Provider Relief Fund Overview and Access Guide

Updated November 2, 2020 – Includes Modifications Based on October 22 HHS Guidance and October 28 FAQs

In the past several weeks, the U.S. Department of Health and Human Services (HHS) has announced two significant Provider Relief Fund updates.

I. New $20 Billion Phase 3 General Distribution of the Provider Relief Fund

This new distribution is available to a wide range of providers of patient care, including:

- Medicare, Medicaid, Child Health Plus (CHP), dental, assisting living facility, and behavioral health providers *regardless of whether they previously received, accepted, or rejected General Distribution payments*. HHS also recently announced that many provider types will be eligible *regardless of whether they bill Medicare, Medicaid, or CHP.*
- Providers that were previously excluded from General Distribution payments, including:
  - Certain behavioral health providers, such as addiction counseling centers, mental health counselors, and psychiatrists.
  - Providers that began practicing between January 1, 2020 and March 31, 2020.

This distribution is meant to:

- Ensure that all eligible providers receive *at least* a 2% of net patient revenue payment; and
- Provide *add-on payments* (above 2% of net patient revenue) to selected providers based on the financial impact of COVID-19.

See pages 2-6 for additional information about who is eligible, how to apply, and what is known about the payment methodology. HHS encourages applicants to apply as soon as possible; **applications are due November 6.**

II. Reporting Requirements for Recipients of More than $10,000 in Aggregate Provider Relief Fund Payments

HHS also published guidance about the reporting obligations of providers that receive more than $10,000 in aggregate Provider Relief Fund payments. The reporting guidance:

- Outlines reporting deadlines and expectations; and
- Defines eligible uses of Provider Relief Fund payments. Federal law requires Provider Relief Fund payments to be used for (1) expenses attributable to COVID-19 and (2) lost revenues attributable to COVID-19. HHS clarifies the definition of "lost revenues" and how it will determine whether providers must return any funding.

See pages 7-9 for additional information about these deadlines and implications of the new "lost revenues" definition.

I. New $20 Billion Phase 3 General Distribution of the Provider Relief Fund

1) Am I eligible for Phase 3 funding?

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 eligible Phase 3 applicants to include not only these provider types, but also a wide range of eligible practices *regardless of whether they accept Medicare or Medicaid.* If you meet the eligibility criteria below *and/or* are one of 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)

Provider Types Enumerated by HHS as Eligible *Regardless of Whether They Accept Medicare or Medicaid*:

- Behavioral health providers
- Allopathic & Osteopathic providers
- Dental providers
- Assisted living facilities
- Chiropractors
- Nursing service and related providers
- Hospice providers
- Respiratory, developmental, rehabilitative and restorative service providers
- Emergency medical service providers
- Hospital units
- Residential treatment facilities
- Laboratories
- Ambulatory health care facilities
- Eye and vision service providers
- Physician assistance and advanced practice nursing providers
- Nursing and custodial care facilities
- Podiatric medicine and surgery service providers

2) How will HHS determine my payment amount?

HHS plans to take the following steps:

- **STEP 1:** First, HHS will ensure that all eligible providers that apply for funding in Phase 3 receive a 2% of patient revenue payment. Providers' payments resulting from this step will equal 2% of patient revenue *less* any General Distribution Provider Relief Fund payments received to date. For example, if 2% of a provider's net patient revenue is $10,000 and the provider automatically received a General Distribution Phase 1 payment of $2,000 in April and no further General Distribution payments since that date, the provider can expect to receive $8,000.

- **STEP 2:** After calculating Step 1 payments, HHS will use the remaining balance of the $20 billion budget to calculate add-on payments that consider the following three factors:
    - A provider's change in operating revenues from patient care
    - A provider's change in operating expenses from patient care, including expenses incurred related to coronavirus
    - Payments already received through Provider Relief Fund distributions[1]

  HHS has not provided the exact methodology it will use to calculate payments in Step 2. HHS indicates that it will use the above information to pay providers a to-be-determined percentage of their change in operating revenues from patient care minus their operating expenses from patient care, and also will "take into account" other Provider Relief Fund payments. HHS seems to be seeking to assess the degree to which any other

[1] A summary of Provider Relief Fund distributions issued to date is available here.

Provider Relief Fund payments the provider has received have offset the provider's lost revenues and expenses resulting from COVID-19.

The ultimate distribution of payments will depend on the exact methodology HHS employs to calculate payments and the applicant pool.

For providers that began providing patient care in 2020, HHS indicates that the payment will be "approximately 2% of patient care revenue" based on the applicant's reported financial information for those months in 2020 that they were in operation.

