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Provider Relief Fund General Information

Overview

Who is eligible to receive payments from the Provider Relief Fund? (Modified 12/4/2020)

Provider Relief Fund payments are being disbursed via both “General” and “Targeted” Distributions.

To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in 2019, be a known Medicaid and CHIP or dental provider and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

A description of the eligibility for the announced Targeted Distributions can be found [here](#). U.S. health care providers may be eligible for payments from future Targeted Distributions. Information on future distributions will be shared when publicly available.

All providers retaining funds must sign an attestation and accept the Terms and Conditions associated with payment.

Is this a loan or a grant that I will need to pay back?

Retention and use of these funds are subject to certain terms and conditions. If these terms and conditions are met, payments do not need to be repaid at a later date. These Terms and Conditions can be found [here](#).

Why would a provider not be eligible for a General or Targeted Distribution Provider Relief Fund payment? (Added 10/5/2020)

In order to be eligible for a payment under the Provider Relief Fund, a provider must meet the eligibility criteria for the distribution. Additionally, a provider must not be currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; must not be currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and must not currently have Medicare billing privileges revoked as determined by either the Centers for Medicare & Medicaid Services or the HHS Office of Inspector General in order to be eligible to receive a payment under the Provider Relief Fund.

Is there a minimum amount for the Provider Relief Fund to issue payments? (Added 12/11/2020)

Yes. The Provider Relief Fund does not issue individual General and Targeted Distributions payments that are less than \$100.

If a provider returns a payment to the Provider Relief Fund and the returned amount is greater than what should be returned to the Government, will the Provider Relief Fund refund amounts returned in error? (Added 12/11/2020)

The Provider Relief Fund will refund returned payments that are determined to be \$500 or more in excess of the required returned amount.

Will HHS allow providers to make corrections to the data used to determine Targeted Distribution eligibility and payment amounts? (Added 10/28/2020)

Going forward, HHS will allow providers that submitted data as part of the COVID-19 High Impact Area Distribution and/or the Nursing Home Infection Control/Quality Incentive Payment Distribution, a limited opportunity to submit corrected data for up to 5 business days after the submission deadline. HHS will only accept corrections within the 5-day time period that are accompanied by a justification for why the provider erred in the initial data submission. HHS will review each request for correction on a case-by-case basis and may determine that a previous payment be amended to align with the updated data. Providers who submit updated data may have their payments delayed for up to 90 days from the date of submission pending review and adjudication. All HHS decisions are final and there is no appeals process.

If a provider returns a Provider Relief Fund payment to HHS, must it also return any accrued interest on the payment? (Modified 12/11/2020)

Yes, for Provider Relief Fund payments that were held in an interest-bearing account, the provider must return the accrued interest associated with the amount being returned to HHS. However, if the funds were not held in an interest-bearing account, there is no obligation for the provider to return any additional amount other than the Provider Relief fund payment being returned to HHS. HHS reserves the right to audit Provider Relief Fund recipients in the future to ensure that payments that were held in an interest-bearing account were subsequently returned with accrued interest.

To return accrued interest, visit pay.gov. On the webpage, locate “Find an agency,” and select “Health and Human Services (HHS) Program Support Center HQ.” Verify that the description is “PSC HQ Payment” and form number is “HSHQ,” then click continue. You will then need to complete the following steps:

Step 1: Preview the form, then click “Continue.”

Step 2: Indicate whether you are completing on behalf of an individual or business and enter the following information.

Business Name Field: Legal name of organization that received the payment

Invoice or Ticket Number Field: “HHS-COVID-Interest”

Contract/Agreement Number Field: Tax Identification Number (TIN) of organization or provider that received the payment

Point of contact: Business contact information

Payment Amount: (The payment amount must match the interest earned on the payment received.)

Step 3: Verify the interest return payment amount and select to pay by ACH or debit/credit card, then select “Continue.”

Step 4: Enter the required information to complete the payment, then select “Review and Submit.”

Step 5: Ensure that all information is correct and select “Submit.”

I received an email, voicemail, or letter stating that I have not taken appropriate action to update financial information in order to receive a payment that I am eligible to receive. Are my funds still available? (Added 9/3/2020)

If you received a notice from the Provider Relief Fund that you had funds available, but did not take action within 90 days of the original payment issuance date, the payment is no longer available to you. If it is past the 90-day period for a General Distribution payment, you may

apply for a Phase 2 – General Distribution payment through the [Provider Relief Attestation and Application Portal](#). If it is within 90 days of the original payment issuance date, you must contact the Provider Support Line to reinitiate your ACH payment. In order to distribute the funds in a timely manner, it is important to maintain current ACH information.

How should providers classify the Provider Relief Fund payments in terms of revenue type for cost reports? (Modified 9/3/2020)

Please refer to CMS [FAQs](#) on how Provider Relief Fund payments should be reported on cost reports.

How can a health care provider find more information on the status of their Provider Relief Fund payment or application? (Added 7/8/2020)

Providers should contact the Provider Support Line at (866) 569-3522 (for TTY, dial 711), if they have questions about the status of their payment or application. When calling, providers should have ready the last four digits of the recipient's or applicant's Tax Identification Number (TIN), the name of the recipient or applicant as it appears on the most recent tax filing, the mailing address for the recipient or applicant as it appears on the most recent tax filing, and the application number (begins with either "DS" or "CR") if they have submitted an application in the Provider Relief Fund Payment Portal.

Are hospitals and health systems in all states and territories eligible for a Provider Relief Fund payment? (Modified 8/4/2020)

Yes. Hospitals and health systems in all states and territories eligible for Provider Relief Fund payments.

Will health care providers that experienced a change in ownership that disqualified them from receiving a Provider Relief Fund payment be able to receive a payment that was returned by the previous owner? (Added 7/8/2020)

In order to ensure program integrity and transparency, HHS made Provider Relief Fund payments to health care providers based on the latest data available for a TIN. As previous owners are not permitted to transfer funds to the new owner, they were instructed to return the funds to HHS. At this time, HHS will not reissue returned payments to the new owners. Providers that have not received payments under the Provider Relief Fund due to issues related to change of ownership will be eligible to apply for future allocations. Additional information will be posted as available at <https://www.hhs.gov/provider-relief/index.html>.

My hospital has not been eligible for any of the Targeted Distributions. Will the hospital be eligible for future funding in an effort to create parity between hospitals? (Added 8/7/2020)

Future General Distributions will take into account previous allocations, including General Distributions and Targeted Distributions. HHS may consider providers that have only received a Provider Relief Fund General Distribution for priority under future General Distributions.

Can providers who have ceased operation due to the COVID-19 pandemic still receive this funding? (Added 5/29/2020)

If a provider ceased operation as a result of the COVID-19 pandemic, they are still eligible to receive Provider Relief Fund payments so long as they provided on or after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19, therefore, care does not have to be

specific to treating COVID-19. Recipients of funding must still comply with the Terms and Conditions related to permissible uses of Provider Relief Fund payments.

If a provider secures COVID-19-related funding separate from the Provider Relief Fund, such as the Small Business Administration’s Paycheck Protection Program, does that affect how they can use the payments from the Provider Relief Fund? Does accepting Provider Relief Fund payments preclude a provider organization from seeking other funds authorized under the CARES Act? (Added 5/29/2020)

There is no direct ban under the CARES Act on accepting a payment from the Provider Relief Fund and other sources, so long as the payment from the Provider Relief Fund is used only for permissible purposes and the recipient complies with the Terms and Conditions. By attesting to the Terms and Conditions, the recipient certifies that it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Are Provider Relief funds accessible in whole or in part to bankruptcy creditors and other creditors in active litigation? (Added 6/8/2020)

Payments from the Provider Relief Fund shall not be subject to the claims of the provider’s creditors and providers are limited in their ability to transfer Provider Relief Fund payments to their creditors. A provider may utilize Provider Relief Fund payments to satisfy creditors’ claims, but only to the extent that such claims constitute eligible health care related expenses and lost revenues attributable to coronavirus and are made to prevent, prepare for, and respond to coronavirus, as set forth under the Terms and Conditions.

May a health care provider that receives a payment from the Provider Relief Fund exclude this payment from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code (Code)? (Added 7/10/2020)

No. A payment to a business, even if the business is a sole proprietorship, does not qualify as a qualified disaster relief payment under section 139. The payment from the Provider Relief Fund is includible in gross income under section 61 of the Code. For more information, visit the Internal Revenue Services’ website at <https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments>.

Is a tax-exempt health care provider subject to tax on a payment it receives from the Provider Relief Fund? (Added 7/10/2020)

Generally, no. A health care provider that is described in section 501(c) of the Code generally is exempt from federal income taxation under section 501(a). Nonetheless, a payment received by a tax-exempt health care provider from the Provider Relief Fund may be subject to tax under section 511 if the payment reimburses the provider for expenses or lost revenue attributable to an unrelated trade or business as defined in section 513. For more information, visit the Internal Revenue Services’ website at <https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments>.

Will I receive a Form 1099? (Added 12/18/2020)

Yes, you will receive a Form 1099 if you received and retained within the calendar year 2020 a total net payment from either or both of the Provider Relief Fund and COVID-19 Claims

Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured that is in excess of \$600.

When will my Form 1099 be available? (Added 12/18/2020)

Form 1099s will be mailed by January 31st, 2021. If you have previously established an account with UnitedHealth Group and elected to receive electronic copies of documents and notices, you will not receive a mailed copy.

Who do I contact if I have question regarding my Form 1099? (Added 12/18/2020)

Please call the Provider Support Line (866) 569-3522 (for TTY, dial 711) for any questions you may have regarding your Form 1099.

What is HHS doing with payments that are returned to the Provider Relief Fund? (Added 6/30/2020)

HHS will allocate returned payments to future distributions of the Provider Relief Fund.

Which sections of 45 CFR 75 – UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR HHS AWARDS are applicable to the General and Targeted Distributions of the Provider Relief Fund? (Added 12/28/2020)

Recipients (both non-federal entities and commercial organizations) of the General and Targeted Distributions of the Provider Relief Fund are subject to 45 CFR 75 Subpart A (Acronyms and Definitions) and B (General Provisions), subsections §§75.303 (Internal Controls), and 75.351-.353 (Subrecipient Monitoring and Management), and Subpart F (Audit Requirements). In addition, the terms and conditions of the PRF payments incorporate by reference the obligation of recipients to comply with the requirements to maintain appropriate financial systems at 75.302 (Financial management and standards for financial management systems) and the requirements for record retention and access at 75.361 through 75.365 (Record Retention and Access).

Attestation

What action does a provider need to take after receiving a Provider Relief Fund payment? (Modified 10/28/2020)

The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meet these terms and conditions of the payment. The [CARES Act Provider Relief Fund Payment Attestation Portal](#) or the [Provider Relief Fund Application and Attestation Portal](#) will guide you through the attestation process to accept or reject the funds. Not returning the payment within 90 days of receipt will be viewed as acceptance of the [Terms and Conditions](#). A provider must attest for each of the Provider Relief Fund distributions received.

Do the Provider Relief Fund attestation portals require payment recipients to attest that the payment amount was received? (Modified 10/28/2020)

Yes. The attestation portals require payment recipients to (1) confirm they received a payment and the specific payment amount that was received; and (2) agree to the Terms and Conditions of the payment.

What if I attested and accepted a Provider Relief Fund payment, but would now like to reject the funds and retract my attestation? (Added 6/3/2020)

If you affirmatively attested to a Provider Relief Fund payment already received and later wish to reject those funds and retract your attestation, you may do so by calling the provider support line at (866) 569-3522; for TTY dial 711. Note, HHS is posting a public list of providers and their payments once they attest to receiving the payment and agree to the Terms and Conditions.

Rejecting Payments

How can I return a payment I received under the Provider Relief Fund? (Modified 8/10/2020)

Providers may return a payment by going into the attestation portal within 90 days of receiving payment and indicating they are rejecting the funds. The [CARES Act Provider Relief Fund Payment Attestation Portal](#) or the [Provider Relief Fund Application and Attestation Portal](#) will guide providers through the attestation process to reject the funds. Providers must return the payment within 15 calendar days of rejecting the payment.

To return the money, the provider needs to contact their financial institution and ask the institution to refuse the received Automated Clearing House (ACH) credit by initiating an ACH return using the ACH return code of "R23 - Credit Entry Refused by Receiver." If a provider received the money via ACH they must return the money via ACH. If a provider was paid via paper check, after rejecting the payment in the Payment Attestation Portal, the provider should destroy the check if not deposited or mail a paper check to UnitedHealth Group with notification of their request to return the funds.

How should a provider return a payment it received via check? (Modified 10/28/2020)

If the provider received a payment via check and has not yet deposited it, destroy, shred, or securely dispose of it. If the provider has already deposited the check, mail a refund check for the full amount, payable to "UnitedHealth Group" to the address below via United States Postal Service (USPS); mailing services such as FedEx and UPS cannot be used with this PO box. Please list the check number from the original Provider Relief Fund check in the memo. Mail a refund check for the full amount payable to "UnitedHealth Group" to the address below.

UnitedHealth Group
Attention: Provider Relief Fund
PO Box 31376
Salt Lake City, UT 84131-0376

How does a provider who received an electronic payment return funding if their financial institution will not allow them to return the payment electronically? (Added 5/12/2020)

Contact UnitedHealth Group's Provider Support Line at (866) 569-3522 (for TTY, dial 711).

If I changed my mind after I rejected a Provider Relief Fund payment through one of the attestation portals and returned the payment, can I receive a new payment? (Modified 10/28/2020)

No, HHS will not issue a new payment to a provider that received and then subsequently rejected and returned the original payment. The provider may be considered for future distributions if it meets the eligibility criteria for that distribution.

Terms and Conditions

What if my payment is greater than expected or received in error? (Modified 12/4/2020)

If HHS identifies a payment made in error, HHS will recoup the erroneous amount. If a provider receives a payment that is greater than expected and believes the payment was made in error, the provider should contact the Provider Support Line at (866) 569-3522 (for TYY, dial 711) and seek clarification.

Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the General or Targeted Distribution payments? (Modified 11/5/2020)

The Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund. Provider Relief Fund payment amounts that have not been fully expended on the combination of healthcare expenses and lost revenues attributable to coronavirus by the end of the final reporting period, must be returned to HHS. HHS reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with the Terms and Conditions may be grounds for recoupment.

Can providers use Provider Relief Fund distributions to repay payments made under the CMS Accelerated and Advance Payment (AAP) Program? (Added 10/9/2020)

No, this is not a permissible use of Provider Relief Fund payments.

For how long are the Terms and Conditions of the Provider Relief Fund applicable? (Added 6/19/2020)

All recipients receiving payments under the Provider Relief Fund will be required to comply with the [Terms and Conditions](#). Some Terms and Conditions relate to the provider's use of the funds, and thus they apply until the provider has exhausted these funds. Other Terms and Conditions apply to a longer time period, for example, regarding maintaining all records pertaining to expenditures under the Provider Relief Fund payment for three years from the date of the final expenditure.

Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19? (Modified 10/28/2020)

As explained in the notice of reporting requirements on the Provider Relief Fund website, funds must be expended no later than June 30, 2021. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to coronavirus.

What is the definition of individuals with possible or actual cases of COVID-19? (Added 5/6/2020)

Unless the payment is associated with specific claims for reimbursement for COVID-19 testing

or treatment provided on or after February 4, 2020 to uninsured patients, under the Terms and Conditions associated with payment, providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

Not every possible case of COVID-19 is a presumptive case of COVID 19.

