Provider Relief Programs:
Provider Relief Fund and ARP Rural Payments
Frequently Asked Questions

Skilled Nursing Facilities Targeted Distribution
Indian Health Service Targeted Distribution
Safety Net Hospitals Targeted Distribution
Nursing Home Infection Control Distribution

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? ***(Added 4/25/2020)***
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.

Are Provider Relief Fund recipients required to notify HRSA if they have filed a bankruptcy petition? ***(Added 12/9/2021)***
Yes. Provider Relief Fund recipients must immediately notify HRSA about their bankruptcy petition or involvement in a bankruptcy proceeding so that the Agency may take the appropriate steps. When notifying HRSA about a bankruptcy, please include the name that the bankruptcy is filed under, the docket number, and the district where the bankruptcy is filed. You must submit this information to PRFbankruptcy@hrsa.gov. If a Provider Relief Fund recipient has filed a bankruptcy petition or is involved in a bankruptcy proceeding, federal financial obligations will be resolved in accordance with the applicable bankruptcy process, the Bankruptcy Code, and applicable non-bankruptcy federal law.

What is the Assistance Listing (AL) (formerly the Catalog of Federal Domestic Assistance (CFDA)) number for the Provider Relief Fund program? ***(Added 9/29/2021)***
The AL number is 93.498.

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.

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.

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 for cost reports? ***(Modified 9/3/2020)***
Please refer to CMS FAQs on how Provider Relief Fund payments should be reported on cost reports.

How can a health care provider find more information on the status of their Provider Relief Fund payment or application? ***(Added 7/8/2020)***
Providers should contact the Provider Support Line at (866) 569-3522 (for TTY, dial 711), if they have questions about the status of their payment or application. When calling, providers should have ready the last four digits of the recipient's or applicant's Tax Identification Number (TIN), the name of the recipient or applicant as it appears on the most recent tax filing, the mailing address for the recipient or applicant as it appears on the most recent tax filing, and the application number (begins with either "DS" or "CR") if they have submitted an application in the Provider Relief Fun Payment Portal.

Are hospitals and health systems in all states and territories eligible for a Provider Relief Fund payment? ***(Modified 8/4/2020)***
Yes. Hospitals and health systems in all states and territories eligible for Provider Relief Fund payments.

Will health care providers that experienced a change in ownership that disqualified them from receiving a Provider Relief Fund payment be able to receive a payment that was returned by the previous owner? ***(Added 7/8/2020)***
In order to ensure program integrity and transparency, HHS made Provider Relief Fund payments to health care providers based on the latest data available for a TIN. As previous owners are not permitted to transfer funds to the new owner, they were instructed to return the funds to HHS. At this time, HHS will not reissue returned payments to the new owners. Providers that have not received payments under the Provider Relief Fund due to issues related to change of ownership will be eligible to apply for future allocations. Additional information will be posted as available at https://www.hrsa.gov/provider-relief/future-payments.

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.

Can providers who have ceased operation due to the COVID-19 pandemic still receive this funding? ***(Added 5/29/2020)***
If a provider ceased operation as a result of the COVID-19 pandemic, they are still eligible to receive Provider Relief Fund payments so long as they provided on or 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, therefore, care does not have to be specific to treating COVID-19. Recipients of funding must still comply with the Terms and Conditions related to permissible uses of Provider Relief Fund payments.

If a provider secures COVID-19-related funding separate from the Provider Relief Fund, such as the Small Business Administration's Paycheck Protection Program, does that affect how they can use the payments from the Provider Relief Fund? Does accepting Provider Relief Fund payments preclude a provider organization from seeking other funds authorized under the CARES Act? ***(Added 5/29/2020)***
There is no direct ban under the CARES Act on accepting a payment from the Provider Relief Fund and other sources, so long as the payment from the Provider Relief Fund is used only for permissible purposes and the recipient complies with the Terms and Conditions. By attesting to the Terms and Conditions, the recipient certifies that it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Are Provider Relief funds accessible in whole or in part to bankruptcy creditors and other creditors in active litigation? ***(Added 6/8/2020)***
Payments from the Provider Relief Fund shall not be subject to the claims of the provider's creditors and providers are limited in their ability to transfer Provider Relief Fund payments to their creditors. A provider may utilize Provider Relief Fund payments to satisfy creditors'

claims, but only to the extent that such claims constitute eligible health care related expenses and lost revenues attributable to coronavirus and are made to prevent, prepare for, and respond to coronavirus, as set forth under the Terms and Conditions.

May a health care provider that receives a payment from the Provider Relief Fund exclude this payment from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code (Code)? ***(Added 7/10/2020)***
No. A payment to a business, even if the business is a sole proprietorship, does not qualify as a qualified disaster relief payment under section 139. The payment from the Provider Relief Fund is includible in gross income under section 61 of the Code. For more information, visit the Internal Revenue Services' website at https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments.

Is a tax-exempt health care provider subject to tax on a payment it receives from the Provider Relief Fund? ***(Added 7/10/2020)***
Generally, no. A health care provider that is described in section 501(c) of the Code generally is exempt from federal income taxation under section 501(a). Nonetheless, a payment received by a tax-exempt health care provider from the Provider Relief Fund may be subject to tax under section 511 if the payment reimburses the provider for expenses or lost revenue attributable to an unrelated trade or business as defined in section 513. For more information, visit the Internal Revenue Services' website at https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments.

Will I receive a Form 1099? ***(Added 12/18/2020)***
Yes, you will receive a Form 1099 if you received and retained within the calendar year 2020 a total net payment from either or both of the Provider Relief Fund and COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured that is in excess of $600.

When will my Form 1099 be available? ***(Added 12/18/2020)***
Form 1099s will be mailed by January 31st, 2021. If you have previously established an account with UnitedHealth Group and elected to receive electronic copies of documents and notices, you will not receive a mailed copy.

Who do I contact if I have question regarding my Form 1099? ***(Added 12/18/2020)***
Please call the Provider Support Line (866) 569-3522 (for TTY, dial 711) for any questions you may have regarding your Form 1099.

What is HHS doing with payments that are returned to the Provider Relief Fund? ***(Added 6/30/2020)***
HHS will allocate returned payments to future distributions of the Provider Relief Fund.

Which sections of 45 CFR 75 – UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR HHS AWARDS are

applicable to the General and Targeted Distributions of the Provider Relief Fund? ***(Added 12/28/2020)***
Recipients (both non-federal entities and commercial organizations) of the General and Targeted Distributions of the Provider Relief Fund are subject to 45 CFR 75 Subpart A (Acronyms and Definitions) and B (General Provisions), subsections §§75.303 (Internal Controls), and 75.351-.353 (Subrecipient Monitoring and Management), and Subpart F (Audit Requirements). In addition, the terms and conditions of the PRF payments incorporate by reference the obligation of recipients to comply with the requirements to maintain appropriate financial systems at 75.302 (Financial management and standards for financial management systems) and the requirements for record retention and access at 75.361 through 75.365 (Record Retention and Access).

Attestation

What action does a provider need to take after receiving a Provider Relief Fund payment? ***(Modified 10/28/2020)***
The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meet these terms and conditions of the payment. The CARES Act Provider Relief Fund Payment Attestation Portal or the Provider Relief Fund Application and Attestation Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 90 days of receipt will be viewed as acceptance of the Terms and Conditions. A provider must attest for each of the Provider Relief Fund distributions received.

Do the Provider Relief Fund attestation portals require payment recipients to attest that the payment amount was received? ***(Modified 10/28/2020)***
Yes. The attestation portals require payment recipients to (1) confirm they received a payment and the specific payment amount that was received; and (2) agree to the Terms and Conditions of the payment.

What if I attested and accepted a Provider Relief Fund payment, but would now like to reject the funds and retract my attestation? ***(Added 6/3/2020)***
If you affirmatively attested to a Provider Relief Fund payment already received and later wish to reject those funds and retract your attestation, you may do so by calling the provider support line at (866) 569-3522; for TTY dial 711. Note, HHS is posting a public list of providers and their payments once they attest to receiving the payment and agree to the Terms and Conditions.

Rejecting or Returning Payments

How can I return a payment I received under the Provider Relief Fund? (*Modified 10/26/2021)*
The following instructions are to return the full payment amount:

If the provider received payment via electronic transfer, the provider needs to contact their financial institution and ask the institution to initiate a "R23 - Credit Entry Refused by Receiver" code on the original Automated Clearing House (ACH) transaction.

If a provider was paid via paper check, the provider should destroy the check if it is not deposited, or mail a paper check to UnitedHealth Group with notification of their request to

return the funds. Mail a refund check for the full amount payable to "UnitedHealth Group" to the address below.

UnitedHealth Group
Attention: Provider Relief Fund
PO Box 31376
Salt Lake City, UT 84131-0376

Returning the payment in full or not depositing the payment received by paper check within 90 days without taking further action in the attestation portal is considered a de facto rejection of the terms and conditions associated with the payment.

The following instructions are to return a <u>partial</u> payment amount:

Entities can return partial payments via Pay.gov. For more information on this process, please review the instructions available at https://na3.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=45c01db6-78db-403a-baa3-480c1950f596&env=na3&acct=dd54316c-1c18-48c9-8864-0c38b91a6291&v=2.

If I rejected a Provider Relief Fund payment through one of the attestation portals and returned the payment or returned a payment through Pay.gov, but then I changed my mind, can I receive a new payment? *(Modified 10/26/2021)*
HHS will not issue a new payment to a provider that received and then subsequently submitted a full or partial return of a payment, using either the attestation portal or Pay.gov, if the rejected payment and potential new payment are within the same distribution. The provider may be considered for future distributions if it meets the eligibility criteria for that distribution.

How can a provider return unused Provider Relief Fund payments that it has partially spent? *(Modified 10/20/2021)*
Providers that have Provider Relief Fund payments that they cannot expend on allowable expenses or lost revenues attributable to coronavirus by the Period of Availability that corresponds to the Payment Received Period are required to return such funds to the federal government.

Period	Payment Received Period	Period of Availability
Period 1	April 10, 2020 to June 30, 2020	January 1, 2020 to June 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2020 to December 31, 2021
Period 3	January 1, 2021 to June 30, 2021	January 1, 2020 to June 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2020 to December 31, 2022

To return any unused funds, use the Return Unused PRF Funds Portal. Instructions for returning any unused funds are available at: https://na3.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=45c01db6-78db-403a-baa3-480c1950f596&env=na3&acct=dd54316c-1c18-48c9-8864-0c38b91a6291&v=2.

The Provider Relief Fund Terms and Conditions and applicable laws authorize HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are/were met. HHS is authorized to recover any Provider Relief Fund payment amounts that

were made in error, exceed lost revenue or expenses due to coronavirus, or do not otherwise meet applicable legal and program requirements.

If a provider rejects the payment in the attestation portal but does not return the payment within 15 calendar days, is the provider still subject to the Terms and Conditions? ***(Added 8/30/2021)***

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

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 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.

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."

How should a provider return a payment it received via check? *(Modified 10/28/2020)*
If the provider received a payment via check and has not yet deposited it, destroy, shred, or securely dispose of it. If the provider has already deposited the check, mail a refund check for the full amount, payable to "UnitedHealth Group" to the address below via United States Postal Service (USPS); mailing services such as FedEx and UPS cannot be used with this PO box. Please list the check number from the original Provider Relief Fund check in the memo. Mail a refund check for the full amount payable to "UnitedHealth Group" to the address below.

UnitedHealth Group
Attention: Provider Relief Fund
PO Box 31376
Salt Lake City, UT 84131-0376

How does a provider who received an electronic payment return funding if their financial institution will not allow them to return the payment electronically? *(Added 5/12/2020)*
Contact UnitedHealth Group's Provider Support Line at (866) 569-3522 (for TTY, dial 711).

Provider Relief Fund Terms and Conditions

What financial transactions are Reporting Entities required to report in order to satisfy the requirement in the Terms and Conditions for Phase 4 that recipients must notify HHS of a merger with or acquisition of any other health care provider during the Payment Received Period within the Reporting Time Period? *(Added 12/9/2021)*
The Terms and Conditions for Phase 4 require that recipients that receive payments greater than $10,000 notify HHS during the applicable Reporting Time Period of any mergers with or acquisitions of any other health care provider that occurred within the relevant Payment Received Period. HRSA considers changes in ownership, mergers/acquisitions, and consolidations to be reportable events.

If a merger or acquisition was planned before receiving Phase 4 General Distribution payments, will health care providers still need to report these activities? *(Modified 12/9/2021)*
If a Reporting Entity that received a Phase 4 General Distribution payment undergoes a merger or acquisition during the Payment Received Period, as described in the Post-Payment Notice of Reporting Requirements, the Reporting Entity must report the merger or acquisition during the applicable Reporting Time Period.

What type of review will HRSA do after a merger or acquisition has been reported by recipients of a Phase 4 General Distribution payment? *(Modified 12/9/2021)*
If a Reporting Entity that received a Phase 4 General payment indicates when they report on the use of funds that they have undergone a merger or acquisition during the applicable Payment Received Period, this information will be a component that is factored into whether an entity is audited.

Does HHS intend to recover any payments made to providers not associated with specific claims for reimbursement, such as the General or Targeted Distribution payments? *(Modified 10/20/2021)*

The Provider Relief Fund Terms and Conditions require that recipients be able to demonstrate that lost revenues or expenses attributable to coronavirus, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, meet or exceed total payments from the Provider Relief Fund. Provider Relief Fund payment amounts that have not been fully expended on health care expenses or lost revenues attributable to coronavirus by the deadline to use funds that corresponds to the Payment Received Period must be returned to HHS. The Provider Relief Fund Terms and Conditions and applicable legal requirements authorize HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are met. Provider Relief Fund payments that were made incorrectly, or exceed lost revenues or expenses due to coronavirus, or do not otherwise meet applicable legal and program requirements must be returned to HHS, and HHS is authorized to recover these funds.

What should providers do if they have remaining Provider Relief Fund payments that they cannot expend on allowable expenses or lost revenues by the relevant deadline? *(Modified 10/20/2021)*

Providers that have Provider Relief Fund payments that they cannot expend on allowable expenses or lost revenues by the deadline to use funds that corresponds to the Payment Received Period, as outlined in the Post-Payment Notice of Reporting Requirements, will return this money to HHS. The Provider Relief Fund Terms and Conditions and legal requirements authorize HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are met. HHS is authorized to recover any Provider Relief Fund amounts that were made incorrectly or exceed lost revenues or expenses due to coronavirus, or do not otherwise meet applicable legal and program requirements.

What oversight and enforcement mechanisms will HHS use to ensure providers meet the Terms and Conditions of the Provider Relief Fund? *(Modified 10/20/2021)*

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

What if my payment is greater than expected or received in error? *(Modified 10/14/2021)*

If HHS identifies a payment made incorrectly, HHS will recover the amount paid incorrectly or overpaid. If a provider receives a payment that is greater than expected and believes the

payment was made incorrectly, the provider should contact the Provider Support Line at (866) 569-3522 (for TYY, dial 711) and seek clarification.

Certain recipients are required to notify HHS of a merger with or acquisition of any other health care provider during the Payment Received Period (as defined in the Provider Relief Fund Post Payment Notice of Reporting Requirements). How will recipients report this information to HHS/HRSA? ***(Added 9/29/2021)***
To streamline the process and minimize provider burden, this information will be collected in the Provider Relief Fund Reporting Portal as part of the regular reporting process. Additional reporting information will be forthcoming for impacted providers.

If a provider cannot expend its Provider Relief Fund payment by the applicable deadline to use funds, what is the deadline to return the unused funds to the government? ***(Modified 9/29/2021)***
The provider must return any unused funds to the government within 30 calendar days after the end of the applicable Reporting Time Period or any associated grace period.

Is there a set period of time in which providers must use the payments to cover allowable expenses or lost revenues attributable to COVID-19? ***(Modified 8/30/2021)***

Yes. Providers have at least 12 months, and as much as 18 months, based on the payment received date, to control and use the payments for expenses and lost revenues attributable to coronavirus incurred during the Period of Availability.

The payment is considered received on the deposit date for automated clearing house (ACH) payments, or the check cashed date for all other payments.

