HHS formula for $20 billion in CARES Act provider grants prompts questions

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The formula HHS will use to distribute $20 billion in COVID-19 relief grants is unclear about how much money providers will get and if enough money will be left after the first direct deposits go out Friday.

HHS Secretary Alex Azar said Wednesday that the department will soon pay out an additional $20 billion from the Coronavirus Aid, Relief, and Economic Security Act's provider relief fund to top up providers that were disadvantaged in the department's first $30 billion round of grant funds based on Medicare fee-for-service reimbursement. The department will now use ***2018 net patient revenue*** to decide providers' total share of the total $50 billion, and send out the second round of grants accordingly.

But cost report data is incomplete, and Azar said some of the funds will be distributed on Friday before the department begins collecting data from providers who don't already have information on file. Some are worried that they could be left out, or that funds could be delayed.

The second round of funds should benefit some providers who were largely excluded from the earlier tranche, such as children's hospitals. The first round's formula emphasized Medicare revenue. According to Azar, one large children's hospital that got $233,000 from the first round of funds will get an additional $32 million on Friday.

But a Modern Healthcare analysis found that nearly a quarter of the 82 children's hospitals that filed full-year 2018 CMS cost reports failed to fill out the net patient revenue field that will be used to distribute the funds.

Children's Hospital Association chief operating officer Amy Knight said the new distribution formula is an improvement for children's hospitals, but a lack of centralized data will complicate the effort.

"That data is hard to come by, which is a challenge for children's hospitals," Knight said.

Independent physician groups are also worried about their share of the funds, as they don't file CMS cost reports. American Academy of Family Physicians Senior Vice President Shawn Martin said he was concerned that some physician practices have additional reporting and data analysis obstacles to obtaining the funds.

With data missing, McDermott+Consulting vice president Mara McDermott said it's difficult to tell what total proportion HHS is using to send out the first wave of direct deposit payments, and how much will be left over.

"It feels like a total black box to me. How do you rebalance the funds with less than you started with?" McDermott said.

With funds going to smooth uneven grants from the first round, some providers will likely get less than they would have if the $20 billion had just been determined proportionally on cost report data. Federation of American Hospitals President and CEO Chip Kahn said he is disappointed the formula isn't focused on COVID-19 related losses, and is unsure his member hospitals will get enough support in the second round.

"I can't say until we see all of the money, but I have my doubts and I sincerely hope they find other ways to give out what's left and the new $75 billion," Kahn said, referring to Congress' passage of a bill replenishing grant funds on Thursday.

While HHS chose to distribute funds to rural hospitals and Indian Health Service providers based on operating expenses, they are allocating general funds by net patient revenue.
Health policy experts including Guidehouse healthcare partner Dave Moseley said the net patient revenue metric favors providers with more commercially insured patients, which are largely better off anyway. But Moseley also noted HHS had to make hard choices to get the grants out fast.

"When there is an expediency requirement, equitability is not as high on the priority list," Moseley said.

Many variables such as different organizational structures, market pricing, and payer mix are difficult to account for using any one metric, Knight said.

"It's messy, and people are working hard to create some sense of relief. No number is perfect," Knight said.

2018 net patient revenue vs. operating expenses

Highest net patient revenue	Highest operating expenses
New York Presbyterian Hospital, New York **$5,951,047,108**	New York Presbyterian Hospital, New York **$5,889,911,000**
Cleveland Clinic Hospital, Cleveland **$5,164,424,360**	Cleveland Clinic Hospital, Cleveland, Ohio **$5,775,457,364**
KFH - Fontana, Fontana, Calif. **$4,404,479,570**	NYU Langone Hospitals, New York **$4,358,450,898**
Stanford Health Care, Stanford, Calif. **$4,132,132,686**	Vanderbilt University Medical Center, Nashville, Tenn. **$4,032,836,216**
NYU Langone Hospitals, New York **$4,101,296,000**	Memorial Hospital for Cancer and Allied Diseases, New York **$3,879,672,753**
AdventHealth Orlando, Orlando, Fla. **$3,769,768,374**	Massachusetts General Hospital, Boston, Mass. **$3,820,595,000**
KFH - Los Angeles, Los Angeles, Calif. **$3,653,264,695**	Montefiore Medical Center, Bronx, N.Y. **$3,810,931,000**
UCSF Medical Center, San Francisco, Calif. **$3,620,962,130**	Stanford Health Care, Stanford, Calif. **$3,798,273,217**
UT MD Anderson Cancer Center, Houston, Texas **$3,480,505,919**	UCSF Medical Center, San Francisco, Calif. **$3,575,085,309**
Vanderbilt University Medical Center, Nashville, Tenn. **$3,442,776,569**	Indiana University Health, Indianapolis, Ind. **$3,469,131,965**

Source: 2018 cost reports

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