What oversight and enforcement mechanisms will HHS use to ensure providers meet the Terms and Conditions of the Provider Relief Fund payments? (Added 5/6/2020)

Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of some or all of the payment. Per the Terms and Conditions, all recipients will be required to submit documents to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

What is the definition of Executive Level II pay level, as referenced in the Terms and Conditions? (Added 5/29/2020)

The Terms and Conditions state that none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other mechanism, at a rate in excess of Executive Level II. The salary limitation is based upon the Executive Level II of the Federal Executive Pay Scale. Effective January 5, 2020, the Executive Level II salary is \$197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Fund payments may pay an individual's salary amount in excess of the salary cap with non-federal funds.

How will HHS recoup funds from providers that are required to repay all or part of a Provider Relief Fund payment? (Added 5/29/2020)

HHS has not yet detailed how recoupment or repayment will work. However, the Terms and Conditions associated with payment require that the Recipient be able to certify, among other requirements, that it was eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus). Additionally, recipients must submit all required reports as determined by the Secretary. Non-compliance with any term or condition is grounds for the Secretary to direct recoupment of some or all of the payments made. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

The Terms and Conditions state that Provider Relief Fund payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the Recipient only for health care-related expenses or lost revenues that are attributable to coronavirus.

What expenses or lost revenues are considered eligible for reimbursement? (Modified 10/28/2020)

Please refer to the [Post-Payment Notice of Reporting Requirements](#), released on September 19

and updated October, 22, 2020, and associated FAQs on reporting for the most current information on use of funds, as well as the definitions on health care-related expenses and lost revenue.

The term “healthcare related expenses attributable to coronavirus” is a broad term that may cover a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:

- supplies used to provide health care services for possible or actual COVID-19 patients;
- equipment used to provide health care services for possible or actual COVID-19 patients;
- workforce training;
- developing and staffing emergency operation centers;
- reporting COVID-19 test results to federal, state, or local governments;
- building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide health care services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- acquiring additional resources, including facilities, equipment, supplies, health care practices, staffing, and technology to expand or preserve care delivery.

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus. HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

The term “lost revenues that are attributable to coronavirus” means any revenue that you as a health care provider lost due to coronavirus. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care. Providers can use Provider Relief Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining health care delivery capacity, such as using Provider Relief Fund payments to cover:

- Employee or contractor payroll
- Employee health insurance
- Rent or mortgage payments
- Equipment lease payments
- Electronic health record licensing fees

You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the [Terms and Conditions](#) and specified in on HHS' website available at www.hhs.gov/providerrelief.

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? (Modified 10/28/2020)

No. Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if on June 30, 2021, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately.

The Terms and Conditions set forth a list of “statutory provisions” that “also apply” to the Provider Relief Fund payment. Do these requirements apply to any government funding received by the recipient, or only the Provider Relief Fund payment associated with those Terms and Conditions? (Added 6/8/2020)

The “statutory provisions” listed in the Terms and Conditions apply to the Provider Relief Fund payment associated with those Terms and Conditions. Those statutory provisions may also independently apply to other government funding that you receive.

Ownership Structures and Financial Relationships

Must a parent organization that received a Provider Relief Fund Targeted Distribution on behalf of a subsidiary in which it has a direct ownership relationship remit the payment to the subsidiary? (Modified 12/11/2020)

Yes. The purpose of Targeted Distribution payments is to support the specific financial needs of the eligible healthcare provider that received the payment. Control and use of the funds must be delegated to the entity that was eligible for the Targeted Distribution payment if a parent entity received the Targeted Distribution payment on behalf of an eligible subsidiary. The only exception to this occurs when the funds were received as part of the Skilled Nursing Facility Targeted Distribution or Nursing Home Infection Control Distribution (but not bonus payments received as part of the Nursing Home Infection Control Quality Incentive Program), in which case parent entities may distribute funds among those subsidiaries that were eligible for payment at its discretion.

If a parent organization received a Provider Relief Fund Targeted Distribution on behalf of a subsidiary, which organization should attest to the Terms and Conditions for the payment? (Added 8/27/2020)

The parent entity should attest to the Terms and Conditions for the Targeted Distribution payment if it is the entity that received the payment. It may attest on behalf of any or all subsidiaries that qualified for a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment. The parent entity must transfer a Provider Relief Fund Targeted Distribution payment to any or all subsidiaries that qualified for a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area)

payment. Control and use of the funds must be delegated to the entity that was eligible for the Targeted Distribution payment if a parent entity received the Targeted Distribution payment on the behalf of an eligible subsidiary.

How should an organization currently undergoing a change in ownership to purchase a practice report revenue in its application? (Added 5/20/2020)

Until the purchase is complete, the organization should only report current gross receipts in its application and should exclude the practice it is intending to purchase. Any changes in ownership that have not occurred should not be included in your revenue submission. Submissions must be based on the organization that exists at the time of application, not a projection of expected lost revenue from the practice that is being acquired.

If a seller receives Provider Relief Fund money prior to the completion of a sale, can the seller transfer some or all of the Provider Relief Fund money to the buyer? (Modified 6/22/2020)

If the transaction is a purchase of the recipient entity (e.g., a purchase of its stock or membership interests), then the Provider Relief Fund recipient may continue to use the funds, regardless of its new owner. But if the transaction is an asset purchase (whether for some or all of the Provider Relief Fund recipient's assets), then the original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS. In these circumstances, the Provider Relief Fund money does not transfer to the buyer, however, buyers in these circumstances will be eligible to apply for future Provider Relief Fund payments. If a bankrupt recipient is liquidated, it must similarly use the funds for its eligible expenses and lost revenues and return any unused funds to HHS.

If, as a result of the sale of a practice/hospital, the TIN that received a Provider Relief Fund payment is no longer providing health care services as of January 31, 2020, is it required to return the payment? (Modified 6/12/2020)

Yes. If, as a result of the sale of a practice/hospital, the TIN that received a Provider Relief Fund payment did not provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, the provider must reject the payment. The [Provider Relief Fund Payment Attestation Portal](#) will guide you through the attestation process to reject the payment.

Can an organization that sold its only practice or facility under a change in ownership in 2019 or 2020 and is no longer providing services accept payment and transfer it to the new owner? (Modified 10/28/2020)

No. A provider that sold its only practice or facility must reject the Provider Relief Fund payment because it cannot attest that it was providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, as required by the Terms and Conditions. Seller organizations should not transfer a payment received from HHS to another entity. If the current TIN owner has not yet received any payment from the Provider Relief Fund, it may still receive funds in other distributions.

Can a provider that purchased a TIN in 2019 or 2020 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? (Modified 10/28/2020)

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms

and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment. However, the new TIN owner may still receive funds in other distributions.

Can an organization that received a Provider Relief Fund payment and provided care on or after January 31, 2020 that sold, terminated, transferred, or otherwise disposed of a provider accept the payment (received via ACH or check) associated with the sold provider? (Modified 6/12/2020)

If an organization that sold, terminated, transferred, or otherwise disposed of a provider that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Can a provider that purchased a TIN in 2019 or 2020 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? (Modified 10/28/2020)

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment. If the new TIN owner did not receive a direct payment under the Provider Relief Fund, it is not eligible to receive a payment under the General Distribution. However, the new TIN owner may still receive funds in other distributions.

An organization that sold part of a practice in 2019 or January 2020 received a payment under the General Distribution that reflected the 2019 Medicare fee-for-service billing of that part of the practice. Can it return a portion of the payment for the part of the practice it no longer owns? (Added 5/20/2020)

No. A provider may not return a portion of a Provider Relief Fund payment. If a provider that sold a practice that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

A vertically-integrated organization has both patient care revenues as well as revenues that are not directly related to patient care (e.g. insurance, retail, real estate). How should this scenario be addressed with respect to the application? (Added 5/21/2020)

The applying organization should complete an application by listing the Billing TINs of the eligible subsidiaries that provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. In the application, the parent entity should enter the sum of all “gross sales or receipts” or “program service revenue” of all eligible subsidiary entities that provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19 and enter the subsidiaries’ Billing TINs in the applicable fields in the application form. Further, the parent entity should submit a statement on the first page of the uploaded tax return file stating (i) the parent entity’s Filing TIN and (ii) a schedule of the eligible subsidiaries, their Billing TINs, and gross sales or receipts. Any revenues

from subsidiaries that are not directly providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 may not be included.

Can a parent organization with a direct ownership relationship with a subsidiary that received a Provider Relief Fund Targeted Distribution payment control and allocate that Targeted Distribution payment among other subsidiaries that were not themselves eligible and did not receive a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment? (Added 7/22/2020)

No. The parent entity may not transfer a Provider Relief Fund Targeted Distribution payment from the recipient subsidiary to a subsidiary that did not receive the payment. Control and use of the funds must remain with the entity that received the Targeted Distribution payment. The purpose of Targeted Distribution payments is to support the specific financial needs of the payment recipient.

Can a parent organization transfer General Distribution Provider Relief Fund payments to its subsidiaries? (Modified 7/23/2020)

Yes, a parent organization can accept and allocate General Distribution funds at its discretion to its subsidiaries. The Terms and Conditions place restrictions on how the funds can be used. In particular, the parent organization will be required to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

In the case of a parent organization with multiple billing TINs that may have each received a General Distribution payment, may the parent organization attest to the Terms and Conditions and keep the payments? (Modified 7/23/2020)

Yes, the parent organization with subsidiary billing TINs that received General Distribution payments may attest and keep the payments as long as providers associated with the parent organization were providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020 and can otherwise attest to the Terms and Conditions. The parent organization can allocate funds at its discretion to its subsidiaries. If the parent organization would like to control and allocate Provider Relief Fund payments to its subsidiaries, the parent organization must attest to accepting its subsidiaries' payments and agreeing to the Terms and Conditions.

Can a parent organization allocate Provider Relief Fund General Distribution to subsidiaries that do not report income under their parent's employee identification number (EIN)? (Added 7/22/2020)

Yes. The Terms and Conditions place restrictions on how the funds can be used. In particular, the parent organization will be required to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Auditing and Reporting Requirements

Will HHS provide guidance to certified public accountants and those organizations that providers will rely on to perform audits? (Added 12/4/2020)

Yes. Providers who received \$10,000 or more in aggregate Provider Relief Fund payments will need to submit a report on how they used the PRF payment, and for more information on how to accurately fill out these reports, please refer to <https://www.hhs.gov/sites/default/files/post-payment-notice-of-reporting-requirements-november-2020.pdf> and <https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf>. Some providers will also be subject to Single Audit requirements. Additional relevant guidance will be posted as an Addendum to the 2020 Compliance Supplement, which is available here at <https://www.whitehouse.gov/omb/management/office-federal-financial-management/>.

Are Provider Relief Fund payments to non-Federal entities (states, local governments, Indian tribes, institutions of higher education, and nonprofit organizations) subject to Single Audit? (Modified 7/30/2020)

Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) to non-Federal entities are Federal awards and must be included in determining whether an audit in accordance with 45 CFR Part 75, Subpart F is required (i.e., annual *total federal awards expended* are \$750,000 or more).

Audit reports must be submitted to the Federal Audit Clearinghouse electronically at <https://harvester.census.gov/facides/Account/Login.aspx>.

(Requirements for audit of payments to commercial organizations are discussed in a separate question.)

Are Provider Relief Fund payments to commercial (for-profit) organizations subject to Single Audit in conformance with the requirements under 45 CFR 75 Subpart F? (Modified 7/30/2020)

Commercial organizations that receive \$750,000 or more in annual awards have two options under 45 CFR 75.216(d) and 75.501(i): 1) a financial related audit of the award or awards conducted in accordance with Government Auditing Standards; or 2) an audit in conformance with the requirements of 45 CFR 75 Subpart F.

Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) must be included in determining whether an audit in accordance with 45 CFR Subpart F is required (i.e., annual *total awards received* are \$750,000 or more).

Audit reports of commercial organizations must be submitted directly to the U.S. Department of Health and Human Services, Audit Resolution Division at AuditResolution@hhs.gov.

Can my organization get an extension to the submission due date for 2019 audit year reports conducted under 45 CFR Part 75? (Modified 12/11/2020)

Yes. The Office of Management and Budget (OMB) in OMB M-20-26, Extension of Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations, dated June 18,

2020, provided recipients, which include non-federal entities and commercial organizations, extensions beyond the normal due date to submit 2019 audit year reports. Please see the OMB website for more details: <https://www.whitehouse.gov/omb/information-for-agencies/memoranda/>. Recipients with questions about their ability to obtain extensions should email HRSA's Division of Financial Integrity at SARFollowup@hrsa.gov.

The Terms and Conditions for all Provider Relief Fund payments require recipients who receive at least \$150,000 in the aggregate from any statute primarily making appropriations for the coronavirus response to submit quarterly reports to HHS and the Pandemic Response Accountability Committee. This requirement is from section 15011 of the CARES Act. What do providers need to do in order to be in compliance with this provision in the Terms and Conditions? (Added 6/13/2020)

Recipients of Provider Relief Fund payments do not need to submit a separate quarterly report to HHS or the Pandemic Response Accountability Committee. HHS will develop a report containing all information necessary for recipients of Provider Relief Fund payments to comply with this provision. For all providers who attest to receiving a Provider Relief Fund payment and agree to the Terms and Conditions (or retain such a payment for more than 90 days), HHS is posting the names of payment recipients and their payment amounts on its [public website here](#). HHS is also working with the Department of Treasury to reflect the aggregate total of each recipient's attested to Provider Relief Fund payments on [USAspending.gov](https://www.usaspending.gov). Posting these data meets the reporting requirements of the CARES Act. See Appendix A of OMB Memo M-20-21 [Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)].

However, the Terms and Conditions for all Provider Relief Fund payments also require recipients to submit any reports requested by the Secretary that are necessary to allow HHS to ensure compliance with payment Terms and Conditions. HHS will be requiring recipients to submit future reports relating to the recipient's use of its PRF money. For more information on these requirements, please visit www.hhs.gov/providerrelief.

Use of Funds

My state or territorial Medicaid or Children's Health Insurance Program (CHIP) agency has directed providers to use Provider Relief Fund dollars before applying Medicaid or CHIP reimbursement, as well as Medicaid COVID-19 supplemental payments, to cover health care-related expenses or lost revenues attributable to coronavirus. Is this permissible? (Added 12/28/2020)

No. As it relates to expenses, providers identify their health care-related expenses, and then apply any amounts received through other sources (e.g., direct patient billing, commercial insurance, Medicare/Medicaid/CHIP, reimbursement from the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, or funds received from FEMA or SBA/Department of Treasury's Paycheck Protection Program) that offset the health care-related expenses. Provider

Relief Fund payments may be applied to the remaining expenses or cost, after netting the other funds received or obligated to be received which offset those expenses.

Are expenses related to securing and maintaining adequate personnel reimbursable expenses under the Provider Relief Fund? *(Added 12/11/2020)*

Yes, expenses incurred by providers to secure and maintain adequate personnel, such as offering hiring bonuses and retention payments, child care, transportation, and temporary housing, are deemed to be COVID-19-related expenses if the activity generating the expense was newly incurred after the declaration of the Public Health Emergency and the expenses were necessary to secure and maintain adequate personnel.