Period	Payment Received Period	Period of Availability
Period 1	April 10, 2020 to June 30, 2020	January 1, 2020 to June 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2020 to December 31, 2021
Period 3	January 1, 2021 to June 30, 2021	January 1, 2020 to June 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2020 to December 31, 2022

Provider Relief Fund recipients must use payments only for eligible expenses, including services rendered and lost revenues attributable to coronavirus, incurred by the end of the Period of Availability that corresponds to the Payment Received Period. Providers are required to maintain supporting documentation that demonstrates that costs were incurred during the Period of Availability, as required under the Terms and Conditions. However, providers are not required to submit that documentation when reporting. Providers must promptly submit copies of such supporting documentation upon the request of the Secretary of HHS. Examples of costs incurred for an entity using accrual accounting, during the Period of Availability include:

- Services that were received
- Renovation or construction that was completed
- Tangible property ordered, but need not have been delivered

For purchases of tangible items made using PRF payments, the purchase does not need to be in the provider's possession (i.e., back ordered PPE, ambulance, etc.) to be considered an eligible expense but the costs must be incurred by the end of the Period of Availability. Providers must follow their basis of accounting (e.g., cash, accrual, or modified accrual) to determine expenses. For projects that are a bundle of services and purchases of tangible items that cannot be separated, such as capital projects, construction projects, or alteration and renovation projects, the project costs cannot be reimbursed using Provider Relief Fund payments unless the project was fully completed by the end of Period of Availability associated with the Payment Received Period.

Recipients may use payments for eligible expenses or lost revenues incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. However, HHS expects that it would be highly unusual for providers to have incurred eligible expenses or lost revenues prior to January 1, 2020.

HHS reserves the right to audit Provider Relief Fund recipients now or in the future, and may pursue collection activity to recover any Provider Relief Fund payment amounts that have not been supported by documentation or payments not used in a manner consistent with program requirements or applicable law. All payment recipients must attest to the Terms and Conditions, which require maintaining documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus.

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? ***(Modified 6/11/2021)***
No. Providers do not need to be able to prove that prior and/or future lost revenues and expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment at the time they accept such a payment. Providers must report on the use of Provider Relief Fund payments in accordance with legal and program requirements in the relevant Reporting Time Period. Recipients may use payments for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. Providers must follow their basis of accounting to determine expenses. Duplication of expenses and lost revenues is not permitted. All recipients are subject to audit.

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. 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.

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.

What is the definition of Executive Level II pay level, as referenced in the Terms and Conditions? *(Added 5/29/2020)*
The Terms and Conditions state that none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other mechanism, at a rate in excess of Executive Level II. The salary limitation is based upon the Executive Level II of the Federal Executive Pay Scale. Effective January 5, 2020, the Executive Level II salary is $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.

The Terms and Conditions set forth a list of "statutory provisions" that "also apply" to the Provider Relief Fund payment. Do these requirements apply to any government funding received by the recipient, or only the Provider Relief Fund payment associated with those Terms and Conditions? *(Added 6/8/2020)*
The "statutory provisions" listed in the Terms and Conditions apply to the Provider Relief Fund payment associated with those Terms and Conditions. Those statutory provisions may also independently apply to other government funding that you receive.

ARP Rural Payments Terms and Conditions

What financial transactions are Reporting Entities required to report in order to satisfy the requirement in the Terms and Conditions for ARP Rural payments that recipients must notify HHS of a merger with or acquisition of any other health care provider during the Payment Received Period within the Reporting Time Period? *(Modified 12/9/2021)*
The Terms and Conditions for ARP Rural payments require that recipients that receive payments greater than $10,000 notify HHS during the applicable Reporting Time Period of any mergers with or acquisitions of any other health care provider that occurred within the Payment Received Period. HRSA considers changes in ownership, mergers/acquisitions, and consolidations to be reportable events.

If a merger or acquisition was planned before receiving ARP Rural payments, will health care providers still need to report these activities? *(Modified 12/9/2021)*
If a Reporting Entity that received an ARP Rural payment undergoes a merger or acquisition during the Payment Received Period, the Reporting Entity must report the merger or acquisition during the applicable Reporting Time Period.

What type of review will HRSA do after a merger or acquisition has been reported by recipients of an ARP Rural payment? *(Modified 12/9/2021)*
If a Reporting Entity that received an ARP Rural payment indicates when they report on the use of funds that they have undergone a merger or acquisition during the applicable Payment Received Period, this information will be a component that is factored into whether an entity is audited.

How long do I have to expend the ARP Rural payment? *(Added 9/29/2021)*
Providers that received funds in calendar year 2021 have through December 31, 2022 to incur eligible expenses and may apply the payment to lost revenues incurred since January 1, 2020. Providers may not use ARP Rural payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Can an applicant allocate ARP Rural payments to its non-rural subsidiaries? *(Added 9/29/2021)*
No. As required by the Terms and Conditions, control and use of the ARP Rural payment must be delegated to the provider associated with the billing TIN that was eligible for the ARP Rural payment. The provider cannot not transfer or allocate the ARP Rural payment to another entity not associated with the billing TIN.

What can ARP Rural payment recipients use funds for? *(Added 9/29/2021)*
Payment recipients must certify that the payment will only be used to prevent, prepare for, and respond to COVID-19, and that the payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus not reimbursed by other sources or that other sources are obligated to reimburse.

Lost revenues attributable to the coronavirus may include other income not derived from delivery of health care services that has been customarily used to support the delivery of health care services by the recipient. Examples include, but are not limited to, decreases in tax revenue and non-federal, government grant funding. In accounting for such lost revenues, the recipient must document the historical sources and uses of these revenues. For more information about lost revenues, please review HRSA's Lost Revenues Guide available at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/prf-lost-revenues-guide.pdf.

Additionally, expenditures to prevent, prepare for, and respond to coronavirus may include those incurred expenses necessary to maintain health care delivery capacity by the recipient or to increase health care delivery capacity in the future as informed by community health needs. This may include outreach and education about the vaccine for the provider's staff, as well as the general public.

Ownership Structures and Financial Relationships

Can a provider that purchased, merged with, or consolidated with another entity (purchaser/new owner) in 2019, 2020, 2021, or 2022, accept a Provider Relief Fund payment from a seller/previous owner, and complete the attestation for the Terms and Conditions? *(Modified 12/9/2021)*
The answer depends on the status of the TIN that received the PRF payment. The purchaser/new owner cannot accept the payment directly from another entity nor attest to the Terms and

Conditions on behalf of the seller/previous owner in order to retain the Provider Relief Fund payment, including payment under the Nursing Home Infection Control Quality Incentive Payment Program, unless the seller's Medicare provider agreement and TIN was accepted by the purchaser in the transaction. However, the purchaser/new owner may apply for and/or receive future funds.

An organization that sold part of a practice in 2019 or January 2020 received a payment under Phase 1 of the General Distribution that reflected the 2019 Medicare fee-for-service billing of the part of the practice that was sold. Can the parent entity return a portion of the payment for the part of the practice it no longer owns? *(Modified 7/1/2021)*
If a provider has unused funds, it may return all or a portion of the funds when the first reporting period begins. If a provider that sold a practice that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Can an organization that received a Provider Relief Fund payment and provided care on or after January 31, 2020 that sold, terminated, transferred, or otherwise disposed of a provider accept the payment (received via ACH or check) associated with the sold provider? *(Modified 7/1/2021)*
If an organization that sold, terminated, transferred, or otherwise disposed of a provider that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus up to the date of the sale, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

If, as a result of the sale of a practice/hospital, the TIN that received a Provider Relief Fund payment is no longer providing health care services as of January 31, 2020, is it required to return the payment? *(Modified 7/1/2021)*
Yes. If, as a result of the sale of a practice/hospital, the TIN that received a Provider Relief Fund payment did not provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, the provider must reject the payment. The Provider Relief Fund Payment Attestation Portal guides providers through the attestation process to reject the attestation and return the payment to HRSA.

Can a parent organization transfer General Distribution Provider Relief Fund payments to its subsidiaries? *(Modified 3/31/2021)*
Yes, a parent organization can accept and allocate General Distribution funds at its discretion to its subsidiaries, as long as the Terms and Conditions are met. Eligible health care entities, including those that are parent organizations must substantiate that these funds were used for health care-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Can a parent organization allocate Provider Relief Fund General Distribution to subsidiaries that do not report income under their parent's employee identification number (EIN)? ***(Modified 3/31/2021)***

Yes, as long as the Terms and Conditions are met. The parent organization (an eligible health care entity) must substantiate that these funds were used for health care-related expenses or lost revenue attributable to COVID-19, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

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 1/28/2021)***

No. The parent organization may allocate the Targeted Distribution to any of its subsidiaries that are eligible health care providers in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act.

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? ***(Modified 1/28/2021)***

The parent entity must attest to the Terms and Conditions for the Targeted Distribution payment if it is the entity that received the payment. It may attest on behalf of any or all subsidiaries that qualified for a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment. The parent organization may allocate the Targeted Distribution to any of its subsidiaries that are eligible health care providers in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act.

Can a parent organization with a direct ownership relationship with a subsidiary that received a Provider Relief Fund Targeted Distribution payment control and allocate that Targeted Distribution payment among other subsidiaries that were not themselves eligible and did not receive a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment? ***(Modified 1/28/2021)***

Yes, in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act. The parent organization may allocate the Targeted Distribution up to its pro rata ownership share of the subsidiary to any of its other subsidiaries that are eligible health care providers. To determine whether an entity is the parent organization, the entity must follow the methodology used to determine a subsidiary in their financial statements. If none, the entity with a majority ownership (greater than 50 percent) will be considered the parent organization.

In the case of a parent organization with multiple billing TINs that may have each received a General Distribution payment, may the parent organization attest to the Terms and Conditions and keep the payments? ***(Modified 1/28/2021)***

Yes, the parent organization with subsidiary billing TINs that received General Distribution payments may attest and keep the payments as long as providers associated with the parent organization were providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020 and can otherwise attest to the Terms and Conditions. The parent organization can allocate funds at its discretion to its subsidiaries.

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 and return any unused funds to HHS.

Can an organization that sold its only practice or facility under a change in ownership in 2019 or 2020 and is no longer providing services accept payment and transfer it to the new owner? *(Modified 10/28/2020)*
No. A provider that sold its only practice or facility must reject the Provider Relief Fund payment because it cannot attest that it was providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, as required by the Terms and Conditions. Seller organizations should not transfer a payment received from HHS to another entity. If the current TIN owner has not yet received any payment from the Provider Relief Fund, it may still receive funds in other distributions.

Auditing and Reporting Requirements

Do commercial organizations that do not submit their audit through the Federal Audit Clearinghouse get an extension to the submission due date for their audit? *(Added 12/9/2021)*
Yes. Both commercial organizations and non-federal entities are granted a six-month extension to the submission of audits that have a fiscal-year end through June 30, 2021. As a reminder, audits are due 30 calendar days after receipt of the audit report or nine months after the end of the audit period – whichever is earlier. On March 19, 2021, the Office of Management and Budget (OMB) Memo (M-21-20) extended the deadline for Single Audit submissions to six months beyond the normal due date, and on October 28, 2021, HHS granted the same extension to commercial organizations.
If you have questions about this extension or want to inform HRSA you will be taking advantage of this flexibility, please email HRSA's Division of Financial Integrity at PRFaudits@hrsa.gov.
If you have questions about the audit in accordance with 45 CFR 75.501 for Provider Relief Fund payments, please email your questions to ProviderReliefContact@hrsa.gov.

A non-profit corporation has multiple subsidiaries, including a for-profit subsidiary, that are consolidated for financial reporting purposes. Can the Single Audit of the non-profit corporation include the expenditures of federal awards of the for-profit subsidiary? ***(Added 9/13/2021)***

Yes, the non-profit corporation can include the expenditures of federal awards of its for-profit subsidiary in its Single Audit. Federal regulations at 45 CFR § 75.501 or "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards" (Uniform Guidance) permits a for-profit subsidiary to be included in the Single Audit, as long as the for-profit subsidiary's operations are included in the consolidated financial statements and program expenditures are included in the Schedule of Expenditure of Federal Awards (SEFA). The inclusion of the for-profit subsidiary in the consolidated entity's Single Audit would meet the for-profit entity's responsibility for an audit under 45 CFR § 75.501(i).

A for-profit corporation has multiple subsidiaries that are consolidated for financial reporting purposes, and some of the subsidiaries also report separately. Can the for-profit entity fulfill the 45 CFR § 75.501 audit requirements by having one financial-related audit of all HHS awards in accordance with Government Auditing Standards that incorporates all entities that are consolidated under Generally Accepted Accounting Principles (GAAP)? ***(Added 9/13/2021)***

Yes, the for-profit entity can have one financial-related audit of all HHS awards that incorporates all entities. 45 CFR § 75.501(i) audit requirements permit this approach.

Multiple for-profit entities under common control issue combined financial statements. Can each of the for-profit entities fulfill the 45 CFR § 75.501 audit requirements by having one financial-related audit of all HHS awards in accordance with Government Auditing Standards that incorporates each of the entities? ***(Added 9/13/2021)***

Yes, multiple for-profit entities under common control that issue combined financial statements can have one financial-related audit of all HHS awards that incorporates each of the entities. 45 CFR § 75.501(i) audit requirements permit this approach.

Can my organization get an extension to the submission due date for Single Audits conducted under 45 CFR Part 75? ***(Modified 9/13/2021)***

Yes. As a reminder, audits are due 30 calendar days after receipt of the auditor report or nine months after the end of the audit period – whichever is earlier. However, an Office of Management and Budget (OMB) Memo (M-21-20) extended the deadline for Single Audit submissions, allowing recipients and subrecipients that have not submitted their Single Audits with the Federal Audit Clearinghouse as of March 19, 2021, and have a fiscal-year end through June 30, 2021, to delay the submission of the Single Audit reporting package by six months beyond the normal due date.

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

If you have questions about the Single Audit for Provider Relief Fund, please email your questions to ProviderReliefContact@hrsa.gov.

When should Provider Relief Fund expenditures and/or lost revenue be reported on a for-profit entity's Schedule of Expenditures of Federal Awards (SEFA) or other schedules prepared for the financial-related audit option conducted in accordance with Government Auditing Standards? ***(Added 8/30/2021)***
Similar to non-federal entities, for-profit entities will include Provider Relief Fund expenditures and/or lost revenues on their SEFAs or other schedules for fiscal year ends (FYEs) ending on or after June 30, 2021.

How will a for-profit entity determine the amount of expenditures and/or lost revenues to report on its SEFA or other schedules prepared for the financial-related audit option conducted in accordance with Government Auditing Standards (for FYEs ending on or after June 30, 2021)? ***(Added 8/30/2021)***
Similar to non-federal entities, a for-profit entity's SEFA (or other schedules) is linked to its report submissions to the Provider Relief Fund Reporting Portal. Therefore, the timing of reporting of Provider Relief Fund payments on the SEFA (or other schedules) will be as follows:

- For FYE's of June 30, 2021 through FYEs of December 30, 2021, recipients must report on the SEFA (or other schedules) the total expenditures and/or lost revenues included in the Period 1 report submission to the Provider Relief Fund Reporting Portal.
- For FYE's of December 31, 2021 through FYEs of June 29, 2022, recipients must report on the SEFA (or other schedules) the total expenditures and/or lost revenues included in both the Period 1 and Period 2 report submissions to the Provider Relief Fund Reporting Portal.

For FYEs on or after June 30, 2022, reporting guidance for the SEFA or other schedules related to Period 3 and Period 4 will be provided at a later date.

When should Provider Relief Fund expenditures and/or lost revenue be reported on a non-federal entity's Schedule of Expenditures of Federal Awards (SEFA)? ***(Modified 8/30/2021)***
Non-federal entities will include Provider Relief Fund expenditures and/or lost revenues on their SEFAs for fiscal year ends (FYEs) ending on or after June 30, 2021. Please refer to the *2021 OMB Compliance Supplement,* available at https://www.whitehouse.gov/wp-content/uploads/2021/08/OMB-2021-Compliance-Supplement_Final_V2.pdf, for additional information.

How will a non-federal entity determine the amount of expenditures and/or lost revenues to report on its SEFA for FYEs ending on or after June 30, 2021? ***(Added 7/15/2021)***
A non-federal entity's SEFA reporting is linked to its report submissions to the Provider Relief Fund Reporting Portal. Therefore, the timing of SEFA reporting of PRF will be as follows:

- For a FYE of June 30, 2021, and through FYEs of December 30, 2021, recipients are to report on the SEFA, the total expenditures and/or lost revenues from the **Period 1** PRF report submission to the PRF reporting portal.

- For a FYE of December 31, 2021, and through FYEs of June 29, 2022, recipients are to report on the SEFA, the total expenditures and/or lost revenues from both the **Period 1** and **Period 2** PRF report submissions to the PRF reporting portal.
- For FYEs on or after June 30, 2022, SEFA reporting guidance related to **Period 3** and **Period 4** will be provided at a later date.

Will HHS release separate requirements for recipients of the Skilled Nursing Facility (SNF) and Nursing Home Infection Control Distribution payments? ***(Added 6/11/2021)***
No. HHS included requirements on how recipients of the SNF and Nursing Home Infection Control Distribution payments will report on these funds in the June 2021 Post-Payment Notice of Reporting Requirements. Recipients of this funding will be able to submit a consolidated report that distinguishes use of SNF and Nursing Home Infection Control Distribution funds from use of other General and Targeted Distribution payments.

