CARES Act Provider Relief Fund
Frequently Asked Questions

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Overview

My hospital has not been eligible for any of the Targeted Distributions. Will the hospital be eligible for future funding in an effort to create parity between hospitals? *(Added 8/7/2020)* Future General Distributions will take into account previous allocations, including General Distributions and Targeted Distributions. HHS may consider providers that have only received a Provider Relief Fund General Distribution for priority under future General Distributions.

Who is eligible to receive payments from the Provider Relief Fund? *(Modified 7/14/2020)* 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, or prevented in the spread 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 distributionswill 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.

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

When calculating lost revenue, can health care providers include portions of anticipated lost value-based payments (for example, due to quality measures that do not account for stay-at-home orders)? *(Added 6/19/2020)*
Lost revenue estimates should be based on budget-to-actual or year-over-year, and should include revenue from all sources that can be attributed to COVID-19. This may include value-based payments, such as quality measure achievement payments.

~~**Targeted Distributions**~~

Phase 3

Overview and Eligibility

How does Phase 3 differ from the previous phases of the General Distribution? *(Added 10/5/2020)*
Phase 3 of the General Distribution will take into account documentation of financial impact of COVID-19, as reported by applicants. The payment methodology will ensure a provider has received 2% of annual revenue from patient care either as part of the previous phases of the General Distribution or under a Phase 3 payment. Phase 3 will also take into account a provider's change in operating revenues from patient care, minus their operating expenses from patient care. Phase 3 payment will also take into account funds received and kept under prior General and Targeted Distributions. While HHS has made payments on a rolling basis under the previous general distributions, Phase 3 final payment amounts for applicants who have already received payments equaling 2% of annual patient care revenue will be determined once all applications have been received and reviewed.

Who is eligible for Phase 3 – General Distribution? *(Added 10/5/2020)*
To be eligible to apply, the applicant must meet all of the following requirements:

1. Either
   a. Must have either (i) directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018 to March 31, 2020, or (ii) own (on the application date) an included subsidiary that has either directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018 to March 31, 2020;
   b. or Must be a dental service provider who, as of March 31, 2020, has either (i) directly billed health insurance companies for oral health care-related services, or
   (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for oral health care-related services; or
   c. Must be a licensed dental service provider who does not accept insurance and has, as of March 31, 2020, either (i) directly billed patients for oral health care-related services, or (ii) who owns (on the application date) an included
   subsidiary that does not accept insurance and has directly billed patients for oral health care- related services;
   d. Must have billed Medicare fee-for-service during the period of January 1, 2019 and March 31, 2020;
   e. Must be a Medicare Part A provider that experienced a change in ownership that was approved by the Centers for Medicare & Medicaid services by August 10,

2020 and billed Medicare fee-for-service during the period of January 1, 2019 and March 31, 2020;

f. Must be a state-licensed/certified assisted living facility as of March 31, 2020;
g. Must be a behavioral health provider who, as of March 31, 2020, has either (i) directly billed health insurance companies for health care-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for health care-related services; or
h. Must be a behavioral health provider who does not accept insurance and has, as of March 31, 2020, either (i) directly billed patients for health care-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for health care-related services; or
i. Must have received a Targeted Distribution payment.

2. Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 if in operation before January 1, 2020 or quarterly tax returns for fiscal years 2020 if operations began on or after January 1, 2020 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or health care clinic); and
3. Must have provided patient care after January 31, 2020; and
4. Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
5. If the applicant is an individual that was providing patient care have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

Providers who have previously received a payment under Phase 1 or Phase 2 of the General Distribution are eligible to apply for a payment even if they have previously received a disbursement of 2% of annual revenue from patient care. Providers who have not previously received a General Distribution payment, or an amount that is less than 2% of patient care revenue, may also apply for funds if they meet the above eligibility criteria.

What will be the methodology/formula used to calculate provider payment in Phase 3? ***(Added 10/5/2020)***

Providers will be paid a percentage of their change in operating revenues from patient care minus their operating expenses from patient care. HHS will calculate payments for providers that began providing patient care partway through 2019 or in 2020, and, therefore, do not have data from all of the requested quarters, based on the applicant's financial information that is available and data from the same type of provider as the applicant.

