Member Q&A on CARES Act Medicaid Provider Relief Fund Distribution

To assist with the application process for the CARES Act Provider Relief Fund distribution, ANCOR has highlighted key resources and excerpts from the CARES Act Provider Relief Fund website that addresses questions posed during an ANCOR member briefing.

NOTE: Because the CARES Act Provider Relief Fund FAQs are continually updated, any references to specific sections / pages of the CARES Act FAQ mentioned below are from the June 17, 2020 version of the FAQ (PDF copy distributed with this resource).

***DEADLINE TO APPLY** for Medicaid Provider Relief Funds: July 20, 2020*

Will healthcare providers that have not had their TINs validated by the application deadline of July 20, 2020 be able to submit an application after that date? (Added 7/8/2020)

Yes. A healthcare provider must submit their TIN for validation by end of day July 20, 2020. If they receive the results of that validation after July 20, they will still be able to complete and submit their application.

KEY RESOURCES

Main **CARES Act Provider Relief Fund website:**
https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

Medicaid Provider Relief Fund Application Process (submit data by July 20, 2020)**:**

- Medicaid Provider Relief Fund Terms and Conditions: https://www.hhs.gov/sites/default/files/terms-and-conditions-medicaid-relief-fund.pdf
- Medicaid Provider Relief Fund Instructions: https://www.hhs.gov/sites/default/files/medicaid-provider-distribution-instructions.pdf
- Medicaid Provider Relief Fund Application downloadable form: https://www.hhs.gov/sites/default/files/medicaid-provider-distribution-application-form.pdf
- Medicaid Provider Relief Fund Payment Portal: cares.linkhealth.com/#

FAQs: *check frequently for updates*

- CARES Act Provider Relief Fund FAQs: https://www.hhs.gov/coronavirus/cares-act- provider-relief-fund/faqs/index.html

Provider Relief Fund General Information FAQs cover:

- Overview
- Attestation
- Rejecting payments
- Terms & conditions
- Reporting requirements

- Balance billing
- Appeals
- Publication of payment data

- **General Distribution FAQs** cover:
  - Overview & eligibility
  - Payment portal
  - Determining additional payments
  - Data sharing

- **Targeted Distribution FAQs**:
  - Medicaid Targeted Distribution specific FAQs: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html#medicaid-targeted

Technical Support on Application Process:

HHS is not taking direct inquiries from providers, and no remedy or appeals process will be available. For additional information, please call the **Provider Support Line at (866) 569-3522 (for TTY, dial 711).** *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 11.*

ANCOR MEMBER BRIEFING QUESTIONS AND ANSWERS

Q&A on Eligibility: ***Member Question(s): Various questions on eligibility requirements*** *ANCOR recommendation: See HHS guidance from Instructions and FAQs below:*

Who is eligible to receive payments from the Provider Relief Fund?(Modified 7/14/2020) Provider Relief Fund payments are being disbursed via both "General" and "Targeted" Distributions. To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in 2019, be a known Medicaid and CHIP or dental provider and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19, or prevented in the spread of COVID-19. HHS broadly views every patient as a possible case of COVID-19. A description of the eligibility for the announced Targeted Distributions can be found here. U.S. healthcare 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 2.*

What entities are eligible for the Medicaid Provider Relief Fund? To be eligible to apply, the applicant must meet all of the following requirements:
1. must not have received payment from the $50 billion General Distribution; and
2. must have directly billed Medicaid or CHIP for healthcare-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 billed Medicaid or CHIP for healthcare-related services during the period of January 1, 2018, to December 31, 2019; and
3. 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 healthcare clinic); and 4. must have provided patient care after January 31, 2020; and 5. must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and 6. 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. **Applicants must meet all six requirements in order to submit an application.** *Source: Instructions for the Medicaid Provider Distribution, pg.1*

I am a provider that did not receive a General Distribution payment and does not meet the eligibility for the Medicaid Distribution. Will I be eligible for a Provider Relief Fund payment? (Added 6/30/2020) HHS has not yet determined the methodology for future Provider Relief Fund distributions at this time, but will share additional information in the future. 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 29*

