

# Completing the CARES Application for Pediatric Practices

Last updated 6/17/20

This document outlines the process for your Medicaid-accepting practice to get Provider Relief Funds through the HHS CARES Act Portal.

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## Warning

Even though the Portal does have an option under **Other Actions** called **Finish Later**, The Portal does not reliably allow you to save data entered in one session for a subsequent session. **Gather all the information before attempting to attest.** Read more in the section called “Step 3: Application: General Tips.”

## References, definitions, and links

Definitions used in the rest of this document:

- **TIN:** Tax ID Number. Also called EIN (employee ID number.)
- **The Portal:** The Cares Act Provider Relief Fund Payment Attestation Portal. The home page is here: <https://cares.linkhealth.com/#/>
- **The Instructions:** Instructions for the Medicaid Provider Distribution. How to complete your application.  
<https://www.hhs.gov/sites/default/files/medicaid-provider-distribution-instructions.pdf>
- **The Application:** A PDF version of the questions that you can see what’s being asked before you log in to the Portal.  
<https://www.hhs.gov/sites/default/files/medicaid-provider-distribution-application-form.pdf>
- **The FAQ:** HHS’ web page containing frequently asked questions from providers. It is getting updated regularly.  
<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html#medicaid-targeted>
- **The Terms and Conditions:** Acceptance of Terms and Conditions. Legal language about restriction on use of the funds you receive from HHS.  
<https://www.hhs.gov/sites/default/files/terms-and-conditions-medicaid-relief-fund.pdf>
- **Reference Year:** The most recent year for which you have submitted a tax return. This will be either 2017, 2018, or 2019. You must submit/upload a copy of the completed tax form for the year you choose.

## Is my practice eligible to get money?

To be eligible to apply, your practice TIN must meet the following conditions:

1. **Must not have received payment from the \$50 billion General Distribution (the “Medicare tranche” that was sent out in April 2020)**
  - a. If your practice received money through the Medicare tranche, you are not eligible to apply. (It is likely you would have received something if your practice TIN billed Medicare Part B for any patient healthcare in 2019. The Medicare tranche’s first distribution was released starting April 10, 2020; additional distributions were released starting April 24, 2020 on a rolling basis to Medicare providers who submitted applications.)
  - b. If you received money automatically through the Medicare tranche, you cannot apply for the Medicaid tranche. This is true whether or not your practice applied for the second Medicare distribution (the 2% of gross receipts offered to Medicare physicians.) If this scenario applies to you, please contact the AAP at [covid-19@aap.org](mailto:covid-19@aap.org) for more information.
  - c. If your practice was eligible for, but turned down, the Medicare payment, you are still not eligible to apply for the Medicaid distribution.
  - d. If your practice received other targeted funds (e.g., rural health funds, Indian Health Service funds), but not monies from the general (Medicare) distribution, you are eligible to apply for the Medicaid distribution.
  - e. To see if your practice has received already funds from either the Medicare tranche and/or a targeted tranche, you can review data here:  
<https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6/data>
2. **Must have billed Medicaid or CHIP for healthcare services for at least one patient for at least one date of service in 2018 or 2019**
  - a. This includes billing either state-run Medicaid programs (e.g., CO, NC, AL, AR, OK, SD, WY, ID, MT, AK, CT, VT, ME) or Medicaid managed care organizations (e.g., Amerigroup, Centene, WellCare, CareSource, and many others).
  - b. This also includes billing CHIP plans, either stand-alone CHIP plans or CHIP plans integrated with Medicaid.
  - c. If you did not file any claims with any Medicaid or CHIP plans in either 2018 or 2019, you are not eligible for this program.
3. **Must have either (i) filed a federal income tax return for fiscal years 2017, 2018, or 2019 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g., a state-owned hospital or healthcare clinic); and**
4. **Must have provided patient care after January 31, 2020 and must be continuing to provide care.**

Note: there is no requirement that you must be a primary care provider to apply. Type of clinician (PCP vs. specialist vs. ancillary care) is not part of the HHS requirements. [HHS also states](#) that it expects a variety of medical personnel to be eligible:

*Examples of providers serving Medicaid/CHIP beneficiaries, possibly eligible for this funding, include pediatricians, obstetrician-gynecologists, dentists, opioid treatment and behavioral health providers, assisted living facilities and other home and community-based services providers.*

## What you'll need

### Make decisions

- **Choose a single person to complete the application for your practice.** You cannot apply as individual clinicians, only as a practice. Only one person can link the attestation to your tax ID. Once that person has been linked (Step 1 and Step 2), that person is compelled to complete the application.
- **Determine your Reference Year.** This is the most recent year for which the practice filed a federal income tax return.

### Gather documents

- **The practice's federal income tax return for the Reference Year** (2017, 2018, or 2019) or a written statement explaining why the applicant is exempt from filing a federal income tax return (e.g., a state-owned hospital or healthcare clinic). The form(s) to use are as follows:

If the applicant for tax purposes is a ...

... sole proprietor or disregarded entity owned by an individual:	Upload IRS Form 1040 including Schedule C.
... partnership:	Upload IRS Form 1065.
... C corporation:	Upload IRS Form 1120.
... S corporation:	Upload IRS Form 1120-S.
... tax-exempt organization:	Upload IRS Form 990.
... trust or estate:	Upload IRS Form 1041 including Schedule C.

- **The practice's Employer's Quarterly Federal Tax Return on IRS Form 941 for Q1 2020**, Employer's Annual Federal Unemployment (FUTA) Tax Return on IRS Form 940, or a statement explaining why the applicant is not required to submit either form (e.g. no employees).

## Download required spreadsheets

- **The FTE Worksheet:**  
<https://www.uhcprovider.com/content/dam/provider/docs/public/other/PRF-FTE-Worksheet.xlsx>
  - Note: this spreadsheet was updated on 6/14/20 to address an incorrectly triggered error message. If you see an error message for an NPI entry that is 10 digits, please download a new copy of the worksheet from this link. Some practices have reported that using the original worksheet prevented them from successfully submitting their application.
- **The Gross Revenue Worksheet**, if your practice/entity acquired or disposed of other practices/entities/TINs during their Reference year. *If your practice did not undergo a merger/acquisition or disposition of this type, you do not need to download or submit this worksheet.*  
<https://www.uhcprovider.com/content/dam/provider/docs/public/other/PRF-Gross-Revenues-Worksheet.xlsx>

## Get reports and data

- **All employees of the practice (W-2 employees) as of 5/31/2020 and their FTE equivalents.** “FTE equivalents” for the purposes of this program can be however your practice determines FTEs. You’ll use this to answer Questions 27-29 (and Question 8, if you are a facility).
- **Accounting Profit and Loss report** for the Reference Year. In Quickbooks, you can go to Reports/Company & Financial/Profit and Loss Standard to run this for your Reference Year. You’ll use this to answer Question 12 (see that section for more information on use of this report).
- **Summary of receipts by payer type** for all patient-care related payments received during the Reference Year. You’ll use this to answer Questions 17-24.
- **A report of your increased expenses due to COVID in March and April 2020.** This includes supplies, equipment, workforce hiring and training, reporting, and building/construction costs. One source for this data is Reports/Company & Financial/Profit and Loss Standard, for March and April 2020, comparing it to March and April for 2019. You’ll use this to answer Question 14.
- **The sum of SBA monies you have received as of 5/31/2020.** This includes PPP loans, EIDL loans, and EIDL grants (\$1,000-\$1,0000 depending on number of employees). If the money has been disbursed to you as of 5/31/2020, you should count it, irrespective of whether you’ve spent or expensed it yet. You’ll use this to answer Question 25.
- **The sum of FEMA monies you have received as of 5/31/2020.** If your practice has received monies from FEMA, have this number available. You’ll use this to answer Question 26.

## Review Excel if necessary

The following Excel tutorials may be useful in preparing your reports:

- General tutorials:
  - <http://bit.ly/1Sd914s>
  - <http://bit.ly/1VaLroL>
  - <http://bit.ly/1Sd91S9>
- Pivot Tables
  - <http://bit.ly/1DZYQHQ>
- Conditional formatting (e.g. color coding by a field)
  - <http://bit.ly/2vIRhRM>
  - <http://bit.ly/2yvha0g>
- SUMIF, SUMIFS, COUNTIF (e.g. summing column A only if column B is “Medicaid”)
  - <http://bit.ly/1HvmMsR>

# Step 1: Get an Optum ID

Most practices who do business with United Healthcare or its subsidiaries already have an Optum ID. If you do not have one, or to recover your login credentials, you can go to the Portal, click on **Set Up Optum ID**, and click the **start registration here** link:

The screenshot shows the top of the portal with the CARES PROVIDER RELIEF FUND logo and a 'Sign In' button. Below is a light blue banner with the heading 'Welcome to the CARES Act Provider Relief Fund Payment Attestation Portal.' and a paragraph explaining the portal's purpose. A navigation menu below the banner has four items: 'Overview', 'Set Up Optum ID', 'What You Need', and 'Resources and Support'. A red arrow points to 'Set Up Optum ID'. Below the menu is a grey box with a paragraph of text and a section titled 'Set up Optum ID' with two numbered instructions. A red arrow points to the first instruction. To the right is a 'Create an Optum ID' form with fields for 'First name' and 'Last name', and a 'Sign In Information' section.

