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Sources of Federal Funding for Health Care Facilities: Frequently Asked Questions

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Sources of Federal Funding for Health Care Facilities: Frequently Asked Questions

Health facilities, including hospitals, may face a number of financial challenges. In recent years, some hospitals have reported that financial issues have contributed to closures or reductions in services. Other types of health facilities may also face financial challenges, such as increasing costs related to facility upgrades, maintenance, training, and other expenses. Although health facilities receive federal payments for services provided to individuals enrolled in federal programs, these payments are generally not intended to keep health facilities operational. The challenges that health facilities may face raise questions about potential sources of federal support.

This report compiles Frequently Asked Questions (FAQs) to provide examples of how the federal government supports health facilities. It focuses primarily on hospitals because of recent reports of hospital closures or potential closures. This report also highlights select programs that may provide support to other types of health facilities.

The FAQs in this report discuss federal payments to hospitals for services rendered to beneficiaries and enrollees in federal programs, as well as additional payments that these programs provide. The FAQs also describe programs that may be available to support health facilities during an emergency or natural disaster, as well as grant programs, technical assistance, and ad hoc funding sources that may be available. This report does not address programs that support the health care workforce, nor does it discuss programs that support federal health facilities, such as those operated by the Department of Veteran's Affairs or the Department of Health and Human Services' Indian Health Service.

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Health care facilities, including hospitals, may face a number of financial challenges, some of which if they persist can lead to hospital closures or a reduction of services. Though the reasons for hospital financial distress are complex, hospitals are required to have certain services and maintain operations 24 hours a day, thus they have high fixed costs. Fixed costs may be hard to manage for certain hospitals, in particular small hospitals that have low patient volume. Prior literature has identified several factors that are associated with financial distress, including the demographics and health status of the patients served by the hospital, the hospital's size or patient volume, and the payer mix of the hospital. Specifically, the balance of payers between those who are uninsured or self-pay, covered by government programs such as Medicare and Medicaid, and those who have private health insurance coverage is associated with differences in financial stability. Payers generally pay hospitals different rates for services, and hospitals generally receive the lowest (or no payment) for individuals who are uninsured. Hospitals that have a high volume of uninsured patients, or serve those who are covered by Medicaid, which pays less than Medicare or private health insurance, may face challenges in meeting their fixed costs.¹

In addition to general challenges with meeting the fixed costs of operating a health facility, facilities may need funding for capital improvements. The financial challenges that hospitals and other types of health facilities may face, compounded by the need for additional funding for capital improvements, raise questions about potential sources of federal support for health facilities. This compilation of Frequently Asked Questions (FAQs) provides examples of how the federal government supports health facilities. Although the FAQs focus primarily on hospitals because of reports of closures, they also address programs that may provide support for a broader group of health facilities. This report discusses federal payments to hospitals for services rendered to beneficiaries and enrollees in federal programs and additional payments that these programs provide. Other questions in this report address potential grant programs, technical assistance, and temporary funding sources that may be available to health facilities in emergency situations. In many cases, assistance is not exclusive to hospitals or other health facilities. This FAQ report does not address programs that support the health care workforce, nor does it discuss programs that support federal health facilities, such as those operated by the Department of Veteran's Affairs or the Indian Health Service.

Do Medicare and Medicaid Pay Hospitals to Prevent Discontinuation of a Service or Hospital Closure?

No. Federal health insurance programs such as Medicare and Medicaid generally *pay for covered services furnished* to beneficiaries and enrollees. Medicare and Medicaid do *not provide direct financial assistance to support* financially distressed hospitals or to prevent discontinuation of a service or a hospital closure through payments to providers and suppliers.²

¹ For a longer discussion of the complexities of hospital financial distress, see CRS Report R47526, *Closed, Converted, Merged, and New Hospitals with Medicare Rural Designations: January 2018-November 2022*.

² For more information, see CRS Report R40425, *Medicare Primer*, and CRS Report R43357, *Medicaid: An Overview*.

Medicare

How Does Medicare Pay Acute Care Hospitals?

For inpatient acute care (as opposed to, for example, psychiatric or rehabilitation) hospital services, the traditional Medicare Part A (as opposed to Medicare Advantage, Part C) payment system is called the inpatient prospective payment system, or IPPS. For hospital outpatient department services, under traditional Medicare Part B, the payment system is called the outpatient prospective payment system or OPDS.³

The IPPS payment rate is based on the historic costs to provide hospital services to Medicare beneficiaries, trended forward to account for inflation—called the *base* payment rate.⁴ IPPS consists of two base payment rates: one that incorporates hospital operating costs (e.g., labor and supplies) and another for the capital costs (e.g., depreciation, interest, rent, and property-related insurance and taxes) of furnishing inpatient hospital services to Medicare beneficiaries. Thus, Medicare pays an acute care hospital two per-discharge payments for each Medicare inpatient—an operating payment and a capital payment. The IPPS base payment rates—operating and capital—reflect the average cost per hospital discharge for furnishing inpatient hospital services to Medicare beneficiaries.⁵

The OPDS payment is also a predetermined, fixed payment for each ambulatory payment classification (APC) based on historical costs, trended forward for inflation and adjusted by a conversion factor (CF) that reflects the average cost of furnishing outpatient hospital services to Medicare beneficiaries. The OPDS payment is intended to cover both the direct costs of care, including nursing services and medical supplies, and indirect costs, such as the amortization and depreciation of equipment and rooms.⁶

Medicare pays separately for professional services (e.g., physician services such as surgeon, anesthesiologist) furnished during a hospital inpatient stay or an outpatient visit. The payment system for professional services is called the physician fee schedule (PFS).⁷

Some hospitals, such as Critical Access Hospitals, are exempt from IPPS and OPDS. These hospitals receive payments based on the specific, individual hospital's cost of furnishing inpatient services to Medicare beneficiaries, commonly referred to as “cost-based” payment.

