McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY
Sound Health Policy Objectives Achieved

Policy Update

HHS Distributes $22B to Hotspots and Rural Providers

On May 1, 2020, the US Department of Health and Human Services (HHS) announced additional funding details for two previously announced distributions from the Provider Relief Fund: hospitals in areas heavily affected by the Coronavirus (COVID-19) pandemic, and rural hospitals and clinics. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) established the Fund to provide $100 billion in financial relief to support healthcare providers affected by the COVID-19 pandemic. The Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) provided an additional $75 billion to the Fund. With this and previous distributions from the Fund, HHS has distributed $72.4 B, leaving $102.6 billion yet to distribute.

Key Takeaways

- HHS will distribute $10 billion to hospitals that have been particularly affected by the COVID-19 outbreak, or "hotspots" using a fixed per admission formula.
- HHS will also provide a previously unannounced additional $2 billion to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments.
- $10 billion will be distributed to rural general acute care hospitals and critical access hospitals (CAHs), rural health clinics (RHCs) and community health centers (CHCs) located in rural areas.
- Stakeholders are still awaiting clarity on how HHS will reach and support providers that have not yet received any funds, particularly those that primarily serve the Medicaid population, and others that have received funds that are inadequate against need.

Helpful Links

- Press Release
- Allocation by State and County
- More Detail on the Fund
- CARES Funding Opportunities

High-Impact Areas (Hotspots)

HHS allocated $10 billion from the Fund to 395 hospitals across 33 states in areas highly affected by the COVID-19 outbreak. This group represents 71% of COVID-19 admissions. To receive these funds, hospitals were required to provide information through an authentication portal by April 25, 2020. Hospitals applying for these funds reported their total number of intensive care unit beds as of April 10, 2020, and total number of admissions with a positive diagnosis for COVID-19 from January 1 to April 10, 2020.

Payment Distribution
HHS announced that the $10 billion for hotspots will be distributed to any hospital that reported serving 100 or more COVID-19 patients. Hospitals will be paid a fixed amount per COVID-19 inpatient admission. Hospitals will begin receiving funds via direct deposit in the coming days. HHS will also provide a previously unannounced additional $2 billion to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments. It remains unclear from HHS's statements if all of the 395 recipients will receive a share of this $2 billion, or whether HHS is using a specific Medicare, Medicaid, and uncompensated care cut-off.

Fund Allocation ($175 billion)	
$50 billion	Medicare facilities and providers
$12 billion	Hospitals in hotspots
$10 billion	Rural health clinics and hospitals
$400 million	Indian Health Service
Remaining Funds	
$102.6 billion	
Remaining Priorities Identified by HHS	
Uninsured, sole Medicaid providers, nursing facilities and dentists	

Rural Providers

HHS allocated $10 billion to almost 8,000 rural general acute care hospitals, CAHs, RHCs and CHCs across 56 states and territories. Even prior to the COVID-19 crisis, the financial outlook of rural hospitals and clinics was bleak, with a record number of rural hospital closures in 2019. Rural hospital profit margins generally are about half those of urban hospitals, and many rural hospitals run negative margins. This precarious financial position renders them especially vulnerable at this time, making them a priority for HHS and Congress.

Payment Distribution
Through this distribution, non-hospital clinics will each receive a minimum base payment of $100,000, while rural general acute care hospitals and CAHs will receive a minimum level of support of no less than $1 million. An additional payment will be provided based on operating expenses. This expense-based method is intended to account for operating costs and lost revenues.

Eligible providers will begin receiving funds in the coming days via direct deposit, based on the physical address of the facilities as reported to the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration.

A substantial unknown at this point is how HHS is defining "rural" for purposes of this distribution. Current HHS programs deploy nearly a half-dozen different definitions of rural, with some programs relying on Metropolitan Statistical Area schemes, others relying on rural census tracts, and others using different measures of rurality. Some providers who view themselves as "rural," but who may be outside one of the rural areas captured by these tools may find themselves not receiving funds under this distribution.

Providers, including those in the high-impact areas, are required to attest to certain Terms and Conditions in order to keep the funding. It remains unclear if these rural providers will have to do the same.

What's Ahead

HHS has now started to release, or has already released, three of the five previously announced allocations: $50 billion for the general fund, $12 billion for hotspots and $10 billion for rural healthcare providers. HHS has yet to release or provide additional information on the $400 million promised for the Indian Health Service.

The agency has also set up a portal for providers seeking reimbursement for treating and testing uninsured individuals for COVID-19. Although HHS will begin accepting claims this month, it has yet to announce how much of the Fund will be allocated for this purpose.

Currently, $102.6 billion remains uncommitted in the Fund. Beyond its commitment to covering COVID-19 testing and treatment for the uninsured, HHS continues to indicate its intention to more specifically target providers that have not yet received funds, such as those that serve a high Medicaid population. But this next allocation is likely to still leave a substantial chunk of the remaining funds uncommitted. Many stakeholders believe more money will be necessary to support healthcare providers on the frontlines and to supplement lost revenue. It is unclear HHS will distribute the remaining $102.6 billion.

For more information, please contact Rachel Stauffer, Sheila Madhani or Mara McDermott.