Are outsourced or third-party vendor services that enable access to health care services reimbursable expenses under the Provider Relief Fund? *(Added 12/11/2020)*

Yes, outsourced or third-party vendor services that enable sustained access to health care services and daily operations, such as food/patient nutrition services, facilities management, laundering, and disinfection/anti-contamination services, are considered reimbursable expenses if they are attributable to coronavirus.

Can providers use Provider Relief Fund payment to pay taxes? *(Added 12/11/2020)*

Yes. HHS considers taxes imposed on Provider Relief Fund payments to be “healthcare related expenses attributable to coronavirus” that are reimbursable with Provider Relief Fund money, except for Nursing Home Infection Control Distribution payments.

When reporting my organization’s healthcare expenses attributable to coronavirus, how do I calculate the “expenses attributable to coronavirus not reimbursed by other sources?” *(Modified 12/11/2020)*

Healthcare related expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, employees, and other healthcare related costs/expenses for the calendar year. The classification of items into categories should align with how Provider Relief Fund recipients maintain their records. Providers can identify their healthcare related expenses, and then apply any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children’s Health Insurance Program (CHIP), or other funds received from the Federal Emergency Management Agency (FEMA), the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, and the Small Business Administration (SBA) and Department of Treasury’s Paycheck Protection Program (PPP) that offset the healthcare related expenses. Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting the other funds received or obligated to be received which offset those expenses. The Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus. For example, assume the following:

A \$5 increase in expense or cost to provide an office visit is calculated by pre-pandemic cost vs. post-pandemic cost, regardless of reimbursement source:

- Pre-pandemic average expense or cost to provide an office visit = \$80
- Post-pandemic average expense or cost to provide an office visit = \$85

Examples of reimbursed amounts may include, but not be limited to:

- Example 1
Medicaid reimbursement: \$70 (Report \$85-\$80 = \$5 as expense attributable to coronavirus but unreimbursed by other sources)
- Example 2
Medicare reimbursement: \$80 (Report \$85-\$80 = \$5 as expense attributable to coronavirus but unreimbursed by other sources)
- Example 3
Commercial Insurance reimbursement: \$85 (Report \$5, commercial insurer did not reimburse for \$5 increased cost of post-pandemic office visit)
- Example 4
Commercial Insurance reimbursement: \$85 + \$5 insurer supplemental coronavirus-related reimbursement (Report zero since insurer reimbursed for \$5 increased cost of post-pandemic office visit)
- Example 5
COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured: \$80 (Report \$5 as expense attributable to coronavirus but unreimbursed by other sources)

Funds from the Federal Emergency Management Administration (FEMA) are generally intended to be the last source of reimbursement, however, the Post-Payment Notice of Reporting Requirements indicates that FEMA funds would be applied prior to the Provider Relief Fund distributions. In which order should governmental funding sources be applied and reported? (Modified 12/11/2020)

As it relates to expenses, providers identify their health care-related expenses, and then apply any amounts received through other sources (e.g., direct patient billing, commercial insurance, Medicare/Medicaid, reimbursement from the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, or funds received from FEMA or SBA/Department of Treasury's Paycheck Protection Program) that offset the health care-related expenses. Provider Relief Fund payments may be applied to the remaining expenses or cost, after netting the other funds received or obligated to be received which offset those expenses.

Do providers report total purchase price of capital equipment or only the depreciated value? (Modified 12/11/2020)

Providers who use accrual or cash basis accounting may report the relevant depreciation amount based on the equipment useful life, purchase price and depreciation methodology otherwise applied.

For additional information on capital depreciation, please refer to the other Frequently Asked Questions related to capital equipment and capital facility projects.

Will the Provider Relief Fund limit qualifying expenses for capital equipment purchases to 1.5 years of depreciation, or can providers fully expense capital equipment purchases? (Added 11/18/2020)

Expenses for capital equipment and inventory may be fully expensed only in cases where the purchase was directly related to prevent, prepare for and respond to the coronavirus. Examples of these types of equipment and inventory expenses include:

- Ventilators, computerized tomography scanners, and other intensive care unit- (ICU)

related equipment put into immediate use or held in inventory

- Masks, face shields, gloves, gowns
- Biohazard suits
- General personal protective equipment
- Disinfectant supplies

Can providers include the entire cost of capital facilities projects as eligible expenses, or will eligible expenses be limited to the depreciation expense for the period? (Added 11/18/2020)

Expenses for capital facilities may be fully expensed only in cases where the purchase was directly related to preventing, preparing for and responding to the coronavirus. Examples of these types of facilities projects include:

- Upgrading a heating, ventilation, and air conditioning (HVAC) system to support negative pressure units
- Retrofitting a COVID-19 unit
- Enhancing or reconfiguring ICU capabilities
- Leasing or purchasing a temporary structure to screen and/or treat patients
- Leasing a permanent facility to increase hospital or nursing home capacity

At the bottom of page 1 of the reporting requirements announcement in PDF, Step 2 states "PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues, net of the healthcare related expenses attributable to coronavirus calculated under step 1." Is the underlined language still applicable under the reporting requirements notice that HHS posted on October 22, 2020? (Modified 12/4/2020)

No, healthcare related expenses are no longer netted against the patient care lost revenue amount in Step 2. A revised notice was posted to remove this language.

What is included in use of funds for salaries and employee compensation? (Added 10/28/2020)

Direct employee (full and part-time), contract labor, and temporary worker expenses are eligible expenses provided they are not reimbursed from other sources, or only the incremental unreimbursed amounts are claimed.

The Terms and Conditions associated with each Provider Relief Fund payment do not permit recipients to use Provider Relief Fund money to pay salaries at a rate in excess of Executive Level II which is currently set at \$197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Fund payments may pay an individual's salary amount in excess of the salary cap with non-federal funds.

An example of how this Executive Level II Salary cap is applied to aggregated personnel expenses is shown below. Reimbursement from other sources is applied in Step Two. Providers should apply reasonable assumptions when estimating the portion of personnel costs that are reimbursed from other sources.

Step One

Personnel Category	Number of Personnel	Personnel Expenses	Personnel Expenses (Below Salary Cap)	Ineligible for Federal Reimbursement
Medical Director	1	\$250,000	\$197,300	\$52,700
Registered Nurses	25	\$1,250,000	\$1,250,000	0
Security	2	\$80,000	\$80,000	0
	28	\$1,580,000	\$1,527,300	\$52,700

Step Two

Personnel Expenses (Below Salary Cap)	Less FEMA Reimbursement	Less Reimbursement from other sources	Eligible Personnel Expenses
\$1,527,300	\$(50,000)	\$(1,000,000)	\$477,300

Are fringe benefits for both patient care staff and General and Administrative (G&A) staff considered Provider Relief Fund eligible expenses under the “expenses attributable to coronavirus not reimbursed by other sources”? (Added 10/28/2020)

Yes, fringe benefits associated with both types of personnel may be eligible if not reimbursed by other sources.

When reporting my organization’s G&A expenses attributable to coronavirus, how do I calculate the “expenses attributable to coronavirus not reimbursed by other sources”? (Added 10/28/2020)

Providers should calculate incremental G&A expenses incurred that were attributable to coronavirus and then estimate the portion of those expenses that were not covered through operational revenues, other direct assistance, donations or other sources.

Examples may include expenses such as:

Hiring additional security personnel, increased hazard pay, increased cost of utilities to operate temporary facilities, or similar items attributable to the coronavirus that were not normally incurred.

When reporting my organization’s other healthcare related expenses attributable to coronavirus, how do I calculate the “expenses attributable to coronavirus not reimbursed by other sources”? (Added 10/28/2020)

Providers first calculate their expenses for supplies, equipment, IT, facilities, employees, and other healthcare related costs/expenses for calendar years 2019 and 2020, calculate the change in year over year expenses and identify the portion that is attributable to coronavirus. Provider will then apply reasonable assumptions to determine the amount of their “Total Revenue /Net Charges from Patient Care Related Sources” and “Other Assistance Received” that applies to each type of healthcare expense attributable to coronavirus.

For example:

PPE Supplies in 2019 = \$1,000

PPE supplies in 2020 = \$4,000

$\$4,000 - \$1,000 = \$3,000$ in expenses over and above normal operations attributable to coronavirus

Of that \$3,000, approximately \$2,500 was attributable to coronavirus, and of that \$2,500 approximately \$1,000 was reimbursed, leaving a balance of \$1,500 in unreimbursed healthcare related expenses attributable to coronavirus.

Can providers allocate parent overhead costs to the entities that received CARES Act Provider Relief Funds? (Added 10/28/2020)

Yes, providers that already have a cost allocation methodology in place, may allocate normal and reasonable overhead costs to their subsidiaries which may be an eligible expense if attributable to coronavirus and not reimbursed from other sources.

When reporting use of funds, how will my organization's "lost revenues attributable to coronavirus" be calculated? (Added 10/28/2020)

Lost revenues attributable to coronavirus are calculated based upon a calendar year comparison of 2019 to 2020 actual revenue/net charges from patient care (prior to netting with expenses).

The amount of lost revenues eligible for reimbursement through the Provider Relief Fund is capped at the change in 2019 to 2020 actual revenue from patient care related sources, less the Provider Relief Fund amount used to cover healthcare expenses attributable to coronavirus not reimbursed by other sources.

Reporting Entities with unused funds after December 31, 2020, must submit a second and final report no later than July 31, 2021 that includes patient care related revenue and expenses for January 1–June 30, 2021.

Note: Reported patient care revenue is net of uncollectible patient service revenue recognized as bad debts.

What is the maximum allotment of my organization's Provider Relief Fund amount that can be allocated to lost revenue in 2020? (Added 10/28/2020)

Unreimbursed expenses attributable to coronavirus are considered first in the overall use of funds calculation. Provider Relief Fund payment amounts not fully expended on unreimbursed healthcare related expenses attributable to coronavirus are then applied to lost revenues for 2020, which is capped at the change in 2019 to 2020 actual revenue from patient care (i.e., patient care revenue in 2019 less patient care revenue in 2020).

Recipients that reported increased revenue from patient care in 2020 as compared to 2019, are eligible to use Provider Relief Fund payments toward expenses attributable to coronavirus not reimbursed by other sources, however, they would not be considered to have lost revenues attributable to coronavirus for the initial reporting period.

Is interest earned on Provider Relief Fund funds considered a reportable revenue source to HHS? (Added 10/28/2020)

Yes, if funds were held in an interest-bearing account. Interest earned would then be reported in "Other Assistance." If interest is earned on Provider Relief Fund disbursements that the

Reporting Entity expended in full, the interest amounts may be retained and applied toward a reportable use of funds.

If interest is earned on funds that are only partially expended, the interest on remaining unused funds must be calculated, reported and returned if not applied to a permissible use of funds.

Can I use 2020 budgeted revenues as a basis for reporting lost revenues? (Added 10/28/2020)

No. When reporting use of Provider Relief Fund money toward lost revenues attributable to coronavirus, Reporting Entities must report actual patient care revenues and expenses for 2019 and 2020, to allow for a year-over-year calculation of change in revenue. In cases where funds are not fully expended by December 31, 2020, the Reporting Entity must report actuals from January 1-June 30, 2021 to be compared against the same six-month period in 2019.

How does “other assistance received” factor into my reported expenses? (Added 10/28/2020)

Other assistance received is reported as operating revenue and used in the calculation of year-over-year change in patient care related revenue.

What is considered when calculating “Total Revenue/Net Charges?” (Added 10/28/2020)
Revenue from Patient Care Payer Mix (2019 and 2020, and for some recipients, 2021 where applicable)

- a) Medicare Part A+B: The actual revenues/net charges received from Medicare Part A+B for patient care for the calendar year.
- b) Medicare Part C: The actual revenues/net charges received from Medicare Part C for patient care for the calendar year.
- c) Medicaid: The actual revenues/net charges received from Medicaid/Children’s Health Insurance Program (CHIP) for patient care for the calendar year.
- d) Commercial Insurance: The actual revenues/net charges received from commercial payers for patient care for the calendar year.
- e) Self-Pay (No Insurance): The actual revenues/net charges received from self-pay patients, including the uninsured or individuals without insurance who bear the burden of paying for healthcare themselves, for the calendar year.
- f) Other: The actual gross revenues/net charges from other sources received for patient care services and not included in the list above for the calendar year.

Note: All sources of patient care revenue should be reported net of uncollectible patient service revenue recognized as bad debts.

How does cost reimbursement relate to my Provider Relief Fund payment? (Added 10/28/2020)

Recipient must follow CMS instructions for completion of cost reports. Under cost reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. In these instances, if the full cost was reimbursed based upon this method, there is nothing eligible to report as an expense attributable to coronavirus because the expense was fully reimbursed by another source. In cases where a ceiling is applied to the cost reimbursement and the reimbursed amount does not fully cover the actual cost due to unanticipated increases in providing care attributable to coronavirus, those incremental costs that

were not reimbursed are eligible for reimbursement under the Provider Relief Fund.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? (Added 10/28/2020)

HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money and/or allocate the money to other subsidiary TINs, as it deems appropriate. Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

Supporting Data

What documentation is required for reporting? (Added 10/28/2020)

No external documentation is required at the time information is submitted via the reporting portal. Supporting worksheets (for providers who received \$500,000 or above in Provider Relief Fund payments) will be included to assist providers within the reporting tool.

What are the documentation retention requirements for the Provider Relief Fund? (Added 10/28/2020)

Providers need to retain original documentation for three years after the date of submission of the final expenditure report, in accordance with 2 CFR 200.333.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? (Added 10/28/2020)

HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money

and/or allocate the money to other subsidiary TINs, as it deems appropriate. Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

Change of Ownership

Who is responsible for reporting use-of-funds in the event of a change of ownership after receipt of a Provider Relief Fund payment? (Added 10/28/2020)

The following chart outlines Provider Relief Fund reporting actions in the event of change of ownership of a subsidiary that received Provider Relief Fund dollars.

Distribution	Change of Ownership Scenario	Program Guidance	Reporting Action
General Distribution	Purchase of stock or membership interest of subsidiary	<i>If the transaction is a purchase of the recipient entity (e.g., a purchase of its stock or membership interests), then the Provider Relief Fund recipient may continue to use the funds, regardless of its new owner.</i> <u>FAO dated 6/22/2020</u>	Subsidiary may use the Provider Relief Fund dollars and report on the use, or its new parent/owner (if an eligible healthcare provider) may direct and report on the use.
General Distribution	Asset Purchase of subsidiary	<i>If the transaction is an asset purchase (whether for some or all of the Provider Relief Fund recipient's assets), then the original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS. In these circumstances, the Provider Relief Fund money does not transfer to the buyer, however, buyers in these circumstances will be eligible to apply for future Provider Relief Fund payments.</i> <u>FAO dated 6/22/2020</u>	Subsidiary must use the Provider Relief Fund payment (returning any unused funds) and must report on the use itself. The new owner of the assets cannot use the relief fund money or report on the use.
General Distribution	Subsidiary entity is acquired and merged with another entity	<i>The entity resulting from the merger is the successor entity and can use the Provider Relief Fund payment. If this successor entity is a subsidiary of a new parent, that new parent, if it is an eligible healthcare provider, can direct the use of the relief fund money</i>	Subsidiary may use the Provider Relief Fund money and report on its use, or its new owner (if an eligible healthcare provider) may direct the use of the relief fund money and report on the use.
Targeted Distributions	Purchase of stock or membership interest of recipient subsidiary Asset purchase of recipient entity Subsidiary is acquired and merged with another entity	<i>Only the subsidiary can use the Targeted Distribution.</i> <u>FAO dated 9/3/2020</u>	Subsidiary reports on use of Targeted Distribution.

