NCPA Member Summary of the CARES Act
Provider Relief Fund

The Department of Health and Human Services (HHS) is distributing the $100 billion Provider Relief Fund (PRF) provided for in the Coronavirus Aid, Relief and Economic Security (CARES) Act. Details regarding eligibility, payment distribution determination, and more are summarized below.

September 13 update: Clarifications regarding cost-based reimbursements, calculating expenses not reimbursed by other sources, and reporting requirements

HHS has clarified in its most recent FAQ document the following regarding use of PRF payments:

- Expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, personnel, and other health care-related costs/expenses for the period of availability. The classification of items into categories should align with how Provider Relief Fund payment recipients maintain their records. Providers can identify their expenses attributable to coronavirus, and then offset any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children’s Health Insurance Program (CHIP); other funds received from the federal government, including the Federal Emergency Management Agency (FEMA); the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured (Uninsured Program); the COVID-19 Coverage Assistance Fund (CAF); and the Small Business Administration (SBA) and Department of the Treasury’s Paycheck Protection Program (PPP). Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting the other funds received or obligated to be received which offset those expenses. The Provider Relief Fund permits reimbursement of expenses related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse.

- Reimbursements received from the Uninsured Program and CAF should be included as “other” in the “Total Revenues/Net Charges from Patient Care Related Sources” section of the reporting portal. Reimbursements from these programs should not be included as “HHS CARES Act Testing” or “other assistance” under the “Other Assistance Received” section of the reporting portal.

- The PRF payment recipient has discretion in allocating the payments to support its subsidiaries’ health care-related expenses or lost revenues attributable to coronavirus, so long as the payment is used to prevent, prepare for, or respond to coronavirus and those expenses or lost revenues are not reimbursed from other sources or other sources were not obligated to reimburse. Option iii, from the Post-Payment Notice of Reporting Requirements, provides Reporting Entities flexibility in the reconciliation of lost revenues. Lost revenues
September 13 update (continued)

may then be applied as the reporting entity sees fit. Reporting Entities should work with their accounting firms to determine an appropriate way to allocate expenses and lost revenues. The Reporting Entity is responsible for ensuring that adequate documentation is maintained. PRF payments may be applied to expenses and lost revenues attributable to coronavirus according to the Period of Availability of funding. However, expenses and lost revenues may not be duplicated: payments may not be applied to the same expenses and lost revenues that were reported on in prior reporting periods.

- Reimbursements received from the Uninsured Program and CAF should be included as “other” in the “Total Revenues/Net Charges from Patient Care Related Sources” section of the reporting portal. Reimbursements from these programs should not be included as “HHS CARES Act Testing” or “other assistance” under the “Other Assistance Received” section of the reporting portal.
- A for-profit corporation that has multiple subsidiaries that are consolidated for financial reporting purposes can fulfill audit requirements by having one financial-related audit of all HHS awards in accordance with Government Auditing Standards that incorporates all entities that are consolidated under Generally Accepted Accounting Principles (GAAP).
- Each of the for-profit entities in a multiple for-profit entities under common control and issue combined financial statements can fulfill audit requirements by having one financial-related audit of all HHS awards in accordance with Government Auditing Standards that incorporates each of the entities.
- Similar to non-federal entities, for-profit entities will include PRF expenditures and/or lost revenues on their Schedule of Expenditures of Federal Awards (SEFA) or other schedules for fiscal year ends (FYE) ending on or after June 30, 2021. Similar to non-federal entities, a for-profit entity’s SEFA (or other schedules) is linked to its report submissions to the PRF Reporting Portal. Therefore, the timing of reporting of PRF payments on the SEFA (or other schedules) should be as follows:
  - For FYE’s of June 30, 2021 through FYEs of December 30, 2021, recipients must report on the SEFA (or other schedules) the total expenditures and/or lost revenues included in the Period 1 report submission to the PRF Reporting Portal.
  - For FYE’s of December 31, 2021 through FYEs of June 29, 2022, recipients must report on the SEFA (or other schedules) the total expenditures and/or lost revenues included in both the Period 1 and Period 2 report submissions to the PRF Reporting Portal.
  - For FYEs on or after June 30, 2022, reporting guidance for the SEFA or other schedules related to Period 3 and Period 4 will be provided at a later date.

An organization can get an extension to the submission due date for Single Audits, which are due 30 calendar days after receipt of the auditor report or nine months after the end of the audit period—whichever is earlier. However, an OMB Memo extended the deadline for Single Audit submissions, allowing recipients and subrecipients that have not submitted their Single Audits with the Federal Audit Clearinghouse as of March 19, 2021, and have a FYE through June 30, 2021, to delay the submission of the Single Audit reporting package by six months. For this flexibility, please email HRSA’s Division of Financial Integrity at PRFaudits@hrsa.gov.
September 13 update (continued)

months beyond the normal due date. This extension applies to recipients of COVID-19 related Federal financial assistance awards, as well as recipients affected by COVID-19. If you choose to delay your Single Audit submissions, you are not required to seek prior approval. However, you should maintain documentation of the reason for the delayed filing. If you have questions about this extension or want to inform HRSA you will be taking advantage of this flexibility, please email HRSA's Division of Financial Integrity at PRFaudits@hrsa.gov.