The actual percentage paid to providers will be in part dependent of how many providers apply in Phase 3, and will be determined after the application deadline. Payments will also take into account funds received as part of previous Targeted Distributions. Providers that have not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of the General Distribution will receive at least that amount as part of their Phase 3 payment. Providers that began providing patient care in 2020 will be paid approximately 2% of patient care revenue based on the applicant's reported financial information for those months in 2020 that they were in operation.

What is the payment amount that an applicant should expect to receive from Phase 3 of the General Distribution? *(Added 10/5/2020)*
If an applicant has not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of either Phase 1 or 2 of the General Distribution, then they will receive at least that amount in Phase 3 payment. Payments will also take into account funds received as part of previous Targeted Distributions. HHS will determine final payment amounts above 2% of annual patient care revenue for applicants after the deadline once all applications have been received and reviewed.

When will Phase 3 payments be made? *(Added 10/5/2020)*
HHS intends to issue Phase 3 – General Distribution payments as soon as practical following the Phase 3 application deadline for those entities that have not yet received 2% of annual revenue from patient care.

How will Phase 3 payment be calculated for providers that began operations part way through 2019 or in 2020 that do not have complete financial information from 2019 or the first quarter of 2020? *(Added 10/5/2020)*
HHS will calculate the percentage of change in operating revenues from patient care minus operating expenses from patient care for providers that began operations partway through 2019 or in 2020, and, therefore, do not have data from all of the requested quarters, based on the applicant's financial information that is available and data from the same type of provider as the applicant. Providers that began operation in 2020 will be paid approximately 2% of patient care revenue based on the applicant's reported financial information for those months in 2020 that they were operation.

I am a provider that is newly eligible for Phase 3 of the General Distribution. Should I submit an application as part of Phase 3 or will there be another opportunity to receive a General Distribution payment? *(Added 10/5/2020)*
Providers that are newly eligible should submit their TIN for validation as soon as practical in order to ensure that they can submit an application before the deadline. HHS has not yet determined whether there will be additional General Distribution phases. Providers should not have the expectation that they will be advantaged by applying for funds from one distribution over another. Providers should apply for a Provider Relief Fund payment in the first distribution in which they are eligible.

Are providers that received payments under Phase 3 of the General Distribution limited to using these funds to cover coronavirus-related losses or increased expenses experienced during the first two quarters of calendar year 2020? *(Added 10/5/2020)*
No. The Terms and Conditions require payment recipients to certify that funds will only be used to prevent, prepare for, and respond to coronavirus, and will only reimburse the recipient for health care-related expenses or lost revenues that are attributable to coronavirus. The Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses provided that funds are expended by July 31, 2021, per reporting guidelines. HHS is collecting information on the losses and expenses associated with the first two quarters of 2020 for purposes of making additional General Distribution payments to those providers with demonstrated financial need.

What are the reasons that I would not be eligible for a Phase 3 – General Distribution payment? *(Added 10/5/2020)*
You must meet the five eligibility requirements for the Phase 3 – General Distribution; 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. In addition, your billing TIN must be included in the State-provided list of eligible Medicaid and CHIP providers, the HHS-created list of dental providers, the list of providers who received a General or Targeted Distribution payment, the list of Medicare Part A providers that experienced a change in ownership in 2019 or 2020, or your application must pass additional validation by HHS. If you received payment under previous Targeted Distributions, these funds will be factored into whether you will receive any further payments under Phase 3.

How should an applicant set up an Optum ID if it is applying for Phase 3 – General Distribution payment on behalf of multiple subsidiaries? *(Added 10/5/2020)*

If the applicant is a parent entity applying on behalf of multiple subsidiaries and it would like each subsidiary to receive its own payment, the applicant should create an Optum ID account and submit an application for each TIN that should receive its own payment. The applicant should include the unique banking information for each subsidiary's application.

If the applicant is a parent entity applying on behalf of multiple subsidiaries and it would like a single payment for all of the included subsidiaries, the applicant should create one Optum ID account for the parent entity and submit a single application with the filing TIN.

