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Provider Relief Fund

Overview

- Congress appropriated $175 billion to the Department of Health & Human Services (HHS) to distribute to eligible healthcare entities for healthcare related expenses or lost revenues that are attributable to COVID-19. HHS is distributing these payments through the “Provider Relief Fund” (PRF).

- HHS began distributing the funds in April 2020 and continue to do so through October through a General Distribution, available broadly to providers, as well as Targeted Distributions for COVID hot spots, skilled nursing facilities, safety net hospitals, and Medicaid providers.

- This resource will focus on the General Distributions, which to date have totaled $70B as of October.
Tips for Staying Informed

Where to go for help

- Group practices with questions should call the CARES Provider Relief line at (866) 569-3522.
- 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 PRF Portal.

Watch for updates to guidance

- HHS has been rolling out guidance and making announcements through its PRF landing page. This includes frequently updated FAQs.
- Guidance has evolved frequently over time; MGMA endeavors to keep members updated with pertinent changes or updates, but also recommends that group practice leaders bookmark the PRF homepage and watch for any updates.

Payment conditions

- If you receive a PRF payment, you do not need to pay it back so long as you comply with the program’s associated terms and conditions (T&C).
- The T&C contain limitations on how the funds can be used, reporting requirements, and other guidelines that must be followed.
HHS announces $20 billion in new funding for providers under “Phase 3” of the General Distribution. Eligible providers can apply from Oct. 5 through Nov. 6, 2020. [How to apply](#).

Additional guidance and a timeline for reporting requirements is released. [See updated resource](#).

Application portal for “Phase 2” General Distribution funds closes.
Provider Relief Fund: Distributions to Date

Allocations in Billions

- General Distributions, $85.0
- Unallocated, $31.1
- High-impact hospitals, $22.0
- Safety net hospitals, $13.3
- Rural health clinics and hospitals, $11.3
- SNFs, $7.4
- Uninsured testing & treatment, $3.0
- Children’s hospitals, $1.4
- IHS, $0.5

Total: $175 Billion

Phase 1: Medicare providers, $50.0
Phase 2: Medicaid/CHIP providers, $15.0
Phase 3: Previously ineligible providers, $20.0
General Distributions to Date: Phases 1-3
From April 10, 2020 through April 17, HHS distributed $30 billion to providers via an automatic electronic funds transfer or paper check. Eligible providers were those who billed Medicare in 2019.

Overview

To date, HHS has made three rounds of general distributions, totaling $70 billion.

Although payment formulas have changed with each Phase, in general, HHS has stated it intends to allocate payments to applicants to equal approximately 2% of annual revenue from patient care. There may be opportunity for additional payments in excess of this figure under Phase 3.

1 Phase One: $30B

From April 10, 2020 through April 17, HHS distributed $30 billion to providers via an automatic electronic funds transfer or paper check.

Eligible providers were those who billed Medicare in 2019.

2 Phase Two: $20B

On April 24, HHS began distributing an additional $20 billion based on applications submitted through its portal.

Eligibility was initially limited to those entities that received Phase I payments, however HHS later expanded eligibility.

3 Phase Three: $20B

On Oct. 1, HHS announced an additional $20 billion in funds that are available through an application process.

Eligibility includes those that received Phase 1 and/or 2 payments, plus new provider types.
## General Distribution: Three Phases

