

## **CARES Act Provider Relief Fund**

### **General Distribution FAQs:**

#### ***How does this program work?***

Congress has appropriated \$100 billion to reimburse providers for lost revenues and increased expenses due to the coronavirus pandemic. Funds are being distributed by the Health Resources Service Administration (HRSA) section of the US Department of Health and Human Services (HHS). The funds do not need to be repaid if certain terms and conditions are met.

As of Friday April 24<sup>th</sup>, HRSA has distributed \$30 billion of the \$100 billion to healthcare providers, in proportion to providers' Medicare Fee for Service payments in 2019. Payments were sent directly to providers by automatic deposit or by paper check. Providers were not required to engage in any activity or application in order to get these funds, though providers are required to sign an attestation if they wish to keep the funds. Additionally, some providers were sent a second payment based on their Medicare Cost Reports.

Medicare providers who have *already received a payment* from the Provider Relief Fund are now eligible to apply for *additional* funds by submitting data about their annual revenues and estimated COVID-related losses via the Provider Relief Fund Application Portal. Providers who have NOT yet received any payment from the Provider Relief Fund should NOT use the General Distribution Portal. However, providers who have NOT yet received any payments from the Provider Relief Fund may still receive funds in other distributions.

A detailed description of the entire Provider Relief Fund program can be found [here](#).

#### ***Who is eligible to receive additional payments by submitting an Application to the Provider Relief Fund Payment Portal?***

Any provider who has already received a payment from the Provider Relief Fund as of 5:00 pm EST Friday, April 24<sup>th</sup> can and should apply for additional funding via the Provider Relief Fund Application Portal.

Providers who have not received funding as of 5:00 pm EST Friday April 24<sup>th</sup> are NOT eligible to use the Provider Relief Fund Application Portal, HOWEVER these providers may still be eligible for payments from the Provider Relief Fund through other mechanisms, including the Targeted Distributions being made from the Fund.

#### ***Who is eligible to receive payments from the Provider Relief Fund?***

Provider Relief Funds are being disbursed via both "General" and "Targeted" Distributions.

##### ***General Distribution***

To be eligible for the general distribution, a provider must have billed Medicare in 2019 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. \$50 billion will be disbursed in the General Distribution.

##### ***Targeted Distributions***

A description of the eligibility for the announced Targeted Distributions can be found [here](#).

U.S. healthcare providers may be eligible for payments from the remaining funds through Targeted Distributions that have not yet been announced. Information on future Targeted Distributions will be shared when publicly available.

All providers retaining funds must sign an attestation and accept the terms and conditions associated with payment. Providers must also submit tax documents and financial loss estimates if they wish to be eligible for additional funds.

**Which types of providers are eligible to receive a General Distribution Provider Relief Payment? *(Added 5/6/2020)***

To be eligible for a General Distribution payment, providers must have billed Medicare on a fee-for-service basis (Parts A or B) in Calendar Year 2019. Additionally, under the Terms and Conditions associated with payment, these providers are eligible only if they 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.

All providers retaining funds must sign an attestation and accept the terms and conditions associated with payment. Providers must also submit tax documents and financial loss estimates if they wish to be eligible for additional funds.

**What should a provider do if a General Distribution payment is greater than expected or received in error? *(Added 5/6/2020)***

Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 30 days of payment. Generally, if a provider does not have or anticipate having COVID-related lost revenues or increased expenses equal to or in excess of the relief payments received, they should return the funds. If a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment. If a provider believes they are underpaid, they should accept the payment and submit their revenues in the provider portal to determine their correct payment.

**Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the General Distribution payments? *(Added 5/6/2020)***

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. Generally, HHS does not intend to recoup funds as long as a provider's lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received. 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 other Terms and Conditions may also be grounds for recoupment.

**What is the definition of individuals with possible or actual cases of COVID-19? *(Added 5/6/2020)***

Unless the payment is associated with specific claims for reimbursement for COVID-19 testing or treatment provided on or after February 4, 2020 to uninsured patients, under the Terms and Conditions associated with payment, providers are eligible only if they 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. Not every possible case of COVID-19 is a presumptive case of COVID 19. For clarification as it relates to presumptive COVID 19 cases, refer to the Frequently Asked Question that defines a presumptive case of COVID-19.

