COVID-19 EMERGENCY FEDERAL FUNDING SOURCES FOR HOSPITALS

Name	How to Apply	Key Dates	Description	Forms & Resources
Federal Supplemental Payments & Other Financial Relief				
Public Health and Social Services Emergency Fund (the Department of Health and Human Services [HHS])	Hospitals received their distributions from the $50B automatically but must agree to the terms and conditions and submit revenue data. HHS is using hospital data reported through the TeleTracking portal to inform the distributions for high-impact areas. To receive reimbursement for testing and treatment of the uninsured, providers must enroll as participants. Hospitals eligible for the safety net distribution received payments automatically. Eligible hospitals must have entered data into the HHS portal by September 13 to receive payments	Providers must attest to separate Terms and Conditions within 90 days of receiving each payment from the Provider Relief Fund	Congress appropriated $175 billion in a Provider Relief Fund (PRF) for hospitals and other providers nationwide to prevent, prepare for, and respond to COVID-19 to be distributed through grants and other payment mechanisms; eligible expenses include lost revenues from cancelled procedures, building new structures or retrofitting existing buildings, purchasing supplies, training staff, and other COVID-19-related costs. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided an initial $100 billion, and Congress added $75 billion to the fund in the Paycheck Protection Program Increase Act of 2020. **General Distributions** *Phase 1* HHS allocated $50B to providers in "general distributions" based on 2018 net patient revenue. HHS initially released $30B based on a provider's proportionate share of 2019 Medicare fee-for-service (FFS) total payments. HHS distributed an additional $20 billion to providers allocated such that, when added to the initial distribution, it equaled a provider's proportionate share of 2018 net patient revenue. Providers that received a proportionately higher initial distribution received a relatively smaller distribution, or no funds at all, in the second round. Providers that file cost reports received payment automatically based on their reported revenue data. HHS's FAQ document states that it will not recoup funds from providers whose share of Medicare FFS revenue (the	GNYHA Member Letter (ML) on CARES Act Provider Relief Fund Payment Terms and Conditions GNYHA ML on Distribution Portal Provider Relief Fund General Distributions General Distribution FAQs Provider Relief Fund "High-Impact" Distributions GNYHA ML on HHS Data Request for Additional High-Impact Area Distribution

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Public Health and Social Services Emergency Fund (continued)	from the Phase 2 General Distribution. Providers eligible for the Phase 3 General Distribution must have applied through the HHS portal by November 6.		formula for distributing the first $30 billion) exceeded their share of net patient service revenue and thus did not receive funds in the second round unless the amounts exceed the provider's lost revenues and COVID-related expenses not otherwise reimbursed. All providers were required to enter revenue data into the General Distribution Portal, including estimated revenue losses in March and April. Providers that received payments automatically should not have received payment adjustments based on what they entered into the portal for lost revenue, but these amounts are used to cap any additional distributions from the $20 billion if the lost revenue amount is less than net patient revenue. HHS did not use estimated revenue losses to allocate the $50 billion general distribution, but stated that the data may inform future PRF distributions. *Phase 2* HHS also distributed $18 to certain providers—mainly Medicaid and Children's Health Insurance Program (CHIP) providers—that did not receive funds from the Phase 1 General Distributions. Eligible Medicaid/CHIP providers must have not received a Phase 1 General Distribution and directly billed their state Medicaid/CHIP program or Medicaid managed care plans for healthcare related services between January 1, 2018-May 31, 2020. They were also required to report information, including their annual patient revenues and number of Medicaid patients, into HHS's enhanced PRF portal. HHS also allowed assisted living facilities and certain Medicare providers to apply that had a recent change of ownership that made them ineligible for the Phase 1 General Distribution to apply. Eligible providers should have received 2% of their revenues from patient care from their most recent federal income tax return for 2017, 2018, or 2019.	GNYHA ML on $8.5B Targeted Distribution GNYHA ML on Safety Net and Medicaid Distributions GNYHA ML on Phase 3 General Distribution GNYHA ML on Requirements for Phase 3 General Distribution GNYHA ML on PRF FAQs- Auditing and Reporting Requirements GNYHA ML on PRF Revenue Loss Definition COVID-19 Claims Reimbursement for Testing and Treatment to Health Care Providers and Facilities Serving the Uninsured