- Providers have at least 12 months, and as much as 18 months, based on the payment received date, to control and use the payments for expenses and lost revenues attributable to coronavirus incurred during the Period of Availability. The payment is considered received on the deposit date for automated clearing house (ACH) payments, or the check cashed date for all other payments.

August 30 update: Clarifications regarding cost-based reimbursements, calculating expenses not reimbursed by other sources, and reporting requirements

HHS has clarified in its most recent FAQ document the following regarding use of PRF payments:

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- If a provider does not return the payment within 15 calendar days of rejecting the payment in the attestation portal, the provider is considered to have accepted the payment and must abide by the Terms and Conditions associated with the distribution. The government may pursue collection activity to collect the unreturned payment.

- Providers have at least 12 months, and as much as 18 months, based on the payment received date, to control and use the payments for expenses and lost revenues attributable to coronavirus incurred during the Period of Availability. The payment is considered received on the deposit date for automated clearing house (ACH) payments, or the check cashed date for all other payments.

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<thead>
<tr>
<th>Period</th>
<th>Payment Received Period</th>
<th>Period of Availability</th>
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<tr>
<td>Period 1</td>
<td>April 10, 2020 to June 30, 2020</td>
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<td>Period 2</td>
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<td>Period 3</td>
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<td>Period 4</td>
<td>July 1, 2021 to December 31, 2021</td>
<td>January 1, 2020 to December 31, 2022</td>
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PRF recipients must use payments only for eligible expenses, including services rendered and lost revenues attributable to coronavirus, incurred by the end of the Period of Availability that corresponds to the Payment Received Period. Providers are required to maintain supporting documentation that demonstrates that costs were incurred during the Period of Availability, as required under the Terms and Conditions. However, providers are not required to submit that documentation when reporting. Providers must promptly submit copies of such supporting documentation upon the request of the Secretary of HHS.
Examples of costs incurred for an entity using accrual accounting, during the Period of Availability include: 1) services that were received; 2) renovation or construction that was completed; and 3) tangible property ordered, but need not have been delivered. For purchases of tangible items made using PRF payments, the purchase does not need to be in the provider’s possession (i.e., back ordered PPE, ambulance, etc.) to be considered an eligible expense but the costs must be incurred by the end of the Period of Availability. Providers must follow their basis of accounting (e.g., cash, accrual, or modified accrual) to determine expenses. For projects that are a bundle of services and purchases of tangible items that cannot be separated, such as capital projects, construction projects, or alteration and renovation projects, the project costs cannot be reimbursed using PRF payments unless the project was fully completed by the end of Period of Availability associated with the Payment Received Period. Recipients may use payments for eligible expenses or lost revenues incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. However, HHS expects that it would be highly unusual for providers to have incurred eligible expenses or lost revenues prior to January 1, 2020. HHS reserves the right to audit PRF recipients now or in the future, and may pursue collection activity to recover any PRF payment amounts that have not been supported by documentation or payments not used in a manner consistent with program requirements or applicable law. All payment recipients must attest to the Terms and Conditions which require maintaining documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus.

- To be considered an allowable expense under the PRF, the expense must be used to prevent, prepare for, and respond to coronavirus. PRF payments may also be used for lost revenues attributable to the coronavirus. Reporting Entities are required to maintain adequate documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Reporting Entities are not required to submit that documentation when reporting. Providers are required to maintain supporting documentation which demonstrates that costs were incurred during the Period of Availability. The Reporting Entity is responsible for ensuring that adequate documentation is maintained.

- Expenses for capital facilities may be fully expensed only in cases where the purchase was directly related to preventing, preparing for and responding to the coronavirus. Examples of these types of facilities projects include:
  - Upgrading a heating, ventilation, and air conditioning (HVAC) system to support negative pressure units
  - Retrofitting a COVID-19 unit
  - Enhancing or reconfiguring ICU capabilities
  - Leasing or purchasing a temporary structure to screen and/or treat patients
  - Leasing a permanent facility to increase hospital or nursing home capacity

In order for the capital facilities projects’ costs to be expensed, the project must be fully completed by the end of the Period of Availability associated with the Payment Received Period.
August 30 update (continued)

- For providers that selection Option I (Comparison of Actual Lost Revenues) at the time of reporting, lost revenues are calculated for each quarter during the Period of Availability, as a standalone calculation, with 2019 quarters serving as a baseline. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount. The annual lost revenues are then added together. There is no offset.

