LeadingAge Provider Relief Fund
Background, Considerations & Frequently Asked Questions

Last Updated: May 18, 2020 at 6 p.m.ET

**What's new: New information added from: 1) updated HHS FAQ published May 14; 2) May 8 Meeting between Katie Smith Sloan and HHS Deputy Secretary Eric Hargan; and 3) May 12 interview with HHS Senior Advisor Nick Uehlecke*

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.

Provider Relief Fund

On March 27, the Coronavirus Aid, Relief, and Economic Security Act (CARES) was passed and signed into law, appropriating $100 billion to a Provider Relief Fund for the COVID-19 pandemic. 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 and announced its plan for a second round which HHS will begin distributing on April 24.

An additional $75 billion was appropriated to the Provider Relief Fund through the Paycheck Protection Program and Health Care Enhancement Act for a total of $175 billion made available to provide relief to health care providers.

Fund Distributions

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." These were made to providers of Medicare services looking at both their 2019 Medicare FFS payments (1st round) and their net patient revenue from their most recent CMS Cost Report (2nd round).

- **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. Some of these will begin being deposited the week of April 27.

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. **UPDATE(5/18)** – This list will be updated biweekly.

As of April 24, there have been two rounds of general distribution payments sent to providers:

NEW – HHS's goal for the $50 billion General Distribution to Medicare providers was to provide roughly 2% of 2018 net patient revenue (as reported on Medicare cost reports) in relief payments to these providers regardless of the provider's payer mix. According to HHS, payments are determined based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April 2020. If the initial General Distribution payment a provider received between April 10 and April 17 was determined to be at least 2% of your annual patient revenue, the provider will not receive additional General Distribution payments but may be eligible for a future Targeted Distribution related to COVID-19.

Total estimated allocation can be calculated using: On the attestation portal, HHS provides the following formula for calculating your estimated total allocation from the $50 billion general distribution:

- Divide your "Gross Receipts or Sales" or "Program Service Revenue" by 2.5 trillion and then multiply by 50 billion. = ((Gross Receipts or Sales) / 2,500,000,000,000) * 50,000,000,000 = Total Allocation (total of first plus second payment)

- **First round of payments distributed between April 10 -17:** $30 billion distributed 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 reimbursements.
  - **Formula for calculating 1st payment:** A provider can estimate their payment by dividing their 2019 Medicare FFS (not including Medicare Advantage) payments they received by $484,000,000,000 and multiply that ratio by $30,000,000,000.

- **Second round of payments distributed April 24:**
  - $20 billion being distributed in payments to Medicare facilities and providers for whom Medicare FFS reflects a small share of their revenue and based off of 2018 cost report data.
    - **Formula for estimating this payment**: Providers can estimate their expected 2nd general distribution payment using the following formula: (Individual Provider 2018 Revenue/$2.5 Trillion) X $50 Billion – Amount of First Payment Provider received = Expected 2nd General Distribution
    - Providers may not receive a second distribution payment if the provider received a first distribution payment of equal to or more than 2% of patient revenue.
  - $10 billion to targeted hospitals in areas particularly impacted by the COVID-19 outbreak (application required)
  - $10 billion for rural health clinics and hospitals (distributions to begin week of April 27)

- $400 million for the Indian Health Service facilities based upon operating expenses. (distributions to begin week of April 27)
- Unspecified amount going to skilled nursing facilities, dentists, and providers that exclusively serve Medicaid recipients.
- An unspecified portion (as announced in early April) will be used to reimburse health care providers at Medicare rates for COVID-19 treatment of uninsured individuals, until funds run out.

Resources

To help our members be prepared for potential future audits, reporting and compliance with these programs, LeadingAge has put together the following items to provide a roadmap:

- **CARES Act Provider Relief Fund Backgrounder, Considerations and FAQ document (**this document) including "Questions Providers Should Consider Before Completing the Attestation and Using the Money" (below)
- **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.