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Public Health and Social Services Emergency Fund (continued)			*Phase 3* HHS announced in October that it will distribute $20 billion to providers that have not yet received PRF general distribution payments equal to 2% of their annual patient revenue through the Phase 1 and Phase 2 distributions. Eligible providers include: • Providers who previously received, rejected, or accepted a provider relief fund payment (but have not received 2% of patient care revenue) • 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, including Medicare, Medicaid, and CHIP providers, dentists, assisted living facilities, and behavioral health providers Phase 3 distributions, when combined with any prior payments received, will equal 2% of the provider's patient care revenue. With the remaining funds from the Phase 3 general distribution, HHS will calculate an add-on payment for certain providers in excess of 2% of their annual patient revenues that considers financial losses and changes in operating expenses due to COVID-19. Providers must have submitted the following data for Q1 and Q2 of 2019 and 2020 to be considered for an add-on payment: • Change in operating revenues from patient care, defined as net patient service revenue from the delivery of health care services directly to patients, including pharmacy revenue derived through the 340B program. • Change in operating expenses from patient care, including COVID-19-related expenses, defined as operating expenses incurred as part of the delivery of	COVID-19 Uninsured Claims Reimbursement Portal and FAQ GNYHA ML on COVID-19 Uninsured Reimbursement

Name	How to Apply	Key Dates	Description	Forms & Resources
Public Health and Social Services Emergency Fund (continued)			care, including salaries, benefits, medical supplies, contracted and/or employed physicians, and interest and depreciations on building and equipment used in the provision of patient care. • Payments received through prior PRF distributions. HHS has not stated how previous funding will be incorporated into the distribution methodology. The payment methodology will be determined after HHS reviews the applications deadline and will depend in part on how many providers applied and the overall financial need. **Targeted Distributions** *High Impact* HHS initially allocated $12 billion in targeted "high impact" distributions to providers that have been particularly affected by the increased burden in caring for COVID-19 patients (defined as 100+ COVID-19 admissions). In May, eligible providers received $76,975 per COVID-19 admission based on data submitted on admissions through April 10 ($10 billion), and received an additional amount based on their Medicare disproportionate share funding ($2 billion). In July, HHS provided an additional $10 billion to high impact areas (defined as >160 COVID-19 admissions or having at least 0.54864 COVID-19 admissions per bed) using data submitted on COVID-19 admissions through June 10. Eligible hospitals should have received $50,000 per COVID-19 admission, offset by amounts received from the first high impact distribution. *Safety Net Distribution* In June, HHS distributed $10 billion to safety net hospitals that met the specified eligibility criteria. Qualifying hospitals must have a Medicare Disproportionate Payment Percentage of 20.2 or greater, average uncompensated care	

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Public Health and Social Services Emergency Fund (continued)			per bed of $25,000 or more, and profitability (i.e., total profit margin) of 3% or less, as reported on the hospital's most recent Medicare cost report. The minimum payment was $5 million and the maximum payment was $50 million. On July 20th, HHS distributed an additional $3 billion to 215 safety net hospitals. The addition funds were distributed to hospitals that did not qualify for the first safety net distribution but qualified under the revised profitability criteria. HHS revised the profitability threshold to less than a 3% total profit margin "averaged consecutively over two or more of the last five cost reporting periods" as reported on the Medicare cost report. The previous criterion excluded safety net hospitals that had certain one-time transactions that temporarily boosted their "profitability" above the 3% threshold. Importantly, the averaged consecutive cost report year must include the most recent cost report year. On August 14, HHS distributed an additional $1.4 billion in safety net funds to freestanding children's hospitals. *Targeted Distribution for Nursing Homes* HHS allocated $9.4 billion to nursing homes, $2 billion of which will be distributed as a performance-based incentive payment. In May, HHS distributed the first $4.9 billion to facilities with at least six beds by providing a fixed payment of $50,000 plus $2,500 per certified bed. A subsequent $2.5 billion was distributed in August to the same eligible facilities with a fixed payment of $10,000 per facility plus a per-bed payment of $1,450. *Rural Distribution* In May, HHS distributed $10 billion to rural hospitals and health clinics based on their operating expenses. In July. HHS allocated an additional $1 billion to 500 hospitals, expanding its previous rural distribution formula to include certain special rural Medicare designated hospitals in urban areas and others in small metropolitan areas that serve rural populations.	