How did HHS create the list of TINs that are eligible for funding? (Added 6/30/2020) CMS issued a data call to States that sought information on eligible Medicaid providers including Tax Identification Number (TIN). HRSA used the TINs from this CMS-developed list, coupled with federal T-MSIS data to establish the “curated” list of potentially eligible providers who are permitted to submit a full Medicaid Distribution payment application. Providers with TINs on the “curated” list must meet other eligibility requirements including operating in good standing with States and CMS and not be excluded from receiving Medicaid, Medicare, or federal payments. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 29*

How can a healthcare provider find out if they are on the curated list? (Modified 7/10/2020) When a healthcare providers applies, the first step of the application process is to validate that their TIN is on a curated list of known Medicaid providers that were supplied by each state or providers who appear in T-MSIS. Applicants that are not on that list will be validated through an additional process with the state to determine if the provider is a known Medicaid or CHIP provider that was not captured initially. HRSA will be working directly with State/Territory 29 Medicaid or CHIP agencies for validation and will not be reaching out to individual providers for validation. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 28*

What if a Medicaid or CHIP provider's TIN is flagged as invalid because it is not on the filing TIN list submitted by states to CMS? (Modified 6/30/2020) Payments will be made to applicant providers who are in the filing TIN curated list from CMS. If a TIN is not on the curated list of state-submitted eligible Medicaid providers or T-MSIS, it will be flagged as invalid. In these cases, HHS will work with the states to verify whether the TIN should be included as a valid Medicaid provider in good standing. If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign. Please note, working with the states to verify TINs may result in a slight delay in process the application. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 289*

If my TIN will take more than 15 days to be validated, when will I be notified?(Added 7/10/2020) 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). *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 35*

Will healthcare providers that have not had their TINs validated by the application deadline of July 20, 2020 be able to submit an application after that date? (Added 7/8/2020) Yes. A healthcare provider must submit their TIN for validation by end of day July 20, 2020. If they receive the results of that validation after July 20, they will still be able to complete and submit their application. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 36*

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 healthcare-related services between January 1, 2018, to December 31, 2019 prevent these providers from being eligible for funding from the relief fund? (Added 6/25/2020)
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' healthcare 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 30*

Some states have identified providers who may not have been included in their data submissions that should have been. May states correct these situations via an amended submission or some other mechanism to ensure that all eligible providers may receive relief? (Added 6/25/2020)
If applicants are not on the curated list provided by state, HHS is using additional data, to validate a provider's eligibility. We have accepted amended submissions from states as well. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 31*

Is a healthcare provider eligible to receive a payment from the Provider Relief Fund Medicaid Distribution even if the provider received funding from the Small Business Administration's (SBA) Payroll Protection Program or the Federal Emergency Management Agency (FEMA)?(Added 6/25/2020)
Yes. Receipt of funds from SBA and FEMA for coronavirus recovery does not preclude a healthcare provider from being eligible for the Medicaid Distribution if the healthcare provider otherwise meets the criteria for eligibility and can substantiate that the Provider Relief Fund payments were used for increased healthcare related expenses or lost revenue attributable to COVID-19, so long as they are not reimbursed from other sources and other sources were not obligated to reimburse them. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 31*

Are healthcare providers who bill for Medicaid or CHIP services through a county behavioral health provider network eligible for the Medicaid Distribution? (Added 6/25/2020)
Yes. Healthcare providers that bill for Medicaid or CHIP services through a county behavioral health provider network are eligible for the Medicaid General Distribution if they otherwise meet the other eligibility criteria. If a TIN is not on the curated list of state-submitted eligible Medicaid providers, it will be flagged as invalid. In these cases, HHS will work with the states to verify whether the TIN should be included as a valid Medicaid provider in good standing. HHS will notify these providers of their finding within 15 businesses days. If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 31*

