

National Rural Health Resource Center

COVID-19 Funding Sources Impacting Rural Providers

December 2020



NATIONAL
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RESOURCE CENTER

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This report was prepared by:



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Introduction and Use of this Resource

This reference resource is intended to support rural health care providers, along with their state and local partners, navigate the availability of federal funds to support the novel coronavirus (COVID-19) pandemic response and recovery efforts. Seven (7) tables, or matrices, are provided for quick reference at the beginning of this resource. The tables can be used to check eligibility of participation in funding sources by provider type (Table 1). The tables also provide an at-a-glance view for each provider type sharing the different types of funds that may be accessed from various funding sources dependent on their participation eligibility (Tables 2 – 7). Each funding source is described in its own section of this resource with an executive summary followed by further detail on the use of funds and reporting requirements. Hyperlinks to the legislation and detailed information is provided for each funding source.

This resource is intended as a reference guide. It does not seek to provide legal counsel or financial advice. It is not intended to cover any individual situation or concern, as the contents are intended for general information purposes only. Users are urged not to act upon the information contained in the guide without first consulting legal, accounting, or other professional advice regarding implications of a particular factual situation. All eligibility, usage of funds, and reporting requirements are the at the sole discretion of the awarding agency and all questions should be directed to the awarding agency to provide clarification.

This resource will be regularly updated as new information is released.

Acronyms

- ASPR – Assistant Secretary for Preparedness and Response
- CAH – Critical Access Hospital
- CARES Act - Coronavirus Aid, Relief, and Economic Security Act
- CHC – Community Health Center
- EMS – Emergency Medical Services
- ERC – Employee Retention Credit
- FEMA – Federal Emergency Management Agency
- FAQ – Frequently Asked Questions
- FQHC – Federally Qualified Health Center
- IHS – Indian Health Service
- LTC – Long Term Care
- PHE – Public Health Emergency
- PPP – Paycheck Protection Program
- PPS – Prospective Payment System
- RHC – Rural Health Clinic
- SBA – Small Business Administration
- SHIP – Small Rural Hospital Improvement Grant Program
- SNF – Skilled Nursing Facility

Table 1: Program Eligibility Matrix by Provider Type

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	PROVIDER TYPE						
	PPS Hospital	CAH Hospital	RHC	FQHC	Tribal Facility	LTC/SNF	EMS
<u>Paycheck Protection Program</u>	X	X	X	X		X	X
<u>Employee Retention Credit</u>	X	X	X	X		X	X
<u>\$50B General Allocation</u>	X	X	X	X		X	X
<u>\$10B Rural Allocation</u>	X	X	X	X			
<u>SNF Allocations</u>						X	
<u>\$500 M Tribal Allocation</u>					X		
<u>Uninsured Allocation</u>	X	X	X	X	X	X	X
<u>Medicaid/General Allocation</u>				X		X	X
<u>\$20B Phase 3 Allocation</u>	X	X	X	X	X	X	X
<u>Accelerated/ Advance Payments</u>	X	X	X	X		X	X
<u>FEMA – Disaster Relief</u>	X	X	X	X	X	X	X
<u>Telehealth Program</u>	X	X	X	X	X	X	
<u>ASPR – Grants</u>	X	X					
<u>SHIP Funding</u>	X	X					
<u>RHC COVID-19 Testing Program</u>			X				

Table 2: Use of Funds Matrix, Hospitals, CAH and PPS

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
<u>Paycheck Protection Program</u>	X	X	X	X						
<u>Employee Retention Credit</u>	X									
<u>\$50 Billion General Allocation</u>					X	X				
<u>\$10 Billion Rural Allocation</u>					X	X				
<u>Uninsured Allocation</u>							X			
<u>\$20B Phase 3 Allocation</u>					X	X				
<u>Accelerated / Advance Payments</u>									X	
<u>FEMA Disaster Relief</u>										X
<u>COVID-19 Telehealth Program</u>								X		
<u>ASPR Grants</u>										X
<u>SHIP Funding</u>										X

Table 3: Use of Funds Matrix, Rural Health Clinics (RHC)

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
<u>Paycheck Protection Program</u>	X	X	X	X						
<u>Employee Retention Credit</u>	X									
<u>\$50 Billion General Allocation</u>					X	X				
<u>\$10 Billion Rural Allocation</u>					X	X				
<u>Uninsured Allocation</u>							X			
<u>\$20B Phase 3 Allocation</u>					x	x				
<u>Accelerated/Advance Payments</u>									X	
<u>FEMA Disaster Relief</u>										X
<u>COVID-19 Telehealth Program</u>								X		
<u>RHC COVID-19 Testing Program</u>	X	X				X				

Table 4: Use of Funds Matrix, Federally Qualified Health Centers (FQHC)

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
<u>Paycheck Protection Program</u>	X	X	X	X						
<u>Employee Retention Credit</u>	X									
<u>\$50 Billion General Allocation</u>					X	X				
<u>\$10 Billion Rural Allocation</u>					X	X				
<u>Uninsured Allocation</u>							X			
<u>Medicaid/ General Allocation</u>					X	X				
<u>\$20B Phase 3 Allocation</u>					x	x				
<u>Accelerate/ Advance Payments</u>									X	
<u>FEMA Disaster Relief</u>										X
<u>COVID-19 Telehealth Program</u>								X		

