THORN RUN PARTNERS
GOVERNMENT RELATIONS

Memorandum *May 26, 2020*

COVID-19 Relief and the Public Health and Social Services Emergency Fund

Introduction

On March 27, President Trump signed the Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748), a $2.2 trillion package that includes over $120 billion in funding for frontline providers, drug development, manufacturing capability, and more under the Public Health and Social Services Emergency Fund (PHSSEF). This follows the first COVID-19 response bill, which provided up to $3.4 billion for the PHSSEF. President Trump later signed another package bolstering the CARES Act's funding, including an additional $75 billion for providers. Congress chose not to make any changes to the language on provider funding in that "phase 3.5" legislation, though it is possible that Congress may consider modifications in future packages.

The PHSSEF is a discretionary fund under the Office of the Secretary at the Department of Health and Human Services (HHS) that largely goes to financing projects at various HHS agencies outside of their base funding allocations. The bills provide significant funding that may be accessed by the private sector through grants and other funding mechanisms intended to boost medical surge capacity, manufacturing capacity, and research and development initiatives. $175 billion is made available for hospitals and other providers furnishing COVID-19 care who have lost revenues or incurred expenses due to the emergency. Additionally, the CARES Act provided $250 million for the Hospital Preparedness Program. Other PHSSEF funds made available in the CARES Act will go to reimburse the Health Resources and Services Administration (HRSA) for expenses related to COVID-19, including rural health initiatives, and funds that will be made available by the phase 3.5 bill will go to bolster testing efforts nationwide.

HHS began the distribution of the $100 billion Provider Relief Fund approved in the CARES Act in April, and announcements and distributions continued through May. $50 billion is allocated for Medicare providers and facilities, $10 billion for rural health clinics and hospitals, $12 billion for hospitals in COVID-19 hotspots, $500 million for Indian Health Service (IHS) facilities, and $4.9 billion for nursing homes. Additionally, HHS established a Health Resources and Services Administration (HRSA)-administered program to fund COVID-19 care for the uninsured. Given the distinct purposes for each allocation, HHS has developed separate requirements for providers accessing each tranche of funding. HHS has said that it plans to distribute funding to other providers, including Medicaid-only providers, though it has not yet released any details.

This memo provides additional information on the PHSSEF, explores the legislation that has provided or will provide funding to the PHSSEF, and details Provider Relief Fund allocations and parameters.

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PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND OVERVIEW

The PHSSEF, not to be confused with the Public Health Emergency Fund, supports biodefense, disaster response, and information security across HHS, including the Biomedical Advanced Research and Development Authority (BARDA), the Strategic National Stockpile, the National Disaster Medical System, and the Hospital Preparedness Program. It also supports preparation and response for pandemic influenza. Programs supported by PHSSEF are largely directed by the Assistant Secretary for Preparedness and Response (ASPR), with some exceptions.[1] The PHSSEF does not have an authority in law and is used to separate appropriations for projects from agencies' base appropriations.[2]

BARDA, which draws funding from the PHSSEF, commonly uses Other Transaction Authority (OTA) agreements to fund initiatives in the private sector.[3]

The Hospital Preparedness Program, which draws funding from the PHSSEF, provides grants to state and local governments for preparation for public health emergencies in the U.S. Hospitals may be sub-grantees.[4,5]

CORONAVIRUS 1

In the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (H.R. 6074), Congress appropriated two separate sums for the PHSSEF. One is available immediately, and the other is available on an emergency basis. The two appropriations are as follows:

[1] https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf
[2] https://crsreports.congress.gov/product/pdf/RL/RL33579
[3] https://www.phe.gov/about/amcg/otar/Pages/default.aspx
[4] https://www.phe.gov/Preparedness/planning/hpp/Pages/about-hpp.aspx
[5] https://www.grants.gov/web/grants/view-opportunity.html?oppId=290860

- **Immediately Available** — $3.1 billion for the development of countermeasures; supporting manufacturing technologies for such countermeasures with U.S.-based capabilities; purchasing vaccines, therapeutics and diagnostics; purchasing medical surge capacity; developing enhancements to manufacturing platforms; grants for the construction, alternation, or renovation of non-federally owned facilities for the production of vaccines, therapeutics, and diagnostics as determined as necessary by the Secretary. Of this, $100 million was made available for grants under the Health Centers Program as administered by the Health Resources and Services Administration (HRSA).
- **Reserve Amount** — $300 million for purchasing vaccines, therapeutics, and diagnostics if necessary. The HHS Secretary would need to certify to the two Appropriations Committees that the funding is necessary for it to be released.