Are healthcare providers that only bill Medicaid or CHIP through a waiver eligible for the Medicaid Distribution? (Added 6/30/2020) Yes. Healthcare providers that bill for services in Medicaid or CHIP that are covered under either a waiver or state plan are eligible for the Medicaid Distribution if they otherwise meet the other eligibility criteria. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 35*

How would a healthcare provider know if they had received a payment from General Distribution of the Provider Relief Fund? (Added 6/30/2020) General Distribution payments were made between April 10 and April 17. Payments were primarily sent via Automated Clearing House (ACH). The automatic payments were sent via Optum Bank with "HHSPAYMENT" in the payment description. Payments were sent to the group's central billing office. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 42*

Will payments be sent at one time, or disbursed in phases? (Added 7/10/2020) 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 43*

Member Question(s): Are community providers who only do Employment & Day Activity Services (i.e., no residential or supported living) eligible? *ANCOR recommendation: Based on our understanding, yes, as long as you provide Medicaid billed services and have not received previous funding through one of the Medicare tranches. This understanding is supported by definitions provided on page 1 of the instructions.*

- Definition of "**Patient care**" means health care, services and supports, as provided in a medical setting, at home, or in the community to individuals who may currently have or be at risk for COVID-19, whereby HHS broadly views every patient as a possible case of COVID-19.
- Eligibility requirements *(listed above)* *Source: Instructions for the Medicaid Provider Distribution, pg. 1*

Q&A on Authorized Use of the Relief Payments: ***Member Question(s): Various questions on allowable expenses*** *ANCOR recommendation: See HHS guidance from FAQs below:*

The Terms and Conditions state that Provider Relief Fund payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the Recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus. What expenses or lost revenues are considered eligible for reimbursement? (Modified 6/19/2020) The term "healthcare related expenses attributable to coronavirus" is a broad term that may cover a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:

- supplies used to provide healthcare services for possible or actual COVID-19 patients;
- 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 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery.

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus. HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

The term "lost revenues that are attributable to coronavirus" means any revenue that you as a healthcare provider lost due to coronavirus. This may include 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. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover:

- Employee or contractor payroll
- Employee health insurance
- Rent or mortgage payments
- Equipment lease payments
- Electronic health record licensing fees

You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the Terms and Conditions and specified in future directions issued by the Secretary. HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at https://www.hhs.gov/provider-relief/index.html. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pgs. 8.*

Q&A on Required Data to Complete an Application: ***Member Question(s): Various questions on specific data requested on application*** *ANCOR recommendation: See HHS guidance from FAQs below:*

What information is HHS collecting in the Provider Relief Fund Payment Portal? The Provider Relief Fund Payment Portal has been deployed to collect information from providers who received 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 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:

Scenario 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.

Scenario 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg 20.*

What documentation must be uploaded to the application form? (Added 7/10/2020)

• 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 healthcare clinic).
•The applicant's Employer's Quarterly Federal Tax Return on IRS Form 941 for Q1 2020, Employer's Annual Federal Unemployment (FUTA) Tax Return on IRS Form 940, or a statement explaining why the applicant is not required to submit either form (e.g. no employees).
•The applicant's FTE Worksheet (provided by HHS).
•If required by Field 15, the applicant's Gross Revenue Worksheet (provided by HHS). *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg 42.*

What specific revenue information should I enter into the application portal? (Added 6/30/2020) Applicants should enter the most recent gross revenues number from its federal tax return of 2017, 2018, or 2019. If the applicant for tax purposes is a:

•Sole prorietor 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 36*

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? (Added 6/15/2020) If the parent organization does not have an NPI, the NPI field can be left blank. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 40.*

How should provider applicants account for multiple NPIs and multiple 941 forms?(Added 6/25/2020)
The NPI field may be left blank. For applicants with multiple 941 forms, the applicant should upload all of the organizations 941 forms. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 38*

The application instructions indicate that "real estate revenues" should be excluded from gross revenues from patient care. For residents that live in skilled nursing facilities, are 36 resident fees that cover their accommodations considered service revenue or real estate revenues? (Added 6/25/2020) Resident fees that cover their accommodations can be considered patient service revenue. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg.38*