### **Terms and Conditions**

#### **What oversight and enforcement mechanisms will HHS use to ensure providers meet the Terms and Conditions of the Provider Relief Fund payments? *(Added 5/6/2020)***

Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of 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 increased healthcare-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 will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES ACT to ensure that Federal dollars are used appropriately.

### ***Balance Billing***

#### **Do the Terms and Conditions for the General, Rural or High Impact 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 don’t 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 associated with the two General Distribution payments and the Rural and High Impact payments 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? *(Added 5/6/2020)***

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.

#### **How will a provider know the in-network rates to be able to comply with the requirement to**

**bill a presumptive or actual COVID-19 patient for cost-sharing at the in-network rate?**

*(Added 5/6/2020)*

Providers accepting the Provider Relief Fund payment should submit a claim to the patient's health insurer for their services. Most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer's prevailing in-network rate. But if the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

**If a hospital receives a Provider Relief Fund payment under the General, Rural or High Impact Distribution and the hospital contracts with an independently contracted provider (e.g., anesthesiologist or laboratory), is that independently contracted provider banned from balance billing for care provided to a "presumptive or actual COVID-19 patient"? *(Added 5/6/2020)***

Yes, if the independently contracted provider also attested to receiving a payment from the Provider Relief Fund.

**Rejecting Payments**

**How can I return a General Distribution payment I received under the Provider Relief Fund? *(Added 5/6/2020)***

Providers may return their General Distribution payment by going into the attestation portal within 30 days of receiving payment and indicating they are rejecting the funds. The [CARES Act Provider Relief Fund Payment Attestation Portal](#) will guide providers through the attestation process to reject the funds.

As explained in the attestation portal, to return the money, the provider would need to contact their financial institution and ask the institution to refuse the received Automated Clearinghouse (ACH) credit by initiating an ACH return using the ACH return code of "R23 - Credit Entry Refused by Receiver." If a provider received the money via ACH they must return the money via ACH. If a provider was paid via paper check, after rejecting the payment in the attestation portal, the provider should destroy the check if not deposited or mail a paper check to UnitedHealth Group with notification of their request to return the funds.

***Reporting Requirements***

**What are the reporting requirements for providers attesting to receipt of Provider Relief Fund payments and when will reporting begin? *(Added 5/6/2020)***

All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the [Terms and Conditions](#) and specified in future directions issued by the Secretary. The specific reporting obligations imposed on providers receiving \$150,000 or more from any Act primarily making appropriations for the coronavirus response and related activities, which is a statutory requirement, begins for the calendar quarter ending June 30. The Secretary may request additional reports prior to that date. HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at <https://www.hhs.gov/provider-relief/index.html>.

## ***Provider Relief Fund Payment Portal***

### ***Could you give me an overview of the application process?***

HHS is distributing \$50 billion from the \$100 billion CARES Act Provider Relief Fund via a “General Distribution.” HHS would like the General Distribution to replace a percentage of a provider’s annual gross receipts, sales, or program service revenue.

HHS will distribute additional moneys via “Targeted Distributions” aimed at providers who are disproportionately impacted by COVID or who have not received payments in the General Distribution.

Providers will only get a General Distribution payment if they billed Medicare in 2019 and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.

The Provider Relief Fund Application Portal has been deployed in order to collect information from providers ***who have already received General Distribution payments prior to April 24<sup>th</sup> 2020 at 5 pm EST.***

The Provider Relief Fund Application Portal is collecting four pieces of information for use in allocating remaining General Distribution funds:

- 1) a provider’s “Gross Receipts or Sales” or “Program Service Revenue” as submitted on its federal income tax return;
- 2) the provider’s estimated revenue losses in March 2020 and April 2020 due to COVID;
- 3) a copy of the provider’s most recently filed federal income tax return;
- 4) a listing of the TINs any of the provider’s subsidiary organizations that have received relief funds but that DO NOT file separate tax returns.

This information may also be used in allocating other Provider Relief Fund distributions.