Previous bills have provided for grants to bolster state and local public health capabilities, including the construction, alteration, and renovation of non-federally owned facilities (for instance: H.R. 5325 (114), the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act). However, a thorough but non-exhaustive look at legislation passed into law yielded no language similar to that in H.R 6074 giving the Secretary the authority to make grants for the construction, alteration, and renovation of non-federally owned facilities, seemingly without the restriction that the grants go to state and local entities and opening eligibility up to private entities.

CORONAVIRUS 3

In the third COVID-19 package, the Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748), there are a number of expansions on funding provided in the first package as well as new funding targets. This package repeats much of the language in H.R. 6074 regarding the ability to provide funding to construct or improve non-federally owned facilities.

Funding outlined in the bill may be used for boosting medical surge capacity, improving manufacturing capabilities, and purchasing vaccines, therapeutics, and diagnostics in sufficient quantities to meet public health needs.

Public Health and Social Services Emergency Fund

Provision	CARES Act
Total Funding	BOTTOM LINE: $127,289,500,000 in three separate appropriations: • $27,014,500,000 in general. • $275,000,000 for HRSA programs. May be used to restore amounts spent prior to enactment. • $100,000,000,000 available for reimbursements through grants or other mechanisms, for public entities, nonprofits, and Medicare and Medicaid

Provision	CARES Act
	providers including for-profits for health care related expenses or lost revenues attributable to COVID-19.
General	$27,014,500,000 for development of necessary countermeasures and vaccines, prioritizing platform-based technologies with U.S.-based manufacturing capabilities, the purchase of vaccines, therapeutics, diagnostics, necessary medical supplies, medical surge capacity and related administrative activities, the blood supply chain, workforce modernization, telehealth access and infrastructure, initial advanced manufacturing, novel dispensing, enhancements to the U.S. Commissioned Corps, and other preparedness and response activities.
Manufacturing	Funds may be used to develop and demonstrate innovations and enhancements to manufacturing platforms to support capabilities.
Vaccine, Therapeutic, and Diagnostic Purchasing	The Secretary shall purchase sufficient quantities of vaccines developed using funds made available under this legislation in sufficient quantities to address the public health need. Additionally, any products including vaccines, diagnostics, and therapeutics shall be purchased at fair and reasonable pricing. The Secretary may take measures to make items developed with these funds affordable in the commercial market. Funds may be used for the Covered Countermeasure Process Fund. Not more than $16 billion is allocated for procurements of countermeasures for the strategic national stockpile.
State and Local Facilities	Appropriated funds may be used for grants for construction, alteration, or renovation of non-federally owned facilities to improve preparedness and response capability at the state and local level.
Hospital Preparedness Program	Not less than $250 million is available for grants or cooperative agreements with grantees or sub-grantees of the Hospital Preparedness Program.
BARDA	Not less than $3.5 billion for BARDA, including necessary expenses of manufacturing, production, and purchase at the discretion of the Secretary.
Manufacturing	Funds under full heading may be used for the construction, alteration, or renovation of non-federally owned facilities for the production of vaccines, therapeutics, and diagnostics. BARDA funds may be used for the construction or renovation of U.S.-based next generation manufacturing facilities not owned by the United States Government.
VA	Funding may be used to reimburse VA for preventing, preparing for, and responding to COVID-19 for individuals not otherwise eligible for care.
Quarantined Individuals	Up to $289 million may be transferred as necessary to other federal agencies for expenses related to individuals eligible for treatment due to being under a legal quarantine order or in the custody of the Immigration and Naturalization Service.
Supply Chain Report	$1.5 million for a report with the National Academies on the security of the U.S. medical product supply chain.