3) When should I apply?

As soon as possible. Even if you have not yet prepared the information needed for your application, start by submitting your TIN for validation. The Provider Relief Fund Application and Attestation Portal is currently open and HHS strongly encourages all applicants to apply as soon as possible.

For providers that have had their TIN validated in Phase 2 or received funds in Phase 1 of the General Distribution, the application deadline is **November 6, 2020 at 11:59 pm ET**. Any entity that has not yet received a General Distribution payment must submit their TIN for validation by **November 6, 2020 at 11:59 pm ET**, and will have until **November 27, 2020 at 11:59 pm ET** to submit their application (which can only be done if the TIN is validated).

4) What if I received Small Business Administration (SBA) and/or Federal Emergency Management Agency (FEMA) payments for coronavirus recovery; am I eligible?

Yes (provided all other eligibility criteria are met). Receiving other assistance does not make a provider ineligible.

5) What if I already received payment(s) from the Provider Relief Fund; am I eligible?

Yes (provided all other eligibility criteria are met).

6) What if I had already started to apply for a Phase 2 General Distribution payment?

The deadline to submit your tax identification number (TIN) for Phase 2 payment occurred on September 13. For providers that received TIN validation after September 13, the deadline to submit their application in full was October 4. Applications that were not completed by the October 4 deadline are voided by HHS. These providers should apply for Phase 3.

7) How do I apply for a Phase 3 General Distribution payment?

- Register and submit your TIN in the Provider Relief Fund Application and Attestation Portal.
    - *If your TIN is "recognized" by HHS*, you will be automatically validated and be notified to complete the application.
    - *If your TIN is not recognized by HHS*, HHS will take three steps to validate your TIN. To validate your TIN, HHS will: (1) share your TIN with third party validators,

including Medicaid/CHIP agencies, dental organizations, national provider organizations, etc. (2) receive results from the third party validator regarding whether the provider is actively in practice, in good standing, etc. (3) accept the determination, update the portal, and notify you that you may re-enter the portal to apply.

- Review the HHS application instructions and sample application form and gather the necessary information and documentation to apply (see question 8 regarding documentation).
- Apply in the Provider Relief Fund Application and Attestation Portal by November 6 or November 27, 2020 at 11:59 pm ET (see question 3 to determine which deadline applies to you).

8) What documentation will I need to provide in my application?

- Most recent federal income tax return for 2017, 2018, or 2019 if in operation before January 1, 2020 *or* quarterly tax returns for fiscal years 2020 if operations began on or after January 1, 2020 *or* a written statement explaining why the applicant is exempt from filing an income tax return (e.g., a state-owned healthcare clinic)
- *If entering an adjusted revenue number* from the applicable number shown on its most recent federal income tax return, a completed revenue worksheet using the HHS Excel template (instructions for completing the revenue worksheet are listed on page 8 of the HHS application instructions, under "Field 15")
- Supporting documents for operating revenues and expenses from patient care in Q1-Q2 2019 (January 1-June 30, 2019) and Q1-Q2 2020 (January 1-June 30, 2020). These documents should substantiate the information provided in response to fields 13 and 14 in the sample application form and may be internally-generated financial statements

Note: On pages 10-11 of the HHS application instructions, HHS provides instructions for providers that are New 2019 Providers (defined as a new entity, with a corresponding new TIN, established in 2019 which began delivering patient care for the first time during the period of January 1, 2019 to December 31, 2019) and New 2020 Providers (defined as a new entity, with a corresponding new TIN, established in 2020 which began delivering patient care during the period of January 1, 2020 to March 31, 2020).

9) Do I need to submit new documentation if I already submitted revenue details for a previous Provider Relief Fund distribution?

Yes. The application has been updated to include additional data entries to calculate payment based on financial impact of COVID-19.

10) How do I apply if I am a subsidiary of a parent entity?

Coordinate with the parent entity to determine next steps. If the applying entity is a parent entity applying on behalf of multiple subsidiaries and it would like each subsidiary to receive its own payment, the applicant should create an Optum ID account and submit an application for

each TIN that should receive its own payment (and include the unique banking information for each TIN).

The parent entity also has the option to apply on behalf multiple subsidiaries and receive a single payment for all of the included subsidiaries; in this instance, the applicant should create one Optum ID account for the parent entity and submit a single application with the filing TIN.

11) Where can I find additional information?

In addition to the HHS application instructions and sample application form noted above, HHS also has been responding to Frequently Asked Questions (FAQs) regarding Phase 3 distribution eligibility, the TIN validation process, and the application process. On page 1, providers can click on "Phase 3" under General Distribution to be taken to the relevant FAQs.