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Public Health and Social Services Emergency Fund (continued)			*Uninsured Patients with COVID-19* HHS will reimburse providers treating uninsured patients with a primary COVID-19 diagnosis (except for pregnancy, when COVID-19 may be listed as secondary) at Medicare rates (the 20% DRG add-on will not apply), for claims on or after February 4, 2020, subject to available funding. Providers must submit claims electronically, and must not "balance bill" any patient for COVID-19-related treatment services. About $30 billion from the Provider Relief Fund has not yet been allocated. A portion of the remaining funds will be used to pay claims for uninsured COVID-19 patients.	
Suspension of Medicare Sequester (the Centers for Medicare & Medicaid Services [CMS])	N/A; will apply automatically to claims	May-December 2020	The CARES Act suspended the Medicare sequester (2% of all Medicare fee-for-service payments) from May 1-December 2020; the Medicare sequester was extended from 2029 to 2030. Applicability to Medicare Advantage (MA) plans will depend on a hospital's contract terms.	GNYHA ML on CARES Act

20% Medicare Add-On Payment for COVID-19 Cases (CMS)	N/A; will apply automatically to claims	During the public health emergency (PHE), starting 1/27	The CARES Act provided a 20% add-on to the otherwise applicable diagnosis-related group operating payment rate for patients with a COVID-19 diagnosis. The add-on is for hospital claims billed through the Inpatient Prospective Payment System (IPPS) that include certain ICD-10-CM diagnosis codes (applicability to MA plans will depend on a hospital's contract terms):
			
			• Discharges from January 27, 2020—March 31, 2020
			  ◦ B97.29 - Other coronavirus as the cause of diseases classified elsewhere
			• Discharges occurring on or after April 1, 2020
			  ◦ U07.1 - COVID-19
			
			Claims billed on or before April 20, 2020 were automatically reprocessed.
			
			Starting September 1, hospitals will only be eligible for
				GNYHA ML on CARES Act
				
				CMS MLN Article
				
				CDC Coding Guidance before March 31 and April 1–September 30

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20% Medicare Add-On Payment for COVID-19 Cases (continued)			**the add-on payment if the patient has a positive COVID-19 test result documented in the medical record.** Positive tests must be demonstrated by viral tests (molecular or antigen) performed during or up to 14 days before the hospital admission. CMS will conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, will recoup the 20% add-on payment.	
Hospital Preparedness Program (HHS and the Office of the Assistant Secretary for Preparedness and Response [ASPR])	$175 million has been distributed automatically by state/regional hospital associations.	Initial amount distributed to hospitals in early May; second round of funding distributed in late July.	At least $550 million will be appropriated nationwide—$175 million of which was already distributed to hospitals—to reimburse providers for health care-related expenses related to COVID-19, including training staff to implement pandemic or emergency preparedness plans, procuring supplies and equipment, ramping up infection control and triage training, retrofitting separate areas to screen/treat persons with suspected COVID-19 infections, including isolation areas in or around hospital emergency departments to assess persons under investigation, implement expanded telemedicine/telehealth capabilities, and increase beds to provide surge capacity using alternate care sites. The remainder will help hospitals prepare for other, future novel disease outbreaks. Amounts were appropriated by the Coronavirus Preparedness and Response Supplemental Appropriations Act and the CARES Act. Of the $175 million that was allocated through state/regional hospital associations, GNYHA distributed $3.5 million to New York City hospitals, and the Healthcare Association of New York State distributed $4.8 million to hospitals in the rest of New York State. Connecticut received $557,396, and New Jersey received $1,232,698. Connecticut received $1.9 million and New Jersey received $4.3 million through their State hospital associations.	GNYHA ML on first COVID-19 Supplemental GNYHA ML on CARES Act HPP COVID-19 Supplemental Funding Overview HPP Supplemental Funding Table

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Capital Payments for Extraordinary Circumstances (CMS)	IPPS hospitals must apply in writing to their CMS Regional Office explaining the circumstances that led to the unanticipated capital expense (with supporting documentation), estimated expenditure, and any expected reimbursement directly related to the expenditure (e.g., insurance payments)	Hospitals must apply to the CMS Regional Office within **180 days of the end of the COVID-19 PHE** as declared by the President	Hospitals may request additional payment for unanticipated capital expenditures in excess of $5 million (net of proceeds from other payment sources, such as insurance and other government programs) due to extraordinary circumstances. Payment varies by hospital type: Sole Community Hospitals are reimbursed 100% of Medicare's share of allowable capital-related costs attributable to the extraordinary circumstance, but all other hospitals are reimbursed based on a minimum amount of 85% for Medicare's share of allowable capital-related costs attributable to the extraordinary circumstance. Total exception payments are capped at 10% of total capital prospective payments. If aggregate capital exception payments exceed the 10% cap, exception payments to all facilities will be reduced proportionately. Note: Total exception payments include exception payments outside of those for extraordinary circumstance (i.e., payments made through the special exceptions process). Applicants may submit an initial request to the CMS Regional Office that demonstrates the expense is related to the COVID-19 public health emergency and that the expenditure will exceed the $5 million threshold. They may provide supplemental data (e.g., supporting documentation) after the submission of the initial request. Hospitals should contact their CMS regional office for more information on the application process.	42 CFR 412.348: Regulation Pertaining to Capital Exception Payments CMS FAQ on Emergency-related Policies and Procedures that Do not Require 1135 Waivers
COVID-19 Telehealth Program (Federal Communications Commission [FCC])	Providers must apply to the FCC.	The FCC stopped accepting new applications on June 25th	The CARES act appropriated $200 million to the COVID-19 Telehealth Program to help health care providers provide connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. The program supports providers by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services. Funds were distributed on a first come first served basis until the program's funds had been exhausted.	FCC COVID-19 Telehealth Program Homepage