Table 5: Use of Funds Matrix, Tribal Facility

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
<u>\$500 M Tribal Allocation</u>					X	X				
<u>Uninsured Allocation</u>							X			
<u>\$20B Phase 3 Allocation</u>					x	x				
<u>FEMA Disaster Relief</u>										X
<u>COVID-19 Telehealth Program</u>								X		

Table 6: Use of Funds Matrix, Long Term Care (LTC) or Skilled Nursing Facility (SNF)

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
<u>Paycheck Protection Program</u>	X	X	X	X						
<u>Employee Retention Credit</u>	X									
<u>\$50 Billion General Allocation</u>					X	X				
<u>SNF Allocations</u>					X	X				
<u>Uninsured Allocation</u>							X			
<u>Medicaid/ General Allocation</u>					X	X				
<u>\$20B Phase 3 Allocation</u>					x	x				
<u>Accelerated/ Advance Payments</u>									X	
<u>FEMA Disaster Relief</u>										X
<u>COVID-19 Telehealth Program</u>								X		

Table 7: Use of Funds Matrix, Emergency Medical Services (EMS)

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
<u>Paycheck Protection Program</u>	X	X	X	X						
<u>Employee Retention Credit</u>	X									
<u>\$50 Billion General Allocation</u>					X	X				
<u>Uninsured Allocation</u>							X			
<u>Medicaid/General Allocation</u>					X	X				
<u>\$20B Phase 3 Allocation</u>					x	x				
<u>Accelerated/ Advance Payments</u>									X	
<u>FEMA Disaster Relief</u>										X

Paycheck Protection Program (PPP)

Executive Summary

Overview

Small Business Administration (SBA) loan that help businesses keep their workforce employed during the Public Health Emergency (PHE). Over \$500 billion approved.

Eligible Providers

- Any small business that meets the SBA's size or other standards, including 501(c)(3) non-profits.
- Governmental hospitals that can demonstrate they meet 501(c)(3) non-profit criteria are also eligible.

Websites

- [Paycheck Protection Program \(PPP\)](#)
- [PPP FAQ](#)

Use of Funds

Payroll, rent, mortgage interest, and utilities

Attestation Requirements

Loan forgiveness application

Funding Process

Overview

You can apply through any existing SBA 7(a) lender or through any federally insured depository institution, federally insured credit union, and Farm Credit System institution that is participating. Other regulated lenders will be available to make these loans once they are approved and enrolled in the program. You should consult with your local lender as to whether it is participating in the program.

- [Farm Credit System website for reference](#)

Instructions on how to calculate loan amount

- [How to calculate maximum loan amounts – by business type.](#)

Eligible Providers

- Any small business that meets the SBA's size or other standards, including 501(c)(3) non-profits.
 - Governmental hospitals that can demonstrate they meet 501(c)(3) non-profit criteria are also eligible.
 - [See more details](#)

Use of Funds, Staffing, and Reporting Requirements

Use of Funds

- Funds must be used for payroll, rent, mortgage interest, and utilities.
- 24-week period to use funds
- Increased from 8-week period
- 60% must be used for payroll expenses
- Previously decreased from 75%

- Limitations on maximum salary amounts for an individual that may be claimed as part of the program.

Full Time Equivalent (FTE) staffing requirements

- FTE levels at year end in compliance with regulation, including required comparisons to levels at certain earlier dates.
- Exceptions for voluntary terminations, etc.

Reporting Requirements

STEPS REQUIRED

[Complete application for loan forgiveness](#)

Repayment

- Providers may return now if desired.
- If forgiveness is fully approved, then no repayment is required.
- Partial or no forgiveness will require repayment over subsequent years (up to 5) at 1% interest rate.
 - Balance may be paid off at any time during this period.

Employee Retention Credit

Executive Summary

Overview

The Employee Retention Credit is a fully refundable tax credit for employers equal to 50 percent of qualified wages (including allocable qualified health plan expenses) that Eligible Employers pay their employees.

Eligible Providers

- Eligible Employers for the purposes of the Employee Retention Credit are employers that carry on a trade or business during calendar year 2020, including tax-exempt organizations, that either:
- Fully or partially suspend operation during any calendar quarter in 2020 due to orders from an appropriate governmental authority limiting commerce, travel, or group meetings (for commercial, social, religious, or other purposes) due to COVID-19; or
- Experience a significant decline in gross receipts during the calendar quarter.

Websites

- [Employee Retention Credit FAQs](#)
- [Employee Retention Credit COVID-19 Related FAQs](#)

Use of Funds

No additional limitations or restrictions on use of the credit provided.

Attestation Requirements

Reported on the quarterly Internal Revenue Service (IRS) Form 941 return.

Funding Process

General Information

The Employee Retention Credit (ERC) equals 50 percent of the qualified wages (including qualified health plan expenses) that an Eligible Employer pays in a calendar quarter. The maximum amount of qualified wages taken into account with respect to each employee for all calendar quarters is \$10,000, so that the maximum credit for qualified wages paid to any employee is \$5,000.