12) What do I do if I am having trouble with my application or have other questions not addressed in the above resources?

Contact the HHS Provider Support Line by dialing 866-569-3522; for TTY, dial 711. It is open Monday through Friday from 8:00 am to 11:00 pm Eastern Time.

13) When will I receive my payment?

HHS will make STEP 1 payments to ensure all eligible providers receive a payment of at least 2% of patient revenue on a rolling basis (see question 2 above). HHS will make STEP 2 payments once all applications have been received and reviewed.

14) What do I do after I receive my payment?

To *accept* the funds, recipients must agree to the Terms and Conditions within 90 days of payment. To *reject* the funds, providers must return the funds within 15 calendar days of the attestation. The attestation process also occurs in the Provider Relief Fund Application and Attestation Portal. Recipients also should review the reporting requirements described below to ensure appropriate documentation of how funds are used.

15) Where can I learn more?

As described above, HHS has prepared application instructions and posted a sample application form to help providers gather the necessary information prior to logging in to the application portal. HHS typically posts updates for providers on this landing page.

In addition, NYC hosted a **webinar**, conducted by Manatt Health, about how to apply and what to expect. The webinar recording is available at https://vimeo.com/472396913/2d81242355.

II. Reporting Requirements for Recipients of More than $10,000 in Aggregate Provider Relief Fund Payments

1) Do I need to report information to HHS about how I have used provider relief fund payments?

If you have received Provider Relief Fund payment(s) greater than $10,000 in aggregate, you must report required information including use of funds and other data elements described in October 22 guidance. (This guidance has been updated from the guidance issued in September; HHS explains the updates here.)

All Provider Relief Fund payments (General and Targeted distributions) count *except* Nursing Home Infection Control distribution payments. Additionally, HRSA COVID-19 Uninsured Program claims reimbursements do *not* count.

2) When do I need to pay attention to the reporting requirements?

Immediately. Even though reports are not due until 2021, providers will need to be carefully accounting for COVID-19 expenses, COVID-19 lost revenues, and other COVID-19 relief payments in compliance with the requirements set out in the guidance.

Providers also will want to assess whether—based on calculation of lost revenues attributable to COVID-19 and expenses attributable to COVID-19—they are likely to be able to keep all of their Provider Relief Fund payments or may need to return funds to HHS.

However, it is important to acknowledge that many details of these calculations are still being worked out by HHS. Providers will want to have a general understanding of what HHS will consider to be lost revenues and expenses attributable to COVID-19, and understand how the sum of those items relates to the amount of Provider Relief Fund payments they have received. If lost revenues and expenses attributable to COVID-19 are less than the amount of Provider Relief Fund and other relief payments received, providers may want to reserve unspent Provider Relief Fund payments and not book it as an asset (acknowledging the potential to need to return some portion of the funding).

3) How does the latest reporting guidance vary from prior reporting guidance from HHS?

Federal law establishes that Provider Relief Fund payments may be used for two purposes: (1) lost revenues attributable to COVID-19; and (2) expenses attributable to COVID-19.

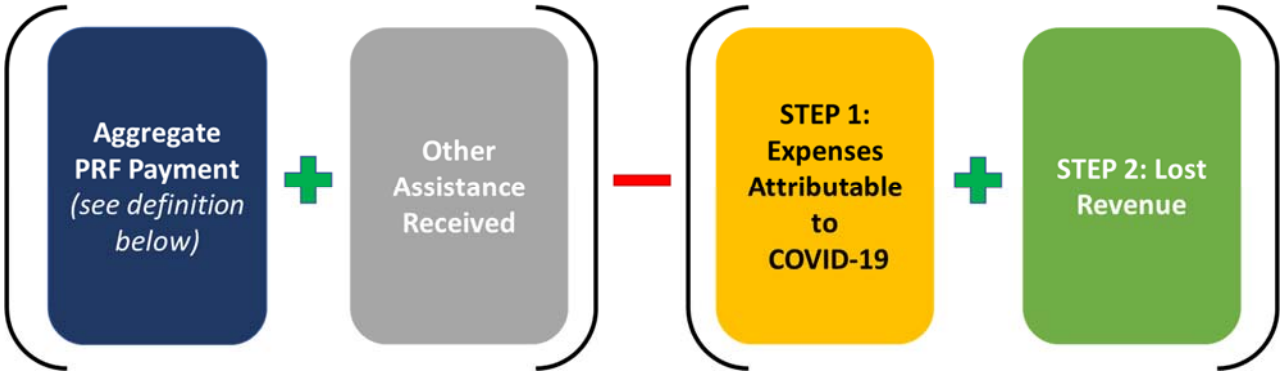
The definition of "lost revenues" has been a contentious topic, particularly following guidance issued by HHS in September that, in essence, changed the definition of "lost revenues" to mean lost profits from patient care. On October 22, HHS issued updated guidance, walking back the September change; in the latest guidance, HHS defines lost revenues as the 2020-to-2019 change in actual revenues from patient care. HHS also subtracts any payments received from other COVID-19 relief sources from the lost revenue calculation.