Non-Financial Data

What are the categories for classifying personnel? (Added 10/28/2020)

- a) Full-time: personnel employed on average 30 hours of service per week, or 130 hours for a calendar month.
- b) Part-time: personnel employed any time between 1 and 34 hours per week, whom may or may not qualify for benefits.
- c) New hires: personnel not previously employed by the employer; or previously employed but voluntarily or involuntarily separated for at least 60 consecutive days.
- d) Re-hires: personnel that left a company due to voluntary or involuntary separation and are brought back to work by employer.
- e) Voluntary separation: personnel voluntarily submits a written or verbal notice of resignation.
- f) Involuntary separation: management decides to terminate its relationship with an employee because of either economic necessity or poor fit; includes lay-offs and expired contracts.
- g) Furloughed: when a staff member involuntarily takes unpaid leave of absences.
- h) Leave of Absence: personnel voluntarily take an extended period of time away from work while still maintaining their employee status; can be paid or unpaid.

Note: Definitions of personnel are derived from either the Internal Revenue Service or the National Institute for Aging, as applicable.

What are the categories for patient admission? (Added 10/28/2020)

- a) Inpatient Admissions: someone admitted to the hospital on a doctor's order (i.e. direct admit); someone formally admitted from the Emergency Room to the hospital (i.e. emergency admission).
- b) Outpatient Admissions: also called a department use/event/encounter is made during the person's visit to the healthcare center that provides health and medical services but does not require stay exceeding 23 hours.
- c) Emergency Visit: someone seen in an Emergency Department for care/treatment of an acute episode; following treatment or stabilization the patient is discharged back to their primary place of residence. This may include patients on observation status who are cared for no longer than 72 hours but not formally admitted to a hospital.

What is a resident patient for the purpose of Provider Relief Fund payment? (Added 10/28/2020)

A patient that is admitted to a Nursing Home or Skilled Care Facility (with at least 6 beds) for continued short or long term care.

What is considered a "staffed bed" for reporting KPI? (Added 10/28/2020)

A staffed bed is licensed and physically available with staff on hand to attend to patients; includes both occupied and available beds.

Miscellaneous

Should providers include fundraising revenues, grants or donations when determining patient care revenue? (Added 12/4/2020)

To calculate lost revenues attributable to coronavirus, providers are required to report revenues received from Medicare, Medicaid, commercial insurance, and other sources for patient care services. Other sources include fundraising revenues, grants or donations if they contribute to funding patient care services.

Providers may have significant fluctuations in year-over-year net patient revenues due to settlements or payments made to third parties relating to care delivered outside the reporting period (2019-2020). Should Provider Relief Fund recipients exclude from the reporting of net patient revenue payments received for care not provided in 2019 or 2020? (Added 11/18/2020)

Provider Relief Fund recipients shall exclude from the reporting of net patient revenue payments received or payments made to third parties relating to care not provided in 2019 or 2020.

What does “primary Tax Identification Number (TIN)” and “subsidiary TIN” refer to? (Added 10/28/2020)

Primary TIN refers to the TIN of the parent company, and subsidiary TIN refers to the TIN of an entity that is a subsidiary of the parent company. Providers may have received payments directly to a parent and/or its subsidiary entities.

What is meant by “For some recipients, this may be analogous to Social Security number (SSN) or Employer Identification Number (EIN)” with respect to the TIN? (Added 10/28/2020)

Some recipients may be individual providers for whom their TIN will be their SSN; similarly, for some entities the TIN will be the EIN.

What are the required timelines for reporting? (Added 10/28/2020)

All recipients of aggregated Provider Relief Fund payments greater than \$10,000 must report use of funds as of December 31, 2020 at any time during the window that begins January 15, 2021, but no later than February 15, 2021.

Recipients with funds unexpended after December 31, 2020, have six more months from January 1 – June 30, 2021 to use remaining funds, and then must submit a second and final report no later than July 31, 2021.

If an entity incurred enough lost revenue in April and May 2020 to justify its use of the Provider Relief Fund payments received, can it only report those two months? (Added 10/28/2020)

No. The Reporting Entity must report revenue and expense for the full calendar years 2019 and 2020. If funds were not expended in full by December 31, 2020 then a second and final report will be required on use of funds for the period January 1, 2021 - June 30, 2021 which is due no later than July 31, 2021.

What is the process to return unused funds? (Added 10/28/2020)

Details on how to return unused amounts will be provided in advance of the second 2021 reporting deadline, which is July 31, 2021.

If an entity received payments totaling over \$10,000, but returned some, do they still have to report? (Added 10/28/2020)

A Reporting Entity must report only when they have retained \$10,000 or more in aggregated Provider Relief Fund dollars. This includes payments received by the parent and general distribution payments received by related subsidiaries for which the parent will report on behalf of.

Should entrance fee amortization be excluded from patient care? (Added 10/28/2020)

If the provider includes entrance fee amortization as operating revenue on its financial statements, it should be considered as revenue associated with patient services. Entrance fee amortization must be handled in a consistent manner in both 2019 and 2020.

How do shareholder or partnership payments impact the lost revenue calculation? (Added 10/28/2020)

“Lost revenue attributable to coronavirus” is calculated based on operating revenue from patient care sources. Shareholder and partnership payments are not eligible to be included in the lost revenue calculation.

If all funds are expended through the G&A and healthcare related expenses, are recipients still required to submit lost revenue information? (Added 10/28/2020)

Yes, all providers above the \$10,000 threshold are required to report both revenues and expenses for the calendar year.

Are Intergovernmental Transfers (IGTs) related to state provider taxes allowable G&A expenses? (Added 10/28/2020)

A portion of a Provider Relief Fund recipient’s state provider taxes may be eligible expenses, but only to the extent the Provider Relief Fund recipient owes incrementally increased state provider taxes, where the incremental increase is attributable to coronavirus.

Vaccine Distribution and Administration

Can Provider Relief Fund payments be used to support COVID-19 vaccine distribution? (Modified 12/11/2020)

Provider Relief Fund payments may be used to support expenses associated with distribution of a COVID-19 vaccine licensed or approved by the Food and Drug Administration (FDA) that have not been reimbursed from other sources or that other sources are not obligated to reimburse. Funds may also be used ahead of an FDA-licensed or approved vaccine becoming available. This may include using funds to purchase additional refrigerators, personnel costs to provide vaccinations, and transportation costs not otherwise reimbursed.

Can Provider Relief Funds be used to cover the cost of vaccination, including doses and administration fees, for Medicare, Medicaid, or CHIP beneficiaries? (Modified 12/11/2020)

In line with the Terms and Conditions, funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are *obligated* to reimburse, which include, but is not limited to, Medicare, Medicaid, and CHIP. If reimbursement does not cover the full expense of administering vaccines, Provider Relief Funds may be used to cover the remaining associated costs.

Balance Billing

The Terms and Conditions require recipients to attest that for all care for a presumptive or actual case of COVID-19 the recipient will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient. How should dental providers comply with this requirement? (Added 7/22/2020)

The prohibition on balance billing applies to “all care for a presumptive or actual case of COVID-19.” A presumptive case of COVID-19 is a case where a patient’s medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record. Dental providers who are not caring for patients with presumptive or actual cases of COVID-19 would not be subject to this provision.

Do the Terms and Conditions for the General and Targeted Distributions require attesting to a ban on balance billing for all patients and/or all care, because “HHS broadly views every patient as a possible case of COVID-19”? (Added 5/6/2020)

No. As set forth in the Terms and Conditions, the prohibition on balance billing applies to “all care for a presumptive or actual case of COVID-19.”

The Terms and Conditions provision related to balance billing suggests that providers that provide out-of-network care to an insured, presumptive or actual COVID-19 patient can bill the patient’s insurer any amount, as long as they do not bill the patient directly. Is that correct? (Added 5/6/2020)

The Terms and Conditions do not impose any limitations on the ability of a provider to submit a claim for payment to the patient’s insurance company. However, an out-of-network provider delivering COVID-19-related care to an insured patient may not seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

The Terms and Conditions require that “for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient.” How does HHS define a presumptive case of COVID-19? (Modified 6/12/2020)

A presumptive case of COVID-19 is a case where a patient’s medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.

How will a provider know the in-network rates to be able to comply with the requirement to bill a presumptive or actual COVID-19 patient for cost-sharing at the in-network rate? (Added 5/6/2020)

Providers accepting the Provider Relief Fund payment should submit a claim to the patient’s health insurer for their services. Most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer’s prevailing in-network rate. If the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient

would have otherwise been required to pay if the care had been provided by an in-network provider.

Appeals

Who determines the amount my organization will receive?

HHS will apportion relief funds to US health care providers with the intention of optimizing the beneficial impact of the funds.

Who can I talk to at HHS about my distribution payment?

HHS is not taking direct inquiries from providers, and no remedy or appeals process will be available. For additional information, please call the Provider Support Line at (866) 569-3522 (for TTY, dial 711).

How do I appeal or dispute a decision made?

There is no appeals or dispute process.

Publication of Payment Data

Is there a publicly available list of providers and the payments they received through the Provider Relief Fund? (Modified 6/12/2020)

HHS has posted a [public list](#) of providers and their payments once they attest to receiving the money and agree to the Terms and Conditions. All providers that received a payment from the Provider Relief Fund and retain that payment for at least 90 days without rejecting the funds are deemed to have accepted the Terms and Conditions. Providers that affirmatively attest through the Payment Attestation Portal or that retain the funds past 90 days, but do not attest, will be included in the public release of providers and payments. The list includes current total amounts attested to by providers from each of the Provider Relief Fund distributions, including the General Distribution and Targeted Distributions.

What providers are included in the Provider Relief Fund data file on the CDC website? (Modified 6/12/2020)

The data that are posted in the [public list](#) represent providers that received one or more payments from the Provider Relief Fund and that have attested to receiving at least one payment and agreed to the associated Terms and Conditions. If a provider has received more than one payment but has not accepted all of the payments (by attesting and agreeing to the Terms and Conditions), only the dollar amount associated with the accepted payment or payments will appear. These data displayed on the website will be updated biweekly.

Why might a provider not be listed or listed with a different address than their service location? (Added 5/12/2020)

Provider Relief Fund payments are being made to providers or groups of providers that are organized within a Tax Identification Number (TIN). The information displayed is of providers by billing TIN that have received at least one payment, which they have attested to, and the address associated with that billing TIN. Providers will not be listed if they have not yet attested to the payment terms and conditions or if they are within a larger billing entity that received payment. In addition, the address listed for the billing TIN often corresponds with the billing location (based on the Center for Medicare & Medicaid Services' Provider Enrollment, Chain, and Ownership System (PECOS)), and may not align with the physical location of a health care

practice site. Updated data will be made available on the Center for Disease Control and Prevention's (CDC) website.

Will HHS release additional data elements, such as provider types, payment amount per distribution, or payment recipients' NPIs, on the public list of providers and payments? (Added 5/12/2020)

HHS does not have plans to include additional data fields in the [public list](#) of providers and payments.

Can a provider choose to have its payment data omitted from the [Provider Relief Fund public list](#) on the CDC's website? (Added 5/20/2020)

No. To ensure transparency, HHS will publish the names of payment recipients and the amounts accepted and attested to by the payment recipient.

General Distribution

Phase 1

Overview and Eligibility

Which types of providers are eligible to receive a Phase 1 – General Distribution Provider Relief Payment? (Modified 6/12/2020)

To be eligible for a Phase 1 – General Distribution payment, providers must have billed Medicare fee-for-service (Parts A or B) in Calendar Year 2019. Additionally, under the Terms and Conditions associated with payment, these providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

All providers retaining funds must sign an attestation and accept the Terms and Conditions associated with payment.

Why am I receiving an email requesting that I submit my financial information in response to the payment I received as part of Phase 1 of the General Distribution? (Added 9/3/2020)

The [Terms and Conditions](#) for payments received on or around April 24, 2020, as part of the additional \$20 billion under Phase 1 of the General Distribution require that recipients submit their revenue information. Based on HHS's records, due in some instances to system issues, the Department did not receive your required revenue information necessary for program integrity purposes and consideration for additional payments. In order to be considered for an additional payment, recipients must submit this revenue information by September 13, 2020. If a health care provider rejected the funds received on or around April 24 and does not want to keep any additional funds received as a result of submitting revenue, they may return a payment by going into the attestation portal within 90 days of receiving payment and indicating they are rejecting the funds. Providers must return the payment within 15 calendar days of rejecting the payment.

I received an email from the Provider Relief Fund’s DocuSign application web portal informing me that my CARES Act Provider Relief Fund Application DocuSign submission (“envelope”) has expired. Does this mean I am not eligible to receive a General Distribution payment? (Modified 7/14/2020)

No. You received an automated email sent by DocuSign to providers who initiate one or more entries that were not completed or submitted. A number of providers opened duplicate entries in the DocuSign web portal, resulting in one or more of the entries (referred to as “envelopes” by DocuSign) becoming “orphaned” and incomplete. The expiration status of one DocuSign entry does not affect any other submissions by that provider. If an application was completed and submitted, no further action is required on the healthcare provider’s part.

I am a health care provider that received a previous Phase 1 – General Distribution payment and I submitted my revenue information through the Provider Relief Fund Payment Portal. Why am I not receiving an additional payment? (Modified 6/12/2020)

HHS is distributing an additional \$20 billion of the General Distribution to providers to augment their initial allocation so that \$50 billion is allocated proportional to providers' share of 2018 gross receipts or sales/program service revenue. Payments are determined based on the lesser of 2% of a provider’s 2018 (or most recent complete tax year) gross receipts or the sum of incurred losses for March and April. If the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual gross receipts or sales/program service revenue, you may not receive additional General Distribution payments. There may be additional distributions in the future for which providers are eligible.

Why might a provider that bills Medicare fee-for-service not have received a payment from the initial \$30 billion Phase 1 – General Distribution? (Added 6/15/2020)

To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in CY2019. Phase 1 – General Distribution payments were made to the billing organization according to its Taxpayer Identification Number (TIN). Payments to providers and practices that are part of larger medical groups went to the group’s central billing office.

Some providers who did bill Medicare fee-for-service in CY2019 were not eligible for payment because either the provider is terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; or currently has Medicare billing privileges revoked as determined by either the Centers for Medicare & Medicaid Services or the HHS Office of Inspector General.

If the provider’s TIN that was intended for payment identifies both a social security number of an individual Medicare provider and another Medicare provider’s employer identification number, that TIN was excluded from the General Distribution. Providers were also excluded from the General Distribution if there was incomplete banking information and/or personal contact information. HHS is working to determine eligibility for a General Distribution payment for those affected providers.

Determining Additional Payments

How can I estimate the total payment amount I can anticipate through the Phase 1 – General Distribution? (Modified 6/12/2020)

In general, providers can estimate payments from the Phase 1 – General Distribution of approximately 2% of 2018 (or most recent complete tax year) gross receipts or sales/program service revenue. To estimate your payment, use this equation:

$(\text{Individual Provider Revenues}/\$2.5 \text{ Trillion}) \times \$50 \text{ Billion} = \text{Expected Combined General Distribution.}$

Providers should work with a tax professional for accurate submission.

