Provider Relief Fund Phase 3 Distribution and Reporting Requirements
Frequently Asked Questions (FAQs)

Updated November 2, 2020

Overview

On October 26, Manatt hosted a webinar for New York City providers regarding two important Provider Relief Fund updates:

- The opportunity to apply for Provider Relief Fund payments via the $20 billion Phase 3 General Distribution; and
- What is known at this time about the reporting requirements Provider Relief Fund payment recipients will need to meet.

This document includes FAQs sent to Manatt by New York City providers regarding each of these topics. We also distributed an access guide with an overview of key information and resources, and the webinar recording is available here.

Should you have questions not addressed in this FAQs document, please send them to COVIDProviderSupport@cityhall.nyc.gov. For assistance applying for Phase 3 of the General Distribution, please contact the Department of Health and Human Services' Provider Relief Fund Support Line at (866) 569-3522; for TTY dial 711. Hours of operation are 8:00 am – 11:00 pm ET, Monday through Friday.

We note that HHS continues to update guidance regarding the Provider Relief Fund application process and reporting requirements. Providers should monitor the following HHS Provider Relief Fund webpages for updates:

- The "For Providers" page. HHS often posts announcements/updates about funding here.
- The "Reporting and Auditing" page. HHS posts reporting guidance here.
- The Provider Relief Fund FAQs. HHS indicates in this document when questions are modified or added by dating each individual question.

FAQ

General Distribution Phase 3

General Questions

1. **Is this funding opportunity a NYC or an HHS opportunity?**
   This is a federal funding opportunity, administered by the U.S. Department of Health and Human Services.

Eligibility

2. **Can you define which providers are eligible? We are a Community Based Organization that connects low income residents to providers, and we provide on-site behavioral counsel. This is a relatively small part of our business.**
   As of this writing, HHS application instructions indicate that providers must meet the below-listed eligibility criteria. On October 22, HHS announced that it was further expanding the pool of Phase 3

applicants to include a wide range of eligible providers regardless of whether they accept Medicare or Medicaid. If you meet the eligibility criteria below *and/or* are one of the named provider types in HHS' October 22 announcement, you should apply.

Eligibility Criteria

Applicants must meet at least **one** of the following criteria:

- Billed Medicaid/CHIP programs or Medicaid managed care plans for health-related services between January 1, 2018 and March 31, 2020
- Billed a health insurance company for oral healthcare-related services as a dental service provider as of March 31, 2020
- Be a licensed dental service provider as of March 31, 2020 who does not accept insurance and has billed patients for oral healthcare-related services
- Billed Medicare fee-for-service during the period of January 1, 2019 and March 31, 2020
- Be a Medicare Part A provider that experienced a CMS approved change in ownership prior to August 10, 2020
- Be a state-licensed/certified assisted living facility as of March 31, 2020
- Be a behavioral health provider as of March 31, 2020 that has billed a health insurance company or who does not accept insurance and has billed patients for healthcare-related services as of March 31, 2020
- Received a prior targeted distribution

Applicants also must meet **all** of the following requirements:

- Filed a federal income tax return for fiscal years 2017, 2018, 2019 if in operation before January 1, 2020 *or* be exempt from filing a return
- Provided patient care after January 31, 2020 (note: patient care includes health care, services, and support, as provided in a medical setting, at home, or in the community)
- Did not permanently cease providing patient care directly or indirectly
- For individuals providing care before January 1, 2020, have gross receipts or sales from patient care reported on Form 1040 (or other tax form)

3. As a home care agency, we already received about 2% of revenue in August. Should we apply again in this Phase 3 opportunity?

Yes, you likely should apply. Providers that already have received a payment amounting to 2% of net patient revenue may be eligible for an "add-on" payment, based on information they submit regarding the financial impact (operating revenues and expenses from patient care) of COVID-19 on their business in January through June 2020.

4. If you did not receive the 2% of net patient revenue payment to date, what is the criteria for eligibility?

Eligibility criteria does not differ for providers that already received General Distribution payments amounting to 2% of net patient revenue. Eligible providers that have received Provider Relief Fund payments and eligible providers that have not received General Distribution payments to date are eligible.

5. **We have an Adult Day Care that was totally closed down. Should we still apply (if we look only at the Adult Day Care part, it was closed)?**
   Yes, you likely should apply. So long as the Adult Day Care did not *permanently* cease providing patient care, temporarily closing down does not impact your ability to apply for funding.

6. **We are a small 501(c)3 mental health organization serving firefighters. Do we qualify for the Phase 3 Distribution?**
   Behavioral health providers are eligible (provided all eligibility criteria are met). However, your payment will be assessed based on operating revenues from patient care, which is payments received for the delivery of health care services directly to patients. If you do not bill patient insurance (Medicare, Medicaid, CHP, and/or private insurance) *and* you do not bill patients directly for services, you may not have any operating revenues from patient care to report (and therefore may not be eligible for payment). You should call the Provider Support Line to clarify.

