act; they do not yet contemplate how HHS will distribute the additional \$75 billion.

This analysis provides:

- An overview of the available funds, the resources HHS has made available to providers, and the steps that providers will need to take (or must have already taken) to access these funds. *See pages [2-7](#).*
- An overview of the longer-term reporting and documentation requirements that providers will need to satisfy by way of accepting these funds. *See page [8](#).*

In late May and early June, HHS updated its Provider Relief Fund FAQs to include new and modified guidance related to (among other issue areas):

- ***The methodology for calculating provider allocations of the \$50 billion General Distribution.*** Originally, HHS indicated that the second \$20 billion tranche of General Distribution funds would be distributed in such a way that the \$50 billion is, in total, based on 2018 net patient revenue. In May 26 modifications to its FAQs, HHS instead indicates that payments from the second tranche are based on the *lesser of 2%* of a provider’s net patient revenue *or* the sum of incurred losses for March and April. Further, if a provider’s Tranche 1 payment is determined to be at least 2% of annual patient revenue, the provider may not receive a payment from Tranche 2.
- ***The time period for accepting Provider Terms and Conditions.*** Providers now have 90 days for the date of the payment to attest to receiving payment and accepting the terms and conditions.
- ***The definition of uninsured patient for purposes of submitting claims via the Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program.*** Recent guidance clarified that providers do not need to assess whether uninsured individuals are *eligible* for other forms of coverage, only that they are not currently *enrolled* in other forms of coverage, in order to submit payments to the HRSA fund. HRSA’s contractor will run a coordination of benefits process to ensure that HRSA COVID-19 Uninsured Program funds are not used for individuals enrolled in other coverage.



Available Funds and Steps Providers Should Take to Access Them

This table summarizes posted guidance as of June 4, 2020. Providers should monitor the Provider Relief Fund “[landing page](#)” for updates and information on new distributions. This “for providers” [page](#) has links to the Terms and Conditions for each of the distributions. These Terms and Conditions include various requirements specific to the Provider Relief Fund as well as various provisions that are applicable to funding made available under standard HHS appropriations rules.

Additional information also is available via the provider portals established by HHS:

- CARES Act Provider Relief Fund Payment Attestation Portal: <https://covid19.linkhealth.com/#/step/1> (to attest to receipt of the funds and agree to the terms and conditions within 90 days of payment)
- General Distribution Portal: <https://covid19.linkhealth.com/docusign/#/step/1> (to submit tax forms/financial statements for the \$20 billion “Tranche 2” General Distribution)
- COVID-19 Uninsured Program Portal: coviduninsuredclaim.linkhealth.com (to submit claims for providing COVID-19 testing or treatment for uninsured patients)
- Lists of certain providers that have received funding through the Provider Relief Fund [distributions](#) or the [HRSA Uninsured Program](#)

| Distribution | Overview of Payment Methodology | Provider Requirements to Access Funds | Payment Timing |
|---|---|---|--|
| General Distribution \$50 Billion (Updated) | <ul style="list-style-type: none"> • Payments, in total, are generally based on the provider’s share of 2018 net patient revenue for all payers; however, because of the way the General Distribution was allocated across two tranches of payments, the share of 2018 net patient revenue covered by the fund is unlikely to be consistent among individual providers <ul style="list-style-type: none"> ○ Tranche 1: Based on the provider’s share of total 2019 Medicare fee-for- | “Tranche 1” \$30 Billion <i>Note: HHS has published and continues to update two supporting documents related to the General Fund: FAQs and an interactive User Guide. HHS also has established a CARES Act Provider Relief hotline (866-569-3522)</i> <ul style="list-style-type: none"> • Funding was automatically allocated to providers who had billed Medicare fee-for-service in 2019 • All providers that received these funds are asked to attest to receipt and agree to a set of Terms and Conditions specific to this funding pool. Key attestations include: <ul style="list-style-type: none"> ○ Funding will only be used to prevent, prepare for, and respond to coronavirus and payments will only be used for health care related expenses or lost revenues attributable to coronavirus ○ Payment will not be used to reimburse expenses/losses that | <ul style="list-style-type: none"> • Tranche 1: Payment was distributed between April 10 and April 17 and is complete as of April 24 |