This includes any payments under the first \$30 billion General Distribution as well as under the \$20 billion General Distribution allocations. Providers may not receive a second distribution payment if the provider received a first distribution payment of equal to or more than 2% of gross receipts.

Provider Relief Fund Payment Portal – Phase 1 - General Distribution

An organization has prescription sales as part of its revenue. Can these sales be captured in the data submitted as “gross sales or receipts” or “program service revenue?” (Modified 6/22/2020)

Generally no. Only patient care revenues from providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 may be included. Patient care revenues do include savings obtained by providers through enrollment in the 340B Program.

What information is HHS collecting for Phase 1 – General Distribution in the Provider Relief Fund Payment Portal?

The Provider Relief Fund Payment Portal has been deployed to collect information from providers who received Phase 1 – General Distribution payments prior to April 24, 2020 at 5:00 pm EST. The Provider Relief Fund Payment Portal collects four pieces of information to allocate remaining Phase 1 – General Distribution funds:

1. A provider’s “Gross Receipts or Sales” or “Program Service Revenue” as submitted on its federal income tax return;
2. The provider’s estimated revenue losses in March 2020 and April 2020 due to COVID;
3. A copy of the provider’s most recently filed federal income tax return;
4. A listing of the TINs for any of the provider’s subsidiary organizations that received relief funds but DO NOT file separate tax returns.

This information may also be used to allocate other Provider Relief Fund distributions.

HHS is collecting: the “gross receipt or sales” or “program service revenue” data to have an understanding of a provider’s usual operations; the revenue loss information to have an understanding of COVID impact; and, tax forms to verify the self-reported information. HHS is collecting information about organizational structure and subsidiary TINs so that we do not overpay or underpay providers who file tax returns covering multiple legal entities (e.g. consolidated tax returns).

Providers meeting the following criteria are required to submit a separate portal application:

- (a) Provider has received Provider Relief Fund payments as of 5:00pm EST Friday April 24, 2020 **AND**
- (b) Provider has filed a federal income tax return for 2017, 2018, or 2019.

As such, each entity that files a federal income tax return is required to file an application even if it is part of a provider group. However, a group of corporations that files one consolidated return will have only the tax return filer apply.

Each provider submitting an application is required to list the TINs of each subsidiary that (a) has received Provider Relief Fund payments as of 5:00 EST Friday April 24, 2020 **AND** (b) **has not filed** federal income tax returns for 2017, 2018, or 2019.

Do not list any subsidiary's TIN that has filed a federal income tax return, because such subsidiary is required to submit a separate application.

For example:

- 1) A parent entity and two subsidiaries received Provider Relief Fund payments. The parent filed a federal income tax return, but the two subsidiaries did not as they are consolidated with the parent.

The parent should submit an application and list the subsidiary TINs therein. The subsidiaries cannot submit an application as they did not file a tax return.

- 2) A parent entity and two subsidiaries A and B received Provider Relief Fund payments. The parent and subsidiary A filed a federal income tax return, but the subsidiary B did not as it is consolidated with the parent.

The parent and subsidiary A should submit separate applications. The parent would list the TIN subsidiary B in its application.

Data Sharing

Why am I being redirected to DocuSign to fill out certain elements?

HHS is using DocuSign to securely pass encrypted data to HHS. Neither DocuSign nor UnitedHealth Group will have access to your data.

What is DocuSign doing with my data?

DocuSign is securely passing your data to HHS in encrypted files. Neither DocuSign nor UnitedHealth Group will have access to your data.

What information is shared with UnitedHealth Group, UnitedHealthcare, Optum, or any other subsidiary of UnitedHealth Group?

UnitedHealth Group and its subsidiaries will not have access to any information collected from providers, nor do they participate in determining the methodology used to allocate Provider Relief Fund payments. UnitedHealth Group will know the amounts of relief funding paid to providers as UnitedHealth Group is processing the payments.

Who has access to my revenue data?

HHS will have access to your revenue data to optimally allocate Provider Relief Fund payments. HHS will not share your revenue data with any other entities, in or outside of government, except as prescribed by law.

Phase 2

Overview and Eligibility

Who is eligible for Phase 2 – General Distribution? (Modified 9/1/2020)

To be eligible to apply, the applicant must meet all of the following requirements:

1. Either
 - a. Must have either (i) directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018, to December 31, 2019, or (ii) own (on the application date) an included subsidiary that has either directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018, to December 31, 2019; or
 - b. Must be a dental service provider who has either (i) directly billed health insurance companies for oral health care-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for oral health care-related services; or
 - c. Must be a licensed dental service provider who does not accept insurance and has either (i) directly billed patients for oral health care-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for oral health care-related services;
 - d. Must have billed Medicare fee-for-service during the period of January 1, 2019 and December 31, 2019;
 - e. Must be a Medicare Part A provider that experienced a change in ownership and billed Medicare fee-for-service in 2019 and 2020 that prevented the otherwise eligible provider from receiving a Phase 1 - General Distribution payment; or
 - f. Must be a state-licensed/certified assisted living facility.
2. Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or health care clinic); and
3. Must have provided patient care after January 31, 2020; and
4. Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
5. If the applicant is an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

Providers who have received a payment under Phase 1 of the General Distribution are no longer prohibited from submitting an application under Phase 2 of the General Distribution. Providers who received a previous Phase 1 – General Distribution payment are eligible to apply and, if they have not yet received a payment that is approximately 2% of annual revenue from patient care, may receive additional funds.

What was the methodology/formula used to calculate provider payment? (Modified 9/1/2020)

The Phase 2 – General Distribution methodology will be based upon 2% of (revenues * percent of revenues from patient care) from the applicant’s most recent federal income tax return for 2017, 2018 or 2019 and with accompanying submitted tax documentation. Payments will be made to applicant providers who are on the filing TIN curated list submitted by state/territory Medicaid or CHIP agencies, HHS-developed lists of dental providers and assisted living facilities, the list of providers who received a Phase 1 – General Distribution payment, or the list of approved CMS-approved Medicare Part A providers who experienced a change in ownership as of August 10, 2020 or whose applications underwent additional validation by HHS.

Will Phase 2 - General Distribution payments be made to the billing TIN or filing TIN for those who received a payment that was less than 2% of revenue as part of the Phase 1 - General Distribution? (Added 8/10/2020)

In line with the policies established for the Phase 2 - General Distribution, HHS will be making payments to applicants based on filing TIN for all those who apply as part of this newer distribution.

Will practices or facilities that experienced a change in ownership that prevented them from receiving a Targeted Distribution payment, such as a Skilled Nursing Facility payment or Safety Net Hospital payment, be eligible for more than 2% of revenue from patient care? (Modified 12/4/2020)

At this time, HHS is only expanding eligibility to the Phase 2 - General Distribution to those health care providers that experienced a change in ownership that prevented them from receiving a Phase 1 - General Distribution payment. Providers that experienced a change in ownership may be eligible for future Targeted Distributions.

What are the reasons that I would not be eligible for a Phase 2 – General Distribution payment? (Modified 8/10/2020)

You must meet the five eligibility requirement for the Phase 2 – General Distribution; must not be currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; must not be currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and must not currently have Medicare billing privileges revoked. In addition, your billing TIN must be included in the State-provided list of eligible Medicaid and CHIP providers, the HHS-created list of dental providers, the list of providers who received a Phase 1 – General Distribution payment, the list of Medicare Part A providers that experienced a change in ownership in 2019 or 2020, or your application must pass additional validation by HHS.

Does payment from the Phase 1 – General Distribution affect what I may receive as a Phase 2 – General Distribution payment? (Modified 8/10/2020)

Yes. Payments received as part of the Phase 1 - General Distribution will be taken into account when determining payment amounts for the Phase 2 - General Distribution. If a health care provider has not yet received a payment that equals approximately 2% of revenue from patient care, it may now be eligible for a Phase 2 - General Distribution payment.

Additionally, prior payment in a Provider Relief Fund Targeted Distribution (like the High Impact Area, Rural, Indian Health Service, and Skilled Nursing Facility Targeted Distributions) does not affect eligibility for, or amount of, a possible payment.

Will payments be sent at one time or disbursed in phases? (Added 6/9/2020)

Payments will be disbursed on a rolling basis, as information is validated. HHS may seek additional information from providers as necessary to complete its review.

Tax Identification Number (TIN) Validation Process

What if an applicant's TIN is flagged as invalid because it is not on the filing TIN list submitted by states/territories to CMS or the curated list of eligible providers? (Modified 10/1/2020)

Payments will be made to applicant providers who are in the filing TIN curated list from CMS if they are a Medicaid or CHIP provider. If a TIN is not on the curated list of state-submitted eligible Medicaid/CHIP providers or T-MSIS, it will be flagged as invalid. In these cases, HHS will work with the states/territories to verify whether the TIN should be included as a valid Medicaid or CHIP provider in good standing.

If a TIN is not on the curated list of dental providers, HHS will conduct additional analysis related to the TIN and any active dental providers associated with the TIN.

If a TIN is not on a curated list of assisted living facilities, HHS will conduct additional analysis related to the TIN and any currently operating assisted living facilities associated with the TIN.

If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign even if validation occurs after the September 13, 2020 deadline. Applicants validated after that date will have until October 4, 2020, 11:00pm EST to submit an application to be considered for funding under Phase 2. TINs that cannot be validated will not receive funding. Please note, the additional TIN validation may result in a delay in processing the application.

When is the deadline to submit an application? (Modified 10/1/2020)

The deadline to submit a TIN for validation for the Phase 2 – General Distribution is September 13, 2020. Applications must be submitted by October 4, 2020, 11:00pm EST. Applications that are not completed by the October 4 deadline will be voided and applicants will have the opportunity to submit an application for Phase 3 by going back into the portal and clicking on “Get Started.”

Will health care providers that have not had their TINs validated by the application deadline of September 13, 2020 be able to submit an application after that date? (Modified 10/1/2020)

Yes. A health care provider must submit their TIN for validation by end of day September 13, 2020. If they receive the results of that validation after September 13, they must submit an application by October 4, 2020, 11:00pm EST for consideration under Phase 2. Applications that are not completed by the October 4 deadline will be voided and applicants will have the opportunity to submit an application for Phase 3 by going back into the portal and clicking on “Get Started.”

If my TIN will take more than 15 days to be validated, when will I be notified? (Modified 10/1/2020)

If your TIN cannot be validated within 15 days of submission, you will receive an email 13 days after submission notifying you that additional verification is required by the State/Territory Medicaid or CHIP agency. If you do not receive an email, please contact the Provider Support Line at (866) 569-3522 (for TTY, dial 711). Please note that it may take additional time to validate your TIN in these instances, particularly when close to deadlines. If you receive the results of that validation after September 13, you must submit an application by October 4, 2020, 11:00pm EST for consideration under Phase 2. Applications that are not completed by the October 4 deadline will be voided and you will have the opportunity to submit an application for Phase 3 by going back into the portal and clicking on “Get Started.”

Application Process

How should a parent organization that files taxes on behalf of its subsidiaries report NPIs if the NPIs are associated with the subsidiaries’ TINs, not the filing TIN? (Modified 9/4/2020)

If the parent organization does not have an NPI, the applicant should insert the subsidiary Group NPI that is best representative of the health care services delivered by the parent organization’s subsidiaries. If the parent organization and its subsidiaries do not have an NPI, the applicant should enter “not applicable.” The field cannot be left blank.

What is the difference between the first Provider Relief Fund Payment Portal and the Provider Relief Fund Application and Attestation Portal for the Phase 2 – General Distribution? (Modified 7/17/2020)

The first Provider Relief Fund Payment Portal was used for providers who received a General Distribution payment prior to Friday, April 24th. These providers were required to submit financial information in order to receive approximately 2% of revenues derived from patient care.

HHS has developed the new Provider Relief Fund Application and Attestation Portal for providers who bill Medicaid and CHIP (e.g., pediatricians, long-term care, and behavioral health providers) or are dental providers. HHS has since expanded eligibility to other providers, including those who may not have received additional funds as part of the Phase 1 – General Distribution.

What specific revenue information should I enter into the application portal? (Modified 7/17/2020)

Applicants should enter the most recent revenues number from its federal tax return of 2017, 2018, or 2019. If the applicant for tax purposes is a:

- Sole proprietor or disregarded entity owned by an individual: Enter Line 3 from IRS Form 1040, Schedule C excluding any income reported on W-2.
- Partnership: Enter Line 1c minus Line 12 from IRS Form 1065.
- C corporation: Enter Line 1c minus Line 15 from IRS Form 1120.
- S corporation: Enter Line 1c minus Line 10 from IRS Form 1120-S.
- Tax-exempt organization: Enter Line 9 from IRS Form 990 minus any joint venture income, if included in Part VIII lines 2a – 2f.
- Trust or estate: Enter Line 3 from IRS Form 1040, Schedule C.
- Entity not required to file any of the previously mentioned IRS forms: Enter a “net

patient service revenue” number or equivalent from the applicant’s most recent audited financial statements (or management-prepared financial statements)

- Applicants with gross revenue adjustments should enter an adjusted gross revenues number as calculated using the Gross Revenues Worksheet in Field 15 available at: <https://www.uhcprovider.com/content/dam/provider/docs/public/other/PRF-Gross-Revenues-Worksheet.xlsx>.

How long will it take from portal submission to payment decision or receipt? (Added 6/9/2020)

HHS is working to process all providers’ submissions as quickly as possible. HHS may seek additional information from providers as necessary to complete its review.

What documentation must be uploaded to the application form? (Added 6/9/2020)

- The applicant’s most recent federal income tax return for 2017, 2018 or 2019 or a written statement explaining why the applicant is exempt from filing a federal income tax return (e.g. a state-owned hospital or health care clinic).
- If required by Field 15, the applicant’s Gross Revenue Worksheet (provided by HHS).

Phase 3

Overview and Eligibility

How does Phase 3 differ from the previous phases of the General Distribution? (Modified 10/8/2020)

Phase 3 of the General Distribution will take into account documentation of financial impact of COVID-19, as reported by applicants. The payment methodology will ensure a provider has received 2% of annual revenue from patient care either as part of the previous phases of the General Distribution or under a Phase 3 payment. Phase 3 may also take into account a provider’s change in operating revenues from patient care, minus their operating expenses from patient care. Phase 3 payment will also take into account funds received and kept under prior General and Targeted Distributions. While HHS has made payments on a rolling basis under the previous general distributions, Phase 3 final payment amounts for applicants who have already received payments equaling 2% of annual patient care revenue will be determined once all applications have been received and reviewed.