7. **If I have received funding from HHS on either April 10th or the 17th, then am I eligible for this funding?**
   Yes, you may be eligible for funding regardless of whether you received a Phase 1 of Phase 2 General Distribution payment from HHS.

Application Information and Process

8. **Some providers are having trouble getting their TIN # validated prior to the deadline. What should they do?**
   On October 28, HHS clarified:
   - Providers that have received an automatic General Distribution payment from HHS (which would have occurred in April) or have had their TIN validated through the Phase 2 application process must submit their *complete application* by 11:50 pm ET on November 6, 2020.
   - Providers that have *not* received a General Distribution payment from HHS must submit their *TIN for validation* by 11:50 pm ET on November 6, 2020. These providers will have until November 27, 2020 at 11:50 ET to submit an application (following TIN validation).

   HHS has indicated that TINs that cannot be validated will not receive funding. All providers should submit their TINs as soon as possible, to give HHS as much time as possible to resolve any potential TIN validation issues prior to the application deadline.

   If a provider has submitted their TIN for validation and has not heard back from HHS, the provider should contact HHS via the Support Line.

9. **We already received funding from Phase 2 of the General Distribution. Is another validation is not necessary?**
   You should still submit your TIN, but can expect to receive an automatic TIN validation since HHS already has completed the TIN validation process. Nonetheless, the least risky approach for all providers is to submit their TINs for validation as soon as possible.

10. **Where can I find the list of TIN providers that are already recognized for purposes of TIN validation?**
    HHS has not made publicly available the list of "recognized" TINs for its use in validating TIN numbers. The only way providers can know whether they are on the list is to submit their TIN for validation.

11. **We submitted our TIN for validation months ago and still have not received anything; what should we do?**
    Phase 3 of the General Distribution was not available at that time; you likely submitted your TIN for Phase 2 of the General Distribution, which has since closed. You should submit your TIN for Phase 3 of the General Distribution and, if you do not hear back from HHS regarding your TIN validation, contact HHS via the Provider Support Line. Once TIN validation is received, you will need to submit the application for Phase 3.

12. **We sent in our tax returns for 2017, 2018, and 2019 for a previous Provider Relief Fund application. Do we have to submit this information again for Phase 3?**
    You may need to resubmit this information and should have it ready to submit as part of your Phase 3 application.

13. **We received a payment in Phase 2 of the General Distribution. It seems like the information HHS is requesting in Phase 3 is very similar to the information in Phase 2. Is the primary difference that we are sending operating expenses and revenues information for Q1 and Q2 2020 instead of just April and May 2020?**
    Payments in Phase 2 of the General Distribution were based on 2% of annual net patient revenue (not just revenue in April and May, although HHS had providers submit this information). In Phase 3, HHS is introducing a new potential payment.

    HHS' first step in Phase 3 will be to assess whether the provider applicant has received General Distribution payment(s) amounting to 2% of annual net patient revenue and, if not, issue a payment to the provider for the 2% of annual net patient revenue less any General Distribution payments that the provider has received and accepted to date. HHS' second step will be to assess whether to give the provider an additional "add-on" payment—above and beyond the 2% of annual net patient revenue amount. That "add-on" payment will be based on how COVID-19 financially impacted your practice in Q1-Q2 2020 (January to June 2020).

14. **Is there a way for Nursing Facilities that changed ownership after 3/31/2020 to apply? The guidance only addresses changes in ownerships through 3/31/2020.**
    It seems likely that you would be able to apply; however, the instructions are not clear with respect to eligibility for entities that were providers of care between January 1 and March 31 but have since had a change in ownership. We suggest contacting the Provider Relief Fund Support Line.

    Note: the way HHS treats any funds that may have been paid to the previous owner are addressed in the Provider Relief Fund FAQs (see the chart under "Change of Ownership").

15. **Should we submit this application before our application for FEMA reimbursement? I think FEMA is the funder of last resort, but if the HHS Phase 3 doesn't get reconciled until next July, I am wondering if we should be applying and submitting to FEMA in the meantime.**
    FEMA recently issued interim guidance clarifying, for all work effective September 15, Public Assistance (PA) program funding should not be considered funding of last resort, as was historically

the case. Instead, the guidance encourages applicants to consider PA program funding concurrently with other federal agency programs and services.

Provider Relief Fund payments are generally more flexible than FEMA funding, and may be a preferred source of funding because the payments are made prospectively. Providers should assess whether, based on the October 22 reporting guidance, they are likely to apply all of their Provider Relief Fund payments to lost revenues projected through June 30, 2021.

