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Overview and Access Guide for Behavioral Health Providers Seeking Provider Relief Funding from HHS Allocation to Medicaid Providers

On June 9, the U.S. Department of Health and Human Services (HHS) announced the allocation of $15 billion in funding to be distributed to **Medicaid/CHIP providers who did not receive a payment from the $50 billion General Distribution.** In addition to behavioral health and opioid treatment providers, pediatricians, OB/GYNs, assisted living facilities, and other home-and community-based service providers may be eligible for funding. The below table summarizes the funding allocations, eligibility requirements, and the process to apply. Medicaid/CHIP providers must apply no later than **August 3, 2020. We encourage all Medicaid providers that may be eligible to begin the application process as soon as possible by submitting their Tax Identification Number (TIN) through the CARES Act Provider Relief Fund Attestation Portal.**

Medicaid Allocation	Requirements for Eligibility	How to Apply
***Funding amount**: At least* 2% of reported gross revenues from patient care ***Deadline**:* The deadline to apply is August 3, 2020; payments made on a rolling basis	**Applicants must meet all six of the following criteria:** 1. Must **not** have received payment from the $50 billion General Distribution of the Provider Relief Fund – *Providers who received even a de minimis amount of funding from the General Distribution are not eligible to receive funding from the Medicaid Distribution. Providers would have received an automatic payment from HHS on or around April 10 or April 17.* 2. Must have directly billed, or owned a subsidiary that billed, Medicaid for healthcare-related services during the period of January 1,2018, to December 31, 2019 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 4. Must have provided patient care after January 31, 2020 5. Must not have permanently ceased providing patient care directly, or indirectly, through included subsidiaries	**Providers apply through the CARES Act Provider Relief Fund Payment Attestation Portal.** Eligible providers should review the HHS Medicaid Provider Distribution Instructions and application form to gather the appropriate documentation. The first step of the application process is to submit the provider's TIN for HHS to validate. ***Providers must complete this step by August 3; if the provider receives results of that validation after August 3, they will still be able to complete and submit their application.*** If the provider does not receive an email regarding its TIN validation within 13 days of submission, the provider should contact the Provider Support Line (see below).[i] **To complete the application, providers will need to upload the following documentation to the application form:** 1. 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

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	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	tax return (e.g., the applicant is a state-owned hospital or clinic) 2. 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., the applicant has no employees) 3. FTE Worksheet, available **here** 4. If required (i.e., for providers with a gross revenue adjustment), the Gross Revenue Worksheet, available **here** **Within 90 days of receipt of payment**, sign the attestation confirming receipt of the funds and agree to the Terms and Conditions. *If you are having issues with the Application Portal, please contact the **Provider Support Line**, open Monday through Friday from 8 am to 11 pm Eastern Time: (866) 569-3522; for TTY dial 711.*

Ongoing Guidance about Use of Funds and Other Information

Generally, Provider Relief Fund payments are meant to reimburse eligible healthcare providers for expenses or lost revenues attributable to COVID-19 and not reimbursed by other funding sources. HHS continues to provide additional information about use of and accounting for Provider Relief Funds via its regularly updated FAQs. These FAQs address all of the Provider Relief Fund allocations issued to date, including those

directly related to the Medicaid distribution. The "Provider Relief Fund General Information FAQs" and "Medicaid Targeted Distribution" sections currently house FAQs and HHS guidance pertinent to the Medicaid distribution. Providers should check back regularly for updates.

Ongoing Reporting Requirements

HHS has stipulated that providers who receive funding from the Provider Relief Fund will be required to maintain records and cost documentation related to this funding and that HHS may in the future request reports or validating information.

The Terms and Conditions that accompany each of the Provider Relief Fund distributions further state that any entity that receives more than $150,000 total in funding from federal coronavirus funds (including from the CARES Act, 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, will be required to submit a quarterly report to HHS on use of funds in accordance with Federal funding accountability rules. The Terms and Conditions stipulate that these reports will be due no later than 10 days after the end of each calendar quarter. On May 6, via its Provider Relief Fund FAQs, HHS had indicated that these reporting requirements would begin for the calendar quarter ending June 30.

However, on June 13, HHS posted a new FAQ clarifying that providers who receive distributions from the Provider Relief Fund in an amount greater than $150,000 will not have to submit the additional quarterly report (as outlined above). HHS is posting the names of Fund recipients and their payment amounts on a public facing website and expects to also be able to post the aggregate total of each recipient's attested to Provider Relief Fund payments. HHS indicates these actions will satisfy the CARES Act reporting requirement on behalf of recipients.

In the new FAQ, HHS also states that providers will still be required to submit information on how providers use the Provider Relief Funds. HHS will be issuing further guidance on the format and timing of this requirement.

Questions or comments? Send them to the NYC COVID-19 Resource Center at COVIDProviderSupport@cityhall.nyc.gov.

[i] HHS has generated a "curated list" of known Medicaid/CHIP providers, using information provided by state Medicaid agencies and information available in the Transformed Medicaid Statistical Information System (T-MSIS). For more information, see HHS's FAQs.