**CARES**  
PROVIDER RELIEF FUND

Sign In

## Welcome to the CARES Act Provider Relief Fund Payment Attestation Portal.

This portal allows providers to attest to relief fund payments made for healthcare-related expenses or lost revenue attributable to COVID-19.

Overview **Set Up Optum ID** What You Need Resources and Support

The Department of Health and Human Services has contracted with UnitedHealth Group to administer Provider Relief Fund payments. Therefore, some steps in the process involve existing UnitedHealth Group tools. Specifically, you'll need to set up an Optum ID in order to access the portal. The process will not involve credentialing or contracting with UnitedHealth Group, and the information you submit will be used to administer the Provider Relief Fund payment.

### Set up Optum ID

- 1. If you do not have an Optum ID**  
You will need to create an Optum ID to access the portal, [start registration here](#) to begin.
- 2. If you have an Optum ID already**

Create an Optum ID

An Optum ID already manages your account so that you can use one Optum ID and password to log into all registered applications.

Already have an Optum ID? Sign In now

**Profile Information**

First name

Last name

**Sign In Information**

# Step 2: Sign in and Validate Your TIN

From The Portal, use your Optum ID to login



Sign In With Your Optum ID

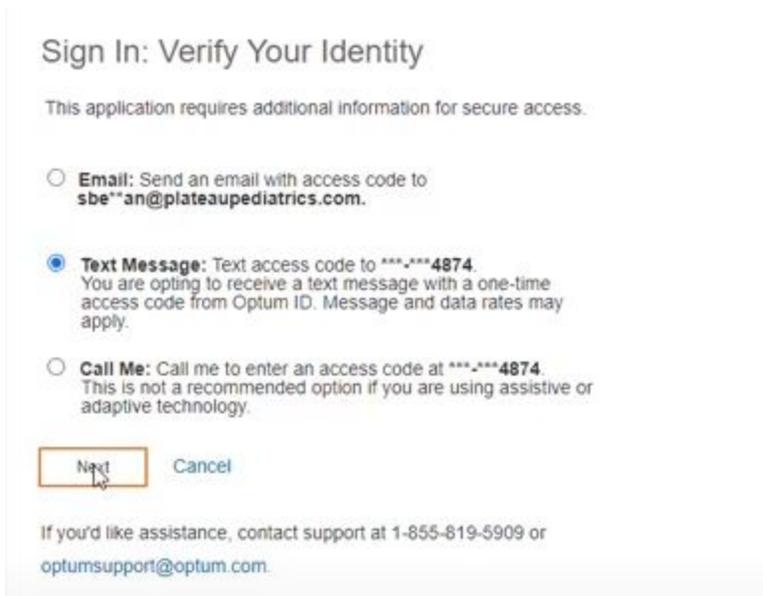
Optum ID or email address

Password

[Forgot Optum ID](#) | [Forgot Password](#)

**Additional options:**  
[Create an Optum ID](#)  
[Manage your Optum ID](#)  
[What is an Optum ID?](#)

You may have some authentication steps:



Sign In: Verify Your Identity

This application requires additional information for secure access.

- Email:** Send an email with access code to **sbe\*\*an@plateaupediatrics.com**.
- Text Message:** Text access code to **\*\*\*-\*\*\*4874**. You are opting to receive a text message with a one-time access code from Optum ID. Message and data rates may apply.
- Call Me:** Call me to enter an access code at **\*\*\*-\*\*\*4874**. This is not a recommended option if you are using assistive or adaptive technology.

If you'd like assistance, contact support at 1-855-819-5909 or [optumsupport@optum.com](mailto:optumsupport@optum.com).

You are asked to share your Optum ID with “COVID-19 Dental”:

## Share My Optum ID

Using your Optum ID to sign in to COVID-19 Dental means that COVID-19 Dental uses your Optum ID account information to verify your access. We share this information with COVID-19 Dental:

- Optum ID
- Name
- Email address

By clicking I Agree,

- You give Optum ID permission to share your account information with COVID-19 Dental;
- You acknowledge that your account information is being provided to COVID-19 Dental and it is subject to the COVID-19 Dental privacy policy; and
- You acknowledge that the COVID-19 Dental privacy policy may be different from the Optum ID privacy policy.

You then arrive at the Welcome page. First, enter your email address and click **Sign Up**:

# CARES

PROVIDER RELIEF FUND

## Welcome

Welcome to the CARES Act Provider Relief Fund Payment Attestation Portal. This portal allows eligible providers to attest to relief fund payments made for healthcare-related expenses or lost revenue attributable to COVID-19.

**Sign Up for Updates**

We'll contact you with updates and requests for additional information. Your email address will only be used for CARES Act and the Paycheck Protection Program and Health Care Enhancement Act.

Email Address (required)\*

**New to this site?**

To get started, please add a Billing Taxpayer Identification Number (TIN). We recommend completing one TIN at a time, but you will be able to add more TINs later. You will be guided through the process.

**Add Organization TIN**
\* Required Fields

Organization TIN\* !

Provider Name (as shown on IRS Form W-9 for this TIN)\*

Then enter your practice TIN, your practice's name, and click **Add Organization TIN**. Then attest to the four checkboxes, the "I'm not a robot CAPTCHA box", and click **I Accept**. Once you have made this attestation, you are obliged to complete the application from this Optum

account. Remember, this individual is attesting for the entire practice, not just for one clinician at the practice.

## Program Administrator Attestation

**Program Administrator Attestation for Organization TIN €**

I attest that I am submitting on my own behalf and I am the provider associated with this Organization TIN; or I have the authority to submit a request on behalf of the provider group(s) associated with this Organization TIN.

I certify that all information provided as part of this process is true, accurate and complete, to the best of my knowledge.

I understand that any person who knowingly and with intent to defraud the Government or the Company, files information containing materially false information, or conceals for the purpose of misleading the company commits a fraudulent insurance act.

I understand that only one person may submit information on behalf of an Organization TIN. I understand that my name and email will be shared if duplicate information is received for the same Organization TIN; if I am no longer able to submit information on behalf of the provider group associated with this Organization TIN, then I will withdraw my name and a different person will be added in my place.

I'm not a robot  reCAPTCHA  
Privacy - Terms

Next, choose your federal tax classification. This is based on your practice's legal registration and ownership. In this case, the attestor is choosing "partnership."

**Tax Validation**
\* Required Fields

Provider Name (as shown on IRS Form W-9 for this TIN)\*

Platea

Federal Tax Classification\*

Partnership

**Exempt payee code** ⓘ

<p><input type="radio"/> 1 - An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)</p> <p><input type="radio"/> 2 - The United States or any of its agencies or instrumentalities</p> <p><input type="radio"/> 3 - A state, the District of Columbia, a U.S commonwealth or possession, or any of their political subdivisions, agencies, or instrumentalities</p> <p><input type="radio"/> 4 - A foreign government or any of its political subdivisions, agencies, or instrumentalities</p> <p><input type="radio"/> 5 - A corporation</p> <p><input type="radio"/> 6 - A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S commonwealth or possession</p>	<p><input type="radio"/> 7 - A futures commission merchant registered with the Commodity Futures Trading Commission</p> <p><input type="radio"/> 8 - A real estate investment trust</p> <p><input type="radio"/> 9 - An entity registered at all times during the tax year under the investment Company Act of 1940</p> <p><input type="radio"/> 10 - A common trust fund operated by a bank under section 58(a)</p> <p><input type="radio"/> 11 - A financial institution</p> <p><input type="radio"/> 12 - A middleman known in the investment community as a nominee or custodian</p> <p><input type="radio"/> 13 - A trust exempt from tax under section 664 or described in section 4947</p>
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**Exempt from FATCA reporting code** ⓘ

If applicable, select one *Exempt payee code* and one *Exempt from FATCA reporting code*. These choices are the same as your practice would report on your W-9 form (see instructions at <https://www.irs.gov/pub/irs-pdf/iw9.pdf>)

**Virtually all practices will select nothing in either option list.** Note that exempt payee code option 5, “a corporation,” is accidentally truncated. It should specify that it refers to very particular types of publicly-traded financial organizations and foreign financial entities, as per the W-9 instructions. Do not select this option if your practice is organized as a corporation, professional corporation, or S-corp; these common practice types are not exempt from tax withholding.

Then click **Continue**. Now enter the organization address and whether or not you use a billing company for the TIN. If you use a billing company, select Yes then complete the fields for the mailing address of the billing company which appear below. Then click **Continue**.

**Organization TIN Address** \*Required Fields

Street Line 1\*

Street Line 2

City\*

State\*

ZIP Code\*

**Billing Company** \*Required Fields

Do you use a billing company for this TIN?

Enter your practice's service location in the next section. If you have multiple offices, choose your "main" office. Also complete the Submitter Information section for the person completing this form.