³ Providers and suppliers that furnish care to program beneficiaries are paid according to the appropriate Medicare payment system, determined in part by the type of provider or supplier, as well as the site of service. Different types of hospitals—acute care, psychiatric, or rehabilitation—have their unique Medicare payment systems and payment methodologies, and payments for inpatient services furnished at an acute care hospital are determined by a payment system distinct from outpatient services received at the same facility.

⁴ The IPPS base rate was originally established using hospital operating and capital costs in the early 1980s. The base rate is updated annually by an inflation factor. The base rate amount reflects a sort of “average” cost of furnishing inpatient hospital services to a Medicare beneficiary. For an overview of Medicare IPPS, see Medicare Payment Advisory Commission (MedPAC), “Hospital Acute Inpatient Services Payment System,” revised October 2023, https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_hospital_FINAL_SEC.pdf.

⁵ U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), “Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services,” 48 *Federal Register* 39752, September 1, 1983, p. 39764. HCFA is now the Centers for Medicare & Medicaid Services.

⁶ For an overview of Medicare IPPS, see Medicare Payment Advisory Commission (MedPAC), “Outpatient Hospital Services Payment System,” revised October 2023, [MedPAC_Payment_Basics_23_OPD_FINAL_SEC.pdf](#).

⁷ For an overview of the Medicare PFS, see Medicare Payment Advisory Commission (MedPAC), “Physician and Other Health Professional Payment System,” revised October 2023, [MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf](#).

Under the capitated payment structure of Medicare Advantage (MA, or Medicare Part C), Medicare pays private insurers (rather than hospitals and providers directly) a fixed per member, per month amount. The insurers (or MA plans) then contract with and pay providers (e.g., hospitals) to furnish covered health care services. MA plans set payment rates based on negotiations with providers such as hospitals.

Under both *traditional* and MA payment methods, hospitals manage the revenues from Medicare and other sources such as Medicaid and private insurance to help maintain financial viability.

Do Acute Care Hospitals Receive Medicare Payments for Costs Other than Services to Beneficiaries?

Yes. Medicare pays hospitals for certain costs that may not be compensated by the Medicare IPPS and OPSS *predetermined, fixed payment rates*. The IPPS and OPSS *base* payment rates are subject to certain adjustments based on hospital activities and characteristics that are associated with higher costs not accounted for by the base IPPS or OPSS payment rates. However, these payments are not made specifically and directly to prevent a hospital closure or a reduction in services. Such adjustments may take the form of a percentage increase to each Medicare per-discharge payment or it may be a fixed dollar amount paid to a hospital (e.g., an add-on payment). These Medicare IPPS and OPSS payment adjustments are listed in the text box below, along with brief descriptions of each. Payment adjustments or add-ons for hospital performance on quality and safety measures/metrics, or for meaningful use of electronic health record technology, are not included in the list because they are penalties or bonuses for hospital performance or achievement rather than for hospital costs. Unless otherwise noted, the adjustment or add-on applies to both the operating and capital IPPS payments. And all of the adjustments and add-ons listed below apply only to IPPS payments, unless OPSS is explicitly noted.

The adjustments and add-ons are not intended to make hospitals “whole.” Rather, they defray a portion of the associated additional costs (e.g., for serving a disproportionate number of low-income patients), and the payments and adjustments apply only to Medicare payments for inpatient services furnished to Medicare beneficiaries covered under traditional Medicare. These adjustments may not be available under MA or through other payers such as Medicaid or private/commercial insurance payments. Thus, even a hospital that is financially distressed and qualifies for these Medicare payments and adjustments may not receive similar adjustments for its non-Medicare patients.

Medicare Hospital Payment Adjustments and Add-ons

Payment Adjustments

Geographic Adjustments. The IPPS and OPSS base are adjusted to reflect geographic factors, including area hospital wages relative to the national average hospital wages, commonly referred to as the “hospital wage index” adjustment. Additionally, the IPPS payment is further adjusted by a cost-of-living adjustment (COLA) for hospitals located in Alaska and Hawaii.

Case Mix Adjustment. The IPPS and OPSS base payments are adjusted to account for a patient’s clinical condition, diagnosis(es), and related treatment costs relative to the average Medicare case costs. The adjustment amount under IPPS is based on a classification system for assigning a weight to clinical cases called the Medicare Severity Diagnosis Related Groups, or MS-DRGs. The adjustment amount under OPSS is based on a classification system for assigning a weight to outpatient services based on clinical and cost similarity called the ambulatory payment classification (APC).

High-Cost Outlier Cases. Medicare adjusts IPPS and OPSS payments for cases whose costs are extremely high relative to a case’s assigned DRG or APC weight/amount, subject to meeting a predetermined fixed-loss ratio.

Medicare Disproportionate Share Hospital (DSH). DSHs may receive an adjustment of the IPPS base payments to account for the higher costs associated with treating a disproportionately high share of low-income (insured) patients.

Medicare Indirect Medical Education (IME). Teaching hospitals may also receive an adjustment of the IPPS base payments for the increased indirect costs of teaching hospitals relative to nonteaching hospitals.

Medicare Low-Volume Hospital (LVH) Adjustment. Qualifying hospitals may receive an adjustment of the IPPS payment amount to account for the incremental increase in the cost (greater than the national base rate) associated with a low volume of patients.