The parent entity should add its TIN as the "Organizational TIN" on their dashboard. If applying on behalf of subsidiaries, the parent entity will have the opportunity to enter multiple subsidiary TINs associated with the parent organization TIN. After adding the "Organizational TIN," the applicant should click "Get Started" once they arrive on the "Practice Detail" page, under the "Group/Individual Information" heading. The applicant can enter up to 1,200 subsidiary TINs into the "List of Subsidiary TINs Associated with This Entity" field. The applicant may paste a list of TINs directly into this field. Next, the applicant should review their information and click "Submit TIN." Once the organization or subsidiary TINs are verified, the applicant will progress to the DocuSign form, where they can submit the applicable tax information that accounts for each TIN included in the application.

Is a health care provider that did not deposit a check from the Phase 1 – General Distribution that was subsequently voided after 90 days, eligible to apply for the Phase 3 – General Distribution? *(Added 10/5/2020)*

Yes. The health care provider is eligible to apply for a Phase 3 – General Distribution payment if it otherwise meets the eligibility criteria.

In the situation where the Medicaid provider is a management company that bills Medicaid, but the revenues from patient care are ultimately reflected on the property owner's parent company's tax returns (with the management company retaining a portion as a management fee), and the Medicaid provider/management company is not a subsidiary of the property owner or its parent company, which entity should apply for the Medicaid Provider Relief Fund Distribution? *(Added 10/5/2020)*

The Medicaid provider/management company must apply, because neither the property owner nor its parent company is an eligible healthcare provider. The Medicaid provider/management company must use the funds for eligible healthcare related expenses or lost revenues attributable to coronavirus. However, the Medicaid provider/management company could, for example, purchase PPE from the property owner or its parent company.

Is a health care provider eligible to receive a payment from the Phase 3 – General Distribution even if the provider received funding from the Small Business Administration's (SBA) Payroll Protection Program or the Federal Emergency Management Agency (FEMA) or has received Medicaid HCBS retainer payments? *(Added 10/5/2020)* Yes. 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 increased 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.

Providers of self-directed Home- and Community-based Services (HCBS), who do not work for provider agencies, often receive payment through a fiscal management service (FMS) organization who bills Medicaid and remits payment to the provider. Will the requirement that a provider either have directly billed their state Medicaid/CHIP programs or Medicaid managed care plans for health care-related services between January 1, 2018, to March 31, 2019 prevent these providers from being eligible for funding from the relief fund? *(Added 10/5/2020)*
While the self-directed providers are eligible to receive Provider Relief Fund money, payments from the Provider Relief Fund will be made to the filing TIN entity. If the FMS organization is the filing TIN entity, it will need to apply on behalf of the self-directed providers and distribute the funds as appropriate to the providers. If self-directed providers were included in the provider files submitted by CMS from states or are included T-MSIS files, they might be eligible to apply directly for payment. Where a FMS organization receives the Provider Relief Fund payment, it has discretion in allocating the Provider Relief Fund payments among self-directed providers, to support the providers' health care related expenses or lost revenue attributable to COVID-19, so long as the payment is used to prevent, prepare for, or respond to coronavirus and those expenses or lost revenue are not reimbursed from other sources or other sources were not obligated to reimburse them.

Are health care providers that only bill Medicaid or CHIP through a waiver eligible for the Phase 3 – General Distribution? *(Added 10/5/2020)*
Yes. Health care providers that bill for services in Medicaid or CHIP that are covered under either a waiver or state plan, including disability service providers and other providers of Medicaid-funded HCBS (e.g., day habilitation, HCBS waiver program services), are eligible for the Phase 3 **–** General Distribution if they otherwise meet the eligibility criteria.

Are health care providers that only bill Medicaid or CHIP through managed care arrangements eligible for the Phase 3 – General Distribution? *(Added 10/5/2020)*
Yes. Health care providers that bill either fee-for-service or managed care in Medicaid or CHIP are eligible for the Phase 3 – General Distribution if they otherwise meet the other eligibility criteria.