- For Option ii, lost revenues are calculated for each quarter during the period of availability, as a standalone calculation, with budgeted quarters serving as a baseline. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount. The annual lost revenues for the years included in the period of availability are then added together. There is no offset. Reporting Entities may use budgeted revenues if the budget(s) and associated documents covering the Period of Availability were established and approved prior to March 27, 2020.

- When reporting on lost revenues, patient care-related revenue should be reported net of adjustments for all third-party payers, charity care adjustments, bad debt, and any other discounts or adjustments, as applicable when reporting patient care-related revenue sources.

- There is not a maximum or minimum allotment of an organization’s PRF amount that can be allocated to lost revenues during the period of availability of funds. Reporting Entities will see the reporting system asks for unreimbursed expenses attributable to coronavirus first in the overall use of funds calculation; it is possible for a Reporting Entity to enter “0.” PRF payment amounts not fully expended on unreimbursed health care-related expenses attributable to coronavirus during the period of availability are then applied to lost revenues. Lost revenues or expenses must only have been incurred during the Period of Availability correlating to the Payment Received Period as described in the June 11 Post-Payment Notice of Reporting Requirements. For Option i (Comparison of Actual Lost Revenues), lost revenues are calculated for each quarter during the Period of Availability, as a standalone calculation, with 2019 quarters serving as a baseline. For Option ii (Comparison of Budgeted to Actual Lost Revenues), Reporting Entities may use budgeted revenue if the budget(s) and associated documents covering the Period of Availability were established and approved prior to March 27, 2020. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount. There is no offset. Option iii provides maximum flexibility to providers by allowing providers to calculate lost revenues using an alternate reasonable methodology.

- Actual revenue from quarters in 2019 will serve as the baseline period of comparison for the Period of Availability for Option i. Budgeted revenue from the quarters reported in 2020 or 2021 will serve as the baseline period of comparison for Option ii. For Option ii, Reporting Entities may use budgeted revenues if the budget(s) and associated documents covering the Period of Availability were established and approved prior to March 27, 2020.

- Non-federal entities will include PRF expenditures and/or lost revenues on their SEFAs FYEs ending on or after June 30, 2021. Please refer to the 2021 OMB Compliance Supplement for additional information.
July 15 update: Clarifications regarding return of unexpended funds

HHS has clarified in its most recent FAQ document the following regarding PRF payments:

- Providers that have remaining PRF payments that they cannot expend on allowable expenses or lost revenues attributable to coronavirus by the relevant deadline to use funds are required to return this money to the federal government. To return any unused funds, use the Return Unused PRF Funds Portal. Instructions for returning any unused funds are available here.

- A non-federal entity’s SEFA reporting is linked to its report submissions to the PRF Reporting Portal. Therefore, the timing of SEFA reporting of PRF will be as follows:
  - For a FYE of June 30, 2021, and through FYEs of December 30, 2021, recipients are to report on the SEFA, the total expenditures and/or lost revenues from the Period 1 PRF report submission to the PRF reporting portal.
  - For a FYE of December 31, 2021, and through FYEs of June 29, 2022, recipients are to report on the SEFA, the total expenditures and/or lost revenues from both the Period 1 and Period 2 PRF report submissions to the PRF reporting portal.
  - For FYEs on or after June 30, 2022, SEFA reporting guidance related to Period 3 and Period 4 will be provided at a later date.

July 1 update: Clarifications regarding HHS recoupment of payments

HHS has clarified in its most recent FAQ document the following regarding PRF payments:

The PRF Terms and Conditions require that recipients be able to demonstrate that lost revenues or expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, meet or exceed total payments from the PRF. PRF payment amounts that have not been fully expended on health care expenses or lost revenues attributable to coronavirus by the deadline to use funds that corresponds to the Payment Received Period must be returned to HHS. The PRF Terms and Conditions and applicable legal requirements authorize HHS to audit PRF recipients now or in the future to ensure that program requirements are met. PRF payments that were made in error, or exceed lost revenues or expenses due to COVID-19, or do not otherwise meet applicable legal and program requirements must be returned to HHS, and HHS is authorized to recoup these funds.
If a provider has unused funds, it may return all or a portion of the funds when the first reporting period begins. If a provider that sold a practice that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

If an organization that sold, terminated, transferred, or otherwise disposed of a provider that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus up to the date of the sale, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

If, as a result of the sale of a practice/hospital, the TIN that received a PRF payment did not provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, the provider must reject the payment. The PRF Payment Attestation Portal guides providers through the attestation process to reject the attestation and return the payment to HRSA.

If a provider purchased a TIN in 2019, 2020, or 2021 from a previous owner, the new TIN owner cannot accept the payment directly from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the PRF payment. However, the new TIN owner may still otherwise apply for and/or receive funds.

Health care-related operating expenses are limited to costs incurred to prevent, prepare for, and respond to coronavirus. The amount of mortgage or rent eligible for PRF reimbursement is limited to that which was incurred to prevent, prepare for, and respond to coronavirus. Providers are required to maintain documents to substantiate that these funds were used for health care-related expenses attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. The burden of proof is on the provider to ensure that documentation is maintained to show that expenses are to prevent, prepare for, and respond to coronavirus.

