

LeadingAge Provider Relief Fund Explainer

Last Updated: July 13, 2020 at 5 p.m.ET

Background

Providers have access to a number of new funding sources as a result of COVID-19. Each of these funding sources requires providers/organizations to agree to certain terms and each has their own documentation requirements.

Providers/organizations should establish tracking systems now in order to be able to accurately report eligible expenses and losses attributable to the COVID-19 crisis.

This document summarizes the information known as of the last update (noted above) regarding the availability of funds, implementation and compliance with the Provider Relief Funds and the related Terms & Conditions. It also incorporates information from the HHS FAQs where it has direct relation to aging services providers and broad application. Members are encouraged to review the HHS FAQs for questions related to specific circumstances or scenarios.

Provider Relief Fund Overview

On March 27, the Coronavirus Aid, Relief, and Economic Security Act (CARES) was passed and signed into law, appropriating \$100 billion to the Provider Relief Fund (PRF) for the COVID-19 pandemic and an additional \$75 billion was appropriated under the Paycheck Protection Program and Health Care Enhancement Act for a total of \$175 billion available for the Provider Relief Fund. The fund is managed by the Office of the Secretary of the Department of Health and Human Services (HHS) and dollars are held within its Health Resources Services Administration (HRSA). The funds are being distributed as automatic payments through United Health Group(UHG) via Optum Bank with "HHSPAYMENT" as the payment description. HHS began distributing these dollars on April 10.

Provider Relief Fund Distributions

There are two types of payments from the Provider Relief Fund -- General and Targeted

- **General Distributions:** A total of \$50 billion in payments have been distributed to providers and are designed to “replace a percentage of a provider’s annual gross receipts, sales or program service revenue.”
- **Targeted Distributions** are aimed at providers who have been disproportionately impacted by COVID-19 or who have not received payments as part of the General Distribution. The first targeted payments began being deposited the week of April 27.
 - A SNF-Only distribution was sent to providers on May 22.
 - Estimated \$15 billion Medicaid/CHIP Distribution announced June 9 requires eligible providers to apply.
 - \$10 billion targeted hospital hot spot distribution to hospitals in areas particularly impacted by the COVID-19 outbreak (application required)

- \$10 billion for rural health clinics, health centers and hospitals (distributions began week of April 27) plus an additional \$1 billion (announced 7/10) for rural and small metro hospitals.
- \$400 million for the Indian Health Service facilities based upon operating expenses. (distributions to begin week of April 27)
- \$500 million for tribal hospitals, clinics and urban health centers
- \$10 billion (June 9) for safety net hospitals plus additional \$3 billion (announced July 10)

In addition, providers with uncompensated Medicare service costs related to COVID-19 can apply for reimbursement through PRF:

- **Reimbursement for Medicare Services Provided to Uninsured:** Providers who have provided testing, testing-related visits or treatment for uninsured patients with a COVID-19 diagnosis on or after February 4, 2020 can apply for reimbursement for these services via a separate process under the PRF.

HHS has posted a [file](#) listing all providers who received payments and have attested to the terms and conditions along with the amounts they have accepted as of May 4, 2020. This list is updated biweekly.

General Distribution Payment Information

Eligibility for: Provider organizations who billed Medicare fee-for-services(FFS) in 2019 and who provided or are providing “diagnoses, testing or care for individuals with possible or actual cases of COVID-19” after January 31, 2020. HHS indicated that they broadly view every patient as a possible case of COVID-19.

Amount of Distribution: \$50 billion distributed in two separate payments - \$30 billion in first tranche and \$20 billion tranche.

Allocation methodology: HHS’s goal for the \$50 billion General Distribution to Medicare providers was to provide with at least 2% of that provider’s gross receipts regardless of the provider’s payer mix.

- **Initial payments distributed between April 10 -17:** HHS automatically distributed \$30 billion through direct deposit from UHG’s Optum Bank into the accounts of providers who billed Medicare fee-for-service (FFS) based upon a percentage of their total 2019 Medicare FFS billings. This first payment was based off of the provider’s 2019 Medicare FFS payments.
- **Second payments:** Providers who received a first payment were eligible to receive a second payment from an additional \$20 billion tranche. This payment looked more broadly at a provider’s revenues by initially using Medicare cost report data and later federal income tax information not just Medicare FFS. Some providers received a second payment automatically by April 24 at 5p.m. The remaining providers had to apply for the second payment by submitting additional financial information through the General Distribution Portal by June 3. The objective of these payments is essentially to ensure a total General Distribution payment that equals the lesser of 2% of a provider’s 2018 (or most recent complete tax year) gross receipts or sales/program service revenue regardless of payer mix, or the sum of incurred losses for March

and April 2020. (Originally, HHS was using a 2% of net patient revenue from the 2018 Medicare cost report data. The allocation methodology changed in mid-June).

It should be noted that not all providers will receive a second payment even after submitting additional financial data to HHS. If the initial General Distribution payment a provider received is determined to be at least 2% of an organization's annual gross receipts, the provider may not receive an additional General Distribution payment but may be eligible for a future Targeted Distributions related to COVID-19.

Formula: Divide your "Gross Receipts or Sales" or "Program Service Revenue" by \$2.5 trillion and then multiply by \$50 billion.

Expected Combined General Distribution Payment =

$$(\text{Individual Provider Revenues}/\$2,500,000,000,000) \times \$50,000,000,000$$

Requirements: All providers who receive General Distribution payments must attest to receipt of payments and the corresponding terms and conditions related to the first and second payments or reject the funds within 90 days of receiving each of the payments. All providers are also required to submit additional financial data which includes federal income tax forms and information on the receiving organization's lost revenues for March and April 2020. Providers who had not received a second payment as of April 24 were required to submit this additional financial information as of June 3 in order to be eligible for a second payment from the General Distribution. All other providers must submit the additional financial information through the General Distribution Portal after they attest and before the 90-days following receipt of payment. After HHS receives and validates the data, they will be sending out payments weekly to eligible providers on a rolling basis. It appears that HHS is reaching out to some providers who submitted their financial/revenue information through the portal but were flagged for data verification. These providers "may require additional follow-up and communication prior to receiving funds." Some of the reasons for being flagged include: "information entered not matching tax documentation, providers with significantly lower than expected Medicare revenue, and apparent data entry errors."

Key Dates:

- **April 10 – April 17:** HHS Timeframe in which HHS via UnitedHealth Group/Optum deposited the first, automatic payments into providers' bank accounts
- **April 24, 5p EST:** Date by which HHS via UnitedHealth Group/Optum deposited the second automatic payments into some providers' bank accounts
- **June 3:** Deadline by which Medicare providers who did not automatically receive a second General Distribution payment to attest to the first payment and apply for a second payment from the \$50 billion tranche by submitting required financial information.
- **July 9:** Attestation deadline for General Distribution payments received April 10
- **July 23:** Attestation deadline for General Distribution payments received April 24

Targeted SNF-Only Distribution

Overview: HHS sent out payments through UnitedHealth Group's Optum Bank on May 22 to 13,000 certified Skilled Nursing Facilities and some portion of the 333 Medicaid-only nursing homes. HHS has continued to distribute these targeted distributions to Medicaid-only nursing homes as they are able to verify their information. In some cases, nursing homes may have received a paper check instead of an ACH payment.