We are collecting the “gross receipt or sales” or “program service revenue” data to have an understanding of a provider’s usual operations. We are collecting the revenue loss information to have an understanding of COVID impact. We are collecting tax forms in order to verify the self-reported information. And we are collecting information about organizational structure and subsidiary TINs so that we do not overpay or underpay providers who file tax returns covering multiple legal entities (e.g. consolidated tax returns).

Providers meeting the following criteria are required to submit a separate portal application:

- (a)** Provider has received Provider Relief Fund payments as of 5:00 EST Friday April 24<sup>th</sup> **AND**
- (b)** Provider has filed a federal income tax return for 2017, 2018, or 2019.

As such, each entity that files a federal income tax return is required to file an application even if it is part of a provider group. However, a group of corporations that files one consolidated return will have only the tax return filer apply.

Each provider submitting an application is required to list the TINs of each subsidiary that (a) has

received Provider Relief Fund payments as of 5:00 EST Friday April 24<sup>th</sup> **AND (b) has not filed** federal income tax returns for 2017, 2018, or 2019.

**Do not list any subsidiary's TIN that has filed a federal income tax return, because such subsidiary is required to submit a separate application.**

For example:

- 1) A parent entity and two subsidiaries received Provider Relief Fund payments. The parent filed a federal income tax return, but the two subsidiaries did not as they are consolidated with the parent.

The parent should submit an application and list the subsidiary TINs therein. The subsidiaries cannot submit an application as they did not file a tax return.

- 2) A parent entity and two subsidiaries A and B received Provider Relief Fund payments. The parent and subsidiary A filed a federal income tax return, but the subsidiary B did not as it is consolidated with the parent.

The parent and subsidiary A should submit separate applications. The parent would list the TIN subsidiary B in its application.

***What information do I need to have before I start the application process?***

☐ **Eligibility**

To enter the Provider Relief Fund Application Portal you must meet 2 criteria:

1. You must have already received a Provider Relief Fund Payment by 5:00 pm EST, Friday April 24<sup>th</sup>
2. You must attest to having received the payment via the Provider Attestation Portal, and you must agree to the Terms and Conditions on the attestation portal.

☐ **Data**

Before you initiate your application via the Provider Relief Fund Application Portal, please collect the following data

1. The Taxpayer Identification Number for the organization applying for relief funds. ("Application TIN")
2. The Taxpayer Identification Number(s) of any subsidiary organizations if and only if those organizations do not file separate tax returns, but rather consolidate into the returns of the "Application TIN". If your organization has subsidiaries that file separate tax returns, a separate application must be made for each subsidiary that files a separate return.
3. An estimate the organization's lost revenue for March 2020 and April 2020. Lost revenue can be estimated by comparing year-over-year revenue, or by comparing budgeted revenue to actual revenue. For April 2020, an estimate of the total monthly loss based on data from the first few weeks in April or by extrapolation from March data is acceptable.
4. A copy of the most recent tax form filed by the organization associated with the Application TIN.

***Will I be penalized if I take several days to collect the necessary information?***

No. We will be processing applications in batches every Wednesday at 12:00 noon EST. Funds will NOT be disbursed on a first-come-first-served basis, which is to say, an applicant will be

given equal consideration regardless of when they apply.

***I received payment and have already attested, am I eligible to request more funds?***

You are eligible to apply for additional relief funding. A description of the additional distributions of funding may be found [here](#).

***Why does the web site say my TIN is not eligible?***

We are collecting tax and financial loss data from *providers who have already received payments* from the Provider Relief Fund. If you have not already received relief funds you do not need to submit your tax and financial loss information to the Provider Relief Fund Application Portal. However, this does NOT mean that you are ineligible for forthcoming relief funds.

If you have received relief funds and are being told that your TIN is ineligible, please check to see if you entered your TIN correctly and check to see that the TIN matches the TIN for the organization that received relief funds.

***Why does the web site say I have to attest before requesting additional funds?***

The CARES Act requires that providers meet certain terms and conditions in order to receive Provider Relief Funds. In order to keep the funds already received, and in order to be eligible to receive additional funds, you must attest that you meet these terms and conditions and you must submit your financial and tax information.