| Distribution | Overview of Payment Methodology | Provider Requirements to Access Funds | | Payment Timing |
|--------------|---|---|---|--|
| | <p>service expenditures</p> <ul style="list-style-type: none"> ○ Tranche 2: Based on the <i>lesser</i> of 2% of a provider’s 2018 (or most recent complete tax year) net patient revenue <i>or</i> the sum of incurred losses for March and April. ● To be eligible for both tranches of payments, providers must: <ul style="list-style-type: none"> ○ Have billed Medicare Parts A or B in 2019 <i>and</i> ○ Provide or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 (i.e., any patient)¹ | | <p>have been reimbursed from other sources or that other sources are obligated to reimburse</p> <ul style="list-style-type: none"> ○ Provider will not collect out-of-pocket expenses from patients in an amount greater than what the patient would pay if care was provided in-network (or “balance bill”) ● IF the provider received an automatic payment from the Provider Relief Fund on April 10 or payment dated April 17, these are payments from Tranche 1 of the General Distribution. <ul style="list-style-type: none"> ○ To accept the funds, the provider should sign an attestation confirming receipt of the funds and agree to the terms and conditions specific to this funding pool within 90 days² of payment via the “CARES Act Provider Relief Fund Payment Attestation Portal” ○ To return the funds, providers must initiate the process within 90 days of receipt of payment. The “CARES Act Provider Relief Fund Payment Attestation Portal” will guide providers on how to accept or reject the funds and several questions regarding “rejecting payments” are included in the FAQs | |
| | | <p>“Tranche 2” <i>\$20 Billion</i></p> | <ul style="list-style-type: none"> ● Funding was or may be allocated to providers that billed Medicare in 2019 (and therefore received a payment from Tranche 1) based on a combination of their 2018 total net patient revenue and consideration of the payment amount received via Tranche 1 (see methodology description in the column to the left) ● Providers must agree to the Terms and Conditions specific to this funding pool, which, unlike the Tranche 1 T&Cs noted above, required recipients to submit general revenue data for calendar year 2018. This information was due to HHS on June 3, 2020. ● IF the provider <i>automatically</i> received a second payment from the Provider Relief Fund (on or around April 24,): <ul style="list-style-type: none"> ○ The provider must submit data for validation via the new | <ul style="list-style-type: none"> ● Tranche 2: Began on April 24 to those for which HHS had Medicare Cost Report data; weekly on a rolling basis thereafter |

¹ HHS clarifies on its [Provider Relief Fund website](#) and in [General Distribution Portal FAQs](#) that it “broadly views every patient as a possible case of COVID-19” and states on the Provider Relief Fund webpage that “Care does not have to be specific to treating COVID-19.”

² HHS [extended](#) this deadline from 30 days to 45 days on May 7 and, on May 22, [extended](#) this deadline from 45 days to 90 days.

| Distribution | Overview of Payment Methodology | Provider Requirements to Access Funds | | Payment Timing |
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| | | | <ul style="list-style-type: none"> ○ General Distribution Portal (due June 3) <ul style="list-style-type: none"> ○ Provider must also attest to receipt of the funds and accept the terms and conditions through the Payment Attestation Portal ○ This will primarily apply to hospitals with adequate Medicare Cost Report data on file with HHS ● IF the provider received a payment from Tranche 1 (above) but <i>did not automatically</i> received a second payment from the Provider Relief Fund (on or around April 24): <ul style="list-style-type: none"> ○ The provider was required to submit data to “apply” for a second round of funding via the General Distribution Portal (due June 3) ○ After receipt of funds, providers attest to receipt and accept the terms and conditions through the Payment Attestation Portal, within 90 days ○ This primarily applies to physician practices and other non-hospital organizations that received funding from Tranche 1 ○ HHS will process applications in batches on a rolling basis (as noted under methodology in the column to the left, not all providers that receive Tranche 1 payments will receive Tranche 2 payments) ● IF the provider <i>has not received any payments</i> from the Provider Relief Fund (from Tranche 1 or Tranche 2) as of April 24, 2020, there are no immediate next steps to take. HHS indicates that these providers “may be eligible for relief funds in future distributions.” <ul style="list-style-type: none"> ○ This will primarily apply to providers who are not enrolled in Medicare and/or who primarily receive funding from non-Medicare related payers, such as Medicaid | |
| COVID-19 Testing and Treatment for | <ul style="list-style-type: none"> ● Payments are <i>claims reimbursements</i> for COVID-19 testing and treatment³ for | <p><i>Note: HRSA has published two sets of FAQs—one set of FAQs that responds to questions posed during provider webinars and one more general set of FAQs, which it continues to update—and an interactive User Guide.</i></p> | | <ul style="list-style-type: none"> ● Rolling basis, beginning |