4) Based on the latest (October 22) guidance, how will HHS assess whether I need to return a payment?

HHS guidance regarding the exact calculation continues to evolve. However, providers can begin to assess the amount of funding (if any) they may need to return by calculating the aggregate PRF payment(s) received by the provider *plus* any other COVID-19 assistance received and subtracting from that amount the sum of (1) expenses attributable to COVID-19 and (2) lost revenue, defined as the 2020-to-2019 change in revenues from patient care.

Note: The current guidance is unclear with respect to how providers should account for the "other assistance" they have received (i.e., whether other assistance—such as Paycheck Protection Program payments—should be netted out of expenses attributable to COVID-19 or lost revenue). In the formula below, we assume that other assistance should be accounted for just once.

Amount of Funding that Must be Returned to HHS =



Aggregate PRF Payment includes General Distribution and Targeted Distribution Provider Relief Fund payments to providers. It does *not* include the Nursing Home Infection Control Distribution or reimbursement from the HRSA COVID-19 Uninsured Program.

Other Assistance Received includes any federal, state, or local coronavirus-related assistance received by the recipient and the other TINs included in its report. This includes, for example, Paycheck Protection Program payments, and other sources of funding described on pages 4-5 of the October 22 guidance.

Step 1: HHS defines **expenses attributable to COVID-19** beginning on the bottom of page 2 of the October 22 guidance. These include general and administrative expenses attributable to COVID-19 (e.g., personnel expenses, fringe benefits) and healthcare expenses attributable to COVID-19 (e.g., PPE and other supplies/equipment) *net* of other sources of funding (i.e., payments from insurance, the HRSA COVID-19 Uninsured Program, and/or patients).

Note: although HHS lists a wide range of general and administrative expense types, it is not yet clear in what instances some of these expense types (such as mortgage and rent) would be considered *attributable to COVID-19* and therefore allowable uses of the Provider Relief Fund. We expect HHS to provide additional guidance on this topic. In the interim, to avoid any question about whether expenses are indeed *attributable to COVID-19*, providers can think of expenses to include as expenses that—were it not for COVID-19—would not exist. Those expenses include, for example, expenses related to separating COVID-19 patients, purchasing PPE, providing fringe benefits, training providers to conduct testing, equipment purchases such as ventilators, and surge capacity related expenses (among others). If the expense would have existed—but would have been less costly prior to the pandemic—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.

Step 2: HHS defines **lost revenue attributable to COVID-19** beginning on page 4 of the October 22 guidance. To calculate lost revenue, providers should calculate the change in 2020 revenue from patient care compared to 2019 revenue from patient care.

2019 revenue from patient care should include Medicare Part A+B, Part C, Medicaid and CHP, commercial insurance, self-pay, and any revenues from other sources of payment for patient care services. The guidance appears to exclude pharmacy revenue *except* 340B revenues which, barring additional guidance, should be included.

2020 revenue from patient care should include all of the same sources of revenue for 2019.

If providers have leftover funds after subtracting the sum of Step 1 and Step 2 and other assistance received from the sum of their aggregate PRF payment amount and other assistance received, they may need to return funding to HHS. Conversely, if providers have expenses attributable to COVID-19 and lost revenue that are equal to or larger than their aggregate PRF payment and other assistance received, they likely will not need to return funding to HHS. Funds must be expended on eligible expenses by June 30, 2021.

5) When are reports due to HHS?

HHS plans to open the reporting system on January 15. **The first reporting deadline is February 15**; on that date, providers will need to submit information regarding 2019 and 2020 expenditures and revenues (along with other demographic information).

For providers with unused funds after December 31, 2020, a second and final report is due no later than July 31, 2021 (regarding financial information for January 1 – June 30, 2021).

6) Where can I find additional information?

HHS' Provider Relief Fund reporting and auditing page includes the latest guidance and HHS has also begun to post FAQs to this page as well as a new "Auditing and Reporting Requirements" section of the Provider Relief Fund FAQs. We expect HHS to continue to publish updated guidance and FAQs and to announce future webinar information. Providers should monitor these pages for updates as they prepare to meet the 2021 reporting requirements.