Coming soon we will be sharing supporting tools that will:

- **Assist with funds documentation**: that will help providers identify what items to track related to the Provider Relief Funds to be able to submit future reports to HHS.
- **Clarify HHS expectations** regarding the use of the funds (awaiting reply to LeadingAge CEO Katie Sloan's letter to HHS Secretary Alex Azar)

Timeline

- **April 10:** UnitedHealth Group begins depositing the first $26 billion of Provider Relief Funds into Medicare provider accounts on behalf of CMS 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:**
    - Second round distributions begin going out to hospitals hard hit by COVID-19, rural health clinics and hospitals, and Indian Health Service facilities.
    - Providers can enroll in program to reimburse providers care and services provided to uninsured COVID-19 patients

- **TBD:** Distribution of unspecified dollars to Medicaid-exclusive providers.

- **May 7:** HHS announces extension of the attestation deadline, now 45 days from receipt of payment.

- **May 24**: Deadline for providers to sign attestation or return Provider Relief Fund dollars for those who first received payments on April 10. All other providers have **45** days from receipt of payment.

- **June 7:** Deadline for providers to sign attestation to the terms and conditions for $20 billion distributed to Medicare providers in a second round of payments on April 24 and to upload required financial information through the General Distribution Portal. All other providers who received payments after April 24 have **45** days from receipt of payment.

Providers who received General Distribution payments as of April 24, 5p EST must:

- First submit an attestation agreeing to the terms and conditions for the payments received via the Attestation Portal. See the section on considerations before signing
- Second, after the attestation is submitted, providers must submit tax documents and estimated lost revenue information through a separate General Distribution Portal, which HHS appears to call the "Provider Relief Fund Application Portal "in the HHS General Distribution Portal FAQ document. **UPDATE 5/12--** This step is especially important if a provider only received a first General Distribution payment. It is possible that the provider may be eligible for another payment (s) by providing this additional information.

Attestation

All providers receiving CARES Act Provider Relief Funds must complete the online attestation agreeing to the terms and conditions related to the payment received within **45** days of receiving the funds regardless of whether the provider intends to keep the funds or not. The original timeframe was 30 days, but this was updated to 45 days on May 7 to give providers longer to attest.

Providers need to attest separately for each payment they have received from the Provider Relief Fund, as the terms and conditions are "slightly different" for each round of payments. Terms and Conditions for each type of payment can be found here. The Terms & Conditions for the second round of payments to Medicare providers 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 **45** 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.

HHS Resources

HHS has also put together a CARES Act Provider Relief Fund Application Guide that walks providers through the General Distribution Portal website and a General Distribution Portal FAQ that answers key questions and assists providers in preparing to complete the information required through the General Distribution portal.

Providers who choose to reject the funds must complete the attestation indicating their rejection of the funds. **UPDATE 5/12 -** Providers must return the payments in the way that the payment was received. So, if the payment was received via:

1. **ACH payment**: 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, HHS would like you to contact the UnitedHealth Group's Provider Support Line at 866-569-3522.

2. **Paper check**: If the provider received a payment via 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 ACH payment or check in the memo. UnitedHealth Group Attention: CARES Act Provider Relief Fund PO Box 31376 Salt Lake City, UT 84131-0376

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

These questions and considerations were compiled originally with guidance from **LeadingAge Silver Sponsor, CLA and updated to reflect additional information received from HHS.**

LeadingAge thinks that it will be appropriate for most members to sign the attestation agreement but as we noted in our April 20 letter to HHS Secretary Alex Azar, there are many questions we still need HHS to answer and clarify so we are able to comply. The questions and information below are designed to make sure you've thought through the systems or processes you need to put in place to comply.

To sign the attestation and accept the Terms and Conditions providers must use this link.

- **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"?**

  The terms and conditions don't define the following terms "care" nor "possible cases of COVID-19". The HHS website on the CARES Act Provider Relief Fund states and the General Distribution Portal FAQ from HHS reiterates, however, that "HHS broadly views every patient as a possible case of COVID-19." However, this same statement is not included in the Relief Fund Payment Terms and Conditions document. We have asked for further clarification from HHS on this point and will share updates with members as they become available.