Medicare-Dependent Hospital (MDH) Designation. Qualifying hospitals may receive an adjustment of the IPPS *operating* base payment rate if their Medicare patient population reaches a certain threshold relative to their total patient population that results in a payment that is greater than the national base rate.

Organ Acquisition. Medicare pays hospitals for the costs of acquiring an organ(s) from Medicare and non-Medicare live and deceased organ donors for an organ recipient who is a Medicare beneficiary.

Sole Community Hospital (SCH) Designation. The SCH designation allows a qualifying rural or geographically isolated hospital to receive an alternative IPPS *operating* base rate—a hospital-specific rate or HSR, rather than the national base rate—that may result in a payment that is greater, but no less, than the national base rate. SCHs also receive a +7.1% payment increase under OPSS.

Add-on Payments

Bad Debt. Hospitals receive a payment that compensates them for a portion of Medicare beneficiaries' unpaid, uncollectible coinsurance and deductibles.

Blood Clotting Factors. Hospitals receive an add-on payment for the costs of administering blood clotting factors to patients with hemophilia.

Direct Graduate Medical Education (DGME). Teaching hospitals receive a payment for expenses related to the salary, stipend, and fringe benefits incurred by the hospital's approved medical residency program. This payment also includes the costs for faculty and overhead for the administration and operation of a residency program.

Islet Cell Transplantation Clinical Trial. Medicare pays hospitals for the costs of participating in a National Institutes of Health (NIH)-sponsored islet cell transplantation clinical trial for patients with Type I diabetes.

New Technology Add-On Payment (NTAP). Medicare pays hospitals for the costs of treating Medicare beneficiaries with certain newly FDA-approved, costly technologies. IPPS and OPSS have distinct criteria and methodologies for determining add-on payments for new technology.

Nursing and Allied Health Education. Qualifying hospitals receive an add-on payment for the cost of nursing and allied health education activities.

Uncompensated Care. Hospitals that qualify may receive a payment that compensates them for a portion of their uncompensated care costs. Uncompensated care costs are charity care, non-Medicare bad debt, and nonreimbursable Medicare bad debt.

Sources: Centers for Medicare & Medicaid Services, MLN Education Tool, Medicare Payment Systems, Acute Care Hospital Inpatient Prospective Payment System, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Acute> and Hospital Outpatient Prospective Payment System, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospital>.

Medicaid

How Does Medicaid Pay Acute Care Hospitals?

For the most part, states establish their own payment rates for Medicaid providers, such as acute care hospitals, to deliver services to Medicaid enrollees. Payment rates vary by state. Federal statute requires these rates to be “consistent with efficiency, economy, and quality of care and ... sufficient to enlist enough providers so that care and services are available” to Medicaid enrollees

at least to the same extent they are available to the general population in the same geographic area.⁸ This requirement is referred to as the *equal access provision*.

These provider rates for services provided to Medicaid enrollees are referred to as *base rates*. Low Medicaid base rates in many states and their impact on provider participation have been perennial policy concerns. Studies have shown that many providers, particularly physicians, do not accept Medicaid patients in part due to low Medicaid payment rates, which limits patients' access to care.⁹

Do Acute Care Hospitals Receive Medicaid Payments for Costs Other than Services to Beneficiaries?

Yes. States may make supplemental payments to hospitals, which are Medicaid payments to providers that are separate from—and in addition to—the payments for services rendered to Medicaid enrollees.¹⁰ States may provide supplemental payments to hospitals to support quality initiatives, graduate medical education (GME), and certain types of facilities (e.g., rural providers), among other reasons. Typically, providers receive supplemental payments in a lump sum. States make most supplemental payments through the fee for service (FFS) model of service delivery, but states have the option to make supplemental payments through the managed care model of service delivery.¹¹

Most states make FFS supplemental payments. Some of these payments are federally required, whereas others are optional for states. The federally required FFS supplemental payments are Medicaid disproportionate share hospital (DSH) payments.¹² States are permitted, but not required, to make other non-DSH FFS supplemental payments, which typically are limited by upper payment limits (UPLs) for certain institutional providers. These UPLs are what Medicare would pay for the same or comparable services.

Most states and the District of Columbia make non-DSH supplemental payments in addition to DSH payments under FFS, and together these payments represent a sizeable percentage of total Medicaid spending. In FY2022, total Medicaid DSH and non-DSH supplemental payment to hospitals constituted more than half (57%) of total Medicaid FFS medical assistance expenditures for inpatient hospital services. Medicaid DSH payments were \$15.0 billion, and non-DSH supplemental payments were \$23.3 billion. For outpatient hospital services, supplemental payments were 26% of the total Medicaid FFS medical assistance expenditures to inpatient hospital services, or \$3.9 billion.¹³

⁸ §1902(a)(30)(A) of the Social Security Act.

⁹ Medicaid and CHIP Payment and Access Commission, “Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey,” Issue Brief, June 2021. Sandra L. Decker, “In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help,” *Health Affairs*, vol. 31, no. 8 (August 2012), pp. 1673-1679.

¹⁰ For more information about Medicaid supplemental payments, see CRS Report R45432, *Medicaid Supplemental Payments*.

¹¹ Medicaid enrollees generally receive benefits via one of two service delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, Medicaid enrollees get some or all of their services through an organization under contract with the state. Most states use a combination of FFS and managed care. For more information about these service delivery systems, see CRS Report R43357, *Medicaid: An Overview*.