Provision	CARES Act
HRSA	$275 million for HRSA, including $90 million for Ryan White, $5 million for Health Care Systems at HRSA, and $180 million for the Rural Health program at HRSA, including for telehealth and other rural health activities. May be used to restore amounts spent prior to enactment.
Provider Relief Fund	$100,000,000,000 to reimburse, through grants or other mechanisms, health care providers for health care expenses or lost revenues attributable to COVID-19. None of the funds may be used for costs that have already been reimbursed or are eligible for reimbursement from other sources. Additional information on the Provider Relief Fund can be found below.

Unobligated Funds Under Total Supplemental Appropriation

	Senate Proposal
Total PHSSEF Appropriation	**$127,289,500,000**
As-of-yet Unobligated	**$6,974,000,000**

CORONAVIRUS 3.5

On April 24, President Trump signed the Paycheck Protection Program and Health Care Enhancement Act (H.R. 266), a "phase 3.5" effort to add $75 billion in funding for the PHSSEF's Provider Relief Fund and $25 billion for COVID-19 testing.

Provider Relief Fund

The phase 3.5 bill provides an additional $75 billion to the Provider Relief Fund. The language under which the funds would be distributed is identical to that in the CARES Act.

Testing

The phase 3.5 bill provides $25 billion for the research, development, validation, manufacture, purchase, administration, and capacity expansion of COVID-19 tests.

Phase 3.5 Testing Funding

Allocation	Amount
States, localities, territories, and tribes	$11B
CDC	$1B
NIH	$1.8B
BARDA	$1B
FDA	$22M

Allocation	Amount
Community Health Centers	$825M
Testing Coverage for the Uninsured	Up to $1B
Total	**$16.647B**
Unallocated (Secretary has Flexibility)	**$8.353B**

HHS may transfer testing funding not allocated to States, localities, territories, tribes, and tribal organizations to the CDC, FDA, NIH, and other PHSSEF funds for the purpose of addressing the COVID-19 crisis.

The funding for states, localities, territories, and tribes is allocated in the following tranches:

- $2 billion according to the Public Health Emergency Preparedness grant formula
- $4.25 billion for areas based on relative number of COVID-19 cases
- $750 million to tribes, tribal organizations, and urban Indian health organizations connected to IHS
- The remaining $4 billion is up to Secretarial discretion.

PROVIDER RELIEF FUND

On April 7, 2020, CMS Administrator Seema Verma announced the distribution of a first tranche of $30 billion from the Provider Relief Fund to be distributed to Medicare providers based on their 2019 Medicare fee-for-service (FFS) revenue. On April 22, HHS announced an additional $20 billion for Medicare providers and facilities, $10 billion for rural health clinics and hospitals, $10 billion for hospitals in COVID-19 hotspots, and $400 million for Indian Health Service (IHS) facilities. Additionally, HHS established a Health Resources and Services Administration (HRSA)-administered program to fund COVID-19 care for the uninsured.

On May 22, CMS announced $4.9 billion in funding for skilled nursing facilities (SNF) from the fund, to be distributed in a per-facility lump sum basis plus a per-bed allocation. It also announced that provider relief funding for IHS would be $500 million rather than the previously announced $400 million. CMS said in its April 22 announcement that it would be looking to designate funding for Medicaid-focused providers, such as Certified Community Behavioral Health Clinics, and other provider types that may have particular unaddressed need due to the crisis. However, those needs are still unaddressed.

Provider Relief Fund

Allocation	Amount	Targeted Providers	Distribution Timeline
General Allocation	$50B	Medicare FFS Providers	$26B April 10
		Medicare FFS Providers	$4B April 17
		All Medicare Providers	$20B April 24

Allocation	Amount	Targeted Providers	Distribution Timeline
Targeted Allocation	$12B (updated from $10B)	Hospitals with disproportionate numbers of COVID-19 cases	Providers were required to submit information to HHS on April 25
Uninsured Fund	Unbounded. Would come from unallocated amount	Any provider providing COVID-19 care to an uninsured individual	Providers may register for the program April 27and may begin submitting claims in early May
Rural Allocation	$10B	Rural Health Clinics and Rural Hospitals	Week of April 27
IHS Allocation	$500M (updated from $400M)	IHS facilities	Week of April 27
SNFs	$4.9B	SNFs	May 22
Additional Allocations	Unspecified	Possibilities include dentists and Medicaid-focused providers	Unspecified
Total	**$77.4B**		
Unallocated	**$97.6B**		