**Practice Information** \*Required Fields

**Primary Servicing Location**

Street Line 1\*

Street Line 2

City\*

State\*

ZIP Code\*

Phone Number\*

Extension

**Submitter Information**

Submitter Title

Submitter Name\*

Submitter Email Address\*

Submitter Phone Number

Extension

In the **Group/Individual Information** section, choose whether your TIN is associated with a group practice (Group) or a solo provider (Individual). The required information depends on your selection.

## Group practices

The screenshot shows a web form titled "Group/Individual Information". On the left side, under "Registration Type\*", there are two radio buttons: "Group" (which is selected) and "Individual". Below this are three input fields: "Group NPI\*" containing the letter "I", "Group NPI Effective Date\*" with a placeholder "MM/DD/YYYY", and "Medical/DOH/License Number" with a small icon on the right. On the right side, there is a section titled "List of all Subsidiary TIN(s) Associated with this Entity\*" containing an example of two TINs: "123456789" and "987654321". Below that is a section titled "Account Number(s)" with a large empty text area. A red horizontal line is visible at the bottom of the form area.

**Group practices:** Group practices should enter the practice's NPI/group NPI, not the individual NPI of one of the physicians. To find the "group NPI effective date" and to confirm that the registration type is for an organization/group (not an individual), you can look up the NPI at <https://npiregistry.cms.hhs.gov/>, then click on the highlighted NPI number in the results row, which will show you details about the NPI.

This NPI is an organization ("group") NPI [red arrow]. The enumeration date [green arrow] can be used as the Group NPI Effective date.



Last Updated: 2011-04-25

Certification Date:

## Details

Name	Value
NPI	1043285729
Enumeration Date	2006-02-17 
NPI Type	2- Organization 
Status	Active

Group practices should leave the “Medical/DOH/License Number” field blank.

## Individual practices

**Group/Individual Information**
\*Required Fields

**Registration Type**

Group

Individual

**Date of Birth\***

**Individual NPI**

**Account Number(s)**

Add account numbers separated by commas.

**List of all Subsidiary TINs Associated with this Entity\***

Type or copy/paste TIN(s) here. TINs should be separated by commas. If your organization does not have subsidiary TINs, please re-enter your organization TIN

**Social Security Number (if there is no NPI)**

**Medical/DOH/License Number\***

**Individual practices** should enter the solo provider’s date of birth, NPI, and medical license number. Using the CMS NPI lookup service at <https://npiregistry.cms.hhs.gov>, confirm that the NPI is registered as the Individual type:

Name	Value
NPI	1235297847
Enumeration Date	2006-12-05
NPI Type	1 - Individual 

To prevent confusion, enter the **Medical/DOH/License** number exactly as it is shown in the CMS NPI lookup service. For example, this clinician’s license has several leading zeroes listed in the License Number field. Entering simply “MD12315” without the leading zeroes listed in the official CMS app might cause a rejection.

Taxonomy	Primary Taxonomy	Selected Taxonomy	State	License Number 
	Yes	174400000X - Specialist	TN	MD0000012315

Both group and individual practices should *re-enter their main TIN* (without dashes) in the box called **List of all Subsidiary TIN(s) Associated with this Entity**. Any subsidiary TINs should also be entered, separated by commas as shown in the Group practice example screenshot, above.

All practices should leave the **Account Number(s)** field blank. Then click **Continue**.

You’ll be taken to a confirmation page where you should review the data you entered. If everything is correct, click **Submit TIN**.

You’ll return to the Dashboard page. If your submission is successful, you’ll see a green checkmark in the **Validate TIN** stage:

## Organization TIN Dashboard

Please see status details and complete any actions required below.

Organization Tax ID Number: 6 Provider Name: P

Action Required for this TIN	Status	Action
Revenue and Tax Information Not available yet.	Complete	Get Started
Attest to Payment and Terms	Available Now	Get Started
	Not Available Yet	Once payment has been issued, you will be able to attest to fund distribution.

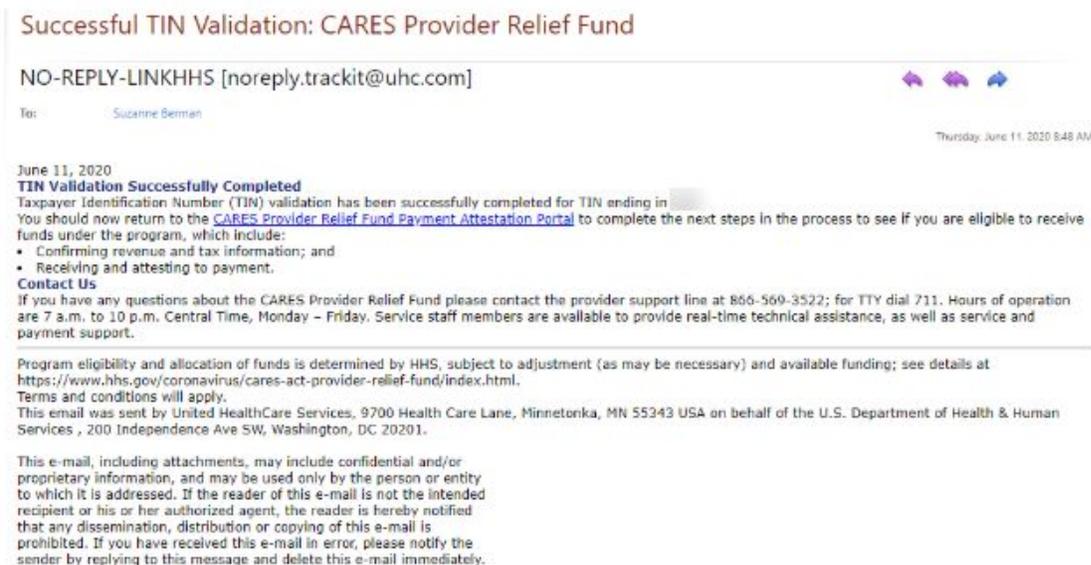
**Add Another Organization TIN** \*Required Field:

Organization TIN\*

Provider Name (as shown on IRS Form W-9 for this TIN)\*

**Add Organization TIN**

You should also receive (in 30-60 seconds) a confirmatory email from [noreply.trackit@uhc.com](mailto:noreply.trackit@uhc.com) called “Successful TIN Validation: CARES Provider Relief Fund”:



## What should I do if my TIN does not show a green checkmark and/or I don't get a confirmation email?

Many practices are reporting immediate or near-immediate validation; others are reporting lags of several days without verification. Optum says that TIN validation can take 1-2 business days

to process. If this period has elapsed, you can call the attestation portal provider help line at (866) 569-3522 from 7 AM-10 PM Central time, Monday through Friday.

It is possible that these providers were not included on their states' lists of Medicaid- and CHIP- participating providers and will need to undergo an alternative TIN verification method. **The AAP is actively investigating this issue with HHS.**

## Step 3: Application: General Tips

Even though the Portal does have an option under **Other Actions** called **Finish Later**, The Portal does not reliably allow you to save data entered in one session for a subsequent session. There is nothing more frustrating than carefully entering all but one field, then logging out (or timing out) while you check it, only to find upon re-entry that everything you entered was lost and must be re-entered. **Therefore, gather all the data first**, then enter it all in one sitting. You can preview what you'll be asked for reviewing the Application and the Instructions.

**Once you submit your application, you can't edit it, void it, or recall it.** Make sure all your numbers have the right number of digits!

To enter your tax, revenue, FTE and other information, click on the Get started link under the yellow icon with **Revenue and Tax Information**. After a moment, you'll be taken to a screen asking you for an access code:

## Please enter the access code to view the document



### HRSA CARES Act Provider Relief 2.0

Department of Health and Human Services

An email containing a validation code has been sent to the address you specified. To proceed, please open the email and enter the code in the box below. Keep this browser window open while you get your email.

Access Code



Show Text

VALIDATE

I NEVER RECEIVED AN ACCESS CODE

Within the next 30-60 seconds, you'll get an email from [dse\\_NA3@docusign.net](mailto:dse_NA3@docusign.net) called "Email Validation: CARES Act Provider Relief Fund":



Copy and enter the validation code above into the access page to finish the CARES Act Provider Relief Fund application.

At any point before completing your submission, you may return to the application by clicking on the Resume Signing button in this email.

Powered by

#### Do Not Share This Email

This email contains a secure link to DocuSign. Please do not share this email, link, or access code with others.



## Step 4: Application Questions 1-9

In Questions 1-4, enter the contact information for the person who is authorized to submit the application and can answer follow-up questions from HHS, if necessary.

In Question 5, choose the best code for your practice from the table from The Instructions. Most pediatric practices will enter PE:

Applicant Type Code	Description
AG	Agencies (ex. foster care, PACE, developmental disabl
BE	Behavioral Health (Outpatient)
CA	Case Management
CL	Clinic/Center
CO	Community-based Social Support Providers
DE	Dental Services
EM	Emergency
HO	Home Health
HS	Hospital
NO	Non-emergency Medical Transport
NU	Nursing Service Providers
OB	Obstetrics/ Gynecology
OP	Other Physician
PE	Pediatrics
PP	Primary Care Physician
RF	Residential Facilities
RB	Residential Facilities (Behavioral)
SA	Substance Abuse (Rehabilitation)
OT	Other

**Questions 6-9 should only be answered if your practice is, or owns, a facility.**

“A facility” is an entity that has been CMS certified to bill Medicare Part A (institutional) billing, as opposed to Medicare Part B (professional) billing. CMS certification is achieved through a state agency conducting an inspection; facilities receive 6 digit CMS Certification Numbers (CCNs). The vast majority of pediatric practices, with the exception of pediatric practices who are federally qualified health centers (FQHCs) or rural health clinics (RHCs), are not facilities.