Eligible Providers

- Fully or partially suspend operation during any calendar quarter in 2020 due to orders from an appropriate governmental authority limiting commerce, travel, or group meetings (for commercial, social, religious, or other purposes) due to COVID-19; or
- Experience a significant decline in gross receipts during the calendar quarter.
- [COVID-19-Related Employee Retention Credits: Determining When an Employer is Considered to have a Significant Decline in Gross Receipts and Maximum Amount of an Eligible Employer's Employee Retention Credit FAQs](#)

Providers Not Eligible

- Governmental employers
- Employers that receive a PPP loan

Use of Funds and Reporting Requirements

Use of Funds

No additional limitations or restrictions on use of the credit provided.

Reporting Requirements

Reported on the quarterly IRS Form 941 return.

\$50 Billion General Allocation

Executive Summary

Overview

\$50 billion of funding allocated proportional to providers' share of 2018 net patient revenue.

Eligible Providers

All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 and provided care after January 31, 2020.

Websites

- [General Information about Coronavirus Aid, Relief, and Economic Security \(CARES\) Act Provider Relief Fund](#)
- [CARES Act Provider Relief Fund FAQs](#)
- [S.3548 CARES Act](#)

Reporting Requirements and Auditing Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 90 days of receipt of funds.
- Ongoing future reporting to show compliance regarding use of funds.
- Initial report was submitted by Health and Human Services (HHS).

- Future reporting requirements are detailed below.

Funding Process

General Information

- \$50 billion is allocated proportional to providers' share of 2018 net patient revenue. The allocation methodology is designed to provide relief to providers, who bill Medicare fee-for-service, with at least 2% of that provider's net patient revenue regardless of the provider's payer mix. Payments are determined 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.
- Paid in two phases
 - \$30 Billion initial rapid distribution based on provider's share of Medicare fee-for-service reimbursements in 2019
 - \$20 Billion based on CMS costs reports/data or incurred losses

Eligible Providers

- All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for the initial rapid distribution.
- Second phase based on 2018 net patient service revenue from cost reports or tax returns.
- Reporting required to receive second phase (completed by June 3).

Use of Funds and Reporting Requirements

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Funds may be used for eligible expenses incurred prior to receiving funds.

Revenue

Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

- Net of expenses attributable to coronavirus

Expenses

Healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare-related operating expenses.

The definition of eligible lost revenue and expenses has been updated several times. Please refer to [FAQs](#) for latest guidance.

Reporting Requirements

STEPS REQUIRED

- Attest to acknowledge receipt of funds and agree to terms and conditions via portal within 90 days of receipt of payment.
- [CARES Provider Relief Fund – Step 1 Eligibility](#)
- Initial report was submitted by HHS.
- Summary of subsequent reporting requirement for recipients
 - Recipients of more than \$10,000 in payments are required to report their use of funds
 - January 15, 2021 portal opens
 - February 15, 2021 first reporting deadline
 - July 31, 2021 final reporting deadline
 - Reporting based on calendar year results, not fiscal year
 - Links to reporting requirement details:

[Post-Payment Reporting Requirements](#)

Reporting Instructions

- Single Audit required if over \$750,000 in funds expended.

Repayment

- Providers may return now if desired.
- Funds unused by end of the PHE will have to be repaid.
- HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

\$10 Billion Rural Allocation

Executive Summary

Overview

\$10 billion of funding to rural providers.

Eligible Providers

Rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural area. [Website for Centers for Medicare and Medicaid Services \(CMS\) Conditions of Participation.](#)

Websites

- [CARES Act Provider Relief Fund General Information](#)
- [CARES Act Provider Relief Fund Targeted Distribution FAQs](#)
- [Reporting Requirements and Auditing](#)

Use of Funds (same as general allocation)

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 90 days of receipt of funds.
- Ongoing future reporting to show compliance regarding use of funds.
- Initial report was submitted by HHS.

- Future reporting requirements are detailed below.

Funding Process

General Information for eligible providers

RURAL ACUTE HOSPITALS AND CAHS

- The methodology provides hospitals with supplemental funds based on a graduated base amount plus an additional amount to account for a portion of their usual operating costs and the volume of care they regularly provide, according to the following formula.
- Graduated based payment + 1.97% of hospital's operating expenses
- Minimum base payment of \$1 million and maximum base payment of \$3 million

RHCS (INDEPENDENT)

- A base amount plus a percentage of total operating costs were calculated for independent RHCs not associated with a hospital using RHC Cost Report data according to the following formula.
- \$100,000 per clinic site + 3.6% of the RHC's operating expenses

RURAL COMMUNITY HEALTH CENTERS (CHC) / FQHCS:

- The allocation for health centers in rural areas was a flat payment amount per health center site of \$100,000. Funds are distributed to each FQHC organization based on the number of individual rural clinic sites it operates.

Use of Funds and Reporting Requirements

Use of Funds (Same as general allocation)

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Funds may be used for eligible expenses incurred prior to receiving funds.