¹² For more information about Medicaid disproportionate share hospitals payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

¹³ CRS analysis of the Centers for Medicare & Medicaid Services (CMS), Form CMS-64. Data as reported by states to (continued...)

At the state level, total Medicaid DSH and non-DSH supplemental payment expenditures as a share of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative expenditures) for hospital services varied widely across all 50 states and the District of Columbia.

States are able to make a type of supplemental payment through managed care.¹⁴ These payments are called *state-directed payments*, and they can be made to providers (including hospitals) separately from and in addition to the payments for services rendered to Medicaid enrollees. State-directed payments are required to (1) be based on the utilization and delivery of services; (2) be directed equally to the class of providers; (3) advance at least one of the goals and objectives in the quality strategy; and (4) have an evaluation plan, among other requirements.¹⁵ In 2022, the Centers for Medicare & Medicaid Services approved 169 state-directed payments in 38 states, and most of these payments involved hospitals.¹⁶

Do Other Health Care Facilities Receive Medicaid Payments for Expenses Other than Services to Beneficiaries?

Yes. In addition to the Medicaid payments for services provided to enrollees, states may make supplemental payments to other health facilities.

Hospitals receive a vast majority of the supplemental payments under Medicaid FFS (see the previous question for more information), but other health facilities also receive these payments. For instance, states have the option to make Medicaid DSH payments to mental health facilities; in FY2022, states made such payments totaling \$2.9 billion. In addition, states made non-DSH supplemental payments to nursing facilities (\$2.9 billion), intermediate care facilities for individuals with intellectual disabilities (\$0.1 billion),¹⁷ and clinics (\$0.1 billion).¹⁸

Under managed care, states are also able to make *state-directed payments* (discussed in the previous question) to other health facilities in addition to hospitals.

What Grant and Loan Programs Can Support Health Facilities?

Few current grant programs¹⁹ provide financial assistance directly to health facilities. However, a number of broader funding opportunities—block grants, competitive grants, and loan programs—

the Medicaid Budget and Expenditure System, as of August 11, 2023, at <https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html>.

¹⁴ For more information about Medicaid managed care, see CRS Report R43357, *Medicaid: An Overview*.

¹⁵ 42 C.F.R. §438.6(c)(2).

¹⁶ U.S. Government Accountability Office, *Medicaid Managed Care: Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency*, GAO-24-106202, December 2023, <https://www.gao.gov/assets/d24106202.pdf>.

¹⁷ The primary purpose of the intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) is to furnish health or rehabilitative services to persons with intellectual disabilities or other related conditions. ICFs/IID must provide certain services, including nursing, physician, dental, pharmacy, and laboratory services.

¹⁸ CRS analysis of the CMS, Form CMS-64. Data as reported by states to the Medicaid Budget and Expenditure System, as of August 11, 2023, at <https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html>.

¹⁹ Historically, the Hill-Burton program provided funding to hospitals in exchange for free or reduced care. The (continued...)

may be relevant. Several examples of these programs are listed below (note that the list of examples is not comprehensive).

Facilities often seek capital funding for construction or renovation projects; however, many federal programs specifically preclude capital or building activities and expenses under the funding program, so these types of projects may be ineligible. This prohibition varies from program to program. Exceptions where capital projects are permissible are noted below.

For general information on federal assistance, see CRS resources on grants and federal assistance, such as CRS Report RL34035, *Grants Work in a Congressional Office*, and CRS Report RL34012, *Resources for Grantseekers*.

What Are Examples of Block Grants that Can Support Health Facilities?

Most federal grant funding (more than 80%) is awarded to states in the form of formula or block grants that are then distributed by state agencies through grants or contracts to local entities that run specific programs or offer specific services. Information on how to apply for these funding opportunities is available from the entity (often a state-level agency) that received the prime federal grant. Examples of a few federal formula grant programs that might be relevant for health facilities are listed below, along with links to contact information for the state agencies that administer the programs.

- **Preventive Health and Health Services Block Grant (PHHS)**, through the Department of Health and Human Services (HHS), provides funds to states, territories, and tribes to address public health needs.²⁰
- **Community Services Block Grant (CSBG)**, through HHS, provides federal funds to states, territories, and tribes for distribution to local agencies to support a wide range of community-based activities to reduce poverty.²¹
- **Community Development Block Grant (CDBG)**, through the Department of Housing and Urban Development (HUD), provides funds to address a wide range of unique community development needs. (Certain types of capital projects may be allowable expenses under CDBG.)²²
- **Social Services Block Grant (SSBG)**, through HHS, awards funds to support a variety of initiatives for children and adults, including certain health services.²³

program does not provide current funding, but some facilities may still have an obligation to provide care under this program because of prior receipt of funds. For more information on the Hill-Burton program and the facilities that still have an obligation to provide free or reduced care under that program, see Health Resources and Services Administration (HRSA), “Hill-Burton Free and Reduced-Cost Health Care,” <https://www.hrsa.gov/get-health-care/affordable/hill-burton>.

²⁰ Centers for Disease Control and Prevention, “Preventive Health and Health Services (PHHS) Block Grant,” <https://www.cdc.gov/phhs-block-grant/>. For state agencies’ contact information, see <https://snapshot2024.cdc.gov/phhsblockgrant/phhscontacts.htm>.

²¹ CRS Report RL32872, *Community Services Block Grants (CSBG): Background and Funding*; HHS, Office of Community Services, “Community Services Block Grant (CSBG),” <https://www.acf.hhs.gov/ocs/programs/community-services-block-grant-csbg>. For state agencies’ contact information, see <https://www.acf.hhs.gov/ocs/map/csbg-map-state-and-territory-grantee-contact-information>.