Who is eligible for Phase 3 – General Distribution? (Added 10/5/2020)

To be eligible to apply, the applicant must meet all of the following requirements:

1. Either
 - a. Must have either (i) directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018 to March 31, 2020, or (ii) own (on the application date) an included subsidiary that has either directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018 to March 31, 2020; or
 - b. Must be a dental service provider who, as of March 31, 2020, has either (i) directly billed health insurance companies for oral health care-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for oral health care-related services; or

- c. Must be a licensed dental service provider who does not accept insurance and has, as of March 31, 2020, either (i) directly billed patients for oral health care-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for oral health care-related services;
- d. Must have billed Medicare fee-for-service during the period of January 1, 2019 and March 31, 2020;
- e. Must be a Medicare Part A provider that experienced a change in ownership that was approved by the Centers for Medicare & Medicaid services by August 10, 2020 and billed Medicare fee-for-service during the period of January 1, 2019 to March 31, 2020;
- f. Must be a state-licensed/certified assisted living facility as of March 31, 2020;
- g. Must be a behavioral health provider who, as of March 31, 2020, has either (i) directly billed health insurance companies for health care-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for health care-related services; or
- h. Must be a behavioral health provider who does not accept insurance and has, as of March 31, 2020, either (i) directly billed patients for health care-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for health care-related services; or
 - i. Must have received a Targeted Distribution payment.
2. Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 if in operation before January 1, 2020 or quarterly tax returns for fiscal years 2020 if operations began on or after January 1, 2020 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or health care clinic); and
3. Must have provided patient care after January 31, 2020; and
4. Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
5. If the applicant is an individual that was providing patient care have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

Providers who have previously received a payment under Phase 1 or Phase 2 of the General Distribution are eligible to apply for a payment even if they have previously received a disbursement of 2% of annual revenue from patient care. Providers who have not previously received a General Distribution payment, or an amount that is less than 2% of patient care revenue, may also apply for funds if they meet the above eligibility criteria.

**What will be the methodology/formula used to calculate provider payment in Phase 3?
(Modified 12/28/2020)**

Providers will be paid up to 88 percent of their reported losses and net change in their operating expenses from patient care from the first half of 2020. Some applicants will not receive an additional payment either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed

reimbursement of 88 percent of reported losses. Providers that have not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of the General Distribution will receive at least that amount as part of their Phase 3 payment. .

What is the payment amount that an applicant should expect to receive from Phase 3 of the General Distribution? (Modified 12/28/2020)

If an applicant has not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of either Phase 1 or 2 of the General Distribution, then they will receive at least that amount in Phase 3 payment. In addition to this amount, providers will be paid up to 88 percent of their reported losses and net change in their operating expenses from patient care from the first half of 2020. Some applicants will not receive an additional payment either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88 percent of reported losses.

When will Phase 3 payments be made? (Modified 12/28/2020)

HHS began issuing Phase 3 – General Distribution payments in mid-December, 2020, and will continue making payments through the first months of 2021.

Are providers that received payments under Phase 3 of the General Distribution limited to using these funds to cover coronavirus-related losses or increased expenses experienced during the first two quarters of calendar year 2020? (Modified 10/28/2020)

No. The Terms and Conditions require payment recipients to certify that funds will only be used to prevent, prepare for, and respond to coronavirus, and will only reimburse the recipient for health care-related expenses or lost revenues that are attributable to coronavirus. The Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses provided that funds are expended by June 30, 2021, per reporting guidelines. HHS is collecting information on the losses and expenses associated with the first two quarters of 2020 for purposes of making additional General Distribution payments to those providers with demonstrated financial need.

How will Phase 3 payment be calculated for providers that began operations part way through 2019 or in 2020 that do not have complete financial information from 2019 or the first quarter of 2020? (Added 10/5/2020)

HHS will calculate the percentage of change in operating revenues from patient care minus operating expenses from patient care for providers that began operations partway through 2019 or in 2020, and, therefore, do not have data from all of the requested quarters, based on the applicant's financial information that is available and data from the same type of provider as the applicant. Providers that began operation in 2020 will be paid approximately 2% of patient care revenue based on the applicant's reported financial information for those months in 2020 that they were operation.

I am a provider that is newly eligible for Phase 3 of the General Distribution. Should I submit an application as part of Phase 3 or will there be another opportunity to receive a General Distribution payment? (Added 10/5/2020)

Providers that are newly eligible should submit their TIN for validation as soon as practical in order to ensure that they can submit an application before the deadline. HHS has not yet determined whether there will be additional General Distribution phases. Providers should not

have the expectation that they will be advantaged by applying for funds from one distribution over another. Providers should apply for a Provider Relief Fund payment in the first distribution in which they are eligible.

What are the reasons that I would not be eligible for a Phase 3 – General Distribution payment? (Modified 10/8/2020)

You must meet the five eligibility requirements for the Phase 3 – General Distribution; must not be currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; must not be currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and must not currently have Medicare billing privileges revoked. In addition, your billing TIN must be included in the State-provided list of eligible Medicaid and CHIP providers, the HHS-created list of dental providers, the list of providers who received a General or Targeted Distribution payment, the list of Medicare Part A providers that experienced a change in ownership in 2019 or 2020, or your application must pass additional validation by HHS. If you received payment under previous Targeted Distributions, these funds may be factored into whether you will receive any further payments under Phase 3.

How should an applicant set up an Optum ID if it is applying for Phase 3 – General Distribution payment on behalf of multiple subsidiaries? (Added 10/5/2020)

If the applicant is a parent entity applying on behalf of multiple subsidiaries and it would like each subsidiary to receive its own payment, the applicant should create an Optum ID account and submit an application for each TIN that should receive its own payment. The applicant should include the unique banking information for each subsidiary's application.

If the applicant is a parent entity applying on behalf of multiple subsidiaries and it would like a single payment for all of the included subsidiaries, the applicant should create one Optum ID account for the parent entity and submit a single application with the filing TIN.

The parent entity should add its TIN as the "Organizational TIN" on their dashboard. If applying on behalf of subsidiaries, the parent entity will have the opportunity to enter multiple subsidiary TINs associated with the parent organization TIN. After adding the "Organizational TIN," the applicant should click "Get Started" once they arrive on the "Practice Detail" page, under the "Group/Individual Information" heading. The applicant can enter up to 1,200 subsidiary TINs into the "List of Subsidiary TINs Associated with This Entity" field. The applicant may paste a list of TINs directly into this field. Next, the applicant should review their information and click "Submit TIN." Once the organization or subsidiary TINs are verified, the applicant will progress to the DocuSign form, where they can submit the applicable tax information that accounts for each TIN included in the application.

Is a health care provider that did not deposit a check from the Phase 1 – General Distribution that was subsequently voided after 90 days, eligible to apply for the Phase 3 – General Distribution? (Added 10/5/2020)

Yes. The health care provider is eligible to apply for a Phase 3 – General Distribution payment if it otherwise meets the eligibility criteria.

In the situation where the Medicaid provider is a management company that bills Medicaid, but the revenues from patient care are ultimately reflected on the property owner's parent company's tax returns (with the management company retaining a portion as a management fee), and the Medicaid provider/management company is not a subsidiary of the property owner or its parent company, which entity should apply for the Medicaid Provider Relief Fund Distribution? (Added 10/5/2020)

The Medicaid provider/management company must apply, because neither the property owner nor its parent company is an eligible healthcare provider. The Medicaid provider/management company must use the funds for eligible healthcare related expenses or lost revenues attributable to coronavirus. However, the Medicaid provider/management company could, for example, purchase PPE from the property owner or its parent company.

Is a health care provider eligible to receive a payment from the Phase 3 – General Distribution even if the provider received funding from the Small Business Administration's (SBA) Payroll Protection Program or the Federal Emergency Management Agency (FEMA) or has received Medicaid HCBS retainer payments? (Added 10/5/2020)

Yes. If the health care provider otherwise meets the criteria for eligibility, receipt of funds from SBA and FEMA for coronavirus recovery or of Medicaid Home-and Community-Based Services (HCBS) retainer payments, does not preclude a health care provider from being eligible for Phase 3 – General Distribution; however, the health care provider must substantiate that the Provider Relief Fund payments were used for increased health care related expenses or lost revenue attributable to COVID-19, and those expenses or lost revenue were not reimbursed from other sources or other sources were not obligated to reimburse.

Providers of self-directed Home- and Community-based Services (HCBS), who do not work for provider agencies, often receive payment through a fiscal management service (FMS) organization who bills Medicaid and remits payment to the provider. Will the requirement that a provider either have directly billed their state Medicaid/CHIP programs or Medicaid managed care plans for health care-related services between January 1, 2018, to March 31, 2019 prevent these providers from being eligible for funding from the relief fund? (Added 10/5/2020)

While the self-directed providers are eligible to receive Provider Relief Fund money, payments from the Provider Relief Fund will be made to the filing TIN entity. If the FMS organization is the filing TIN entity, it will need to apply on behalf of the self-directed providers and distribute the funds as appropriate to the providers. If self-directed providers were included in the provider files submitted by CMS from states or are included T-MSIS files, they might be eligible to apply directly for payment. Where a FMS organization receives the Provider Relief Fund payment, it has discretion in allocating the Provider Relief Fund payments among self-directed providers, to support the providers' health care related expenses or lost revenue attributable to COVID-19, so long as the payment is used to prevent, prepare for, or respond to coronavirus and those expenses or lost revenue are not reimbursed from other sources or other sources were not obligated to reimburse them.

Are health care providers that only bill Medicaid or CHIP through a waiver eligible for the Phase 3 – General Distribution? (Added 10/5/2020)

Yes. Health care providers that bill for services in Medicaid or CHIP that are covered under either a waiver or state plan, including disability service providers and other providers of

Medicaid-funded HCBS (e.g., day habilitation, HCBS waiver program services), are eligible for the Phase 3 – General Distribution if they otherwise meet the eligibility criteria.

Are health care providers that only bill Medicaid or CHIP through managed care arrangements eligible for the Phase 3 – General Distribution? (Added 10/5/2020)

Yes. Health care providers that bill either fee-for-service or managed care in Medicaid or CHIP are eligible for the Phase 3 – General Distribution if they otherwise meet the other eligibility criteria.

If a health care provider is paid through a certified public expenditure (CPE), will the provider be eligible for the Phase 3 – General Distribution? (Added 10/5/2020)

These payment mechanisms do not impact eligibility for the Provider Relief Fund. Phase 3 – General Distribution payments will be paid to the filing TIN entity based on the entity's percentage of total revenue from patient care and change in operating revenues from patient care, minus their operating expenses from patient care.

Are health care providers that are paid through Organized Healthcare Delivery Systems (OHCDS) and voluntarily assign their direct payment rights to an OHCDS eligible for the Provider Relief Fund Phase 3 – General Distribution? (Added 10/5/2020)

Phase 3 – General Distribution payments will be made to the filing TIN entities. If the OHCDS is the filing TIN entity, the payment will go to that entity, who has the sole discretion about how funds are distributed. The Provider Relief Fund payment recipient has discretion in allocating the Provider Relief funds to support its subsidiaries' health care related expenses or lost revenue attributable to COVID-19, so long as the payment is used to prevent, prepare for, or respond to coronavirus and those expenses or lost revenue are not reimbursed from other sources or other sources were not obligated to reimburse.

Are health care providers who bill for Medicaid or CHIP services through a county behavioral health provider network eligible for the Phase 3 – General Distribution? (Added 10/5/2020)

Yes. Health care providers that bill for Medicaid or CHIP services through a county behavioral health provider network are eligible for the Phase 3 – General Distribution if they otherwise meet the other eligibility criteria.

Tax Identification Number (TIN) Validation Process

When is the deadline to submit an application? (Modified 11/12/2020)

The deadline to start an application by submitting a TIN for validation under Phase 3 – General Distribution is November 6, 2020 at 11:59 PM EST. If the TIN validation is initialized by November 13, 2020 at 11:59 PM EST, the entity will have until November 27, 2020 at 11:59 PM EST to submit an application.

Is there anything different about the TIN validation process for Phase 3 compared to the process for Phase 2? (Added 10/5/2020)

Providers that have received General Distribution payments under Phases 1 and/or 2 will not undergo any further validation. Providers that are newly eligible under Phase 3 will be subject to TIN validation processes similar to those employed under Phase 2.

What if an applicant’s TIN is flagged as invalid because it is not on the curated list of eligible providers? (Added 10/5/2020)

If a TIN is not on the curated list of eligible providers, HHS will conduct additional analysis related to the TIN and any active providers associated with the TIN. If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign. TINs that cannot be validated will not receive funding.

I received an email saying my Taxpayer Identification Number (TIN) was under review. What does that mean? (Added 10/5/2020)

HHS is validating provider eligibility for General Distribution funds by using curated lists generated by state/territory Medicaid and CHIP agencies and third parties for those provider types that do not participate in Medicaid and CHIP. In most instances, HHS will respond within 15 business days; however, this process may take up to several weeks.

Application Process

An organization has the sale of medical supplies, such as durable medical equipment and prescription glasses and contacts, as part of its revenue and expenses. Can these sales be captured in the data submitted as a part of revenue and operating expenses from patient care? (Added 10/28/2020)

No. Any revenue or expenses related to the sale of medical supplies, including durable medical equipment and prescription glasses and contacts, may not be included as part of revenue or expenses from patient care. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included.

Hospitals and health care systems may have joint ventures, such as a hospital or health system that owns a portion of an ambulatory surgery center, in which the hospital or health care system provides services. Should the revenue and expenses associated with these agreements and ventures be included from reported revenues and expenses in the Phase 3 application? (Added 10/28/2020)

No. The associated revenues and expenses that are associated with joint ventures with other health care entities should not be included in the hospital or health care system’s application for Phase 3 funds.

Does “operating expenses from patient care” include costs that support the delivery of care, such as the health care providers’ information technology, finance, and human resources costs? (Added 10/28/2020)

Yes. Applicant may include costs that support the delivery of care, such as the health care providers’ information technology, finance, and human resources costs, as part of “operating expenses from patient care” when applying for Phase 3 General Distribution payments.

Does “most recent federal income tax return of 2017, 2018, or 2019” mean filed return? (Added 10/28/2020)

Yes. Applicants must submit the most recently filed tax return along with their application for Phase 3 General Distribution payments. If an applicant has applied for funds in previous General Distributions and filed taxes in the interim, it must use its most recent tax return; the applicant is not required to submit the same return included with previous General Distribution applications.

If a parent entity is applying for the Phase 3 General Distribution on behalf of itself and multiple subsidiaries, and the parent and subsidiaries file a group tax return, should the parent entity submit the joint tax return as part of its application? (Added 10/28/2020)

Yes. Similar to the Phase 2 General Distribution application, in cases where a parent files a group tax return for itself and all/or some of its subsidiaries, the parent entity should submit the group tax return that includes all subsidiaries on behalf of which the parent entity is applying.

Should a parent entity applying on behalf itself and subsidiaries report the proportion of revenues from patient care, along operating revenue and operating expenses for patient care, aggregated across all entities or break out each figure by TIN? (Added 10/28/2020)

The parent entity that is applying on behalf of itself and multiple subsidiaries should break out by TIN revenues and operating expenses for patient and non-patient care when applying for Phase 3 funds on behalf of multiple subsidiaries. The applying entity should ensure that these figures reconcile to ones provided on the submitted tax return.

May a parent entity applying on behalf of multiple subsidiaries that would like each subsidiary to receive its own payment submit as documentation for each individual subsidiary the common group tax return? (Added 10/28/2020)

Yes. The parent entity that is applying on behalf of multiple subsidiaries may submit the same required financial documentation as part of multiple applications if the documentation includes the requested financial information for each of the subsidiaries. The parent entity that is applying on behalf of multiple subsidiaries should include a break-out by TIN of the revenues and operating expenses for patient and non-patient care for each of the TINs included in the filed tax return that reconciles to the figures on the return.

How should intercompany rent be treated when reporting “operating expenses from patient care?” (Added 10/28/2020)

Intercompany rent should be included when reporting “operating expenses from patient care” as well as “operating revenue from patient care.”