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Employee Retention Credit (ERC) (Treasury Department/IRS)	Employers can receive the credit immediately by reducing their required deposits of payroll taxes that have been withheld from employees' wages by the amount of the credit.	March 12, 2020 to December 31, 2020	The ERC Program provides a refundable tax credit of 50% of up to $10k in wages for each employee paid by an employer who has been financially impacted by the COVID-19 emergency. Eligible employers include for profit and non-profit businesses of all sizes. The employers must either have their business fully or partially suspended by a government order due to COVID-19 during the calendar year or their gross receipts are below 50% of the comparable quarter in 2019. Once the employer's receipts surpass 80% of the comparable quarter in 2019, they are no longer eligible after the end of the quarter. Wages paid between March 12, 2020, and January 1, 2021, are eligible for the credit. Wages are not limited to cash payments, but also include the employer's qualified health plan expenses. Qualifying wages are based on the average number of employees in 2019. For employers with less than 100 employees the credit is based on wages paid to all employees, regardless if they worked or not. For employers with more than 100 employees, the credit is allowed only for wages paid to employees who did not work during the calendar quarter. Eligible employers will report their total qualified wages and the related health insurance costs on their quarterly employment tax returns or Form 941 beginning with the second quarter. If the employer's employment tax deposits are not sufficient to cover the credit, the employer may receive an advance payment from the IRS by submitting Form 7200.	IRS Employee Retention Credit FAQ Form 7200, Advance Payment of Employer Credits Due to COVID-19 IRS ERC Factsheet

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Loan Opportunities				
Accelerated and Advance Medicare Payments (CMS)	Must apply through the Medicare Administrative Contractor. CMS is not accepting new applications for the Advance Payment Program (Part B providers) and is reevaluating applications for Accelerated Payments (Part A providers)	N/A	The CARES Act expanded the existing program to allow acute, cancer, and children's hospitals to request an advance payment of up to 100% of their Medicare payments for a six-month period, while critical access hospitals were able to request up to 125%. Other Medicare providers and suppliers (including physicians) could request up to three months advance payment. In October, CMS released new details of the repayment terms in accordance with the Continuing Appropriations Act, 2021 and Other Extensions Act enacted on October 1, which changed the terms of the program to delay recoupment: • The start of the repayment period will be delayed from 120 days from the issuance of the loan to 12 months. • Beginning 12 months from the issuance of the loan, providers' Medicare claims will be offset by 25% in months 13-23 and by 50% in months 24-29 until the balance is paid off. Providers will see the offset amount on their remittance advice. Prior policy required a 100% offset to Medicare claims. • The interest free loan period will be increased from 12 months to 29 months. If a balance remains after 29 months from the date their loan was issued, providers will receive a demand letter from their MAC. Providers will have 30 days from the date of the letter to repay the balance in full without interest. • The interest rate after 29 months will be lowered from 9.65% to 4%. CMS also clarified that Periodic Interim Payment (PIP) providers will be treated the same as non-PIP providers.	CMS Fact Sheet Information from National Government Services (NGS) NGS hotline: (888) 802-3898 GNYHA ML on Accelerated and Advance Medicare Payments GNYHA ML on New Repayment Terms for Medicare Advances CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program

