CARES Act Provider Relief Fund
Frequently Asked Questions

Provider Relief Fund General Information

Overview

Who is eligible to receive payments from the Provider Relief Fund? *(Modified 12/4/2020)*
Provider Relief Fund payments are being disbursed via both "General" and "Targeted" Distributions.

To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in 2019, be a known Medicaid and CHIP or dental provider and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

A description of the eligibility for the announced Targeted Distributions can be found here. U.S. health care providers may be eligible for payments from future Targeted Distributions. Information on future distributions will be shared when publicly available.

All providers retaining funds must sign an attestation and accept the Terms and Conditions associated with payment.

Is this a loan or a grant that I will need to pay back?
Retention and use of these funds are subject to certain terms and conditions. If these terms and conditions are met, payments do not need to be repaid at a later date. These Terms and Conditions can be found here.

Why would a provider not be eligible for a General or Targeted Distribution Provider Relief Fund payment? *(Added 10/5/2020)*
In order to be eligible for a payment under the Provider Relief Fund, a provider must meet the eligibility criteria for the distribution. Additionally, a provider must not be currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; must not be currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and must not currently have Medicare billing privileges revoked as determined by either the Centers for Medicare & Medicaid Services or the HHS Office of Inspector General in order to be eligible to receive a payment under the Provider Relief Fund.

Is there a minimum amount for the Provider Relief Fund to issue payments? *(Added 12/11/2020)*
Yes. The Provider Relief Fund does not issue individual General and Targeted Distributions payments that are less than $100.

If a provider returns a payment to the Provider Relief Fund and the returned amount is greater than what should be returned to the Government, will the Provider Relief Fund refund amounts be returned in error? *(Added 12/11/2020)*
The Provider Relief Fund will refund returned payments that are determined to be $500 or more in excess of the required returned amount.

Will HHS allow providers to make corrections to the data used to determine Targeted Distribution eligibility and payment amounts? *(Added 10/28/2020)*

Going forward, HHS will allow providers that submitted data as part of the COVID-19 High Impact Area Distribution and/or the Nursing Home Infection Control/Quality Incentive Payment Distribution, a limited opportunity to submit corrected data for up to 5 business days after the submission deadline. HHS will only accept corrections within the 5-day time period that are accompanied by a justification for why the provider erred in the initial data submission. HHS will review each request for correction on a case-by-case basis and may determine that a previous payment be amended to align with the updated data. Providers who submit updated data may have their payments delayed for up to 90 days from the date of submission pending review and adjudication. All HHS decisions are final and there is no appeals process.

If a provider returns a Provider Relief Fund payment to HHS, must it also return any accrued interest on the payment? *(Modified 12/11/2020)*

Yes, for Provider Relief Fund payments that were 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 recipients in the future to ensure that payments that were held in an interest-bearing account were subsequently returned with accrued interest.

To return accrued interest, visit pay.gov. On the webpage, locate "Find an agency," and select "*Health and Human Services (HHS) Program Support Center HQ."* Verify that the description is "*PSC HQ Payment"* and form number is *"HHSHQ,"* then click continue. You will then need to complete the following steps:

- Step 1: Preview the form, then click "Continue."
- Step 2: Indicate whether you are completing on behalf of an individual or business and enter the following information:
    - **Business Name Field:** Legal name of organization that received the payment
    - **Invoice or Ticket Number Field:** "HHS-COVID-Interest"
    - **Contract/Agreement Number Field:** Tax Identification Number (TIN) of organization or provider that received the payment
    - **Point of contact:** Business contact information
    - **Payment Amount:** (The payment amount must match the interest earned on the payment received.)
- Step 3: Verify the interest return payment amount and select to pay by ACH or debit/credit card, then select "Continue."
- Step 4: Enter the required information to complete the payment, then select "Review and Submit."
- Step 5: Ensure that all information is correct and select "Submit."

I received an email, voicemail, or letter stating that I have not taken appropriate action to update financial information in order to receive a payment that I am eligible to receive. Are my funds still available? *(Added 9/3/2020)*

If you received a notice from the Provider Relief Fund that you had funds available but did not take action within 90 days of the original payment issuance date, the payment is no longer

available to you. If it is past the 90-day period for a General Distribution payment, you may apply for a Phase 2 – General Distribution payment through the Provider Relief Attestation and Application Portal. If it is within 90 days of the original payment issuance date, you must contact the Provider Support Line to reinitiate your ACH payment. In order to distribute the funds in a timely manner, it is important to maintain current ACH information.