²² CRS Report R43520, *Community Development Block Grants and Related Programs: A Primer*. For state and local contacts, access this link, choose “CDBG” and the specific state: <https://www.hudexchange.info/grantees/contacts/>.

²³ Health and Human Services, “Social Services Block Grant,” <https://www.acf.hhs.gov/programs/ocs/programs/ssbg/> (continued...)

- **Maternal and Child Health Services Block Grant (MCHBG)**, through HHS, awards funds to states to improve public health systems for mothers, children, and their families. Funds may be used for health services.²⁴

What Are Examples of Competitive Grant Programs that Can Provide Assistance to Health Facilities?

Competitive project grant programs are awarded directly to individual entities; examples of a few direct grants that may be relevant to health facilities are below.²⁵ However, these programs may not necessarily have open competitions at this time. The organization would need to monitor Grants.gov or review individual agency websites for open grant competitions under these programs.

- **Investments for Public Works and Economic Development Facilities** grants from the Economic Development Administration (EDA) at the Department of Commerce can be used to support the construction or rehabilitation of essential public infrastructure and other facilities to assist areas experiencing long-term economic distress or sudden and substantial economic dislocation. (Certain types of capital projects may be allowable expenses.)
- **Community Facilities Direct Loan & Grant Program**, through the U.S. Department of Agriculture (USDA), provides affordable funding to develop essential community facilities in rural areas. (Certain types of capital projects may be allowable expenses).²⁶
- **Rural Economic Development Loan and Grant Program**, through USDA, which provides zero-interest loans to local utilities that in turn pass through to local businesses for rural projects. Funds can be used for facilities and equipment for medical care for rural residents. The rural businesses then repay the local utility.²⁷
- **Distance Learning and Telemedicine Program**, through USDA, which is a competitive grant program for rural communities to purchase equipment and broadband, among other technology, related to delivering distance learning and telemedicine programs.²⁸

about. For state agencies' contact information, see <https://www.acf.hhs.gov/ocs/contact-information/ssbg-grantee-contact-information>.

²⁴ HRSA, Maternal & Child Health, "Title V Maternal and Child Health Services Block Grant," <https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-services-block-grant>. For regional office contract information, see <https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-block-grant/staff>.

²⁵ Outpatient primary care entities that provide care to all patients in a given service area, regardless of their ability to pay, may be eligible to apply for health center operating grants to become health centers. Health Centers are eligible for grants for technical assistance and some emergency funding, as discussed in "What Federal Programs Can Provide Technical Assistance to Health Facilities?" and "How Has HRSA Supported Health Care Facilities During Emergencies?" Also see CRS Report R43937, *Federal Health Centers: An Overview*.

²⁶ USDA, Rural Development, "Community Facilities Direct Loan & Grant Program," <https://www.rd.usda.gov/programs-services/community-facilities/community-facilities-direct-loan-grant-program>.

²⁷ See USDA, Rural Development, "Business and Industry Loan Guarantees," <https://www.rd.usda.gov/programs-services/business-programs/business-industry-loan-guarantees>.

²⁸ See USDA, Rural Development, "Distance Learning & Telemedicine Grants," <https://www.rd.usda.gov/programs-services/telecommunications-programs/distance-learning-telemedicine-grants>.

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**, through HHS, may award grants that may be available to health facilities that serve specific populations and conditions. See the grant announcements for the current fiscal year.²⁹
- **Health Resources and Services Administration (HRSA) Rural Health Funding Opportunities** provides a list of funding sources that may be applicable to rural facilities.³⁰

Other federal sources of information and funding support include the following:

- The **Small Business Administration (SBA)** provides a wide range of resources and opportunities to locate funding for small businesses; loans and technical assistance (such as free business counseling) are typical forms of assistance. (Certain types of capital projects may be allowable expenses.)³¹
- **DSIRE Database, through the NC Clean Energy Technology Center**, with support from the **U.S. Department of Energy**, maintains a database (DSIRE) of energy incentives. The incentives are searchable by state, coverage area, eligible sector (e.g., nonprofit), and other filters. (Certain types of capital projects may be allowable expenses.)³²
- **U.S. General Services Administration’s Office of Personal Property Management** helps state and local agencies and nonprofits acquire surplus federal property, which may include equipment, furniture, and vehicles, among other items.³³

What Are Examples of Loan Programs that Can Provide Assistance to Health Facilities?

In addition to block and competitive grant programs, loan programs offered through federal agencies may be applicable to health facilities seeking financial support. Examples are provided below; some are cross-listed since they provide both grants and loans.

²⁹ Substance Abuse and Mental Health Services Administration, “Grants,” <https://www.samhsa.gov/grants>.

³⁰ HRSA, “Find Grant Funding,” <https://www.hrsa.gov/grants/find-funding?search=&status=All&bureau=90>.

³¹ Small Business Administration, “Funding Programs,” <https://www.sba.gov/funding-programs>. For district offices, see <https://www.sba.gov/about-sba/sba-locations/sba-district-offices>. Also see CRS In Focus IF12449, *Connecting Constituents with Federal Assistance for Businesses*.

³² Database of State Incentives for Renewables & Efficiency (DSIRE), <https://www.dsireusa.org/>. Also refer to “Compendium of Federal Resources for Health Sector Emissions Reduction and Resilience,” <https://www.hhs.gov/climate-change-health-equity-environmental-justice/climate-change-health-equity/actions/health-care-sector-pledge/federal-resources/index.html>, and the Department of Energy’s “Better Buildings,” <https://betterbuildingsolutioncenter.energy.gov/>.