If a health care provider is paid through a certified public expenditure (CPE), will the provider be eligible for the Phase 3 – General Distribution? *(Added 10/5/2020)*
These payment mechanisms do not impact eligibility for the Provider Relief Fund. Phase 3 – General Distribution payments will be paid to the filing TIN entity based on the entity's

percentage of total revenue from patient care and change in operating revenues from patient care, minus their operating expenses from patient care.

Are health care providers that are paid through Organized Healthcare Delivery Systems (OHCDS) and voluntarily assign their direct payment rights to an OHCDS eligible for the Provider Relief Fund Phase 3 – General Distribution? *(Added 10/5/2020)*
Phase 3 – General Distribution payments will be made to the filing TIN entities. If the OHCDS is the filing TIN entity, the payment will go to that entity, who has the sole discretion about how funds are distributed. The Provider Relief Fund payment recipient has discretion in allocating the Provider Relief funds to support its subsidiaries' health care related expenses or lost revenue attributable to COVID-19, so long as the payment is used to prevent, prepare for, or respond to coronavirus and those expenses or lost revenue are not reimbursed from other sources or other sources were not obligated to reimburse.

Are health care providers who bill for Medicaid or CHIP services through a county behavioral health provider network eligible for the Phase 3 – General Distribution? *(Added 10/5/2020)*
Yes. Health care providers that bill for Medicaid or CHIP services through a county behavioral health provider network are eligible for the Phase 3 – General Distribution if they otherwise meet the other eligibility criteria.

Tax Identification Number (TIN) Validation Process

Is there anything different about the TIN validation process for Phase 3 compared to the process for Phase 2? *(Added 10/5/2020)*
Providers that have received General Distribution payments under Phases 1 and/or 2 will not undergo any further validation. Providers that are newly eligible under Phase 3 will be subject to TIN validation processes similar to those employed under Phase 2.

When is the deadline to submit an application? *(Added 10/5/2020)*
The deadline to submit an application under Phase 3 – General Distribution is November 6, 2020.

What if an applicant's TIN is flagged as invalid because it is not on the curated list of eligible providers? *(Added 10/5/2020)*
If a TIN is not on the curated list of eligible providers, HHS will conduct additional analysis related to the TIN and any active providers associated with the TIN. If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign. TINs that cannot be validated will not receive funding.

I received an email saying my Taxpayer Identification Number (TIN) was under review. What does that mean? *(Added 10/5/2020)*
HHS is validating provider eligibility for General Distribution funds by using curated lists generated by state/territory Medicaid and CHIP agencies and third parties for those provider types that do not participate in Medicaid and CHIP. In most instances, HHS will respond within 15 business days; however, this process may take up to several weeks.

Application Process

If I entered my TIN for validation as part of Phase 2 but it was not validated until October

5, 2020 or later, which application will I fill out? *(Added 10/5/2020)*
Providers that submitted a TIN for validation as part of Phase 2 but had their TIN validated on or after October 5, will fill out a Phase 3 application and be considered for additional payment based on Phase 3 payment methodology in addition to approximately 2% of annual revenue from patient care.

Why am I required to reenter information previously submitted as part of Phase 1 and/or Phase 2? *(Added 10/5/2020)*
In order for HHS to make payments as part of Phase 3, the Department needs the most recent financial information available.

I have completed my application and submitted it in the portal, but the portal still says "Get Started" as if I have not submitted. Why is this? *(Added 10/5/2020)*
The portal currently will say "Get Started" until a final determination has been made on provider payment. If and when a payment has been made, you will be able to move on in the portal to attest to the payment.

What is "operating revenues from patient care?" *(Added 10/5/2020)*
HHS considers "operating revenues from patient care" to be net patient service revenue from the delivery of health care services directly to patients. "Net patient service revenue" is defined as gross charges for patient services delivered, minus contractual adjustments from all third party payors, charity care adjustments, bad debt, and any other discounts or adjustments necessary to arrive at net patient service revenue.

What is "operating expense from patient care?" *(Added 10/5/2020)*
HHS considers "operating expenses from patient care" to be the operating expenses incurred as part of the delivery of care, including salaries, benefits, medical supplies, contracted and/or employed physicians, interest, and depreciations. Operating expenses from patient care do not include any non-operating expenses, such as costs incurred on any rental property as well as contributions made, gains, and/or losses on investments.