If an applicant healthcare 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 6/25/2020)
If an applicant healthcare provider bills for care under a single TIN that provides care across multiple different facilities, the parent organization may report patient revenue for every facility that bills underneath the TIN. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 38*

Many assisted living and memory care communities also offer independent living units within the same community and those independent living residents benefit from services and supports offered by the community. Does the revenue from independent living units fits within the definition of "patient care?"(Added 6/25/2020)
Yes. The revenue from independent living units fits within the definition of "patient care" applying for the Medicaid Distribution. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 38*

If a healthcare provider employs an individual who practices independently without physician supervision and with their own license and NPI, but is not listed as one the "primary provider FTE" types, should the applicant include that individual provider as a "primary provider" or "non-primary provider?" (Added 6/30/2020) If a healthcare provider employs an individual that does not require physician supervision and can practice independently under their own license, e.g., a registered dietician, the provider applicant should include this FTE as a "primary provider" in Field 27 of the application. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 37*

I received an email saying my Taxpayer Identification Number (TIN) was under review. What does that mean? (Added 6/30/2020) HRSA is validating provider eligibility using State-provided lists of eligible Medicaid and CHIP providers. If you are not on those lists, HHS is taking additional steps to validate your eligibility using T-MSIS data. In most instances, HHS will respond within 15 business days; however, this process may take up to several weeks. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 37*

Why did the status not change in the portal after I submitted my application? (Added 6/30/2020) After your application is submitted through DocuSign, your information is passed to HRSA for evaluation. The status will update/change once the evaluation is completed. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 37*

Can an applicant use Form 1120 or Form 1165 in place of Form 1040? (Added 6/30/2020) No. Applicants must use the forms referenced in the Medicaid Distribution application instructions that correspond to the applicant's tax filer status. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 37*

Should I set up an electronic payment Automated Clearing House (ACH) account before my application is approved? (Added 6/30/2020) Yes, in order to most effectively and quickly deliver funds to providers, HHS recommends that applicants sign up for ACH at the same time they submit a Provider Relief Fund application. This will prevent delays in issuing payment once an application has been approved. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 37*

How long will it take from portal submission to payment decision or receipt? (Added 7/10/2020) 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 42*

Member Question(s): various questions on the FTE requirement *ANCOR recommendation: See HHS definitions from application instructions below:*

Field 8: Total number of FTE Enter the full-time equivalent (FTE) of W-2 employees (i.e. not independent contractors) providing patient care. A 1.0 FTE

works whichever number of hours the applicant considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute FTE of a part-time provider, divide the total hours worked by the provider by the total number of hours that your organization considers to be a normal workweek.

Field 29: **Other FTE** Enter the Other FTE of the applicant as of 5/31/2020. Include only W-2 employees (i.e. not independent contractors). “Other FTE” includes all employees not directly providing patient care, e.g. scheduling, billing, and accounting.

Field 31: FTE Worksheet Upload the FTE Worksheet including each primary provider, NPI, and FTE. Enter the total FTE as reported in the FTE worksheet in Field 27. Include only W-2 employees (i.e. not independent contractors). The worksheet is provided by HHS and is available at: https://www.uhcprovider.com/content/dam/provider/docs/public/other/PRF-FTE-Worksheet.xlsx. “Primary provider” includes physicians, dentists, nurse practitioners, physician assistants and midwives if these are not under a supervisory relationship with a physician. If you have more than 125 primary providers, enter the actual number of FTE in Field 27, and report only 125 on the FTE Worksheet.