PRF payments may be applied to expenses or lost revenues attributable to coronavirus, after netting the other funds received or obligated to be received which offset those expenses. If a provider has submitted an application to FEMA, but has not yet received the FEMA funds, the provider should not report the requested FEMA amounts in the PRF report. If FEMA funds are received during the same Payment Received Period in which provider is reporting on use of PRF payments, the receipt and application of each payment type is required in the PRF

**July 1 update (continued)**
July 1 update (continued)

reporting process. If an entity receives a retroactive payment from FEMA that overlaps with the period of availability, the entity must not use the FEMA payment on expenses or lost revenues already reimbursed by PRF payments.

- For purchases of tangible items made using PRF payments, the purchase does not need to be in the Reporting Entity’s possession (i.e., backordered personal protective equipment, capital equipment) to be considered an eligible expense. However, the costs must be incurred before the Deadline to Use Funds. Providers must follow their basis of accounting (e.g., cash, accrual, or modified accrual) to determine expenses.

- Providers that already have a cost allocation methodology in place at the time they received funds, may allocate normal and reasonable overhead costs to their subsidiaries, which may be an eligible expense if attributable to coronavirus and not reimbursed from other sources.

- Providers that have remaining PRF money that they cannot expend on permissible expenses or losses by the relevant deadline will return this money to HHS. Deadlines to use funds correspond to the date they received payment, as outlined in the Post-Payment Notice of Reporting Requirements. The PRF Terms and Conditions and legal requirements authorize HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are met. HHS is authorized to recoup any PRF amounts that were made in error or exceed lost revenue or expenses due to COVID-19, or in cases of noncompliance with the Terms and Conditions.

June 11 update: Clarifications regarding expenses at the time of PRF payment receipt and deadline to expend funds

HHS has clarified in its most recent [FAQ document](#) the following regarding PRF payments:

- Providers do not need to be able to prove that prior and/or future lost revenues and expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their PRF payment at the time they accept such a payment. Providers must report on the use of PRF payments in accordance with legal and program requirements in the relevant Reporting Time Period. Recipients may use payments for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. Providers must follow their basis of accounting to determine expenses. Duplication of expenses and lost revenues is not permitted. All recipients are subject to audit.

- Providers that have remaining PRF money that they cannot expend on permissible expenses or losses by the relevant deadline will return this money to HHS. Deadlines to use funds correspond to the date they received payment, as outlined in the Post-Payment Notice of Reporting Requirements. The PRF Terms and Conditions and legal requirements authorize
June 11 update (continued)

- HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are met. HHS is authorized to recoup any PRF amounts that were made in error or exceed lost revenue or expenses due to COVID-19, or in cases of noncompliance with the Terms and Conditions.

March 31 update: Clarifications regarding cost-based reimbursements, calculating expenses not reimbursed by other sources, and reporting requirements

HHS has clarified in its most recent FAQ document the following regarding use of Provider Relief Funds:

- Recipients must follow CMS instructions for completion of cost reports, available here. Under cost-based reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. In these instances, if the full cost was reimbursed based upon this method, there is nothing eligible to report as an expense attributable to coronavirus because the expense was fully reimbursed by another source. Provider Relief Fund payments cannot be used to cover costs that are reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if Medicare or Medicaid makes a payment to a provider based on the provider’s cost, such payment generally is considered to fully reimburse the provider and no money from the PRF would be available. However, in cases where a ceiling is applied to the cost reimbursement and the reimbursed amount by Medicare or Medicaid does not fully cover the actual cost due to unanticipated increases in providing care attributable to coronavirus, those incremental costs that were not reimbursed are eligible for reimbursement under the Provider Relief Fund.

- If the health care provider otherwise meets the criteria for eligibility, receipt of funds from SBA and FEMA for coronavirus recovery or of Medicaid Home-and Community-Based Services (HCBS) retainer payments, does not preclude a health care provider from being eligible for Phase 3 – General Distribution; however, the health care provider must substantiate that the Provider Relief Fund payments were used for health care related expenses or lost revenue attributable to COVID-19, and those expenses or lost revenue were not reimbursed from other sources or other sources were not obligated to reimburse.

- Healthcare related expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, employees, and other healthcare related costs/expenses for the calendar year. The classification of items into categories should align with how Provider Relief Fund recipients maintain their records. Providers can identify their healthcare related expenses, and then apply any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/ CHIP, or other funds received from FEMA, the Provider Relief Fund COVID-19 Claims Reimbursement to
Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, and SBA and Department of Treasury’s Paycheck Protection Program (PPP) that offset the healthcare related expenses. Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting the other funds received or obligated to be received which offset those expenses. The Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse.