- **Does your organization have "health care related expenses or lost revenues that are attributable to coronavirus?"** **UPDATE -** 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."

  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 has not offered any written guidance on eligible expenses, such as specific types of eligible expenses, beyond the above. In a May 12 call with LeadingAge members, HHS staff indicated that they are hesitant to get too specific on which expenses are eligible because by doing so it can lead to relevant items being excluded. Instead he suggested that all expenses should have a nexus to COVID-19.

  However, HHS has clarified how providers might estimate lost revenues in its General Distribution Portal FAQ. Members have questioned if the lost revenues are limited to those attributable to their Medicare business or apply to all lines of business under the tax identification number. HHS in conversations has hinted that they likely we consider lost revenues and eligible expenses across all lines of business across the TIN but this has not yet been confirmed in writing or HHS's FAQ document.

  Given that HHS is asking for lost revenues from March and April 2020, we anticipate that HHS will seek expenses from a comparable timeframe and dates going forward throughout the duration of the national emergency. This information will likely be collected through a yet-to-be-established reporting process. A first report will be due July 10 for the calendar quarter that runs April – June.

  We think it is likely that many of the additional expenses and lost revenues providers have incurred will be eligible as COVID-19 related, as they were required for prevention and

preparation for the virus but LeadingAge has also asked for additional guidance from HHS. At this point, we would recommend that members track all expenses and lost revenues they believe are related to COVID-19 and as further information becomes available from HHS, providers can sort out those that may not qualify or might be eligible under other funds received.

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

  UPDATE - Beyond the CARES Act reference to the uses for Provider Relief Funds, HHS has not provided little information, in writing, about their expectations related to reporting on their COVID-19 expenses and lost revenue, but reports are required under the Terms & Condition and the CARES Act (See below for more information on reporting). The HHS Senior Advisor hinted that their intent is to take a broad view of these terms as long as there is a nexus to COVID-19. However, at least the U.S. House has introduced a bill, called the Heroes Act, that would potentially limit how much of the revenues will be reimbursed through the PRF but would also add workforce retention and testing costs to the list of eligible expenses, along with additional appropriation to the PRF.

  Until further information is available or action confirmed, CLA has recommended:

  - **Track COVID-19 Expenses**: Staff bonuses, hazard or incentive pay; use of agency staff; personal protection equipment; additional 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 and ineligible items can be excluded after further guidance is issued.
  - Set up **separate general ledger(GL) accounts** and report excess expenses in the GL accounts.
  - **For lost revenue**: According to HHS's General Distribution Portal FAQ , "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:** HHS has not clarified in writing whether the funds must be used exclusively related to Medicare services or apply to all service lines (e.g., SNF, home health vs. assisted living) across the organization receiving funds under a single Tax Identification Number(TIN). HHS has hinted that future FAQs will likely look at eligible expenses and lost revenues across services provided under the TIN receiving the funds. For now, it is recommended to track expenses by payer and provider type pending further written HHS guidance.
  - **Timeframe:** Reports will be required quarterly to HHS and the Pandemic Response Accountability Committee according to the Relief Fund Terms and Conditions. The first report is expected to be due July 10 for funds distributed in April – June 2020. HHS has indicated that it will be issuing further guidance in the future on reporting.

- **What if your organization receives more money through various relief funds than is expended? How is that money to be returned?**

  UPDATE- In its General Distribution FAQ, HHS notes that it generally does not intend to recoup funds as long as a provider's lost revenue and increased expenses exceed the amount of the payment(s) received. It also notes that it reserves the right to audit PRF recipients in the future to ensure that this requirement is met and collect any amounts made in error or where payments don't exceed lost revenues and expenses. The HHS CARES Act Provider Relief Fund website states, "These are payments, not loans, to healthcare providers, and will not need to be repaid." This is reinforced in the HHS FAQ which notes that the funds won't need to be repaid as long as the associated terms and conditions are followed. The CARES Act Relief Payment Terms & Conditions clearly establish an expectation that the funds will only be used for "health care related expenses or lost revenues, that are attributable to coronavirus." See above for the list of eligible expenses outlined in the CARES Act. We would like to emphasize the importance of providers tracking their expenses and lost revenues now to ensure they can document and report this information to HHS and the Pandemic Response Accountability Committee at the prescribed times (see below in FAQs for additional details on reporting requirements) including the rationale for why this is a COVID-19 related expense or how it is was used, "…to prevent, prepare for and respond to coronavirus..."