Will HHS provide guidance to certified public accountants and those organizations that providers will rely on to perform audits? ***(Modified 6/11/2021)***
The only guidance HHS provides to auditors is through the Office of Management and Budget Compliance Supplement. Non-Federal Entities subject to Single Audit requirements can find guidance in the 2020 Compliance Supplement Addendum, which is available at https://www.whitehouse.gov/wp-content/uploads/2020/12/2020-Compliance-Supplement-Addendum_Final.pdf and in the forthcoming 2021 Compliance Supplement. The applicable Assistance Listings numbers include 93.498 [Provider Relief Fund] and 93.461 [HRSA COVID-19 Uninsured Program].

Are Provider Relief Fund payments to commercial (for-profit) organizations subject to Single Audit *in conformance with the requirements under 45 CFR 75 Subpart F*? *(Modified 6/11/2021)*
Commercial organizations that expend $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 Generally Accepted Government Auditing Standards; or 2) an audit in conformance with the requirements of 45 CFR 75.514 (Single Audit).
Provider Relief Fund General and Targeted Distribution payments (93.498) and Uninsured Testing, Treatment, and Vaccine Administration reimbursement payments (93.461) must be included in determining whether an audit in accordance with 45 CFR Subpart F is required (i.e., annual *total awards expended* are $750,000 or more).

Audit reports of commercial organizations must be submitted via email to HRSA's Division of Financial Integrity at PRFaudits@hrsa.gov.

The Rural Health Clinic (RHC) COVID-19 Testing Program requires that recipients report payments received separately from the payment(s) received as part of the Provider Relief Fund. How do RHCs determine whether they received payment as part of the RHC COVID-19 Testing Program? *(Added 2/24/2021)*
RHCs that were issued a payment with the descriptor "HHSPAYMENT" or "COVID*RuralHealthTestingPmt*HHS.GOV" on or around May 20, 2020, June 9, 2020, December 7, 2020, and/or January 20, 2021, received these payments as part of RHC COVID-19 Testing Program. HHS provided $49,461.42 for each eligible RHC with a unique CMS

Certification Number (CCN) associated with an eligible Tax Identification Number (TIN). TIN organizations must report data associated with COVID-19 testing payments on the Rural Health Clinic COVID-19 Testing Report Portal available at https://www.rhccovidreporting.com/. For additional information, please visit HRSA's website at https://www.hrsa.gov/rural-health/coronavirus/frequently-asked-questions#rhc. If you have additional questions please email RHCcovidreporting@narhc.org for technical assistance.

Are Provider Relief Fund payments to non-Federal entities (states, local governments, Indian tribes, institutions of higher education, and nonprofit organizations) subject to Single Audit? ***(Modified 7/30/2020)***
Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) to non-Federal entities are Federal awards and must be included in determining whether an audit in accordance with 45 CFR Part 75, Subpart F is required (i.e., annual *total federal awards expended* are $750,000 or more).

Audit reports must be submitted to the Federal Audit Clearinghouse electronically at https://harvester.census.gov/facides/Account/Login.aspx.

(Requirements for audit of payments to commercial organizations are discussed in a separate question.)

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 https://www.hrsa.gov/provider-relief/reporting-auditing.

Use of Funds

If a provider received Provider Relief Fund payments and ARP Rural payments, can they use these payments for the same eligible expenses or lost revenues? ***(Added 10/26/2021)***
No. A provider may not use an ARP Rural payment to cover eligible health care expenses or lost revenues attributable to coronavirus or COVID-19 if the provider has already reported that Provider Relief Fund payments have covered the eligible expense or lost revenues. If a provider receives both types of funding, the provider should apply Provider Relief Fund payments toward eligible health care expenses and lost revenues attributable to coronavirus before utilizing ARP Rural payments to cover eligible health care expenses and lost revenues attributable to COVID-19.

How does cost-based reimbursement relate to my Provider Relief Fund payment? (Modified 10/26/2021)
Recipient must follow CMS instructions for completion of cost reports available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.

Under cost-based reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. If the full cost was reimbursed based upon this method, there is nothing eligible to report as a Provider Relief Fund expense attributable to coronavirus because the expense was fully reimbursed by another source. Provider Relief Fund payments cannot be used to cover costs that are reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if Medicare or Medicaid makes a payment to a provider based on the provider's Medicare or Medicaid cost, such payment generally is considered to fully reimburse the provider for the costs associated with providing care to Medicare or Medicaid patients and no payment from the PRF would be available for those identified Medicare and Medicaid costs. Per its authorizing statutes, Provider Relief Fund resources may only be used for allowable expenses and lost revenues attributable to coronavirus, and may only be reimbursed once. Reporting Entities should work with their accountants and maintain documentation demonstrating that any reported health care expenses that Provider Relief Fund payments were applied to were not reimbursed by any other source, or obligated to be reimbursed by another source.

However, in cases where a ceiling is applied to the cost reimbursement, or the costs are not reimbursed under cost-based reimbursement (such as costs for care to commercial payer patients), and the reimbursed amount by Medicare or Medicaid does not fully cover the actual cost, those non-reimbursed costs are eligible for reimbursement under the Provider Relief Fund.

Must HRSA Health Center Program-funded health centers and look-alikes fully draw down Health Center Program COVID-19 Supplemental grant funding received from HRSA before using Provider Relief Fund payments for eligible expenses and lost revenues attributable to coronavirus? (Modified 8/30/2021)
Yes, Health Center Program COVID-19 Grants awarded to FQHCs and FQHC Look-Alikes for costs for expenses or losses that are potentially eligible for payments under the Provider Relief Fund would need to be fully drawn down before Provider Relief Fund payments could be used during the applicable period of availability. The Provider Relief Fund requires that payments not be used to reimburse expenses or lost revenues that have been reimbursed from other sources or

that other sources are obligated to reimburse. If FQHCs or FQHC Look-alikes have incurred expenses or lost revenues attributable to coronavirus that these grant awards do not cover, they may use Provider Relief Fund payments towards those expenses or losses. Grant funding may be awarded to support either broad or specific allowable uses, depending on the terms and conditions of the award. Recipients must use grant funding awarded by HRSA for the purposes (as budgeted) approved by HRSA. Should those costs also be eligible for payment under the Provider Relief Fund, a Health Center Program-funded health center or look-alike must use their grant funds before utilizing Provider Relief Fund payments.

How does a Reporting Entity determine whether an expense is eligible for reimbursement through the Provider Relief Fund? ***(Modified 8/30/2021)***
To be considered an allowable expense under the Provider Relief Fund, the expense must be used to prevent, prepare for, and respond to coronavirus. Provider Relief Fund payments may also be used for lost revenues attributable to the coronavirus. Reporting Entities are required to maintain adequate documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

Reporting Entities are not required to submit that documentation when reporting. Providers are required to maintain supporting documentation which demonstrates that costs were incurred during the Period of Availability. The Reporting Entity is responsible for ensuring that adequate documentation is maintained.

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? ***(Modified 8/30/2021)***
Expenses for capital facilities may be fully expensed only in cases where the purchase was directly related to preventing, preparing for and responding to the coronavirus. Examples of these types of facilities projects include:

- Upgrading a heating, ventilation, and air conditioning (HVAC) system to support negative pressure units
- Retrofitting a COVID-19 unit
- Enhancing or reconfiguring ICU capabilities
- Leasing or purchasing a temporary structure to screen and/or treat patients
- Leasing a permanent facility to increase hospital or nursing home capacity

In order for the capital facilities projects' costs to be expensed, the project must be fully completed by the end of the Period of Availability associated with the Payment Received Period.

If rent or mortgages were paid during the applicable period of availability but staff worked remotely, could those expenses be claimed as eligible expenses? ***(Added 7/1/2021)***
Health care-related operating expenses are limited to costs incurred to prevent, prepare for, and respond to coronavirus. The amount of mortgage or rent eligible for Provider Relief Fund reimbursement is limited to that which was incurred to prevent, prepare for, and respond to coronavirus. Providers are required to maintain documents to substantiate that these funds were used for health care-related expenses attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse

them. The burden of proof is on the provider to ensure that documentation is maintained to show that expenses are to prevent, prepare for, and respond to coronavirus.

If a Reporting Entity anticipates that it will receive coronavirus-related assistance, such as from FEMA, but that assistance has not yet been received, should that be accounted for in its Provider Relief Fund reporting? ***(Added 7/1/2021)***

Provider Relief Fund payments may be applied to expenses or lost revenues attributable to coronavirus, after netting the other funds received or obligated to be received which offset those expenses. If a provider has submitted an application to FEMA, but has not yet received the FEMA funds, the provider should not report the requested FEMA amounts in the Provider Relief Fund report. If FEMA funds are received during the same Payment Received Period in which provider is reporting on use of Provider Relief Fund payments, the receipt and application of each payment type is required in the Provider Relief Fund reporting process. If an entity receives a retroactive payment from FEMA that overlaps with the period of availability, the entity must not use the FEMA payment on expenses or lost revenues already reimbursed by Provider Relief Fund payments.

Must the Reporting Entity be in receipt of purchases made using Provider Relief Fund Payments in order for the expense to be considered eligible for reimbursement? ***(Added 7/1/2021)***

No. For purchases of tangible items made using Provider Relief Fund payments, the purchase does not need to be in the Reporting Entity's possession (i.e., backordered personal protective equipment, capital equipment) to be considered an eligible expense. However, the costs must be incurred before the Deadline to Use Funds. Providers must follow their basis of accounting (e.g., cash, accrual, or modified accrual) to determine expenses.

Can providers allocate parent overhead costs to the entities that received Provider Relief Funds? ***(Modified 7/1/2021)***

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

How do I determine if expenses should be considered "expenses attributable to coronavirus not reimbursed by other sources?" ***(Modified 9/13/2021)***

Expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, personnel, and other health care-related costs/expenses for the period of availability. The classification of items into categories should align with how Provider Relief Fund payment recipients maintain their records. Providers can identify their expenses attributable to coronavirus, and then offset any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance Program (CHIP); other funds received from the federal government, including the Federal Emergency Management Agency (FEMA); the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured (Uninsured Program); the COVID-19 Coverage Assistance Fund (CAF); and the Small Business Administration (SBA) and Department of the Treasury's Paycheck Protection Program (PPP). Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting the other funds received or obligated to be received which offset those expenses. The Provider Relief Fund permits reimbursement of expenses

related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse.

Can Reporting Entities claim the time spent by staff and director-level resources on COVID-19-specific matters, such as participating in task forces or preparing their health care organization's COVID-19 response, that they would not have otherwise spent time on in the absence of the pandemic? ***(Added 2/24/2021)***
Time spent by staff on COVID-19-specific matters may be an allowable cost attributable to coronavirus so long as it was not reimbursed or obligated to be reimbursed by other sources. If the personnel salaries are reimbursed by any other source of funding they cannot be also reimbursed by the Provider Relief Fund. In addition, no one individual may be allocated as greater than one full-time equivalent (FTE) across all sources of funding. All costs must be tangible expenses (not opportunity costs) and must be supported by documentation.

The Reporting Entity must maintain appropriate records and cost documentation including, as applicable, documentation described in 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient must promptly submit copies of such records and cost documentation upon the request of the Secretary, and the Reporting Entity agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

Are there any restrictions on how hospitals that receive Medicaid disproportionate share hospital (DSH) payments can use Provider Relief Fund General and Targeted Distribution payments? ***(Added 2/24/2021)***
Yes. Providers may not use PRF payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if a hospital has received Medicaid DSH payments for the uncompensated costs of furnishing inpatient and/or outpatient hospital services to Medicaid beneficiaries and to individuals with no source of third party coverage for the services, these expenses would be considered reimbursed by the Medicaid program and would not be eligible to be covered by money received from a General or Targeted Distribution payment. For more information on the calculation of the Medicaid hospital-specific DSH limit, see https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

Is interest earned on Provider Relief Fund funds considered a reportable revenue source to HHS? ***(Modified 1/28/2021)***
Yes, if funds were held in an interest-bearing account, they would be considered reportable revenue. If interest is earned on Provider Relief Fund disbursements that the Reporting Entity expended in full, the interest amounts may be retained and applied toward a reportable use of funds.

If interest is earned on funds that are only partially expended, the interest on remaining unused funds must be calculated, reported, and returned.

My state or territorial Medicaid or Children's Health Insurance Program (CHIP) agency has directed providers to use Provider Relief Fund dollars before applying Medicaid or

CHIP reimbursement, as well as Medicaid COVID-19 supplemental payments, to cover health care-related expenses or lost revenues attributable to coronavirus. Is this permissible? *(Added 12/28/2020)*
No. 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/CHIP, 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.

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.

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

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

Personnel Category	Number of Personnel	Personnel Expenses	Personnel Expenses (Below Salary Cap)	Ineligible for Federal Reimbursement
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.

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.

Calculating Eligible Expenses and Lost Revenue

How should reimbursements received from the HRSA COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured (Uninsured Program) and the HRSA COVID-19

Coverage Assistance Fund (CAF) be reported in the Provider Relief Fund Reporting Portal? ***(Added 9/13/2021)***

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

How should providers that require separate reporting on behalf of parent entities and/or subsidiaries calculate lost revenue across these entities? ***(Added 9/13/2021)***

The Provider Relief Fund payment recipient has discretion in allocating the payments to support its subsidiaries' health care-related expenses or lost revenues attributable to coronavirus, so long as the payment is used to prevent, prepare for, or respond to coronavirus and those expenses or lost revenues are not reimbursed from other sources or other sources were not obligated to reimburse.

Option iii, from the Post-Payment Notice of Reporting Requirements, provides Reporting Entities flexibility in the reconciliation of lost revenues. Lost revenues may then be applied as the reporting entity sees fit. Reporting Entities should work with their accounting firms to determine an appropriate way to allocate expenses and lost revenues. The Reporting Entity is responsible for ensuring that adequate documentation is maintained. Provider Relief Fund payments may be applied to expenses and lost revenues attributable to coronavirus according to the Period of Availability of funding. However, expenses and lost revenues may not be duplicated: payments may not be applied to the same expenses and lost revenues that were reported on in prior reporting periods.

Should grants awarded to FQHCs under the Health Center Program and COVID-specific grants to FQHC Look-Alikes be factored into the lost revenue calculation? ***(Added 8/30/2021)***

No. Grants awarded to Health Center Program-funded health centers and look-alikes are used to support specific operating costs of the FQHC, as approved by HRSA through the annual budgeting process, and are not considered to be patient services revenue. Therefore, such grants should not be factored into the lost revenues calculation.

How will HRSA calculate lost revenues for providers that select Option i (Comparison of Actual Lost Revenues) at the time of reporting? ***(Modified 8/30/2021)***

For Option i, lost revenues are calculated for each quarter during the Period of Availability, as a standalone calculation, with 2019 quarters serving as a baseline. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount. The annual lost revenues are then added together. There is no offset.

How will HRSA calculate lost revenues for providers that select Option ii (Comparison of Budgeted to Actual Lost Revenues) at the time of reporting? ***(Added 8/30/2021)***

For Option ii, lost revenues are calculated for each quarter during the period of availability, as a standalone calculation, with budgeted quarters serving as a baseline. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount. The annual lost revenues for the years included in the period of

availability are then added together. There is no offset. Reporting Entities may use budgeted revenues if the budget(s) and associated documents covering the Period of Availability were established and approved prior to March 27, 2020.

When reporting on lost revenues, how should Reporting Entities treat "contractual adjustments from all third party payers" and "charity care adjustments" when determining patient care-related revenue sources? ***(Modified 8/30/2021)***
Patient care-related revenue should be reported net of adjustments for all third party payers, charity care adjustments, bad debt, and any other discounts or adjustments, as applicable when reporting patient care-related revenue sources. For example, if a provider's gross patient revenue was $5,000, and the contractual adjustment from the third-party payer or charity care adjustments was $3,000, the provider should report on the PRF report $2,000 in patient care-related revenue.

What is the maximum allotment of my organization's Provider Relief Fund amount that can be allocated to lost revenues during the period of availability of funds? ***(Modified 8/30/2021)***
There is not a maximum or minimum that can be allocated. Reporting Entities will see the reporting system asks for unreimbursed expenses attributable to coronavirus first in the overall use of funds calculation; it is possible for a Reporting Entity to enter "0". Provider Relief Fund payment amounts not fully expended on unreimbursed health care-related expenses attributable to coronavirus during the period of availability are then applied to lost revenues. Lost revenues or expenses must only have been incurred during the Period of Availability correlating to the Payment Received Period as described in the June 11 Post-Payment Notice of Reporting Requirements.