Providers that have limited lost revenues (as defined by the guidance) may want to spend Provider Relief Fund dollars on COVID-19-attributable expenses prior to seeking funding from other sources. Conversely, providers with COVID-19 attributable expenses that, in combination with lost revenue, exceed Provider Relief Fund dollars may want to consider applying for other sources of funding, such as FEMA.

Payment

16. When will awards be announced?

HHS is taking the following steps to issue up to two payments to each Phase 3 provider applicant:

- HHS will first determine whether the provider has received via the General Distribution payment(s) of at least 2% of annual net patient revenue. If the provider has *not* received payment(s) totaling 2% of annual net patient revenue, HHS will on a rolling basis issue a payment to the provider amounting to 2% of annual net patient revenue, *less* any previous General Distribution payment. (For example, if 2% of a provider's net patient revenue is $15,000 and the provider received $1,000 via an automatic payment in April and no further General Distribution payment since then, the provider will receive $14,000).

- *After all 2% of net patient revenue payments have been made,* HHS will use the remainder of the $20 billion in funding to determine which providers will receive "add-on" payments and the amount of those payments. HHS has not yet announced the timing for those payments, but providers can expect that these payments likely will not be issued until after November 27, 2020 (when *all* provider types' applications are due, as described in Question 8).

17. Does private pay count as patient revenue?

Yes. HHS defines operating revenues from patient care as "revenues that represent amounts received for the delivery of health care services directly to patients. Operating revenues from patient care includes revenues for patient services delivered and pharmacy revenue derived through the 340B program. This amount should exclude non-patient care revenue such as insurance, retail, or real estate revenues (exception for nursing and assisted living facilities' real estate revenue where resident fees are allowable); pharmacy revenues (exception when derived through the 340B program); grants or tuition; contractual adjustments from all third party payors; charity care adjustments; bad debt; any gains and/or losses on investments, and any prior Provider Relief Funds received."

18. **Our home care agency is a hospital-based organization. The hospital received Phase 1 monies. Do I need to check if our information was on their application for funds before we submit an application?**
    Yes, you should coordinate with the hospital.

19. **We are a social adult day program paid by MLTC's --are we eligible?**
    Yes, you likely are eligible (provided all eligibility criteria, such as being in good standing are met).

Provider Relief Fund Reporting Requirements

General Questions

20. **Didn't HHS change the definition of lost revenue on October 22?**
    Yes. On October 22, HHS issued updated guidance and a memo explaining the updates it was making. Generally, the October 22 guidance defines lost revenue as the year-over-year actual change in operating revenues from patient care between 2019 and 2020. The now-rescinded September 22 guidance used a definition that essentially compared net profits, rather than revenues, between 2019 and 2020.

21. **I called the Provider Relief hotline and asked if there was a format available to make our reports. At that time, there was no answer.**
    HHS has not yet published a template demonstrating the exact format in which providers will be expected to report information to HHS on February 15, 2021 (when the first reports are due to HHS). HHS has indicated that the reporting system will become available to providers on January 15, 2021. Providers should continue to monitor the HHS Reporting and Auditing page for updates.

Revenues and Expenses to Include in "Expenses Attributable to Coronavirus Not Reimbursed by Other Sources" and "Lost Revenues Attributable to Coronavirus"

22. **Should we include payments that we made for COVID testing to labs?**
    You could include payments made to labs for COVID-19 testing as an expense attributable to COVID-19 not reimbursed by other sources, so long as you were not reimbursed for the lab testing.

23. **If a health center had a significant drop in revenue due to COVID but also cut expenses - does that affect the amount of funding that may be received or need to be returned?**
    Whether you need to return funding will depend on several variables. However, because HHS, per the October 22 guidance, is examining year-over-year operating revenues (and not net profits) from patient care, you are likely able to apply PRF payments to lost revenue.

24. **Is there a detailed listing of reimbursable expenses documented anywhere?**
    There is no definitive list, but there is some helpful guidance. HHS has provided a general overview of the types of expenses that could be considered expenses attributable to COVID-19 in the October 22 reporting guidance. Importantly, however, providers should only include expenses *attributable to COVID-19*. A good rule of thumb is to ask yourself whether the expense would have existed had COVID-19 not occurred. If "yes," then the expense likely is not attributable to COVID-19. If "no," the expense likely is attributable to COVID-19. If "partially," providers may need to

identify the difference between the expense in 2020 and the expense in 2019; HHS expands upon this issue in the "Auditing and Reporting Requirements" section of the Provider Relief Fund FAQs.

