Health and Human Services (HHS) CARES Act Provider Relief Fund Frequently Asked Questions (FAQs added/modified on 7/30/20)

The chart below contains new/modified FAQs from the HHS Provider Relief Fund FAQ document.

Date Added/ Modified	Question	Answer
Provider Relief Fund General Information FAQs – Overview		
7/30 – *Added*	Must a parent organization that received a Provider Relief Fund Targeted Distribution on behalf of a subsidiary in which it is has a direct ownership relationship remit the payment to the subsidiary?	Yes. The parent entity must transfer a Provider Relief Fund Targeted Distribution payment to any or all subsidiaries that qualified for a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment. Control and use of the funds must be delegated to the entity that was eligible for the Targeted Distribution payment if a parent entity received the Targeted Distribution payment on the behalf of an eligible subsidiary. The purpose of Targeted Distribution payments is to support the specific financial needs of the eligible healthcare provider.
Provider Relief Fund General Information FAQs – Terms and Conditions		
7/30 – *Modified*	Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19?	As explained in the notice of reporting requirements on the Provider Relief Fund website, reports on the use of Provider Relief Fund money must be submitted no later than July 31, 2021, and accordingly HHS expects that providers will fully expend their payments by that date. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for increased healthcare related expenses or lost revenue attributable to coronavirus.
Provider Relief Fund General Information FAQs – Auditing and Reporting Requirements		
7/30 – *Modified*	Are Provider Relief Fund payments fund payment to non-Federal entities (states, local governments, Indian tribes, institutions of higher education, and nonprofit organizations) subject to Single Audit?	Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) to non-Federal entities are Federal awards and must be included in determining whether an audit in accordance with 45 CFR Part 75, Subpart F is required (i.e., annual total federal awards expended are $750,000 or more). Audit reports must be submitted to the Federal Audit Clearinghouse electronically at https://harvester.census.gov/facides/Account/Login.aspx.

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		(Requirements for audit of payments to commercial organizations are discussed in a separate question.)
7/30 – *Modified*	Are Provider Relief Fund payments to commercial (for-profit) organizations subject to Single Audit in conformance with the requirements under 45 CFR 75 Subpart F?	Commercial organizations that receive $750,000 or more in annual awards have two options under 45 CFR 75.216(d) and 75.501(i): 1) a financial related audit of the award or awards conducted in accordance with Government Auditing Standards; or 2) an audit in conformance with the requirements of 45 CFR 75 Subpart F. Provider Relief Fund General and Targeted Distribution payments (CFDA 93.498) and Uninsured Testing and Treatment reimbursement payments (CFDA 93.461) must be included in determining whether an audit in accordance in accordance with 45 CFR Subpart F is required (i.e., annual total awards received are $750,000 or more). Audit reports of commercial organizations must be submitted directly to the U.S. Department of Health and Human Services, Audit Resolution Division at AuditResolution@hhs.gov.
7/30 – *Modified*	Can my organization get an extension to the submission due date for audits?	Yes. The Office of Management and Budget (OMB) in OMB M-20-26, Extension of Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations, dated June 18, 2020, provided non-Federal entities extensions beyond the normal due date to submit audit reports. Please see the OMB website for more details: https://www.whitehouse.gov/omb/information-for-agencies/memoranda/. Commercial organizations with questions about their ability to obtain extensions should email HRSA's Division of Financial Integrity at SARFollowup@hrsa.gov.
Medicaid, CHIP, and Dental Providers Distribution FAQs – Overview and Eligibility		
7/30 – *Modified*	How can a healthcare provider find out if they are on the curated list?	When a healthcare providers applies, the first step of the application process is to validate that their TIN is on a curated list of known Medicaid/CHIP providers that were supplied by each state or providers who appear in T-MSIS or who are on the filing TIN curated list of known dental providers created by HHS. Applicants that are not on that list will be validated through an additional process with the state to determine if the provider is a known Medicaid or

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		CHIP provider that was not captured initially. HRSA will be working directly with State/Territory Medicaid or CHIP agencies for validation and will not be reaching out to individual providers for validation. Please note that it may take additional time to validate an applicant's TIN. If they receive the results of that validation after August 3, they will still be able to complete and submit their application.
7/30 – *Modified*	How were dental providers determined to be eligible for this Distribution?	Many dental providers have already successfully applied for funding under the Medicaid-focused General Distribution. To support payments to dental providers who may not bill Medicare or Medicaid, HHS has developed a curated list of dental practice TINs from third party sources and HHS datasets. Providers with TINs on the curated list must meet other eligibility requirements including operating in good standing and not be excluded from receiving federal payments. As a next step, HHS will work with states and its vendors to authenticate dental providers not on the curated list. Please note that it may take additional time to validate an applicant's TIN. If they receive the results of that validation after August 3, they will still be able to complete and submit their application.
7/30 – *Modified*	Is a healthcare provider eligible to receive a payment from the Provider Relief Fund Medicaid, CHIP, and Dental Providers Distribution even if the provider received funding from the Small Business Administration's (SBA) Payroll Protection Program or the Federal Emergency Management Agency (FEMA) or has received Medicaid HCBS retainer payments?	Yes. Receipt of funds from SBA and FEMA for coronavirus recovery or of Medicaid HCBS retainer payments does not preclude a healthcare provider from being eligible for the Medicaid, CHIP, and Dental Providers Distribution if the healthcare provider otherwise meets the criteria for eligibility and can substantiate that the Provider Relief Fund payments were used for increased healthcare related expenses or lost revenue attributable to COVID-19, so long as they are not reimbursed from other sources and other sources were not obligated to reimburse them.
7/30 – *Modified*	Are healthcare providers that only bill Medicaid or CHIP	Yes. Healthcare providers that bill for services in Medicaid or CHIP that are covered under either a waiver or state plan, including disability service