- The Provider Relief Fund Terms and Conditions require that recipients be able to demonstrate that lost revenues and expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, meet or exceed total payments from the Provider Relief Fund. Provider Relief Fund payment amounts that have not been fully expended on health care expenses or lost revenues attributable to coronavirus by the end of the final reporting period must be returned to HHS. The Provider Relief Fund Terms and Conditions and applicable legal requirements authorize HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are met. Provider Relief Fund payments that were made in error, or exceed lost revenue or expenses due to COVID-19, or do not otherwise meet applicable legal and program requirements must be returned to HHS, and HHS is authorized to recoup these funds.

- Providers receiving payments from the Provider Relief Fund must comply with the Terms and Conditions and applicable legal requirements. Failure by a provider that received a payment to comply with any term or condition can result in action by HHS to recoup some or all of the payment. Per the Terms and Conditions, all recipients will be required to submit documents to substantiate that these funds were used for health care-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. HHS monitors the funds distributed, and oversees payments to ensure that Federal dollars are used in accordance with applicable legal and program requirements. In addition, the HHS Office of the Inspector General fights fraud, waste and abuse in HHS programs, and may review these payments.

- If an organization that sold, terminated, transferred, or otherwise disposed of a provider that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for health care related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

- A provider may not return a portion of a Provider Relief Fund payment. If a provider that sold a practice that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for health care related expenses or lost revenue attributable to coronavirus, and that those
March 31 update (continued)

expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

For the latest information on the Provider Relief Fund, please refer to the HHS Provider Relief Fund website.

February 24 update: Clarification regarding staff time spent on COVID-19 specific matters

HHS has clarified in its most recent FAQ document the following regarding use of Provider Relief Funds:

- Time spent by staff on COVID-19-specific matters may be an allowable cost attributable to coronavirus so long as it was not reimbursed or obligated to be reimbursed by other sources. If the personnel salaries are reimbursed by any other source of funding they cannot be also reimbursed by the Provider Relief Fund. In addition, no one individual may be allocated as greater than one fulltime equivalent (FTE) across all sources of funding. All costs must be tangible expenses (not opportunity costs) and must be supported by documentation. The Reporting Entity must maintain appropriate records and cost documentation including, as applicable, documentation described in 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient must promptly submit copies of such records and cost documentation upon the request of the Secretary, and the Reporting Entity agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

For the latest information on the Provider Relief Fund, please refer to the HHS Provider Relief Fund website.

January 28 update: Vaccine administration and distribution, ownership structures, and reporting requirements

HHS has clarified in its most recent FAQ document the following regarding use of Provider Relief Funds:

- The costs associated with administering a COVID-19 vaccine to a patient with Medicare Part A, but not Part B, coverage is considered unreimbursed under the Provider Relief Fund and payments could be used to cover incurred expenses.
- Provider Relief Fund payments may be used to support expenses associated with distribution of a COVID-19 vaccine licensed or authorized by the FDA that have not been reimbursed from other sources or that other sources are not obligated to reimburse. Funds may be used ahead
January 28 update (continued)

- of an FDA-licensed or authorized vaccine becoming available. This may include using funds to purchase additional refrigerators or freezers, personnel costs to provide vaccinations, and transportation costs not otherwise reimbursed.
- A parent organization that received a Provider Relief Fund Targeted Distribution may allocate it to any of its subsidiaries that eligible health care providers in accordance with the Coronavirus Aid, Response and Relief Supplemental Appropriations Act in which it has a direct ownership relationship.
- A parent organization must attest to the Terms and Conditions for the Targeted Distribution payment if it is the entity that received the payment; it may attest on behalf of any or all subsidiaries that qualified for a Targeted Distribution.
- In the event of a parent organization with multiple billing TINs that may have each received a General Distribution payment, the parent organization may attest and keep the payments as long as providers associated with the parent organization were providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020 and can otherwise attest to the Terms and Conditions; the parent organization can allocate funds at its discretion to its subsidiaries.
- Reporting entities that received General and Targeted Distribution payment should submit a consolidated report through the Provider Relief Reporting Portal rather than report each payment separately.
- If Provider Relief Funds were held in an interest-bearing account, they would be considered reportable revenue. If interest is earned on Provider Relief Fund disbursements that the Reporting Entity expended in full, the interest amounts may be retained and applied toward a reportable use of funds. If interest is earned on funds that are only partially expended, the interest on remaining unused funds must be calculated, reported, and returned.
- When reporting use of Provider Relief Fund money towards lost revenues attributable to coronavirus, Reporting entities may use budgeted revenues if the budget(s) and associated documents covering calendar year 2020 were established and approved on or before March 26, 2020. To be considered an approved budget, the budget must have been ratified, certified, or adopted by the Reporting Entity’s financial executive or executive officer as of that date, and the Reporting Entity will be required to attest that the budget was established and approved on or before March 26, 2020. Documents related to the budget, including the approval, must be maintained in accordance with the Terms and Conditions.