How should providers classify the Provider Relief Fund payments in terms of revenue type if I changed my mind after I rejected a Provider Relief Fund payment through one of the attestation portals and returned the payment, can I receive a new payment? ***(Modified 10/28/2020)***

No, HHS will not issue a new payment to a provider that received and then subsequently rejected and returned the original payment. The provider may be considered for future distributions if it meets the eligibility criteria for that distribution.

Terms and Conditions

What if my payment is greater than expected or received in error? ***(Modified 12/4/2020)***

If HHS identifies a payment made in error, HHS will recoup the erroneous amount. If a provider receives a payment that is greater than expected and believes the payment was made in error, the provider should contact the Provider Support Line at (866) 569-3522 (for TYY, dial 711) and seek clarification.

Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the General or Targeted Distribution payments? ***(Modified 11/5/2020)***

The Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund. Provider Relief Fund payment amounts that have not been fully expended on the combination of healthcare expenses and lost revenues attributable to coronavirus by the end of the final reporting period, must be returned to HHS. HHS reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with the Terms and Conditions may be grounds for recoupment.

Can providers use Provider Relief Fund distributions to repay payments made under the CMS Accelerated and Advance Payment (AAP) Program? ***(Added 10/9/2020)***

No, this is not a permissible use of Provider Relief Fund payments.

For how long are the Terms and Conditions of the Provider Relief Fund applicable? ***(Added 6/19/2020)***

All recipients receiving payments under the Provider Relief Fund will be required to comply with the Terms and Conditions - PDF. Some Terms and Conditions relate to the provider's use of the funds, and thus they apply until the provider has exhausted these funds. Other Terms and Conditions apply to a longer time period, for example, regarding maintaining all records pertaining to expenditures under the Provider Relief Fund payment for three years from the date of the final expenditure.

Must a parent organization that received a Provider Relief Fund Targeted Distribution on behalf of a subsidiary in which it is has a direct ownership relationship remit the payment to the subsidiary? *(Modified 12/11/2020)*

Yes. The purpose of Targeted Distribution payments is to support the specific financial needs of the eligible healthcare provider that received the payment. Control and use of the funds must be delegated to the entity that was eligible for the Targeted Distribution payment if a parent entity received the Targeted Distribution payment on behalf of an eligible subsidiary. The only exception to this occurs when the funds were received as part of the Skilled Nursing Facility Targeted Distribution or Nursing Home Infection Control Distribution (but not bonus payments received as part of the Nursing Home Infection Control Quality Incentive Program), in which case parent entities may distribute funds among those subsidiaries that were eligible for payment at its discretion.

If a parent organization received a Provider Relief Fund Targeted Distribution on behalf of a subsidiary, which organization should attest to the Terms and Conditions for the payment? *(Added 8/27/2020)*

The parent entity should 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 (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment. The parent entity must transfer a Provider Relief Fund Targeted Distribution payment to any or all subsidiaries that qualified for a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment. Control and use of the funds must be delegated to the entity that was eligible for the Targeted Distribution payment if a parent entity received the Targeted Distribution payment on the behalf of an eligible subsidiary.

How should an organization currently undergoing a change in ownership to purchase a practice report revenue in its application? *(Added 5/20/2020)*

Until the purchase is complete, the organization should only report current gross receipts in its application and should exclude the practice it is intending to purchase. Any changes in ownership that have not occurred should not be included in your revenue submission. Submissions must be based on the organization that exists at the time of application, not a projection of expected lost revenue from the practice that is being acquired.