Eligibility for: Medicare or Medicaid certified nursing facilities with six or more beds. "All standalone and/or hospital-based skilled nursing facilities with at least six beds."

Amount of Distribution: \$4.9 Billion. Individual payments ranged from \$65,000 to \$3.25 million with a national average payment of \$315,000 per facility.

Allocation methodology: Each eligible nursing home received a payment equal to \$50,000 plus \$2,500 per bed. HHS has yet to confirm what data source it used to determine a nursing home's bed count. Some providers have reported an inaccurate based on their current bed count.

Formula: \$50,000 + \$2,500 per bed.

Requirements: All providers must attest to receipt of the payment and to the related terms and conditions within 90 days of receipt of the payment. For most providers, this must be done by August 20.

Key Dates:

- **May 22:** HHS sends payments to skilled nursing facilities.
- **August 20:** Deadline for most to submit attestation for this distribution.

Targeted Medicaid/CHIP Distribution

Overview: HHS announced June 9 that it would distribute an estimated \$15 billion to Medicaid, Medicaid Managed Care and CHIP providers who had not yet received a General Distribution payment via an application process. Applications must be submitted by July 20 through the [Enhance Provider Relief Fund Provider Payment Portal](#) Providers are encouraged to use the [instructions](#) and sample [application](#) form provided on the Provider Relief Fund website to prepare all needed documents in advance of entering information into the portal. Payments will be made to applicant providers who are on the filing TIN curated list submitted by states to HHS or whose applications undergo additional validation by HHS.

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

1. must not have received payment from the \$50 billion PRF General Distribution; and
2. must have directly billed **Medicaid or CHIP** for healthcare-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 billed **Medicaid or CHIP** for healthcare-related services during the period of January 1, 2018, to December 31, 2019; (this includes billing Medicaid Managed Care) and

3. 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 healthcare clinic); and
4. must have provided patient care after January 31, 2020; and
5. must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
6. 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.

Additional notes on eligibility for this distribution: In addition to the above criteria, providers are considered eligible if:

- They bill Medicaid managed care instead of or in addition to Medicaid FFS,
- They bill through a Medicaid waiver,
- Were enrolled in Medicaid prior to 2020,
- Providers of self-directed home and community-based services(HCBS),
- Providers paid through a certified public expenditure(CPE) or an
- Providers paid through an Organized Healthcare Delivery Systems(OHCDS).

However, for the last three bullets, HHS clarifies that the payments must be applied for and will be distributed to the filing Tax Identification Number(TIN) entity, which maybe the fiscal management service, CPE, or OHCDS. Some self-directed providers who are included in the T-MSIS files or are in the curated HHS list of Medicaid providers may be able to apply directly. Additional details are in the [HHS FAQs](#). HHS also outlined some additional scenarios where some providers may still be eligible including:

A subsidiary of ours received payments from the \$50 billion General Distribution, but another subsidiary of ours did not and is a Medicaid provider – can I apply for this Medicaid Targeted Distribution? (Added 6/9/2020)

As long as the Filing TIN or one of the Billing TINs was not eligible for the \$50 billion General Distribution but is a Medicaid or CHIP provider and is on the State-provided list of eligible Medicaid and CHIP providers, then they are eligible to apply. Medicaid or CHIP providers who are not on the State-provided list, their applications will undergo additional validation by HHS.

Ineligible providers: HHS has explicitly stated (July 8) that Programs for All Inclusive Care for the Elderly (PACE) are NOT eligible to apply under this distribution. They view PACE programs as payers and have committed to not using the PRF to assist payers.

Also, providers who rejected General Distribution payments are NOT eligible to apply for the Medicaid Distribution nor are those who accepted a General Distribution payment. This is one of the most frustrating issues for many members as they may have received an insignificant or small General Distribution payment that makes them ineligible, at present, to apply for payments from this distribution. HHS has indicated, however, that there should be parity between what a provider received under the General Distribution and what they would receive under the Medicaid Distribution. This is likely due to a quietly made change in the formula in mid-June to base General Distribution payments off of gross revenues as reported on federal income tax forms. (See General Distribution Payment section for more details on this formula change.)

According to a June 9 HHS FAQ, there appears to be an exception to this rule if a Filing or Billing TIN of an organization did not receive a payment and it is a Medicaid provider and on the curated list of TINs. While the FAQ does not explicitly note this, based upon other FAQs, this would only apply in cases where the Filing or Billing TIN also files a separate federal tax return.

Amount of Distribution: Estimated \$15 Billion

Allocation methodology: The Medicaid/CHIP Targeted Distribution methodology will be based upon 2% of (gross revenues * percent of gross revenues from patient care) for CY 2017, or 2018 or 2019, as selected by the applicant and with accompanying submitted tax documentation. Payments will be made to applicant providers who are on the filing TIN curated list submitted by states to HHS. Those who apply and their TIN is not found on the curated list will undergo additional validation by HHS.

Formula: (gross revenue x % of gross revenue from patient care for CY2017, 2018 or 2019) x 0.02

Requirements: Unlike other PRF distributions, eligible providers must apply through the [Enhanced Provider Relief Fund Payment Portal](#) by July 20. Providers are to only submit one application and as such, are encouraged to wait to apply until they have pulled together all the required information and documentation for the [application form](#). Providers can edit data on the electronic form until the form is submitted.

There are numerous steps to the application process. Providers will create an Optum Id (Optum facilitates the distribution of payments on behalf of HHS), establish an Automated Clearing House (ACH) account (recommended to complete at same time as the application) and submit information to validate their organizations TIN. 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).

HHS notes the following information will need to be uploaded as part of application:

- 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 healthcare clinic).
- The applicant's Employer's Quarterly Federal Tax Return on IRS Form 941 for Q1 2020, Employer's Annual Federal Unemployment (FUTA) Tax Return on IRS Form 940, or a statement explaining why the applicant is not required to submit either form (e.g. no employees).
- The applicant's FTE Worksheet (provided by HHS).
- If required by Field 15, the applicant's Gross Revenue Worksheet (provided by HHS).

Providers will receive status notices when the submission is complete, and their eligibility status for the funds. If eligible, they will receive a payment. Providers who receive payments will need to attest to receipt of the payments and acceptance of the Terms and Conditions within 90 days of receiving the payment.

Payments will be distributed on a rolling basis as information is validated. HHS anticipates most payments will be distributed by the end of August barring any unforeseen issues.

Please note that as of June 25, **eligible unlicensed providers** were being prevented from completing the applications process due to a glitch in the system. HHS is working to resolve this problem and will provide more information as it becomes available.

Application resources: HHS has made several resources available to providers to assist them in completing the application process.

- Providers can review a [recorded HHS webinar](#) on the application process
- [Medicaid Application Instructions](#)
- [Application Form](#)
- “Enhanced Provider Relief Fund Payment Portal” section of the [HHS FAQs](#) for detailed information about what information needs to be submitted in each field of the form and which information to report. Providers are encouraged to review this FAQ section as it includes details about what lost revenues can be reported, information on various provider scenarios related to TINs and NPIs and subsidiaries, and details about the data sources providers should be reporting.

Key Dates

- **June 9:** HHS announces application process for a Medicaid/CHIP Distribution from the PRF.
- **July 20:** Deadline to submit their TIN for validation for a payment from the Medicaid/CHIP Distribution. If approved, the application can be completed and submitted after this date.