For Option i (Comparison of Actual Lost Revenues), lost revenues are calculated for each quarter during the Period of Availability, as a standalone calculation, with 2019 quarters serving as a baseline. For Option ii (Comparison of Budgeted to Actual Lost Revenues), Reporting Entities may use budgeted revenue if the budget(s) and associated documents covering the Period of Availability were established and approved prior to March 27, 2020. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount. There is no offset. Option iii provides maximum flexibility to providers by allowing providers to calculate lost revenues using an alternate reasonable methodology.

What is the baseline comparison period for providers that report on patient care revenue using Option i (Comparison of Actual Lost Revenues) or Option ii (Comparison of Budgeted to Actual Lost Revenues)? ***(Modified 8/30/2021)***
Actual revenue from quarters in 2019 will serve as the baseline period of comparison for the Period of Availability for Option i. Budgeted revenue from the quarters reported in 2020 or 2021 will serve as the baseline period of comparison for Option ii. For Option ii, Reporting Entities may use budgeted revenues if the budget(s) and associated documents covering the Period of Availability were established and approved prior to March 27, 2020.

Can recipients use 2020 budgeted revenues as a basis for reporting lost revenues? *(Modified 7/1/2021)*

Yes. When reporting use of Provider Relief Fund payments toward lost revenues attributable to coronavirus, Reporting Entities may use budgeted revenues if the budget(s) and associated documents covering calendar year 2020 were established and approved prior to March 27, 2020. To be considered an approved budget, the budget must have been ratified, certified, or adopted by the Reporting Entity's financial executive, executive officer or other responsible representative as of that date, and the Reporting Entity will be required to attest that the budget was established and approved prior to March 27, 2020. Documents related to the budget, including the approval, must be maintained in accordance with the Terms and Conditions.

How will HRSA use "Other Assistance Received" when calculating expenses or lost revenues? *(Added 7/1/2021)*

The Other Assistance Received reported to HRSA will not be used in the calculation of expenses or lost revenues. Reporting Entities are expected to make a determination of their expenses applied to Provider Relief Fund payments after considering "Other Assistance Received" and taking into account that Provider Relief Fund payments may not be used for expenses or lost revenues that other sources have reimbursed or that other sources are obligated to reimburse.

How will HRSA use the net unreimbursed expenses attributable to coronavirus in the calculation of expenses or lost revenues? *(Added 7/1/2021)*

The net unreimbursed expenses attributable to coronavirus reported to HRSA will not be used in the calculation of expenses or lost revenues. Reporting Entities are expected to determine their net unreimbursed expenses attributable to coronavirus after taking into consideration the application of Other Assistance Received and all Provider Relief fund payments. HRSA expects that Provider Relief Fund payments would be applied to unreimbursed expenses attributable to coronavirus that are not obligated to be reimbursed by other sources before Provider Relief Fund payments are used for lost revenues. Reporting Entities will see the reporting system asks for unreimbursed expenses attributable to coronavirus first in the overall use of funds calculation; it is possible for a Reporting Entity to enter "0".

Will patient care revenue be counted against a Reporting Entity twice if the entity reported in "Other Assistance Received" and in the "Patient Care/Lost Revenue" sections of the Reporting Portal? *(Added 7/1/2021)*

Patient care revenue should not be reported as part of "Other Assistance Received" as it is a source of revenue, not a source of other assistance as defined by Provider Relief Fund reporting requirements. The "Other Assistance Received" reported to HRSA will not be used in the calculation of expenses applied to Provider Relief Fund payments or lost revenues.

If a Reporting Entity has more lost revenue for a "Payment Received Period" than it received Provider Relief Fund payments for the same period, can that lost revenue be carried forward and applied against payments received during later "Payment Received Periods" and included in the lost revenues reported during later reporting periods? *(Added 7/1/2021)*

Yes. Provider Relief Fund payments may be applied to expenses and lost revenues according to the period of availability of funding. However, expenses and lost revenues may not be duplicated. Specifically, payments received may not be applied to the same expenses and lost revenues that Provider Relief Fund payments received in prior payment periods already

reimbursed. The Payment Received Periods described in the June 11, 2021 Post-Payment Notice of Reporting Requirements determine the period of availability of funding and when reports are due.

Reporting Entities have varying fiscal year ends (e.g., June 30, September 30, or December 31). How should providers report lost revenues if their fiscal year does not align with the calendar year? ***(Added 7/1/2021)***
All Reporting Entities that opt to report lost revenues using Option i (Comparison of Actual Revenue) or Option ii (Comparison of Budgeted Revenue to Actual Revenue) must enter their patient care revenue for each quarter within the entire period of availability. Reporting Entities using Option iii must enter their lost revenues, calculated by any reasonable method, for each quarter during the period of availability.

If a Reporting Entity experienced quarterly patient care revenue losses during some, but not all, of the quarters during the period of availability of funds, may Provider Relief Fund payments be used to cover losses during those quarters only? ***(Added 7/1/2021)***
Yes, lost revenues are calculated for each quarter during the period of availability, as a standalone calculation. Provider Relief Fund payments may be used to cover those quarters where patient care revenue losses occurred as long as those losses were attributable to coronavirus.

Supporting Data

What documentation is required for reporting? ***(Modified 6/11/2021)***
Supporting worksheets will be available to assist Reporting Entities with completion of reports. In addition, Reporting Entities who are using a portion of their funds for lost revenues may be required to upload supporting documentation when reporting on their calculation of lost revenues. The documentation required is dependent upon which method of calculating lost revenues providers select. Please review the most recently published Post-Payment Notice of Reporting Requirements for additional details.

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.

Change of Ownership

Who is responsible for reporting use-of-funds in the event of a change of ownership after receipt of a Provider Relief Fund payment? ***(Modified 6/11/2021)***
In the case of a change in ownership after receipt of a Provider Relief Fund payment, the responsibility for reporting in the Provider Relief Fund Reporting Portal is dependent on whether funds were from the General or Targeted Distribution.

For General Distribution payments: A parent entity may report on its subsidiaries' General Distribution payments regardless of whether the subsidiary TINs received the General Distribution payments directly or whether General Distribution payments were transferred to

them by the parent entity. The parent entity may report on these General Distribution payments regardless of whether the parent or the subsidiary attested to the Terms and Conditions.

For Targeted Distribution payments: The original recipient of a Targeted Distribution payment is always the Reporting Entity. A parent entity may not report on its subsidiaries' Targeted Distribution payments as part of its consolidated report. The original recipient of a Targeted Distribution must report on the use of funds in accordance with the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act. This is required regardless of whether the parent or subsidiary received the payment or whether that original recipient subsequently transferred the payment. A Reporting Entity that is a subsidiary must indicate the payment amount of any of the Targeted Distributions it received that were transferred to/by the parent entity, if applicable.

Non-Financial Data

Why is HRSA requiring Reporting Entities to report patient metrics? ***(Added 12/9/2021)***
HRSA is requiring Reporting Entities to report patient metrics to gather information on the number of patients treated by Provider Relief Fund recipients. Depending on recipient type, these patients may be treated in either inpatient, outpatient, or residential settings. These metrics enable HRSA to quantify respective volumes of inpatient, in-person, and virtual outpatient visits, as well as emergency visit patients.

What if a Reporting Entity does not believe their patient encounters align with one of the patient visit type options? ***(Added 12/9/2021)***
If a Reporting Entity cannot identify a fitting patient visit type for their patient encounters, the entity should count the distinct encounters or visits in the category that is the most fitting category available.

Should dialysis chairs be counted as staffed beds if a patient is admitted as an inpatient? ***(Added 9/13/2021)***
No. Further, only the facility that owns the bed should report on the staffed beds.

What are the categories for patient metrics? ***(Modified 7/1/2021)***
Patient metric categories include a) inpatient admissions; b) outpatient visits (in-person and virtual); c) emergency department visits; and d) facility stays (for long-term and short-term residential facilities). The definitions are included below.

a) Inpatient Admissions: number of hospital admissions on a clinician's order (i.e., direct admit) or formally admitted from the emergency department to the hospital (i.e., emergency admission).
b) Outpatient Visits: number of in-person or virtual patient encounters with a clinician in an office-based, clinic, or hospital outpatient department setting that do not require an inpatient admission.
c) Emergency Department Visit: number of emergency department encounters for care or treatment. This may include patients on observation status who are cared for no longer than 72 hours but not formally admitted to a hospital.
d) Facility Stays: number of stays (defined as unique admissions) for patients residing in a long-term or short-term care or treatment facility.

A comprehensive user guide with definitions will be made available when the first reporting period begins.

What are the categories for classifying personnel? ***(Modified 6/11/2021)***
Personnel will be classified as either "clinical" or "non-clinical" staff using the following categories: a) full-time; b) part-time; c) contractor; d) furloughed; e) separated; and f) hired.

a) Full-time: number of personnel employed on average 30 hours of service per week, or 130 hours for a calendar month.
b) Part-time: number of personnel employed any time between 1 and 34 hours per week, whom may or may not qualify for benefits.
c) Contractor: number of personnel employed as an individual or under organizational contracts and do not receive direct benefits or compensation from the Reporting Entity.
d) Furloughed: number of personnel on involuntary and unpaid leave of absence.
e) Separated: number of personnel who 1) voluntarily submitted a written or verbal notice of resignation or 2) the Reporting Entity decided to terminate its relationship with the employee(s) (includes lay-offs and expired contracts).
f) Hired: number of personnel 1) not previously employed by the Reporting Entity or 2) that left a company due to voluntary or involuntary separation and are brought back to work by employer.

What is considered a "staffed bed" for reporting facility metrics? ***(Modified 6/11/2021)***
A staffed bed is licensed and physically available with staff on hand to attend to patients; includes both occupied and available beds.

Extensions

Will HRSA allow late report submissions? ***(Modified 10/26/2021)***
In general, HRSA will not accept late report submissions after the applicable deadline associated with the Payment Received Period. However, in light of the challenges that providers across the country are facing due to recent natural disasters and the Delta variant, HRSA has authorized a 60-day grace period for the first reporting period only, in order to help providers adhere to their Provider Relief Fund reporting requirements, should they fail to meet the September 30, 2021 reporting deadline. This grace period is designed to help providers who are facing hardships and will end on November 30, 2021, at 11:59pm Eastern Standard Time (EST). Repayment and/or recovery activities or other enforcement actions will not be initiated during the 60-day grace period (October 1 – November 30, 2021). Providers who do not submit reports timely will be considered out of compliance with program Terms and Conditions until they report.

Are providers able to request extensions on submissions of their required reports for any of the required reporting periods? ***(Modified 9/29/2021)***
No. Providers that received one or more payments exceeding $10,000, in the aggregate, during a Payment Received Period are required to report in each applicable Reporting Time Period. Providers that are required to report and do not submit a completed report by the applicable deadlines will be deemed out of compliance with the program Terms and Conditions and may be subject to repayment and/or recovery activities.

Are providers able to request extensions on the deadline to use funds? ***(Modified 9/29/2021)***
No. HRSA will not approve extensions on the use of funds for any providers. Any unused funds must be returned to the government within 30 calendar days after the end of the relevant Reporting Time Period or any associated grace period.

Miscellaneous

Should state and federal tax credits (e.g., employee retention tax credits) be reported as "other assistance received?" ***(Added 12/9/2021)***
No. Tax credits are not considered a revenue source for purpose of reporting within the Provider Relief Fund report.

What are the required timelines for reporting? ***(Modified 9/29/2021)***
Provider Relief Fund recipients are required to report in each Payment Received Period in which they received one or more payments exceeding, in the aggregate, $10,000, as indicated in the table below. Reporting must be completed and submitted to HRSA by the last date of the relevant Reporting Time Period. Provider Relief Fund recipients that do not report within the respective Reporting Time Period are out of compliance with payment Terms and Conditions and funds may be subject to repayment and/or recovery activities.

Period	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	July 1, 2021 to September 30, 2021*
Period 2	July 1, 2020 to December 31, 2020	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2023 to March 31, 2023

* Grace period until November 30, 2021. For more information, please see HRSA's announcement available at https://www.hhs.gov/about/news/2021/09/10/hhs-announces-the-availability-of-25-point-5-billion-in-covid-19-provider-funding.html.

How will a Reporting Entity know if HRSA determines if its revenue estimation approach is considered reasonable? ***(Added 7/1/2021)***
HRSA will notify a Reporting Entity if their proposed methodology is not reasonable, including if it does not demonstrate with a reasonable certainty that claimed lost revenues were caused by coronavirus. If HRSA determines that a Reporting Entity's proposed alternate methodology is not reasonable, the entity will be asked to resubmit its report within 30 days of notification using either Option i or Option ii to calculate lost revenues attributable to coronavirus.

Providers may have significant fluctuations in year-over-year net patient revenues due to settlements or payments made to third parties relating to care delivered outside the reporting period (2019-2021). Should Provider Relief Fund recipients exclude from the

reporting of net patient revenue payments received for care not provided in 2019, 2020, or 2021? ***(Modified 7/1/2021)***
Provider Relief Fund recipients shall exclude from the reporting of net patient revenue payments received or payments made to third parties relating to care not provided in 2019, 2020, or 2021.

Who is required to report when the portal opens? ***(Added 6/11/2021)***
A Reporting Entity must report only when they have retained over $10,000 in aggregated Provider Relief Fund payments received during a single Payment Received Period.

If an entity received payments totaling over $10,000, but returned some, do they still have to report? ***(Modified 6/11/2021)***
A Reporting Entity must report only when they have retained over $10,000 in aggregated Provider Relief Fund payments received during a Payment Received Period.

What is the process to return unused funds? ***(Modified 6/11/2021)***
When the first reporting period begins, providers will be able to return unused funds through the Reporting Portal.

If a parent organization received a Provider Relief Fund Targeted Distribution on behalf of a subsidiary, which organization should report on the use? ***(Added 1/28/2021)***
The parent organization as the original recipient of the payment must report on the use of funds in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act.

If a subsidiary organization received a Provider Relief Fund Targeted Distribution, and subsequently transferred it to its parent organization, which organization should report on the use? ***(Added 1/28/2021)***
The subsidiary as the original recipient of the payment must report on the use of funds in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act.

Are Reporting Entities required to report each General and/or Targeted Distribution payment separately? ***(Added 1/28/2021)***
Reporting Entities that received General and Targeted Distribution payments will submit a consolidated report through the Provider Relief Fund Reporting Portal.

If all funds are expended to cover unreimbursed healthcare related expenses attributable to coronavirus, are Reporting Entities still required to submit lost revenue information? ***(Modified 1/28/2021)***
Reporting Entities are required to submit actual patient care revenue for calendar years 2019 and 2020 in order to inform program integrity and HRSA's audit strategy.

Should providers include fundraising revenues, grants or donations when determining patient care revenue? ***(Added 12/4/2020)***
To calculate lost revenues attributable to coronavirus, providers are required to report revenues received from Medicare, Medicaid, commercial insurance, and other sources for patient care services. Other sources include fundraising revenues, grants or donations if they contribute to funding patient care services.

What does "primary Tax Identification Number (TIN)" and "subsidiary TIN" refer to? ***(Added 10/28/2020)***
Primary TIN refers to the TIN of the parent company, and subsidiary TIN refers to the TIN of an entity that is a subsidiary of the parent company. Providers may have received payments directly to a parent and/or its subsidiary entities.

What is meant by "For some recipients, this may be analogous to Social Security number (SSN) or Employer Identification Number (EIN)" with respect to the TIN? ***(Added 10/28/2020)***
Some recipients may be individual providers for whom their TIN will be their SSN; similarly, for some entities the TIN will be the EIN.

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.

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.

COVID-19 Vaccine Distribution and Administration

If a provider administers a COVID-19 vaccine to a patient that has Medicare Part A, but not Part B, coverage, can the provider use Provider Relief Fund payments to cover the unreimbursed costs associated with vaccine administration? ***(Added 1/28/2021)***
Yes. The costs associated with administering a vaccine to a patient with Medicare Part A, but not Part B, coverage would be considered unreimbursed under the Provider Relief Fund, and payments could be used to cover incurred expenses.

Can Provider Relief Fund payments be used to support COVID-19 vaccine distribution? ***(Modified 1/28/2021)***
Provider Relief Fund payments may be used to support expenses associated with distribution of a COVID-19 vaccine licensed or authorized 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 authorized vaccine becoming available. This may include using funds to purchase additional refrigerators or freezers, personnel costs to provide vaccinations, and transportation costs not otherwise reimbursed.

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.

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. 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.

Appeals

How do I appeal or dispute a payment decision? ***(Modified 10/20/2021)***

If after reviewing the Phase 3 methodology, available at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/phase-3-methodology-overview.pdf, you believe your payment was calculated incorrectly, complete the PRF Reconsideration Request Form by November 12, 2021 at 11:59:59 pm EST, available at https://powerforms.docusign.net/034c7d84-45d9-40c2-9d0b-c4648f225bc3?env=na3&acct=dd54316c-1c18-48c9-8864-0c38b91a6291&accountId=dd54316c-1c18-48c9-8864-0c38b91a6291.