³³ U.S. General Services Administration (GSA), “Personal property for reuses and sale,” <https://www.gsa.gov/buy-through-us/government-property-for-sale-or-lease/personal-property-for-reuse-and-sale>. For contacts for state agencies, see <https://www.gsa.gov/buy-through-us/government-property-for-sale-or-lease/personal-property-for-reuse-and-sale/for-state-agencies-and-public-organizations/contact-a-state-agency>. For information on programs available for states and nonprofits, see GSA, “For State Agencies and Public Organizations,” <https://www.gsa.gov/buy-through-us/government-property-for-sale-or-lease/personal-property-for-reuse-and-sale/for-state-agencies-and-public-organizations>, and GSA, “Eligible Organizations and Activities,” <https://www.gsa.gov/buy-through-us/government-property-for-sale-or-lease/personal-property-for-reuse-and-sale/for-state-agencies-and-public-organizations/eligible-organizations-and-activities#nonprofit>.

- **Community Facilities Direct Loan & Grant Program**, through the U.S. Department of Agriculture, provides affordable funding to develop essential community facilities in rural areas. (Certain types of capital projects may be allowable expenses.)³⁴
- **Business and Industry Loan Guarantee Program**, through the USDA, which offers loan guarantees to rural businesses.³⁵
- **Rural Economic Development Loan and Grant Program**, through USDA, which provides zero-interest loans to local utilities that in turn pass through to local businesses for rural projects. Funds can be used for facilities and equipment for medical care for rural residents. The rural businesses then repay the local utility.³⁶
- HUD’s Office of Hospital Facilities administers the **Section 242 Hospital Mortgage Insurance program** to assist hospitals with obtaining financing. (Certain types of capital projects may be allowable expenses.)³⁷
- The **Small Business Administration** provides a wide range of resources and opportunities to locate funding for small businesses; loans and technical assistance (such as free business counseling) are typical forms of assistance. (Certain types of capital projects may be allowable expenses.)³⁸

How Can Health Facilities Search for Grants?

In addition to the specific grants listed above, health facilities can search Grants.gov and other federal sites, as well as those of state/local health agencies and nongovernmental sources of private funding.

Sources available to aid health facilities in their search for grants include the following:

Federally Funded Sources:

- **Grants and Federal Assistance (CRS)**. A collection of CRS products highlights sources to aid congressional offices in conducting funding searches. Though this page is not accessible to constituents, congressional offices may share the sources as needed.³⁹
- **Grants.gov**. This website provides a search feature for grant seekers to find and apply for many (but not all) federal funding opportunities.⁴⁰ Users can reference

³⁴ See footnote 26.

³⁵ See USDA, Rural Development, “Business and Industry Loan Guarantees,” <https://www.rd.usda.gov/programs-services/business-programs/business-industry-loan-guarantees>.

³⁶ See footnote 27.

³⁷ U.S. Department of Housing and Urban Development, “Federal Housing Administration, Healthcare Programs, Residential Facilities/Home 242,” https://www.hud.gov/federal_housing_administration/healthcare_facilities/residential_care/home_242.

³⁸ See footnote 31.

³⁹ See CRS, “Grants and Federal Assistance,” <https://www.crs.gov/Resources/Grants>. CRS reports are available to the public at <https://crsreports.congress.gov/>.

⁴⁰ One significant limitation to Grants.gov is the exclusion of state-administered federal grant program information. For example, Grants.gov provides information only about the funding opportunities for primary grant recipients. However, federal grant funds may first be received by a state government (a “primary” recipient) and then passed through to the local level as sub-awards to more local sub-recipients. Thus, a local grantseeker would not be able to access information on Grants.gov about the possibility of receiving federal sub-grants from a state-level agency.

the Grants Learning Center⁴¹ to learn about finding and applying for grants, and can submit community questions.

- **Rural Health Information Hub (RHIfhub).** RHIfhub provides listings of funding opportunities sortable by type, sponsor, topic, and state. The site also provides guides to grantmaking and funding alerts, as well as customized searches.⁴²
- **HHS’s Office of Minority Health (OMH).** OMH conducts customized funding searches for eligible groups to identify available opportunities.⁴³

Nongovernmental Sources:

- **Candid.** Formerly known as the Foundation Center, Candid maintains the Funding Information Network, a directory of libraries and other organizations across the United States that can assist nonprofits with grant searches from private sources. Candid’s map-based search highlights locations in each state.⁴⁴
- **Community Foundations.** These local foundations throughout the United States may be particularly interested in funding local projects of various types.⁴⁵

What Federal Programs Can Provide Technical Assistance to Health Facilities?

In addition to providing financial assistance, the Department of Health and Human Services supports programs that provide technical assistance to health facilities. Examples include the following:

- **Rural Health Information Hub.** HHS provides a grant that supports RHIfhub,⁴⁶ which provides information and “how-to” guides for rural health providers. These services and resources are designed to help rural health providers apply for funding (including funding for capital projects).⁴⁷
- **Federal Office of Health Policy.** HHS’s Federal Office of Health Policy administers programs that provide technical assistance to rural hospitals that face financial distress or are at risk of closure. The office also funds grant and technical assistance programs that seek to create health care networks in rural areas that aim to increase coordination and reduce duplication of services.⁴⁸
- **Technical Resources, Assistance Center, and Information Exchange (TRACIE).** HHS’s Administration for Strategic Preparedness and Response (ASPR) administers the Technical Resources, Assistance Center, and Information Exchange, an online portal for resources and technical assistance. Health care

⁴¹ See Grants.gov, “Grants Learning Center,” <https://grants.gov/learn-grants>.