Revenue

Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

- Net of expenses attributable to coronavirus

Expenses

Healthcare-related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare-related operating expenses.

The definition of eligible lost revenue and expenses has been updated several times. Please refer to [FAQ](#) for latest guidance reporting requirements (same as general allocation).

STEPS REQUIRED

- Attest to acknowledge receipt of funds and agree to terms and conditions via portal within 90 days of receipt of payment.
- [CARES Provider Relief Fund – Step 1 Eligibility](#)
- Initial report was submitted by HHS.
- Summary of subsequent reporting requirement for recipients
 - Recipients of more than \$10,000 in payments are required to report their use of funds
 - January 15, 2021 portal opens
 - February 15, 2021 first reporting deadline
 - July 31, 2021 final reporting deadline
 - Reporting based on calendar year results, not fiscal year
 - Links to reporting requirement details:
[Post-Payment Reporting Requirements](#)

Reporting Instructions

- Single Audit required if over \$750,000 in funds expended.

Repayment

- Providers may return now if desired.
- Funds unused by end of the PHE will have to be repaid.
- HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

SNF Allocations

Executive Summary

Overview

HHS will distribute \$4.9 billion in additional funding to more than 13,000 skilled nursing facilities. Each Skilled Nursing Facility received a fixed distribution per facility of \$50,000 plus \$2,500 per bed.

A second distribution of \$2.5 billion distributed a fixed amount of \$10,000 per facility plus \$1,450 per bed.

A third “incentive” distribution of \$2 billion for facilities that pass two initial gateway qualification tests on both their rate of infection and rate of mortality.

Eligible Providers

A “certified” skilled nursing facility must be certified under Medicare and/or Medicaid to be eligible for this targeted distribution. All standalone and/or hospital-based skilled nursing facilities with at least six beds were eligible.

Websites

- [CARES Act Provider Relief Fund General Information](#)

Reporting Requirements and Auditing Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 90 days of receipt of funds.

- Ongoing future reporting to show compliance regarding use of funds.
- Initial report was submitted by HHS.
- Future reporting requirements are detailed below.

Use of Funds and Reporting Requirements

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Funds may be used for eligible expenses incurred prior to receiving funds.

Revenue

Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

- Net of expenses attributable to coronavirus

Expenses

Healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare related operating expenses.

The definition of eligible lost revenue and expenses has been updated several times. Please refer to [FAQ](#) for latest guidance reporting requirements.

STEPS REQUIRED

- Attest to acknowledge receipt of funds and agree to terms and conditions via portal within 90 days of receipt of payment.
- [CARES Provider Relief Fund – Step 1 Eligibility](#)
- Initial report was submitted by HHS.

- Summary of subsequent reporting requirement for recipients for first two allocations:
 - Recipients of more than \$10,000 in payments are required to report their use of funds
 - January 15, 2021 portal opens
 - February 15, 2021 first reporting deadline
 - July 31, 2021 final reporting deadline
 - Reporting based on calendar year results, not fiscal year
 - Links to reporting requirement details:

[Post-Payment Reporting Requirements](#)

[Reporting Instructions](#)

- Third “incentive” allocation
 - In order for a facility to be eligible for payment, they must pass two initial gateway qualification tests on both their rate of infection and rate of mortality.
 - First, a facility must demonstrate a rate of COVID infections that is below the rate of infection in the county in which they are located. This benchmark requirement for infection rate reflects the goal of the incentive program to recognize and reward facilities that establish a safer environment than the community in which they are located.
 - Second, facilities must also have a COVID death rate that falls below a nationally established performance threshold for mortality among nursing home residents infected with COVID.
 - Performance periods run monthly from September 2020 to December 2020.
- Payments Calculation

- For each performance period, the total available bonus payments will be determined based on aggregate performance on the infection measure. This total will then be split into separate payment pools for performance on the infection and mortality measures.
 - First, 80% of bonus payments will be available to providers that have positive performance on the infection measure. As discussed in previous sections, these payments will be made available to any facility that meets the gateway criteria.
 - Second, 20% of bonus payments will be available to providers that have positive performance on the mortality measure. Providers scoring below a threshold level of performance on the mortality measure will be deemed ineligible for payment in both the infection and mortality payment pools.
- Single Audit required if over \$750,000 in funds expended

Repayment

- Providers may return now if desired.
- Funds unused by end of the PHE will have to be repaid.
- HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

\$500 Million Tribal Allocation

Executive Summary

Overview

\$500 million of funding for IHS, Tribal and Urban Indian Health programs. This includes Indian Health Services (IHS) and Tribal hospitals.

Eligible Providers

Approximately 300 facilities in IHS, Tribal, and Urban Indian Health programs.

Websites

- [CARES Act Provider Relief Fund General Information](#)
- [Reporting Requirements and Auditing](#)

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 90 days of receipt of funds.
- Ongoing future reporting to show compliance regarding use of funds.
- Initial report was submitted by HHS.
- Future reporting requirements are detailed below.