Applicants are encouraged to apply early to facilitate review and expedite any revised payments made as a result of the reconsiderations process.

HRSA is only reconsidering Phase 3 General Distribution applications and payments at this time. For more information, please review HRSA's Phase 3 Reconsiderations page, available at https://www.hrsa.gov/provider-relief/payment-reconsideration. Any corrections to payment determinations are subject to the availability of funds.

Publication of Payment Data

Is there a publicly available list of providers and the payments they received through the Provider Relief Fund? ***(Modified 6/12/2020)***

HHS has posted a public list of providers and their payments once they attest to receiving the money and agree to the Terms and Conditions. All providers that received a payment from the Provider Relief Fund and retain that payment for at least 90 days without rejecting the funds are deemed to have accepted the Terms and Conditions. Providers that affirmatively attest through the Payment Attestation Portal or that retain the funds past 90 days, but do not attest, will be included in the public release of providers and payments. The list includes current total amounts attested to by providers from each of the Provider Relief Fund distributions, including the General Distribution and Targeted Distributions.

What providers are included in the Provider Relief Fund data file on the CDC website? ***(Modified 6/12/2020)***

The data that are posted in the public list represent providers that received one or more payments from the Provider Relief Fund and that have attested to receiving at least one payment and agreed to the associated Terms and Conditions. If a provider has received more than one

payment but has not accepted all of the payments (by attesting and agreeing to the Terms and Conditions), only the dollar amount associated with the accepted payment or payments will appear. These data displayed on the website will be updated biweekly.

Why might a provider not be listed or listed with a different address than their service location? ***(Added 5/12/2020)***
Provider Relief Fund payments are being made to providers or groups of providers that are organized within a Tax Identification Number (TIN). The information displayed is of providers by billing TIN that have received at least one payment, which they have attested to, and the address associated with that billing TIN. Providers will not be listed if they have not yet attested to the payment terms and conditions or if they are within a larger billing entity that received payment. In addition, the address listed for the billing TIN often corresponds with the billing location (based on the Center for Medicare & Medicaid Services' Provider Enrollment, Chain, and Ownership System (PECOS)), and may not align with the physical location of a health care practice site. Updated data will be made available on the Center for Disease Control and Prevention's (CDC) website.

Will HHS release additional data elements, such as provider types, payment amount per distribution, or payment recipients' NPIs, on the public list of providers and payments? ***(Added 5/12/2020)***
HHS does not have plans to include additional data fields in the public list of providers and payments.

Can a provider choose to have its payment data omitted from the Provider Relief Fund public list on the CDC's website? ***(Added 5/20/2020)***
No. To ensure transparency, HHS will publish the names of payment recipients and the amounts accepted and attested to by the payment recipient.

Provider Relief Fund General Distribution and ARP Rural Payments

Phase 1

Overview and Eligibility

Which types of providers are eligible to receive a Phase 1 – General Distribution Provider Relief Payment? ***(Modified 6/12/2020)***
To be eligible for a Phase 1 – General Distribution payment, providers must have billed Medicare fee-for-service (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.

Why am I receiving an email requesting that I submit my financial information in response to the payment I received as part of Phase 1 of the General Distribution? ***(Added 9/3/2020)***
The Terms and Conditions for payments received on or around April 24, 2020, as part of the additional $20 billion under Phase 1 of the General Distribution require that recipients submit

their revenue information. Based on HHS's records, due in some instances to system issues, the Department did not receive your required revenue information necessary for program integrity purposes and consideration for additional payments. In order to be considered for an additional payment, recipients must submit this revenue information by September 13, 2020. If a health care provider rejected the funds received on or around April 24 and does not want to keep any additional funds received as a result of submitting revenue, they may return a payment by going into the attestation portal within 90 days of receiving payment and indicating they are rejecting the funds. Providers must return the payment within 15 calendar days of rejecting the payment.

I received an email from the Provider Relief Fund's DocuSign application web portal informing me that my CARES Act Provider Relief Fund Application DocuSign submission ("envelope") has expired. Does this mean I am not eligible to receive a General Distribution payment? ***(Modified 7/14/2020)***

No. You received an automated email sent by DocuSign to providers who initiate one or more entries that were not completed or submitted. A number of providers opened duplicate entries in the DocuSign web portal, resulting in one or more of the entries (referred to as "envelopes" by DocuSign) becoming "orphaned" and incomplete. The expiration status of one DocuSign entry does not affect any other submissions by that provider. If an application was completed and submitted, no further action is required on the healthcare provider's part.

I am a health care provider that received a previous Phase 1 – General Distribution payment and I submitted my revenue information through the Provider Relief Fund Payment Portal. Why am I not receiving an additional payment? ***(Modified 6/12/2020)***

HHS is distributing an additional $20 billion of the General Distribution to providers to augment their initial allocation so that $50 billion is allocated proportional to providers' share of 2018 gross receipts or sales/program service revenue. Payments are determined based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) gross receipts or the sum of incurred losses for March and April. If the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual gross receipts or sales/program service revenue, you may not receive additional General Distribution payments. There may be additional distributions in the future for which providers are eligible.

Why might a provider that bills Medicare fee-for-service not have received a payment from the initial $30 billion Phase 1 – General Distribution? ***(Added 6/15/2020)***

To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in CY2019. Phase 1 – General Distribution payments were made to the billing organization according to its Taxpayer Identification Number (TIN). Payments to providers and practices that are part of larger medical groups went to the group's central billing office.

Some providers who did bill Medicare fee-for-service in CY2019 were not eligible for payment because either the provider is terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; or currently has Medicare billing privileges revoked as determined by either the Centers for Medicare & Medicaid Services or the HHS Office of Inspector General.

If the provider's TIN that was intended for payment identifies both a social security number of an individual Medicare provider and another Medicare provider's employer identification

number, that TIN was excluded from the General Distribution. Providers were also excluded from the General Distribution if there was incomplete banking information and/or personal contact information. HHS is working to determine eligibility for a General Distribution payment for those affected providers.

Determining Additional Payments

How can I estimate the total payment amount I can anticipate through the Phase 1 – General Distribution? ***(Modified 6/12/2020)***
In general, providers can estimate payments from the Phase 1 – General Distribution of approximately 2% of 2018 (or most recent complete tax year) gross receipts or sales/program service revenue. To estimate your payment, use this equation:

(Individual Provider Revenues/$2.5 Trillion) X $50 Billion = Expected Combined General Distribution.

Providers should work with a tax professional for accurate submission.

This includes any payments under the first $30 billion General Distribution as well as under the $20 billion General Distribution allocations. Providers may not receive a second distribution payment if the provider received a first distribution payment of equal to or more than 2% of gross receipts.

Provider Relief Fund Payment Portal – Phase 1 - General Distribution

An organization has prescription sales as part of its revenue. Can these sales be captured in the data submitted as "gross sales or receipts" or "program service revenue?" ***(Modified 6/22/2020)***
Generally no. Only patient care revenues from providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 may be included. Patient care revenues do include savings obtained by providers through enrollment in the 340B Program.

What information is HHS collecting for Phase 1 – General Distribution in the Provider Relief Fund Payment Portal? ***(Added 4/25/2020)***
The Provider Relief Fund Payment Portal has been deployed to collect information from providers who received Phase 1 – General Distribution payments prior to April 24, 2020 at 5:00 pm EST. The Provider Relief Fund Payment Portal collects four pieces of information to allocate remaining Phase 1 – 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 for any of the provider's subsidiary organizations that received relief funds but DO NOT file separate tax returns.

This information may also be used to allocate other Provider Relief Fund distributions.

HHS is collecting: the "gross receipt or sales" or "program service revenue" data to have an understanding of a provider's usual operations; the revenue loss information to have an understanding of COVID impact; and, tax forms to verify the self- reported information. HHS is 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 5:00pm EST Friday April 24, 2020 **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, 2020 **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.

Data Sharing

Why am I being redirected to DocuSign to fill out certain elements? ***(Added 4/25/2020)***
HHS is using DocuSign to securely pass encrypted data to HHS. Neither DocuSign nor UnitedHealth Group will have access to your data.

What is DocuSign doing with my data? ***(Added 4/25/2020)***
DocuSign is securely passing your data to HHS in encrypted files. Neither DocuSign nor UnitedHealth Group will have access to your data.

What information is shared with UnitedHealth Group, UnitedHealthcare, Optum, or any other subsidiary of UnitedHealth Group? ***(Added 4/25/2020)***
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 Provider Relief Fund payments. UnitedHealth Group will know the amounts of relief funding paid to providers as UnitedHealth Group is processing the payments.

Who has access to my revenue data? ***(Added 4/25/2020)***
HHS will have access to your revenue data to optimally allocate Provider Relief Fund payments. HHS will not share your revenue data with any other entities, in or outside of government, except as prescribed by law.

Phase 2

Overview and Eligibility

Who is eligible for Phase 2 – General Distribution? ***(Modified 9/1/2020)***
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 December 31, 2019, 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 December 31, 2019; or
    b. Must be a dental service provider who 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 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 December 31, 2019;
    e. Must be a Medicare Part A provider that experienced a change in ownership and billed Medicare fee-for-service in 2019 and 2020 that prevented the otherwise eligible provider from receiving a Phase 1 - General Distribution payment; or
    f. Must be a state-licensed/certified assisted living facility.
2. Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 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, 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 received a payment under Phase 1 of the General Distribution are no longer prohibited from submitting an application under Phase 2 of the General Distribution. Providers who received a previous Phase 1 – General Distribution payment are eligible to apply and, if they have not yet received a payment that is approximately 2% of annual revenue from patient care, may receive additional funds.

What was the methodology/formula used to calculate provider payment? ***(Modified 9/1/2020)***
The Phase 2 – General Distribution methodology will be based upon 2% of (revenues * percent of revenues from patient care) from the applicant's most recent federal income tax return for 2017, 2018 or 2019 and with accompanying submitted tax documentation. Payments will be made to applicant providers who are on the filing TIN curated list submitted by state/territory Medicaid or CHIP agencies, HHS-developed lists of dental providers and assisted living facilities, the list of providers who received a Phase 1 – General Distribution payment, or the list of approved CMS-approved Medicare Part A providers who experienced a change in ownership as of August 10, 2020 or whose applications underwent additional validation by HHS.

I applied for funds as part of Phase 2 of the General Distribution. Why have I not yet received a payment? ***(Added 1/15/2021)***
Many applicants that believe that their organization has not yet been paid under Phase 2 have received funds that can only be accessed after setting up an Automated Clearing House (ACH) account. Organizations with revenue greater than $5,000,000 are 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. For assistance in setting up an ACH account, please contact the Provider Support Line at (866) 569-3522 (for TTY, dial 711).

Other applicants may have received Phase 2 funds in November or December that the applicant believes were part of Phase 3 of the General Distribution. Additionally, HHS has requested that a small number of applicants resubmit their application and financial information for data verification. In some instances, HHS has not received the requested resubmissions, and therefore, cannot adjudicate those applications.

Will Phase 2 - General Distribution payments be made to the billing TIN or filing TIN for those who received a payment that was less than 2% of revenue as part of the Phase 1 - General Distribution? ***(Added 8/10/2020)***
In line with the policies established for the Phase 2 - General Distribution, HHS will be making payments to applicants based on filing TIN for all those who apply as part of this newer distribution.

Will practices or facilities that experienced a change in ownership that prevented them from receiving a Targeted Distribution payment, such as a Skilled Nursing Facility

payment or Safety Net Hospital payment, be eligible for more than 2% of revenue from patient care? ***(Modified 12/4/2020)***
At this time, HHS is only expanding eligibility to the Phase 2 - General Distribution to those health care providers that experienced a change in ownership that prevented them from receiving a Phase 1 - General Distribution payment. Providers that experienced a change in ownership may be eligible for future Targeted Distributions.

What are the reasons that I would not be eligible for a Phase 2 – General Distribution payment? ***(Modified 8/10/2020)***
You must meet the five eligibility requirement for the Phase 2 – 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 Phase 1 – General 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.

Does payment from the Phase 1 – General Distribution affect what I may receive as a Phase 2 – General Distribution payment? ***(Modified 8/10/2020)***
Yes. Payments received as part of the Phase 1 - General Distribution will be taken into account when determining payment amounts for the Phase 2 - General Distribution. If a health care provider has not yet received a payment that equals approximately 2% of revenue from patient care, it may now be eligible for a Phase 2 - General Distribution payment.

Additionally, prior payment in a Provider Relief Fund Targeted Distribution (like the High Impact Area, Rural, Indian Health Service, and Skilled Nursing Facility Targeted Distributions) does not affect eligibility for, or amount of, a possible payment.

Will payments be sent at one time or disbursed in phases? ***(Added 6/9/2020)***
Payments will be disbursed on a rolling basis, as information is validated. HHS may seek additional information from providers as necessary to complete its review.

Tax Identification Number (TIN) Validation Process

What if an applicant's TIN is flagged as invalid because it is not on the filing TIN list submitted by states/territories to CMS or the curated list of eligible providers? ***(Modified 10/1/2020)***
Payments will be made to applicant providers who are in the filing TIN curated list from CMS if they are a Medicaid or CHIP provider. If a TIN is not on the curated list of state-submitted eligible Medicaid/CHIP providers or T-MSIS, it will be flagged as invalid. In these cases, HHS will work with the states/territories to verify whether the TIN should be included as a valid Medicaid or CHIP provider in good standing.

If a TIN is not on the curated list of dental providers, HHS will conduct additional analysis related to the TIN and any active dental providers associated with the TIN.

If a TIN is not on a curated list of assisted living facilities, HHS will conduct additional analysis related to the TIN and any currently operating assisted living facilities associated with the TIN.

If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign even if validation occurs after the September 13, 2020 deadline. Applicants validated after that date will have until October 4, 2020, 11:00pm EST to submit an application to be considered for funding under Phase 2. TINs that cannot be validated will not receive funding. Please note, the additional TIN validation may result in a delay in processing the application.

When is the deadline to submit an application? ***(Modified 10/1/2020)***
The deadline to submit a TIN for validation for the Phase 2 – General Distribution is September 13, 2020. Applications must submitted by October 4, 2020, 11:00pm EST. Applications that are not completed by the October 4 deadline will be voided and applicants will have the opportunity to submit an application for Phase 3 by going back into the portal and clicking on "Get Started."

Will health care providers that have not had their TINs validated by the application deadline of September 13, 2020 be able to submit an application after that date? ***(Modified 10/1/2020)***
Yes. A health care provider must submit their TIN for validation by end of day September 13, 2020. If they receive the results of that validation after September 13, they must submit an application by October 4, 2020, 11:00pm EST for consideration under Phase 2. Applications that are not completed by the October 4 deadline will be voided and applicants will have the opportunity to submit an application for Phase 3 by going back into the portal and clicking on "Get Started."

If my TIN will take more than 15 days to be validated, when will I be notified? ***(Modified 10/1/2020)***
If your TIN cannot be validated within 15 days of submission, you will receive an email 13 days after submission notifying you that additional verification is required by the State/Territory Medicaid or CHIP agency. If you do not receive an email, please contact the Provider Support Line at (866) 569-3522 (for TTY, dial 711). Please note that it may take additional time to validate your TIN in these instances, particularly when close to deadlines. If you receive the results of that validation after September 13, you must submit an application by October 4, 2020, 11:00pm EST for consideration under Phase 2. Applications that are not completed by the October 4 deadline will be voided and you will have the opportunity to submit an application for Phase 3 by going back into the portal and clicking on "Get Started."

Application Process

How should a parent organization that files taxes on behalf of its subsidiaries report NPIs if the NPIs are associated with the subsidiaries' TINs, not the filing TIN? ***(Modified 9/4/2020)***
If the parent organization does not have an NPI, the applicant should insert the subsidiary Group NPI that is best representative of the health care services delivered by the parent organization's subsidiaries. If the parent organization and its subsidiaries do not have an NPI, the applicant should enter "not applicable." The field cannot be left blank.

What is the difference between the first Provider Relief Fund Payment Portal and the Provider Relief Fund Application and Attestation Portal for the Phase 2 – General Distribution? ***(Modified 7/17/2020)***

The first Provider Relief Fund Payment Portal was used for providers who received a General Distribution payment prior to Friday, April 24th. These providers were required to submit financial information in order to receive approximately 2% of revenues derived from patient care.

HHS has developed the new Provider Relief Fund Application and Attestation Portal for providers who bill Medicaid and CHIP (e.g., pediatricians, long-term care, and behavioral health providers) or are dental providers. HHS has since expanded eligibility to other providers, including those who may not have received additional funds as part of the Phase 1 – General Distribution.