Name	How to Apply	Key Dates	Description	Forms & Resources
Accelerated and Advance Medicare Payments (continued)			CMS has suspended recoupments under the Accelerated and Advance payment Program but has not provided further details on timing. GNYHA and other stakeholders have been advocating for loan forgiveness (or at a minimum, significantly improved repayment terms and lower interest rates). On April 26, CMS announced that it would reevaluate advance amounts for all Part A applicants (both pending and new).	
Employer Payroll Tax Delay (the Internal Revenue Service [IRS])	No need to notify the IRS	March 27-December 21, 2020	Under the CARES Act, employers can defer payment of the 6.2% FICA tax on wages paid between March 27 and December 21, 2020. Fifty percent of the deferred payment is due by December 31, 2021, and the remaining 50% is due by December 31, 2022. All employers are eligible unless they have had a loan forgiven through the Paycheck Protection Program.	IRS Notice GNYHA ML on CARES Act
Main Street Lending Program (Federal Reserve)	TBD		The CARES Act authorized the creation of the Main Street Lending Program to provide loans for small and mid-size businesses that meet certain requirements. The Federal Reserve has finalized its proposal to expand the Main Street Lending Program to nonprofit organizations, including hospitals. The nonprofit loans have the same terms as the business loans with additional borrower eligibility requirements. The executive compensation restrictions in the Main Street business loans apply to the nonprofit loans. The Federal Reserve made some changes from its proposed term sheet to the finalized version including reducing the required number of days cash on hand, reducing the required asset-to-debt ratio, reducing the ratio of adjusted earnings before interest, depreciation and amortization to unrestricted operating revenues, and increasing the allowed proportion of revenues sourced from donations. Eligible borrowers have annual 2019 revenues of less than $5 billion with less than 40% sourced from donations and an	Main Street Lending Program Proposal to Expand Main Street Lending Program to Non-Profits Nonprofit Organization Expanded Loan Facility Term Sheet Nonprofit Organization New Loan Facility Term Sheet

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Main Street Lending Program (continued)			endowment cap of $3 billion. Eligible borrowers must also have profit margins of at least 2%, at least 60 days of cash on hand, and an asset-to-debt ratio greater than 55%. The program is restricted to nonprofits with 10-15k employees that have been in operation for at least five years. Eligible loans range from $250k to $35 million for new loans and from $10 million to $300 million for expanded loans, with a five-year term. Principal repayment will be deferred for two years, with amortization of 15% at the end of the third year, 15% at the end of the fourth year, and 70% at the end of the fifth year. Interest will be deferred for one year at a rate of LIBOR +3%.	Nonprofit Frequently Asked Questions
Federal Emergency Management Administration (FEMA) Assistance				
Public Assistance (PA) Program (FEMA)	Hospitals, outpatient facilities, rehabilitation facilities, and long-term care facilities should attend a New York Division of Homeland Security and Emergency Services (DHSES) virtual briefing and must submit a request for public assistance (RPA) form through the FEMA grants portal or directly through DHSES	Recommended to apply ASAP, but deadline is waived	President Trump's March 13, 2020, national emergency declaration and subsequent March 20 major disaster declaration for New York unlocked FEMA PA funds for "Category B" reimbursement for emergency protective measures. This includes management, control, and reduction of immediate threats to public safety, emergency medical care, and medical sheltering. It does not include additional categories such as infrastructure repair and replacement. Eligible hospital costs include but are not limited to emergency and inpatient clinical care costs for COVID-19 patients that are not covered by another funding source, establishing and operating alternative care sites to expand capacity, certain administrative costs such as overtime pay, and purchases such as personal protective equipment used directly for medical care. Business-related costs such as revenue loss are not eligible. The PA program includes a 75% Federal cost share; the remaining 25% cannot be covered with other Federal grants/loans. FEMA may recommend an increase up to 90 percent if actual Federal obligations, excluding administrative costs, meet or exceed a qualifying	GNYHA/Witt O'Briens webinar (4/2/20) DHSES information on FEMA PA program for COVID-19 FEMA Public Assistance Program and Policy Guide RPA form DHSES procurement standards guidance for the COVID-19 crisis

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PA Program (continued)			threshold ($100 per capita of State population as of 2002, adjusted annually for inflation using the Consumer Price Index for All Urban Consumers). Although FEMA grant programs are subject to Federal procurement standards, "exigent or emergency circumstances" permit the use of non-competitive procurements. FEMA was involved in other COVID-19 response projects in the New York City area including the construction of temporary hospital sites at the Javits Center and the USS Comfort as part of a "mission assignment." These costs were covered by the Federal government. The CARES Act provided $45 billion on top of an existing $42 billion for the FEMA Disaster Relief Fund (DRF) to fund the PA program. Otherwise, there are no caps on the funding an applicant may receive for eligible expenses.	FEMA COVID-19 Medical Care Costs Eligible for Public Assistance