  Providers who choose to reject the funds must complete the attestation indicating their rejection of the funds. **UPDATE 5/12 -** Providers must return the payments in the way that the payment was received. So, if the payment was received via:

  1. **ACH payment**: 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.

  2. **Paper check**: If the provider received a payment via 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 ACH payment or check in the memo. UnitedHealth Group Attention: CARES Act Provider Relief Fund PO Box 31376 Salt Lake City, UT 84131-0376

- **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 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. 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.

NEW -- Also, it is not clear if this provision also applies to charitable contributions 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?**
  UPDATED - HHS indicates in its General Distribution FAQ 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, no further details are 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 does not appear to be an appeals process.

- **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.)

- **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:** 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. **UPDATED –** In its General Distribution FAQ, HHS states it, "does not intend to recoup funds as long as a provider's lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received." It should be noted that the U.S. House has introduced the Heroes Act which would modify how the Provider Relief Fund operates including only reimbursing up to 60% of lost revenues, changing how lost revenues are calculated and adding new eligible expenses and an additional $100 billion for PRF.

  - **Payback of unused funds: UPDATED –** In both the General Distribution FAQ and in a May 8 meeting with the Deputy Secretary Eric Hargan, HHS has 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:** Future guidance may not include expenses or lost revenues your organization incurred in the HHS definition of eligible expenses and lost revenues, or your incurred expenses or lost revenues may have been incurred outside the yet-to-be-determined timeframe. Nonetheless, you will have a number of expenses and lost revenues that will be counted.

- **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 General Distribution FAQ 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.

- **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.

Applying for 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:** Beginning April 27, 2020, 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.

Frequently Asked Questions (FAQs)

Q. Who qualifies as an "eligible health care provider" to receive Provider Relief Funds?

Answer: According to the CARES Act, an "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." **UPDATED -** $50 billion has been distributed to providers who bill Medicare fee-for-service(FFS) with a goal of providing a General Distribution relief payment that is roughly at least 2% of a provider's 2018 net patient revenue as reported on their Medicare cost reports.

Q. Who should I call if my organization did not receive any funds and we provide Medicare services so believe we are eligible for the funds?

Answer: As of April 24, all providers who provide Medicare services should have received at least one payment from the Provider Relief Fund. For those providers for whom Medicare FFS is a small share of the organization's revenue and who did not receive a payment on April 24, it may be that HHS has insufficient cost report data for your organization to complete this transaction. These providers will need to submit revenue information through the General Distribution Portal. After HHS receives and validates the data, they will be sending out payments weekly to eligible providers on a rolling basis. This should occur within 10 business days

Providers can submit their questions about the funds to: HOSPITALCOVID19@hhs.gov

In addition, HHS has established a **toll-free CARES Provider Relief line** where providers who believe they qualify for a payment from the General Distribution (Medicare providers) but have not yet received one can **call (866) 569-3522** to determine the status of their payments and the amount they will receive.

Additionally more details about the Fund can be found at the HHS CARES Act Relief Fund website.

Q. If a facility received funds but no longer owns the facility, how is the money to be paid back?

Answer: UPDATE (5/6) - More than one facility has run into this scenario because distributions were based off of ownership and Medicare FFS revenues in 2019. In the HHS General Distribution Portal FAQ document, HHS clarifies that If a provider believes it received a payment in error, it should reject the entire General Distribution payment through the Attestation Portal and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment.

Providers must go into the Attestation Portal within 45 days of receiving the payment to reject it. If this is not done within the 45 days, HHS will assume the provider has accepted the payments and the associated terms and conditions.