If a seller receives Provider Relief Fund money prior to the completion of a sale, can the seller transfer some or all of the Provider Relief Fund money to the buyer? *(Modified 6/22/2020)*

If the transaction is a purchase of the recipient entity (e.g., a purchase of its stock or membership interests), then the Provider Relief Fund recipient may continue to use the funds, regardless of its new owner. But if the transaction is an asset purchase (whether for some or all of the Provider Relief Fund recipient's assets), then the original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS. In these circumstances, the Provider Relief Fund money does not transfer to the buyer, however, buyers in these circumstances will be eligible to apply for future Provider Relief Fund payments. If a bankrupt recipient is liquidated, it must similarly use the funds for its eligible expenses and lost revenues

Commercial organizations that receive $750,000 or more in annual awards have two options under 45 CFR 75.216(d) and 75.501(i): 1) a financial related audit of the award or awards conducted in accordance with Government Auditing Standards; or 2) an audit in conformance with the requirements of 45 CFR 75 Subpart F.

Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) must be included in determining whether an audit in accordance with 45 CFR Subpart F is required (i.e., annual *total awards received* are $750,000 or more).

Audit reports of commercial organizations must be submitted directly to the U.S. Department of Health and Human Services, Audit Resolution Division at AuditResolution@hhs.gov.

Can my organization get an extension to the submission due date for 2019 audit year reports conducted under 45 CFR Part 75? *(Modified 12/11/2020)*
Yes. The Office of Management and Budget (OMB) in OMB M-20-26, Extension of Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations, dated June 18, 2020, provided recipients, which include non-federal entities and commercial organizations, extensions beyond the normal due date to submit 2019 audit year reports. Please see the OMB website for more details. Recipients with questions about their ability to obtain extensions should email HRSA's Division of Financial Integrity at SARFollowup@hrsa.gov.

The Terms and Conditions for all Provider Relief Fund payments require recipients who receive at least $150,000 in the aggregate from any statute primarily making appropriations for the coronavirus response to submit quarterly reports to HHS and the Pandemic Response Accountability Committee. This requirement is from section 15011 of the CARES Act. What do providers need to do in order to be in compliance with this provision in the Terms and Conditions? *(Added 6/13/2020)*
Recipients of Provider Relief Fund payments do not need to submit a separate quarterly report to HHS or the Pandemic Response Accountability Committee. HHS will develop a report containing all information necessary for recipients of Provider Relief Fund payments to comply with this provision. For all providers who attest to receiving a Provider Relief Fund payment and agree to the Terms and Conditions (or retain such a payment for more than 90 days), HHS is posting the names of payment recipients and their payment amounts on its public website here. HHS is also working with the Department of Treasury to reflect the aggregate total of each recipient's attested to Provider Relief Fund payments on USAspending.gov. Posting these data meets the reporting requirements of the CARES Act. See Appendix A of OMB Memo M-20-21 [Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)].

However, the Terms and Conditions for all Provider Relief Fund payments also require recipients to submit any reports requested by the Secretary that are necessary to allow HHS to ensure compliance with payment Terms and Conditions. HHS will be requiring recipients to submit future reports relating to the recipient's use of its PRF money. For more information on these requirements, please visit www.hhs.gov/providerrelief.

Use of Funds

Are expenses related to securing and maintaining adequate personnel reimbursable expenses under the Provider Relief Fund? *(Added 12/11/2020)*
Yes, expenses incurred by providers 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.

Are outsourced or third-party vendor services that enable access to health care services reimbursable expenses under the Provider Relief Fund? ***(Added 12/11/2020)***
Yes, outsourced or third-party vendor services that enable sustained access to health care services and daily operations, such as food/patient nutrition services, facilities management, laundering, and disinfection/anti-contamination services, are considered reimbursable expenses if they are attributable to coronavirus.

Can providers use Provider Relief Fund payment to pay taxes? ***(Added 12/11/2020)***
Yes. 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, except for Nursing Home Infection Control Distribution payments.

When reporting my organization's healthcare expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources?" ***(Modified 12/11/2020)***
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/Children's Health Insurance Program (CHIP), or other funds received from 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, and the Small Business Administration (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. For example, assume the following:

A $5 increase in expense or cost to provide an office visit is calculated by pre-pandemic cost vs. post-pandemic cost, regardless of reimbursement source:

- Pre-pandemic average expense or cost to provide an office visit = $80
- Post-pandemic average expense or cost to provide an office visit = $85

Examples of reimbursed amounts may include, but not be limited to:

- **Example 1**
  Medicaid reimbursement: $70 (Report $85-$80 = $5 as expense attributable to coronavirus but unreimbursed by other sources)
- **Example 2**
  Medicare reimbursement: $80 (Report $85-$80 = $5 as expense attributable to coronavirus but unreimbursed by other sources)
- **Example 3**
  Commercial Insurance reimbursement: $85 (Report $5, commercial insurer did not reimburse for $5 increased cost of post-pandemic office visit)
- **Example 4**

Commercial Insurance reimbursement: $85 + $5 insurer supplemental coronavirus-related reimbursement (Report zero since insurer reimbursed for $5 increased cost of post-pandemic office visit)

- **Example 5**
  COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured: $80 (Report $5 as expense attributable to coronavirus but unreimbursed by other sources)

Funds from the Federal Emergency Management Administration (FEMA) are generally intended to be the last source of reimbursement, however, the Post-Payment Notice of Reporting Requirements indicates that FEMA funds would be applied prior to the Provider Relief Fund distributions. In which order should governmental funding sources be applied and reported? *(Modified 12/11/2020)*

As it relates to expenses, providers identify their health care-related expenses, and then apply any amounts received through other sources (e.g., direct patient billing, commercial insurance, Medicare/Medicaid, reimbursement from the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, or funds received from FEMA or SBA/Department of Treasury's Paycheck Protection Program) that offset the health care-related expenses. Provider Relief Fund payments may be applied to the remaining expenses or cost, after netting the other funds received or obligated to be received which offset those expenses.

Do providers report total purchase price of capital equipment or only the depreciated value? *(Modified 12/11/2020)*

Providers who use accrual or cash basis accounting may report the relevant depreciation amount based on the equipment useful life, purchase price and depreciation methodology otherwise applied.

For additional information on capital depreciation, please refer to the other Frequently Asked Questions related to capital equipment and capital facility projects.

Will the Provider Relief Fund limit qualifying expenses for capital equipment purchases to 1.5 years of depreciation, or can providers fully expense capital equipment purchases? *(Added 11/18/2020)*

Expenses for capital equipment and inventory may be fully expensed only in cases where the purchase was directly related to prevent, prepare for and respond to the coronavirus. Examples of these types of equipment and inventory expenses include:

- Ventilators, computerized tomography scanners, and other intensive care unit-(ICU) related equipment put into immediate use or held in inventory
- Masks, face shields, gloves, gowns
- Biohazard suits
- General personal protective equipment
- Disinfectant supplies

Can providers include the entire cost of capital facilities projects as eligible expenses, or will eligible expenses be limited to the depreciation expense for the period? *(Added 11/18/2020)*

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

At the bottom of page 1 of the reporting requirements announcement in PDF, Step 2 states "PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues, net of the healthcare related expenses attributable to coronavirus calculated under step 1." Is the underlined language still applicable under the reporting requirements notice that HHS posted on October 22, 2020? ***(Modified 12/4/2020)***
No, healthcare related expenses are no longer netted against the patient care lost revenue amount in Step 2. A revised notice was posted to remove this language.

What is included in use of funds for salaries and employee compensation? ***(Added 10/28/2020)***
Direct employee (full and part-time), contract labor, and temporary worker expenses are eligible expenses provided they are not reimbursed from other sources, or only the incremental unreimbursed amounts are claimed.
The Terms and Conditions associated with each Provider Relief Fund payment do not permit recipients to use Provider Relief Fund money to pay salaries at a rate in excess of Executive Level II which is currently set at $197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Fund payments may pay an individual's salary amount in excess of the salary cap with non-federal funds.

An example of how this Executive Level II Salary cap is applied to aggregated personnel expenses is shown below. Reimbursement from other sources is applied in Step Two. Providers should apply reasonable assumptions when estimating the portion of personnel costs that are reimbursed from other sources.

Step One

Personnel Category	Number of Personnel	Personnel Expenses	Personnel Expenses (Below Salary Cap)	Ineligible for Federal Reimbursement
Medical Director	1	$250,000	$197,300	$52,700
Registered Nurses	25	$1,250,000	$1,250,000	0
Security	2	$80,000	$80,000	0
	28	$1,580,000	$1,527,300	$52,700

Step Two

Personnel Expenses (Below Salary Cap)	Less FEMA Reimbursement	Less Reimbursement from other sources	Eligible Personnel Expenses
$1,527,300	$(50,000)	$(1,000,000)	$477,300

Are fringe benefits for both patient care staff and General and Administrative (G&A) staff considered Provider Relief Fund eligible expenses under the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*
Yes, fringe benefits associated with both types of personnel may be eligible if not reimbursed by other sources.