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Total $</th>
<th>Eligibility</th>
<th>Payment Formula</th>
<th>How Much to Expect</th>
<th>Application Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20B</td>
<td>Billed Medicare in CY 2019 and provided services after 1/1/20.</td>
<td>Payment Allocation per Provider = (2019 FFS Payments / $453 Billion**) x $30 Billion</td>
<td>In general, providers can estimate payments from Phase 1 and 2 to be approximately 2% of 2018 (or most recent complete tax year) gross receipts or sales/program service revenue.</td>
<td>N/A – automatically disbursed</td>
<td></td>
</tr>
<tr>
<td>Phase 2</td>
<td>$30B</td>
<td>Received payment in Phase 1, or billed Medicaid/CHIP between 2018-2019, or a dental provider.</td>
<td>Payment Allocation per Provider = ((\text{Most Recent Tax Year Annual Gross Receipts} \times $50 \text{ Billion}) / $2.5 \text{ Trillion}) - \text{Initial General Distribution Payment to Provider})</td>
<td></td>
<td>Sept. 13</td>
</tr>
<tr>
<td>Phase 3</td>
<td>$20B</td>
<td>Expanded provider types, new providers (see <a href="#">here</a> for comprehensive info on eligibility).</td>
<td>Providers eligible to receive a Phase 3 General Distribution will receive a payment that, when combined with prior payments (if any), equals 2% of patient care revenue. HHS will calculate payments based on (i) a provider’s change in operating revenues from patient care, (ii) a provider’s change in operating expenses from patient care, including expenses incurred related to COVID-19, and (iii) payments already received through prior Provider Relief Fund distributions.</td>
<td>The actual percentage paid to providers will be in part dependent of how many providers apply in Phase 3 and will be determined after the application deadline. Providers that have not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of the General Distribution will receive at least that amount as part of their Phase 3 payment.</td>
<td>Nov. 6</td>
</tr>
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</table>
General Distributions

Phase Three
**Phase Three: Application Portal Open Through Nov. 6**

**Overview**

The Phase 3 General Distribution is intended to support providers who have been most significantly impacted by COVID-19, as measured by changes in their revenues and expenses from patient care.

If a provider did not previously receive approximately **2% of annual revenues from patient care**, they will receive this amount consistent with prior general distributions.

Once HHS allocates Phase 3 payments to allocate 2% of each recipient’s annual patient care revenue, it will issue additional payments to applicants.

**Application**

The application portal is open from Oct. 5 through Nov. 6.

HHS is advising potential applicants to apply early to expedite the process.

See the [application guide](#); [instructions](#); [sample form](#).
Phase 3: Eligibility

Providers eligible for Phase 3 must meet one of the following criteria:

- Billed Medicaid / CHIP programs or Medicaid managed care plans for health-related services between Jan. 1, 2018-Mar. 31, 2020;
- Billed a health insurance company for oral healthcare-related services as a dental service provider as of Mar. 31, 2020;
- Be a licensed dental service provider as of Mar. 31, 2020 that does not accept insurance and has billed patients for oral healthcare-related services;
- Billed Medicare fee-for-service during the period of Jan. 1, 2019-Mar. 31, 2020;
- Be a Medicare Part A provider that experienced a CMS-approved change in ownership prior to Aug. 10, 2020;
- Be a state-licensed / certified assisted living facility as of Mar. 31, 2020; or
- Be a behavioral health provider as of Mar. 31, 2020 that has billed a health insurance company or that does not accept insurance and has billed patients for healthcare-related services as of Mar. 31, 2020.

Additionally, if a provider meets the above criteria, they must meet all of the below criteria to be eligible for funding:

- Filed a federal income tax return for fiscal years 2017, 2018, 2019 if in operation before Jan. 1, 2020, or be exempt from filing a return; and
- Provided patient care after Jan. 31, 2020 (Note: patient care includes health care, services, and support, as provided in a medical setting, at home, or in the community); and
- Did not permanently cease providing patient care directly or indirectly; and
- For individuals providing care before Jan. 1, 2020, have gross receipts or sales from patient care reported on Form 1040 (or other tax form).
Phase 3: Payment Calculation

Providers who have *not yet* received PRF payments of 2% of annual patient revenue under a previous distribution will receive a payment under Phase 3 that, when combined with prior payments (if any), equals 2% of patient care revenue.

Entities may also be eligible to receive additional payments in excess of this 2% figure, depending on several factors identified on the next page.