25. How will PPP funds affect the PRF allocations? Is there something to know about how to document this?

HHS suggests in its October 22 reporting guidance that providers should subtract non-Provider-Relief Fund COVID-19 relief payments, including Paycheck Protection Program payments, from lost revenue (i.e., it should be treated as a revenue, allowing providers only to apply Provider Relief Fund payments to lost revenues not offset by PPP and other payments). However, in recent updates to the "Auditing and Reporting Requirements" section of the Provider Relief Fund FAQs, HHS also notes that other relief payments should be subtracted from the calculation of expenses attributable to COVID-19. HHS will need to further clarify exactly how other sources of relief funding will be factored into the equation. Until more information is available, providers should assume that—regardless of exactly how the payments are netted out—HHS will assess other payments when determining whether providers owe a portion of their Provider Relief Fund payment back to HHS.

In other words, if the other funding you have received, combined with Provider Relief Fund payments, exceeds your lost revenues and expenses attributable to COVID-19, you may need to return funding to HHS.

26. We have education programs with grants and tuition. Should we exclude them from patient care revenues and expenses?

Yes. HHS specifically indicates that grants and tuition should be excluded.

27. If nursing facilities were acquired after 6/30/2020, all the revenue inputs would be 0 unless reporting prior owner revenue. What should they report?

For purposes of the Phase 3 distribution application, HHS will consider lost revenues in Q1 and Q2 2020 (based on a comparison of these revenues to revenues in the same time period in 2019). If a provider does not have lost revenues in this period, they should not report any lost revenues in the application.

Separate from the Phase 3 distribution application, HHS is requiring all providers that received aggregate Provider Relief Fund payments of $10,000 or more[1] to submit a report regarding their use of funds: (1) by February 15, 2021, regarding 2020 use of funds; and (2) by July 31, 2021, regarding January 1, 2021 through June 30, 2021 use of funds.

28. We have an increase in revenue but also a significant increase in expenses. Is that lost revenue?

Under the October 22 reporting guidance, HHS will compare 2020 actual revenue from patient care to 2019 actual revenue from patient care. If 2020 revenue is higher than 2019 revenue, the provider will not be able to apply Provider Relief Fund dollars to lost revenues. *However,* the provider may still use the Provider Relief Fund for expenses attributable to COVID-19.

29. Acute Care Facilities could not allow new admissions for many months. Can this be counted as lost revenue?

Under the October 22 reporting guidance, HHS will compare 2020 actual revenue from patient care to 2019 actual revenue from patient care to determine lost revenue. Not allowing new admissions

[1] The Nursing Home Infection Control distribution is not counted.

for several months in 2020 likely would result in significantly less revenue from patient care in 2020 than in 2019—which would be counted as lost revenue.

30. To prove there is the lost revenue, do you need to provide year-to-year revenue comparisons?
The exact information that HHS will require providers to submit will be clearer in January, when HHS launches the reporting portal. However, regardless of what information providers are required to submit in the reporting template, providers should be prepared to demonstrate their calculations with financial records.

31. As a small home care agency, we experienced a number of COVID related client deaths - does that qualify as loss of revenues?
Under the October 22 reporting guidance, HHS will compare 2020 actual revenue from patient care to 2019 actual revenue from patient care to determine lost revenue. Providers do not need to justify why the change in revenue occurred (it could be due to deaths, due to fewer well visits, or any number of changing dynamics). In summary, if the home care agency received less revenue from patient care in 2020 than in 2019, it would have lost revenues.

32. You mentioned that the supporting document for the loss of revenue needs to include the PPP funding received. How do we break down the full PPP funds to proportionately fit into Qtr. 1 & 2 in 2020?
The reference to supporting documents during the webinar related to the Phase 3 application—which requires providers to submit revenues and operating expenses from patient care in January-June of 2019 and 2020. Providers are not asked to submit information about PPP funds in the application.

The reports regarding use of any Provider Relief Fund payments, which require providers to report other sources of assistance received, are not limited to the first and second quarters of 2020.

Other Provider Relief Fund Questions

33. Is there an update on when the nursing home infection control fund will be released?
HHS issued nearly $2.5 billion in Nursing Home Infection Control payments in August and indicated that it planned to issue approximately $2 billion in payments based on certain performance indicators that it planned to share in the future. Since then, HHS announced that it plans to make payments on a monthly basis beginning in October 2020 and ending in February 2021 (5 payments total), as shown in the table below.

Performance Period	Tentative Payment Date	Tentative Audit Date
September 2020 October 2020 November 2020 December 2020	October 2020 November 2020 December 2020 January 2021	November 2020 December 2020 January 2021 February 2021
Aggregate	February 2021	March 2021

On October 28, HHS announced that it has begun making the first performance payments. For more

information about the performance requirements, see the question titled “How is the $2 billion incentive payment to skilled nursing facilities being determined?” under “Allocation for Skilled Nursing Facilities” on HHS’ Provider Relief Fund General Information page.