For the latest information on the Provider Relief Fund, please refer to the HHS Provider Relief Fund website.
HHS has clarified in its most recent FAQ document the following regarding use of Provider Relief Funds:

- **Expenses incurred “to secure and maintain adequate personnel”,** such as offering hiring bonuses and retention payments, child care, transportation, and temporary housing, are deemed to be COVID-19-related expenses if the activity generating the expense was newly incurred after the declaration of the Public Health Emergency and the expenses were necessary to secure and maintain adequate personnel.”
- **Provider Relief Fund payments can be used to pay taxes,** and HHS “considers taxes imposed on Provider Relief Fund payments to be ‘healthcare related expenses attributable to coronavirus’ that are reimbursable with Provider Relief Fund money.”
- **“Provider Relief Fund payments may be used to support expenses associated with distribution of a COVID-19 vaccine licensed or approved by the Food and Drug Administration (FDA) that have not been reimbursed from other sources or that other sources are not obligated to reimburse,”** which “may include using funds to purchase additional refrigerators, personnel costs to provide vaccinations, and transportation costs not otherwise reimbursed.” HHS also states that funds may “not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse, which include, but is not limited to, Medicare, Medicaid, and CHIP,” adding that if “reimbursement does not cover the full expense of administering vaccines, Provider Relief Funds may be used to cover the remaining associated costs.”

HHS has also clarified that the Provider Relief Fund does not issue payments that are less than $100, and that there is a minimum amount for the Provider Relief Fund to issue payments, and if a provider returns a payment to the Provider Relief Fund determined to be $500 or more in excess of the required returned amount, HHS will issue a refund.

For the latest information on the Provider Relief Fund, please refer to the HHS Provider Relief Fund website.

**October 28 update: Durable medical equipment excluded from patient care revenue, accrued interest on any returned payments**

HHS has clarified in its most recent FAQ document that the sale of durable medical equipment should not be included when reporting gross sales or program service revenue when applying for the Phase 3 General Distribution of the Provider Relief Fund.

HHS has also clarified that if a provider returns a Provider Relief Fund payment to HHS, if the payment was held in an interest-bearing account, the provider must return the accrued interest associated with the amount being returned to HHS. However, if the funds were not held in an interest-bearing account, there is no obligation for the provider to return any additional amount other than the Provider Relief Fund payment being returned to HHS. HHS reserves the right to audit Provider Relief Fund payments.
October 28 update (continued)

recipients in the future to ensure that payments that were held in an interest-bearing account were subsequently returned with accrued interest.

You will have until November 6, 2020 to apply for Phase 3 General Distribution funding through the HHS Provider Relief Fund website.

October 16 update: Prescription sales excluded from patient care revenue

HHS has clarified in its most recent FAQ document that prescription drug sales should not be included when reporting gross sales or program service revenue when applying for the Phase 3 General Distribution of the Provider Relief Fund. Patient care revenues do include savings obtained by providers through enrollment in the 340B Program. You will have until November 6, 2020 to apply for Phase 3 General Distribution funding through the HHS Provider Relief Fund website.

October 1 update: Provider Relief Fund third general distribution

HHS has announced a Phase 3 General Distribution allocation of $20 billion in new funding for providers. Providers that have previously received, rejected, or accepted a General Distribution Provider Relief Fund payment are invited to apply for additional funding that considers financial losses and changes in operating expenses caused by coronavirus. Providers will be considered for payment against the following criteria:

- Applicants that have not yet received Provider Relief Fund payments of 2 percent of patient revenue will receive a payment that, when combined with any prior payments, equals 2 percent of patient care revenue.
- The remaining balance of the $20 billion in new funding will be calculated as equitable add-on payments that consider the following:
  - 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; and
  - Payments already received through prior Provider Relief Fund distributions.

Providers will have from October 5, 2020 through November 6, 2020 to apply for Phase 3 General Distribution funding through the HHS Provider Relief Fund website. Please be aware that when submitting your Provider Relief Fund application to not include prescription drug sales when reporting gross sales or program service revenue. NCPA is working to get clarification from HHS officials regarding potential exceptions to this exclusion.
September 19 update: Provider Relief Fund reporting requirements

HHS has released guidance on the reporting requirements for Provider Relief Fund recipients. Providers who received a payment exceeding $10,000 will need to submit an initial report outlining how funds were used in 2020 once the reporting system opens in early 2021 (originally scheduled for October 2020). Providers that do not expend their Provider Relief Fund payments in full by the end of calendar year 2020 will have an additional six months in which to use the remaining amounts towards expenses attributable to coronavirus but not reimbursed by other sources, or to apply towards lost revenues in an amount not to exceed 2019 net gain from healthcare related sources. A second and final report will need to be filed no later than July 31, 2021 for any funds expended after December 31, 2020. Please be sure to regularly check the HHS Provider Relief Fund website for updates to reporting requirements.