What specific revenue information should I enter into the application portal? ***(Modified 7/17/2020)***

Applicants should enter the most recent revenues number from its federal tax return of 2017, 2018, or 2019. If the applicant for tax purposes is a:

- Sole proprietor or disregarded entity owned by an individual: Enter Line 3 from IRS Form 1040, Schedule C excluding any income reported on W-2.
- Partnership: Enter Line 1c minus Line 12 from IRS Form 1065.
- C corporation: Enter Line 1c minus Line 15 from IRS Form 1120.
- S corporation: Enter Line 1c minus Line 10 from IRS Form 1120-S.
- Tax-exempt organization: Enter Line 9 from IRS Form 990 minus any joint venture income, if included in Part VIII lines 2a – 2f.
- Trust or estate: Enter Line 3 from IRS Form 1040, Schedule C.
- Entity not required to file any of the previously mentioned IRS forms: Enter a "net patient service revenue" number or equivalent from the applicant's most recent audited financial statements (or management-prepared financial statements)
- Applicants with gross revenue adjustments should enter an adjusted gross revenues number as calculated using the Gross Revenues Worksheet in Field 15 available at: **https://www.uhcprovider.com/content/dam/provider/docs/public/other/PRF-Gross-Revenues-Worksheet.xlsx**.

How long will it take from portal submission to payment decision or receipt? ***(Added 6/9/2020)***

HHS is working to process all providers' submissions as quickly as possible. HHS may seek additional information from providers as necessary to complete its review.

What documentation must be uploaded to the application form? ***(Added 6/9/2020)***

- The applicant's most recent federal income tax return for 2017, 2018 or 2019 or a written statement explaining why the applicant is exempt from filing a federal income tax return (e.g. a state-owned hospital or health care clinic).
- If required by Field 15, the applicant's Gross Revenue Worksheet (provided by HHS).

Phase 3

Overview and Eligibility

How does Phase 3 differ from the previous phases of the General Distribution? ***(Modified 10/8/2020)***

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 may 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; or
    b. 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 to 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 General Distributions? ***(Modified 1/28/2021)***
Providers will be paid the greater of up to 88 percent of their reported losses (both lost revenue and health care-related expenses attributable to coronavirus incurred during the first half of 2020) or 2 percent of annual revenue from patient care. Some applicants will not receive an additional payment, either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88 percent of reported losses or 2 percent of revenue from patient care.

Certain applicants may not receive these full amounts because HHS determined the revenues and operating expenses from patient care reported on their applications included figures that were not exclusively from patient care (as defined in the instructions), reported figures were not reflected in submitted financial documentation, or reported figures were extreme outliers in comparison to other applicants of the same provider type; instead, HHS capped the amount paid to these provider types based on industry estimates of revenue and operating expenses from patient care.

What is the payment amount that an applicant should expect to receive from Phase 3 of the General Distribution? ***(Modified 1/28/2021)***
If an applicant has not yet received and kept a payment that is approximately 2 percent 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. In addition to this amount, providers will be paid up to 88 percent of their reported losses (both lost revenue and health care-related expenses attributable to coronavirus incurred during the first half of 2020) if losses exceeded 2 percent of

annual revenue from patient care. Some applicants may not receive this proportion of the losses reported on their applications, because HHS determined the reported revenues and operating expenses from patient care were not exclusively from patient care (as defined in the instructions) or because reported figures were not reflected in submitted financial documentation. Additionally, some applicants will not receive an additional payment either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88 percent of reported losses.

When will Phase 3 payments be made? ***(Modified 1/12/2021)***
HHS began issuing Phase 3 – General Distribution payments in mid-December, 2020, and will continue making payments through the first months of 2021 to those providers that experienced a change in revenues or net expenses attributable to COVID-19 and that have not already received funds that equal or exceed reimbursement of 88 percent of reported losses, as well as to those that have 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. HHS is continuing to review and validate applications received and will disperse payments in batches as applications are adjudicated.

Are providers that received payments under Phase 3 of the General Distribution limited to using these funds to cover coronavirus-related losses or expenses experienced during the first two quarters of calendar year 2020? ***(Modified 6/11/2021)***
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. While HHS collected information on the losses and expenses associated with the first two quarters of 2020 for the purposes of making additional General Distribution payments to those providers with demonstrated financial need, the Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses.

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.

What are the reasons that I would not be eligible for a Phase 3 – General Distribution payment? ***(Modified 10/8/2020)***
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 may be factored into whether you will receive any further payments under Phase 3.

How should an applicant set up a One Healthcare ID (formerly known as Optum ID) if it is applying for Phase 3 – General Distribution payment on behalf of multiple subsidiaries? ***(Modified 2/19/2021)***
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 a One Healthcare 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 One Healthcare 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? ***(Modified 3/31/2021)***

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 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

When is the deadline to submit an application? ***(Modified 11/12/2020)***
The deadline to start an application by submitting a TIN for validation under Phase 3 – General Distribution is November 6, 2020 at 11:59 PM EST. If the TIN validation is initialized by November 13, 2020 at 11:59 PM EST, the entity will have until November 27, 2020 at 11:59 PM EST to submit an application.

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.

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

An organization has the sale of medical supplies, such as durable medical equipment and prescription glasses and contacts, as part of its revenue and expenses. Can these sales be captured in the data submitted as a part of revenue and operating expenses from patient care? ***(Added 10/28/2020)***
No. Any revenue or expenses related to the sale of medical supplies, including durable medical equipment and prescription glasses and contacts, may not be included as part of revenue or expenses from patient care. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included.

Hospitals and health care systems may have joint ventures, such as a hospital or health system that owns a portion of an ambulatory surgery center, in which the hospital or health care system provides services. Should the revenue and expenses associated with these agreements and ventures be included from reported revenues and expenses in the Phase 3 application? ***(Added 10/28/2020)***
No. The associated revenues and expenses that are associated with joint ventures with other health care entities should not be included in the hospital or health care system's application for Phase 3 funds.

Does "operating expenses from patient care" include costs that support the delivery of care, such as the health care providers' information technology, finance, and human resources costs? ***(Added 10/28/2020)***
Yes. Applicant may include costs that support the delivery of care, such as the health care providers' information technology, finance, and human resources costs, as part of "operating expenses from patient care" when applying for Phase 3 General Distribution payments.

Does "most recent federal income tax return of 2017, 2018, or 2019" mean filed return? ***(Added 10/28/2020)***
Yes. Applicants must submit the most recently filed tax return along with their application for Phase 3 General Distribution payments. If an applicant has applied for funds in previous General Distributions and filed taxes in the interim, it must use its most recent tax return; the applicant is not required to submit the same return included with previous General Distribution applications.

If a parent entity is applying for the Phase 3 General Distribution on behalf of itself and multiple subsidiaries, and the parent and subsidiaries file a group tax return, should the parent entity submit the joint tax return as part of its application? ***(Added 10/28/2020)***
Yes. Similar to the Phase 2 General Distribution application, in cases where a parent files a group tax return for itself and all/or some of its subsidiaries, the parent entity should submit the group tax return that includes all subsidiaries on behalf of which the parent entity is applying.

Should a parent entity applying on behalf itself and subsidiaries report the proportion of revenues from patient care, along operating revenue and operating expenses for patient care, aggregated across all entities or break out each figure by TIN? ***(Added 10/28/2020)***
The parent entity that is applying on behalf of itself and multiple subsidiaries should break out by TIN revenues and operating expenses for patient and non-patient care when applying for Phase 3 funds on behalf of multiple subsidiaries. The applying entity should ensure that these figures reconcile to ones provided on the submitted tax return.

May a parent entity applying on behalf of multiple subsidiaries that would like each subsidiary to receive its own payment submit as documentation for each individual subsidiary the common group tax return? ***(Added 10/28/2020)***
Yes. The parent entity that is applying on behalf of multiple subsidiaries may submit the same required financial documentation as part of multiple applications if the documentation includes the requested financial information for each of the subsidiaries. The parent entity that is applying on behalf of multiple subsidiaries should include a break-out by TIN of the revenues and operating expenses for patient and non-patient care for each of the TINs included in the filed tax return that reconciles to the figures on the return.

How should intercompany rent be treated when reporting "operating expenses from patient care?" ***(Added 10/28/2020)***
Intercompany rent should be included when reporting "operating expenses from patient care" as well as "operating revenue from patient care."

What is "operating revenues from patient care?" ***(Modified 10/28/2020)***
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. For the definition of "revenue" for purposes of reporting and use of funds, please refer to the reporting requirements available at https://www.hrsa.gov/provider-relief/reporting-auditing.

What is "operating expense from patient care?" ***(Modified 10/28/2020)***
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 that is not the site of patient care delivery, as well as contributions made, gains, and/or losses on investments. For the definition of "expenses" for purposes of reporting and use of funds, please refer to the reporting requirements available at https://www.hrsa.gov/provider-relief/reporting-auditing.

An organization has prescription sales as part of its revenue. Can these sales be captured in the data submitted as a part of revenue from patient care? ***(Added 10/15/2020)***
Generally no, prescriptions sale revenue may not be captured as part of revenue from patient care. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included. Patient care revenues do include savings obtained by providers through enrollment in the 340B Program.

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.

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? ***(Modified 12/4/2020)***
If an applicant health care provider bills for care under a single TIN that provides care across multiple different facilities, the parent organization must 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.

Phase 4 and ARP Rural Payments

Phase 4 Overview and Eligibility

Who is eligible for Phase 4 – General Distribution? ***(Added 9/29/2021)***
To be eligible to apply, the applicant must meet all of the following requirements:

1. Must fall into one of the following categories:
    a. Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, their state/territory Medicaid program (fee-for service or managed care) or Children's Health Insurance Program (CHIP) for health care-related services during the period of January 1, 2019 to December 31, 2020; or
    b. Must be a dental service provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for oral health care-related services during the period of January 1, 2019 to December 31, 2020;
    c. Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, Medicare fee-for-service (Parts A and/or B) or Medicare Advantage (Part C) for health care-related services during the period of January 1, 2019 to December 31, 2020;
    d. Must be a state-licensed/certified assisted living facility on or before December 31, 2020;
    e. Must be a behavioral health provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for health care-related services during the period of January 1, 2019 to December 31, 2020;
    f. Must have received a prior Targeted Distribution payment.

2. Must have either (i) filed a federal income tax return for fiscal years 2018, 2019, or 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.

How will HRSA treat prior payments received from the Provider Relief Fund when calculating the Phase 4 Base Payment amount? ***(Added 10/26/2021)***
HRSA will deduct from the Phase 4 Base Payment any prior Provider Relief Fund payments received by the applicant and any of its subsidiaries/billing TINs included in its Phase 4/ARP Rural application, which were not previously deducted from the Phase 3 General Distribution payment. The Phase 4 deductions include any prior Provider Relief Fund payments that exceeded 2% of annual patient care revenue or 88% of changes in operating revenues and expenses for the first half of calendar year 2020. For example, if an entity applied to Phase 3 after receiving $100,000 in prior Provider Relief Fund payments, including a General Distribution payment that was equal to 2% of annual patient care revenue, and reported a change in operating revenues and expenses in the first half of 2020 that equaled $75,000, then the entity did not receive a Phase 3 payment. In Phase 4, the remaining $25,000 that was not yet deducted will be taken into account when calculating the Phase 4 Base Payment amount.

Why is HRSA requesting that applicants include all its billing TINS in the Phase 4/ARP Rural payments application portal? ***(Added 10/26/2021)***
Applicants must include all billing TINs under the filing TIN that provide patient care to ensure that applicants receive the maximum payment amount for which they are eligible. Applicants must include an exhaustive list of TINs and must ensure that all TINs included in the application belong to the filing TIN that is applying. HRSA will calculate the ARP Rural and a portion of Phase 4 payments based on the submitted billing TINs, as well as assess eligibility for ARP Rural payments for each of the included billing TINs.

How will provider size be determined for purposes of determining the percentage of changes in operating revenues and expenses that applicants will receive in Phase 4 payment? ***(Added 10/20/2021)***
HRSA will use the applicant's adjusted gross revenue to categorize providers' size. Please note that providers must apply at the filing TIN level and include all subsidiary billing TINs.

What are the total amounts allocated for Phase 4 payments based on changes in operating revenues and expenses and bonus payments for Medicaid, CHIP, and Medicare providers? ***(Added 10/20/2021)***
HRSA will make $12.75 billon (75% of $17 billion) in payments based on changes in operating revenue and expenses and $4.25 billion (25% of $17 billion) in bonus payments.

Are providers that received payments under Phase 4 of the General Distribution limited to using these funds to cover coronavirus-related losses or expenses experienced during the third and fourth quarters of calendar year (CY) 2020 or first quarter of CY2021? ***(Added 9/29/2021)***

No. Providers may use these payments to cover eligible health care-related expenses or lost revenues that are attributable to coronavirus incurred between January 1, 2020 and the end of applicable period of availability. Providers have at least 12 months, and as much as 18 months, based on the payment received date, to control and use the payments for expenses and lost revenues attributable to coronavirus incurred during the Period of Availability. For more information, please refer to the Post-Payment Notice of Reporting Requirements available at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-post-payment-notice-of-reporting-requirements-june-2021.pdf.

How do I know if I am eligible for a Phase 4 – General Distribution payment? ***(Added 9/29/2021)***

You must meet all of the five eligibility requirements for the Phase 4 – General Distribution, which include

1. Falling into one of the following categories:
    a. Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, their state/territory Medicaid program (fee-for service or managed care) or Children's Health Insurance Program (CHIP) for health care-related services during the period of January 1, 2019 to December 31, 2020; or
    b. Must be a dental service provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for oral health care-related services during the period of January 1, 2019 to December 31, 2020;
    c. Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, Medicare fee-for-service (Parts A and/or B) or Medicare Advantage (Part C) for health care-related services during the period of January 1, 2019 to December 31, 2020;
    d. Must be a state-licensed/certified assisted living facility on or before December 31, 2020;
    e. Must be a behavioral health provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for health care-related services during the period of January 1, 2019 to December 31, 2020;
    f. Must have received a prior Targeted Distribution payment.
2. Having either (i) filed a federal income tax return for fiscal years 2018, 2019, or 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. Having provided patient care after January 31, 2020; and
4. Having not permanently ceased providing patient care directly, or indirectly through included subsidiaries; and

5. If the applicant is an individual that was providing patient care, having 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.

You also 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 or filing TIN must be included in the list of providers that HRSA has determined to be eligible or your application must pass additional validation by HRSA. Some providers may be eligible for a payment but the payment calculation will be $0 due to risk mitigation and cost containment safeguards.

How should an applicant set up a One Healthcare ID (formerly known as Optum ID) if it is applying for Phase 4 – General Distribution payment on behalf of multiple subsidiaries? ***(Added 9/29/2021)***

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.

> **Multiple payments**. 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 a One Healthcare 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.
>
> **Single payment**. 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 One Healthcare ID account for the parent entity and submit a single application with the filing TIN.

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 Phase 4 of the General Distribution? ***(Added 9/29/2021)***
The Medicaid provider/management company must apply, because neither the property owner nor its parent company is an eligible health care provider. The Medicaid provider/management company must use the funds for eligible health care-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 4 – 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 Home- and Community-Based Services (HCBS) retainer payments? ***(Added 9/29/2021)***
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 HCBS retainer payments, does not preclude a health care provider from being eligible for Phase 4 – General Distribution; however, at the time of post-payment reporting, the health care provider must substantiate that the Provider Relief Fund payments were used for health care related expenses or lost revenue attributable to COVID-19, and those expenses or lost revenue were not reimbursed from other sources or other sources were not obligated to reimburse.

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/territory Medicaid program (fee-for service or managed care) or Children's Health Insurance Program (CHIP) for health care-related services, between January 1, 2019 and December 31, 2020, prevent these providers from being eligible for Phase 4 payments? ***(Added 9/29/2021)***
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 in 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 coronavirus, 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 Children's Health Insurance Program (CHIP) through a waiver, managed care arrangement, or county behavioral health provider network eligible for the Phase 4 – General Distribution? ***(Added 9/29/2021)***
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 Home- and Community-based Services (HCBS) (e.g., day habilitation, HCBS waiver program services), are eligible for the Phase 4 – General Distribution if they otherwise

meet the eligibility criteria. Health care providers that bill Medicaid or CHIP through a managed care arrangement or county behavioral health provider network are also eligible for Phase 4.

If a health care provider is paid through a certified public expenditure (CPE), will the provider be eligible for the Phase 4 – General Distribution? ***(Added 9/29/2021)***
These payment mechanisms do not impact eligibility for the Provider Relief Fund. Phase 4 – 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.

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 fiscal management service (FMS) organization to apply for the Phase 4 – General Distribution? ***(Added 9/29/2021)***
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 4 – 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.