In Phase 3, HHS will determine additional payment amounts above 2% of annual patient care revenue once its processed all applications. The exact formula for determining these add-on payments is not yet known as it will be in part dependent of how many providers apply in Phase 3. HHS also states that it will consider:

- A provider’s change in operating revenues from patient care
- A provider’s change in operating expenses from patient care, including expenses incurred related to coronavirus
- Payments already received through prior Provider Relief Fund distributions.

While HHS has made payments on a rolling basis under the previous general distributions, Phase 3 final payment amounts for these applicants will be determined once all applications have been received and reviewed.
Overpayments

How much funding should I expect from the PRF? What do I do if I think I’ve been overpaid?

Because HHS has changed payment formulas and PRF guidance several times, there is some uncertainty over these questions.

In general, PRF payments are intended to reimburse costs or offset losses. Since these are neither a loan, nor a fixed amount grant, there is uncertainty about circumstances in which a provider may be required to return some amount of funding. In a FAQ dated 5/6/2020, HHS stated: “Generally, HHS does not intend to recoup funds as long as a provider’s lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received.”

HHS has also instructed that recipients of funds must be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund.
Permissible Uses of PRF Payments
Permissible Uses of PRF Payments

General rule: Funds can only be used to prevent, prepare for, and respond to COVID-19 and reimburse providers for healthcare related expenses or lost revenues that are attributable to COVID-19.

Providers do not need to be able to prove, at the time they accept a PRF payment that prior and/or future lost revenues and increased expenses attributable to COVID-19 meet or exceed the PRF payment. Instead, if, at the conclusion of the pandemic, providers have leftover PRF money that they cannot expend on permissible expenses or losses, then they should return this money to HHS.

- In other words, PRF payments can be used to cover eligible expenses incurred on any date, so long as those expenses were attributable to coronavirus. HHS expects that it would be “highly unusual for providers to have incurred eligible expenses prior to January 1, 2020” and also expects that providers will fully expend payments by July 31, 2021, which is the deadline for submitting reports.

Funds cannot be used to reimburse providers for expenses or losses reimbursed from other sources. HHS confirmed that receiving Relief Fund payments does not prohibit a provider from also securing COVID-19 relief funding from other sources, such as the Small Business Administration’s Paycheck Protection Program. However, Provider Relief payments cannot be used to cover the same expenses.
Permissible Uses of PRF Payments on *Healthcare Expenses*

**What expenses can I cover with PRF payments?**

Healthcare related *expenses* attributable to coronavirus include:

- Employee or contractor payroll and health insurance; rent/mortgage payments; equipment leases; EHR licensing fees; supplies or equipment used to provide healthcare services for possible or actual COVID-19 patients; workforce training; developing and staffing emergency operation centers; reporting COVID-19 test results to federal, state, or local governments; building or constructing temporary structures to expand capacity for COVID-19; acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery;

PRF payments can be used to cover eligible expenses incurred on any date, so long as those expenses were attributable to coronavirus. HHS expects that it would be “highly unusual for providers to have incurred eligible expenses prior to January 1, 2020” and also expects that providers will fully expend payments by July 31, 2021, which is the deadline for submitting reports.

Funds may **not** be used to pay the direct salary of an individual at a rate in excess of Executive Level II of the Federal Executive Pay Scale, which as of January 5, 2020, is $197,300. Direct salary does not include fringe benefits and indirect costs. Recipients may use Relief Funds to pay salaries of those earning in excess of this cap, though amounts over it must be paid from non-federal funds.
What *lost revenue* can I cover with PRF payments?

PRF payments must only be used for lost revenues attributable to coronavirus, which HHS states includes “revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care. Providers can use Provider Relief Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus.”
Terms and Conditions
Providers must agree to the terms & conditions (T&C) when attesting to acceptance of any funds. If a provider does not wish to agree to the T&C, they should not accept funds.

The T&C contain important limitations and requirements that groups must be aware of.

Failure to adhere to the requirements and Terms and Conditions could expose recipients to government enforcement and recoupment actions.

Each distribution has its own T&C, so groups that receive payments under multiple distributions (e.g., Phase 1, Phase 2, and/or a targeted distribution) should be prepared to attest to T&C for each payment through a portal.