August 25 update: Medicare, Medicaid/CHIP distribution deadlines extended to September 13

HHS announced that the deadline for applications to the Provider Relief Fund Medicare and Medicaid/CHIP distribution would be extended to September 13, 2020 (previously August 28). Please be sure to check the HHS Provider Relief Fund website for further instructions here. As a reminder, when submitting your Provider Relief Fund application to not include prescription drug sales when reporting gross sales or program service revenue.

July 31 update: HHS to accept Medicare applications again beginning August 10, Medicaid/CHIP distribution deadline extended to August 3

HHS has announced that beginning August 10, 2020, HHS will allow Medicare providers who missed the opportunity to apply for additional funding from the Medicare General Distribution, to complete an application to be considered for the balance of their additional funding up to 2 percent of their annual patient revenues, exclusive of prescription drug sales. The deadline to complete an application is August 28, 2020. Be sure to check the HHS Provider Relief Fund website for further instructions on August 10.

HHS announced that the deadline for applications to the Provider Relief Fund Medicaid/CHIP distribution would be extended to August 3, 2020 (previously July 20). Please be sure to begin the application process by August 3, 2020 on the HHS Provider Relief Fund provider portal here.

July 21, 2020 update: Medicaid/CHIP distribution deadline extended to August 3

HHS announced that the deadline for applications to the Provider Relief Fund Medicaid/CHIP distribution would be extended to August 3, 2020 (previously July 20). Please be sure to begin the application process by August 3, 2020 on the HHS Provider Relief Fund provider portal here.
July 10, 2020 update: HHS announces additional Provider Relief Fund payments, updates FAQ document

HHS has announced a second phase of General Distribution from the Provider Relief Fund, beginning with $4 billion to be made available through the Health Resources and Services Administration (HRSA) to hospitals serving vulnerable populations on thin margins. This second phase of General Distribution will continue to expand to include other providers submitting applications for future relief funding opportunities as directed by HHS.

Be sure to check the Provider Relief Fund FAQs regularly as HHS continues to update with new information. In the latest update: returned payments will be allocated by HHS to future Provider Relief Fund distributions; HHS will notify Provider Relief Fund recipients in the coming weeks with applicable audit requirements that need to be met to comply with the Terms and Conditions; and specific examples from multiple types of tax forms applicable to different organization categories are given to clarify what specific revenue information should be entered into the Enhanced Provider Relief Payment Portal.

July 6, 2020 update: General Distribution Fund reopening

The Administration is working to reopen the General Distribution Fund for the nearly one-third of providers who received a small General Distribution payment and who may have missed an opportunity to apply for additional funding due to confusion about the deadline and eligibility requirements. Many providers did not apply for additional General Distribution payments assuming they would be eligible for the round of funding targeted at Medicaid providers and were surprised that any amount of payment received under the General Distribution resulted in ineligibility for the Medicaid distribution. HHS has indicated that any provider that missed the deadline will be able to apply and be eligible to receive 2 percent of their revenue from seeing patients exclusive of prescription drug sales. More guidance will be forthcoming.

July 2, 2020 update: HHS to allocate returned Provider Relief Fund payments to future distributions

Be sure to check the Provider Relief Fund FAQs regularly for HHS updates. Latest updates include: information regarding HHS allocation of returned payments to future distributions; specific examples of revenue information to be entered into the Enhanced Provider Relief Payment Portal; and notice that HHS will notify Provider Relief Fund recipients in the coming weeks with applicable audit requirements to comply with the Terms and Conditions.
June 9, 2020 update: HHS announces additional distributions to Medicaid and CHIP providers, updates FAQ document

HHS has updated instructions on how to report gross sales or receipts for program service revenue when submitting an application for the Provider Relief Fund—prescription drug sales should not be included in calculating gross sales or revenue when submitting an application.

HHS also announced in a press release that it plans to distribute approximately $15 billion from the Provider Relief Fund to eligible providers that participate in Medicaid and CHIP and have not received a payment from the general allocation that was targeted to Medicare providers. HHS will launch an enhanced payment portal on June 10 to allow eligible Medicaid and CHIP providers to report their annual patient revenue, which will be used as a factor in determining Provider Relief Fund payments. HHS has indicated that each provider will receive at least 2 percent of reported gross revenue from patient care. Eligibility is limited to providers that did not receive payment from the $50 billion Provider Relief general distribution and have either directly billed state Medicaid/CHIP programs or Medicaid managed care plans for healthcare-related services between January 1, 2018 to May 31, 2020.

HHS also posted an updated version of its frequently asked questions (FAQ) document regarding terms and conditions, balance billing requirements for all distribution categories, distribution of funds to high impact areas, and distribution of funds to skilled nursing facilities. Please be sure to visit the FAQ document as it is updated on a regular basis.

May 27, 2020 update: Accept terms and conditions and submit revenue information by June 3, 2020

HHS is reminding eligible providers that they have until June 3, 2020 to accept the terms and conditions and submit revenue information to support receiving an additional payment from the Provider Relief Fund $50 billion General Distribution. All providers who automatically received an additional General Distribution payment prior to 5:00 pm, Friday, April 24, 2020 must provide HHS with an accounting of their annual revenues by submitting tax forms or financial statements through the General Distribution portal. These providers must also agree to the terms and conditions if they wish to keep the funds.