***Why are you asking me to enter in payment amount and account number (ACH)?***

***Why are you asking me for payment amount and check number (Check)?***

HRSA would like to confirm that all funds distributed were in fact properly received by providers. We are asking for this information to ensure program integrity.

***Where do I find the payment amount on a payment received?***

This is the amount received from HRSA either by direct deposit or check.

***Where do I find the check number on a payment that has been issued?***

If you were issued payment by check, it would have been mailed to you from UnitedHealth Group. The top left address on the check is “Health Resources & Services Administration, Processed by UnitedHealth Group / OptumRx” and the check number is in the top right corner.

***Why is the data I am entering in not matching?***

Make sure you have entered your data correctly, including the exact payment amount (including decimal point) and last six digits of your account number or the check number.

The system is only capturing data from providers who have already received funding. If you haven’t received funding, you will not be able to fill out the attestation form.

***How long does it take for HHS to make a decision on additional funding?***

For providers submitting tax and financial loss information, HHS intends to distribute additional funds within 10 business days of the submission.

For healthcare providers who have not yet received any distribution of funds, HHS is performing an ongoing assessment of how to distribute relief to these providers. It is the Department’s intention to distribute relief funds as quickly as possible.

***How do I find out if my funding request was not approved?***

If you have attested and submitted tax forms and loss estimates, you should receive a payment or other response within 10 business days.

***How does HHS calculate who gets specific amounts of funding?***

HRSA distributed the initial \$30 billion in relief funds in proportion to a provider's Medicare Fee For Service billings.

A description of the allocation methodologies is provided [here](#).

***Are Tax ID's that did not receive initial payment eligible?***

Organizations that have not received any payments as of April 24, 2020 may be eligible for relief funds in future distributions. The portal is only collecting tax IDs from providers who have received an initial payment.

***Are hospitals and health systems in all states and territories eligible?***

Yes.

***Is this a loan or a grant?***

If a provider meets certain terms and conditions, the payments received do not need to be repaid at a later date. These terms and conditions can be found [here](#).

***Do I have to pay this back?***

Retention and use of 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.

***Why do I need to upload my tax forms?***

The \$50 billion general allocation is apportioned based on provider revenue. Tax forms are needed to ascertain and confirm provider revenue.

***What documents do I need in order to begin this process?***

1. TIN that has received prior Provider Relief Fund payments
2. TINS of subsidiary organizations that have received prior Provider Relief Funds *but do not file separate tax forms* (i.e., subsidiary organizations that are accounted for in the parent organization's tax filing)
3. Amount of payments received
4. Relief Fund payment transaction numbers / check numbers
5. A copy of your most recently filed tax forms

***What is DocuSign doing with my data?***

DocuSign is securely passing your data to HHS in encrypted files. Neither DocuSign nor United Healthcare will have access to your data.

***How many requests should I make?***

One for each TIN that has received prior Provider Relief Fund payments.

***How will HHS notify me that my application has been processed?***

You will receive an email when your application is completed.



You will receive no notification from HHS as to the status of your application once submitted. You should expect additional funds, if you are to receive any, within 10 business days of completing your application.

***How will HHS notify me if they need additional information?***

We do not anticipate that you will receive any inquiries from HHS. If additional information is requested, HHS will use the email used to access the Provider Portal.

***How long does the process take?***

Funds should be disbursed within 10 days of the submission of your application.

***When can I expect to receive additional funds?***

Funds should be disbursed within 10 days of the submission of your application.

***How do I appeal or dispute a decision made?***

There is no appeals or dispute process.

***Who should fill out this form?***

Any person authorized by the provider organization may complete this form. We would recommend that it be completed by an organization's corporate office, specifically, the CFO or other accounting professional.

***How will additional stimulus payments be processed or handled?***

A description of additional disbursements can be found [here](#).

***What information is shared with UnitedHealth Group, UnitedHealthcare, Optum, or any other subsidiary of UnitedHealth Group?***

UnitedHealth Group and its subsidiaries will not have access to any information collected from providers, nor do they participate in determining the methodology used to allocate relief fund payments.

UnitedHealth Group will know the amounts of relief funding paid to providers, as UnitedHealth Group is processing the payments.