Funding Process

General Information

- IHS and Tribal Hospital Per Hospital \$ Allocation = \$2.81 Million + 3% of Total Operating Expenses
- IHS and Tribal Clinics and Programs Per Clinic/Program \$ Allocation = \$187,000 + 5% times (Estimated Service Population X Average Cost per User)
- IHS Urban Programs Per Program \$ Allocation = \$181,000 + 6% times (Estimated Service Population X Average Cost per User)

Average Cost per User

HHS identified the service population for most service units and estimated an operating cost of \$3,943 per person per year based on actual IHS spending per user from a 2019 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita.

Use of Funds and Reporting Requirements

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Funds may be used for eligible expenses incurred prior to receiving funds.

Revenue

Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

- Net of expenses attributable to coronavirus

Expenses

Healthcare-related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare related operating expenses.

The definition of eligible lost revenue and expenses has been updated several times. Please refer to [FAQ](#) for latest guidance.

Reporting Requirements

STEPS REQUIRED

- Attest to acknowledge receipt of funds and agree to terms and conditions via portal within 90 days of receipt of payment.
- [CARES Provider Relief Fund – Step 1 Eligibility](#)
- Initial report was submitted by HHS.
- Summary of subsequent reporting requirement for recipients
 - Recipients of more than \$10,000 in payments are required to report their use of funds
 - January 15, 2021 portal opens
 - February 15, 2021 first reporting deadline
 - July 31, 2021 final reporting deadline
 - Reporting based on calendar year results, not fiscal year
 - Links to reporting requirement details:
[Post-Payment Reporting Requirements](#)
[Reporting Instructions](#)
- Single Audit required if over \$750,000 in funds expended.

Repayment

- Providers may return now if desired.
- Funds unused by end of the PHE will have to be repaid.
- HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight

as required in the CARES Act to ensure that Federal dollars are used appropriately.

Uninsured Allocation

Executive Summary

Overview

A portion of the \$100 billion Provider Relief Fund will be used to reimburse health care providers, at Medicare rates, for COVID-related treatment of the uninsured.

Eligible Providers

Every health care provider who has 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.

Websites

- [Human Resources and Services Administration \(HRSA\) COVID-19 Insurance Claim](#)
- [COVID-19 Uninsured Program Portal](#)

Use of Funds

Reimburse providers for uninsured claims related to COVID-19 patients.

Attestation Requirements

Initial attestation.

Funding Process

Health care providers who have conducted COVID-19 testing or provided treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020 can request claims reimbursement through the program electronically and will be reimbursed generally at Medicare rates, subject to available funding.

Steps will involve enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit.

To participate, providers must attest to the following at registration:

- You have checked for health care coverage eligibility and confirmed that the patient is uninsured. You have verified that the patient does not have coverage through an individual, or employer-sponsored plan, a federal health care program, or the Federal Employees Health Benefits Program at the time services were rendered, and no other payer will reimburse you for COVID-19 testing and/or care for that patient.
- You will accept defined program reimbursement as payment in full.
- You agree not to balance bill the patient.
- You agree to program terms and conditions and may be subject to post-reimbursement audit review.

\$18 Billion Medicaid/General Allocation

Executive Summary

Overview

The Medicaid/General distribution methodology will be based upon 2% of (gross revenues X percent of gross revenues from patient care) for calendar year (CY) 2017, or 2018 or 2019, as selected by the applicant and with accompanying submitted tax documentation.

Eligible Providers

Eligible providers include participants in state Medicaid/CHIP programs, Medicaid managed care plans, dentists, and certain Medicare providers, including those who missed Phase 1 General Distribution or had a change in ownership in 2019 or 2020. Assisted living facilities are also eligible to apply.

Websites

- [CARES Act Provider Relief Fund General Information](#)
- [Reporting Requirements and Auditing](#)

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 90 days of receipt of funds.

- Ongoing future reporting to show compliance regarding use of funds.
- Initial report was submitted by HHS.
- Future reporting requirements are detailed below.

Funding Process

General Information

The Medicaid Targeted Distribution methodology will be based upon 2% of (gross revenues X percent of gross revenues from patient care) for CY 2017, or 2018 or 2019, as selected by the applicant and with accompanying submitted tax documentation.

Eligible Providers – Meet All Criteria Below

- Have directly billed Medicaid for healthcare-related services during the period of January 1, 2018, to December 31, 2019, or own (on the application date) an included subsidiary that has billed Medicaid for healthcare-related services during the period of January 1, 2018, to December 31, 2019
- Must be a dental service provider who has either (i) directly billed health insurance companies for oral healthcare-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for oral healthcare-related services; or
- Must be a licensed dental service provider who does not accept insurance and has either (i) directly billed patients for oral healthcare-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for oral healthcare-related services;
- Must have billed Medicare fee-for-service during the period of January 1, 2019 and December 31, 2019; or
- Must be a Medicare Part A provider that experienced a change in ownership and billed Medicare fee-for-service in 2019 and 2020 that prevented the otherwise eligible provider from receiving a Phase 1 - General Distribution payment; or

- Must be a state-licensed/certified assisted living facility.
- Have either filed a federal income tax return for fiscal years 2017, 2018 or 2019 or be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or healthcare clinic)
- Have provided patient care after January 31, 2020
- Have not permanently ceased providing patient care directly, or indirectly through included subsidiaries
- If the applicant is an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

Use of Funds and Reporting Requirements

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Funds may be used for eligible expenses incurred prior to receiving funds.

