Public Health and Social Services Emergency Fund (PHSSEF) Grant FAQs and Updates

April 23, 2020 Update

On April 22, the Department of Health and Human Services (HHS) announced **a second tranche from the $100 billion Provider Relief Fund created by the CARES Act. The second tranche released a total of $70.4 billion.** The April 22 is in addition to the $30 billion the U.S Department of Health and Human Services (DHHS) has already sent to Medicare fee-for-service (FFS) providers based on their 2019 Medicare FFS revenue.

1. ***How is the $70.4 billion allocated and which allocations are AHCA/NCAL eligible for (see table below)?***

Allocation Title	Amount & Method	Distribution Timeline	SNF, AL Eligibility
General Allocation	$50 Billion and Weekly releases	$26B on 4/10 $4B on 4/17 $20B on 4/24	SNFs
Targeted Allocation (e.g., COVID Hotspots	$10 Billion and Lump Sum	Hospitals submit data by midnight, 4/23	No – Hospitals, only
Uninsured Fund	No Dollar Figure Assigned	Providers may register for payments on 4/27 with payments beginning in early May	DHHS states "providers" – may include SNFs. To be determined
Rural Allocation	$10 Billion and Lump Sum	4/27	No – Rural Hospitals and Clinics Only
Indian Health Services (IHS) Allocation	$400 Million and Lump Sum	4/27	No – HIS Network, only
Additional Allocations including Medicaid, only Providers	Unspecified – Likely to include existing funds and funds added by developing Congressional Legislation	NA	SNFs with Medicaid Licensed beds, Medicaid-Financed AL, ICFs/ID-DD
Total	$70.4 Billion		
Unallocated	$29.6 Billion		
Unallocated, including new funds in proposed Congressional Legislation	$104.6 Billion		

2. ***When will Medicare providers who submit Medicare cost reports begin receiving funds from the General Allocation and do they need to do anything to receive this initial payment?***

- On April 24, Medicare providers will automatically be sent an advance payment based off the revenue data they submit to CMS in Medicare cost reports.
- No -- Providers do not need to take any action – DHHS will automatically make the deposits using provide Tax Identification Numbers (TINs).

3. What about subsequent payments from the General Allocation?

Payments will go out weekly (*see schedule in table above),* on a rolling basis, as information is validated, with the first wave being delivered on April 24.

4. DHHS notes "complete submitted cost reports." What if a provider is unsure if their cost reports were complete and/or accepted by CMS?

By ***April 24***, providers without adequate cost report data on file will need to submit their revenue information to a portal opening this week at https://www.hhs.gov/providerrelief for additional general distribution funds.

5. Do providers who automatically received payment on April 24 need to do anything to receive subsequent payments (see table under FAQ one)?

Yes -- Providers (*including those with complete, valid submitted cost reports who received automatic April 24 payments*) must submit revenue information so that it can be verified using https://www.hhs.gov/providerrelief

6. How did DHHS calculate payments from the General Allocation?

To-date, DHHS has not released the exact formula. However, DHHS notes they used cost report data and based payments on net revenue and "allocated proportional to providers' share of 2018 net patient revenue."

Through conversations with DHHS staff, AHCA/NCAL learned that the cost report data used was Medicaid data and the "Other" category of Medicare cost reports which includes Medicare Advantage, Private Insurance, and private pay.

7. What if a provider is a Medicaid-only provider such as a Medicaid-only nursing facility with long-stay residents, Medicaid-financed assisted living, or ICF/ID-DD?

Medicaid-only providers were not included in Tranche 2. DHHS has indicated Medicaid only providers will be covered in a subsequent release of funds.

8. Do providers need to attest, again, for this round of funding?

Yes - Providers who receive funds from the general distribution have to confirm receipt of funds and agree to the terms and conditions of payment and confirm the CMS cost report use the attestation web portal at https://covid19.linkhealth.com/#/step/1

9. Do the Terms and Conditions apply to this second round and are there any changes?

- Yes – Terms and Conditions apply. To view the Terms & Conditions, click Provider Relief Fund Terms and Conditions
- Yes -- The terms and conditions also include other measures to help prevent fraud and misuse of the funds. All recipients will be required to submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to coronavirus. There will be significant anti-fraud and auditing work done by HHS, including the work of the Office of the Inspector General. Additionally, as part of this commitment, as a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a presumptive or actual COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

10. What if a provider believes they should have received funds from the General Allocation but did not?

- Review the following check list:
    - Are these Medicaid only buildings? If yes, they would not have gotten funding in this round;
    - Did the submit cost reports in 2018? If no, they would not have received funding
    - Did they have complete cost reports? If they did not submit complete Medicare cost reports, they would not have received funding. If any required fields were incomplete of filed with data that is not possible (e.g., no administrative costs, etc.) the reports would have been thrown out and note used. Providers with complete cost reports or questionable submission should submit at https://www.hhs.gov/providerrelief
    - Did they have a change in ownership in 2018? If so, they would not have received funding. *DHHS still is working to resolve this issue. At this point, AHCA/NCAL is unable to provide further guidance.*

11. What should a provider do if they are eligible for the General Allocation and still are having difficulty?

If you are experiencing challenges with grant payments, DHHS has requested that providers call the toll-free **CARES Provider Relief Hotline** at **(866) 569-3522.** CARES Provider Relief Hotline provides access to a United Health Group Call Center. The UHG

representatives will be able to look up your information and either address your challenge or log it for follow up. Have the following information ready:

- Company Name
- Building Name
- Certification Number (CCN) for the building (see an explanation of a CCN) and
- The building's TIN

Updates on 4/16/2020

On Friday, April 10, the U.S. Department of Health and Human Services (DHHS) released the first round of the $100 billion in relief funds to hospitals and other health care providers on the front lines of the coronavirus response. This funding will be used to support health care-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19. Learn more on the CARES Act Provider Relief Fund webpage.