When reporting my organization's G&A expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*
Providers should calculate incremental G&A expenses incurred that were attributable to coronavirus and then estimate the portion of those expenses that were not covered through operational revenues, other direct assistance, donations or other sources.

Examples may include expenses such as: Hiring additional security personnel, increased hazard pay, increased cost of utilities to operate temporary facilities, or similar items attributable to the coronavirus that were not normally incurred.

When reporting my organization's other healthcare related expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*
Providers first calculate their expenses for supplies, equipment, IT, facilities, employees, and other healthcare related costs/expenses for calendar years 2019 and 2020, calculate the change in year over year expenses and identify the portion that is attributable to coronavirus. Provider will then apply reasonable assumptions to determine the amount of their "Total Revenue /Net Charges from Patient Care Related Sources" and "Other Assistance Received" that applies to each type of healthcare expense attributable to coronavirus.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? *(Added 10/28/2020)*
HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money and/or allocate the money to other subsidiary TINs, as it deems appropriate.

Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

Supporting Data

What documentation is required for reporting? *(Added 10/28/2020)*
No external documentation is required at the time information is submitted via the reporting portal. Supporting worksheets (for providers who received $500,000 or above in Provider Relief Fund payments) will be included to assist providers within the reporting tool.

What are the documentation retention requirements for the Provider Relief Fund? *(Added 10/28/2020)*
Providers need to retain original documentation for three years after the date of submission of the final expenditure report, in accordance with 2 CFR 200.333.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? *(Added 10/28/2020)*
HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money and/or allocate the money to other subsidiary TINs, as it deems appropriate.

Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

If an entity incurred enough lost revenue in April and May 2020 to justify its use of the Provider Relief Fund payments received, can it only report those two months? *(Added 10/28/2020)*
No. The Reporting Entity must report revenue and expense for the full calendar years 2019 and 2020. If funds were not expended in full by December 31, 2020 then a second and final report will be required on use of funds for the period January 1, 2021 - June 30, 2021 which is due no later than July 31, 2021.

What is the process to return unused funds? *(Added 10/28/2020)*
Details on how to return unused amounts will be provided in advance of the second 2021 reporting deadline, which is July 31, 2021.

If an entity received payments totaling over $10,000, but returned some, do they still have to report? ***(Added 10/28/2020)***
A Reporting Entity must report only when they have retained $10,000 or more in aggregated Provider Relief Fund dollars. This includes payments received by the parent and general distribution payments received by related subsidiaries for which the parent will report on behalf of.

Should entrance fee amortization be excluded from patient care? ***(Added 10/28/2020)***
If the provider includes entrance fee amortization as operating revenue on its financial statements, it should be considered as revenue associated with patient services. Entrance fee amortization must be handled in a consistent manner in both 2019 and 2020.

How do shareholder or partnership payments impact the lost revenue calculation? ***(Added 10/28/2020)***
"Lost revenue attributable to coronavirus" is calculated based on operating revenue from patient care sources. Shareholder and partnership payments are not eligible to be included in the lost revenue calculation.

If all funds are expended through the G&A and healthcare related expenses, are recipients still required to submit lost revenue information? ***(Added 10/28/2020)***
Yes, all providers above the $10,000 threshold are required to report both revenues and expenses for the calendar year.

Are Intergovernmental Transfers (IGTs) related to state provider taxes allowable G&A expenses? ***(Added 10/28/2020)***
A portion of a Provider Relief Fund recipient's state provider taxes may be eligible expenses, but only to the extent the Provider Relief Fund recipient owes incrementally increased state provider taxes, where the incremental increase is attributable to coronavirus.

Vaccine Distribution and Administration

Can Provider Relief Fund payments be used to support COVID-19 vaccine distribution? ***(Modified 12/11/2020)***
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.