How should Medicaid HCBS provider applicants categorize personal care services in Field 5? (Added 6/25/2020) HCBS provider applicants should categorize personal care services as ”Other,” code OT. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 36*

The Medicaid and CHIP Distribution application instructions for fields 27-29 directs applicants to report the number of FTEs as of 5/31/2020. Can applicants include staff that were furloughed as a result of the coronavirus in these figures? (Added 7/8/2020) Yes. Providers may include staff that were furloughed as a result of the coronavirus in the counts of FTEs in fields 27-29. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 36*

In Field 13, does an applicant need to indicate that the amount of lost revenues is a negative value? (Added 7/10/2020) No, HHS will treat the amount entered as an absolute figure regardless of whether the applicant entered a positive or negative value. This updates the previous instructions requiring applicants to enter a negative value to indicate a net loss. If an applicant experienced a net gain due to COVID-19, the applicant should enter “0” (zero). *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 36*

How should Medicaid Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) applicants categorize their services in Field 5?(Added 6/25/2020) ICF/IID applicants should categorize their services as “Residential Facilities,” code RF. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 38*

Is it HHS's intention not to capture FTE data for Medicaid provider agencies that do not have facilities?(Added 6/25/2020) No. HHS would like to know the number of FTEs for all applicant organizations, whether the organization has facilities or not *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 38*

Member Question(s): We have different Subsidiaries (TIN) that bill Medicaid. Safe to assume we would need to file a separate application for each TIN? Our parent organization does NOT bill for any services rendered. *ANCOR recommendation: Recommend reviewing HHS response in FAQs to similar questions from those who received General Distribution funds or other targeted funds for guidance.*

A parent entity files a tax return ("Filing TIN") but does not bill Medicare. The parent entity has one or more subsidiaries that bill Medicare ("Billing TIN") but do not file tax returns (disregarded or consolidated entities). Accordingly, the parent entity did not receive a payment under the $30 billion General Distribution and entering the parent's Filing TIN does not allow the Provider Relief Fund Payment Portal application to proceed. How should this be addressed with respect to the application? (Added 5/21/2020) The parent entity should complete an application by listing the Billing TINs of the respective subsidiaries without entering its own Filing TIN. In the application, the parent entity should enter the sum of all "gross sales or receipts" or "program service revenue" of all subsidiary entities with Billing TINs in the applicable field in the application form. Further, the parent entity should submit a statement on the first page of the uploaded tax return file stating (i) the parent entity's Filing TIN and that it does not bill Medicare and (ii) a schedule of the billing subsidiaries, their Billing TINs, and gross sales or receipts. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, 25*

A parent organization has a subsidiary that received a Provider Relief Fund General Distribution payment, but one or more of its other subsidiaries did not. When the parent entity submits its revenue information, should it report the gross receipts or receipts (or program service revenue) for the parent entity, which includes multiple subsidiaries' data, or only the specific provider/subsidiary that received a payment? (Added 6/8/2020) The parent organization should complete an application by listing the Billing TINs of the eligible subsidiaries that provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. In the application, the parent entity should enter the sum of all "gross sales or receipts" or "program service revenue" of all eligible subsidiary entities that provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19 and enter the subsidiaries' Billing TINs in the applicable fields in the application form.
Any revenues from subsidiaries that are not directly providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 may not be included. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 26.*

A parent entity is submitting revenue information on behalf of its subsidiaries. Each subsidiary has its own Medicare and Medicaid ID number. The parent TIN does not have a Medicare/Medicaid ID number. The distribution portal form allows the parent entity to group the TINs together and report all TINs that would be part of the tax form filed. However, there is only space for one Medicare/Medicaid ID number. How should the Medicare/Medicaid ID number be reported? (Added 6/9/2020) The parent entity should submit a statement on the first page of the uploaded tax return file stating (i) the parent entity's Filing TIN and that it does not bill Medicare and (ii) a schedule of the billing subsidiaries, their Billing TINs, their Medicare/Medicaid ID numbers, and gross sales or receipts. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 28*

A subsidiary of ours received payments from the $50 billion General Distribution, but another subsidiary of ours did not and is a Medicaid provider – can I apply for this Medicaid Targeted Distribution? (Added 6/9/2020) As long as the Filing TIN or one of the Billing TINs was not eligible for the $50 billion General Distribution, but is a Medicaid or CHIP provider, and is on the State-provided list of eligible Medicaid and CHIP providers, then they are eligible to apply. Medicaid or CHIP providers who are not on the State-provided list, their applications will undergo additional validation by HHS. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 33*

Member Question(s): We are a tax-exempt organization and do not file taxes. However, we file a 990. Do we use that instead? *ANCOR recommendation: Yes, see FAQ excerpt below:*

What should I do if I do not have the federal tax form to submit my information? (Added 6/9/2020) 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 42*

Q&A on Gross Revenue: ***Member Question(s): Various questions on the gross revenue requirement*** *ANCOR recommendation: See HHS guidance from application instructions and FAQ responses below:*

HHS application instructions on Gross Revenue data:

Where do I find my Gross Receipts or Sales?