What is “operating revenues from patient care?” (Modified 10/28/2020)

HHS considers “operating revenues from patient care” to be net patient service revenue from the delivery of health care services directly to patients. “Net patient service revenue” is defined as gross charges for patient services delivered, minus contractual adjustments from all third party payors, charity care adjustments, bad debt, and any other discounts or adjustments necessary to arrive at net patient service revenue. For the definition of “revenue” for purposes of reporting and use of funds, please refer to the reporting requirements available at www.hhs.gov/providerrelief.com.

What is “operating expense from patient care?” (Modified 10/28/2020)

HHS considers “operating expenses from patient care” to be the operating expenses incurred as part of the delivery of care, including salaries, benefits, medical supplies, contracted and/or employed physicians, interest, and depreciations. Operating expenses from patient care do not include any non-operating expenses, such as costs incurred on any rental property that is not the site of patient care delivery, as well as contributions made, gains, and/or losses on investments. For the definition of “expenses” for purposes of reporting and use of funds, please refer to the reporting requirements available at www.hhs.gov/providerrelief.com.

An organization has prescription sales as part of its revenue. Can these sales be captured in the data submitted as a part of revenue from patient care? (Added 10/15/2020)

Generally no, prescriptions sale revenue may not be captured as part of revenue from patient care. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included. Patient care revenues do include savings obtained by providers through enrollment in the 340B Program.

If I entered my TIN for validation as part of Phase 2 but it was not validated until October 5, 2020 or later, which application will I fill out? (Added 10/5/2020)

Providers that submitted a TIN for validation as part of Phase 2 but had their TIN validated on or after October 5, will fill out a Phase 3 application and be considered for additional payment based on Phase 3 payment methodology in addition to approximately 2% of annual revenue from patient care.

Why am I required to reenter information previously submitted as part of Phase 1 and/or Phase 2? (Added 10/5/2020)

In order for HHS to make payments as part of Phase 3, the Department needs the most recent financial information available.

I have completed my application and submitted it in the portal, but the portal still says “Get Started” as if I have not submitted. Why is this? (Added 10/5/2020)

The portal currently will say “Get Started” until a final determination has been made on provider payment. If and when a payment has been made, you will be able to move on in the portal to attest to the payment.

Am I able to edit or resubmit my Phase 3 – General Distribution application in the Provider Relief Fund Application and Attestation Portal? (Added 10/5/2020)

You can only submit one application. You can edit the data on the application form, until the form is submitted. You cannot edit or resubmit the application form once it is submitted. You should not apply until you have available all of the required information and documentation necessary to submit a complete and accurate application.

If an organization neither files taxes nor has audited financial statements, what financial documents should it submit with its application? (Added 10/5/2020)

If an organization does not have tax filings, nor audited financial statements, it may submit internally-generated financial statements; in the case of entities receiving Federal grants, the most recent four quarters of SF-425 forms; or for eligible federal entities, the most recent annual report submitted to Unified Financial Management System (UFMS).

What should I do if I do not have the federal tax form to submit my information? (Added 10/5/2020)

Upload a statement explaining why the entity is not required to file a federal tax form (note that non-profit entities should submit a Form 990) or is unable to provide the required information. In addition, provide the most recent audited financial statements (or management prepared financial statements) for the TIN entity. If the financial information of a TIN entity is reported as part of a parent organization, it may be necessary to provide consolidating audited financial statements that breakout the revenue and expenses for the TIN entity.

If a health care provider has changed tax status between the most recent tax filing and the current year, which status should the practice use to apply? (Added 10/5/2020)

The health care provider should use the status that was included in the most recent tax filing when applying for Provider Relief Fund payments. For example, if a practice was a C corporation in 2019 and is an S corporation in 2020, it should apply as a C corporation if the provider's most recent tax filing is from 2019.

If a tax-exempt organization receives federal, state, and/or local grant funds, which is reported on line 8 of Form 990, can it include this revenue with the revenue reported in line 9 of the Form 990, in field 10 of the application? (Added 10/5/2020)

No. The applicant may only include patient care revenue in its application for Provider Relief Fund payments, which is found in line 9 of Form 990 for tax-exempt organizations.

Should I set up an electronic payment Automated Clearing House (ACH) account before my application is approved? (Added 10/5/2020)

Yes, in order to most effectively and quickly deliver funds to providers, HHS recommends that applicants sign up for an ACH account at the same time they submit a Provider Relief Fund application. This will prevent delays in issuing payment once an application has been approved.

Why do I need to set up an electronic payment Automated Clearing House (ACH) account? (Added 10/5/2020)

ACH payments are a secure and expeditious way to transfer money. The majority of payments will be made through bank transfer. Organizations with revenue greater than \$5,000,000 will be required to set up ACH accounts to allow the Department of Health and Human Services (HHS) to most effectively and quickly deliver funds to providers, as well as maximize program integrity and fraud avoidance.

What if I am a health care provider that is not required to be licensed by my state/territory? How should I fill out Medical/DOH/License Number field in the Group/Individual Information of the Provider Relief Fund Application and Attestation Portal? (Added 10/5/2020)

If you are a provider that is not required to be licensed by your state but otherwise meets the eligibility criteria for the second phase of the General Distribution, you should enter "not applicable" in the field. The field cannot be left blank.

How can an individual Home- and Community-based Services (HCBS) self-directed provider determine whether they should be applying on their own behalf or relying on the FMS organization to apply for the Phase 2 – General Distribution? (Added 10/5/2020)

In general, if the individual is being paid through an FMS organization, the organization is likely the filing and billing TIN and would be eligible to apply for the Phase 3 – General Distribution. In that situation, the self-directed provider should contact the FMS organization to confirm that the organization is submitting an application on their behalf or whether the provider should submit an application as an individual self-directed provider.

FMS organizations typically have two Taxpayer Identification Numbers (TINs) to comply with Internal Revenue Service requirements. One TIN is used to submit claims and receive payment from the state Medicaid program and the other is used to process payroll to pay participant-directed workers on behalf of Medicaid beneficiaries who receive participant-directed services. Can an FMS organization include both TINs and use the associated revenue from both TINs' tax returns in their application? (Added 10/5/2020)

Yes. The FMS organization can include both TINs and associated revenues in their application for the Phase 3 – General Distribution, as long as the services delivered under both TINs qualify as “patient care” and the entity can meet the attestation requirements for both TINs.

Can FMS organizations' revenue from administrative fees provided by the state Medicaid program be included as “patient care”? (Added 10/5/2020)

Yes. Applicants may include administrative fees provided by the state Medicaid program in the reported revenue, as well as in the percentage of revenue from patient care reported in field 12.

If an applicant health care provider bills for care under a single TIN that provides care across multiple different facilities, can the parent organization report patient revenue for every facility that bills underneath the TIN? (Modified 12/4/2020)

If an applicant health care provider bills for care under a single TIN that provides care across multiple different facilities, the parent organization must report patient revenue and the provider's change in operating revenues from patient care, minus their operating expenses from patient care for every facility that bills underneath the TIN.

Targeted Distributions

Rural Targeted Distribution

What was the formula used to make the Rural/Small Metropolitan Areas Targeted Distribution payments? (Added 7/10/2020)

The payment formula varied depending on hospital location and Medicare designation. For hospitals with a special Medicare payment designation of Sole Community Hospitals (SCH) or Medicare Dependent Hospitals (MDH), and for hospitals in small metro areas with a designation of Rural Referral Center (RRC), the payment amount was based on 1% of operating expenses (calculated based on their most recent Medicare Cost Report) with a minimum payment of \$100,000, a supplement of \$50 for each rural inpatient day, and a maximum payment of \$4.5 million. HHS also provided a supplemental payment of \$1,000,000 for 10 isolated urban hospitals that are 40 or more miles away from another hospital open to the public. HHS estimated the number of inpatient days provided by these hospitals to rural residents by calculating the proportion of patient days attributed to Medicare patients from rural zip codes using the [Hospital Service Area File](#), calendar year 2018 (the most recent data available), multiplied by the total number of patient days as reported in the hospital's Medicare cost report.

For small metro area hospitals without a special Medicare designation, the payment amount was based on 1% of operating expenses (calculated based on their most recent Medicare cost report) with a minimum payment of \$100,000 and a maximum of \$2 million each.

The payment formula for rural specialty hospitals (Psychiatric, Rehabilitation, and Long Term Acute Care) used the previous Rural Targeted Distribution methodology (graduated base

payment + approximately 2% of operating expenses) adjusted for the rural patient share (calculated as percent of inpatient days provided to rural patients) with a minimum payment of \$100,000 and a maximum of \$4.5 million. Operating expenses were determined based on the most recent Medicare Cost Report. Rural patient share was estimated using the proportion of patients from rural zip codes as reported in the Hospital Service Area File.

How was “small metropolitan area” and “rural” defined for these the Rural/Small Metropolitan Area Targeted Distribution payments? (Added 7/10/2020)

“Small metropolitan” was defined as a metro area with less than 250,000 in population as identified by the county-level [Rural-Urban Continuum Codes](#) developed by the U.S. Department of Agriculture.

Eligible rural specialty hospitals included Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Acute Care Hospitals (LTACHs) located in a geography that meets the following rural definition:

1. All non-Metro counties.
2. All Census Tracts 1 within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties.
3. 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.

What types of health care providers received a payment under the Rural/Small Metropolitan Areas Targeted Distribution? (Added 7/10/2020)

Rural/Small Metropolitan Areas Targeted Distribution payments were limited to hospitals in small cities and rural areas that had not previously received payment in the Rural Targeted Distribution.

Which data source did HHS use for the Rural/Small Metropolitan Areas Targeted Distribution payments for hospitals? (Added 7/10/2020)

Payments were calculated based on hospitals’ most recent Medicare cost reports and patient residence identified in the Hospital Service Area File.

What was the formula used to make the Rural Targeted Distribution payment to rural hospitals? (Added 5/12/2020)

Rural Targeted Distribution payments were made to rural acute care general hospitals and critical access hospitals (CAHs), rural health clinics (RHCs), and community health centers located in rural areas. Hospitals and RHCs will each receive a minimum base payment plus a percent of their annual expenses. This method accounts for operating cost and lost revenue incurred by rural hospitals for both inpatient and outpatient services. The base payment will account for RHCs with no reported Medicare claims, such as pediatric RHCs, and CHCs lacking expense data, by ensuring that all clinical, non-hospital sites receive a minimum level of support no less than \$100,000, with additional payment based on operating expenses. Rural acute care general hospitals and CAHs will receive a minimum level of support of no less than \$1,000,000, with additional payment based on operating expenses.

How does HHS define rural for these payments? (Added 5/12/2020)

For the Rural Targeted Distribution, HHS used the Federal Office of Rural Health Policy's definition of rural, which includes:

1. All non-Metro counties.
2. All Census Tracts within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties.
3. 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.

COVID-19 High Impact Area Targeted Distribution

How was the second round of COVID-19 High Impact Area funds allocated? (Added 7/22/2020)

HHS made payments in this second round of COVID-19 High Impact Area Targeted Distribution based on a formula for hospitals with a COVID-19 admission count over 160 between January 1 and June 10, 2020, or the facility experienced an above average intensity of COVID admission per bed (at least 0.54864). Hospitals were paid \$50,000 per eligible admission from January 1 through June 10. HHS also took into account previous High Impact Area payments for those hospitals that received initial payments from this Targeted Distribution.

How many payments did HHS make under the second COVID-19 High Impact Area Targeted Distribution? (Added 7/22/2020)

HHS is distributing \$10 billion in payments to over 1,000 hospitals in areas heavily impacted by COVID-19 in this second round of targeted distribution payments.

What was the rationale behind requiring a minimum number of admissions or intensity of COVID-19 to be eligible for the second High Impact Area payment? (Added 7/22/2020)

This round of Targeted Distribution payments provides relief for over 83% of inpatient COVID-19 admissions through June 10 at \$50,000 per admission, taking into account previous High Impact Area payments. Those hospitals treating inpatient COVID-19 positive admissions have experienced a large increase in expenses due to staffing costs, personal protective equipment costs, protocol changes, re-training, and general system changes.

How is the second round of the COVID-19 High Impact Area Targeted Distribution different from the initial distribution of High Impact Funding? (Modified 7/22/2020)

The first round of funding was based on a formula that distributed funds to hospitals with 100 or more COVID-19 admissions between January 1 and April 10, 2020 and paid \$76,975 per eligible admission. The second round of funding was based on a formula for hospitals with over 161 COVID-19 admissions between January 1 and June 10, 2020, or one admission per day, or that experienced a disproportionate intensity of COVID admissions (exceeding the average ratio of COVID admissions/bed). Hospitals will be paid \$50,000 per eligible admission. This previous high impact payments were also taken into account when determining each hospital's payment in this second round distribution.

Why is HHS targeting High Impact Areas for COVID-19 funding? (Added 5/12/2020)

In allocating the funds, the Administration is working to address both the economic harm across the entire health care system due to COVID-19 and the economic impact on providers directly

treating patients with COVID-19. The distribution takes into consideration the challenges faced by facilities serving a significantly disproportionate number of low-income patients and that inpatient admissions are a primary driver of costs to hospitals related to COVID-19.

Should providers continue to update their High Impact data? (Modified 6/8/2020)

Providers should update their capacity and COVID-19 census data to ensure that HHS can make timely payments in the event that the provider becomes a High Impact Area provider. Providers can continue to update their information through the same method they used previously.

Skilled Nursing Facilities Targeted Distribution

What is the Skilled Nursing Facility funding amount and how did HHS determine the amount? (Added 5/26/2020)

HHS will distribute \$4.9 billion in additional funding (over and above General Distributions received) to more than 13,000 skilled nursing facilities. Eligible facilities range in size between six and 1,389 beds. This represents a range of distributions between \$65,000 and \$3,255,500 and a national average distribution of ~\$315,600 per facility. Each Skilled Nursing Facility received a fixed distribution per facility of \$50,000 plus distribution of \$2,500 per bed.

Which Skilled Nursing Facility providers received a payment under the SNF Targeted Distribution? (Added 5/26/2020)

HHS allocated funding for certified Skilled Nursing Facilities with a capacity between six and 1,389 beds.

How will HHS disperse the Skilled Nursing Facility Targeted Distribution payments? (Added 5/26/2020)

Most SNF fund payments will be dispersed electronically based upon banking account information associated with the organization's billing TIN. If the organization's billing TIN does not have a bank routing number associated with it, the organization will most likely receive a paper check.

What constituted a "certified" skilled nursing facility for purposes of the Targeted Distribution? (Added 6/8/2020)

A "certified" skilled nursing facility must be certified under Medicare and/or Medicaid to be eligible for this Targeted Distribution. All standalone and/or hospital-based skilled nursing facilities with at least six beds were eligible for this Targeted Distribution.

Indian Health Service Targeted Distribution

Which Indian Health Service (IHS) providers received a payment under the IHS Targeted Distribution? (Added 5/29/2020)

HHS allocated funding for IHS, Tribal, and Urban Indian Health programs. This includes IHS and Tribal hospitals.

How was IHS Targeted Distribution funding allocated across eligible entities? What was the formula used to make the IHS Targeted Distribution payment to IHS providers? (Added 5/29/2020)

HHS allocated \$500 million to IHS, Tribal, and Urban Indian Health programs. Approximately 4% of the \$500 million in available funding was allocated for Urban Indian Health programs,

consistent with the percent of patients served by Urban Indian Organizations (UIOs) in relation to the total IHS active user population, as well as prior allocations of IHS COVID-19 funding. IHS divided remaining funding equally between hospitals (48%) and clinics (48%). HHS used different formulas for each of the different facility types.