Providers must return the payments in the way that the payment was received. So, if the payment was received via:

- **ACH payment**: 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.

- **Paper check**: If the provider received a payment via 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 ACH payment or check in the memo. UnitedHealth Group Attention: CARES Act Provider Relief Fund PO Box 31376 Salt Lake City, UT 84131-0376 .

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, the Terms & Conditions also 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. " **UPDATE -** HHS has indicated in its recent FAQ 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. It should be noted that the U.S. House has introduced the Heroes Act that proposes some new parameters for the Provider Relief Fund that would limit lost revenues eligible for reimbursement, adds some additional eligible expenses like testing and workforce retention. So, the program could still evolve further if this or similar legislation is passed.

Q. What are the terms and conditions?

Answer: This is the link to the various Relief Fund Payment Terms and Conditions documents
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" any patient for COVID-related treatment;
- Must report quarterly to HHS and the Pandemic Response Accountability Committee;
- Not 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.

- 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.

It appears that providers can retain the funds while determining which expenses can be paid using these dollars and return any unused portion.

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 my organization is not willing to agree to the terms and conditions or needs to return any portion of the Provider Relief Funds for any reason, how do I indicate that to HHS and what is the process for returning funds?

Answer: UPDATE – All providers receiving funds must go to the Attestation Portal and either agree to the terms and conditions or reject them through this process within 45 days of receiving the payment(s). If this is not done within the 45 days, HHS will assume the provider has accepted the payment(s) and the associated terms and conditions.

Once the provider rejects the payment, it must be returned through the same way it was received. So, if the payment was received via:

- **ACH payment**: 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.

- **Paper check**: If the provider received a payment via 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 ACH payment or check in the memo. UnitedHealth Group Attention: CARES Act Provider Relief Fund PO Box 31376 Salt Lake City, UT 84131-0376 .

Q. If I take no action within 45 days of receipt of the funds related to the attestation of the Payment Relief Fund Terms & Conditions, what happens?

Answer: UPDATE --The HHS General Distribution Portal FAQ posted on the HHS CARES Act Provider Relief Fund website 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 **45** 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 **45** days will be assumed to have accepted the terms and conditions. Providers wishing to attest or reject the payments should go to the Attestation Portal.

Q. What must I document now in order to comply with the terms and conditions of the Provider Relief Fund?

Answer: 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.

UPDATE - HHS has indicated in its recent General Distribution Portal FAQ document that additional details on reporting will be coming out in the future. We would anticipate this information to become available soon as the first report is due July 10 for April 1 – June 30, 2020.

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. How will HHS distribute the remaining dollars and what providers, or expenses will it be for?

Answer: UPDATE - As of April 24, the second round of general distribution funds were distributed to providers: for whom a small share of their revenue is derived from Medicare FFS. HHS has distributed targeted funds to hospitals in COVID-19 hotspots, rural health clinics and hospitals, and Indian Health Service facilities. It is still working on sending payments to Medicaid-only providers now that it has data from state Medicaid agencies, which helps it identify eligible providers. It is unknown how much will be distributed and there is little specificity about the eligible providers beyond Medicaid-only nursing homes, dentists and other providers. LeadingAge has advocated for these targeted

distributions to go to adult day centers, assisted living, home and community-based services providers, PACE programs and Medicaid-only nursing homes.

Q. What must be reported? To whom shall it be reported? And when are these reports due? What funds do these reports cover?

Answer: The first submission of financial information to HHS is via the General Distribution portal and must be completed after attesting to the terms and conditions (which must be completed within 45 days of the receipt of the payment). By submitting the required IRS forms and lost revenue information, it can make providers eligible for an additional payment within 10 days of the submission.

In addition, Providers are required under the Relief Fund Terms and Conditions to submit a quarterly report to the HHS Secretary and the Pandemic Response Accountability Committee if the recipient received more than $150,000 across all enacted stimulus bills/Acts making appropriations for the coronavirus response and related activities. **Reporting Timeline:** These reports will be due no later than 10 days following the calendar quarter end or minimally: July 10, 2020; October 10, 2020; and January 10, 2021.
The reports must include the following content:

- 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.