- Form 1040: Box 1 of Schedule C

- Form 1065: Box 1a
- Form 1120: Box 1a
- Form 1120-S: Box 1a
- Form 990: Use Part I, 9 “Program Services revenue”
- Form 1041: Box 1 of Form 1040 Schedule C

• [Note: you use a Form 1040 Schedule C also for Form 1041] *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 22*

What information do I need before I start the application process? Lost revenue can be estimated by comparing year-over-year revenue or by comparing budgeted revenue to actual revenue. For April 2020, an estimate of the total monthly loss based on data from the first few weeks in April or by extrapolation from March data is acceptable. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 21 (see item #3 under “Data”)*

A vertically-integrated organization has both patient care revenues as well as revenues that are not directly related to patient care (e.g. insurance, retail, real estate). How should this scenario be addressed with respect to the application? (Added 5/21/2020) The applying organization should complete an application by listing the Billing TINs of the eligible subsidiaries that provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. In the application, the parent entity should enter the sum of all "gross sales or receipts" or "program service revenue" of all eligible subsidiary entities that provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19 and enter the subsidiaries' Billing TINs in the applicable fields in the application form. Further, the parent entity should submit a statement on the first page of the uploaded tax return file stating (i) the parent entity's Filing TIN and (ii) a schedule of the eligible subsidiaries, their Billing TINs, and gross sales or receipts. Any revenues from subsidiaries that are not directly providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 may not be included. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 25 - 26*

I am a provider using financial statements to complete the application. In Field 10 where it asks for “gross revenue,” should I report net patient revenue, gross patient revenue, or total operating income from the financial statements? (Added 7/14/2020) The amount reported in Field 10 should be net patient revenue plus other operating income. Net patient revenue is gross patient revenue less contractual adjustments, charity care/financial assistance, and bad debt expense. Other revenues, such as rental income, grants and contributions, joint venture income, and investment income, should be excluded from the amount reported in Field 10. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 36*

Q&A on 2% Calculation: ***Member Question(s): Various questions on the 2% calculation*** *ANCOR recommendation: See HHS guidance from Relief Fund General Information and FAQs below:*

See **Summary of Formulas Used to Determine Funds Allocated:**
Medicaid and CHIP Distribution Payment Allocation per Provider = 2% (Gross Revenues x Percent of Gross Revenues from Patient Care)* **For CY 2017 or 2018 or 2019 as selected by applicant*

What was the methodology/formula used to calculate provider payment? (Added 6/9/2020) The Medicaid Targeted Distribution methodology will be based upon 2% of (gross revenues * percent of gross revenues from patient care) for CY 2017, or 2018 or 2019, as selected by the applicant and with accompanying submitted tax documentation. Payments will be made to applicant providers who are on the filing TIN curated list submitted by states to HHS or whose applications underwent additional validation by HHS. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 32 (https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf)*

Member Question(s): Can you request less money, if you don't think you'll need it all? *ANCOR recommendation: Recommend reviewing HHS response in FAQs to similar questions from those who received General Distribution funds or other targeted funds for guidance.*

