This guidance does not intend to service as business or strategic planning guidance nor does it supplant Certified Public Accountant, Tax Accounting or legal guidance. The information is intended to serve as a general resource and guide.
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1 T&C means Terms and Conditions
CARES ACT RELIEF FUNDS: FREQUENTLY ASKED QUESTIONS

(Updated May 23, 2020)

Division B, title VIII of the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”), Pub. L. No. 116-136 (March 27, 2020), appropriated $100 billion to the Public Health and Social Services Emergency Fund in order “to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus[.]” The CARES Act imposes certain eligibility requirements and restrictions with respect to such funds (“Relief Funds”) and gives the Secretary of Health and Human Services significant discretion in how and when Relief Funds may be distributed and in what amounts.

On April 10, 2020, the Department of Health and Human Services (“DHHS”) issued its first guidance regarding Relief Funds in conjunction with distributing $30 billion of those funds to providers that received Medicare fee-for-service payments in 2019. At the same time, DHHS released its Relief Fund Payment Terms and Conditions (“Relief Terms and Conditions”) that recipients of Relief Funds must agree to be bound by within 30 days of receiving Relief Funds in order to retain such funds. Below we provide our initial views regarding certain issues in the form of frequently asked questions (“FAQs”).

* * *

1. I’ve heard that Relief Funds come with “no strings attached.” Is that correct?

No. The CARES Act imposes restrictions on the use of Relief Funds. For example, the CARES Act contains a proviso (the “Other-Sources Proviso”) stating that Relief Funds “may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse[.]” Moreover, the Relief Terms and Conditions impose a host of requirements and restrictions. For example, the recipient must certify that Relief Funds “will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the [provider] only for health care related expenses or lost revenues that are attributable to coronavirus.”

That being said, HHS’s guidance states unequivocally and in bold letters: “These are payments, not loans, to healthcare providers, and will not need to be repaid.”


2. I received Relief Funds but don’t have the time or the inclination to review the Relief Terms and Conditions within the next 30 days. Do I have more time, now?

Yes. Per DHHS’s guidance: “Providers now have 90 days from the date of each allocation award to attest.” Please note, providers should check each allocation award date (e.g., Tranches 1 and 2 as well as the SNF Allocation and count forward to 90 days out. Moreover, a provider that knowingly retains Relief Funds without executing and submitting the Relief Terms and Conditions on a timely basis may subject itself to liability under the False Claims Act, among other statutes. To view the DHHS press release, click here.

3. What are the Relief Terms and Conditions?

All providers receiving and retaining Relief Funds should review the Relief Terms and Conditions (available here) carefully which differ by allocation. In short, there are two key requirements. First, within 90 days of receiving the payment, providers must sign an attestation confirming receipt of the Relief Funds and agreeing to the Relief Terms and Conditions. Second, providers must comply with the Relief Terms and Conditions. In general, the recipient of the Relief Funds must certify by:

- That it provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare; is not currently excluded from participation in Medicare, Medicaid, and other federal health care programs; and does not currently have Medicare billing privileges revoked;

- That the payment will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the recipient only for health care related expenses or lost revenues that are attributable to coronavirus;

- 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; and

- That it shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on the payment of Relief Funds, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Relief Funds recipients.

Tranches 1& 2 Comparison. AHCA/NCAL has prepared a merged document showing the differences between the Tranche 1 T&Cs and the Tranche 2 T&Cs. Added text is highlighted with accompanying text boxes containing the former text.

In regard to the T&Cs, providers should note important differences. In the accompanying comparison of the original Tranche 1 T&C & the updated Tranche 1 and 2 T&Cs, notable differences include:

- Change from “currently provides” to “provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19;”
- Change from “Medicare” to “is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D;”

- Added:

“The Recipient certifies that all information it provides as part of its application for the Payment, as well as all information and reports relating to the Payment that it provides in the future at the request of the Secretary or Inspector General, are true, accurate and complete, to the best of its knowledge. The Recipient acknowledges that any deliberate omission, misrepresentation, or falsification of any information contained in this Payment application or future reports may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment.”

Also, note that in the Attestation Portal and related to the language added to the T&Cs, providers acknowledge that they understand that, “The information collected is used by DHHS to determine eligibility for payments from the Public Health and Social Services Fund, maintain an accounting of payments, and process payments from the Fund. Examples of other permissible uses include, but are not limited to, a contractor (and/or to its subcontractor) who has been engaged to perform services on an automated data processing (ADP) system used in processing financial transactions, to 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 https://www.federalregister.gov/documents/2015/11/03/2015-27980/privacy-act-of-1974-system-of-records-notice”

- Added:

The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive [NOTE: the term, “presumptive” in the Tranche 2 T&Cs replaced the term, “possible” in the Tranche 1 T&Cs.] or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient.

In regard to the SNF-Only Allocation, the T&Cs, the notable changes include:

- Elimination of the phrase, “billed Medicare in 2019;”

- Elimination of the phrase, “The Recipient shall also submit general revenue data for calendar year 2018 to the Secretary when applying to receive a Payment, or within 30 days of having received a Payment.” [NOTE: Unlike Tranches 1 & 2, the SNF Allocation is not based upon revenue. Thus, no validation of revenue is needed.]

- In regard to the reporting provision, DDHHS added the italicized and red text, below:

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 DHHS under one of the foregoing enumerated Acts; [NOTE: The addition of this language likely is intended to make clear that as part of reporting, DHHS is ensuring providers are not using Paycheck Protection Program loan forgiveness at the same time at Provider Relief Funds for staffing.]

4. Can I negotiate changes to the Relief Terms and Conditions?

No - While the DHHS guidance does not address this issue, most of the Relief Terms and Conditions reflect legal requirements imposed by the CARES Act or other statutes.

5. Generally speaking, for what purposes can I use Relief Funds?

The Relief Terms and Conditions require that the provider certify that Relief Funds “will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the [provider] only for health care related expenses or lost revenues that are attributable to coronavirus.” (Emphasis added.) The CARES Act provides the following illustrative examples: “building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity[.]”

6. Can Relief Funds be used for costs incurred before the receipt of Relief Funds?

Most likely yes. DHHS’s guidance does not address this issue, but the CARES Act contains a proviso stating that the payment of Relief Funds may include “pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary[.]” (Emphasis added.) Moreover, Congress understood that when it enacted the CARES Act, many providers had already incurred significant costs as a result of responding to coronavirus.

7. Can Relief Funds be used to pay back payments received under the Accelerated and Advance Payment Program administered by CMS?

DHHS’s guidance suggests that the answer is “no.” The guidance asserts: “The CMS accelerated and advance payments are a loan that providers must pay back.” While that assertion is correct as a general matter, the CARES Act provides that Relief Funds may be used to reimburse eligible health care providers for “lost revenues that are attributable to coronavirus[.]” To the extent advanced Medicare payments left over and otherwise subject to repayment reflect decreased Medicare utilization caused by coronavirus (e.g., through the cancellation of elective procedures), one may be able to argue that Relief Funds can be used to pay back such remaining
amounts because they reflect lost revenue attributable to coronavirus. For the time being, however, DHHS’s guidance suggests that the agency takes a contrary view.

8. **What effect, if any, does loan forgiveness under the new Payroll Protection Program have on Relief Funds?**

The CARES Act’s Other-Sources Proviso states that Relief Funds “may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse[.]” An unrelated provision of the CARES Act creates a Paycheck Protection Program by which small business concerns and certain other employers can obtain loans through a new program administered by the Small Business Administration. Loan amounts used for such things as payroll costs will be forgiven under certain circumstances. Although DHHS’s guidance does not address this issue, available evidence suggests that in so far as a provider receives such loan forgiveness in connection with expenditures that were reimbursed with Relief Funds, the provider would need to refund the Relief Funds in question or identify other qualifying expenditures.

9. **Can Relief Funds be used to renovate a facility?**

That depends on the underlying reason for the renovation. The Relief Terms and Conditions require that the provider certify that Relief Funds “will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the [provider] only for health care related expenses or lost revenues that are attributable to coronavirus.” (Emphasis added.) The CARES Act provides illustrative examples, including “building or construction of temporary structures” and “retrofitting facilities.” Therefore, to the extent improvements are necessary to respond to coronavirus (e.g., to maintain social distancing), the Relief Funds can be used for that purpose.

10. **Do I have to apply for the Relief Funds?**

For initial allocations, no. The payments to Medicare fee-for-service health care providers will be made automatically by UnitedHealth Group (“UHG”). If you receive payments electronically, UHG will make the deposit via Automated Clearing House account information on file with UHG or the Centers for Medicare & Medicaid Services (“CMS”). The automatic payments will come to providers via Optum Bank with “HHS PAYMENT” as the payment description. If you normally receive a paper check for reimbursement from CMS, you will receive a paper check in the mail.

However, the CARES Act states that in order to be eligible for Relief Funds, a provider “shall submit [to the Secretary] an application that includes a statement justifying the need of the provider for the payment[.]” To operationalize this provision, DHHS allows providers to apply for additional funds under the General Distribution Fund and the Uninsured Funds. The T&Cs also apply to any additional funds. In requesting additional funds, providers must submit supporting documentation. See AHCA/NCAL FAQs document for more information.

11. **How did DHHS calculate award amount?** Award calculations method vary by Tranche:

   - Tranche 1: 2019 Net Medicare Revenue based upon claims
12. **Do I have to pay the Relief Funds back?**

No. Unlike the Accelerated and Advance Payment Program administered by CMS, this is not a loan. As noted above, these are payments, not loans, to health care providers, and will not need to be repaid if they are used for eligible expenses or eligible lost revenues.

However, DHHS has indicated the Department reserves the right to recover or require the return of unused funds, funds which appear to be improperly used, transferred to a third party, or lack sufficient document to justify expenditures for COVID-related costs or losses in the spirit of the statute.

13. **Can I appeal the amount of Relief Funds I received?**

No. However, if a provider believes an error occurred in an award, the provider may submit data and request DHHS review the submitted data and, as noted above, providers may request additional funds.

14. **Do I need to maintain records and documentation of how I use Relief Funds?**

Yes. The Relief Terms and Conditions require that recipients “maintain appropriate records and cost documentation.” These records include, as applicable, documentation required by federal award financial management regulations (45 C.F.R. § 75.302) and federal award record retention and access regulations (45 C.F.R. §§ 75.361–75.365), as well as such “other information required by future program instructions to substantiate the reimbursement of costs under this award.” The overarching goal of these requirements is to ensure that Relief Funds are spent for their intended purpose. Therefore, establishing systems that show how Relief Funds are spent and for what purpose will help providers guard against second-guessing by federal regulators potentially years after the COVID-19 pandemic ends. Of note, DHHS has not yet released reporting guidelines. For now, AHCA/NCAL suggests use of its Grant and Loan Management Guide Version 1 and the AHCA/NCAL COVID-Related Cost/Lost Revenue Calculator.

15. **While providers await future program instructions from DHHS on how to substantiate the use of Relief Funds, are there steps providers can take now to ensure compliance with the applicable record-keeping and cost-documentation requirements?**

Yes. While there is no one-size-fits-all approach to demonstrating compliance with the applicable record-keeping and cost-documentation requirements, recipients of Relief Funds should consider certain best practices around these requirements now to help ensure compliance.
Chief among those best practices is to begin by evaluating the recipient’s financial management systems to ensure they are designed to maintain effective control over, and accountability for, the expenditure of Relief Funds, and to produce reports capable of demonstrating that Relief Funds were expended solely for authorized purposes. See 45 C.F.R. § 75.302. Recipients should also consider segregating Relief Funds from all other funding sources, such as by maintaining Relief Funds in a separate bank account, so that the expenditure of Relief Funds may be more easily tracked. Finally, recipients should track all expenditures of Relief Funds. For example, recipients should track the cost of coronavirus-related expenses, such as those associated with personal protective equipment, training, and staffing (e.g., agency staff, overtime, retention bonuses), as well as coronavirus-related revenue losses such as those associated with the cancellation of elective medical procedures. Ultimately, while recipients have discretion as to how they design and implement their financial management and record-keeping systems, implementing the aforementioned best practices will help ensure that recipients of Relief Funds can adequately substantiate their expenditures. Again, AHCA/NCAL recommends use of its guidance and tools noted above.

16. Is DHHS publishing awards?

Yes. DHHS is posting awards by provide name, state, city and payment. AHCA/NCAL inquired about any additional provider identifying information posting such as TIN, CCN, NPI, etc. DHHS written response via email was “no.” This response is repeated in the FAQs. To view the provider award database, click here.

17. Can commonly owned providers aggregate the Relief Funds they received and redistribute the funds to those affiliated providers most impacted by COVID-19 (e.g., TIN challenges)? See AHCA/NCAL interpretation below.

DHHS has added the following FAQs related to this point on May 22:

A new organization that did not bill Medicare fee-for-service in 2019, and thus did not receive a payment under the General Distribution, purchased in 2019 or January 2020 all or part of a practice (i.e., a full or partial change in ownership) that did bill Medicare fee-for-service in 2019. Can the new organization submit documentation through the Provider Portal to receive payment? (Added 5/21/2020)

If a provider that purchased a practice or facility in 2019 or January 2020 did not bill Medicare fee-for-service in 2019 and did not receive any Provider Relief Fund payment, it is not eligible for payments under the General Distribution and may not submit its gross revenue receipts in the Provider Relief Fund Payment Portal. However, the provider may still receive funds in future distributions.

A parent entity submitting an application for a General Distribution payment from the $20 billion payment tranche has more than 20 subsidiaries with Billing TINs. How should it complete the application in the Provider Relief Fund Payment Portal? (Added 5/20/2020)

The parent entity should attach and submit a statement as the first page of the uploaded tax return file indicating any additional billing TINs not previously entered into the application forms as
Can an organization that received a General Distribution payment and provided care on or after January 31, 2020 that sold, terminated, transferred, or otherwise disposed of a provider accept the General Distribution payment (received via ACH or check) associated with the sold provider? *(Added 5/21/2020)*

If an organization that sold, terminated, transferred, or otherwise disposed of a provider that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for increased healthcare-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Generally, if a provider anticipates that its COVID-related lost revenues or increased expenses will be materially less than the value of the General Distribution payments received, the provider should reject the payment and submit its adjusted gross receipts in the Provider Relief Fund Payment Portal.

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 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.

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.

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.

18. Has DHHS provided any guidance on Change in Ownership (CHOW)? See AHCA/NCAL interpretation below.

Yes – however the guidance is challenging:

Can an organization that sold its only practice or facility under a change in ownership in 2019 and is no longer providing services, accept payment and transfer it to the new owner? (Added 5/19/2020)

No. A provider that sold its only practice or facility must reject the Provider Relief Fund payment because it cannot attest that it was providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, as required by the Terms and Conditions. Seller organizations should not transfer a payment received from DHHS to another entity.

If the current TIN owner has not yet received any payment from the Provider Relief Fund, it may still receive funds in other distributions. Can a provider that purchased a TIN in 2019 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? (Added 5/19/2020)

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment. If the new TIN owner did not receive a direct payment under the General Distribution, it is not eligible to receive a payment under the General Distribution. However, the new TIN owner may still receive funds in other distributions.

If, as a result of the sale of a practice/hospital, the TIN that received a General Distribution payment is no longer providing health care services as of January 31, 2020, is it required to return the General Distribution payment? (Added 5/19/2020)

Yes. If, as a result of the sale of a practice/hospital, the TIN that received a General Distribution payment did not provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, the provider must reject the payment. The CARES Act Provider Relief Fund Payment Attestation Portal will guide you through the attestation process to reject the payment. An organization purchased a practice during or after the year of the organization’s most recent tax filing and the purchased practice’s revenues are not reflected in the most recent tax return.

How does the organization account for these acquisitions when submitting revenue information in the Payment Portal? (Added 5/19/2020)
An organization’s adjusted gross receipts should be calculated as gross receipts as shown on the organization’s most recent tax return plus gross receipts of the practice acquired not reflected in the organization’s tax return minus gross receipts of providers sold not reflected in the organization’s tax return. If an organization’s adjusted gross receipts exceed the gross receipts shown in the tax return by more than 20%, the organization is eligible to enter the adjusted gross receipts figure in the Provider Relief Fund Payment Portal. Otherwise, the organization should enter the gross receipts figure as shown on the tax return. Organizations that have already submitted an application in the Payment Portal can resubmit a revised application using the adjusted gross receipts number accounting for acquisitions, if the adjusted gross receipts exceeds the gross receipts shown in the tax return by more than 20%. Gross receipts of acquired entities that provide care as of January 31, 2020 and file their own tax returns cannot be included in such adjusted gross receipts figure, because they should submit their own application as tax return filers.
Tranches 1 and 2 Merged T&C⁴ Comparison

⁴ T&C means Terms and Conditions
Acceptance of Terms and Conditions

If you receive a payment from funds appropriated in the Public Health and Social Services Emergency Fund for provider relief ("Relief Fund") under Public Law 116-136 and retain that payment for at least 30 days without contacting HHS regarding remittance of those funds, you are deemed to have accepted the following Terms and Conditions. Please also indicate your acceptance below. This is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable.

Your commitment to full compliance with all Terms and Conditions is material to the Secretary’s decision to disburse these funds to you. Non-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payment made from the Relief Fund.

These Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient also apply to subrecipients and contractors, unless an exception is specified.

Relief Fund Payment from Initial $30 Billion General Distribution Terms and Conditions

- The “Payment” means the funds received from the Public Health and Social Services Emergency Fund (“Relief Fund”). The Recipient means the healthcare provider, whether an individual or an entity, receiving the Payment.
- The Recipient certifies that it billed Medicare in 2019; provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.
- The Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.
- 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.
- 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.
The Recipient certifies that all information it provides as part of its application for the Payment, as well as all information and reports relating to the Payment that it provides in the future at the request of the Secretary or Inspector General, are true, accurate and complete, to the best of its knowledge. The Recipient acknowledges that any deliberate omission, misrepresentation, or falsification of any information contained in this Payment application or future reports may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment.

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), 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 each 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.

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.

The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient.
The following statutory provisions also apply:

**General Provisions in FY 2020 Consolidated Appropriation**

**SEC. 202. Executive Pay.** None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

**SEC. 210. Funding Prohibition for Gun Control Advocacy.** None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.

**SEC. 503. Lobbying**

(a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

**SEC. 506. Prohibits Use of Federal Funds for Abortions.**
(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

SEC. 507 Limitations on Abortion Funding Prohibition

(a) The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

Prohibits Use of Funds for Embryo Research

SEC. 508. Prohibits Use of Funds for Embryo Research
(a) None of the funds made available in this Act may be used for—

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term “human embryo or embryos” includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

SEC. 509. Prohibits Promotion of Legalization of Controlled Substances

(a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established by section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

SEC. 515. (b) Prohibits Asking Candidates for Federal Scientific Advisory Committees Their Political Affiliations; Prohibits Distribution of Intentionally False Information

(b) None of the funds made available in this Act may be used to disseminate information that is deliberately false or misleading.

SEC. 520. Pornography.

(a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(b) Nothing in subsection (a) shall limit the use of funds necessary for any Federal, State, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

SEC. 521. Prohibits Funding ACORN or Its Affiliates or Subsidiaries. None of the funds made available under this or any other Act, or any prior Appropriations Act, may be provided to
the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors.

SEC. 527. Prohibits Federal Funding for Needle Exchange Except in Limited Circumstances. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

Government-wide General Provisions

SEC. 718. Propaganda. No part of any appropriation contained in this or any other Act shall be used directly or indirectly, including by private contractor, for publicity or propaganda purposes within the United States not heretofore authorized by the Congress.

SEC. 732. Privacy Act. None of the funds made available in this Act may be used in contravention of section 552a of title 5, United States Code (popularly known as the Privacy Act), and regulations implementing that section.

SEC. 742. Confidentiality Agreements.

(a) None of the funds appropriated or otherwise made available by this or any other Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

(b) The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

SEC. 743. Nondisclosure Agreements

(a) No funds appropriated in this or any other Act may be used to implement or enforce the agreements in Standard Forms 312 and 4414 of the Government or any other nondisclosure policy, form, or agreement if such policy, form, or agreement does not contain the following provisions: “These provisions are consistent with and do not supersede, conflict with, or
otherwise alter the employee obligations, rights, or liabilities created by existing statute or Executive order relating to (1) classified information, (2) communications to Congress, (3) the reporting to an Inspector General of a violation of any law, rule, or regulation, or mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety, or (4) any other whistleblower protection. The definitions, requirements, obligations, rights, sanctions, and liabilities created by controlling Executive orders and statutory provisions are incorporated into this SEC. 743. (a) No funds appropriated in this or any other Act may be used to implement or enforce the agreements in Standard Forms 312 and 4414 of the Government or any other nondisclosure policy, form, or agreement if such policy, form, or agreement does not contain the following provisions: “These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by existing statute or Executive order relating to (1) classified information, (2) communications to Congress, (3) the reporting to an Inspector General of a violation of any law, rule, or regulation, or mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety, or (4) any other whistleblower protection. The definitions, requirements, obligations, rights, sanctions, and liabilities created by controlling Executive orders and statutory provisions are incorporated into this agreement and are controlling.”: Provided, That notwithstanding the preceding provision of this section, a nondisclosure policy form or agreement that is to be executed by a person connected with the conduct of an intelligence or intelligence-related activity, other than an employee or officer of the United States Government, may contain provisions appropriate to the particular activity for which such document is to be used. Such form or agreement shall, at a minimum, require that the person will not disclose any classified information received in the course of such activity unless specifically authorized to do so by the United States Government. Such nondisclosure forms shall also make it clear that they do not bar disclosures to Congress, or to an authorized official of an executive agency or the Department of Justice, that are essential to reporting a substantial violation of law.

(b) A nondisclosure agreement may continue to be implemented and enforced notwithstanding subsection (a) if it complies with the requirements for such agreement that were in effect when the agreement was entered into.

(c) No funds appropriated in this or any other Act may be used to implement or enforce any agreement entered into during fiscal year 2014 which does not contain substantially similar language to that required in subsection (a).

SEC. 744. Unpaid Federal Tax Liability. None of the funds made available by this or any other Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation that has
any unpaid Federal tax liability that has been assessed, for which all judicial and administrative remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the authority responsible for collecting the tax liability, where the awarding agency is aware of the unpaid tax liability, unless a Federal agency has considered suspension or debarment of the corporation and has made a determination that this further action is not necessary to protect the interests of the Government.

SEC. 745. Criminal Felony Limitation. None of the funds made available by this or any other Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation that was convicted of a felony criminal violation under any Federal law within the preceding 24 months, where the awarding agency is aware of the conviction, unless a Federal agency has considered suspension or debarment of the corporation and has made a determination that this further action is not necessary to protect the interests of the Government.

Other Appropriations Provisions

42 U.S.C. 289d note No funds appropriated under this Act or subsequent Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Acts shall be used by the National Institutes of Health, or any other Federal agency, or recipient of Federal funds on any project that entails the capture or procurement of chimpanzees obtained from the wild. For purposes of this section, the term ‘recipient of Federal funds’ includes private citizens, corporations, or other research institutions located outside of the United States that are recipients of Federal funds.

Other Statutory Provisions

Trafficking in Persons
This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104)

a. Provisions applicable to a recipient that is a private entity.
1. You as the recipient, your employees, subrecipients under this award, and subrecipients' employees may not
   i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
   ii. Procure a commercial sex act during the period of time that the award is in effect; or
   iii. Use forced labor in the performance of the award or subawards under the award.
2. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a subrecipient that is a private entity –
   i. Is determined to have violated a prohibition in paragraph a.1 of this award term; or
ii. Has an employee who is determined by the agency official authorized to terminate the award to have violated a prohibition in paragraph a.1 of this award term through conduct that is either:
   A. Associated with performance under this award; or
   B. Imputed to you or the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376.

b. Provision applicable to a recipient other than a private entity.
We as the Federal awarding agency may unilaterally terminate this award, without penalty, if a subrecipient that is a private entity-
1. Is determined to have violated an applicable prohibition in paragraph a.1 of this award term; or
2. Has an employee who is determined by the agency official authorized to terminate the award to have violated an applicable prohibition in paragraph a.1 of this award term through conduct that is either
   i. Associated with performance under this award; or
   ii. Imputed to the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376.

c. Provisions applicable to any recipient.
1. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph a.1 of this award term
2. Our right to terminate unilaterally that is described in paragraph a.2 or b of this section:
   i. Implements section 106(g) of the Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. 7104(g)), and
   ii. Is in addition to all other remedies for noncompliance that are available to us under this award.
3. You must include the requirements of paragraph a.1 of this award term in any subaward you make to a private entity.

d. Definitions. For purposes of this award term:
1. "Employee" means either:
   i. An individual employed by you or a subrecipient who is engaged in the performance of the project or program under this award; or
   ii. Another person engaged in the performance of the project or program under this award and not compensated by you including, but not limited to, a volunteer or individual whose services are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.
2. "Forced labor" means labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the
use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

3. "Private entity":
   i. Means any entity other than a State, local government, Indian tribe, or foreign public entity, as those terms are defined in 2 CFR 175.25.
   ii. Includes:
      A. A nonprofit organization, including any nonprofit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR 175.25(b).
      B. A for-profit organization.

4. “Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C. 7102)

**Whistleblower Protections**
You are hereby given notice that the 48 CFR section 3.908, implementing section 828, entitled “Pilot Program for Enhancement of Contractor Employee Whistleblower protections,” of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013) applies to this award.

**Human Subjects Protections**
If any activities under this project will involve human subjects in any research activities, you must provide satisfactory assurance of compliance with the participant protection requirement of the HHS/OASH Office of Human Research Protection (OHRP) prior to implementation of those research components. This assurance should be submitted to the OHRP in accordance with the appropriate regulations.

**Fraud, Abuse and Waste:**
The HHS Inspector General accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in Department of Health and Human Services' programs. Your information will be reviewed promptly by a professional staff member. Due to the high volume of information that they receive, they are unable to reply to submissions. You may reach the OIG through various channels.
Internet: [https://forms.oig.hhs.gov/hotlineoperations/index.aspx](https://forms.oig.hhs.gov/hotlineoperations/index.aspx)
Phone: 1-800-HHS-TIPS (1-800-447-8477)
Mail: US Department of Health and Human Services
   Office of Inspector General
   ATTN: OIG HOTLINE OPERATIONS
   PO Box 23489
   Washington, DC 20026
For additional information visit [https://oig.hhs.gov/fraud/report-fraud/index.asp](https://oig.hhs.gov/fraud/report-fraud/index.asp)
SNF Allocation Redline of T&Cs
Acceptance of Terms and Conditions

I hereby attest to the following Terms and Conditions on behalf of the provider with the Tax Identification Number associated with this attestation ("Recipient"). I further attest that I am authorized to make such attestation on behalf of the Recipient. The Terms and Conditions below are not an exhaustive list and the Recipient agrees to comply with any other applicable statutes and regulations.

If you receive a payment from funds appropriated in the Public Health and Social Services Emergency Fund for provider relief ("Relief Fund") under Public Law 116-136 or Public Law 116-139 and retain that payment for at least 3045 days without contacting HHS regarding remittance of those funds, you are deemed to have accepted the following Terms and Conditions. Please also indicate your acceptance below. This is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable.

Your commitment to full compliance with all Terms and Conditions is material to the Secretary’s decision to disburse these funds to you. Non-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payments made from the Relief Fund.

These Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient also apply to subrecipients and contractors, unless an exception is specified.

Skilled Nursing Facility Relief Fund Payment from $20 Billion General Distribution Terms and Conditions

- The “Payment” means the funds received from the Public Health and Social Services Emergency Fund, as appropriated in Public Law 116-136 or Public Law 116-139 ("Relief Fund"). The Recipient means the healthcare provider, whether an individual or an entity, receiving the Payment.
- The Recipient certifies that it billed Medicare in 2019; provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.
- The Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.
- 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.
- 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.
• The Recipient consents to the Department of Health and Human Services publicly disclosing the Payment that Recipient may receive from the Relief Fund. The Recipient acknowledges that such disclosure may allow some third parties to estimate the Recipient’s gross receipts or sales, program service revenue, or other equivalent information.

• The Recipient certifies that all information it provides as part of its application for the Payment, as well as all information and reports relating to the Payment that it provides in the future at the request of the Secretary or Inspector General, are true, accurate and complete, to the best of its knowledge. The Recipient acknowledges that any deliberate omission, misrepresentation, or falsification of any information contained in this Payment application or future reports may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment.

• 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 each 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.

• 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.

• The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the
The patient would have otherwise been required to pay if the care had been provided by an in-network Recipient.

The following statutory provisions also apply:

**General Provisions in FY 2020 Consolidated Appropriation**

**SEC. 202. Executive Pay.** None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

**SEC. 210. Funding Prohibition for Gun Control Advocacy.** None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.

**SEC. 503. Lobbying**

(a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

**SEC. 506. Prohibits Use of Federal Funds for Abortions.**

(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.
SEC. 507 Limitations on Abortion Funding Prohibition

(a) The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

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(b) For purposes of this section, the term “human embryo or embryos” includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

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(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

SEC. 515. (b) Prohibits Asking Candidates for Federal Scientific Advisory Committees Their Political Affiliations; Prohibits Distribution of Intentionally False Information

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SEC. 527. Prohibits Federal Funding for Needle Exchange Except in Limited Circumstances. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

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(a) None of the funds appropriated or otherwise made available by this Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement
representative of a Federal department or agency authorized to receive such information.

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Provided, That notwithstanding the preceding provision of this section, a nondisclosure policy form or agreement that is to be executed by a person connected with the conduct of an intelligence or intelligence-related activity, other than an employee or officer of the United States Government, may contain provisions appropriate to the particular activity for which such document is to be used. Such form or agreement shall, at a minimum, require that the person will not disclose any classified information received in the course of such activity unless specifically authorized to do so by the United States Government. Such nondisclosure forms shall also make it clear that they do not bar disclosures to Congress, or to an authorized official of an executive agency or the Department of Justice, that are essential to reporting a substantial violation of law.

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SEC. 745. Criminal Felony Limitation. None of the funds made available by this or any other Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation that was convicted of a felony criminal violation under any Federal law within the preceding 24 months, where the awarding agency is aware of the conviction, unless a Federal agency has considered suspension or debarment of the corporation and has made a determination that this further action is not necessary to protect the interests of the Government.

Other Appropriations Provisions

42 U.S.C. 289d note No funds appropriated under this Act or subsequent Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Acts shall be used by the National Institutes of Health, or any other Federal agency, or recipient of Federal funds on any project that entails the capture or procurement of chimpanzees obtained from the wild. For purposes of this section, the term ‘recipient of Federal funds’ includes private citizens, corporations, or other research institutions located outside of the United States that are recipients of Federal funds.

Other Statutory Provisions

Trafficking in Persons

This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104)

a. Provisions applicable to a recipient that is a private entity.

1. You as the recipient, your employees, subrecipients under this award, and subrecipients' employees may not
   i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
   ii. Procure a commercial sex act during the period of time that the award is in effect; or
   iii. Use forced labor in the performance of the award or subawards under the award.

2. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a subrecipient that is a private entity –
   i. Is determined to have violated a prohibition in paragraph a.1 of this award term; or
   ii. Has an employee who is determined by the agency official authorized to terminate the award to have violated a prohibition in paragraph a.1 of this award term through conduct that is either-
      A. Associated with performance under this award; or
      B. Imputed to you or the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376.
b. Provision applicable to a recipient other than a private entity.

We as the Federal awarding agency may unilaterally terminate this award, without penalty, if a subrecipient that is a private entity-
1. Is determined to have violated an applicable prohibition in paragraph a.1 of this award term; or
2. Has an employee who is determined by the agency official authorized to terminate the award to have violated an applicable prohibition in paragraph a.1 of this award term through conduct that is either
   i. Associated with performance under this award; or
   ii. Imputed to the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376

c. Provisions applicable to any recipient.

1. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph a.1 of this award term
2. Our right to terminate unilaterally that is described in paragraph a.2 or b of this section:
   i. Implements section 106(g) of the Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. 7104(g)), and
   ii. Is in addition to all other remedies for noncompliance that are available to us under this award.
3. You must include the requirements of paragraph a.1 of this award term in any subaward you make to a private entity.

d. Definitions. For purposes of this award term:

1. "Employee" means either:
   i. An individual employed by you or a subrecipient who is engaged in the performance of the project or program under this award; or
   ii. Another person engaged in the performance of the project or program under this award and not compensated by you including, but not limited to, a volunteer or individual whose services are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.
2. "Forced labor" means labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.
3. "Private entity":
   i. Means any entity other than a State, local government, Indian tribe, or foreign public entity, as those terms are defined in 2 CFR 175.25.
   ii. Includes:
      A. A nonprofit organization, including any nonprofit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR 175.25(b). B A for-profit organization.
      4. "Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C. 7102)

Whistleblower Protections
You are hereby given notice that the 48 CFR section 3.908, implementing section 828, entitled “Pilot Program for Enhancement of Contractor Employee Whistleblower protections,” of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013) applies to this award.
Human Subjects Protections
If any activities under this project will involve human subjects in any research activities, you must provide satisfactory assurance of compliance with the participant protection requirement of the HHS/OASH Office of Human Research Protection (OHRP) prior to implementation of those research components. This assurance should be submitted to the OHRP in accordance with the appropriate regulations.

Fraud, Abuse and Waste: The HHS Inspector General accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in Department of Health and Human Services' programs.
Your information will be reviewed promptly by a professional staff member. Due to the high volume of information that they receive, they are unable to reply to submissions. You may reach the OIG through various channels.
Internet: https://forms.oig.hhs.gov/hotlineoperations/index.aspx
Phone: 1-800-HHS-TIPS (1-800-447-8477) Mail: US Department of Health and Human Services Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026 For additional information visit https://oig.hhs.gov/fraud/report-fraud/index.asp
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Provider Relief Fund General Information FAQs

Overview

Who is eligible to receive payments from the Provider Relief Fund?
Provider Relief Funds are being disbursed via both “General” and “Targeted” Distributions.

General Distribution

To be eligible for the general distribution, a provider must have billed Medicare in 2019 and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.
$50 billion will be disbursed in the General Distribution.

All providers retaining funds must sign an attestation and accept the terms and conditions associated with payment. Providers must also submit tax documents and financial loss estimates if they wish to be eligible for additional funds.

Targeted Distributions

A description of the eligibility for the announced Targeted Distributions can be found here.
U.S. healthcare providers may be eligible for payments from the remaining funds through Targeted Distributions. Information on future distributions will be shared when publicly available.

Is this a loan or a grant that I will need to pay back?
Retention and use of these funds are subject to certain terms and conditions. If these terms and conditions are met, payments do not need to be repaid at a later date. These terms and conditions can be found here.

My organization bills Medicare through the Medicare Advantage program. I did not receive funding in the general distribution. When can I expect to receive funding? (Added 5/12/2020)
Providers that did not receive funding under the General Distribution may be included in future allocations under the Provider Relief Fund. Additional information will be posted as available at https://www.hhs.gov/provider-relief/index.html.

How will additional stimulus payments be processed or handled?
A description of additional disbursements can be found here.

Attestation

What action does a provider need to take after receiving a Provider Relief Fund payment? (Modified 5/20/2020)
The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meet these terms and conditions of the payment. The CARES Act Provider Relief Fund Payment Attestation Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 45 days of receipt of payment via ACH or within 60 days of check payment issuance will be viewed as acceptance of the Terms and Conditions. A provider must attest for each of the Provider Relief Fund distributions received.

Does the Provider Relief Fund Payment Attestation Portal require payment recipients to attest that the payment amount was received? (Added 5/12/2020)
Yes. The Payment Attestation Portal requires payment recipients to (1) confirm they received a payment and the specific payment amount that was received; and (2) agree to the Terms and Conditions of the payment.

If a provider received two direct payments through the General Distribution, can a provider accept one payment and then reject the other payment? (Added 5/12/2020)
Yes. If a provider would like to reject one payment, the provider may still accept future distribution payments. The provider must use the Payment Attestation Portal to accept or reject payments.

Rejecting Payments

How can I return a payment I received under the Provider Relief Fund? (Modified 5/20/2020)
Providers may return a payment by going into the attestation portal within 45 days of receiving payment via ACH or within 60 days of check payment issuance and indicating they 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.

**How should a provider return a payment it received via check? (Added 5/12/2020)**
If the provider received a payment via check and has not yet deposited it, destroy, shred, or securely dispose of it. If the provider has already deposited the check, mail a refund check for the full amount, payable to “UnitedHealth Group” to the address below. Please list the check number from the original Provider Relief Fund ACH payment or check in the memo.

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

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

**Terms and Conditions**

**What is the definition of individuals with possible or actual cases of COVID-19? (Added 5/6/2020)**
Unless the payment is associated with specific claims for reimbursement for COVID-19 testing or treatment provided on or after February 4, 2020 to uninsured patients, under the Terms and Conditions associated with payment, providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19. Not every possible case of COVID-19 is a presumptive case of COVID 19. For clarification as it relates to presumptive COVID 19 cases, refer to the Frequently Asked Question that defines a presumptive case of COVID-19.

**What oversight and enforcement mechanisms will HHS use to ensure providers meet the Terms and Conditions of the Provider Relief Fund payments? (Added 5/6/2020)**
Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of some or all of the payment. Per the Terms and Conditions, all recipients will be required to submit documents to substantiate that these funds were used for increased healthcare-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. 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.

**Reporting Requirements**

**What are the reporting requirements for providers attesting to receipt of Provider Relief**
Fund payments and when will reporting begin? *(Added 5/6/2020)*

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. The specific reporting obligations imposed on providers receiving $150,000 or more from any Act primarily making appropriations for the coronavirus response and related activities, which is a statutory requirement, begins for the calendar quarter ending June 30. The Secretary may request additional reports prior to that date. 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](https://www.hhs.gov/provider-relief/index.html).

**Balance Billing**

Do the Terms and Conditions for the General, Rural or High Impact Distributions require attesting to a ban on balance billing for all patients and/or all care, because “HHS broadly views every patient as a possible case of COVID-19”? *(Added 5/6/2020)*

No. As set forth in the Terms and Conditions, the prohibition on balance billing applies to “all care for a presumptive or actual case of COVID-19.”

The Terms and Conditions provision related to balance billing suggests that providers that provide out-of-network care to an insured, presumptive or actual COVID-19 patient can bill the patient’s insurer any amount, as long as they don’t bill the patient directly. Is that correct? *(Added 5/6/2020)*

The Terms and Conditions do not impose any limitations on the ability of a provider to submit a claim for payment to the patient’s insurance company. However, an out-of-network provider delivering COVID-19-related care to an insured patient may not seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

The Terms and Conditions associated with the two General Distribution payments and the Rural and High Impact payments require that “for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient.” How does HHS define a presumptive case of COVID-19? *(Added 5/6/2020)*

A presumptive case of COVID-19 is a case where a patient’s medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.

How will a provider know the in-network rates to be able to comply with the requirement to bill a presumptive or actual COVID-19 patient for cost-sharing at the in-network rate? *(Added 5/6/2020)*

Providers accepting the Provider Relief Fund payment should submit a claim to the patient’s health insurer for their services. Most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer’s prevailing in-network rate. If the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network...
If a hospital receives a Provider Relief Fund payment under the General, Rural or High Impact Distribution and the hospital contracts with an independently contracted provider (e.g., anesthesiologist or laboratory), is that independently contracted provider banned from balance billing for care provided to a “presumptive or actual COVID-19 patient”? *(Added 5/6/2020)*

Yes, if the independently contracted provider also attested to receiving a payment from the Provider Relief Fund.

**Appeals**

**Who determines the amount my organization will receive?**

HHS will apportion relief funds to US healthcare providers with the intention of optimizing the beneficial impact of the funds.

**Who can I talk to at HHS about my distribution payment?**

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.

**How do I appeal or dispute a decision made?**

There is no appeals or dispute process.

**Publication of Payment Data**

**Is there a publicly available list of providers and the payments they received through the Provider Relief Fund?** *(Modified 5/20/2020)*

HHS has posted a public list of providers and their payments once they attest to receiving the money and agree to the Terms and Conditions. All providers that received a payment from the Provider Relief Fund and retain that payment for at least 45 days if received via ACH or 60 days from check issuance without rejecting the funds are deemed to have accepted the Terms and Conditions. Providers that affirmatively attest through the provider portal or that retain the funds past 45 days of receipt of payment via ACH or within 60 days of check payment issuance, but do not attest will be included in the public release of providers and payments. The list includes current total amounts attested to by providers from each of the Provider Relief Fund distributions, including the General Distribution, Rural Distribution, and High-Impact Areas Distribution. The list is available here.

**What providers are included in the Provider Relief Fund data file on the CDC website?** *(Added 5/12/2020)*

The data that are posted here represent the list of providers that received one or more payments from the Provider Relief Fund and that have attested to receiving at least one payment and agreed to the associated Terms and Conditions. If a provider has received more than one payment but has not accepted all of the payments (by attesting and agreeing to the Terms and Conditions), only the dollar amount associated with the accepted payment or payments will appear. These data displayed on the website will be updated biweekly.

**Why might a provider not be listed or listed with a different address than their service location?** *(Added 5/12/2020)*

Provider Relief Fund payments are being made to providers or groups of providers that are
organized within a Tax Identification Number (TIN). The information displayed is of providers by billing TIN that have received at least one payment, which they have attested to, and the address associated with that billing TIN. Providers will not be listed if they have not yet attested to the payment terms and conditions or if they are within a larger billing entity that received payment. In addition, the address listed for the billing TIN often corresponds with the billing location (based on CMS’s Provider Enrollment, Chain, and Ownership System (PECOS)), and may not align with the physical location of a health care practice site. Updated data will be made available on the CDC’s website.

How often will the public reporting of payments data file on the CDC website be updated? *(Added 5/12/2020)*
HHS will update the data biweekly.

Will HHS release additional data such as provider types, payment amount per distribution, or payment recipients’ NPIs on the public reporting of payments data file on the CDC website? *(Added 5/12/2020)*
HHS does not have plans to include additional data fields in this report.

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

General Distribution FAQs

Overview and Eligibility

Which types of providers are eligible to receive a General Distribution Provider Relief Payment? *(Added 5/6/2020)*
To be eligible for a General Distribution payment, providers must have billed Medicare on a fee-for-service basis (Parts A or B) in Calendar Year 2019. Additionally, under the Terms and Conditions associated with payment, these providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

All providers retaining funds must sign an attestation and accept the terms and conditions associated with payment. Providers must also submit tax documents and financial loss estimates if they wish to be eligible for additional funds.

How did HHS determine the additional payments under the General Distribution? *(Added 5/14/2020)*
HHS is distributing an additional $20 billion of the General Distribution to providers to augment their initial allocation so that $50 billion is allocated proportional to providers' share of 2018 net patient revenue. The allocation methodology is designed to provide relief to providers, who bill Medicare fee-for-service, with at least 2% of that provider’s net patient revenue regardless of the provider’s payer mix. Payments are determined based on the lesser of 2% of a provider’s 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April. If the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual patient revenue, you will not receive additional General Distribution payments.
How can I estimate 2% of patient revenue to determine my approximate General Distribution payment? *(Added 5/14/2020)*

In general, providers can estimate payments from the General Distribution of approximately 2% of 2018 (or most recent complete tax year) patient revenue. To estimate your payment, use this equation:

\[
\frac{\text{Individual Provider Revenues}}{\$2.5 \text{ Trillion}} \times \$50 \text{ Billion} = \text{Expected Combined General Distribution.}
\]

To estimate your payment, you may need to use “Gross Receipts or Sales” or “Program Service Revenue.” Providers should work with a tax professional for accurate submission.

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

I am a healthcare provider that received a previous General Distribution payment and I submitted my revenue information through DocuSign. Why am I not receiving an additional payment? *(Added 5/14/2020)*

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

I submitted my financial information on the Provider Relief Fund Payment Portal. Why have I not received funds yet? *(Added 5/14/2020)*

HHS is reviewing providers’ uploaded financial information. Payments will go out weekly, on a rolling basis, as information is validated. HHS may seek additional information from providers as necessary to complete its review.

I did not receive any payments from the previous General Distribution. Can I still receive funding though the additional General Distribution? *(Added 5/14/2020)*

No, only providers that received a previous payment under the General Distribution are eligible to receive funding through this additional distribution.

Can I receive additional funding through the Targeted Distribution if I received a General Distribution payment? *(Added 5/14/2020)*

Yes, you may receive additional funding through Targeted Distribution payments related to COVID-19. Additional allocations will be made separately from General Distribution payments. You may also file claims for testing and treatment of uninsured COVID-19 patients.

Can I modify my application? *(Added 5/14/2020)*

Yes, providers can resubmit a General Distribution application. HHS will review the most recent request.
What should a provider do if a General Distribution payment is greater than expected or received in error? *(Modified 5/20/2020)*

Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 45 days of payment via ACH or within 60 days of check payment issuance. If a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment. If a provider believes they are underpaid, they should accept the payment and submit their revenues in the provider portal to determine their correct payment.

Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the General Distribution payments? *(Added 5/6/2020)*

The Provider Relief Fund and the Terms and Conditions require that recipients 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. 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 reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with the Terms and Conditions may be grounds for recoupment.

If, as a result of the sale of a practice/hospital, the TIN that received a General Distribution payment is no longer providing health care services as of January 31, 2020, is it required to return the General Distribution payment? *(Added 5/19/2020)*

Yes. If, as a result of the sale of a practice/hospital, the TIN that received a General Distribution payment did not provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, the provider must reject the payment. The CARES Act Provider Relief Fund Payment Attestation Portal will guide you through the attestation process to reject the payment.

An organization purchased a practice during or after the year of the organization’s most recent tax filing and the purchased practice’s revenues are not reflected in the most recent tax return. How does the organization account for these acquisitions when submitting revenue information in the Payment Portal? *(Added 5/19/2020)*

An organization’s adjusted gross receipts should be calculated as gross receipts as shown on the organization’s most recent tax return plus gross receipts of the practice acquired not reflected in the organization’s tax return minus gross receipts of providers sold not reflected in the organization’s tax return. If an organization’s adjusted gross receipts exceed the gross receipts shown in the tax return by more than 20%, the organization is eligible to enter the adjusted gross receipts figure in the Provider Relief Fund Payment Portal. Otherwise, the organization should enter the gross receipts figure as shown on the tax return. Organizations that have already submitted an application in the Payment Portal can resubmit a revised application using the adjusted gross receipts number accounting for acquisitions, if the adjusted gross receipts exceeds the gross receipts shown in the tax return by more than 20%. Gross receipts of acquired entities that provide care as of January 31, 2020 and file their own tax returns cannot be included in such adjusted gross receipts figure, because they should submit their own application as tax return filers.

Can an organization that sold its only practice or facility under a change in ownership in
2019 and is no longer providing services, accept payment and transfer it to the new owner? (Added 5/19/2020)
No. A provider that sold its only practice or facility must reject the Provider Relief Fund payment because it cannot attest that it was providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, as required by the Terms and Conditions. Seller organizations should not transfer a payment received from HHS to another entity. If the current TIN owner has not yet received any payment from the Provider Relief Fund, it may still receive funds in other distributions.

Can a provider that purchased a TIN in 2019 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? (Added 5/19/2020)
No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment. If the new TIN owner did not receive a direct payment under the General Distribution, it is not eligible to receive a payment under the General Distribution. However, the new TIN owner may still receive funds in other distributions.

In the case of a merger of a provider entity (billing TIN) into another entity (billing TIN), or the consolidation of two or more entities (each with a billing TIN), resulting in the creation of a new entity (single billing TIN) between January 1, 2018 through January 31, 2020, how should the entities apply? (Added 5/20/2020)
If the non-surviving entity (billing TIN) received a General Distribution payment but was not providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, that provider must reject the General Distribution payment. If the surviving entity (billing TIN) received a General Distribution payment, it should accept the payment and submit its adjusted gross receipts if its adjusted gross receipts exceed the gross receipts shown in the tax return by more than 20% in the Provider Relief Fund Payment Portal to be considered for additional Provider Relief Fund payments.

How should an organization currently undergoing a change in ownership to purchase a practice report revenue in its application? (Added 5/20/2020)
Until the purchase is complete, the organization should only report current gross receipts in its application and should exclude the practice it is intending to purchase. Any changes in ownership that have not occurred should not be included in your revenue submission. Submissions must be based on the organization that exists at the time of application, not a projection of expected lost revenue from the practice that is being acquired.

An organization that sold part of a practice in 2019 or January 2020 received a payment under the General Distribution that reflected the 2019 Medicare fee-for-service billing of that part of the practice. Can it return a portion of the payment for the part of the practice it no longer owns? (Added 5/20/2020)
No. A provider may not return a portion of a Provider Relief Fund payment. If a provider that sold a practice that was included in its most recent tax return gross receipts or sales (or program services revenue) figure, can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for increased healthcare-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Generally, if a provider anticipates that its COVID-related lost revenues or increased expenses
will be materially less than the value of the Provider Relief Fund payment received, the provider should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment.

A new organization that did not bill Medicare fee-for-service in 2019, and thus did not receive a payment under the General Distribution, purchased in 2019 or January 2020 all or part of a practice (i.e., a full or partial change in ownership) that did bill Medicare fee-for-service in 2019. Can the new organization submit documentation through the Provider Portal to receive payment? (Added 5/21/2020)

If a provider that purchased a practice or facility in 2019 or January 2020 did not bill Medicare fee-for-service in 2019 and did not receive any Provider Relief Fund payment, it is not eligible for payments under the General Distribution and may not submit its gross revenue receipts in the Provider Relief Fund Payment Portal. However, the provider may still receive funds in future distributions.

A parent entity submitting an application for a General Distribution payment from the $20 billion payment tranche has more than 20 subsidiaries with Billing TINs. How should it complete the application in the Provider Relief Fund Payment Portal? (Added 5/20/2020)

The parent entity should attach and submit a statement as the first page of the uploaded tax return file indicating any additional billing TINs not previously entered into the application forms as well as the Provider Relief Fund payments that these billing TINs received.

Can an organization that received a General Distribution payment and provided care on or after January 31, 2020 that sold, terminated, transferred, or otherwise disposed of a provider accept the General Distribution payment (received via ACH or check) associated with the sold provider? (Added 5/21/2020)

If an organization that sold, terminated, transferred, or otherwise disposed of a provider that was included in its most recent tax return gross receipts or sales (or program services revenue) figure can attest to meeting the Terms and Conditions, it may accept the funds. The Terms and Conditions place restrictions on how the funds can be used. In particular, all recipients will be required to substantiate that these funds were used for increased healthcare-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. Generally, if a provider anticipates that its COVID-related lost revenues or increased expenses will be materially less than the value of the General Distribution payments received, the provider should reject the payment and submit its adjusted gross receipts in the Provider Relief Fund Payment Portal.

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 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
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.

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.

How does HHS calculate who gets specific amounts of funding?
HRSA distributed the initial $30 billion in Provider Relief funds in proportion to a provider’s 2019 Medicare Fee for Service billings. A description of the allocation methodologies is provided here.

Are hospitals and health systems in all states and territories eligible?
Yes.

If a provider owns several hospitals, can the provider retain the funds or must the provider distribute the funds throughout their system? (Added 5/12/2020)
The Provider Relief Fund payment recipient has discretion in allocating the Provider Relief funds to support health care 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.

Payment Portal

Why does the General Distribution website say I have to attest before requesting additional funds?
The CARES Act requires that providers meet certain terms and conditions to receive Provider Relief Funds. In order to keep the initial General Distribution payment, and in order to be eligible to receive additional General Distribution funds, you must attest that you meet these terms and conditions and you must submit your financial and tax information.
Why do I need to upload my tax forms?
The $50 billion general allocation is apportioned based on provider revenue. Tax forms are needed to ascertain and confirm provider revenue.

What documents do I need to begin entering in the payment portal?
1. TIN that received prior Provider Relief Fund payments
2. TIN(s) of subsidiary organizations that received prior Provider Relief Funds but do not file separate tax forms (i.e., subsidiary organizations that are accounted for in the parent organization’s tax filing)
3. Amount of payments received
4. Relief Fund payment transaction numbers / check numbers
5. A copy of your most recently filed tax forms

Who is eligible to receive additional payments through the Provider Relief Fund Payment Portal?
Any provider who received a payment from the Provider Relief Fund as of 5:00 pm EST Friday, April 24, 2020 can apply for additional funding via the Provider Relief Fund Payment Portal.

Providers who have not received funding as of 5:00 pm EST Friday April 24, 2020 are not eligible to use the Provider Relief Fund Payment Portal. However these providers may still be eligible for payments from the Provider Relief Fund through other mechanisms, including the Targeted Distributions.

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 5:00 pm EST Friday April 24, 2020 AND
(b) Provider has filed a federal income tax return for 2017, 2018, or 2019.
As such, each entity that files a federal income tax return is required to file an application even if it is part of a provider group. However, a group of corporations that files one consolidated return will have only the tax return filer apply.

Each provider submitting an application is required to list the TINs of each subsidiary that (a) has received Provider Relief Fund payments as of 5:00 EST Friday April 24, 2020 AND (b) has not filed federal income tax returns for 2017, 2018, or 2019.

Do not list any subsidiary’s TIN that has filed a federal income tax return, because such subsidiary is required to submit a separate application.

For example:

1) A parent entity and two subsidiaries received Provider Relief Fund payments. The parent filed a federal income tax return, but the two subsidiaries did not as they are consolidated with the parent.

The parent should submit an application and list the subsidiary TINs therein. The subsidiaries cannot submit an application as they did not file a tax return.

2) A parent entity and two subsidiaries A and B received Provider Relief Fund payments. The parent and subsidiary A filed a federal income tax return, but the subsidiary B did not as it is consolidated with the parent.

The parent and subsidiary A should submit separate applications. The parent would list the TIN subsidiary B in its application.

What information do I need before I start the application process?

☐ Eligibility
To enter the Provider Relief Fund Payment Portal you must meet two criteria:
1. You must have already received a Provider Relief Fund Payment by 5:00 pm EST, Friday April 24, 2020
2. You must attest to having received the payment via the Provider Attestation Portal, and you must agree to the Terms and Conditions on the attestation portal.

☐ Data
Before you initiate your application via the Provider Relief Fund Payment Portal, please collect the following data
1. The Taxpayer Identification Number for the organization applying for Provider Relief funds. (“Application TIN”)
2. The Taxpayer Identification Number(s) of any subsidiary organizations if and only if those organizations do not file separate tax returns, but rather consolidate into the returns of the “Application TIN”. If your organization has subsidiaries that file separate tax returns, a separate application must be made for each subsidiary that files a separate return.
3. An estimate of the organization’s lost revenue for March 2020 and April 2020. 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.

4. A copy of the most recent tax form filed by the organization associated with
the Application TIN.

**Who should fill out this form?**

Any person authorized by the provider organization may complete this form. We recommend it
be completed by an organization’s corporate office, specifically, the CFO or other accounting
professional.

**Will I be penalized if I take several days to collect the necessary information?**

No. HHS will be processing applications in batches every week. Funds will not be disbursed on a
first-come-first-served basis, which is to say, an applicant will be given equal consideration
regardless of when they apply.

**Why does the website say my TIN is not eligible?**

HHS is collecting tax and financial loss data from providers who have already received
payments under the General Distribution. If you have not already received a Provider Relief
Fund payment you are not eligible to submit your tax and financial loss information to the
Provider Relief Fund Payment Portal. However, this does not mean that you are ineligible for
forthcoming Provider Relief funds.

If you received a General Distribution payment by 5:00 pm EST, Friday April 24, 2020 and are
being told that your TIN is ineligible, please check to see if you entered your TIN correctly and
check to see that the TIN matches the TIN for the organization that received a Provider Relief
Fund payment.

**Are Tax ID’s that did not receive initial General Distribution payment eligible?**

Organizations that have not received any General Distribution payments as of April 24, 2020
may be eligible for relief funds in future distributions. The Provider Relief Fund Payment Portal
is only collecting tax IDs from providers who have received a General Distribution payment.

**What is a Federal Tax Classification?**

The Federal Tax Classification describes the type of tax filer that the applicant is for purposes of
the applicant’s federal income tax return with the IRS, for example Partnership or S Corporation.

**How do I know if I’m a sole proprietor/disregarded entity? C Corporation? S

The answer is determined by the type of the applicant’s entity and any tax elections the applicant
has made.

**Which tax form did the applicant file for the most recent year?**

- Form 1040 The applicant is a sole proprietor or provides services as the sole member
  of an LLC.
- Form 1065 The applicant is a partnership.
- Form 1120 The applicant is a C corporation.
- Form 1120-S The applicant is an S corporation.
- Form 990 The applicant is a tax-exempt organization.
- Form 1041 The applicant is a trust.
Which type of supporting documentation should I submit if I am an institution without IRS filings? *(Added 5/14/2020)*

All providers that have filed tax returns in 2019 or 2018 should submit the filings as supporting documentation. If a particular healthcare provider has a legitimate reason (e.g. tax exempt) for not having IRS filings, then alternative financial statements are acceptable. If the entity is tax exempt, the entity should use Net Patient Revenues from its most recent audited annual financial statements as a substitute for “Program Services Revenue” when prompted. Further, the entity should submit its most recent audited financial statements as a substitute for the federal income tax return Form 990 requested.

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]

Which information should be submitted in the Provider Relief Fund Payment Portal by a state-run entity (e.g. state university medical center) that has no parent organization that files a federal income tax return?

The applying state entity should select “Tax-Exempt Organization” in the dropdown menu for “Federal Tax Classification.” The state entity should use Net Patient Revenues from its most recent audited annual financial statements as a substitute for “Program Services Revenue”. Further, the state entity should submit its most recent audited financial statements as a substitute for the federal income tax return Form 990.

How do I estimate lost revenue in March or April?

You may use a reasonable method of estimating the revenue during March and April 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.

Why is the Provider Relief Fund Payment Portal asking for Gross Receipts or Sales?

HHS is asking for Gross Receipts because it is a measure of revenues you received during the applicable filing period.

Why is the Provider Relief Fund Payment Portal asking me to estimate my revenue?

HHS realizes that a final revenue number may not be available until a certain time after the end of April. As the program seeks to provide liquidity support to the healthcare system in a timely manner we are using estimated revenues.

Where do I find program service revenue if I am a tax exempt organization?

Box 9 of the Form 990.

Do I submit 2019 or 2018 forms?

Submit the most recent form that you have filed with the IRS (typically 2017, 2018 or 2019).
What if I haven’t filed taxes for the year being requested?
If you are required to, but have not filed a tax return in 2017 or 2018, you are ineligible to apply. You should file the applicable tax return and then re-apply.

If I have more than one Tax ID but I either have not attested or did not receive payments on some or all of them, am I eligible?
You must attest for all payments received to be eligible for additional General Distribution funding. You are only eligible to apply for additional funding through the Provider Relief Fund Payment Portal if you have TINs that have received prior relief fund payments. Fill out one application for each eligible TIN that has received a Provider Relief Fund payment and for which there is a corresponding tax filing. If you are a subsidiary of a tax filing organization, and do not file a separate tax return, you are ineligible to apply for additional funds.

Where do I find my Medicare ID?
Providers may find their Medicare ID number by logging into the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

What is a CAQH Provider ID? Where do I find it?
Council for Affordable Quality Healthcare (CAQH) Provider ID number is the unique identifier assigned to each CAQH ProView user at the time of registration. If you have been invited to join CAQH ProView by a health plan, hospital or other participating organization, you may have received a welcome letter with your CAQH Provider ID Number. New users also have the option to self-register through the CAQH ProView Provider portal: https://proview.caqh.org/pr. Upon completion of the self-registration process, users will receive a welcome email with their unique CAQH Provider ID Number.

How many requests should I make?
You may make one request for each TIN that has received prior Provider Relief Fund payments.

Determining Additional Payments

How can I estimate the total payment amount I can anticipate through the General Distribution? (Added 5/14/2020)
In general, providers can estimate payments from the General Distribution of approximately 2% of 2018 (or most recent complete tax year) patient revenue. To estimate your payment, use this equation:

\[
\text{Expected Combined General Distribution} = \left( \frac{\text{Individual Provider Revenues}}{2.5 \text{ Trillion}} \right) \times 50 \text{ Billion}
\]

To estimate your payment, you may need to use “Gross Receipts or Sales” or “Program Service Revenue.” Providers should work with a tax professional for accurate submission.

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

How long does it take for HHS to make a decision on additional General Distribution funding?
For providers submitting tax and financial loss information, HHS intends to distribute additional
funds within 10 business days of the submission. It is the Department’s intention to distribute relief funds as quickly as possible.

**How do I find out if my funding request was not approved?**
If you have attested and submitted tax forms and loss estimates, you should receive a payment or other response within 10 business days.

**How will HHS notify me that my application has been processed?**
You will receive an email when your application is completed. You will receive no notification from HHS as to the status of your application once submitted. You should expect additional funds, if you are to receive any, within 10 business days of completing your application.

**How will HHS notify me if they need additional information?**
If additional information is requested, HHS will use the email address used to access the Provider Relief Fund Payment Portal.

**When can I expect to receive additional funds?**
Funds should be disbursed within 10 days of the submission of your application.

**Data Sharing**

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

**What is DocuSign doing with my data?**
DocuSign is securely passing your data to HHS in encrypted files. Neither DocuSign nor UnitedHealth Group will have access to your data.

**What information is shared with UnitedHealth Group, UnitedHealthcare, Optum, or any other subsidiary of UnitedHealth Group?**
UnitedHealth Group and its subsidiaries will not have access to any information collected from providers, nor do they participate in determining the methodology used to allocate Provider Relief Fund payments. UnitedHealth Group will know the amounts of relief funding paid to providers, as UnitedHealth Group is processing the payments.

**Who has access to my revenue data?**
HHS will have access to your revenue data to optimally allocate Provider Relief Funds. HHS will not share your revenue data with any other entities, in or outside of government, except as prescribed by law.

**Targeted Distribution FAQs**

**Rural Targeted Distribution**

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

**Is it accurate that rural hospitals would receive 4% of operating expenses from the Rural Distribution? What year’s Medicare cost report was used? (Added 5/12/2020)**

Rural hospitals received a graduated base payment plus approximately 2% of total operating expenses reported on their most recent, publicly available cost reports. The base payment gradually increases from $1 to $3 million depending on hospital operating expenses and establishes a floor for rural hospitals to support their financial stability during the COVID-19-pandemic. The additional amount is a percentage of each individual hospital’s total operating expenses so that payments are related to the actual operating expenses that rural hospitals are incurring. Worksheet G-3, Line 4 of the Medicare hospital cost report was used for total operating expenses. If cost reports were more or less than a year in length, then total operating expenses were adjusted to reflect a full year.

**Will the Rural Distribution include urban health care hospitals that have obtained classifications as rural facilities under a 42 CFR 412.103 exception? (Added 5/12/2020)**

No. Eligibility for Rural Distribution payments is limited to rural acute care general hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers that are located in a rural area as defined by HHS’s Federal Office of Rural Health Policy. The 42 CFR 412.103 exception hospitals include a significant number of very large urban facilities. The Rural Distribution payments focused on smaller rural hospitals that are struggling to remain financially viable.

**How were rural providers identified for the Rural Distribution? (Added 5/14/2020)**

Rural facilities were identified based on their provider type and the physical addresses of the hospital or clinic site as reported to CMS for rural acute care general hospitals, critical access hospitals (CAHs), and independent rural health clinics (RHCs), and to HRSA for Community Health Centers, regardless of affiliation with organizations based in urban areas. HHS used the December 2019 CMS Provider of Services file to identify hospitals, CAHs, and RHCs. Due to data constraints, facilities that were not included in the December 2019 Provider of Services file were not included in the Rural Distribution.

**How does HHS define rural for these payments? (Added 5/12/2020)**

For the Rural Distribution, HHS used the Federal Office of Rural Health Policy’s definition of rural, which includes:

1. All non-Metro counties.
2. All Census Tracts within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties.
3. 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.

**Did both freestanding and provider-based rural health clinics receive funding under the Rural Distribution? (Added 5/14/2020)**
If the RHC is owned by a rural hospital or CAH, the hospital received the payment. Rural hospitals that own RHCs (also known as provider-based RHCs) report their RHCs’ operating expenses as part of the hospital cost report. Since provider-based clinics operate under the ownership and administrative and financial control of the hospital, the RHC expenses are included in the base payments and additional payments calculated for the rural hospital. These provider-based RHCs did not receive separate payments. Urban hospitals did not receive Rural Distribution payments and neither did provider-based RHCs. If the RHC is a freestanding, independent facility, then it received the payment directly.

Which rural providers received a payment under the Rural Distribution? (Added 5/14/2020)
Rural Distribution funding is targeted at organizations that provide acute and primary care in rural areas. Acute care hospitals in rural areas and Critical Access Hospitals (CAHs) in rural areas and non-rural areas are eligible for Rural Provider Relief funding. CAHs outside of rural areas are included in the rural provider distribution because CAHs have a unique safety net role and statutory charge. That statute also initially gave state governors the authority to designate necessary provider CAHs, a number of which did not make a distinction between rural and urban designations.

In addition to hospitals, the following types of organizations received payments: freestanding (not provider-based) Rural Health Clinics (RHCs) and Community Health Centers. For provider-based RHCs, RHC funds were distributed through the rural hospital and CAH allocation.

Which data sources did you use for operating costs for hospitals, rural health clinics, and other facility types? How recent was the data used? (Added 5/14/2020)
HHS analyzed the following files to identify facility locations and operating costs:

- The HRSA Bureau of Primary Health Care extracted data from the most recent Uniform Data System (UDS) to identify rural Community Health Center sites.

Our hospital’s operating costs have gone up dramatically in recent months after COVID-19 started. Will our increased operating costs be reflected in the Rural Distribution formulas? (Added 5/14/2020)
No. Rural provider allocations are based on historical operating expense data to enable rapid distribution of funds to meet immediate rural needs.

How were facilities identified for the Rural Distribution? (Added 5/20/2020)
Facilities were identified from the December 2019 CMS Provider of Services file. Due to data constraints, facilities that were not included in the December 2019 Provider of Services file were not included in this rural allocation.

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

How were COVID-19 High Impact Area funds allocated? *(Added 5/12/2020)*
Of the $12 billion distribution, $10 billion was allocated based on a fixed amount per COVID-19 inpatient admission. The remaining $2 billion of the $12 billion was distributed based off each hospital’s portion of Medicare Disproportionate Share Hospital (DSH) payments and Medicare Uncompensated Care Payments (UCP).

How many payments did HHS make under the COVID-19 High Impact Area Distribution? *(Added 5/12/2020)*
HHS made 336 COVID-19 High Impact Area Distribution payments to 395 hospitals and health systems that provided inpatient care for 100 or more COVID-19 patients through April 10, 2020. Some payments were made to hospitals and health systems that operate more than one hospital.

Should providers continue to update their high-impact data? *(Modified 5/19/2020)*
Providers should update their capacity and COVID-19 census data to ensure that HHS can make timely payments in the event that the provider becomes a high-impact provider. Providers can continue to update their information through the same method they used previously.

How were COVID-19 High Impact Area payments distributed? *(Added 5/12/2020)*
HHS partnered with UnitedHealth Group to deliver funds. Payment were sent via Automated Clearing House (ACH). The automatic payments were sent via Optum Bank with “CARES Act HighImpactAreaPmt*HHS.GOV” in the payment description. Payments were sent to the group’s central billing office. All relief payments were made to provider billing organizations based on their TINs.
DHHS FAQ AHCA/NCAL Highlights & Comments
DHHS CARES Act Provider Relief Fund FAQs & AHCA/NCAL Observations¹

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| **Attestation** | | - Window extended to 90 days from dates of receipt of funds  
- Attestation required for each allocation |
| **What action does a provider need to take after receiving a Provider Relief Fund payment? (Modified 5/20/2020)** | | |
| The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meet these terms and conditions of the payment. The CARES Act Provider Relief Fund Payment Attestation Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 45 days of receipt of payment via ACH or within 60 days of check payment issuance will be viewed as acceptance of the Terms and Conditions. A provider must attest for each of the Provider Relief Fund distributions received. | | |
| **How can I return a payment I received under the Provider Relief Fund? (Modified 5/20/2020)** | | - New Guidance  
- Compare with full and partial acceptance |
| Providers may return a payment by going into the attestation portal within 90 days of receiving payment via ACH or within 60 days of check payment issuance and indicating they 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 | | |

¹ Does not include CHOW and TIN FAQs – see CARES Act General FAQs
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| **What is the definition of individuals with possible or actual cases of COVID-19?** *(Added 5/6/2020)*  
Unless the payment is associated with specific claims for reimbursement for COVID-19 testing or treatment provided on or after February 4, 2020 to uninsured patients, under the Terms and Conditions associated with payment, providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19. Not every possible case of COVID-19 is a presumptive case of COVID 19. For clarification as it relates to presumptive COVID 19 cases, refer to the Frequently Asked Question that defines 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. |
| **What oversight and enforcement mechanisms will HHS use to ensure providers meet the Terms and Conditions of the Provider Relief Fund payments?** *(Added 5/6/2020)*  
Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of some or all of the payment. Per the Terms and Conditions, all recipients will be required to submit documents to substantiate that these funds were used for increased healthcare-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them. 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. | - DHHS has indicated its goal is to provide maximum provider flexibility to address both (emphasis added COVID-Related costs and losses)  
- However, DHHS has added language in several guidance areas about referral to the Office of the Inspector General  
- Note that the Privacy Act provision in the Attestation Portal requires providers to acknowledge DHHS’ right to share data with “all other law enforcement entities” |
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<td><strong>Is there a publicly available list of providers and the payments they received through the Provider Relief Fund? (Modified 5/20/2020)</strong></td>
<td>HHS has posted a public list of providers and their payments once they attest to receiving the money and agree to the Terms and Conditions. All providers that received a payment from the Provider Relief Fund and retain that payment for at least 45 days if received via ACH or 60 days from check issuance without rejecting the funds are deemed to have accepted the Terms and Conditions. Providers that affirmatively attest through the provider portal or that retain the funds past 45 days of receipt of payment via ACH or within 60 days of check payment issuance, but do not attest will be included in the public release of providers and payments. The list includes current total amounts attested to by providers from each of the Provider Relief Fund distributions, including the General Distribution, Rural Distribution, and High-Impact Areas Distribution. The list is available <a href="#">here</a>.</td>
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<td><strong>How did HHS determine the additional payments under the General Distribution? (Added 5/14/2020)</strong></td>
<td>HHS is distributing an additional $20 billion of the General Distribution to providers to augment their initial allocation so that $50 billion is allocated proportional to providers' share of 2018 net patient revenue. The allocation methodology is designed to provide relief to providers, who bill Medicare fee-for-service, with at least 2% of that provider’s net patient revenue regardless of the provider’s payer mix. Payments are determined based on the lesser of 2% of a provider’s 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April. If the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual patient revenue, you will not receive additional General Distribution payments.</td>
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<td><strong>I did not receive any payments from the previous General Distribution. Can I still receive funding through the additional General Distribution? (Added 5/14/2020)</strong></td>
<td>No, only providers that received a previous payment under the General Distribution are eligible to receive funding through this additional distribution.</td>
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<tr>
<td><strong>Can I modify my application? (Added 5/14/2020)</strong></td>
<td>- Providers may submit data for DHHS consideration to update an allocation</td>
</tr>
<tr>
<td>Yes, providers can resubmit a General Distribution application. HHS will</td>
<td>- Providers may update data used to request additional allocations</td>
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<tr>
<td>review the most recent request.</td>
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<td></td>
<td>- Providers should contact the DHHS Cares Hotline to discuss release of a corrected</td>
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<td></td>
<td>award</td>
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<td></td>
<td>- If overpaid, the provider must return the amount.</td>
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<td></td>
<td>- Partial rejection is not allowable.</td>
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<tr>
<td>**What should a provider do if a General Distribution payment is greater</td>
<td>- Careful tracking of fund use relative to other sources of reimbursement or revenue</td>
</tr>
<tr>
<td>than expected or received in error? (Modified 5/20/2020)</td>
<td>loss mitigation is critical</td>
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<td>Providers that have been allocated a payment must sign an attestation</td>
<td>- CARES Act funds are “the payer of last resort” meaning Medicare, Medicaid, private</td>
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<tr>
<td>confirming receipt of the funds and agree to the Terms and Conditions</td>
<td>insurance, PPP and other loans and grants should be billed or used, respectively,</td>
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<td>within 90 days of payment via ACH or within 60 days of check payment</td>
<td>before use of stimulus funds</td>
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<td>issuance. If a provider believes it was overpaid or may have received</td>
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<td>a payment in error, it should reject the entire General Distribution</td>
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<td>payment and submit the appropriate revenue documents through the General</td>
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<td>Distribution portal to facilitate HHS determining their correct payment.</td>
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<tr>
<td>If a provider believes they are underpaid, they should accept the</td>
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<tr>
<td>payment and submit their revenues in the provider portal to determine</td>
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<td>their correct payment.</td>
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<tr>
<td>**Does HHS intend to recoup any payments made to providers not tied to</td>
<td>- Medicare, Medicaid, private insurance, PPP and other loans and grants should be</td>
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<td>specific claims for reimbursement, such as the General Distribution</td>
<td>billed or used, respectively, respectively,</td>
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<td>payments? (Added 5/6/2020)**</td>
<td>before use of stimulus funds</td>
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<tr>
<td>The Provider Relief Fund and the Terms and Conditions require that</td>
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<td>recipients be able to demonstrate that lost revenues and increased</td>
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<td>expenses attributable to COVID-19, excluding expenses and losses that</td>
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<td>have been reimbursed from other sources or that other sources are</td>
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<td>obligated to reimburse, exceed total payments from the Relief Fund.</td>
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<tr>
<td>Generally, HHS does not intend to recoup funds as long as a provider’s</td>
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<td>lost revenue and increased expenses exceed the amount of Provider Relief</td>
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<td>funding a provider has received. HHS reserves the right to audit Relief</td>
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<tr>
<td>Fund recipients in the future to ensure that this requirement is met and</td>
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<td>collect any Relief Fund amounts that were made in error.</td>
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<tr>
<td>Notable FAQ</td>
<td>AHCA/NCAL Observation</td>
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<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
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<tr>
<td>or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with the Terms and Conditions may be grounds for recoupment.</td>
<td>- Reporting should document this pattern</td>
</tr>
</tbody>
</table>