Revenue

Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

- Net of expenses attributable to coronavirus

Expenses

Healthcare-related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare related operating expenses.

The definition of eligible lost revenue and expenses has been updated several times. Please refer to [FAQ](#) for latest guidance.

Reporting Requirements

STEPS REQUIRED

- Attest to acknowledge receipt of funds and agree to terms and conditions via portal within 90 days of receipt of payment.
- [CARES Provider Relief Fund – Step 1 Eligibility](#)
- Quarterly reporting on use of funds.
- Initial report was submitted by HHS.
- Summary of subsequent reporting requirement for recipients
 - Recipients of more than \$10,000 in payments are required to report their use of funds
 - January 15, 2021 portal opens
 - February 15, 2021 first reporting deadline
 - July 31, 2021 final reporting deadline
 - Reporting based on calendar year results, not fiscal year
 - Links to reporting requirement details:
[Post-Payment Reporting Requirements](#)
[Reporting Instructions](#)
- Single Audit required if over \$750,000 in funds expended.

Repayment

- Providers may return now if desired.
- Funds unused by end of the PHE will have to be repaid.

- HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

\$20 Billion Phase 3 Allocation

Executive Summary

Overview

\$20 billion of funding allocated proportional to providers' share of 2018 net patient revenue.

Eligible Providers

Provider relief fund recipients will be invited to apply for additional funding that considers financial losses and changes in operating expenses caused by the coronavirus. Previously ineligible providers, such as those who began practicing in 2020 will also be invited to apply, and an expanded group of behavioral health providers confronting the emergence of increased mental health and substance use issues exacerbated by the pandemic will also be eligible for relief payments.

Providers can apply for funds from October 5, 2020 to November 6, 2020.

HHS is urging all eligible providers to apply early.

Websites

- [General Information about Coronavirus Aid, Relief, and Economic Security \(CARES\) Act Provider Relief Fund](#)
- [Phase 3 Allocation](#)

Reporting Requirements and Auditing Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 90 days of receipt of funds.
- Ongoing future reporting to show compliance regarding use of funds.
- Future reporting requirements are detailed below.

Funding Process

General Information

All provider submissions will be reviewed to confirm they have received a provider relief fund payment equal to approximately 2 percent of patient care revenue from prior general distributions. Applicants that have not yet received relief fund payments of 2 percent of patient revenue will receive a payment that, when combined with prior payments (if any), equals 2 percent of patient care revenue.

With the remaining balance of the \$20 billion budget, HRSA will then calculate an equitable add-on payment that considers the following:

- A provider's change in operating revenues from patient care
- A provider's change in operating expenses from patient care, including expenses incurred related to coronavirus
- Payments already received through prior provider relief fund distributions.

Eligible Providers

- Providers who previously received, rejected or accepted a general distribution provider relief fund payment. Providers that have already received payments of approximately 2% of annual revenue from patient care may submit more information to become eligible for an additional payment.

- Behavioral Health providers, including those that previously received funding and new providers.
- Health care providers that began practicing January 1, 2020 through March 31, 2020. This includes Medicare, Medicaid, CHIP, dentists, assisted living facilities, and behavioral health providers.

Use of Funds and Reporting Requirements

Use of Funds

Funds are for the increased healthcare-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Funds may be used for eligible expenses incurred prior to receiving funds.

Revenue

Lost revenues, as represented by a change in net patient care operating income from 2019 to 2020 (revenue less expenses)

- Net of expenses attributable to coronavirus

Expenses

Healthcare-related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare related operating expenses.

The definition of eligible lost revenue and expenses has been updated several times. Please refer to [FAQ](#) for latest guidance.

Reporting Requirements

STEPS REQUIRED

- Attest to acknowledge receipt of funds and agree to terms and conditions via portal within 90 days of receipt of payment.
- [CARES Provider Relief Fund – Step 1 Eligibility](#)
- Summary of subsequent reporting requirement for recipients

- Recipients of more than \$10,000 in payments are required to report their use of funds
- January 15, 2021 portal opens
- February 15, 2021 first reporting deadline
- July 31, 2021 final reporting deadline
- Reporting based on calendar year results, not fiscal year
- Links to reporting requirement details:

[Post-Payment Reporting Requirements](#)

[Reporting Instructions](#)

- Single Audit required if over \$750,000 in funds expended.

Repayment

- Funds unused by end of the PHE will have to be repaid.
- HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

Accelerated/Advance Payments

Executive Summary

Overview

- Payments intended to provide necessary funds when there is a disruption in claims submission and/or claims processing.
- Program suspended on April 26, 2020 – not accepting any new applications.