⁴² See RHIfhub, “Rural Funding & Opportunities,” <https://www.ruralhealthinfo.org/funding>. For customized searches, see “Request a Custom Search,” <https://www.ruralhealthinfo.org/funding/tips#:~:text=alerts%20by%20email,-,Request%20a%20custom%20search,-of%20federal%2C%20state>.

⁴³ See Office of Minority Health, “Funding Search Request,” <https://minorityhealth.hhs.gov/funding-search-request>.

⁴⁴ See Candid, “Find Us,” <https://candid.org/find-us?fceref=lr>.

⁴⁵ See the Council on Foundations’ *Community Foundation Locator*, at <https://cof.org/page/community-foundation-locator>.

⁴⁶ See Rural Health Information Hub, at <https://www.ruralhealthinfo.org/>.

⁴⁷ See Rural Health Information Hub, “Rural Funding & Opportunities,” <https://www.ruralhealthinfo.org/funding>.

⁴⁸ See HRSA, “Rural Hospital Programs,” <https://www.hrsa.gov/rural-health/grants/rural-hospitals>.

entities, providers, and coalitions may access TRACIE for resources on a variety of health hazards and ask for technical assistance from the ASPR.⁴⁹ In addition, ASPR’s Regional Emergency Coordinators (RECs) serve as regional liaisons between governmental and health care system representatives. RECs may provide a variety of services to bolster the response of stakeholders during public health and medical emergencies.⁵⁰

- **Health Center Resource Clearinghouse.** HHS’s Health Resources and Services Administration developed the Health Center Resource Clearinghouse in partnership with the National Association of Community Health Centers—the advocacy organization for health centers.⁵¹ The Health Center Resource Clearinghouse provides technical assistance to federally funded health centers that receive grants authorized under PHSA Section 330 (42 U.S.C. §254b)—community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing. HRSA may also provide other types of technical assistance to health centers, including webinars and specific technical assistance related to emergency preparedness, response, and recovery.⁵²

Has Congress Used Community Project Funding/Congressionally Directed Spending to Support Health Facilities?

Yes. In FY2022 (P.L. 117-103), FY2023 (P.L. 117-328), and FY2024 (P.L. 118-47) appropriations laws included Community Project Funding that provided infrastructure support to health facilities. In those years, Members could request funding for specific health facility construction projects in accordance with the rules of their respective chamber’s appropriations committee instructions. The committee’s instructions identified accounts, which for FY2022- FY2024 included the Health Resources and Services Administration to fund health care facility projects.⁵³ For FY2025, Senate Appropriations Committee guidance includes this HRSA account again, whereas House Appropriations Committee guidance does not.⁵⁴

⁴⁹ Administration for Strategic Preparedness and Response (ASPR), “Welcome to ASPR Tracie,” <https://asprtracie.hhs.gov/>.

⁵⁰ ASPR, “ASPR Regional Emergency Coordinators,” <https://aspr.hhs.gov/REC/Pages/default.aspx>.

⁵¹ See “Health Center Resource Clearinghouse,” <https://www.healthcenterinfo.org/>.

⁵² See HRSA, Health Center Program, “Technical Assistance,” <https://bphc.hrsa.gov/technical-assistance>.

⁵³ For FY2022-funded projects, see CREC-2022-03-09-bk4.pdf (congress.gov), pp. H27090-H2766; for FY2023-funded projects, see CREC-2022-12-20-bk2.pdf (congress.gov), pp. S8955-S9029; and for FY2024-funded projects, see <https://www.congress.gov/118/crec/2024/03/22/170/51/CREC-2024-03-22-bk2.pdf>, pp. H1910-H1946.

⁵⁴ See Labor, Health and Human Services, Education and Related Agencies “FY2025 Congressionally Directed Spending—Eligible Agencies and Accounts,” https://www.appropriations.senate.gov/imo/media/doc/FY2025_CDS%20Appropriations%20Accounts_LHHS_FINAL_041724.pdf, and House Appropriations Republicans, “Fiscal Year 2025 Member Request Guidance,” <https://appropriations.house.gov/member-requests/fiscal-year-2025-member-request-guidance>.

How Has HRSA Supported Health Care Facilities During Emergencies?

Natural disasters (e.g., hurricanes) and national emergencies (e.g., the COVID-19 pandemic) may affect the level and type of health services provided by hospitals and other health facilities. HHS's HRSA has administered programs that provided financial assistance to certain health care facilities for emergency response.

How Has HRSA Supported Health Centers During Emergencies?

Annual and supplemental laws provide funding to health centers to rebuild following natural disasters such as hurricanes. These laws generally specify the locations and health centers that are eligible to receive funding. For example, P.L. 117-328 provided \$65 million available to health centers affected by Hurricanes Fiona or Ian, and that funding was for “alteration, renovation, construction, equipment and other capital improvement costs as necessary to meet the needs of areas affected by a disaster or emergency.”⁵⁵

Health centers also received supplemental funding to be used to prevent, prepare, or respond to the COVID-19 pandemic. Funds could be used for capital improvements, such as air filtration, or to build temporary testing sites. In total, health centers received more than \$2 billion in supplemental appropriations during 2020.⁵⁶ In FY2021, the American Rescue Plan Act (ARPA, P.L. 117-2) provided \$7.6 billion to health centers for COVID-19 recovery and response (including vaccine administration). The funds could also be used for the acquisition of mobile equipment or infrastructure.⁵⁷ A portion of ARPA funds was available for Federally Qualified Health Center Look-Alike and Native Hawaiian Health Centers. The ARPA funds were also to be used for expenses related to COVID-19 recovery and response (including vaccine administration).