³ Includes specimen collection, diagnostic and antibody testing; testing-related visits in the office, urgent care, emergency room, or telehealth settings; treatment, including office visits (including telehealth), emergency room, inpatient, outpatient/observation, skilled nursing facility, long-term acute care (LTAC), acute inpatient rehab, home health, durable medical equipment (e.g., oxygen,

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| Uninsured <i>Unspecified</i> | uninsured patients, ⁴ on or after February 4 <ul style="list-style-type: none"> Providers reimbursed at Medicare rates, subject to available funding For additional reimbursement rate information, see Health Resources and Services Administration (HRSA) FAQs | <ul style="list-style-type: none"> Enroll in the program by completing the following steps via the HRSA portal: <ul style="list-style-type: none"> Accept the terms and conditions—for testing services and care/treatment services Submit TIN information and receive validation (can take 1-2 business days to process) Enroll in Optum Pay™ Direct (can take 7-10 business days to process), which allows the provider to receive direct deposit payments Submit the provider roster for all providers seeking to submit claims for uninsured patients (can take 1-3 business days to process) NOTE: Only one person per TIN can serve as the program administrator in the HRSA portal Beginning May 6, via the HRSA portal: <ul style="list-style-type: none"> Upload patient information (for uninsured individuals for which the provider will submit claims); this information may be submitted one patient at a time or in batches Attest that the provider: <ul style="list-style-type: none"> Has checked for healthcare coverage and confirmed “to the best of their knowledge” that the patient was uninsured at the time of services Will accept defined program reimbursement (Medicare rates) as payment in full Will not balance bill the patient Agrees to program terms and conditions and may be subject to post-reimbursement audit review Once patient information is submitted, providers will receive a Temporary Member ID (active for 30 days) to use when submitting claims | May 18 |

ventilator); emergency ground ambulance transportation; non-emergent patient transfers via ambulance; Food and Drug Administration (FDA)-approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay; FDA-approved vaccine, once available. For inpatient claims, date of admittance must be on or after February 4, 2020. *Excludes* any treatment without a COVID-19 primary diagnosis, except for pregnancy when the COVID-19 code may be listed as secondary; hospice services; outpatient prescription drugs.

⁴ A patient is considered uninsured for testing and testing-related services if the patient does not have coverage through an individual or employer-sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program at the time the services were rendered. For claims for treatment of positive COVID-19 cases, a patient is considered uninsured if the patient did not have any health coverage at the time the services were rendered. Providers may submit a claim for uninsured individuals before Medicaid eligibility determination is complete. However, if the provider learns that the individual is retroactively enrolled in Medicaid as of the date of service, the provider must return the payment to HRSA.