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 4 – General Distribution? ***(Added 9/29/2021)***
Phase 4 – 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 coronavirus, 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.

ARP Rural Payments Overview and Eligibility

Who is eligible for ARP Rural payments? ***(Added 9/29/2021)***
In accordance with the statutory requirements, to be eligible to apply for ARP Rural Payments, the applicant or at least one subsidiary TINs must be:

1. A rural health clinic as defined in section 1861(aa)(2) of the Social Security Act; or
2. A provider treated as located in a rural area pursuant to section 1886(d)(8)(E), such as critical access hospitals; or
3. A provider or supplier that:
    a. Has directly billed for health care-related services between January 1, 2019 and September 30, 2020:
        i. **Medicare fee-for-service** (Parts A and/or B);
        ii. **Medicare Advantage** (Part C)
        iii. Their state/territory **Medicaid program (fee-for service or managed care); or**
        iv. Their state/territory **Children's Health Insurance Program (CHIP)**; and

b. Operates in or serves patients living in the HHS Federal Office of Rural Health Policy's (FORHP) definition of a rural area:
    i. All non-Metro counties;
    ii. All Census Tracts 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;
    iii. 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; and
    iv. 295 outlying Metropolitan counties with no Urbanized Area population.

How will ARP Rural Payments be calculated for providers that began operations part way through 2019 or 2020 that do not have complete financial information? ***(Added 9/29/2021)***
HRSA will calculate payments based on the paid claims submitted between January 1, 2019 and September 30, 2020 for all eligible providers. HRSA will not adjust or annualize payments to providers that began operations in 2019 or 2020.

Must control and use of the ARP Rural payment be delegated to the entity that was eligible for and received the payment? ***(Added 9/29/2021)***
Yes. To ensure the funds reach providers serving rural communities, control and use of the ARP Rural payment must be delegated to the entity that was eligible for and received the Payment. Unlike Phase 4 of the Provider Relief Fund, ARP Rural payment recipients must certify that they will allocate the ARP Rural payment to the provider(s) associated with the applicable subsidiary or billing TIN.

Are health care providers that only bill Medicaid or Children's Health Insurance Program (CHIP) through a waiver, managed care arrangement, or county behavioral health provider network eligible for ARP Rural Payments? ***(Added 9/29/2021)***
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 Home- and Community-based Services (HCBS) (e.g., day habilitation, HCBS waiver program services), are eligible for the ARP Rural Payments if they otherwise meet the eligibility criteria. Health care providers that bill Medicaid or CHIP through a managed care arrangement or county behavioral health provider network are also eligible for these payments if they meet the eligibility criteria.

HRSA recently updated its definition of "rural." Will the updated definition be used? ***(Added 9/29/2021)***
Yes. HRSA will use the most current definition of "rural" to calculate ARP Rural payments. The HHS Federal Office of Rural Health Policy recently expanded the definition of "rural." For more information, please visit https://www.hrsa.gov/rural-health/about-us/definition/index.html.

Phase 4/ARP Rural Payments Tax Identification Number (TIN) Validation Process

When is the deadline to submit an application? ***(Modified 10/26/2021)***
We encourage all applicants to begin their applications as soon as possible. All applicants must complete the first step of the application process (i.e., submitting their TIN and associated information for Internal Revenue Service (IRS) validation) no later than October 26, 2021 at

11:59 PM EST. The required IRS validation that occurs after completion of the first step may take a few days. If an applicant (1) submits their TIN for validation by the October 26, 2021 deadline and (2) that TIN is subsequently validated by the IRS, the applicant will have until November 3, 2021 at 11:59 PM EST to complete and submit their application.

What "exempt payee code" should I select when registering in the application portal? ***(Added 10/26/2021)***

Applicants should select the exempt payee code based on the following information.

Supporting documentation	**If the applicant for tax purposes is a…**	**Exempt Payee Code**
IRS Form 1040 including Schedule C	**Sole proprietor or disregarded entity owned by an individual**	**None**
IRS Form 1041 including Schedule C	**Trust or estate**	**Charitable Trust = 13 – A trust exempt from tax under section 664 or described in section 4947 Other trusts = none**
IRS Form 1065	**Partnership**	**None**
IRS Form 1120	**C corporation**	**5 – A corporation**
IRS Form 1120-S	**S corporation**	**5 – A corporation**
IRS Form 990	**Tax-exempt organization**	**1 – An organization exempt from tax under section 501(a), any IRA, or custodial account under section 403(b)(7) if the account satisfies the requirement of section 401(f)(2)**
Most recent audited financial statements (or management-prepared financial statements).	**Not required to file federal income taxes (e.g. state or local government entities)**	**3 – A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions, agencies, or instrumentalities**

What is TIN validation and when does it occur? ***(Added 9/29/2021)***

HRSA employs pre-payment risk mitigation strategies, including TIN validation, in order to protect program integrity. TIN validation is a process to ensure applicants are known businesses and are eligible for funds. HRSA requires all applicants to undergo validation with the Internal Revenue Service. Providers that have never received funds under a General or Targeted Distribution will also be subject to TIN validation processes similar to those employed under Phases 2 and 3 to ensure that they are eligible for funds, while those providers that have previously received General Distribution payments will not undergo further validation. If a provider is not on the existing list of validated providers, HRSA sends the provider's application

and subsidiary TINs to state/territorial Medicaid/CHIP agencies and the Substance Abuse and Mental Health Services Administration in attempt to validate the provider. However, the validation process will take place after the application has been submitted in Phase 4 and ARP Rural.

Why do I have to have my TIN validated when I successfully submitted a Phase 3 application? ***(Added 9/29/2021)***
In order to protect program integrity and preserve taxpayer dollars, HRSA requires all applicants to undergo validation with the Internal Revenue Service, similar to previous phases, before they can submit an application. Providers that have received General Distribution payments under Phases 1, 2, or 3 will not undergo any further validation by HRSA.

What if an applicant's TIN is flagged as invalid because it is not on the validated list of eligible providers known to HRSA? ***(Added 9/29/2021)***
If a TIN is not on the validated list of eligible providers known to HRSA, HRSA will conduct additional analyses related to the TIN and any active providers associated with the TIN. Providers will be able to submit an application while their TIN is under review. 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 9/29/2021)***
This means that HRSA will conduct additional validation to ensure provider eligibility with the assistance of state/territory Medicaid and Children's Health Insurance Program (CHIP) agencies and third parties for those provider types that are eligible but do not participate in Medicare, Medicaid, or CHIP. Providers will be able to submit an application while their TIN is under review. TINs that cannot be validated will not receive funding.

How will I know the status of my application? ***(Added 9/29/2021)***
HRSA will send emails throughout the process as you complete different steps. You will receive an email after Internal Revenue Service validation, successful submission of an application, and application adjudication. Applicants not known to HRSA that require further validation will receive an additional email notifying them that they are invited to submit an application. These providers will be able to submit an application while their TIN is under review. TINs that cannot be validated will not receive funding.

Phase 4 Application Process

For reporting net patient revenue, do providers need to exclude prior year cost reports settlements? ***(Added 10/26/2021)***
No. Providers do not need to exclude prior cost report settlements when reporting patient care revenue in the Phase 4 application. Providers may use actual settlements received or their historical information to estimate the amount of cost report settlement, in line with their internal processes and procedures.

Why is HRSA requesting applicants select a provider type? ***(Added 10/26/2021)***
HRSA will employ several pre-payment risk mitigation and cost containment safeguards to ensure that application information is accurate and that HRSA is making payments equitably, including adjusting payments based on self-selected provider type, as described in the payment

methodologies available at https://www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural/payment-methodology. HRSA will determine provider type adjustments after all applications are received. Please note, if an application is flagged, HRSA will conduct a review of the associated supporting documentation. Depending on the results of the review of the documentation, the potential payment for the application may be adjusted based on provider type-based adjustments.

Am I able to edit my Phase 4 – General Distribution application in the Provider Relief Fund Application and Attestation Portal? ***(Modified 10/26/2021)***
For the TIN validation step, you cannot edit the data submitted after you submit this information for IRS validation.

For the Tax and Financial Information submission step in DocuSign, you can resubmit the entire application. That means, if you wish to edit the information in DocuSign, you must re-enter all the financial information and re-upload your supporting documentation. If you submit multiple applications, HRSA will review the last application submitted before the deadline.

To avoid potential mistakes, HRSA strongly encourages applicants to verify that all information is correct before submitting.

Am I able to submit more than one Phase 4 – General Distribution application in the Provider Relief Fund Application and Attestation Portal for consideration? ***(Modified 10/26/2021)***
No. You can only submit one application for consideration.

An organization has prescription drug sales as part of its revenue. Can these sales be captured in the data submitted as a part of revenue from patient care? ***(Modified 10/26/2021)***
No, prescription drug sales revenue may not be captured as part of revenue from patient care. Patient care revenues may properly include savings obtained by providers through enrollment in the 340B Program. However, only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included.

Why am I required to reenter information previously submitted as part of Phases 1, 2, and/or Phase 3? ***(Added 9/29/2021)***
In order for HRSA to make payments as part of Phase 4, HRSA needs the most recent financial information available, including the most recent tax filings or audited financial statements.

An organization has the sale of medical supplies, such as durable medical equipment and prescription glasses and contacts, as part of its revenue and expenses. Can these sales be captured in the data submitted as a part of revenue and operating expenses from patient care? ***(Added 9/29/2021)***
No. Any revenue or expenses related to the sale of medical supplies, including durable medical equipment and prescription glasses and contacts, may not be included as part of revenue or expenses from patient care. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included.

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 9/29/2021)***
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.

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 9/29/2021)***
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 2020 and is an S corporation in 2021, it should apply as a C corporation if the provider's most recent tax filing is from 2020.

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 9/29/2021)***
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 9/29/2021)***
Yes. Organizations that receive payments greater than $100,000 will be required to set up ACH accounts. In order to most effectively and quickly deliver funds to providers, HRSA 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.

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 9/29/2021)***
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.

Phase 4 Complex Financial Situations

How should entities with multiple subsidiaries apply for Phase 4? ***(Added 9/29/2021)***
Applications must be consolidated across eligible subsidiaries and submitted by the parent entity. Applications must be made at the filing TIN level, whenever possible. Applications must include all subsidiaries that provide patient care.

HRSA will review exceptions on a case-by-case basis. Applications that fail to meet this requirement may be deemed ineligible for funding. (See additional requirements in the Instructions at Field 17 Annual Revenues from Patient Care Worksheet and Field 18 Organizational Structure Documentation. You can find the instructions on HRSA's website at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/phase4-arp-application-instructions.pdf.)

Hospitals and health care systems may have joint ventures, such as a hospital or health system that owns a portion of an ambulatory surgery center, in which the hospital or health care system provides services. Should the revenue and expenses associated with these agreements and ventures be included from reported revenues and expenses in the Phase 4 application? ***(Added 9/29/2021)***

No. The revenues and expenses that are associated with joint ventures with other health care entities should not be included in the hospital or health care system's application for Phase 4 funds.

Does "operating expenses from patient care" include costs that support the delivery of care, such as the health care providers' information technology, finance, and human resources costs? ***(Added 9/29/2021)***

Yes. Applicant may include costs that support the delivery of care, such as the health care providers' information technology, finance, and human resources costs, as part of "operating expenses from patient care" when applying for Phase 4 General Distribution payments.

If a parent entity is applying for the Phase 4 General Distribution on behalf of itself and multiple subsidiaries, and the parent and subsidiaries file a group tax return, should the parent entity submit the joint tax return as part of its application? ***(Added 9/29/2021)***

Yes. Similar to the Phases 2 and 3 General Distribution applications, in cases where a parent files a group tax return for itself and all/or some of its subsidiaries, the parent entity must submit the group tax return that includes all subsidiaries on behalf of which the parent entity is applying. (For additional requirements, see Instruction Field 17 Annual Revenues from Patient Care Worksheet. You can find the instructions on HRSA's website at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/phase4-arp-application-instructions.pdf.)

Should a parent entity applying on behalf of itself and subsidiaries report the proportion of revenues from patient care, along with operating revenue and operating expenses for patient care, aggregated across all entities, or break out each figure by TIN? ***(Added 9/29/2021)***

To ensure accurate calculation of payment for complex organizations with multiple subsidiaries, the parent entity must break out by subsidiary TIN annual patient care revenues and quarterly operating revenues and expenses when applying for Phase 4 funds on behalf of multiple subsidiaries. The applying entity must ensure that these figures reconcile to ones provided on the submitted tax return. (For additional requirements, see Instruction Field 17 Annual Revenues from Patient Care Worksheet. You can find the instructions on HRSA's website at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/phase4-arp-application-instructions.pdf.)

How should intercompany rent be treated when reporting "operating expenses from patient care?" ***(Added 9/29/2021)***

Intercompany rent may be included when reporting "operating expenses from patient care" as well as "operating revenue from patient care."

Fiscal management service (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 9/29/2021)***

Yes. The FMS organization can include both TINs and associated revenues in their application for the Phase 4 – 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 fiscal management service (FMS) organizations' revenue from administrative fees provided by the state Medicaid program be included as "patient care"? ***(Added 9/29/2021)***

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 9/29/2021)***

If an applicant health care provider bills for care under a single TIN that provides care across multiple different facilities, the parent organization must 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.

ARP Rural Payments Application Process

What information do I need in order to complete the ARP Rural payments component of the application? ***(Added 9/29/2021)***

Applicants should fill out the single application for Phase 4 and ARP Rural payments. If an applicant believes that it or one of its subsidiaries meets the definition of rural provider, the applicant should answer that it would like to be considered for payment under this distribution. Parent entities applying on behalf of subsidiaries must list all subsidiary TINs in the Provider Relief Fund Application Portal. Please see the Federal Office of Rural Health Policy definition of rural for additional information available at https://www.hrsa.gov/rural-health/about-us/definition/index.html.

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.
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 Metropolitan Areas Targeted Distribution? *(Added 7/10/2020)*
Rural/Small Metropolitan Areas Targeted Distribution payments were limited to hospitals in small cities and rural areas that had not previously received payment in the Rural Targeted Distribution.

Which data source did HHS use for the Rural/Small Metropolitan Areas Targeted Distribution payments for hospitals? *(Added 7/10/2020)*
Payments were calculated based on hospitals' most recent Medicare cost reports and patient residence identified in the Hospital Service Area File.

What was the formula used to make the Rural Targeted Distribution payment to rural hospitals? *(Added 5/12/2020)*
Rural Targeted Distribution payments were made to rural acute care general hospitals and critical access hospitals (CAHs), rural health clinics (RHCs), and community health centers located in rural areas. Hospitals and RHCs will each receive a minimum base payment plus a percent of their annual expenses. This method accounts for operating cost and lost revenue incurred by rural hospitals for both inpatient and outpatient services. The base payment will account for RHCs with no reported Medicare claims, such as pediatric RHCs, and CHCs lacking expense data, by ensuring that all clinical, non-hospital sites receive a minimum level of support no less than $100,000, with additional payment based on operating expenses. Rural acute care general hospitals and CAHs will receive a minimum level of support of no less than $1,000,000, with additional payment based on operating expenses.

How does HHS define rural for these payments? *(Added 5/12/2020)*
For the Rural Targeted Distribution, HHS used the Federal Office of Rural Health Policy's definition of rural, which includes:

1. All non-Metro counties.
2. All Census Tracts 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.

COVID-19 High Impact Area Targeted Distribution

How was the second round of COVID-19 High Impact Area funds allocated? (*Added 7/22/2020)*
HHS made payments in this second round of COVID-19 High Impact Area Targeted Distribution based on a formula for hospitals with a COVID-19 admission count over 160 between January 1 and June 10, 2020, or the facility experienced an above average intensity of COVID admission per bed (at least 0.54864). Hospitals were paid $50,000 per eligible admission from January 1 through June 10. HHS also took into account previous High Impact Area payments for those hospitals that received initial payments from this Targeted Distribution.

How many payments did HHS make under the second COVID-19 High Impact Area Targeted Distribution? (*Added 7/22/2020)*
HHS is distributing $10 billion in payments to over 1,000 hospitals in areas heavily impacted by COVID-19 in this second round of targeted distribution payments.

What was the rationale behind requiring a minimum number of admissions or intensity of COVID-19 to be eligible for the second High Impact Area payment? (*Added 7/22/2020)*
This round of Targeted Distribution payments provides relief for over 83% of inpatient COVID-19 admissions through June 10 at $50,000 per admission, taking into account previous High Impact Area payments. Those hospitals treating inpatient COVID-19 positive admissions have experienced a large increase in expenses due to staffing costs, personal protective equipment costs, protocol changes, re-training, and general system changes.