Eligible Providers

- Billed Medicare for claims within 180 days prior to request.
- Not in bankruptcy, under medical review or integrity investigation and no outstanding delinquent overpayments with Medicare.
- Amount of funding available
 - CAH: 125% of their payment amount for a six-month period
 - Acute, children's or certain cancer hospitals: 100% of their payment amount for a six-month period
 - Other providers: 100% of their payment amount for a three-month period

Websites

[CMS Accelerated and Advanced Payments Fact Sheet](#)

Use of Funds

Provide cash flow to for normal operating expenses. Amounts have to be repaid.

Repayment Terms

- The start of the recoupment period extended from 120 days to one year from date of loan issuance
- Payment withholding reduced from 100% to 25% for the first 11 months and then 50% for the next 6 months
- If full payment has not been completed after 29 months from loan issue date, interest will accrue at 4% on the unpaid balance.

FEMA Disaster Relief

Executive Summary

Overview

Financial assistance programs to address the PHE.

Eligible Providers

State, Territorial, Tribal, and local government entities, and certain private nonprofit organizations. Includes private, non-profit hospitals, clinics, and LTC facilities.

Websites

- [Grants from FEMA](#)
- [FEMA Grants Preparedness Manual](#)

Use of Funds

Determined pursuant to grant request coordinated at the state level. Costs must be directly tied to the performance of eligible work, documented, and compliant with FEMA regulations.

Attestation Requirements

- Quarterly reports using FFR form (SF-425), close out reports and other periodic report.
- Subject to single audit

Application, Use of Funds, and Reporting Requirements

Follow the guidelines laid out in the grant manual link on the previous page. A high-level overview is below:

- Initial application and work plan are submitted.
- Application is reviewed.
- If approved, a notice of award is sent.
- Application must accept the award within 60 days.
- Quarterly reports using FFR form (SF-425), close out reports and other periodic report.

Funds must be used as described in application.

Funds cannot be used to cover expenses that are covered by another funding sources (such as the CARES funding).

Reporting and applications subject to single audit requirements along with oversight by FEMA.

COVID-19 Telehealth Program

Executive Summary

Overview

Help health care providers provide connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic

Eligible Providers

Non-profit and public eligible health care providers that fall within the following categories: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers; (3) local health departments; (4) community mental health centers; (5) non-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers.

Websites

- [FCC COVID-19 Telehealth Program](#)
- [FCC COVID-19 Telehealth Program FAQs](#)

Use of Funds

COVID-19 Telehealth Program funding will provide eligible health care providers support to purchase telecommunications, information services, and connected devices necessary to provide telehealth services to patients in response to the COVID-19 pandemic.

Attestation Requirements

Not a grant program; submit request for reimbursement of eligible expenses and services.

Use of Funds and Reporting Requirements

Use of Funds

COVID-19 Telehealth Program funding will provide eligible health care providers support to purchase telecommunications, information services, and connected devices necessary to provide telehealth services to patients in response to the COVID-19 pandemic. Devices for which funding is requested must be integral to patient care.

The COVID-19 Telehealth Program will only fund devices (e.g., pulse oximetry, blood pressure monitoring devices, etc.) that are themselves connected, and will not fund unconnected devices that patients can use at home and then manually report the results to their medical professional. Connected devices may include devices with Bluetooth or Wi-Fi connectivity, including devices that connect to a consumer's phone, for example.

Examples of eligible services and connected devices that COVID-19 Telehealth Program applicants may seek funding for include:

- Telecommunications Services and Broadband Connectivity Services: Voice services, for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equipment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.

Reporting Requirements

The COVID-19 Telehealth Program is not a grant program. To receive disbursements, eligible health care providers that are approved for funding will be required to submit an invoicing form and supporting documentation in order to receive reimbursement for eligible expenses and services. Applicants who receive funding will be required to comply with all program rules and requirements, including applicable reporting requirements, and may be subject to compliance audits.

[Application link for the COVID-19 Telehealth Program](#)

There is no set funding deadline. Funding decisions will be made on a rolling basis, and the FCC will continue to accept and review applications until the funding is exhausted or the current COVID-19 pandemic has ended.

ASPR Grants

Executive Summary

Overview

\$50 million of funding provided through each state hospital association.

Eligible Provider

Each state hospital association determines the eligible providers and funding calculation for their state.

Websites

[Hospital Association COVID-19 Preparedness and Response Activities](#)

Use of Funds

This funding will support activities that prepare health care systems and providers to identify, isolate, assess, transport, and treat patients with COVID-19 or other special pathogens, or Patients Under Investigation (PUI) for such an illness.

Attestation Requirements

- Project Narrative within 60 days of receipt.
- Semi-annual program process report and Federal Financial Report SF-425.
- Five-year cycle for the program.