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	through a waiver eligible for the Medicaid, CHIP, and Dental Providers Distribution?	providers and other providers of Medicaid-funded home and community-based services (HCBS) (e.g., day habilitation, HCBS waiver program services), are eligible for the Medicaid, CHIP, and Dental Providers Distribution if they otherwise meet the other eligibility criteria.
Medicaid, CHIP, and Dental Providers Distribution FAQs – Enhanced Provider Relief Fund Portal		
7/30 – *Added*	I have completed my application and submitted it in the portal, but the portal still says "Get Started" as if I have not submitted. Why is this?	The portal currently will say "Get Started" until a final determination has been made on provider payment. If and when a payment has been made, you will be able to move on in the portal to attest to the payment.
7/30 – *Added*	Should Fiscal Management Services (FMS) organizations count self-directed providers as FTEs in the relevant fields in the Enhanced Provider Relief Fund Payment Portal?	The FMS organization should include an individual provider in the FTE count if the individual is an employee and receives a W-2. Contracted providers that are not employees should not be included in the FTE count. If the provider works without physician supervision, they should be counted as a primary provider FTE in field 27. If the provider works under physician supervision, they should be counted as a non-primary provider FTE in field 28.
7/30 – *Added*	Do FMS organizations need to calculate their equivalent FTE based upon hours billed?	Yes, the FMS organization should calculate FTE status based on the number of hours billed unless the FMS or state has another method for counting FTEs. A 1.0 FTE works whichever number of hours the applicant considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute FTE of a part-time provider, divide the total hours worked by the provider by the total number of hours that your medical practice considers to be a normal workweek.
7/30 – *Added*	How can an individual Home- and Community-based Services (HCBS) self-directed provider determine whether they should be applying on their own behalf or relying on the FMS organization to apply for the	In general, if the individual is being paid through an FMS organization, the organization is likely the filing and billing TIN and would be eligible to apply for the Medicaid, CHIP, and Dental Providers Distribution. In that situation, the self-directed provider should contact the FMS organization to confirm that the organization is submitting an application on their behalf or whether the provider should submit an application as an individual self-directed provider.

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	Medicaid, CHIP, and Dental Providers Distribution?	
7/30 – *Added*	FMS organizations typically have two Taxpayer Identification Numbers (TINs) to comply with Internal Revenue Service requirements. One TIN is used to submit claims and received payment from the state Medicaid program and the other is used to process payroll to pay participant-directed workers on behalf of Medicaid beneficiaries who receive participant-directed services. Can an FMS organization include both TINs and use the associated revenue from both TINs' tax returns in their application?	Yes. The FMS organization can include both TINs and associated revenues in their application for the Medicaid, CHIP, and Dental Providers Distribution, as long as the services delivered under both TINs qualify as "patient care" and the entity can meet the attestation requirements for both TINs.
7/30 – *Added*	Can FMS organizations' revenue from administrative fees provided by the state Medicaid program be included as "patient care"?	Yes. Applicants may include administrative fees provided by the state Medicaid program in the reported revenue, as well as in the percentage of revenue from patient care reported in field 12.
7/30 – *Modified*	How should Medicaid HCBS provider applicants categorize personal care services in Field 5?	HCBS provider applicants, including FMS organizations applying on behalf of self-directed providers, should categorize personal care services as "Other," code OT.

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7/30 – *Modified*	If my TIN will take more than 15 days to be validated, when will I be notified?	If your TIN cannot be validated within 15 days of submission, you will receive an email 13 days after submission notifying you that additional verification is required by the State/Territory Medicaid or CHIP agency. If you do not receive an email, please contact the Provider Support Line at (866) 569-3522 (for TTY, dial 711). Please note that it may take additional time to validate your TIN in these instances, particularly when close to deadlines. If you receive the results of that validation after August 3, you will still be able to complete and submit your application.
7/30 – *Modified*	What if an applicant's TIN is flagged as invalid because it is not on the filing TIN list submitted by states to CMS or the curated list of dental providers?	Payments will be made to applicant providers who are in the filing TIN curated list from CMS if they are a Medicaid or CHIP provider. If a TIN is not on the curated list of state-submitted eligible Medicaid/CHIP providers or T-MSIS, it will be flagged as invalid. In these cases, HHS will work with the states to verify whether the TIN should be included as a valid Medicaid or CHIP provider in good standing. If a TIN is not on the curated list of dental providers, HHS will conduct additional analysis related to the TIN and any active dental providers associated with the TIN. If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign even if validation occurs after the August 3, 2020 deadline. TINs that cannot be validated will not receive funding. Please note, the additional TIN validation may result in a delay in processing the application.