How is the second round of the COVID-19 High Impact Area Targeted Distribution different from the initial distribution of High Impact Funding? (*Modified 7/22/2020)*
The first round of funding was based on a formula that distributed funds to hospitals with 100 or more COVID-19 admissions between January 1 and April 10, 2020 and paid $76,975 per eligible admission. The second round of funding was based on a formula for hospitals with over 161 COVID-19 admissions between January 1 and June 10, 2020, or one admission per day, or that experienced a disproportionate intensity of COVID admissions (exceeding the average ratio of COVID admissions/bed). Hospitals will be paid $50,000 per eligible admission. This previous high impact payments were also taken into account when determining each hospital's payment in this second round distribution.

Why is HHS targeting High Impact Areas for COVID-19 funding? *(Added 5/12/2020)*
In allocating the funds, the Administration is working to address both the economic harm across the entire health care system due to COVID-19 and the economic impact on providers directly treating patients with COVID-19. The distribution takes into consideration the challenges faced by facilities serving a significantly disproportionate number of low-income patients and that inpatient admissions are a primary driver of costs to hospitals related to COVID-19.

Should providers continue to update their High Impact data? *(Modified 6/8/2020)*
Providers should update their capacity and COVID-19 census data to ensure that HHS can make timely payments in the event that the provider becomes a High Impact Area provider. Providers can continue to update their information through the same method they used previously.

<u>Skilled Nursing Facilities Targeted Distribution</u>

What is the Skilled Nursing Facility funding amount and how did HHS determine the amount? *(Added 5/26/2020)*
HHS will distribute $4.9 billion in additional funding (over and above General Distributions received) to more than 13,000 skilled nursing facilities. Eligible facilities range in size between six and 1,389 beds. This represents a range of distributions between $65,000 and $3,255,500 and a national average distribution of ~$315,600 per facility. Each Skilled Nursing Facility received a fixed distribution per facility of $50,000 plus distribution of $2,500 per bed.

Which Skilled Nursing Facility providers received a payment under the SNF Targeted Distribution? ***(Added 5/26/2020)***
HHS allocated funding for certified Skilled Nursing Facilities with a capacity between six and 1,389 beds.

How will HHS disperse the Skilled Nursing Facility Targeted Distribution payments? ***(Added 5/26/2020)***
Most SNF fund payments will be dispersed electronically based upon banking account information associated with the organization's billing TIN. If the organization's billing TIN does not have a bank routing number associated with it, the organization will most likely receive a paper check.

What constituted a "certified" skilled nursing facility for purposes of the Targeted Distribution? ***(Added 6/8/2020)***
A "certified" skilled nursing facility must be certified under Medicare and/or Medicaid to be eligible for this Targeted Distribution. All standalone and/or hospital-based skilled nursing facilities with at least six beds were eligible for this Targeted Distribution.

Indian Health Service Targeted Distribution

Which Indian Health Service (IHS) providers received a payment under the IHS Targeted Distribution? ***(Added 5/29/2020)***
HHS allocated funding for IHS, Tribal, and Urban Indian Health programs. This includes IHS and Tribal hospitals.

How was IHS Targeted Distribution funding allocated across eligible entities? What was the formula used to make the IHS Targeted Distribution payment to IHS providers? ***(Added 5/29/2020)***
HHS allocated $500 million to IHS, Tribal, and Urban Indian Health programs. Approximately 4% of the $500 million in available funding was allocated for Urban Indian Health programs, consistent with the percent of patients served by Urban Indian Organizations (UIOs) in relation to the total IHS active user population, as well as prior allocations of IHS COVID-19 funding. IHS divided remaining funding equally between hospitals (48%) and clinics (48%).
HHS used different formulas for each of the different facility types.

- IHS Hospitals and Tribal Hospitals
    - *Per hospital allocation = $2. 815 million base + (Total Operating expenses * 3%)*
- IHS and Tribal Clinics/Programs
    - *Per IHS clinic allocation = Base amount of $187,000 + 5% of (estimated service population * average cost per user)*
- IHS Urban Programs
    - *Per IHS Urban Indian health allocation = Base amount of $181,250 + 6% of (estimated service population * average cost per user)*

Which data sources did HHS use for operating costs for IHS and tribal hospitals? How recent was the data used? ***(Added 5/29/2020)***
HHS analyzed the following files to determine the allocation for IHS Targeted Distribution to IHS and tribal hospitals:

- Provider of Services Files, December 2019 update.
- Healthcare Cost Report Information System (HCRIS), 1/17/2020 update, contains the most recent cost report data available. For most hospitals, this is the 2018 fiscal year.
- Total operating expenses are reflected in Worksheet B PART I COL 26 of the cost report.

How did HHS determine operating costs for IHS clinics and Urban Indian Health Organizations? ***(Added 5/29/2020)***
HHS identified the service population for most service units, and estimated an operating cost of $3,943 per person per year based on actual IHS spending per user from a 2019 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita.

Safety Net Hospitals Targeted Distribution

What were the eligibility criteria for children's hospitals in order to receive a payment under the latest round of this Targeted Distribution? ***(Added 8/18/2020)***
To be eligible, a children's hospital must meet the following criteria:

1. Be an inpatient prospective payment system (IPPS)-exempt facility as defined by the Centers for Medicare & Medicaid Services (CMS), or
2. Be a Children's Hospital Graduate Medical Education (CHGME) facility.

Children's hospitals that meet these criteria are free-standing facilities not affiliated with larger hospital systems. In contrast to affiliated children's hospitals, these facilities have not, with minor exceptions, qualified for targeted relief to the same degree as system-affiliated children's hospitals.

As the revenue from children's hospitals was included in the calculations (particularly with regard to general distributions) when paying the larger hospital systems, HHS expects that in kind, the systems will ensure that resources are being provided to ensure patient access and care for parents seeking care for their children.

What was the methodology/formula used to calculate children's hospital payments for this round of the Targeted Distribution of the Provider Relief Fund? ***(Added 8/18/2020)***
Eligible facilities received a payment that equals 2.5% of the annualized net patient revenue. Facility's calculated payment amount below $5,000,000 were adjusted to $5,000,000 and any values above $50,000,000 were adjusted to $50,000,000.

What data sources did HRSA use to determine payment for this round of the Safety Net Hospitals Targeted Distribution? ***(Added 8/18/2020)***
HRSA used the children's hospitals' most recent CMS Cost Report to determine eligibility. HRSA used Worksheet G-3, line 3 of the cost report to determine payment amounts. Net patient revenues were annualized prior to payment calculation. For those hospitals that do not file Cost Reports, HRSA calculated net patient revenue from tax information and audited financial statements submitted by those affected children's hospitals.

Why is HHS distributing a second round of payments under the Safety Net Hospitals Targeted Distribution? ***(Added 7/10/2020)***
Working with stakeholders and Congress, HHS learned that certain acute care hospitals did not qualify for the initial Safety Net Targeted Distribution that HHS believed were the target of the allocation. To address this, community hospitals meeting an expanded profitability threshold will now be eligible for payment.

How were hospitals determined to be eligible for the purpose of this second round of Safety Net Hospitals Targeted Distribution? ***(Added 7/10/2020)***
HHS is expanding the eligibility criteria for payment qualification under the second round of Safety Net Hospitals Targeted Distribution so that certain acute care hospitals that have (1) a profit margin threshold of less than or equal to 3% averaged consecutively over two or more of the last five cost reporting periods and (2) an annualized uncompensated care cost (UCC) of at least $25,000 per bed in the most recent cost report. The other criterion (Medicare Disproportionate Patient Percentage (DPP) of 20.2% or higher) for acute care hospitals remains the same.

What was the methodology/formula used to calculate the payment for this second round of Safety Net Hospitals Targeted Distribution? ***(Added 7/10/2020)***
HHS used the same formula for determining payments from the previous Safety Net Hospitals Targeted Distribution.

What data sources did HRSA use to determine eligibility for this second round of Safety Net Hospitals Targeted Distribution? ***(Added 7/10/2020)***
HHS used hospitals' last two to five Medicare cost report filings for determining eligibility based on profit margin and the latest Medicare cost report filing for determining eligibility based on annualized UCC per bed and Medicare DPP.

How was a safety net hospital defined for the purpose of the first round of targeted distribution payments? ***(Modified 6/30/2020)***
Safety net payments are allocated to acute care and children's hospitals that serve a disproportionate number of Medicaid patients and provide large amounts of uncompensated care.

Qualifying acute care hospitals will have:

- Medicare Disproportionate Patient Percentage (DPP) of 20.2% or higher.
- Uncompensated Care (UCC) of at least $25,000 per bed. (For example, a cost report would need to have 100 beds and $2,500,000 in Uncompensated Care to meet this requirement.)
- Profit Margin of 3% or less.

Qualifying children's hospitals will have:

- A Medicaid-only Ratio of 20.2% or greater.
- Profit Margin of 3.0% or less.

What was the methodology/formula used to calculate safety net hospital distributions from the Provider Relief Fund? ***(Modified 6/30/2020)***
The distribution amount for an eligible safety net hospital is the proportion of the individual facility score (number of facility beds multiplied by DPP for an acute care facility or number of

facility beds multiplied by Medicaid-only ratio for a children's hospital) to the cumulative facility scores for all safety net hospitals, times the $10 billion safety net distribution. Hospitals with a calculated distribution amount of less than $5,000,000 received a minimum amount of $5,000,000, and those with a calculated distribution amount of more than $50,000,000 received a maximum amount of $50,000,000.

HHS pulled the cost reports on May 27, 2020. The latest available cost report period available for a respective facility was used.

HHS pulled the data from the CMS Hospital Cost Reports:

DPP:	W/S E Part A, Line 32, Col. 1
Hospital Beds:	W/S S-3 Part I, Line 14, Col. 2
Net Patient Revenue:	W/S G-3, Line 3, Col. 1
Total Other Income:	W/S G-3, Line 25, Col. 1
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

What is the timeline for distributing quality incentive payments under this distribution? ***(Modified 1/28/2021)***
The incentive payment program is scheduled to be divided into four performance periods (September, October, November, December), lasting a month each. All nursing homes or SNFs

meeting the payment qualifications will be eligible for each of the four performance periods. Nursing homes will be assessed based on a full month's worth of data submissions, which will then undergo additional HHS review and auditing before payments are issued after the close of the reporting period.

If a provider purchases a facility that becomes eligible for a payment under the Quality Incentive Program for a given monthly reporting period, but the provider did not own the facility during the applicable reporting period, may the provider keep the payment? ***(Added 1/12/2021)***

No. If a provider did not own the facility that qualified for a Quality Incentive Program payment during the applicable month on which the payment was based under the Quality Incentive Program and subsequently purchased the facility, the provider must return the payment to HHS. HHS makes payments based on the most current financial information available, which may not reflect the owner's information during the applicable reporting period, in the event of a sale. The current owner may still receive and retain funds for other reporting periods in which it did own the facility if it otherwise meets the eligibility criteria.

How is the infection gateway calculated for determining eligibility for Quality Incentive Program payments under the Nursing Home Infection Control Distribution? ***(Added 12/28/2020)***

The infection gateway criterion specifically excludes facilities that are found to have an infection rate exceeding the estimated infection rate in their county during the performance period. County infection rates are measured using daily COVID-19 community profile reports (CPRs) disseminated under the HHS Protect data program. CPRs contain information on the rate of COVID-19 infections for all residents in each county. County infection rates are not the same as county positivity rates.

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 facility must demonstrate a rate of COVID-19 infections that is below the rate of infection in the county in which they are located. Second, facilities must also have a COVID-19 death rate that falls below a nationally established performance threshold for mortality among nursing home residents infected with COVID-19.

Are there different permissible uses of funds received as quality incentive payments compared to those for the funds distributed previously under the $2.5 billion Nursing Home Infection Control Distribution? ***(Modified 12/4/2020)***

No. The same Terms and Conditions and restrictions on use of funds apply to the quality incentive payments received by nursing homes as under the Nursing Home Infection Control Distribution. Quality incentive payments may only be used for the infection control expenses, as that term is defined in the Terms and Conditions. These include costs associated with administering COVID-19 testing for both staff and residents; reporting COVID-19 test results to local, state, or federal governments; hiring staff to provide patient care or administrative support; incurring expenses to improve infection control, including activities such as implementing infection control "mentorship" programs with subject matter experts, or changes made to physical facilities; and providing additional services to residents, such as technology that permits residents to connect with their families if the families are not able to visit in person.

How will facilities be assessed for purposes of issuing incentive payments? ***(Added 9/18/2020)***

Facilities will have their performance measured on two outcomes. First, facilities will be evaluated based on their overall COVID-19 infection rate among residents. Second, facilities will be evaluated based on their performance for COVID-19 mortality among residents. Performance measurements for each facility will be evaluated based on the population-wide rate of COVID-19 infection in the geographic area in which a facility is located. The goal is to appropriately evaluate facility performance by measuring the baseline level of infection in the community in which a facility is located.

In order to measure facility COVID-19 infection and mortality rates, the incentive program will make use of data from the National Healthcare Safety Network (NHSN) Long-term Care Facility Component COVID-19 Module. Within the NHSN module, the program will incorporate weekly reported data on COVID infections, COVID mortality, and the total count of occupied beds.

In addition, admissions of COVID-19-positive patients will be considered in order to focus accountability on infections acquired among existing residents. Using this weekly information, each facility will receive measurements of their COVID-19 infections per resident and COVID-19 deaths per resident in each performance month.

There will be an additional measurement of the baseline level of COVID-19 infection in the general community in which a facility is located. In order to measure the baseline infection rate, the program will make use of weekly updates of data included in CDC's Community Profile Reports (CPRs). Data from the CPRs includes county-level information on total confirmed and/or suspected COVID infections per capita, which will be used to measure the baseline infection rate for all eligible facilities located in that county.

What is the Nursing Home Infection Control Distribution? ***(Added 8/27/2020)***
Given their congregate nature and resident population of older adults – often with underlying chronic medical conditions – nursing homes are high risk environments that have been disproportionately affected by COVID-19. HHS is distributing $5 billion to nursing homes and skilled nursing facilities to build skills and enhance response to COVID-19, including enhanced infection control. Of this amount, HHS will provide approximately $2.5 billion in upfront funding to nursing homes to support increased testing, staffing, and personal protective equipment (PPE) needs. HHS plans on distributing another $2 billion to nursing homes later this fall based on certain performance indicators that will be shared in the future.

What is the funding amount for the Nursing Home Infection Control Distribution and how did HHS determine the amount? ***(Added 8/27/2020)***
HHS is distributing an initial $2.5 billion of the Nursing Home Infection Control Distribution funding to support nursing homes and skilled nursing facilities in conducting appropriate testing, acquiring necessary personal protective equipment (PPE), investing in staff, to improve infection control. Eligible nursing homes and skilled nursing facilities will receive a per-facility payment of $10,000 plus a per-bed payment of $1,450 in the first round of this distribution.

Additionally, $2 billion in funding will be distributed at a later time for nursing home performance in improving safety and minimizing COVID-19 spread and COVID-19 related fatalities among residents and training, mentorship, and instruction on infection prevention and control in nursing homes across the country. Please check back on https://www.hrsa.gov/provider-relief for updates.

Which nursing home providers received a payment under the Nursing Home Infection Control Targeted Distribution? ***(Added 8/27/2020)***
Nursing homes and skilled nursing facilities that are not revoked, have an active CMS certification, and have at least 6 certified beds, were deemed eligible to receive payments.

What are the permissible uses for this distribution? ***(Added 8/27/2020)***
The Nursing Home Infection Control Distribution can only be used for the infection control expenses defined in the Terms and Conditions. These include costs associated with administering COVID-19 testing for both staff and residents; reporting COVID-19 test results to local, state, or federal governments; hiring staff to provide patient care or administrative support; incurring expenses to improve infection control, including activities such as implementing infection control "mentorship" programs with subject matter experts, or changes made to physical facilities; and providing additional services to residents, such as technology that permits residents to connect with their families if the families are not able to visit in person.

How does this distribution differ from the Skilled Nursing Facility Targeted Distribution? ***(Added 8/27/2020)***
This distribution supplements the $4.9 billion that was previously distributed to skilled nursing facilities. This distribution provides nursing homes and skilled nursing facilities upfront funding to address critical needs in nursing homes including hiring additional staff, implementing infection control programs, increasing testing, and providing additional services, such as technology so residents can connect with their families if they are not able to visit. Because of the limits on use of funds, the Terms and Conditions for this distribution differ from those placed

on the Skilled Nursing Facility Targeted Distribution and other Targeted Distributions payments under the Provider Relief Fund. The Terms and Conditions for the Nursing Home Infection Control Distribution specifically prohibit recipients from taking any actions inconsistent with the best interests of its patients in order to increase potential future outcomes-based payments based on the recipients' successful infection control outcomes.