Reimbursement for Medicare Services Provided to Uninsured

In addition to the direct payments being made to health care providers, an unspecified amount of the Provider Relief Funds will be used to reimburse health care providers who have provided testing, testing-related visits or treatment for uninsured patients with a COVID-19 diagnosis on or after February 4, 2020. Recent updates to the HHS CARES Act Provider Relief Fund website now includes information on the terms and conditions that providers must attest to in order to be eligible to receive these reimbursements.

The Process

- **Provider Enrollment:** As of April 27, 2020, to be eligible to apply for reimbursement, providers must register for the program as a provider participant. Skilled nursing facilities, home health and other post-acute care providers are eligible for this reimbursement. Hospice services are excluded.
- **Confirm Uninsured Status:** All providers seeking reimbursement must check for health care coverage eligibility and confirm that the patient is uninsured. You have verified that the patient does not have individual, employer-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse you for COVID-19 testing and/or care for that patient.
- **Submit Claims:** Enrolled providers can begin submitting claims electronically for care and services provided to confirmed uninsured individuals in the U.S. on May 6, 2020. All claims are subject to Medicare timely filing requirements.
- **Reimbursement rates:** Enrolled providers will be eligible to be reimbursed at current year Medicare fee schedule rates, which will start to be deposited in mid-May for services provided to uninsured individuals. These reimbursements will continue the funds run out. No

specific amount has been designated for this reimbursement. This payment must be accepted as payment in full.

- **No balance billing:** Providers must agree not to balance bill these patients.
- **Payment:** Enrolled providers will receive payment via direct deposit into their bank account.

[Website](#) for more information on how to get reimbursement for care provided to uninsured COVID-19 patients. This site will be updated with “much more information” beginning April 27.

LeadingAge Sponsored Resources

In addition to this LeadingAge Provider Relief Fund Explainer, the following resources are available (some for a fee) to help our members be prepared for potential future audits, reporting and compliance with these programs:

- [COVID 19 Stimulus Bill Facility Eligibility Calculators and Explainer](#), developed by LeadingAge Wisconsin, helps providers assess eligibility for the full array of COVID-19 -related funding options.
- [CLA Expense Tracking Tool to Help Economic Relief Fund Recipients Stay Compliant](#)

Key HHS Provider Relief Fund Resources

- [HHS CARES Act Provider Relief Fund main website](#) – From here providers can find all the information below. Also on this page is where HHS has included PDF documents of each set of Terms and Conditions.
- **CARES Act Provider Relief Fund Provider Support Line:** Call 1-866-569-3522 with questions not answered by FAQs, about returning payments, payment or application status, application assistance, etc. Providers should have the last four digits of the recipient or applicant organization’s Tax Identification Number(TIN), the name of the recipient/applicant and mailing address as it appears on the most recent tax filing, and when appropriate the applications number (starting with “DS” or “CR”).
- [Attestation Portal](#) – This portal is where providers go to accept or reject payments received and agree to the related Terms and Conditions for the payment received from the PRF.
- [General Distribution Portal](#) – This portal is where Medicare providers who received one or more General Distribution payments as of 5p EST on Friday, April 24. This portal was used as a way for eligible providers to apply for an additional payment (deadline was June 3) and/or submit their required financial information for those who had already automatically received two payments. This portal should not be used by providers who have not yet received a payment from the Provider Relief Fund. However, it should be noted that these providers may still be eligible for payments from the Fund
- [Enhance Provider Relief Fund Provider Payment Portal](#) – This portal is used to submit an application for Medicaid/CHIP distribution payment, and possibly will be used for other future PRF distributions. Here providers submit their tax identification information for validation, complete an online application for funds by submitting additional financial information, and attest to payments received under the Medicaid/CHIP Distribution. This portal also includes a Resources and Supports Tab, where providers can obtain more information helpful to applying.
 - [Instructions for applying for the Medicaid Distribution](#)
 - [Application form for the Medicaid Distribution](#)

- [COVID19 Uninsured Program Portal](#) - This portal is for providers wishing to seek reimbursement for uncompensated Medicare services for treatment and testing related expenses for COVID-related patients.
- [HHS Provider Relief Fund FAQs](#) - This document is updated often, sometimes daily, responding to new questions related to available funds, definition of key terms, application information, detailed information on the various distributions including addressing specific provider organization scenarios related to changes of ownership, distribution formula, eligibility criteria and much more.

Timeline or Key Dates

- **April 10:** UnitedHealth Group begins depositing the first \$26 billion of Provider Relief Funds into Medicare provider accounts on behalf of HHS and the CARES Act
- **April 16:** HHS Portal for signing the attestation opened
- **April 17 :** \$4 billion distributed to remaining Medicare providers as part of first round of funds.
- **April 23:** Congress passes bill with additional \$75 billion for the Provider Relief Fund.
- **April 24:**
 - HHS distributes \$20 billion in payments to providers for whom Medicare FFS reflects a small share of their revenue and based off of 2018 net patient revenue as reported in CMS cost report data.
 - President signs the bill adding \$75 billion to the Provider Relief Fund
 - HHS launches General Distribution Portal for submitting financial information for second round of general distribution funds to Medicare providers.
- **Week of April 27:**
 - Distributions began going out to hospitals hard hit by COVID-19, rural health clinics and hospitals, and Indian Health Service facilities.
 - Providers enrollment in program to reimburse providers care and services provided to uninsured COVID-19 patients opens
- **May 7:** HHS announces extension of the attestation deadline, now 45 days from receipt of payment.
- **May 20:** HHS Announces June 3 deadline for providers who did not automatically receive a second General Distribution payment to attest to the first payment and apply for a second payment by submitting the required financial information.

- **May 22:**
 - HHS begins distributing \$4.9 billion Targeted SNF-Only Distribution payments to “certified” Medicare and Medicaid Skilled Nursing Facilities including Medicaid-only nursing homes.
 - HHS announced extension of the attestation deadlines to 90 days from receipt of Provider Relief Fund Payments.
- **June 3:** Last chance for Medicare providers who did not automatically receive a second General Distribution payment to attest to the first payment and apply for a second payment from the \$50 billion tranche by submitting required financial information.
- **June 9:** HHS announces \$15 billion Medicaid/CHIP Targeted Distribution to Medicaid-exclusive providers.
- **July 9:** Attestation deadline for General Distribution payments received April 10
- **July 20:** Deadline for eligible Medicaid & CHIP providers to apply for \$15B Medicaid Distribution.
- **July 23:** Attestation deadline for General Distribution payments received April 24
- **August 20:** Attestation deadline for Targeted SNF-Only Distribution payments received May 22
- **October 10:** Due date for calendar quarter report for July 1 – September 30 due to HHS and Pandemic Response Committee.

Required Provider Actions

Application: HHS has established an [Enhanced Provider Relief Fund Payment Portal](#) for providers to apply for distributions from the Provider Relief Fund. This portal is being used initially to accept applications from Medicaid and CHIP providers who have not received a General Distribution payment. The application process will be open for these providers until July 20 and requires providers to submit: standard contact information, gross revenue data, lost revenues and increased expenses incurred due to COVID-19, federal tax forms, payer mix percentages, amounts received from the Paycheck Protection Program and/or FEMA, FTE information and in some cases, site locations. Upon receipt, HHS will verify the data and compare it with provider information from state Medicaid agencies prior to calculating and distributing payments. This portal is also expected to be used for other future distributions.