Funds specifically covered by the reporting requirement include: Coronavirus Aid, Relief, and Economics Security(CARES) 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.

UPDATE – HHS will be providing future guidance on the type of documentation it expects providers who received payments to submit. This guidance will be posted on the HHS Provider Relief Fund website.

Q. Will HHS or CMS prescribe a reporting format or is each entity free to document as they see fit?
Answer: HHS has indicated that further information is forthcoming on the reporting requirements of the program. We do not know if this guidance will include information on a reporting format, template or portal that providers must use to report their use of these and other COVID-19 funding sources. **UPDATE --** For now, the first report of financial information including lost revenues for

March and April 2020 must be submitted through the General Distribution Portal after submitting the attestation to the terms and conditions for the funds received.

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. HHS clarified on April 24 that Medicare providers receiving more than one payment from the Fund must sign a separate attestation for each payment, as the Terms and Conditions are slightly different for each payment. **UPDATE --** Providers receiving any 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 HHS's General Distribution Portal FAQ.

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

Answer: UPDATE - 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 45 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.

Q. Where and when must our organization submit additional financial information to HHS?

Answer: After your organization submits its attestation agreeing to the terms and conditions for the payment, providers must submit tax documents and estimated lost revenue for March and April 2020 as part of receiving the 2nd round of General Distribution payments through a separate General Distribution Portal, which HHS sometimes refers to as the "Provider Relief Fund Application Portal "in its General Distribution Portal FAQ document. By submitting this financial information, providers may receive an additional payment.

Q. **NEW HHS FAQ** - **Which type of supporting documentation should I submit if I am an institution without IRS filings?** (Added 5/14/2020)
Answer: All providers that have filed tax returns in 2019 or 2018 should submit the filings as supporting documentation. If a particular healthcare provider has a legitimate reason (e.g. tax exempt) for not having IRS filings, then alternative financial statements are acceptable. If the entity is tax exempt, the entity should use Net Patient Revenues from its most recent audited annual financial statements as a substitute for "Program Services Revenue" when

prompted. Further, the entity should submit its most recent audited financial statements as a substitute for the federal income tax return Form 990 requested.

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 Provider Relief Fund. These additional funds will be distributed within 10 business days from when the provider submits the additional financial information through the General Distribution/Application 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 portal do I use?

Answer: Providers who have received General Distribution payments will need to separately access two portals to complete the requirements for retaining the dollars received through the Provider Relief Fund.

- **Attestation Portal**: It is here that all providers must agree to each of the terms and conditions related to the payments they have received from the Provider Relief Fund as of April 24 at 5p EST.
- **General Distribution Portal also referred to as the Provider Relief Fund Application Portal**: This portal can only be used by a provider who received a payment from the Provider Relief Fund as of 5p EST on Friday, April 24. These providers are eligible for additional payments and are encouraged to apply using this portal. 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.

Q. What financial information must be submitted via the Application Portal?

ANSWER: UPDATED - Providers who received a payment as of April 24 at 5p ET must first submit an attestation agreeing to the terms and conditions for each of the payments received via the Attestation Portal within 45 days of receiving the payment. After the attestation(s) is submitted, providers must submit tax documents and estimated lost revenue information through a separate General Distribution Portal. By submitting this data, these providers may be eligible to receive additional payments from the Fund.

- "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.

UPDATE --For Life Plan Communities and other provider organizations whose net patient revenue covers multiple business lines, it is unclear at this time if the payment level received was deliberately meant to cover other lines of business and which lost revenues (organizational vs. Medicare-only)

should be reported. LeadingAge is seeking clarity on these questions from HHS. HHS Senior Advisor indicated he believes HHS will include further guidance in a future FAQ on this item and that the payments received should be able to be used by all business lines under the TIN that received the payment. We would recommend waiting for this to be confirmed in writing by HHS. The most recent FAQ posted on May 14 indicated that a provider that owns several hospitals has the "discretion in allocating the Provider Relief funds to support health care related expenses or lost revenue attributable to COVID-19, so long as they are not reimbursed from other sources and other sources were not obligated to reimburse them." While this FAQ does not directly apply to aging service providers, it may provide an indication of how HHS is approaching these payments and their usage.