CHECKLIST

- Review T&C for each distribution [here](#)
- Attest to T&C within 90 days of payment
- Implement internal protocol to ensure compliance.
Balance Billing

Among other requirements, each T&C states that recipients of funds must refrain from balance billing certain patients, meaning recipients must not balance bill or attempt to collect from the patient any out-of-pocket expenses that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient.

Patients who cannot be balance billed are those who are:
1. Out-of-network and
2. Have an actual or presumptive case of COVID-19

HHS clarified that: “Not every possible case of COVID-19 is a presumptive 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.”
Reporting Requirements
Reporting Requirements

Providers who accept one or more PRF payments exceeding $10k are subject to reporting requirements. On Sept. 19, HHS posted updated guidance with information that must be submitted to HHS and subsequently released a webpage with additional information about reporting and audits.

Reporting Timeline:

- **Jan. 15, 2021**
  - Portal opens

- **Feb. 15, 2021**
  - Deadline for groups that expended all PRF $ prior to 12/31/20

- **July 31, 2021**
  - Deadline for groups with funds unexpended after 12/31/20
# Reporting Guidance

<table>
<thead>
<tr>
<th>Aggregate PRF Payments</th>
<th>Under $10k</th>
<th>Over $150k</th>
<th>$10k - $499,999</th>
<th>$500k or more</th>
<th>$750k or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Criteria</td>
<td>Current reporting guidance does not apply to providers that received PRF payments totaling less than $10,000, but these providers may still be required to submit reports as requested by HHS (per the T&amp;C) in the future.</td>
<td>PRF T&amp;C state that any provider receiving more than $150,000 in stimulus funds will need to submit a quarterly report to HHS, implying this would be in addition to reporting required by Feb. 15, 2021 or July 31, 2021. However, in a FAQ dated June 13, 2020, HHS states that recipients of PRF funding will not need to submit a quarterly report. Instead, providers should abide by guidance on annual reporting requirements.</td>
<td>Must report healthcare related expenses attributable to coronavirus, net of other reimbursed sources (e.g., payments received from insurance and/or patients, and amounts received from federal, state or local governments, etc.) in two aggregated categories: (1) G&amp;A expenses and (2) other healthcare related expenses.</td>
<td>Must report healthcare related expenses attributable to coronavirus, net of other reimbursed sources, and they must do so by reporting more detailed information within the two categories of G&amp;A expenses and other healthcare related expenses, according to enumerated subcategories of expenses.</td>
<td>Subject to single audit requirement, in addition to reporting, if this is expended within one year.</td>
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Providers that Expend over $750k in a Year

Due to longstanding regulations, any organization that receives federal grant funding is required to undergo a single audit to ensure compliance with the grant’s rules and regulations. Funding issued under PRF is catalogued as CFDA 93.498 Provider Relief Fund and CFDA 21.019 Coronavirus Relief Fund.

It is called a single audit because it is a standard used by all federal agencies that covers financial statements and records, expenditures and internal controls, as well as requirements specific to the grant itself. The single audit requirement applies to recipients who expend more than $750,000 in federal dollars in any given year. This requirement may be a new compliance requirement for some PRF recipients. A single audit reviews a targeted funding source for allowable costs incurred within the allowable time period and proper reporting to HHS. A distinction between traditional and single audits is that financial statements and findings (including deficiencies) will be made public as part of the standard process.

Note that while the previous reporting requirements apply to funds received, the single audit requirement is triggered by funds that are expended within a given year.
Additional Guidance
The IRS released guidance indicating that PRF money is included as taxable income:

**Q1:** 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)?

A: 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.

**Q:** Is a tax-exempt health care provider subject to tax on a payment it receives from the Provider Relief Fund?

A: 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.
Questions? Call the CARES Provider Relief line at (866) 569-3522 or e-mail MGMA at govaff@mgma.org

Resources:

- PRF landing page
- PRF FAQs
- Terms & Conditions