Am I able to edit or resubmit my Phase 3 – General Distribution application in the Provider Relief Fund Application and Attestation Portal? *(Added 10/5/2020)*
You can only submit one application. You can edit the data on the application form, until the form is submitted. You cannot edit or resubmit the application form once it is submitted. You should not apply until you have available all of the required information and documentation necessary to submit a complete and accurate application.

If an organization neither files taxes nor has audited financial statements, what financial documents should it submit with its application? *(Added 10/5/2020)*
If an organization does not have tax filings, nor audited financial statements, it may submit internally-generated financial statements; in the case of entities receiving Federal grants, the most recent four quarters of SF-425 forms; or for eligible federal entities, the most recent annual report submitted to Unified Financial Management System (UFMS).

What should I do if I do not have the federal tax form to submit my information? *(Added 10/5/2020)*
Upload a statement explaining why the entity is not required to file a federal tax form (note that non-profit entities should submit a Form 990) or is unable to provide the required information. In addition, provide the most recent audited financial statements (or management

prepared financial statements) for the TIN entity. If the financial information of a TIN entity is reported as part of a parent organization, it may be necessary to provide consolidating audited financial statements that breakout the revenue and expenses for the TIN entity.

If a health care provider has changed tax status between the most recent tax filing and the current year, which status should the practice use to apply? *(Added 10/5/2020)*
The health care provider should use the status that was included in the most recent tax filing when applying for Provider Relief Fund payments. For example, if a practice was a C corporation in 2019 and is an S corporation in 2020, it should apply as a C corporation if the provider's most recent tax filing is from 2019.

If a tax-exempt organization receives federal, state, and/or local grant funds, which is reported on line 8 of Form 990, can it include this revenue with the revenue reported in line 9 of the Form 990, in field 10 of the application? *(Added 10/5/2020)*
No. The applicant may only include patient care revenue in its application for Provider Relief Fund payments, which is found in line 9 of Form 990 for tax-exempt organizations.

Should I set up an electronic payment Automated Clearing House (ACH) account before my application is approved? *(Added 10/5/2020)*
Yes, in order to most effectively and quickly deliver funds to providers, HHS recommends that applicants sign up for an ACH account at the same time they submit a Provider Relief Fund application. This will prevent delays in issuing payment once an application has been approved.

Why do I need to set up an electronic payment Automated Clearing House (ACH) account? *(Added 10/5/2020)*
ACH payments are a secure and expeditious way to transfer money. The majority of payments will be made through bank transfer. Organizations with revenue greater than $5,000,000 will be required to set up ACH accounts to allow the Department of Health and Human Services (HHS) to most effectively and quickly deliver funds to providers, as well as maximize program integrity and fraud avoidance.

What if I am a health care provider that is not required to be licensed by my state/territory? How should I fill out Medical/DOH/License Number field in the Group/Individual Information of the Provider Relief Fund Application and Attestation Portal? *(Added 10/5/2020)*
If you are a provider that is not required to be licensed by your state but otherwise meets the eligibility criteria for the second phase of the General Distribution, you should enter "not applicable" in the field. The field cannot be left blank.

How can an individual Home- and Community-based Services (HCBS) self-directed provider determine whether they should be applying on their own behalf or relying on the FMS organization to apply for the Phase 2 – General Distribution? *(Added 10/5/2020)*
In general, if the individual is being paid through an FMS organization, the organization is likely the filing and billing TIN and would be eligible to apply for the Phase 3 – General Distribution. In that situation, the self-directed provider should contact the FMS organization to confirm that the organization is submitting an application on their behalf or whether the provider should submit an application as an individual self-directed provider.

FMS organizations typically have two Taxpayer Identification Numbers (TINs) to comply with Internal Revenue Service requirements. One TIN is used to submit claims and receive

payment from the state Medicaid program and the other is used to process payroll to pay participant-directed workers on behalf of Medicaid beneficiaries who receive participant- directed services. Can an FMS organization include both TINs and use the associated revenue from both TINs' tax returns in their application? *(Added 10/5/2020)*
Yes. The FMS organization can include both TINs and associated revenues in their application for the Phase 3 – General Distribution, as long as the services delivered under both TINs qualify as "patient care" and the entity can meet the attestation requirements for both TINs.