Attestation: This is a process by which all providers who receive a PRF distribution payment -- both General and Targeted Distributions – acknowledge receipt of the payment and agree to the related Terms and Conditions. This step must be taken within 90 days of receipt of a payment. Alternatively, providers may also opt to reject the payment but must reject and return the payment within the same 90-day timeframe using the [Attestation Portal](#), which walks providers through the necessary steps. See returning payments below for more details. For providers who receive a Medicaid/CHIP distribution, the attestation process will be completed in the [Enhanced Provider Relief Fund Payment Portal](#).

A parent organization, with subsidiary billing TINs that receive payments, may attest to accepting the payments for its subsidiaries agreeing to be responsible for complying with the Terms and Conditions, and retaining the payments. To do this, the providers associated with the parent organization must be providing or have provided diagnoses, testing, or care for individuals with possible or actual COVID-19 cases on or after January 31, 2020. The parent organization can then allocate funds at its discretion to its subsidiaries.

Providers need to attest separately for each payment they receive from the PRF, regardless of whether it was from the General Distribution or one or more Targeted Distributions. It should be noted that each payment has its own terms and conditions, which are “slightly different” for each round of payments. Terms and Conditions for each type of payment can be found [here](#). Providers who received more than one automatic General Distribution payment may reject one payment and accept the other through the Attestation Portal.

Providers who fail to submit an attestation within 90 days of receipt of payment but retain the payments received from the PRF are assumed to have agreed to the Terms & Conditions.

If a provider affirmatively attested to a payment but later changes their mind and wishes to reject the funds and retract their attestation, HHS instructs these providers to call the Provider Support Line at (866) 569-3522 to pursue this process.

HHS publishes a [list](#), updated biweekly, of providers who have attested (or are presumed to have attested by keeping the funds beyond 90 days) and the total amounts to which they have attested. If a provider has received more than one payment but not yet attested for all the payments, HHS will only report the amount that has been accepted. Provider information is listed by Tax Identification Number (TIN) and therefore may be reported based upon the billing location which may not align with the service delivery location. By attesting to the Terms and Conditions, the provider agrees to have its organization’s name and amounts received published as part of this list.

Rejecting Payments: Providers who choose to reject the funds must complete the attestation indicating their rejection of the funds within 90 days of receiving the payment. The Attestation Portal will guide providers through the process to reject funds which also must be completed within 90 days of receipt of payment. HHS will not reissue payments previously rejected and returned if a provider changes its mind later. In HHS’s FAQs, it indicates that a provider should reject a payment if it is greater than expected or received in error. If a provider received a larger payment than expected but anticipates having cumulative lost revenues and increased costs that are attributable to coronavirus during the COVID-19 public health emergency that exceed the intended calculated payment, then the provider may keep the payment. Providers may also retain a payment if it sold, terminated, transferred or otherwise disposed of one or more portions of its health care services/providers that were included in its most recent tax return program services revenue as long as it can attest to the Terms and Conditions.

If a provider does not have or anticipate having these types of COVID-19-related eligible expenses or lost revenues equal to or in excess of the Provider Relief Fund payment received, it should reject the payment in [Provider Relief Fund Attestation Portal](#) and return the entire payment, and work with the Provider Support Line at (866) 569-3522 (for TYY, dial 711) for step-by- step instructions on returning the payment and receiving the correct payment when relevant.

Returning Payments: Payments must be returned in full in cases where: the TIN that received the payment is no longer providing healthcare services as of January 31, 2020, or there has been a change in ownership of the organization or the provider refuses to agree to the Terms and Conditions. Providers may always opt to return the payment. Previous owners who receive a payment cannot transfer the payment to a new owner.

Providers who seek to return a payment must first reject the payment via the [Attestation Portal](#). Then, the full payment must be returned as follows:

- For ACH payments, the provider needs to contact their financial institution and ask the institution to refuse the received Automated Clearinghouse (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 your financial institution won't permit you to return the funds electronically, providers should contact the Provider Support Line at 866-569-3522 for assistance.
- For situations where the provider received a paper check and has not yet deposited it, the provider should destroy, shred, or securely dispose of it. If the provider has already deposited the check, the provider should mail a refund check for the full amount, payable to "UnitedHealth Group" to the address below. Please list the check number from the original Provider Relief Fund check in the memo. Checks to be sent to:

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

HHS will use returned payments for future PRF distributions.

Submission of Financial Information via the General Distribution Portal (a.k.a. DocuSign): Those providers who received a General Distribution payment are also required to submit additional financial information through a separate [General Distribution Portal](#) after completing their attestation via the Attestation Portal. Specifically, providers are to submit:

- "Gross receipts or sales" or "program service revenue" as submitted on its federal income tax return;
- Estimated lost revenues for March and April 2020 due to COVID 19;
- Copy of most recently filed Federal income tax return;
- Tax identification numbers (TINs) of any of your organization's subsidiaries that have received funds but DO NOT file separate federal tax returns.

According to HHS FAQs, "Providers can report lost revenues for all business lines under the same TIN that are actively caring for patients with COVID-19 or actively working to prevent the spread of COVID-19." Therefore, it appears that a life plan community, for example, could report lost revenues in their independent living due to closure of move ins in an effort to prevent spread of COVID-19 within their campus. Members are encouraged to document their rationale for how lost revenue or an eligible expense is related to coronavirus for later substantiation through future HHS reporting.

Each entity that files a federal income tax form is required to file information through the General Distribution Portal even if it is part of a provider group. Those that file a consolidated return will only have a single submission. All subsidiary TINs that do not file federal income taxes must be listed. The [HHS FAQs](#) provide more detailed background on this submission process including clarifying which specific forms must be submitted by federal tax classification, how to calculate lost revenues, situations a provider may encounter in submitting their data and numerous provider scenarios.

Providers who received only one General Distribution payment prior to April 24, 5 p.m. EST were required to submit this information by June 3 (considered an application for additional funds) in order to be eligible for a

second payment from the General Distribution. Upon completion of submitting this information, providers should have received an email confirming the application was considered complete. Providers will also receive a notice of the final status of their application.

Those providers who had automatically received two General Distribution payments prior to April 24, 5 p.m. EST have 90 days from the receipt of each payment to attest to the payment and submit the required financial information via the separate [General Distribution Portal](#).

Please note that providers must first complete their attestation through the [Attestation Portal](#) in order to be able to submit the required financial information through the separate [General Distribution Portal](#).

If you later receive an email notice that your CARES Act Provider Relief Fund Application DocuSign submission has expired, this indicates that you have initiated one or more entries that were not completed or submitted. As long as you have completed the submission of financial information through the General Distribution Portal at least once, you do not need to take any further action.

Reporting: According to the Terms and Conditions, “Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee a report.” However, on June 13, HHS indicated in its [FAQs](#) that, “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 [USApending.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)].”

Providers who received a General Distribution payment were required to report additional financial information through the General Distribution Portal after submitting their attestation through the Attestation Portal.

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. HHS will notify recipients of the content and due date(s) of such reports in the coming weeks.