- IHS Hospitals and Tribal Hospitals
 - *Per hospital allocation = \$2.815 million base + (Total Operating expenses * 3%)*
- IHS and Tribal Clinics/Programs
 - *Per IHS clinic allocation = Base amount of \$187,000 + 5% of (estimated service population * average cost per user)*
- IHS Urban Programs
 - *Per IHS Urban Indian health allocation = Base amount of \$181,250 + 6% of (estimated service population * average cost per user)*

Which data sources did HHS use for operating costs for IHS and tribal hospitals? How recent was the data used? (Added 5/29/2020)

HHS analyzed the following files to determine the allocation for IHS Targeted Distribution to IHS and tribal hospitals:

- [Provider of Services Files](#), December 2019 update.
- [Healthcare Cost Report Information System](#) (HCRIS), 1/17/2020 update, contains the most recent cost report data available. For most hospitals, this is the 2018 fiscal year.
- Total operating expenses are reflected in Worksheet B PART I COL 26 of the cost report.

How did HHS determine operating costs for IHS clinics and Urban Indian Health Organizations? (Added 5/29/2020)

HHS identified the service population for most service units, and estimated an operating cost of \$3,943 per person per year based on actual IHS spending per user from a 2019 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita.

Safety Net Hospitals Targeted Distribution

What were the eligibility criteria for children’s hospitals in order to receive a payment under the latest round of this Targeted Distribution? (Added 8/18/2020)

To be eligible, a children’s hospital must meet the following criteria:

1. Be an inpatient prospective payment system (IPPS)-exempt facility as defined by the Centers for Medicare & Medicaid Services (CMS), or
2. Be a Children’s Hospital Graduate Medical Education (CHGME) facility.

Children’s hospitals that meet these criteria are free-standing facilities not affiliated with larger hospital systems. In contrast to affiliated children’s hospitals, these facilities have not, with minor exceptions, qualified for targeted relief to the same degree as system-affiliated children’s hospitals.

As the revenue from children’s hospitals was included in the calculations (particularly with regard to general distributions) when paying the larger hospital systems, HHS expects that in kind, the systems will ensure that resources are being provided to ensure patient access and care for parents seeking care for their children.

What was the methodology/formula used to calculate children’s hospital payments for this round of the Targeted Distribution of the Provider Relief Fund? (Added 8/18/2020)

Eligible facilities received a payment that equals 2.5% of the annualized net patient revenue. Facility’s calculated payment amount below \$5,000,000 were adjusted to \$5,000,000 and any values above \$50,000,000 were adjusted to \$50,000,000.

What data sources did HRSA use to determine payment for this round of the Safety Net Hospitals Targeted Distribution? (Added 8/18/2020)

HRSA used the children’s hospitals’ most recent CMS Cost Report to determine eligibility. HRSA used Worksheet G-3, line 3 of the cost report to determine payment amounts. Net patient revenues were annualized prior to payment calculation. For those hospitals that do not file Cost Reports, HRSA calculated net patient revenue from tax information and audited financial statements submitted by those affected children’s hospitals.

Why is HHS distributing a second round of payments under the Safety Net Hospitals Targeted Distribution? (Added 7/10/2020)

Working with stakeholders and Congress, HHS learned that certain acute care hospitals did not qualify for the initial Safety Net Targeted Distribution that HHS believed were the target of the allocation. To address this, community hospitals meeting an expanded profitability threshold will now be eligible for payment.

How were hospitals determined to be eligible for the purpose of this second round of Safety Net Hospitals Targeted Distribution? (Added 7/10/2020)

HHS is expanding the eligibility criteria for payment qualification under the second round of Safety Net Hospitals Targeted Distribution so that certain acute care hospitals that have (1) a profit margin threshold of less than or equal to 3% averaged consecutively over two or more of the last five cost reporting periods and (2) an annualized uncompensated care cost (UCC) of at least \$25,000 per bed in the most recent cost report. The other criterion (Medicare Disproportionate Patient Percentage (DPP) of 20.2% or higher) for acute care hospitals remains the same.

What was the methodology/formula used to calculate the payment for this second round of Safety Net Hospitals Targeted Distribution? (Added 7/10/2020)

HHS used the same formula for determining payments from the previous Safety Net Hospitals Targeted Distribution.

What data sources did HRSA use to determine eligibility for this second round of Safety Net Hospitals Targeted Distribution? (Added 7/10/2020)

HHS used hospitals’ last two to five Medicare cost report filings for determining eligibility based on profit margin and the latest Medicare cost report filing for determining eligibility based on annualized UCC per bed and Medicare DPP.

How was a safety net hospital defined for the purpose of the first round of targeted distribution payments? (Modified 6/30/2020)

Safety net payments are allocated to acute care and children’s hospitals that serve a disproportionate number of Medicaid patients and provide large amounts of uncompensated care.

Qualifying acute care hospitals will have:

- Medicare Disproportionate Patient Percentage (DPP) of 20.2% or higher.
- Uncompensated Care (UCC) of at least \$25,000 per bed. (For example, a cost report would need to have 100 beds and \$2,500,000 in Uncompensated Care to meet this requirement.)
- Profit Margin of 3% or less.

Qualifying children’s hospitals will have:

- A Medicaid-only Ratio of 20.2% or greater.
- Profit Margin of 3.0% or less.

What was the methodology/formula used to calculate safety net hospital distributions from the Provider Relief Fund? (Modified 6/30/2020)

The distribution amount for an eligible safety net hospital is the proportion of the individual facility score (number of facility beds multiplied by DPP for an acute care facility or number of facility beds multiplied by Medicaid-only ratio for a children’s hospital) to the cumulative facility scores for all safety net hospitals, times the \$10 billion safety net distribution. Hospitals with a calculated distribution amount of less than \$5,000,000 received a minimum amount of \$5,000,000, and those with a calculated distribution amount of more than \$50,000,000 received a maximum amount of \$50,000,000.

HHS pulled the cost reports on May 27, 2020. The latest available cost report period available for a respective facility was used.

HHS pulled the data from the CMS Hospital Cost Reports:

DPP:	W/S E Part A, Line 32, Col. 1
Hospital Beds:	W/S S-3 Part I, Line 14, Col. 2
Net Patient Revenue:	W/S G-3, Line 3, Col. 1
Total Other Income:	W/S G-3, Line 25, Col. 1
Total Revenue:	Net Patient Revenue + Total Other Income
Net Income:	W/S G-3, Line 29, Col. 1
Profit Margin:	Net Income / Total Revenue
Medicaid Only Days:	Worksheet S-3, Part I, column 7, line 14, plus line 2 and line 32, minus the sum of lines 5 and 6.
Total Days:	Worksheet S-3, Part I, column 8, line 14; plus line 32; minus the sum of lines 5 and 6; plus employee discount days reported on line 30.
Medicaid Only %:	Medicaid Only Days / Total Days

How did HHS calculate “Net Profit Margin”? (Modified 6/30/2020)

Profit margin of 3.0% or less was used as one of the criteria to determine whether a hospital was eligible for payment. The calculations were based on total margins. The calculation is “Net Patient Revenue” plus “Total Other Income”, which equals “Total Revenue”. The calculation is “Net Patient Revenue” plus “Total Other Income”, which equals “Total Revenue”. The “Net Income” divided by “Total Revenue” is the “Net Profit Margin” percent.

Which year’s Medicare cost report was used to calculate the Safety Net Hospital Targeted Distribution eligibility and payment? (Modified 6/25/2020)

The most recent cost report was used to calculate eligibility for the Safety Net Hospital Targeted Distribution. For most hospitals, the 2018 Medicare cost report was used because the verified 2019 cost report was not yet available.

Nursing Home Infection Control Distribution

How is the infection gateway calculated for determining eligibility for Quality Incentive Program payments under the Nursing Home Infection Control Distribution? (Added 12/28/2020)

The infection gateway criterion specifically excludes facilities that are found to have an infection rate exceeding the estimated infection rate in their county during the performance period. County infection rates are measured using daily COVID-19 community profile reports (CPRs) disseminated under the HHS Protect data program. CPRs contain information on the rate of COVID-19 infections for all residents in each county. County infection rates are not the same as county positivity rates.

The Terms and Conditions for the Nursing Home Infection Control limit use of payments to certain infection control expenses, including hiring staff, whether employees or independent contractors, to provide patient care or administrative support. Is “hiring” limited to only bringing on new staff or may funds be used for existing staff? (Added 10/5/2020)

Payments from the Nursing Home Infection Control Distribution may be used to cover “hiring” expenses related to both recruiting new hires and the continued payment and retention of existing staff to provide patient care or administrative support.

How will nursing homes qualify for funds under the quality incentive payment program as part of this distribution? (Added 9/18/2020)

Nursing homes will not have to apply to receive a share of this incentive payment allocation. HHS will be measuring nursing home performance and distributing payments based on required nursing home data submissions. To be eligible to receive an incentive payment, a facility must have an active certification as a nursing home or skilled nursing facility (SNF) and must also receive reimbursement from the Centers for Medicare & Medicaid Services (CMS). HHS will review nursing home certification status through the Provider Enrollment, Chain and Ownership System (PECOS) to identify and remove facilities that have a terminated, expired, or revoked certification or enrollment. Facilities must also report data to Certification and Survey Provider Enhanced Reports (CASPER), which will be used to establish eligibility and collect necessary provider data to inform payment.

Additionally, nursing homes must meet two criteria in order to be eligible for payment. First, a facility must demonstrate a rate of COVID-19 infections that is below the rate of infection in the county in which they are located. Second, facilities must also have a COVID-19 death rate that falls below a nationally established performance threshold for mortality among nursing home residents infected with COVID-19.

Are there different permissible uses of funds received as quality incentive payments compared to those for the funds distributed previously under the \$2.5 billion Nursing Home Infection Control Distribution? (Modified 12/4/2020)

No. The same Terms and Conditions and restrictions on use of funds apply to the quality incentive payments received by nursing homes as under the Nursing Home Infection Control Distribution. Quality incentive payments may only be used for the infection control expenses, as that term is defined in the Terms and Conditions. These include costs associated with administering COVID-19 testing for both staff and residents; reporting COVID-19 test results to local, state, or federal governments; hiring staff to provide patient care or administrative support; incurring expenses to improve infection control, including activities such as implementing infection control “mentorship” programs with subject matter experts, or changes made to physical facilities; and providing additional services to residents, such as technology that permits residents to connect with their families if the families are not able to visit in person.

What is the timeline for distributing quality incentive payments under this distribution? (Added 9/18/2020)

The incentive payment program is scheduled to be divided into four performance periods (September, October, November, December), lasting a month each with \$400 million available to nursing homes in each period. All nursing homes or SNFs meeting the payment qualifications will be eligible for each of the four performance periods. Nursing homes will be assessed based on a full month's worth of data submissions, which will then undergo additional HHS review and auditing before payments are issued the following month. These four individual performance periods would be followed by an aggregate performance period that would measure performance across the entire four month period from September to December. The aggregate performance period would have an available incentive pool of at least \$400 million.

How will facilities be assessed for purposes of issuing incentive payments? (Added 9/18/2020)

Facilities will have their performance measured on two outcomes. First, facilities will be evaluated based on their overall COVID-19 infection rate among residents. Second, facilities will be evaluated based on their performance for COVID-19 mortality among residents. Performance measurements for each facility will be evaluated based on the population-wide rate of COVID-19 infection in the geographic area in which a facility is located. The goal is to appropriately evaluate facility performance by measuring the baseline level of infection in the community in which a facility is located.

In order to measure facility COVID-19 infection and mortality rates, the incentive program will make use of data from the National Healthcare Safety Network (NHSN) Long-term Care Facility Component COVID-19 Module. Within the NHSN module, the program will incorporate weekly reported data on COVID infections, COVID mortality, and the total count of occupied beds.

In addition, admissions of COVID-19-positive patients will be considered in order to focus accountability on infections acquired among existing residents. Using this weekly information, each facility will receive measurements of their COVID-19 infections per resident and COVID-19 deaths per resident in each performance month.

There will be an additional measurement of the baseline level of COVID-19 infection in the

general community in which a facility is located. In order to measure the baseline infection rate, the program will make use of weekly updates of data included in CDC's Community Profile Reports (CPRs). Data from the CPRs includes county-level information on total confirmed and/or suspected COVID infections per capita, which will be used to measure the baseline infection rate for all eligible facilities located in that county.

What is the Nursing Home Infection Control Distribution? (Added 8/27/2020)

Given their congregate nature and resident population of older adults – often with underlying chronic medical conditions – nursing homes are high risk environments that have been disproportionately affected by COVID-19. HHS is distributing \$5 billion to nursing homes and skilled nursing facilities to build skills and enhance response to COVID-19, including enhanced infection control. Of this amount, HHS will provide approximately \$2.5 billion in upfront funding to nursing homes to support increased testing, staffing, and personal protective equipment (PPE) needs. HHS plans on distributing another \$2 billion to nursing homes later this fall based on certain performance indicators that will be shared in the future.

What is the funding amount for the Nursing Home Infection Control Distribution and how did HHS determine the amount? (Added 8/27/2020)

HHS is distributing an initial \$2.5 billion of the Nursing Home Infection Control Distribution funding to support nursing homes and skilled nursing facilities in conducting appropriate testing, acquiring necessary personal protective equipment (PPE), investing in staff, to improve infection control. Eligible nursing homes and skilled nursing facilities will receive a per-facility payment of \$10,000 plus a per-bed payment of \$1,450 in the first round of this distribution.

Additionally, \$2 billion in funding will be distributed at a later time for nursing home performance in improving safety and minimizing COVID-19 spread and COVID-19 related fatalities among residents and training, mentorship, and instruction on infection prevention and control in nursing homes across the country. Please check back on www.hhs.gov/providerrelief for updates.

Which nursing home providers received a payment under the Nursing Home Infection Control Targeted Distribution? (Added 8/27/2020)

Nursing homes and skilled nursing facilities that are not revoked, have an active CMS certification, and have at least 6 certified beds, were deemed eligible to receive payments.

What are the permissible uses for this distribution? (Added 8/27/2020)

The Nursing Home Infection Control Distribution can only be used for the infection control expenses defined in the Terms and Conditions. These include costs associated with administering COVID-19 testing for both staff and residents; reporting COVID-19 test results to local, state, or federal governments; hiring staff to provide patient care or administrative support; incurring expenses to improve infection control, including activities such as implementing infection control “mentorship” programs with subject matter experts, or changes made to physical facilities; and providing additional services to residents, such as technology that permits residents to connect with their families if the families are not able to visit in person.

How does this distribution differ from the Skilled Nursing Facility Targeted Distribution? (Added 8/27/2020)

This distribution supplements the \$4.9 billion that was previously distributed to skilled nursing

facilities. This distribution provides nursing homes and skilled nursing facilities upfront funding to address critical needs in nursing homes including hiring additional staff, implementing infection control programs, increasing testing, and providing additional services, such as technology so residents can connect with their families if they are not able to visit. Because of the limits on use of funds, the Terms and Conditions for this distribution differ from those placed on the Skilled Nursing Facility Targeted Distribution and other Targeted Distributions payments under the Provider Relief Fund. The Terms and Conditions for the Nursing Home Infection Control Distribution specifically prohibit recipients from taking any actions inconsistent with the best interests of its patients in order to increase potential future outcomes-based payments based on the recipients' successful infection control outcomes.