***Why am I being redirected to DocuSign to fill out certain elements?***

HHS is using DocuSign as the vendor to securely pass encrypted data to HHS. Neither DocuSign nor UnitedHealth Group will have access to your data.

***Who has access to my revenue data?***

HHS will have access to your data in order to optimally allocate Provider Relief Funds. HHS will not share your revenue data with any other entities, in or outside of government, except as prescribed by law.

***Who determines the amount my organization will receive?***

HHS will apportion relief funds to US healthcare providers with the intention of optimizing the beneficial impact of the funds.

***Who can I talk to at HHS about my distribution payment?***

HHS is not taking direct inquiries from providers, and no remedy or appeals process will be available.

***What is a Federal Tax Classification?***

The Federal Tax Classification describes the type of tax filer that the applicant is for purposes of the applicant's federal income tax return with the IRS, for example Partnership or S Corporation.

***How do I know if I'm a sole proprietor/disregarded entity? C Corporation? S Corporation? Partnership? Trust? Tax-Exempt Organization?***

The answer is determined by the type of the applicant's entity and any tax elections the applicant has made.

***Which tax form did the applicant file for the most recent year?***

Form 1040 -> The applicant is a sole proprietor or provides services as the sole member of an LLC.

Form 1065 -> The applicant is a partnership.

Form 1120 -> The applicant is a C corporation.

Form 1120-S -> The applicant is an S corporation.

Form 990 -> The applicant is a tax-exempt organization.

Form 1041 -> The applicant is a trust.

***Where do I find my Gross Receipts or Sales?***

Form 1040 -> Box 1 of Schedule C

Form 1065 -> Box 1a

Form 1120 -> Box 1a

Form 1120-S -> Box 1a

Form 990 -> Use Part I, 9 "Program Services revenue"

Form 1041 -> Box 1 of Form 1040 Schedule C

[Note: you use a Form 1040 Schedule C also for Form 1041]

***Which information should be submitted by a state-run entity (e.g. state university medical center) that has no parent organization that files a federal income tax return?***

The applying state entity should select "Tax-Exempt Organization" in the dropdown menu for "Federal Tax Classification." The state entity should use Net Patient Revenues from its most recent audited annual financial statements as a substitute for "Program Services Revenue" when prompted. Further, the state entity should submit its most recent audited financial statements as a substitute for the federal income tax return Form 990 requested.

***How do I estimate lost revenue in March or April?***

You may use a reasonable method of estimating the revenue during March and April compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

***Why are you asking me for Gross Receipts or Sales?***

We are asking for Gross Receipts because it is a measure of revenues you received during the applicable filing period.

***Why are you asking me to estimate my revenue?***

We realize that a final revenue number may not be available until a certain time after the end of

April. As the program seeks to provide liquidity support to the healthcare system in a timely manner we are using estimated revenues.

***Where do I find program service revenue if I am a tax exempt organization?***

Box 9 of the Form 990.

***Do I submit 2019 or 2018 forms?***

Submit the most recent form that you have filed with the IRS (typically 2017, 2018 or 2019).

***What if I haven't filed taxes for the year being requested?***

If you are required to, but have not filed a tax return in 2017 or 2018, you are ineligible to apply. You should file the applicable return and re-apply.

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

You must attest for all payments received to be eligible for additional funding.

You are only eligible to apply for additional funding through this process if you have TINs that have received prior relief fund payments.

Fill out one application for each eligible TIN that has received relief funding and for which there is a corresponding tax filing. If you are a subsidiary of a tax filing organization, and do not file a separate tax return, you are ineligible to apply for additional funds.

***Where do I find my Medicare ID?***

Applicants may find their Medicare ID number by logging into the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

***What is a CAQH Provider ID? Where do I find it?***

Council for Affordable Quality Healthcare (CAQH) Provider ID number is the unique identifier assigned to each CAQH ProView user at the time of registration. If you have been invited to join CAQH ProView by a health plan, hospital or other participating organization, you may have received a welcome letter with your CAQH Provider ID Number. New users also have the option to self-register through the CAQH ProView Provider portal: <https://proview.caqh.org/pr>. Upon completion of the self-registration process, users will receive a welcome email with their unique CAQH Provider ID Number.