May 20, 2020 update: HHS posts updated version of FAQ document regarding implementation of funds

On May 20, HHS posted a further updated version of its frequently asked questions (FAQ) document regarding implementation of funds distributed to health care providers through the COVID-19 Provider Relief Fund. The new update adds and/or modifies information regarding actions a provider must take after receiving a Provider Relief Fund payment, actions a provider should take to return a payment received under the Fund, provider actions if a payment from the “General Distribution,” which applies to Medicare providers, is greater than expected, and more.
May 7, 2020 update: HHS extends deadline for attestation, acceptance of terms and conditions for Provider Relief Fund payments

On May 7, HHS extended the deadline for health care providers to attest to receipt of payments from the Provider Relief Fund and accept the terms and conditions. Providers now have 45 days, increased from 30 days, from the date they receive a payment to attest and accept the terms and conditions or return the funds. Additional information on the Provider Relief Fund and link to attestation form can be found here.

April 27, 2020 update: HHS launches COVID-19 Uninsured Program Portal

On April 27, HHS launched the COVID-19 Uninsured Program Portal that allows health care providers who have conducted COVID-19 testing or provided treatment to uninsured COVID-19 individuals to request claims for reimbursement as part of the CARES Act Provider Relief Fund. The program is being administered by the Health Resources and Services Administration (HRSA), and providers can begin requesting claims reimbursement for eligible services provided on or after February 4, 2020 beginning May 6, 2020. Pharmacies that are permitted under state law to bill for other testing services are eligible to request reimbursement for testing under this program (see HRSA FAQ document). The portal and additional information on the process and eligibility are available here.

April 24, 2020 update: HHS begins distributing remaining $20 billion of the Provider Relief Fund general allocation

HHS will begin distribution of the remaining $20 billion of the Provider Relief Fund general allocation to Medicare facilities and providers impacted by COVID-19 based on eligible providers’ 2018 net patient revenue on April 24, 2020.

A portion of providers will be automatically sent a payment on April 24 based on revenue data submitted to Centers for Medicare & Medicaid Services cost reports. Providers without adequate cost report data on file will need to submit their revenue information through a portal here to receive additional general distribution funds. Providers who automatically receive money will need to submit revenue information for verification through the same portal. All recipients will need to sign the attestation form confirming receipt of funds and agreeing to the terms and conditions.

Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020 can request claims reimbursement at Medicare rates, subject to available funding. Providers can register beginning on April 27, 2020 and begin submitting claims in early May. More information can be found here.
HHS has set up a hotline to answer questions, including eligibility and payment status, at 1-866-569-3522.

Eligibility

- All providers that received Medicare FFS reimbursements in 2019 are eligible.
- As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.
- Providers that have ceased operation as a result of the COVID-19 pandemic are still eligible to receive funds as long as diagnoses, testing, or care was provided for individuals with possible or actual cases of COVID-19. Care does not have to be specific to treating COVID-19; HHS broadly views every patient as a possible case of COVID-19.

Payment distribution determination

- Providers will be distributed a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements (not including Medicare Advantage payments) in 2019.
- To determine how much will be received, an estimate can be calculated by dividing 2019 Medicare FFS payments received by $484 billion and multiplying that ratio by $30 billion.

Next steps

- Providers will be paid via Automated Clearing House (ACH) on file with UnitedHealth Group (HHS has partnered with UHG to provide rapid payment to eligible providers) or Centers for Medicare & Medicaid Services (CMS). Automatic payments will come to providers via Optum Bank with “HHSPAYMENT” as the payment description.
- If you normally receive a paper check for reimbursement from CMS, a paper check in the mail will be received within the next few weeks.
- An attestation form must be signed within 45 days of receiving the payment through the portal here, confirming receipt and agreeing to the terms and conditions of payment.

HHS plans to distribute remaining $70 billion of Provider Relief Fund

HHS will release a formalized application process for providers who did not qualify to receive part of the initial $30 billion, and will be targeting distribution to providers in areas particularly impacted by the COVID-19 pandemic.

April 10, 2020 update: HHS begins distributing initial $30 billion of the Provider Relief Fund

On April 10, HHS began distributing the initial $30 billion of the Provider Relief Fund via direct deposit, providing relief to providers, such as pharmacies enrolled as Medicare Part B suppliers, in areas heavily impacted by the COVID-19 pandemic and providers struggling to keep doors open.

All providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible. These are grants, not loans, and will not need to be repaid.

1 As of May 7, 2020, HHS has extended the deadline for providers to attest to the receipt of payments from the Provider Relief Fund and accept the terms and conditions from 30 days to 45.
COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement, or who predominantly serve the Medicaid population.