| Distribution | Overview of Payment Methodology | Provider Requirements to Access Funds | Payment Timing |
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| | | <ul style="list-style-type: none"> Also beginning May 6, submit claims electronically for professional and facility services (<i>outside</i> of the HRSA portal, through traditional claims submission process) <ul style="list-style-type: none"> All claims must be submitted using an 837 EDI transaction set The Payer ID is 95964 (COVID19 HRSA Uninsured Testing and Treatment Fund) All submitted claims must be <i>complete and final</i>. Interim bills, corrected claims, late charges, voided transactions and appeals will not be accepted. | |
| Hot Spot Hospitals <i>\$12 Billion</i> | <ul style="list-style-type: none"> Eligible hospitals are those that provided inpatient care to 100+ COVID-19 patients through April 10 <ul style="list-style-type: none"> \$10 billion based on a “fixed amount” per COVID-19 admission \$2 billion “taking into account their Medicare and Medicaid disproportionate share and uncompensated care payments” | <ul style="list-style-type: none"> HHS automatically distributed these funds to 395 eligible hospitals on or around May 1, based on data requested from hospitals in April Hospitals that received the payment must accept the Terms and Conditions within 90 days of receipt (or return the funds) | <ul style="list-style-type: none"> Distributed on or around May 1 |
| Rural Providers <i>\$10 Billion</i> | <ul style="list-style-type: none"> Rural acute care hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers (CHCs) in rural areas were eligible The base payment for rural acute care hospitals and CAHs is \$1 million The base payment for RHCs with no reported Medicare claims and CHCs lacking expense data is \$100,000 Additional payments are a “percent of their [the | <ul style="list-style-type: none"> Providers that received the payment must accept the Terms and Conditions within 90 days of receipt (or return the funds) | <ul style="list-style-type: none"> Distributed on or around May 1 |

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| | providers’] annual expenses” | | |
| Indian Health Service (IHS) <i>\$500 Million</i> (Updated) | <ul style="list-style-type: none"> • Payment allocated for Indian Health Service facilities: <ul style="list-style-type: none"> ○ IHS and tribal hospitals: \$2.81 million base payment plus 3% of total operating expenses ○ IHS and tribal clinics and programs: \$187,000 base payment plus 5% of the estimated service population multiplied by the average cost per user ○ IHS urban programs: \$181,000 base payment plus 6% of the estimated service population multiplied by the average cost per user | <ul style="list-style-type: none"> • Providers that received the payment must accept the Terms and Conditions within 90 days of receipt (or return the funds) | <ul style="list-style-type: none"> • Distributed on or around May 22 |
| Skilled Nursing Facilities (SNFs) <i>\$4.9 Billion</i> (Updated) | <ul style="list-style-type: none"> • Payment allocated for certified SNFs with six or more certified beds <ul style="list-style-type: none"> ○ \$50,000 base payment plus \$2,500 per bed | <ul style="list-style-type: none"> • Providers that received the payment must accept the Terms and Conditions within 90 days of receipt (or return the funds) | <ul style="list-style-type: none"> • Distributed on or around May 22 |
| Additional Allocations <i>Unspecified</i> | TBA | <p>HHS indicates only that some providers will receive further, separate funding, including “dentists and providers that solely take Medicaid”</p> <p>HHS solicited 2018 and 2019 fee-for-service and managed care provider-level payment information from state Medicaid agencies to inform distribution of funding to Medicaid providers. No further details are currently available about the distribution of funds.</p> | |

Ongoing Reporting Requirements

HHS has stipulated that providers that receive funding from the Provider Relief Fund will be required to maintain records and cost documentation related to this funding and that HHS may in the future request reports or validating information.

In addition, any entity that receives more than \$150,000 total in funding from federal coronavirus funds (including from the CARES Act, the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, will be required to submit a quarterly report to HHS on use of funds in accordance with Federal funding accountability rules. Reports will be due no later than 10 days after the end of each calendar quarter. HHS indicates that these reporting requirements will begin for the calendar quarter ending June 30.

While no additional information has been released yet as to the format of or process to submit such reports, nor the due date of initial reports, all of the Terms and Conditions released to date (i.e., for both tranches of the General Distribution Fund and both documents required for payment under the Uninsured Relief Fund) indicate that providers will need to submit information on:

- The amount of funds received that were expended or obligated;
- A detailed list of all projects or activities for which the funds were expended or obligated;
- The estimated number of jobs created or retained related to the funding if applicable; and
- Detailed information on any level of subcontracts or subgrants related to the funding.

In a May 6 update to the [Provider Relief Fund FAQs](#), HHS indicated that it will provide guidance “in the future” about the type of documentation it will expect Provider Relief Fund recipients to submit. Once available, the guidance will be posted on the Fund’s [landing page](#).

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