If your practice is not a facility, enter 0, 0, 0 for Questions 6-8 and leave Question 9 blank.

For facility practices like RHCs:

- For Question 6, enter your total number of facilities (each of which will have a different CCN).
- For Question 7, enter the number of beds (RHCs have zero inpatient beds).
- For Question 8, sum your totals for Questions 27 and 28 and enter that here.

- For Question 9, enter your RHC CCN number, which was issued in a formal letter to you by CMS after you successfully passed your RHC inspection. If you have more than one CCN, enter any CCN.

## Step 5: Application Questions 10-16

For Question 10, you'll enter a number that's on the practice tax return from your Reference Year:

If the applicant for tax purposes is a ...

... sole proprietor or disregarded entity owned by an individual:	Enter Line 3 from IRS Form 1040, Schedule C <u>excluding</u> any income reported on W-2.
... partnership:	Enter Line 1c <u>minus</u> Line 12 from IRS Form 1065.
... C corporation:	Enter Line 1c <u>minus</u> Line 15 from IRS Form 1120.
... S corporation:	Enter Line 1c <u>minus</u> Line 10 from IRS Form 1120-S.
... tax-exempt organization:	Enter Line 9 from IRS Form 990 <u>minus</u> any joint venture income, if included in Part VIII lines 2a – 2f.
... trust or estate:	Enter Line 3 from IRS Form 1040, Schedule C.
... entity not required to file any of the previously mentioned IRS forms:	Enter a “net patient service revenue” number or equivalent from the applicant’s most recent audited financial statements (or management-prepared financial statements)

If you acquired or disposed of subsidiaries with different TINs in your Reference Year, you may need to enter a different number here. You'll need to complete the Gross Revenues Worksheet and enter a different number as per The Instructions, page 6. This situation is rare, but might occur if your practice absorbed another practice into its operations during your Reference Year.

For Question 11, enter the Reference Year (i.e., the year of the tax form you used in Question 10).

For Question 12, find the amount of non-patient-care revenue you posted in your Reference Year, determine what percent this is of your gross revenue from Question 10, and subtract that percent from 100%. This question makes an adjustment for any nonmedical revenue.

The calculations and logic for this question are best illustrated by an example.

### EXAMPLE, QUESTIONS 10-12

Maria is completing the CARES submission for her practice. The practice, which has no subsidiaries, is using 2018 as their Reference Year. The practice reported \$1,835,039 on their

2018 IRS Form 1120 line 1c. Line 15 on the same form is \$ 0.00. The practice will enter \$1,835,039 for Question 10, and 2018 for Question 11.

The practice now must figure out how much of the total gross revenue was “patient care.” Maria knows that the vast majority of the revenue was patient care related, but reviews her Quickbooks data for 2018 to find out.

The “income” section of the practice’s Profit and Loss Statement looks as follows:

Ordinary Income/Expense		
	<b>Income</b>	
	<b>Consulting/Medical Research</b>	8,228.00
	<b>Fees</b>	
	Capitation	1,724.45
	Fee Refunds	-1,154.25
	Fees - Other	1,770,148.97
	<b>Total Fees</b>	1,770,719.17
	Grant Income	13,000.00
	<b>Miscellaneous Income</b>	
	Medical Records Fee	663.11
	Miscellaneous Income - Other	305.87
	<b>Total Miscellaneous Income</b>	968.98
	Pay for Performance Income	36,377.50
	Teaching	5,378.06
	<b>Total Income</b>	1,834,671.71

The total income in Quickbooks is \$1,834,671.71; the total revenue from the tax return is \$1,835,039. Maria knows that the difference between the two figures (\$367.29) is minimal (0.02%) and is likely explained by a small end-of-year adjustment or journal entry.

Maria now reviews the various sources of income for the practice. Patient and insurance payments for services are logged under **Fees - Other**. These are clearly “patient care.” But what about the other categories? **Consulting/medical research** was for participating in an ACO research project. **Grant income** was for two providers who received Meaningful Use money. **Capitation** was PMPM revenue for a small plan. **Pay for performance income** was a bonus for high quality care in a BCBS program. **Teaching** is a stipend from the local residency program for accepting a second-year resident for 6 months in a continuity clinic.. **Miscellaneous income - Other** includes several small amounts from multiple sources, including interest payment from the bank and an unclaimed \$20 that was found in the parking lot.

Because there is no guidance from CMS on determining exactly where to draw the line, Maria asks herself:

- Did we get this money in exchange for providing patient care?
- Is this money we expected to get for patient care?
- Can it easily be ascribed to particular patients/payers?
- Is the intent of the CARES act to replace this money?

If the answer to these questions tends toward “yes,” she marks the cells in green; if the answers are “no,” she tends toward red:

Ordinary Income/Expense		
<b>Income</b>		
Consulting/Medical Research		8,228.00
<b>Fees</b>		
Capitation		1,724.45
Fee Refunds		-1,154.25
Fees - Other		1,770,148.97
<b>Total Fees</b>		<b>1,770,719.17</b>
Grant Income		13,000.00
<b>Miscellaneous Income</b>		
Medical Records Fee		663.11
Miscellaneous Income - Other		305.87
<b>Total Miscellaneous Income</b>		<b>968.98</b>
Pay for Performance Income		36,377.50
Teaching		5,378.06
<b>Total Income</b>		<b>1,834,671.71</b>

Maria then subtotals by color. She gets \$1,807,096.67 for patient care revenue and \$ 27,575.04 for other revenue. The non-patient-care revenue is relatively small, but not trivial.

To compute the percentage of medical revenue, Maria divides \$1,807,096.67 by \$1,835,039 (from the tax return) which yields 98.48%. If Maria had decided to divide \$1,807,096.67 by \$1,834,671.71 (her Quickbooks total revenue), this would yield 98.50% (again, a trivial difference).

Maria rounds to the nearest tenth percent and enters 98.5%.

Note: the product of the Question 12 percentage (98.5%) times the Question 10 gross revenue (\$1,835,039) -- which is \$1,807,513.42 -- is the total amount of money that will need to be allocated among payers in Questions 17-24.

For Question 13, estimate the revenue you lost for the period March 1-April 30, 2020 which you attribute to COVID-19.

- This question asks for actual revenue lost in March and April. We understand that most practices did not start having substantial revenue losses until April and May because of the lag time between service and payment due to claims submission. However, do not make substitutions like substituting May for March. Enter your losses for March and April, even if other months are more substantial.
- Even if your revenue for March and April 2020 was increased compared to March and April 2019, it's still possible to compute a COVID-19 related income loss. You can use other estimates of your projected/anticipated income beside simply "prior year."
  - A rapidly growing practice might expect its spring 2020 income to be twice its spring 2019 income. Instead, actual receipts for March and April 2020 increased only 1.5x. The 0.5x difference between expected and actual can be reported as a COVID related loss.
  - A practice that had an extremely busy winter 2019/2020 would already expect its March and April 2020 receipts to be higher than average, based on ongoing revenue from more work in the prior months. If you expected your receipts to be \$150,000 per month, but they were only \$110,000 per month, you can report the \$40,000 per month difference as an \$80,000 COVID-related loss. This may be more accurate than reporting the difference between previous year's revenue (\$130,000 per month) and March-April 2020 revenue (\$110,000 per month), which would be \$20,000.
  - HHS clearly states in The FAQ (under the question "In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received?") that

...Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment, that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment...

- Remember that you should only include decreases that can be reasonably ascribed to COVID. For example, if your clinic had 8 providers in 2019 and only 5 in 2020, it would be reasonable for March and April 2020 to have significantly less revenue than the same period in the prior year, even if COVID hadn't happened.
- **Be sure to record a loss as a negative number in your response.** If you lost \$55,000 and enter "\$55,000" (as a positive number), the system will interpret your answer as having had an increase in revenue due to COVID.

For Question 14, estimate the increased expenses you had in the period March 1-April 30, 2020 which you attribute to COVID-19.