Can FMS organizations' revenue from administrative fees provided by the state Medicaid program be included as "patient care"? *(Added 10/5/2020)*
Yes. Applicants may include administrative fees provided by the state Medicaid program in the reported revenue, as well as in the percentage of revenue from patient care reported in field 12.

If an applicant health care provider bills for care under a single TIN that provides care across multiple different facilities, can the parent organization report patient revenue for every facility that bills underneath the TIN? *(Added 10/5/2020)*
If an applicant health care provider bills for care under a single TIN that provides care across multiple different facilities, the parent organization may report patient revenue and the provider's change in operating revenues from patient care, minus their operating expenses from patient care for every facility that bills underneath the TIN.

When calculating lost revenue, can health care providers include portions of anticipated lost value-based payments (for example, due to quality measures that do not account for stay-at-home orders)? *(Added 10/5/2020)*
Lost revenue estimates should be based on budget-to-actual or year-over-year, and should include revenue from all sources that can be attributed to COVID-19. This may include value-based payments, such as quality measure achievement payments.

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 determine 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.
2. 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.
3. 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.

What types of health care providers received a payment under the Rural/Small

Total Revenue:	Net Patient Revenue + Total Other Income
Net Income:	W/S G-3, Line 29, Col. 1
Profit Margin:	Net Income / Total Revenue
Medicaid Only Days:	Worksheet S-3, Part I, column 7, line 14, plus line 2 and line 32, minus the sum of lines 5 and 6.
Total Days:	Worksheet S-3, Part I, column 8, line 14; plus line 32; minus the sum of lines 5 and 6; plus employee discount days reported on line 30.
Medicaid Only %:	Medicaid Only Days / Total Days

How did HHS calculate "Net Profit Margin"? *(Modified 6/30/2020)*
Profit margin of 3.0% or less was used as one of the criteria to determine whether a hospital was eligible for payment. The calculations were based on total margins. The calculation is "Net Patient Revenue" plus "Total Other Income", which equals "Total Revenue". The calculation is "Net Patient Revenue" plus "Total Other Income", which equals "Total Revenue". The "Net Income" divided by "Total Revenue" is the "Net Profit Margin" percent.

Which year's Medicare cost report was used to calculate the Safety Net Hospital Targeted Distribution eligibility and payment? *(Modified 6/25/2020)*
The most recent cost report was used to calculate eligibility for the Safety Net Hospital Targeted Distribution. For most hospitals, the 2018 Medicare cost report was used because the verified 2019 cost report was not yet available.

Nursing Home Infection Control Distribution

The Terms and Conditions for the Nursing Home Infection Control limit use of payments to certain infection control expenses, including hiring staff, whether employees or independent contractors, to provide patient care or administrative support. Is "hiring" limited to only brining on new staff or may funds be used for existing staff? *(Added 10/5/2020)*
Payments from the Nursing Home Infection Control Distribution may be used to cover "hiring" expenses related to both recruiting new hires and the continued payment and retention of existing staff to provide patient care or administrative support.

How will nursing homes qualify for funds under the quality incentive payment program as part of this distribution? *(Added 9/18/2020)*
Nursing homes will not have to apply to receive a share of this incentive payment allocation. HHS will be measuring nursing home performance and distributing payments based on required nursing home data submissions. To be eligible to receive an incentive payment, a facility must have an active certification as a nursing home or skilled nursing facility (SNF) and must also receive reimbursement from the Centers for Medicare & Medicaid Services (CMS). HHS will review nursing home certification status through the Provider Enrollment, Chain and Ownership System (PECOS) to identify and remove facilities that have a terminated, expired, or revoked certification or enrollment. Facilities must also report data to Certification and Survey Provider Enhanced Reports (CASPER), which will be used to establish eligibility and collect necessary provider data to inform payment.

Additionally, nursing homes must meet two criteria in order to be eligible for payment. First, a