Documentation: HHS has indicated that all expenses and lost revenues should have a nexus to COVID-19. This underscores the importance of not only tracking expense receipts but what the item was used for and how it relates to COVID-19. Providers will likely also have to show that their expenses and lost revenues meet the Terms and Conditions for the Provider Relief Fund and as such were not reimbursed by another source nor was another payment source required to cover these items.

According to the CARES Act, the HHS Secretary will establish reporting and documentation requirements that must be followed. The Relief Fund Terms and Conditions specify that providers must report on the following items quarterly:

- Total amount of funds received from HHS under one of the Acts;
- Amount of received funds that were expended or obligated for each project or activity;
- Detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.

HHS has said it will provide guidance in the future about the type of documentation it expects recipients to submit and that this guidance will be posted at <https://www.hhs.gov/provider-relief/index.html>.

Key Terms

Actual case of COVID-19 : This term is used to determine whether a provider is eligible for a PRF payment and to determine those situations when an out of network provider cannot charge higher out of pocket costs to the patient. The HHS General Distribution FAQ does not specifically define this term but given the definitions and distinctions between possible and presumptive cases (see definitions below), an actual case of COVID-19 is likely to be where the patient’s medical record contains a positive test result.

Eligible expenses: The CARES Act outlines eligible expenses for which the payments can be used:

- building or construction of temporary structures
- leasing of properties
- medical supplies and equipment including personal protective equipment and testing supplies
- increased workforce and training
- emergency operation centers
- retrofitting facilities
- surge capacity.

HHS in its FAQs as of June 19 augments the CARES Act definition:

“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 healthcare services for possible or actual COVID-19 patients;
- equipment used to provide healthcare 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 healthcare 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, healthcare practices, staffing, and technology to expand or preserve care delivery.”

To be eligible, the healthcare related expenses attributable to coronavirus must have been incurred after January 1, 2020 and used to prevent, prepare for, and respond to coronavirus.

Eligible health care provider means “public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities not otherwise described in this proviso as the Secretary may specify, within the US (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.”

Lost revenues: (source: HHS FAQs) “The term ‘lost revenues that are attributable to coronavirus’ means any revenue that you as a healthcare 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.” HHS also clarifies, “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.” So, for example, it would appear that if a provider provides housing and services on a campus and didn’t permit move ins during the height of the pandemic in an effort to prevent the spread of the coronavirus that the lost revenues attributable to this action could be reported as long as all business lines are under the same Tax Identification Number (TIN). Alternatively, HHS also indicated on a LeadingAge Member Call that the action of closing a provider’s physical location, such as an adult day center, would be viewed as an action to prevent COVID-19.

In addition, “HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare 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”

Providers 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.

LeadingAge asked HHS to clarify what lost revenues can be reported when a provider has multiple business lines under the TIN receiving the payment. HHS answered via its FAQs as follows:

Our tax identification number (TIN) covers all our business lines, including our skilled nursing facility (SNF), assisted living facility, home health agency, and independent living services to older adults. Can I submit lost revenues for all these business lines for March and April 2020 if they are

related to COVID-19, or must I only report lost revenues for those business lines that receive Medicare payments (e.g. SNF and/or home health)? (Added 6/9/2020)

Providers can report lost revenues for all business lines under the same TIN that are actively caring for patients with COVID-19 or actively working to prevent the spread of COVID19. Providers must use any payments received from the Provider Relief Fund consistent with associated Terms and Conditions.

Possible case of COVID-19: This term is used to determine whether a provider is eligible for a PRF payment. "HHS broadly views every patient as a possible case of COVID-19." HHS also notes that not every possible case is a presumptive case.

Presumptive cases 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. Under the Terms and Conditions, providers who have received PRF payments are prohibited from collecting out of pocket expenses greater than what the patient would have paid to an in-network provider for all care for a presumptive or actual case of COVID-19.

Terms & Conditions: Each PRF distribution payment requires the provider to attest to a separate set of terms and conditions. The terms and conditions provide the parameters under which the payments may be used, statutory requirements or limits that apply and associated reporting requirements. In general, they apply until the funds received are exhausted. Some terms and conditions extend beyond this period of time (e. g. , record maintenance for three years from final expenditure). So far each set of terms and conditions appear to be substantially similar but there are some differences.

At a high level, the key requirements include:

- Must use funds for COVID-19 related health care expenses and lost revenues;
- Must provide care to those with possible or actual cases of COVID-19;
- Cannot "balance bill" in excess of an in-network cost sharing for all care provided to a patient with a presumptive or actual case of COVID-19;
- Must report quarterly to HHS and the Pandemic Response Accountability Committee;
- Cannot submit reimbursement for expenses covered by another funding source;
- Retain appropriate records and cost documentation.
- Prohibits using the funds to pay an individual through a grant or extramural mechanism in excess of the Executive Level II salary level which as of January 2020 is \$197,300, excluding fringe benefits and indirect costs. An organization may pay a salary amount in excess of this cap with non-federal funds.
- Prohibits using the funds for: gun control advocacy efforts, lobbying, abortions, embryo research, promotion of legalization of controlled substances, pornography, funding Association of Community Organizations for Reform Now or its affiliates; or needle exchange,
- Cannot require employees or contractors to sign internal confidentiality agreements prohibiting them to lawfully act as a whistleblower
- Requires certain terms to be included in nondisclosure agreements
- Funds are not available to entities that have unpaid federal tax liability
- Prohibits knowingly using the funds to contract with a corporation with a felony criminal conviction in the prior 24 months.

Below find the links to the relevant Relief Fund Payment Terms and Conditions documents:

- [\\$30B General Distribution](#)
- [\\$20B General Distribution](#)
- [Targeted SNF Distribution](#)
- [Medicaid/Medicaid Managed Care/CHIP/Dentist Targeted Distribution.](#)

Considerations Before You Attest: Questions Providers Should Consider Before Agreeing to Terms & Conditions and Using the Money

At the time the initial payments were deposited into providers accounts, there were many unanswered questions about how this program would work. For that reason, LeadingAge encouraged members to wait to attest so we could get those answers. At this time, many if not most of those questions have been answered including clarifying the timeframe, eligible uses for the funds, and which expenses and losses are eligible under the program. For these reasons, we would encourage providers to attest if they believe they have need of the funds and meet the Terms and Condition and eligibility criteria to use the funds. The questions and information below are designed to assist you in thinking through the systems or processes you need to put in place to comply.

Providers must attest using the appropriate attestation portal. It appears as of June 25 that those receiving General Distributions and many of the Targeted Distributions (e.g., SNF Distribution) must use the [Attestation Portal](#) but those that receive a Medicaid/CHIP Distribution will use the [Enhanced Provider Relief Fund Payment Portal](#).

Providers should consider the following questions prior to attesting:

- **Since January 31, has your organization provided or does it currently provide “diagnoses, testing, or care for individuals with possible or actual cases of COVID-19”?**

HHS defines “possible cases of COVID-19” in its FAQs and on the HHS CARES Act Provider Relief Fund website, in the following way, “HHS broadly views every patient as a possible case of COVID-19.”

- **Does your organization have “health care related expenses or lost revenues that are attributable to coronavirus?”** The simple answer for most, if not all, providers is going to be yes but make sure you understand which expenses and lost revenues are eligible for PRF. Testing of staff and residents for COVID-19 is currently a key missing expense, at present, although testing supplies and costs for reporting COVID-19 test results are eligible. [The Relief Funds Payment Terms and Conditions](#) for the General Distributions to Medicare providers require that the funds, “... 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.”