General Allocation

HHS said that it had allocated $50 billion to a "general allocation" that would go to Medicare providers based on 2018 net patient revenue. It folded the $30 billion it had already distributed based on providers' Medicare fee-for-service revenues in 2019 into the general allocation and said that the further $20 billion would be allocated such that payments under the general allocation were proportional to Medicare providers' net patient revenue. The next $20 billion will be disbursed starting Friday, April 24 based on CMS cost report data. Providers without sufficient cost report data on file at CMS will need to submit additional information. As with the first tranche of this allocation, the second comes with terms and conditions. Providers have 90 days from the receipt of funds to accept the terms and conditions. HHS has also stated that the department will be conducting significant anti-fraud and auditing work, including by the Office of the Inspector General.

HHS had faced criticism over its initial distribution, with observers noting that distributing funds based on FFS revenue disadvantages areas that have higher Medicare Advantage penetration. Such areas tend to be more densely populated — and thus hit hardest by the pandemic. HHS defended its initial allocation, saying that the "simple formula" was used to get funds out quickly.

Targeted Allocation

HHS allocated $12 billion for hospitals in areas hit particularly hard by the pandemic. Hospitals applied using an HHS portal to submit information including their total number of intensive care unit beds on April 10, 2020 and their total number of admissions with a positive COVID-19 diagnosis from January 1, 2020 to April 10, 2020. 395 hospitals received funding from this allocation. $2 billion of the allocation was distributed to hospitals based on Medicare and Medicaid disproportionate share and uncompensated care payments, and the balance was based on COVID-19 inpatient admissions.

Rural Allocation

HHS set aside $10 billion for rural health clinics and hospitals citing their often-precarious circumstances and their heightened exposure to revenue dips or cost increases. Rural hospitals and rural health clinics (RHC) and rural community health centers (CHC) received a minimum base payment plus a percentage of their annual expenses. Hospitals received no less than $1 million, and non-hospital providers eligible for the payment received no less than $100,000. HHS released a state-by-state breakdown of the funding.

IHS Distribution

HHS initially set aside $400 million for Indian Health Service (IHS) facilities to be distributed as early as the week of April 27 on the basis of operating expenses. However, on May 22, HHS announced that $500 million would be distributed to IHS facilities including hospitals, clinics, and urban health centers.

Care for the Uninsured

HHS will provide reimbursement for the treatment of uninsured COVID-19 payments who received care on or after February 4, 2020. It is notable that Congress did not appear to envision the Provider Relief Fund to be used to cover COVID-19 care for the uninsured. All providers are eligible for reimbursement through the program, and reimbursement will be available for uninsured individuals who qualify for a COVID-19 diagnostic test or have a primary COVID-19 diagnosis. FDA-approved drugs administered as part of an inpatient stay and vaccines will be covered by this program as they become available.

The program is administered by HRSA and providers must enroll as a provider participant through a HRSA portal to receive reimbursement. Participants must agree that reimbursement through the program — which is generally at Medicare rates but may be subject to available funding — will be accepted as payment in full and providers must not balance bill patients. The Kaiser Family Foundation estimated that care for the uninsured for COVID-19 would cost between $13.9 billion and $41.8 billion. There is currently $97.6 unallocated in the Provider Relief Fund, much of which is likely to go to additional allocations, discussed below. Certain items are specifically excluded by the program:

- Air and water ambulances;
- Treatments without COVID-19 primary diagnoses except for pregnancy where COVID-19 is a secondary diagnosis;
- Hospice services; and
- Outpatient drugs covered by Medicare Part D.

SNF Allocation

CMS provided for approximately $4.9 billion in relief for SNFs, including a $50,000 distribution per facility plus $2,500 per bed. Certified SNFs with six or more beds are eligible. HHS has released a state-by-state breakdown of aggregate distributions under the SNF allocation.

Additional Allocations

HHS says that some providers will receive further funding, including dentists, and Medicaid-focused providers. HHS has no specifics to offer at this time though it has issued a request to state Medicaid agencies to submit data to help inform the Administration's plans. CCBHCs, which are Medicaid providers and have been seeking relief through the Provider Relief Fund, are not mentioned.