Funds may also be used ahead of an FDA-licensed or approved vaccine becoming available. This may include using funds to purchase additional refrigerators, personnel costs to provide vaccinations, and transportation costs not otherwise reimbursed.

Can Provider Relief Funds be used to cover the cost of vaccination, including doses and administration fees, for Medicare, Medicaid, or CHIP beneficiaries? ***(Modified 12/11/2020)***
In line with the Terms and Conditions, 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. If reimbursement does not cover the full expense of administering vaccines, Provider Relief Funds may be used to cover the remaining associated costs.

Balance Billing

The Terms and Conditions require recipients to attest that for all care for a presumptive or actual case of COVID-19 the recipient will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient. How should dental providers comply with this requirement? *(Added 7/22/2020)*
The prohibition on balance billing applies to "all care for a presumptive or actual case of COVID-19." A presumptive case of COVID-19 is a case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record. Dental providers who are not caring for patients with presumptive or actual cases of COVID-19 would not be subject to this provision.

Do the Terms and Conditions for the General and Targeted Distributions require attesting to a ban on balance billing for all patients and/or all care, because "HHS broadly views every patient as a possible case of COVID-19"? *(Added 5/6/2020)*
No. As set forth in the Terms and Conditions, the prohibition on balance billing applies to "all care for a presumptive or actual case of COVID-19."

The Terms and Conditions provision related to balance billing suggests that providers that provide out-of-network care to an insured, presumptive or actual COVID-19 patient can bill the patient's insurer any amount, as long as they do not bill the patient directly. Is that correct? *(Added 5/6/2020)*
The Terms and Conditions do not impose any limitations on the ability of a provider to submit a claim for payment to the patient's insurance company. However, an out-of-network provider delivering COVID-19-related care to an insured patient may not seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

The Terms and Conditions require that "for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient." How does HHS define a presumptive case of COVID-19? *(Modified 6/12/2020)*
A presumptive case of COVID-19 is a case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.

Targeted Distributions

Rural Targeted Distribution

What was the formula used to make the Rural/Small Metropolitan Areas Targeted Distribution payments? *(Added 7/10/2020)*
The payment formula varied depending on hospital location and Medicare designation. For hospitals with a special Medicare payment designation of Sole Community Hospitals (SCH) or

Medicare Dependent Hospitals (MDH), and for hospitals in small metro areas with a designation of Rural Referral Center (RRC), the payment amount was based on 1% of operating expenses (calculated based on their most recent Medicare Cost Report) with a minimum payment of $100,000, a supplement of $50 for each rural inpatient day, and a maximum payment of $4.5 million. HHS also provided a supplemental payment of $1,000,000 for 10 isolated urban hospitals that are 40 or more miles away from another hospital open to the public. HHS estimated the number of inpatient days provided by these hospitals to rural residents by calculating the proportion of patient days attributed to Medicare patients from rural zip codes using the Hospital Service Area File, calendar year 2018 (the most recent data available), multiplied by the total number of patient days as reported in the hospital's Medicare cost report.

For small metro area hospitals without a special Medicare designation, the payment amount was based on 1% of operating expenses (calculated based on their most recent Medicare cost report) with a minimum payment of $100,000 and a maximum of $2 million each.

The payment formula for rural specialty hospitals (Psychiatric, Rehabilitation, and Long Term Acute Care) used the previous Rural Targeted Distribution methodology (graduated base payment + approximately 2% of operating expenses) adjusted for the rural patient share (calculated as percent of inpatient days provided to rural patients) with a minimum payment of $100,000 and a maximum of $4.5 million. Operating expenses were determined based on the most recent Medicare Cost Report. Rural patient share was estimated using the proportion of patients from rural zip codes as reported in the Hospital Service Area File.

How was "small metropolitan area" and "rural" defined for these the Rural/Small Metropolitan Area Targeted Distribution payments? *(Added 7/10/2020)*
"Small metropolitan" was defined as a metro area with less than 250,000 in population as identified by the county-level Rural-Urban Continuum Codes developed by the U.S. Department of Agriculture.

Eligible rural specialty hospitals included Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Acute Care Hospitals (LTACHs) located in a geography that meets the following rural definition:

1. All non-Metro counties.

   All Census Tracts 1 within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties.