FOLEY HOAG LLP

Frequently Asked Questions
CARES Act Phase 3 Provider Relief Fund General Distribution

On October, 1, 2020, the U.S. Department of Health and Human Services (HHS) announced the availability of an additional $20 billion in relief funding for providers – including specifically for behavioral health providers and providers that have already received relief payments. The new funding is intended to offset financial losses and changes in operating expenses due to COVID-19. In addition, some providers who were previously ineligible are invited to apply. ***Applications for the Phase 3 General Distribution are due November 6, 2020.***

DISCLAIMER: Please note that the following FAQ is not intended as legal or accounting advice and is no substitute for your own research and due diligence. Questions regarding eligibility for Provider Relief Fund distributions may be sent directly to HHS. HHS also maintains a detailed FAQ on its website and a provider support line available by calling (866) 569-3522; for TTY dial 711. Hours of operation are 7 a.m. to 10 p.m. Central Time, Monday through Friday.

What is the Phase 3 General Distribution and how is it different from the previous Provider Relief Fund distributions? The Phase 3 distribution is intended primarily to: (1) expand the scope of providers eligible to receive 2% of annual patient care revenue; and (2) to provide add-on payments to providers for revenue losses and expenses attributable to COVID-19. As noted above, a wide range of providers are eligible for funding under Phase 3, including providers that have already received funding under previous distributions, behavioral healthcare providers and dental providers who do not bill Federal healthcare programs, and those providers who began practicing in 2020.

Who is eligible for the Phase 3 General Distribution? To be eligible for a Phase 3 distribution, providers must meet at least 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; or
- Be a behavioral health provider as of Mar. 31, 2020 who has billed a health insurance company or who does not accept insurance and has billed patients for healthcare-related services as of Mar. 31, 2020; or
- Billed Medicare fee-for-service during the period of Jan. 1, 2019-Mar. 31, 2020; or
- Be a state-licensed / certified assisted living facility as of Mar. 31, 2020; or
- Be a Medicare Part A provider that experienced a CMS approved change in ownership prior to Aug. 10, 2020; or
- Be a licensed dental service provider as of Mar. 31, 2020 who has billed a health insurance company or who does not accept insurance and has billed patients for oral healthcare-related services; or
- Received a prior targeted distribution.

Will this be the last General Distribution from the Provider Relief Fund? It is very likely in the absence of additional funding from Congress. In the Spring, Congress allocated $175 billion in relief funds to hospitals and other healthcare providers through the CARES Act and the Paycheck Protection and Health Care Enhancement Act. Based on our current estimates, HHS will have expended $143.9 billion of this funding at the conclusion of Phase 3, not including funds already expended by HRSA as part of the COVID-19 Uninsured Program.

If my agency already received 2% of its annual patient care revenue in the previous distributions, is my agency still eligible for additional funding? How much? Yes, you may be eligible for additional funding to compensate for revenue losses and expenses attributable to COVID-19. Phase 3 payments will take place in two stages. First, eligible providers that have not previously received funding equaling 2% of annual patient care revenue will be entitled to that funding. Once that funding has been disbursed and HHS has determined all of the eligible providers, HHS will make additional add-on distributions taking into account: (1) a provider's change in operating revenues from patient care, minus their operating expenses from patient care; and (2) funds received and kept under prior General and Targeted distributions. HHS will not be able to estimate or determine add-on funding amounts until after the application deadline has passed and it has assessed provider needs.

The application asks about our "operating revenues from patient care" and "operating expenses from patient care." What are these amounts and why is HHS asking for this information? After all eligible providers have received 2% of annual patient care revenue, HHS will distribute the remainder of the $20 billion based on a provider's change in operating revenues from patient care, minus their operating expenses from patient care.

HHS considers "operating revenues from patient care" to be net patient service revenue from the delivery of healthcare services directly to patients. "Net patient service revenue" is defined as gross charges for patient services delivered minus contractual adjustments from all third-party payors, charity care adjustments, bad debt, and any other discounts or adjustments necessary to arrive at net patient service revenue.

HHS considers "operating expenses from patient care" to be the operating expenses incurred as part of the delivery of care, including salaries, benefits, medical supplies, contracted and/or employed physicians, interest, and depreciations. Operating expenses from patient care do not include any non-operating expenses, such as costs incurred on any rental property as well as contributions made, gains, and/or losses on investments.

For what purposes can my agency use payments received under Phase 3 of the General Distribution? Like previous distributions, upon receiving funds providers will have 90 days to choose to accept or reject funds through the Provider Relief Fund Application and Attestation portal. Providers that accept funds, will attest (among other requirements) that payments will be used: (1) to prevent, prepare for, and respond to coronavirus; and (2) to reimburse for healthcare-related expenses *or* lost revenue that are attributable to coronavirus. Health-care-

related expenses including such items and services as personal protective equipment and equipment to support telehealth. In September, HHS adopted a narrower definition of "lost revenues" as part of its new Reporting Requirements. As currently set forth in the reporting guidelines, lost revenues must be represented as a negative change in year-over-year net patient care operating income, net of the healthcare-related expenses attributable to coronavirus. The Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses, provided that funds are expended by July 31, 2021.

My agency tried to apply for Phase 3 funding and its says my Tax ID Number (TIN) is not recognized? Why and what happens next? HHS has collected TINs from state-provided 3rd party lists and from prior PRF distributions, so it is possible the HHS system may not recognize your TIN. If your TIN is not recognized, HHS will share your TIN with 3rd party validators and determine your eligibility in 2-3 weeks.

Are health care providers that only bill Medicaid or CHIP through a waiver or through managed care arrangements eligible for Phase 3 funding? Yes. Health care providers that bill for services in Medicaid or CHIP that are covered under either a waiver or state plan (including disability services providers and other providers of Medicaid-funded Home- and Community-Based Services), or else bill directly to a managed care plan, are eligible for Phase 3 funding.

I am an individual HCBS self-directed provider that receives payments through a fiscal management services (FMS) organization who bills Medicaid and then remits payment to me. Am I eligible for funding under Phase 3? Like other providers, payments from Phase 3 will be made to the filing TIN entity. In general, if the individual is being paid through an FMS organization, the FMS organization is likely the filing and billing TIN and would be eligible to apply for the Phase 3 distribution. In that situation, the self-directed provider should contact the FMS organization to confirm that the organization is submitting an application on their behalf or whether the provider should submit an application as an individual self-directed provider.

If my agency already submitted a Phase 3 application, is it too late to make changes and resubmit? Yes. You can only submit one Phase 3 application and changes cannot be made once an application is submitted.

For answers to many more questions, please see: https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.