See Key Terms section of this document for definitions of eligible expenses and lost revenues attributable to coronavirus.

In HHS’s May 22 announcement of the SNF Targeted Distribution payments, it indicated, “These additional funds may help nursing homes address critical needs such as labor, scaling up their testing capacity, acquiring personal protective equipment and a range of other expenses directly linked to

this pandemic.” HHS has suggested that all expenses should have a nexus to COVID-19. This underscores the importance of not only tracking expense receipts but also documenting what the item was used for and how it relates to COVID-19.

HHS has clarified (HHS FAQs as of June 9) that providers can report lost revenues for all business lines under the same TIN that are actively caring for patients with COVID-19 or actively working to prevent the spread of COVID-19. HHS has said that situations where providers, such as adult day providers have had to cease providing services due to the virus are interpreted as “preventing” coronavirus. Providers must use any payments received from the Provider Relief Fund consistent with associated Terms and Conditions.

- **How will you document the expenses incurred were “used to prevent, prepare for and respond to coronavirus”?**

The CARES Act and the various PRF Terms and Conditions establish a reporting requirement. The CARES Act notes that expenses are eligible if they are used to prevent, prepare for and respond to coronavirus.” (See above sections defining eligible expenses and lost revenues and, the section on Terms and Conditions, Documentation and Reporting for details). To date, HHS appears to be taking a broad view of these terms as long as a provider can demonstrate a nexus to COVID-19.

HHS has since clarified that the PRF payments can be used for expenses and lost revenues incurred after January 1, 2020 that are related to coronavirus for the duration of the pandemic.

In general, HHS has said it will reconcile payments to expenses and lost revenues at the end of the pandemic. So, essentially, right now, providers who have eligible expenses and/or lost revenues attributable to the coronavirus that aren’t already covered by another payer source, should use them to cover these items. If providers have leftover PRF money when the pandemic ends that they cannot expend on permissible expenses or losses, then HHS will provide directions on how return the unused funds. We have raised the issue of potentially extending the applicable time period for a certain amount of time after the public health emergency or pandemic ends to allow providers to ramp back up to full strength and for “claims” run out.

Silver Sponsor CLA has a tracking [tool](#) (for a fee) to assist providers in tracking all coronavirus-related funds received. Until further detail is available from HHS on what specifically will need to be reported related to the PRF payments received, CLA recommends the following on how providers might approach tracking and documenting eligible expenses, lost revenues and use of funds to ensure there isn’t duplication:

- **Track COVID-19 Expenses:** Staff bonuses, hazard or incentive pay; use of agency staff; personal protection equipment; additional food or food service , housekeeping and/or laundry costs; anything above the usual and customary expenses. It is not clear yet if all of these will be eligible but at present it is better to be inclusive in compiling these items and exclude ineligible items once further guidance is issued.
- Set up **separate general ledger(GL) accounts** and report excess expenses in the GL accounts.
- **Use HHS definition for calculating lost revenue:** According to the [HHS FAQs](#) , “Lost revenue can be estimated by comparing year-over-year revenue, or by comparing budgeted revenue

to actual revenue. For April 2020, an estimate of the total monthly loss based on data from the first few weeks in April or by extrapolation from March data is acceptable.”

- **Track by payer and provider type:** While this was a potential early consideration, HHS has not indicated any need to track payments, expenses or lost revenues by payer source and/or provider type, as payments are being made primarily based upon TIN-level revenue across payers. Ultimately, the Tax Identification Number (TIN) that received the payment is accountable for complying with the terms and conditions. It appears unlikely that HHS will require reporting by payer or provider type but instead tie it to the TIN that attests to receipt of the payment and the corresponding terms and conditions.
- **Timeframe in which funds can be used:** The HHS FAQs state that “HHS expects that providers will only use Provider Relief Fund payments for as long as they have eligible expenses or lost revenue. 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.”

In addition, “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, at the conclusion of the pandemic, 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.”

- **Reporting:** Reports are required quarterly to HHS and the Pandemic Response Accountability Committee according to the Relief Fund Terms and Conditions. HHS will be submitting the first required quarterly report that would have been due July 10. HHS will provide further guidance related to other reports that may be required by the HHS Secretary, which is part of the Terms & Conditions. For more details on how HHS is covering the reporting requirement this first time, go to the [HHS FAQs](#).
- **Which program funds should your organization use first (e.g. Paycheck Protection Program or CARES Act Provider Relief funds)? What about other relief funds and/or loans?**

As you are tracking expenses and lost revenues, providers should be aware that their expenses can only be counted once across various COVID-19 related relief funds and the Provider Relief Fund dollars are essentially the payer of last resort according to the Terms & Conditions, which state, “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.” A good example is wages and salaries paid under the Paycheck Protection Program cannot also be counted under the Provider Relief Fund for the same time period. In addition, if states increase their Medicaid provider

rates or distribute lump sum funding to providers due to COVID-19, providers will want to carefully document which expenses are tied to these services versus Medicare to ensure that expenses aren't attributed to both pots of money. At this time, it is also unclear how HHS will verify this information.

It remains unclear if this provision also applies to **charitable contributions or donations** that a provider may have received for the purpose of offsetting additional COVID-19 expenses and lost revenues. LeadingAge has posed this question to and is awaiting further guidance from HHS.

- **What will be the audit process following the declared end of the national emergency health? Will funds be taken back if not properly supported? Will there be an appeal process?** HHS indicates in its [FAQs](#) that it “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.” However, further details are not yet available regarding how providers will report to HHS on their use of the funds. While HHS has indicated that the PRF payments should be considered payments not loans, it does reserve the right to recoup dollars from a provider who does not have eligible expenses or lost revenues that equal or exceed the payments received. At present, there is no appeals process. The following represent scenarios where a provider might have to repay some of all of the PRF payments it received:

- Payment was received in error.
- At the end of the pandemic, your organization didn't have eligible expenses and lost revenues that were equal to or greater than the aggregate amount received in payments from the Provider Relief Fund, so the unspent balance would be repaid.
- Your organization did not comply with the Terms and Conditions.
- Your organization did not use the funds to prevent, prepare for or respond to coronavirus.

- **Is your organization in a cost-reimbursed Medicaid state? If so, how will the use of relief funds impact your future Medicaid reimbursement rates? Will the state require the funds to be offset against expenses?** (For example, Minnesota already said yes, the funds must be offset.)

LeadingAge has asked for additional information from HHS how these payments will impact provider Medicaid rates. In a June 12 FAQ, HHS has noted that CMS will issue guidance on how the PRF payments should be treated for purposes of uncompensated care and how they should be reported on cost reports. Several members have noted that states may seek to adjust Medicaid rates based upon receipt of these funds.

- **What are other potential risks of accepting the funds and attesting to the Provider Relief Fund Terms and Conditions?**

Practically speaking, we think the risks of accepting and using the funds are low or no different than other grants or payments that providers accept every day, but providers will need to closely follow the evolving guidance related to the funds to be sure to comply.

- **Future Clawback vs. Reconciliation:** HHS or Congress could clawback some portion of the relief funds from non-COVID areas but in an election year, there is low probability of this occurring.
- **Payback of unused funds:** In both the [HHS FAQs](#) and in a May 8 meeting with the Deputy Secretary Eric Hargan, HHS indicated that providers will only be required to return some or

all of the payments received if: 1) they fail to comply with the terms and conditions; and/or 2) the payment(s) received exceed the provider's eligible expenses and lost revenues related to COVID-19. We anticipate most providers will have some eligible expenses and lost revenues that will use a good portion, if not all, of the funds. So again, we believe this is a relatively low risk.

- **Ineligible expenses/losses:** HHS has clarified its interpretation of the CARES Act regarding eligible expenses and losses (*see Key Terms section in this document for definitions*). In general, it has taken a fairly broad view to date indicating that lost revenues across a TIN that are used to prevent, prepare for, and respond to coronavirus can be reported. One key expense that is glaringly absent from the list of eligible expenses is coverage for testing costs, although testing supplies and costs associated with reporting test results to federal, state or local governments are included.
- **Timeframe for eligible expenses, lost revenues and use of funds:** Another potential risk area is the timeframe in which eligible expenses and lost revenues can be counted against the payments received. It is possible that your COVID-19-related expenses or lost revenues may be incurred outside the approved timeframe. At present, HHS has clarified that a provider may have incurred expenses and losses as far back as January 1, 2020.

HHS on June 22 clarified that the funds can be used through the pandemic and possibly beyond if they still have eligible expenses and losses. The World Health Organization declared the pandemic on March 11, 2020. It is not clear if they would also declare the end of the pandemic or whether HHS will make its own declaration. LeadingAge is advocating for a longer timeframe that acknowledges that our members must continue to be vigilant in preventing the virus and protecting the older adults for which we provide services. This vigilance will minimally require ongoing investments in PPE and testing and lost revenues may persist as we carefully reinstate programming, move ins, etc. Nonetheless, you will have a number of expenses and lost revenues that will be counted as eligible for the Provider Relief Funds.

- **Potential HHS OIG audits:** There is the potential to be audited by the HHS Office of the Inspector General based upon receipt of the funds. HHS indicates in its [HHS FAQs](#) that it "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." If the audit finds funds were improperly used, providers may be subject to civil monetary penalties and/or future exclusion from participation in Medicare, Medicaid, and other government programs. This is nothing new to providers as the HHS OIG could audit existing health care programs that we participate in. [Audits per FAQs](#)
- **False Claims Act:** Submitting required reports to HHS that include false information regardless of intent could subject a provider to potential False Claims Act complaints and other civil liability including financial penalties for each claim.

Hot Topics

Appeals: Providers may have questions or not agree with the amount they have received. However, at present, HHS is not taking direct inquiries from providers and no remedy or appeals process is available related to the PRF payments.

Audits, oversight and enforcement: The CARES Act, the Provider Relief Payment Terms and Conditions and HHS FAQs all discuss how compliance with the law and corresponding terms and conditions for the funds will be enforced. Nonetheless, much more information is still forthcoming on these topics. To date, this is what we know:

- As of June 30, HHS FAQs note that it “will have significant anti-fraud monitoring of the funds distributed, and the Office of the Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately. HHS will notify recipients of applicable audit requirements in the coming weeks.”
- The CARES Act and the PRF Terms and Conditions establish that providers who receive aggregate funds of \$150,000 or more from any statute primarily making appropriations for the coronavirus response” will be required to submit quarterly reports to HHA and the Pandemic Response Accountability Committee. However, as of June 13, HHS said that recipients of PRF payments do not need to submit a separate quarterly report, as HHS is developing a report with the necessary information.
- HHS notes that providers per the PRF Terms and Conditions must submit any reports requested by the HHS Secretary that are necessary for compliance and that HHS will be requiring providers to submit future reports substantiating the PRF money was used for eligible expenses and losses not reimbursed by another source or required to be covered by another source. More information will be made available by HHS related to the content and due dates of these reports.

Balance Billing: Under the Terms and Conditions, HHS establishes that providers are prohibited from billing a patient an amount that exceeds what they otherwise would have paid out-of-pocket to an in-network provider. This includes deductible, co-payments, co-insurance and balance billing. This provision applies to all care for a presumptive or actual case of COVID-19. See Key Terms section for definitions of possible, presumptive and actual case of COVID-19. This does not prevent the provider from billing the individual’s insurer for care provided. HHS encourages providers to submit a claim to the patient’s insurer regardless of whether the provider is in or out of network with the plan. Most insurers have committed to paying out of network providers at in-network rates.

Eligibility for Funds

- **Related to Change in Ownership:** HHS has extensive FAQs covering specific change in ownership issues related to eligibility for Provider Relief Funds. Providers are encouraged to review these FAQs to see if their specific circumstance is covered. Below are highlights of how HHS is approaching these issues:
 - Previous owners who received payments are not permitted to transfer funds to the new owners and are expected to return the received payment(s) in full.
 - Regrettably, returned payments under these situations will not be reissued to the new owner.
 - Providers impacted by change in ownership issues will be eligible for future allocations.
- **Providers who have ceased operations due to the COVID-19 pandemic:** If a provider ceased operation as a result of the COVID-19 pandemic, they are still eligible to receive PRF payments as long as they provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19

on or after January 31, 2020. 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 the payments.

Timeframe for using the payments: Through its FAQs, HHS has made it clear that PRF payments must be used for preparing, preventing and responding to coronavirus and that these eligible expenses and lost revenues related to coronavirus were most likely incurred after January 1, 2020. It has been less clear how long providers can use these payments. However, both in its FAQs and as part of a June 25 webinar, HHS indicates providers can use the funds as long as they have eligible expenses or lost revenues related to the coronavirus. Below are two key FAQs where HHS speaks to the duration for which payments can be used.

- **HHS FAQ: In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? (Added 6/8/2020)**
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, at the conclusion of the pandemic, 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.
- **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? (Added 6/22/2020)**
HHS expects that providers will only use Provider Relief Fund payments for as long as they have eligible expenses or lost revenue. If, at the conclusion of the pandemic, 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. 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 healthcare related expenses or lost revenue attributable to coronavirus.

Frequently Asked Questions (FAQs)

- Q. Who should I call if my organization has questions about Provider Relief Fund payments received, how to return fund, status of payments applied for, assistance with applying for funds did not receive any funds and we provide Medicare services so believe we are eligible for the funds?**
- **Answer:** HHS has established a **toll-free CARES Act Provider Support Line (866-569-3522)** where providers can seek answers to questions not answered by the HHS FAQs, about returning payments, payment or application status, application assistance, etc. Providers should have the last four digits of the recipient or applicant organization's Tax Identification Number(TIN), the name of the recipient/applicant and mailing address as it appears on the most recent tax filing, and when appropriate the applications number (starting with "DS" or "CR").

Additionally more details about the Fund can be found at the [HHS CARES Act Relief Fund website](#).

Q. Are the Provider Relief Funds a loan, a grant, something else?

Answer: HHS clearly states on the CARES Act Provider Relief Fund website, “These are payments, not loans, to healthcare providers, and will not need to be repaid.” However, providers retaining the payments must also abide by the Terms & Conditions, which clearly state the funds are only to be used for certain eligible expenses and lost revenues related to COVID-19. According to the HHS April 22 announcement regarding the second round of funds, HHS reiterated, “All recipients will be required to submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to coronavirus. There will be significant anti-fraud and auditing work done by HHS, including the work of the Office of the Inspector General.” HHS indicated in its FAQs that they only anticipate repayment if payments were made in error, terms and conditions are not followed, and/or a provider’s COVID-19-related expenses and lost revenues do not exceed the amounts received.