Use of Funds and Reporting Requirements

Use of Funds

Hospital associations will distribute funds to hospitals and other related health care entities in their states within 30 days, which may be used for the following:

- Quickly update and train staff to implement pandemic or emergency preparedness plans at the facility level to respond to COVID-19
- Procure supplies and equipment in accordance with Centers for Disease Control and Prevention (CDC) guidelines, especially considering growing supply chain shortages
- Rapidly ramp up infection control and triage training for health care professionals, especially considering growing supply chain shortages
- Retrofit separate areas to screen and treat large numbers of persons with suspected COVID-19 infections, including isolation areas in or around hospital emergency departments to assess potentially large numbers of persons under investigation for COVID-19 infection
- Plan, train, and implement expanded telemedicine and telehealth capabilities to ensure that appropriate care can be provided to individuals in their homes or residential facilities when social distancing measures are used to reduce virus transmission
- Increase the numbers of patient care beds to provide surge capacity using alternate care sites such as temporary hospitals that are deployed in a pandemic

Reporting Requirements

STEPS REQUIRED

- Project Narrative within 60 days of receipt.
- Semi-annual program process report and Federal Financial Report SF-425.
- Five-year cycle for the program.

- Completion of required reports in coordination with hospital association may vary by state.
- Each hospital will likely have to submit information or a report to the grantee or the hospital association.

FY 2020 COVID-19 SHIP Funding

Executive Summary

Overview

- One-time funding provides support to hospitals to prevent, prepare for, and respond to COVID-related public health emergency. This includes:
 - Ensuring hospitals are safe for staff and patients;
 - Detecting, preventing, diagnosing, and treating COVID-19; and
 - Maintaining hospital operations.
- Grant awards made from Federal Office of Rural Health Policy (FORHP) to 46 State Offices of Rural Health (SORH) in April 2020
- SORHs administer the program to individual hospitals
- Funding levels vary by state from \$84,317 to \$71,699

Eligible Providers

Small rural hospitals located in the United States and its territories and include hospitals with 49 available beds or less.

Website

[CARES Act SHIP Funding](#)

Use of Funds

Please see PDF – “FORHP COVID SHIP - Example Uses of Funding.”

Attestation Requirements

- Quarterly progress reports through 2021 and final report in 2022

- Funds may not be used for expenses allocated to CARES, PPP, or other applicable funding and also be allocated to SHIP funding

Rural Health Clinic (RHC) COVID-19 Testing Program

Executive Summary

Overview

\$225 million was awarded via the Paycheck Protection Program and Health Care Enhancement Act to support over 4,500 Rural Health Clinics (RHCs) for COVID-19 testing and related expenses.

Eligible Providers

All RHCs that had CMS Certification Numbers (CCNs) and are 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, were eligible to receive Rural Health Clinic Testing funds from the May 20, 2020 distribution.

Websites

- [Rural Health Clinic COVID-19 Testing Program Terms and Conditions](#)
- [Rural Health Clinic COVID-19 Testing Program FAQs](#)
- [Allocation to Rural Health Clinics for COVID-19 Testing](#)
- [Rural Health Clinic COVID-19 Testing Program Data Report](#)
- [National Association of Rural Health Clinics \(NARHC\)](#)

Website

Rural Health Clinic COVID-19 Testing Program funding may be used for COVID-19 testing and related expenses. As set forth in the [Terms and Conditions](#), examples of related expenses include, but are not limited to, 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. Further, the Rural Health Clinic COVID-19 Testing Program funds may be used for building or construction of temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID-19 testing.

Attestation Requirements

- Initial attestation to acknowledge receipt of funds and agree to terms and conditions.
- Within 45 days of receipt of payment via ACH or within 60 days of check payment issuance. Not returning the payment or attesting to the receipt of funds within this timeframe is viewed as acceptance of the terms and conditions.
- Ongoing future reporting to show compliance regarding use of funds.

Funding Process

General Information

- HHS provided Rural Health Clinic COVID-19 Testing Program funding in the amount of \$49,461.42 for each eligible RHC with a unique CMS Certification Number (CCN) associated with an eligible Tax Identification Number (TIN).
- TIN organizations received \$49,461.42 times the number of RHCs it operates.

Payment Mechanism

- RHC COVID-19 Testing Program utilized the Provider Relief Fund payment mechanism.
- Most Rural Health Clinic Testing funds were dispersed electronically based upon banking account information associated with the organization's TIN.
- If the organization's TIN does not have a bank routing number associated with it, the organization received a paper check.

Reporting Requirements

- To monitor and assess the program, per [the Terms and Conditions](#), funded organizations at the Tax Identification Number (TIN) level are required to report the number of tests conducted and the number of positive tests on a monthly basis for the duration of the reporting period retroactively to May 2020.
- RHC COVID-19 Testing Program reporting includes basic information on the RHC organization, the number of and location of testing sites (active and inactive), information on the use of funds, the total number of tests conducted, and the number of COVID-19 positive tests. HRSA intends to use this information to evaluate the effectiveness of the program at an aggregate level. The reporting requirement does not include any personally identifiable, patient-level information.
- TIN organizations should report data on the RHC COVID-19 Testing Report website RHCcovidreporting.com.
- HRSA has funded the [National Association of Rural Health Clinics \(NARHC\)](#) to provide technical assistance to RHCs on the RHC COVID-19 Testing Program. As part of the cooperative agreement, NARHC developed the [RHC COVID-19 Testing Report website](#). If you have additional questions you may email RHCcovidreporting@narhc.org.
- Data reporting requirements are expected to continue for the foreseeable future. HRSA will issue guidance as more information becomes available.