How Has HRSA Supported Health Facilities Generally During Emergencies?

HRSA administered the Provider Relief Fund (PRF), which provided the \$178 billion in COVID-19 relief funding to health facilities for increased costs and reduced revenue due to the coronavirus. Funding allocations were available to all types of health facilities and providers. Specific allocations of PRF Funds are described in CRS Report R46897, *The Provider Relief Fund: Frequently Asked Questions*.

How Has HRSA Supported Rural Health Facilities During Emergencies?

Though some PRF funds were made explicitly available to rural providers, ARPA included two programs to support rural providers. The first was administered in conjunction with the PRF and

⁵⁵ For an example of recent funding in the FY2023 appropriations law, see <https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf#page=764>.

⁵⁶ CRS Insight IN11367, *Federal Health Centers and COVID-19*, and the “Health Resources and Services” section of CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

⁵⁷ CRS Report R46834, *American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions*.

provided \$8.3 billion to rural providers—including hospitals, rural health clinics, and long-term care facilities—for COVID-19-related increased costs and reduced expenses. The second was administered by the U.S. Department of Agriculture (discussed below).

How Has USDA Supported Health Facilities During Emergencies?

ARPA provided \$500 million in FY2021 to the USDA for Emergency Rural Health Care Grants, which had two tracks. The first was for immediate rural health care needs, and the second was for long-term rural health care needs; in both cases, these needs must have been caused by COVID-19.⁵⁸

How Has the Administration for Strategic Preparedness and Response (ASPR) Supported Health Facilities?

ASPR may be able to provide financial assistance to certain health care system coalitions during a public health emergency or to prepare for such an emergency.⁵⁹ For example, the Hospital Preparedness Program (HPP) provides funding to all 50 states, eight territories and freely associated states, three metropolitan areas, and Washington, DC. Recipients are to use these funds to support health care preparedness capabilities for disasters and the development and enhancement of health care coalitions within their jurisdictions. In certain instances, these funds can also be used to support emergency response efforts.⁶⁰

How Has the Federal Emergency Management Agency (FEMA) Supported Health Facilities During Emergencies?

FEMA provides a range of assistance to certain public and nonprofit health facilities through several programs. When authorized through a presidential declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act, P.L. 93-288, as amended),⁶¹ the FEMA Public Assistance (PA) Program may provide financial and direct assistance to eligible health facilities owned and operated by eligible state, local, tribal, and

⁵⁸ See USDA, Rural Development, “Rural Emergency Health Care Grants,” <https://www.rd.usda.gov/erhc>.

⁵⁹ The ASPR defines a health care coalition as a “network of individual public and private organizations in a defined state or sub-state geographic area that partner to prepare health care systems to respond to emergencies and disasters.” This coalition may contain a number of health care system entities but must include representation from acute hospitals, public health agencies, emergency medical services, and emergency management agencies. ASPR, *Health Care Coalitions (HCC)*, [https://aspr.hhs.gov/HealthCareReadiness/HPP/Documents/Health%20Care%20Coalitions%20\(HCCs\)%20One-Page.pdf](https://aspr.hhs.gov/HealthCareReadiness/HPP/Documents/Health%20Care%20Coalitions%20(HCCs)%20One-Page.pdf).

⁶⁰ ASPR, “U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Hospital Preparedness Program (HPP), Funding Opportunity Announcement and Grant Application Instructions,” 2019, p. 21.

⁶¹ For a discussion of Stafford Act declarations, see CRS Report R42702, *Stafford Act Declarations 1953-2016: Trends, Analyses, and Implications for Congress*.

territorial governments and private nonprofits. Health facilities eligible for PA include clinics, hospitals, outpatient and inpatient facilities, rehabilitation facilities, long-term care facilities, facilities to support home-health services, and laboratories that support emergency medical care.⁶²

PA may provide reimbursement for eligible costs incurred for disaster-related emergency response measures (e.g., emergency medical care, medical supplies, overtime) and the repair or restoration of eligible damaged facilities.⁶³ Historical examples of PA provided to health facilities include financial assistance provided to nonprofit and public hospitals across the country for emergency medical care during the COVID-19 pandemic, and to hospice facilities to cover rebuilding costs following Hurricane Irma in Florida.⁶⁴

Certain nonprofit and public health facilities may also receive funding for eligible hazard mitigation measures (e.g., elevating hospitals in a flood-vulnerable area or relocating facilities) through the Public Assistance program or one of several FEMA hazard mitigation programs, including the Hazard Mitigation Grant Program.⁶⁵

Author Information

Elayne J. Heisler
Specialist in Health Services

Michele L. Malloy
Senior Research Librarian

Marco A. Villagrana
Analyst in Health Care Financing

Alison Mitchell
Specialist in Health Care Financing

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⁶² FEMA, *Public Assistance Program and Policy Guide*, vol. 4, June 1, 2020, pp. 45, https://www.fema.gov/sites/default/files/documents/fema_pappg-v4-updated-links_policy_6-1-2020.pdf.

⁶³ For detailed discussion, see CRS Report R46749, *FEMA's Public Assistance Program: A Primer and Considerations for Congress*.

⁶⁴ OpenFEMA, "Public Assistance Funded Projects – Details," <https://www.fema.gov/openfema-data-page/public-assistance-funded-projects-details-v1>.

⁶⁵ For more information, see CRS Report R46989, *FEMA Hazard Mitigation: A First Step Toward Climate Adaptation*.

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