Q. How should providers classify the Provider Relief Fund payments in terms of revenue type?

Answer: CMS will be issuing future guidance on how these payments should be treated for purposes of uncompensated care and reported on cost reports. It is unclear at this time what impact receipt and use of these payments might have on other cost-based rate structures such as Medicaid payments in some states.

In July 10 HHS FAQs, HHS also indicated that these PRF payments do 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>.

Q. Is a tax-exempt health care provider subject to tax on a payment it receives from the Provider Relief Fund?

Answer: 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>.

Q. What should I consider before signing the Payment Relief Fund Terms and Conditions?

Answer: See the section above titled, “Before You Attest: Questions Providers Should Consider Before Agreeing to Terms & Conditions and Using the Money”

Q. If I take no action within 90 days of receipt of the funds related to the attestation of the Payment Relief Fund Terms & Conditions, what happens?

Answer: The [HHS FAQ](#) indicates that all providers receiving funds, “are required to sign an attestation if they wish to keep the funds.” The terms and conditions documents clearly state, “If you receive a payment from funds appropriated in the Public Health and Social Services Emergency Fund for provider relief (“Relief Fund”) under Public Law 116-136 and retain that payment for at least 90 days without

contacting HHS regarding remittance of those funds, you are deemed to have accepted the following Terms and Conditions.” Therefore, providers who fail to attest within 90 days and retain the funds will be assumed to have accepted the terms and conditions. Providers wishing to attest or reject the payments should use the [Attestation Portal](#).

Q. What accountability is there for this program?

Answer: HHS must report to the House and Senate Committees on Appropriations no later than 3 years following the final payments. This report shall outline the OIG’s audit findings with respect to the program. The HHS Secretary must also report to these committees within 60 days of the enactment of the CARES Act and update the committees every 60 days thereafter until all the funds are spent.

Q. If my organization receives more than one round of Provider Relief Funds, do we need to sign an attestation for each pot of funds?

Answer: YES. All providers must attest for each payment they receive from the Provider Relief Fund as there are separate terms and conditions for each payment. All providers receiving a General Distribution payment must also submit financial data to HHS through the [General Distribution Portal](#). For more information about the types of information to be submitted, providers should review the [HHS FAQs](#).

Q. How are the two sets of General Distribution Terms & Conditions different?

Answer: Providers need to attest separately for each payment they have received from the Provider Relief Fund, as the terms and conditions are “slightly different” according to information received from HHS on April 24, 2020. Terms and Conditions for each round of funds can be found [here](#).

The Terms & Conditions for the second round of General Distribution funds include the following additional items:

- 1) providers cannot be currently precluded from receiving Medicare advantage or Part D payments;
- 2) providers must submit general revenue data for calendar year 2018 to the Secretary when applying to receive the funds or within 90 days of having received a payment;
- 3) Providers must consent to HHS publicly disclosing the payment amount the provider may receive from the Relief Fund knowing that other parties may be able to derive the provider’s gross receipts or sales, revenue or other information from this disclosure; and
- 4) Providers must certify that all information the provided by the recipient of the funds is true, accurate and complete to the best of their knowledge.

Upon review of the Terms and Conditions for the SNF Targeted Distribution, LeadingAge observed no differences of consequence. However, members are encouraged to review all Terms and Conditions prior to agreeing to them.

Q. Which type of supporting documentation should I submit if I am an institution without IRS filings?

Answer: Providers submitting information as part of a General Distribution payment asks for: 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. For tax

exempt organizations they must file a Form 990 and trusts must submit a Form 1041. For additional details on the information required to be submitted or other tax situations, please consult the [HHS FAQs](#) as this information is constantly being updated.

The best source of information for applicants for the Medicaid Distribution is to consult the:

- [Instructions for applying for the Medicaid Distribution](#)
- [Application form for the Medicaid Distribution](#)

Q. Is my organization required to submit financial information in order to keep the second round of General Distribution Funds? What are the advantages of submitting this information?

Answer Yes, and by submitting the financial information the provider becomes eligible to receive future distributions from the General Distribution of the Provider Relief Fund. These additional funds will be distributed as quickly as possible from when the provider submits the additional financial information through the General Distribution Portal. HHS has indicated it will be processing applications for the additional funds in batches every Wed at 12noon ET. Funds will not be disbursed on a first-come-first served basis; applicants will have equal consideration for additional funds regardless of when they apply.

Q. Which lost revenues can an organization with multiple business lines under a single TIN, like SNF, AL, HH and IL, report?

Answer: HHS clarified June 9 that providers such as Life Plan Communities and other provider organizations whose TIN covers multiple business lines can report lost revenues for all business lines under the same TIN that are actively caring for patients with COVID-19 or actively working to prevent the spread of COVID-19. Providers must use any payments received from the Provider Relief Fund consistent with associated Terms and Conditions.

Q. If I have not received funds yet, do I use the Provider Relief Fund Application Portal to receive funds?

Answer: No, providers who did not receive any funding as of 5p ET on Friday, April 24 are NOT eligible to use this portal. If you enter your tax identification number(TIN) into it, you will receive a message saying your it is not eligible. This portal is only for providers who have already received funds to submit financial information.

However, just because your organization did not receive general distribution funds, it may still be eligible to receive payments from the Provider Relief Fund through other mechanisms. As of May 22, HHS continues to grapple with how to identify and get funds out to Medicaid-only providers and other (non-Medicare) providers. Some Medicaid only nursing homes did receive a targeted distribution on May 22

Q. If our organization sought charitable contributions from donors to assist with COVID-19 expenses, do we need to count our additional COVID-19 expenses and lost revenues against these funds first, given the language in the terms and conditions that says, "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 obligate to reimburse." Or does this only apply to funds from the federal or state government?

Answer: LeadingAge has submitted this question to HHS for further guidance. At this time, providers are advised to track all COVID-19-related expenses and lost revenues as some may not be eligible for the

Provider Relief Fund. Providers, in the interim, may want to carefully consider how they approach their charitable solicitations in the event that they may need to be expended prior to using Provider Relief Funds.

Q. Are assisted living providers eligible to receive relief from the PRF?

Answer: Assisted living providers who bill Medicaid or Medicaid Managed Care or are paid under a Medicaid waiver are eligible to apply for the Medicaid/CHIP Distribution, as long as they are not part of TIN that already received a General Distribution from PRF. In addition, HHS has indicated a future distribution to assisted living providers who are neither Medicaid nor Medicare is also in the works but no further details are available at this time. LeadingAge will share information about an Assisted Living Distribution as soon as it is available.

Q. Are nursing homes that are exclusively private pay eligible to receive any of the PRF dollars?

Answer: LeadingAge has been advocating for private pay nursing home and assisted living providers to also receive payments from PRF, as they are also serving individuals with possible cases of COVID-19 and trying to prevent or prepare for COVID-19. HHS continues to endeavor to identify these providers and validate their situation in order to be able to distribute funds.