- As a strategy, you might compare your actual expenses in March and April 2020 to your previous year's expenses for the same time period through your accounting software. Particular areas to review include:
  - **Staff time.** Time spent meeting with your staff for COVID related reasons counts because you have to pay your staff for time spent on COVID-related planning meetings, teaching donning and doffing and storage of PPE, preparing your staff to work from home, and teaching staff how to triage patients in a COVID-world (both telephonically and as they check in). Your managers and practice leaders had to spend time developing a N95 fit check policy, reviewing your practice's new obligations under FFCRA and implementing those policies, writing and instituting new guidelines on sanitizing rooms and equipment, and so much more. Just a review of your emails received and sent during this period will give you a snapshot on how you spent your time organizing, documenting, and activating your practice in ways that you wouldn't have had to do without COVID.
  - **Medical supplies.** Obviously, practices spent much more on masks, gowns, gloves, goggles, hand sanitizer, scanning temperature thermometers, etc than ever before. You may also have had to buy a second blood pressure machine so that one could be thoroughly sanitized while the other was in use.
  - **Linen service.** Practices who used washable isolation gowns will have a greatly increased utilization.
  - **Waste disposal.** If you are charged by the container for waste pickup, you may have had to pay more for regular waste pickup when you increased your PPE use astronomically.
  - **Cleaning supplies/cleaning service.** You may have increased the frequency or made a longer checklist of nightly cleaning for your custodial staff. If your nurses who usually spent only 20 minutes per day cleaning up exam rooms now spent 1.5 hours daily deeply cleaning all services in between every patient, rather than providing patient care, you can account for the 70-minute difference in their wages.
  - **Internet and computer expenses.** Many practices sent their staff home to work and had to provide laptops, new security systems, upgraded their internet, provided mobile access points/"jetpacks," added new seats and subscriptions for security licenses, and so on. You may have had to buy extra scanners or monitors or backup cables.
  - **Phone expenses.** You may have had to upgrade your phone system to accommodate the increase in call volume from patients, as well as to allow telework from home. You may have bought additional cell phones or data so that you could text patients from their cars.
  - **Office supplies.** When people are working at the office, they can share resources, but practices who sent people home to work may have had to order additional supplies like postage meters, scanners, fax machines, signature stamps, and heavy duty shredders for home use.

- **Telemedicine subscriptions.** If you only started doing telemedicine because of COVID, don't forget to put this in as an expense. If you had dipped your toe into telemedicine prior, but COVID required you to greatly increase your capacity, you probably added subscriptions for additional providers and/or upgraded your subscription, at a cost to you.
  - **Other teleconferencing subscriptions.** You may have signed up for, or upgraded your subscription to, GoToMeeting or Zoom or another telework option so you could meet with your team remotely.
  - **Construction and building expenses.** Many practices added outside tents and stations, modified their parking lot, purchased outdoor signs, traffic cones, awnings, and so on. Other practices had plexiglass "sneeze shields" installed to encase their receptionists.
- You may include expenses you paid in the period even though you may not have realized the entire benefit during the period. For example, Wanda's practice purchased 1,000 surgical masks for \$750 on April 1st. The practice started using the masks immediately, but still had not used all these masks by the end of the period. Since the practice incurred and paid all \$750 of expense in March/April, it is appropriate to include the entire \$750.

For Question 15, upload the Gross Revenue Worksheet if you used it to answer Question 10.

**Practices who did not acquire or shed a subsidiary tax ID in their Reference Year can skip this question.**

For Question 16, click the paperclip icon and attach the practice tax return referred to in Questions 10-11.

## Step 6: Application Questions 17-24

This report requires you to give the breakdown percent of all your patient care revenue (the product of Question 10 times Question 12). The answers should be reported to the nearest whole percent.

**Note that you cannot just count your patients with each insurance**, as this will return unreliable results. In an audit situation, you would be hard pressed to defend your answers.

---

### EXAMPLE

Pediatric Partners has 2000 patients, 1000 with Medicaid and 1000 commercial patients. Each patient comes in once per year. Medicaid pays 70% of commercial rates for the same services.

Using the percent of revenue method:

1000 Medicaid visits at \$70 dollars each = \$70,000

1000 commercial visits at \$100 dollars each = \$100,000

Using \$170,000 of the total revenue, Medicaid is 41% and commercial is 59%.

However, just from counting patients or patient visits, Medicaid would be 50% and commercial would be 50%. Patients who have Medicaid now might also have had commercial insurance during the reference year, or vice versa, further skewing the results. Answers based on panel distribution are not close enough to represent percent revenue and should not be reported.

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Your practice management system can give you a report of your posted payments by insurance company for a date range.

Note that the date you post them in your PMS is close to, but not necessarily exactly the same, as the day they arrived in your bank account.

- For example, you may have posted payments on December 29, 2018, that did not actually arrive until January 2, 2019. These would appear in your posted payments for 2018 but not on your 2018 tax return report.
  - Similarly, you might have received payments in your bank account at the end of 2018, but because your staff was out for the holidays, they were not posted until early 2019. This would result in monies appearing in your bank account in 2018 (and thus your 2018 tax return) but not in your 2018 posting data.
  - Even with very tight posting controls, a difference of 3-5 days between posting and bank receipts is not unusual. Some payers, such as Tricare, often have a lag as long as 10-14 days between when an ERA is remitted and the associated EFT is actually deposited in the practice's bank account. 6-10 days of variance (including both the beginning and the end of the year) out of a 365 day year may mean that you have a difference of 1.6%-2.7% between bank/tax posting and PMS posting figures based on this factor alone.
- 

## OP TIP

In Office Practicum (OP), there are several ways to get posted total payments by insurance for a date range. This SQL will show all monies (both insurance and patient side), posted in a calendar year, summed against a particular insurance plan (including self-pay).

You will be prompted for a date range at run time. If you are not familiar with running SQL reports, read this article: <https://op.knowledgeowl.com/help/clip-and-save-sql-quickstart>

```
with pd as ( select ins, sum(p) as paid from (
select a.*, b.ins_carrier_code as ins from (
select patno,txnopaid, payment + copayrecd as p, a_date1, ins_carrier_code
from archive_transactions where a_date1 between :start_date and :end_date
and txnopaid >0 and payment+copayrecd >=0.01 ) a
inner join (select trnsxno, cptcode, ins_carrier_code from archive_transactions
where txnopaid =0) b on a.txnopaid = b.trnsxno ) group by ins)
select * from ( select pd.paid, ins_carrier.ins_carrier_name,
ins_carrier.claim_filing_code from pd left outer join ins_carrier on
ins_carrier.ins_carrier_code = pd.ins) order by paid desc
```

### Question 13: Lost Revenue

Although you are not compelled to use only the difference in your March and April 2019 to March and April 2020 revenue, it's a simple method for most practices to estimate lost revenue due to COVID. Run the above SQL twice, once using 3/1/2019-4/30/19 and again using 3/1/2020-4/30/20 as the dates at runtime. Download both reports as CSVs. The totals in Column 1 for each report give your total revenue for March and April 2019 and 2020 respectively.

### Questions 17-24: Specific Payer Mix

Run the SQL for your entire Reference Year, e.g., start and end dates 1/1/2018 and 12/31/2018 respectively. You'll need to manually add to these numbers any sources of patient care revenue that you didn't log in OP, then compute percents. For screenshots and a practical illustration, see "Jazmin" example below.

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## PCC TIP

PCC will maintain an updated version of this section, with any additional information or guidance, at <http://learn.pcc.com/CARESact>.

### Question 13: Lost Revenue

HHS’s guidance about determining the revenue lost to COVID-19 offers a number of methods, but the easiest for most practices will be to “to compare the revenues to the same period last year.” In order to determine the revenue lost when comparing March and April of 2019 to 2020, PCC clients should make sure to use ‘daysheet’ style payment data in order to distinguish between actual cash flow versus payments on procedures rendered only during that time frame.

The easiest way to determine the cash flow impact for your practice will be to run the “Daysheet Totals by Posting Month” report from the Payment and Proving Out Reports section of SRS. Again, you’ll need to enter date ranges, once for March/April 2019 and once for March/April 2020. There will be one additional option for the report - *make sure* to check off “Include Relinked Payments and Adjustments.”

Daysheet Totals by Posting Month (Wide Style)							
Month	Non Service Charges	Service Charges	Adj	Cash	Check	Credit Card	Refund
2020/03	\$39.68	\$728,316.55	\$338,134.79	\$735.17	\$546,415.50	\$66,570.70	\$0.00
2020/04	\$1.08	\$483,592.05	\$219,382.34	\$315.00	\$369,662.74	\$42,763.74	\$-1,679.46
	\$40.76	\$1,211,908.60	\$557,517.13	\$1,050.17	\$916,078.24	\$109,334.44	\$-1,679.46

Criteria for this report run.  
Posting Date Range: 03/01/20 - 04/30/20

Includes Relinked Payments and Adjustments

Just add up the totals for Cash, Check, and Credit Card and subtract the Refunds. In the example above, we’d have \$1,050.17 + \$916,078.24 + \$109,334.44 - \$1,679.46, for a total of \$1,028,142.31.

As noted in the other sections of the guidance, revenue that you received but did not enter into the system may need to be added to this total. Although PCC recommends that all patient care related revenue be entered into the system (including P4P payments, capitation, etc.), not every practice does so.

### Questions 17-24: Specific Payer Mix

PCC users have multiple ways to generate the data required to determine your practice’s Payer Mix. To keep the process as simple as possible, we will focus on a canned report. The “Total Visits By Payor - Yearly Comparison” report from the [PCC SRS Report Suite](#) found in the Trend Analysis section should provide all the data you need. You will be prompted for a date range; simply enter your Reference Year start and end dates, e.g., 01/01/2019 and 12/31/19.

## Total Visits by Payor - Yearly Comparison

Trans Year: 2019

Trans Year of Service	Ins Group	Number of Visits	Number of Visits Percent	Units Per Visit	Avg Charge Per Visit	Avg Deposited Per Visit	Number of Units	Percent	Charge Amount	Amount Percent	Amount Deposited (all pmts)	Amount Deposited (all pmts) Percent
2019	Meridian (mco)	1586	4.61%	4.26	\$33.83	\$13.75	6758	4.51%	\$53,647.01	4.05%	\$21,804.58	2.51%
2019	UHC-cp/medicaid	1605	4.66%	3.94	\$26.45	\$9.72	6319	4.22%	\$42,453.02	3.21%	\$15,601.66	1.80%
2019	BCBS-Complete (mco)	498	1.45%	4.74	\$22.24	\$8.28	2361	1.58%	\$11,075.03	0.84%	\$4,122.32	0.48%
2019	BCN	2532	7.36%	4.18	\$41.37	\$25.85	10572	7.06%	\$104,747.00	7.92%	\$65,453.72	7.54%
2019	UHC	3779	10.98%	4.58	\$41.16	\$27.16	17315	11.56%	\$155,526.49	11.75%	\$102,641.45	11.83%
2019	~HAP Medicaid-	5	0.01%	3.60	\$0.00	\$0.00	18	0.01%	\$0.00	0.00%	\$0.00	0.00%
2019	Cigna	828	2.41%	4.59	\$44.09	\$34.51	3803	2.54%	\$36,510.00	2.76%	\$28,578.13	3.29%
2019	BCBS	16302	47.37%	4.32	\$42.15	\$29.87	70346	46.96%	\$687,089.00	51.92%	\$486,996.86	56.12%
2019	Aetna	1712	4.97%	4.54	\$48.54	\$28.71	7764	5.18%	\$83,106.02	6.28%	\$49,159.93	5.67%
2019	Medicaid	234	0.68%	3.90	\$41.35	\$11.17	912	0.61%	\$9,676.03	0.73%	\$2,614.91	0.30%
2019	Other	3066	8.91%	4.35	\$39.90	\$26.08	13339	8.90%	\$122,326.00	9.24%	\$79,976.38	9.22%
2019	Personal/No Insurance	2270	6.60%	4.54	\$7.53	\$4.75	10303	6.88%	\$17,096.00	1.29%	\$10,774.99	1.24%
2019		34417	100.00%	4.35	\$38.45	\$25.21	149810	100.00%	\$1,323,251.60	100.00%	\$867,724.93	100.00%
0		34417	0.00%	4.35	\$38.45	\$25.21	149810	0.00%	\$1,323,251.60	0.00%	\$867,724.93	0.00%

Criteria for this report run:

Transaction Date Range: 01/01/19 - 12/31/19

This report will calculate the volume of each insurance group based on visits, charges, and deposits. For the purpose of the CARES report, the “Amount Deposited (all pmts) Percent” column reflects the revenue volume of each payor type (Medicaid, Commercial, Self-Pay, etc.) for your practice. For example, simply add up the values for each of your Medicaid groups to determine your total Medicaid revenue volume. In the example above, we’d presume that the following groups represent Medicaid:

- “Meridian (mco)” (2.51%)
- “UCH-cp/ medicaid” (1.80%)
- “BCBS-Complete (mco)” (0.48%)
- “~HAP Medicaid~” (0%)
- “Medicaid” (0.3%)

Combined, these Medicaid programs represent 5.09% of the practice’s revenue volume for 2019.

PCC clients should ascertain that their insurance companies are properly sorted into the appropriate groups.

Most systems will yield a report in which the columns represent the total amount paid by that payer during the calendar year and the insurance carrier’s name. Some reports may also

contain the claim filing code (which is the user's assignment of the payer to Commercial Insurance (CI), Medicaid (MC), BlueCross (BL), and so on. For a key of claim filing codes, see <https://ushik.ahrq.gov/ViewItemDetails?system=sdo&itemKey=133096000>

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## EXAMPLE

Here is a report Jazmin gets for her small solo practice, obtained from their practice management system. It shows the total payments received by payer for calendar year 2018.

PAID	INS_CARRIER_NAME	CLAIM_FILING_CODE
80121.37	BCBS PPO	BL
57740.03	AETNA	CI
50679.99	MEDICAID	MC
39486.45	EMPIRE BCBS	BL
21268.81	GARDENHEALTH	CI
17550.93	UNITED HEALTH	CI
12422.95	CIGNA	CI
5296.34	INDEP. ADMIN	CI
5067.9	SELF-PAY	9
4052.68	UMR	CI
2169.09	OXFORD UHC	CI
1851.38	HUMANA	CI
1545.96	TRICARE	CI
1413.03	MERITAIN	CI
1361.56	ASRM/RSL	CI
982.12	GOLDEN RULE	CI
966.65	AMERIHEALTH	CI
537.12	CORESOURCE	CI
495.2	WEBTPA	CI
415.44	INDECS	CI
406.55	HERITAGE	CI
393.75	MEDI-SHARE	CI
387.7	AMERIHEALTH	CI
345.76	FREEDOM LIFE	CI
322.01	MAGNACARE	CI
278.02	CWI	CI
168	NEWBORN PENDING	CI
162.72	ALL SAVERS	CI
135.02	NALC HEALTH BEN	CI
92.06	PLUMBERS LOCAL	CI
38		
17.8	HEALTH AMERICA	CI

To see the total amount paid on behalf of all payers, Jazmin can sum the Paid fields in Excel. Jazmin can use the Excel formula =SUM(A:A) or she can highlight all the paid amounts and look at the quick summary in the bottom center edge of the Excel frame:

	A	B	C	D	E	F	G	H
1	PAID	INS_CARRIER_NAME	CLAIM_FILING_CODE					
2	80121.37	BCBS PPO	BL					
3	55740.03	AETNA	CI					
4	50679.99	MEDICAID	MC					
5	39486.45	EMPIRE BCBS	BL					
6	21268.81	GARDENHEALTH	CI					
7	17550.93	UNITED HEALTH	CI					
8	12422.95	CIGNA	CI					
9	5296.34	INDEP. ADMIN	CI					
10	5067.9	SELF-PAY		9				
11	4052.68	UMR	CI					
12	2169.09	OXFORD UHC	CI					
13	1851.38	HUMANA	CI					
14	1545.96	TRICARE	CI					
15	1413.03	MERITAIN	CI					
16	1361.56	ASRM/RSL	CI					
17	982.12	GOLDEN RULE	CI					
18	966.65	AMERIHEALTH	CI					
19	537.12	CORESOURCE	CI					

In this case, the sum of what was paid to this solo practice, based on patient care payments posted in 2018, was \$308,172.39. Can this money be converted to percentages, and these percentages entered in Questions 17-24?

**It depends how close this sum is to the total patient care revenue reported (product of Question 10 and Question 12).**

If the total patient care revenue figure is, for example, \$311,025, that means there's only a difference of \$2,852.61 (0.9%) between it and the sum of the individual payer patient care revenues. Since we need to report Questions 17-24 only to the nearest whole percent, it is unlikely that this difference will greatly skew any of our numbers.

On the other hand, what if the total patient care revenue figure (product of Questions 10 and Question 12) is \$389,845? This means that there is a difference of \$81,672.61 that the practice received and reported as revenue which was not accounted for in the practice management

system. This difference, which is 20.9% of the total patient care revenue, can definitely skew the percents-by-payer figures.

But where did the extra money come from, why is it not in the practice management system, and what payer should it be ascribed to? Simply assuming the extra \$81,000 should be broken down in the same way as the PMS' fee for service revenue is sloppy at best.

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Most practices receive money that is booked in their accounting system (e.g. Quickbooks) that is not booked in their practice management system. Traditional PMS systems are good at tracking fee-for-service claims, that is, insurance and patient monies received against filed claims. They do not typically track the following kinds of patient-care revenue:

- Capitation money (i.e., a fixed per member per month receivable according to an insurance contract)
- Interest paid by insurance companies on late-paid claims
- Money received from a collection agency which has been chasing bad patient debt
- Pay-for-performance and bonus money

It's also possible that the practice did not properly exclude revenue that was not related to patient care in its computation of Question 12. This would include medical business revenue such as:

- Rental income from extra space in the office
- Bank interest payments
- Teaching and research revenue

However, these kinds of revenue are definitely reported in your accounting system and appear on your tax return. If you have a significant difference between the sum of your fee-for-service revenue by payer and your total patient care revenue (product of Question 10 times Question 12), you'll have to return to your accounting software to find the other revenue.

---

## EXAMPLE (CONTINUED)

Let's say Jazmin finds that the \$81,000 can be ascribed to \$50,000 of a BCBS bonus payment and \$30,000 in a Medicaid PMPM payment, and \$1000 can't be identified. She then adds these sums to her report, adding \$50,000 to the commercial subtotal, \$30,000 to the Medicaid subtotal, and \$1,000 to the "Other" subtotal.

PAID	INS_CARRIER_NAME	CLAIM_FILING_CODE
130121.37	BCBS PPO	BL
57740.03	AETNA	CI
80679.99	MEDICAID	MC
39486.45	EMPIRE BCBS	BL
21268.81	GARDENHEALTH	CI
17550.93	UNITED HEALTH	CI
12422.95	CIGNA	CI
5296.34	INDEP. ADMIN	CI
5067.9	SELF-PAY	9
4052.68	UMR	CI
2169.09	OXFORD UHC	CI
1851.38	HUMANA	CI
1545.96	TRICARE	CI
1413.03	MERITAIN	CI
1361.56	ASRM/RSL	CI
982.12	GOLDEN RULE	CI
966.65	AMERIHEALTH	CI
537.12	CORESOURCE	CI
495.2	WEBTPA	CI
415.44	INDECS	CI
406.55	HERITAGE	CI
393.75	MEDI-SHARE	CI
387.7	AMERIHEALTH	CI
345.76	FREEDOM LIFE	CI
322.01	MAGNACARE	CI
278.02	CWI	CI
168	NEWBORN PENDING	CI
162.72	ALL SAVERS	CI
135.02	NALC HEALTH BEN	CI
92.06	PLUMBERS LOCAL	CI
38		
17.8	HEALTH AMERICA	CI
1000	OTHER	

## Classification of payers

Patient paid cost share determined by an insurer should be ascribed to that payer's category. For example, a \$20 copay from a commercial plan should be ascribed to "commercial," not "self-pay."

- **Medicare A + B:** all "original Medicare" plans.
- **Medicare Part C:** "Medicare Advantage" and "Medigap" plans
- **Medicaid** includes state-run Medicaid and state-run CHIP as well as Medicaid MCOs, CHIP MCOs, and mixed Medicaid/CHIP plans. This also includes Medicaid and CHIP plans from states other than your own. This also includes non-medical insurances sponsored by Medicaid and CHIP, such as dental benefits payments from a DBM (like DentaQuest) or vision benefits payments (like Block Vision or March Vision.) Behavioral health plans run by Medicaid (such as North Carolina Medicaid's LMEs) should also have their payments logged in this category.
- **Commercial:** Most other plans purchased by an employer or an individual are classified here. Obviously, include BCBS, Cigna, Humana, Aetna, and United's commercial books of business. Also include Exchange plans, ERISA (self-funded) employer and union plans, and association health plans. Include government-sponsored commercial insurance such as BCBS Federal Employee Plans.
- **Self-pay:** This includes uninsured patients. This also includes patients whose funding source is a "healthcare shared expenses plan" (e.g. faith-based sharing plans like MediShare, Liberty Health, MCS, etc.) It also includes revenues from patients who paid entirely out of pocket for a service, either because their health insurance did not cover the service (e.g. ear piercing) or because you were out of network or the patient exercised HIPAA rights to pay cash and not file any insurance.
- **Other governmental plans:** This includes Tricare, Tricare Regional Contractors (Tricare plans administered by Humana Military, Health Net, International SOS, Wisconsin Physicians Services, and US Family Health Plan), and CHAMPVA/CHAMPUS. Also include public programs that pay after Medicaid, such as the Indian Health Service, the Maternal/Child Health (Title V) block grant program (program name varies according to your state), IDEA payments, and Ryan White HIV/AIDS program. *CHIP does **not** go here.*
- **Other:** This includes worker's compensation, motor vehicle or accident insurance payments, and school accident insurance.

## EXAMPLE (CONTINUED)

Jazmin then groups these into sums by category and color-codes them. She uses the Claim Filing Code as a guide but in the end she individually assigns the payer classification:

PAID	INS_CARRIER_NAME	type
130121.37	BCBS PPO	Commercial
57740.03	AETNA	Commercial
80679.99	MEDICAID	Medicaid
39486.45	EMPIRE BCBS	Commercial
21268.81	GARDENHEALTH	Commercial
17550.93	UNITED HEALTH	Commercial
12422.95	CIGNA	Commercial
5296.34	INDEP. ADMIN	Commercial
5067.9	SELF-PAY	Self pay
4052.68	UMR	Commercial
2169.09	OXFORD UHC	Commercial
1851.38	HUMANA	Commercial
1545.96	TRICARE	Other government
1413.03	MERITAIN	Commercial
1361.56	ASRM/RSL	Commercial
982.12	GOLDEN RULE	Commercial
966.65	AMERIHEALTH	CHIP
537.12	CORESOURCE	Commercial
495.2	WEBTPA	Commercial
415.44	INDECS	Commercial
406.55	HERITAGE	Commercial
393.75	MEDI-SHARE	Self pay
387.7	AMERIHEALTH	CHIP
345.76	FREEDOM LIFE	Commercial
322.01	MAGNACARE	Commercial
278.02	CWI	Commercial
168	NEWBORN PENDING	Unknown
162.72	ALL SAVERS	Commercial
135.02	NALC HEALTH BEN	Commercial
92.06	PLUMBERS LOCAL	Commercial
38		Unknown
17.8	HEALTH AMERICA	Commercial
1000	OTHER	Unknown

**Green rows** are Medicaid and CHIP plans.

**Orange rows** are self pay.

**Grey rows** are “other government” .

**Blue rows** are commercial insurance.

**Yellow rows** are Unknown: “Newborn Pending” is clearly a placeholder when a newborn’s insurance is not known. However, this might have been a commercial plan, Medicaid plan, or self pay. Jazmin looks up these instances and re-allocates them accordingly. \$38 ended up in the practice management system without having a payer ascribed. Finally, Jazmin notes the \$1000 “Other” found in the accounting system. If Jazmin cannot identify and re-classify these as part of a particular payer in one of the other categories, she keeps them as “Other.”

Next, Jazmin makes subtotals by the type of insurance they are. Pivot Tables in Excel work well for this purpose:

Row Labels	Sum of PAID
CHIP	1354.35
Commercial	298924.44
Medicaid	80679.99
Other government	1545.96
Self pay	5461.65
Unknown	1206
<b>Grand Total</b>	<b>389172.39</b>

Again, \$389,845 (from the product of Question 10 and Question 12) compared to this grand total is quite close.

To compute percents, Jazmin divides each row by the grand total:

Row Labels	Sum of PAID	Percent
CHIP	1354.35	0.3%
Commercial	298924.44	76.8%
Medicaid	80679.99	20.7%
Other government	1545.96	0.4%
Self pay	5461.65	1.4%
Unknown	1206	0.3%
<b>Grand Total</b>	<b>389172.39</b>	

Finally, Jazmin reports this data in Questions 17-24 using the defined taxonomies for payers. You can round each payer group to the nearest whole percent. In this case, Jazmin reports to one decimal place since rounding will mean the sum total won’t add to 100%:

Medicare A + B: 0%

Medicare C:	0%
Medicaid:	21.0% (includes CHIP)
Commercial:	76.8%
Self-pay:	1.4%
Other gov:	0.4%
Other:	0.3%

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## Step 7: Application Questions 25-36

For Question 25, enter the total dollar amount of SBA support received by the practice as of 5/31/2020. This includes Paycheck Protection Program (PPP) loans, Economic Injury Disaster Loan (EIDL) loans, and EIDL advances/grants. The amount granted to the practice prior to 5/31/2020 should be included, even if the practice has not yet spent it

For Question 26, enter the amount you received from FEMA for disaster loans and grants. This is quite rare; we expect most pediatric practices to enter \$ 0.00.

For Questions 27-29, sum all the FTE of the practice's employees as of 5/31/2020, classifying them into one of three types. Only include staff members who have received, or will receive, W-2s. The calculations and logic for these questions are best illustrated by an example.

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### EXAMPLE - QUESTIONS 27-29

Kathy has prepared a list of all the employees of Pediatric Partners, their roles, and the number of hours they're usually scheduled to work in a week, as of 5/31/2020. Pediatric Partners defines  $\geq 36$  hours per week as full time according to its Employee Handbook.

Kathy's list looks like this:

Mario	physician	40
Talisa	physician	36
Kyle	nurse practitioner	36
Brittany	PA	40
Joanna	dietician	20
Kathy	manager	40
Janelle	RN	37
Crystal	LPN	40
Kimberly	LPN	40
Sheena	LPN	36
Bekka	front desk	20
Megan	front desk	40
Kellie	billing	36
Angie	billing	40
Erica	referral coordinato	40
Amber	admin assistant	30
Holly	medical records	30

Kathy first converts this list to FTE by dividing the hours worked by 36, with all individuals over 1 FTE being rounded to 1, and all others rounding to the nearest tenth.