What if my Targeted Distribution payment is greater than expected or received in error? (Added 6/15/2020) Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 90 days of payment. In accordance with the Terms and Conditions, if you believe you have received an overpayment and expect that you will have cumulative lost revenues and increased costs that are attributable to coronavirus during the COVID-19 public health emergency that exceed the intended calculated payment, then you may keep the payment. If a provider does not have or anticipate having these types of COVID-19-related eligible expenses or lost revenues equal to or in excess of the Provider Relief Fund payment received, it should reject the payment in Provider Relief Fund Attestation Portal and return the entire payment, and with with the Provider Support Line at (866) 569-3522 (for TYY, dial 711) for step-by-step instructions on returning the payment and receive the correct payment when relevant. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 10*

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? (Added 6/8/2020) No. Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment, that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed

their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if, at the conclusion of the pandemic, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 9*

Q&A on Receipt and Return of Prior CARES Act Funds:

Member Question(s): Can you still return the Medicare payment to become eligible for the Medicaid tranche? Or if you received funds from the General Distribution on April 10, 2020 can you still apply to the Medicaid Provider Relief Funds? *ANCOR recommendation: No, if you were eligible for the General Distribution payment and rejected the payment, you cannot be eligible for Medicaid Targeted Distribution payment. See HHS FAQ responses below.*

If I rejected my initial General Distribution payment, can I apply for a Medicaid and CHIP Distribution payment? (Added 6/9/2020) No, if you were eligible for the initial General Distribution payment and rejected the payment, you cannot be eligible for Medicaid and CHIP Distribution payment. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 32*

If I rejected my initial Medicare-focused General Distribution or Medicaid and CHIP General Distribution payment, can I apply for a new payment?(Added 7/10/2020) If you received an initial Medicare-focused General Distribution or the Medicaid and CHIP General Distribution payment and rejected the payment, you are not eligible for an additional payment at this time. However, you may be eligible in future distributions of the Provider Relief Fund. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 42.*

If I changed my mind after I rejected a Provider Relief Fund Targeted Distribution payment through the Attestation Portal and returned the payment, can I receive a new payment? (Added 5/29/2020) No, HHS will not issue a new Targeted Distribution payment to a provider that received and then subsequently rejected and returned the original payment. The provider may be considered for future distributions if it meets the eligibility criteria for that distribution. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 5.*

Does payment from the first phase $50 billion General Distribution affect what I may receive in this Medicaid and CHIP Distribution? (Added 6/9/2020) Yes. Providers who received payments in the prior $50 billion General Distribution payment are not eligible to receive payment in this current Medicaid and CHIP Distribution, regardless of the size of the payment received. However, 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, i.e. providers who have received a Targeted Distribution may use this portal as long as they have not been paid in the $50 billion General. Distribution *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 32*

How would a healthcare provider know if they had received a payment from the Medicare-Focused General Distribution of the Provider Relief Fund?(Added 7/10/2020) Medicare-focused General Distribution payments were made between April 10 and April 17. Payments were primarily sent via Automated Clearing House (ACH). The automatic payments were sent via Optum Bank with "HHSPAYMENT" in the payment description. Payments were sent to the group's central billing office. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 41.*

What are the reasons that I would not be eligible for a payment? (Added 7/10/2020) You must meet all six of the eligibility criteria described in the application instructions. You 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. Your billing TIN must be included in the curated list of eligible dental providers or your application must pass additional validation by HHS. You also must not have previously received a payment from either the initial Provider Relief Fund $50 billion Medicare-focused General Distribution or the $15 billion Medicaid and CHIP General Distribution. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 41.*

Member Question(s): Knowing the rules are likely to change, should we still apply to the Medicaid Provider Relief even if we received funding from the General Distribution? *ANCOR recommendation: The instructions for filing discourage this. ANCOR will monitor for changes and provide information accordingly.*

Q&A on Receipt of Other Funds: ***Member Question(s): Various questions on Medicaid Relief Funds eligibility if organization received PPP funds or other sources of emergency funds*** *ANCOR recommendation: See HHS guidance in Terms and Conditions and FAQs:*

Medicaid Relief Fund Payment Terms and Conditions: (4th bullet) 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.