The General Distribution Portal FAQ answers numerous questions about why you might be receiving an error when entering data into the portal. Members are encouraged to use this document here if you are having trouble.

Each entity that files a federal income tax return must file its own application even if it is part of a provider group. However, for a group of corporations that file a single consolidated return, the tax return filer will be the only entity that need submit the application information.

HHS indicates that the additional funds will NOT be distributed on a first-come-first-serve basis but instead batched every Wednesday at 12 noon EST. However, HHS intends to distribute these additional funds (or provide another response) within 10 business days of submitting the financial information in the Application Portal.

Q. How does our organization estimate lost revenues for submitting to HHS?

Answer: HHS offers the following options for estimating lost revenues: 1) Compare year-over-year revenue or 2) Compare budgeted to actual revenue. For April 2020, providers may estimate the total monthly loss based on data from the first few weeks and extrapolation from March data.

UPDATE --What is not clear, is if these lost revenues should be reported for all lines of business or just the Medicare portion of the business. LeadingAge is seeking clarity from HHS on this issue but HHS staff have indicated that given that the payments were distributed based off a Tax Identification Number (TIN) that the COVID-19-related lost revenues to be reported could also be at the TIN level. This has NOT been confirmed yet in writing by HHS but the information was discussed on a May 12 call with a Senior Advisor to HHS Secretary Azar.

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 funding as of 5p ET on Friday, April 24 are NOT eligible to use this portal. If you enter your tax identification number into it, you will receive a message saying your TIN 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 18, HHS has not provided additional information on how funds will be distributed to Medicaid-only providers, who are eligible to receive funds and have not yet received any payments from the Funds.

Q. NEW – What are the differences between possible, presumptive and actual cases of COVID-19?

Answer:

- **Possible:** HHS has repeated that they "broadly view every patient as a possible case of COVID-19" Beyond this information, no definition is provided. Possible cases are used in determining a provider's eligibility to receive the Provider Relief Funds. Therefore, if providers have provided diagnoses, testing or care as of January 31, 2020 to possible or actual COVID-19 cases, they are considered eligible to receive the Provider Relief Funds.
- **Presumptive:** This is "a case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positivize in vitro diagnostic test result in his or her medical record." This term is used in reference to when providers are not permitted to balance bill a patient. Providers are not to balance bill for any care provided to patients with a presumptive or actual case of COVID-19. Out-of-network providers can charge cost sharing equivalent to what the patient would have otherwise paid an in-network provider.
- **Actual:** The HHS General Distribution FAQ does not specifically define this term but given the above definitions and distinctions, an actual case of COVID-19 is likely to be where the patient's medical record contains a positive test result.

Q. NEW – 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: **NEW – Which providers received how much from the Provider Relief Fund?**

Answer: HHS has posted a list on the CDC website of all providers who have received a payment and attested to the terms and conditions. Providers who retain the funds past 45 days since receipt of the payment and who have not attested will also be included as it is assumed they have agreed to the terms and conditions. HHS will update the list biweekly.

Q. NEW - If I have more than one Tax ID but I either have not attested or did not receive payments on some or all of them, am I eligible?

Answer: Providers must attest for all payments received to be eligible for additional General Distribution funding. Providers who fail to attest within 45 days of receiving a payment will be assumed to be keeping the payment and have attested to the corresponding terms and conditions for the payment(s). A provider is only eligible to apply for additional funding through the General Distribution Portal if it has TINs that has received prior PRF payments. The provider should fill out one application for each eligible TIN that has received a PRF payment and for which there is a

corresponding tax filing. If a provider is a subsidiary of a tax filing organization, and does not file a separate tax return, it is ineligible to apply for additional funds.