Ongoing Challenges with Payments

If you are experiencing challenges with grant payments, DHHS has requested that providers call the toll-free **CARES Provider Relief Hotline** at **(866) 569-3522.** CARES Provider Relief Hotline provides access to a United Health Group Call Center. The UHG representatives will be able to look up your information and either address your challenge or log it for follow up.

Attestation Portal

On April 16, 2020, DHHS updated the CARES Act Provider Relief Fund website, adding the CARES Act Provider Relief Fund Payment Attestation Portal. Providers who have been allocated a payment from the initial $30 billion general distribution must sign an attestation confirming receipt of the funds and agree to the terms and conditions within 30 days of payment.

DHHS also has added an additional clarifying statement on eligibility under "Who is Eligible for the Initial $30 billion." The statement now reads (bold text is new):

> "If you ceased operation as a result of the COVID-19 pandemic, you are still eligible to receive funds so long as you provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. ***Care does not have to be specific to treating COVID-19. HHS broadly views every patient as a possible case of COVID-19.***"

AHCA/NCAL anticipates this statement applying to the second and third tranches of funding as well but will provide updates on any changes in the language. However, the Provider Relief Fund Terms and Conditions remain in place and providers should development financial management systems to track and report on grant use.

While DHHS has not released detailed reporting instructions, the attestation form includes a statement on how DHHS will determine appropriate use of payments via reporting

requirements including maintaining an accounting of payments, and how providers are processing payments from the Fund. Examples of how DHHS will use fund reporting information include, but are not limited to, monitor contractors (and/or to its subcontractor) who has been engaged to perform services on an automated data processing (ADP) system used in processing financial transactions and to be shared with appropriate law enforcement agencies when relevant to an investigation, to the Treasury Department, and to auditing organizations conducting financial or compliance audits. A complete list of routine uses may be found at here. Additional information will be shared as AHCA/NCAL and members explore the Attestation Portal.

Additional FAQs Specific to Long Term/Post-Acute Care Providers

Of the $100 billion Health Care Relief Fund, how much was released on April 10 and to whom?

DHHS released $30 billion to providers who deliver Medicare-financed services, only. Learn more from AHCA/NCAL's Member Update regarding the first release of funds.

How did DHHS develop the grant allocation amounts?

DHHS calculated the amount of Medicare fee-for service (FFS) payments that were made to Medicare providers in 2019. Medicare Advantage payments, Medicaid and other revenue sources were not accounted for in the first round of $30 billion. Specifically, DHHS based each providers' share of the $30 billion on their share of total Medicare FFS reimbursements in 2019. This means that CMS, as with calculating the Accelerated and Advance Payments, has used net reimbursement based upon claims to calculate the award amounts.

How will I receive these funds and who deposits them?

- DHHS contracted with three banks to distribute the funds;
- Local Administrative Contractors (MACs) were not involved;
- Round One grants were deposited using your Taxpayer Identification Number (TIN) directly into your bank account; and
- Deposit would have been labeled HHSPAYMENT

Do I have to pay these funds back and are their terms and conditions for the grants?

No – the CARES Act Provider Relief Fund provides grants, not loans, so they do not need to be repaid. As with any grant, DHHS does have Terms and Conditions for grant.

Do I need to do anything with the Terms and Conditions?

Acceptance of the grant funds and retention of those funds for 30 days indicates a provider accepts the Terms and Conditions. Providers do not need to sign and return the Terms and Conditions.

How do I report on use of my grant funds?

DHHS will release reporting guidance in the coming weeks. For a high-level overview of reporting, see the Terms and Conditions.

What if I did not receive my payment?

If you are experiencing challenges with grant payments, DHHS has requested that providers call the toll-free **CARES Provider Relief Hotline** at **(866) 569-3522.** CARES Provider Relief Hotline provides access to a United Health Group Call Center. The UHG representatives will be able to look up your information and either address your challenge or log it for follow up.

You can also contact DHHS at HOSPITALCOVID19@hhs.gov. In the email include:

- Company Name
- Building Name
- Certification Number (CCN) for the building (see an explanation of a CCN) and
- The building's TIN

The agency has indicated that Medicare buildings/providers missed in Round One will receive their allocations in Round Two. For providers who continue to have problems, DHHS as noted that a web-portal will be established to support those providers.

Will more funds be available?

Yes – Round Two will address provider Medicaid payments, provider Medicare Advantage payments and providers in COVID hotspots.

Will AHCA/NCAL provide assistance with grant oversight resources?

Yes – AHCA/NCAL is developing an array of tools and resources to help you manage the CARES Act Provider Relief Fund as well as other financing opportunities. These will include:

- Lost Revenue and COVID-Related Expenses Calculator
- Grant and Loan Management Guidance and Checklist
- Billing Guidance – Ensuring Cash Flow