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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg 7-8.*

Can a parent organization transfer Provider Relief Fund payments to its subsidiaries? (Added 5/21/2020) Yes, a parent organization can accept and allocate funds at its discretion to its subsidiaries. The Terms and Conditions place restrictions on how the funds can be used. In particular, the parent organization will be required to substantiate that these funds were used for increased healthcare-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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 17*

Q&A on Editing, Submitting, and Receiving Confirmation of Completed Application: ***Member Question(s): Various questions on submission process*** *ANCOR recommendation: Recommend downloading copy of the application, instructions, and terms and conditions before using the portal. Additionally, see HHS guidance in FAQs below.*

Am I able to edit or resubmit my Medicaid Targeted Distribution application in the Enhanced Provider Relief Fund Payment Portal? (Modified 6/25/2020) 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 information and documentation required by the application form. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 39*

How will HHS notify me that my application has been processed? (Modified 6/12/2020) You will receive an email when your application is completed. You will receive a notification from HHS as to the final status of your application. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 18*

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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 39.*

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 ("envelop") 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 14.*

How can a healthcare 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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 2.*

Q&A on Attestation and Terms & Conditions: ***Member Question(s):***

Various questions on the attestation statement and terms of acceptance

ANCOR recommendation: Review the Medicaid Relief Fund Payment Terms and Conditions. Additionally, see HHS guidance in FAQ responses below.

What if I do not meet the requirements of the Terms and Conditions, either now or after attesting? (Added 6/9/2020) If a provider cannot meet the Terms and Conditions of the payment, they must reject the payment. This can be done by going into the attestation portal within 90 days of receiving payment and indicating you are rejecting the funds. The CARES Act Provider Relief Fund Payment Attestation Portal will guide providers through the attestation process to reject the funds.

To return the money, the provider needs to contact their financial institution and ask the institution to refuse the received Automated Clearinghouse (ACH) credit by initiating an ACH return using the ACH return code of "R23 - Credit Entry Refused by Receiver." If a provider received the money via ACH they must return the money via ACH. If a provider was paid via paper check, after rejecting the payment in the attestation portal, the provider should destroy the check if not

deposited or mail a paper check to UnitedHealth Group with notification of their request to return the funds.

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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 34.*

How will HHS recoup funds from providers that are required to repay all or part of a Provider Relief Fund payment? (Added 5/29/2020) HHS has not yet detailed how recoupment or repayment will work. However, the Terms and Conditions associated with payment require that the Recipient be able to certify, among other requirements, that it was eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus). Additionally, recipients must submit all required reports as determined by the Secretary. Non- compliance with any term or condition is grounds for the Secretary to direct recoupment of some or all of the payments made. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 8.*

Q&A on Reporting Requirement: ***Member Question(s): After we get these funds, are we required to submit any report on how the funds were spent or any other informational report?*** *ANCOR recommendation: Yes. See Terms and Conditions and FAQ excerpts below.*

Additionally, based on ANCOR's contract lobbyist's experience with previous funding rounds for other provider groups, HHS updated the Terms and Conditions during the distribution cycle. As such, lobbyists recommend ANCOR members monitor for updates to Terms and Conditions throughout this process.

Medicaid Relief Fund Payment Terms and Conditions: (5th bullet): The Recipient shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients.

(8th bullet): Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than $150,000 total in funds under the Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136), the

Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee a report. This report shall contain: the total amount of funds received from HHS under one of the foregoing enumerated Acts; the amount of funds received that were expended or obligated for reach project or activity; a detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.

(9th bullet): The Recipient shall 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 shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient 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.

How should providers classify the Provider Relief Fund payments in terms of revenue type? (Added 6/12/2020) CMS will issue guidance about how Provider Relief Fund payments should be treated for purposes of uncompensated care and how it should be reported on cost reports. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 3*

What are the audit requirements that need to be met to comply with Terms and Conditions of the Provider Relief Fund payments? (Added 6/30/2020). HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provider oversight as required in the CARES Act to ensure that Federal dollars are used appropriately. HHS will notify recipients of applicable audit requirements in the coming weeks. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 10*

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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 2*

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. *Source: CARES Act Provider Relief Fund Frequently Asked Questions, pg. 2*