Excel tip: if the hours worked is column C, you can use the following formula for the first row:

`=IF(C1/36>1,1,ROUND(C1/36,1))`

Kathy's new report looks like this:

Mario	physician	40	1
Talisa	physician	36	1
Kyle	nurse practitioner	36	1
Brittany	PA	40	1
Joanna	dietician	20	0.6
Kathy	manager	40	1
Janelle	RN	34	0.9
Crystal	LPN	35	1
Kimberly	LPN	40	1
Sheena	LPN	36	1
Bekka	front desk	20	0.6
Megan	front desk	40	1
Kellie	billing	36	1
Angie	billing	40	1
Erica	referral coordinato	40	1
Amber	admin assistant	30	0.8
Holly	medical records	30	0.8

Now, Kathy classifies each staff member into one of three categories and color-codes their cells:

- **“Primary Provider FTE”** - an independent clinician (physician or dentist, or NP/PA/midwife who is not supervised by a physician) [peach]
- **“Non-Primary FTE”** - all other clinical staff members who provide direct patient care but who don’t fit the definition of “primary provider FTE” [blue].
  - Because Kathy’s practice is located in Michigan where nurse practitioners and PAs are required to have a supervisory relationship with a physician, she colors Kyle and Brittany blue, rather than peach.
  - If Kathy were in Colorado, where nurse practitioners need not be supervised by physicians, and Kyle practiced without supervision, then she would color Kyle peach. Brittany would still be blue, since PAs still require physician supervision in Colorado.
  - Joanna is a registered dietician who practices independently from physicians and does not require supervision. However, she is neither a physician, a dentist, an independent NP, an independent PA, or an independent midwife, so she is colored blue. Joanna would be classified similarly if she were an audiologist, speech therapist, IBCLC, psychologist, or licensed professional counselor.
- **“Other FTE”**- all other staff members who do not provide direct patient care (scheduling, receptionist, billing, administrative, IT, and other support staff) [green]

Kathy’s report now looks like this:

Mario	physician	40	1
Talisa	physician	36	1
Kyle	nurse practitioner	36	1
Brittany	PA	40	1
Joanna	dietician	20	0.6
Kathy	manager	40	1
Janelle	RN	34	0.9
Crystal	LPN	35	1
Kimberly	LPN	40	1
Sheena	LPN	36	1
Bekka	front desk	20	0.6
Megan	front desk	40	1
Kellie	billing	36	1
Angie	billing	40	1
Erica	referral coordinator	40	1
Amber	admin assistant	30	0.8
Holly	medical records	30	0.8

Finally, Kathy removes staff members who are not W-2 employees. Dr. Talisa is the sole owner of the practice, which is organized as a limited liability company (tax partnership.) Because Dr. Talisa does not get a W-2 from the practice, but instead receives a Schedule K-1 form reporting her compensation, she is removed from this list. (If the practice were organized as a corporation, with Dr. Talisa being a shareholder-employee and thus receiving a W-2, she would remain on the list.)

Kathy then totals up the FTE numbers by color:

- Independent clinician (peach): 1 FTE
- Other clinical staff (blue) : 6.5 FTE
- Other staff (green): 7.2 FTE

For Questions 27-29, Kathy reports 1.0, 6.5, and 7.2 respectively.

For Question 30, enter the number of locations owned by the practice where care is provided.

For Question 31, complete the FTE Worksheet listing only the individuals enumerated in Question 27. Remember to remove owners who do not receive W-2s. Enter each individual's name, NPI, and FTE.

A red “Check NPI” alert will appear if the NPI you enter does not have 10 digits. (Note that the sample NPI has 11 digits.)

	NPI	Dentist (D), or Other (O)	FTE	
	12345678910	P	0.75	
	1578612305	P	0.68	
	15688568544	P	1.00	Check NPI
	1043285733	O	0.80	

A prior version of the spreadsheet erroneously expected 11 digit NPIs. If you are getting this message despite proper 10-digit NPIs, download a fresh copy of the spreadsheet from the link given in the Definitions section above.

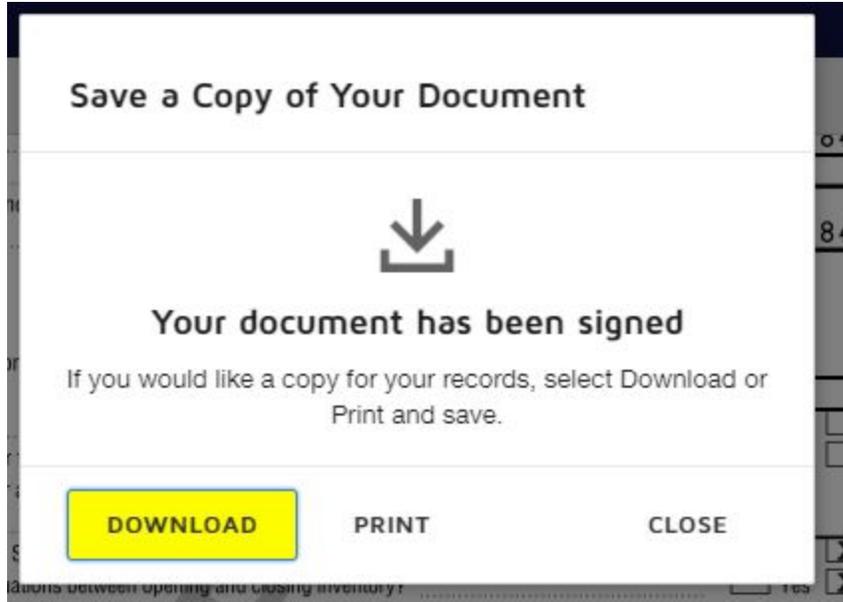
For Question 32, upload your practice’s 941 form for the first quarter of 2020.

For Questions 33-36, enter your bank’s name, bank routing number, name of the bank account holder (e.g. Pediatric Partners), and practice bank account number.

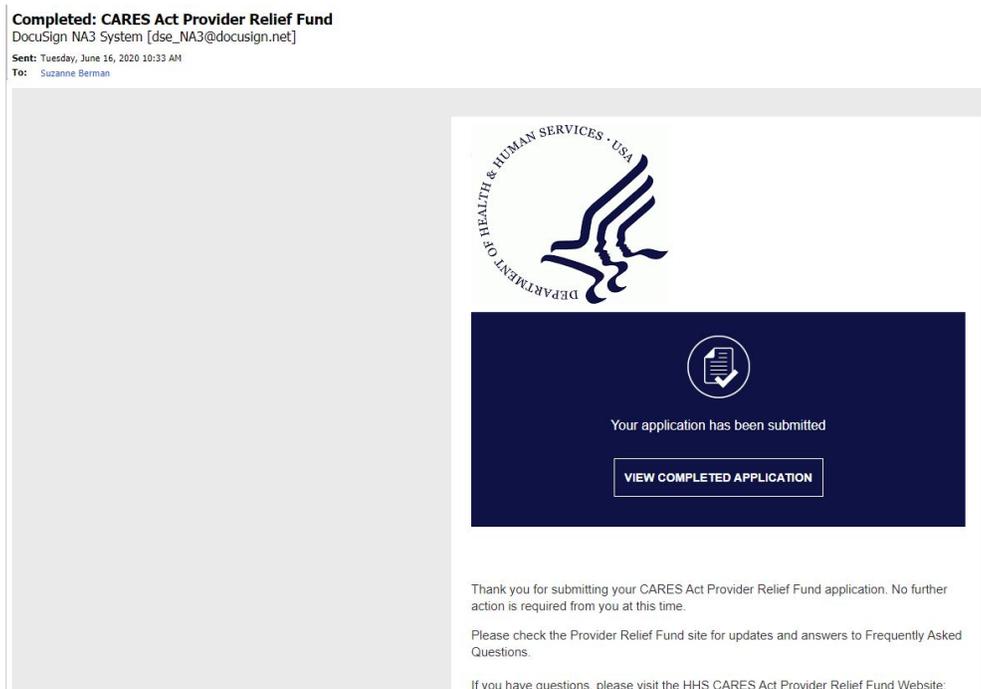
## After submission

### What to expect

After submitting your completed application, you’ll get an opportunity to download and save a copy. **Be sure to do this!**



You'll also get a confirmatory email from DocuSign (email source [dse\\_NA3@docusign.net](mailto:dse_NA3@docusign.net)):



However, your Organization TIN Dashboard will not change its appearance. You will still have the yellow icon above **Revenue and Tax Information**, which will still say Get Started. This is OK.

Organization Tax ID Number: [REDACTED], Provider Name: [REDACTED]

<p>Action Required for this TIN:</p> <p><b>Revenue and Tax Information</b></p> <p>Not available yet:</p> <p><b>Attest to Payment and Terms</b></p>	<p></p> <p><b>Validate TIN</b></p> <p>Complete</p>	<p></p> <p><b>Revenue and Tax Information</b></p> <p>Available Now</p> <p><a href="#">Get Started</a></p>	<p></p> <p><b>Attest to Payment and Terms</b></p> <p>Not Available Yet</p> <p>Once payment has been issued, you will be able to attest to fund distribution.</p>
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## Save your documentation

In the case of an audit, you want to be prepared to justify how you completed the application. Please save copies of the official worksheets and forms you upload, the list of reports from the **Get Reports and Data** section above, as well as your “scratch pages” in which you made computations and adjustments.

## Other Q&A:

### How much money will I get?

We expect practices will get about 2% of their gross patient care revenues received in their Reference Year. **Note that this is not 2% of only Medicaid/CHIP revenue.** CMS has indicated that practices will get the lesser of a) the sum of their estimated losses and their increased expenses, or b) 2% of their gross patient care revenue.

In almost every case, practices lost much more than 2% of their gross revenue. Because CMS is granting the lesser of the two, practices will likely get 2% of their gross revenue rather than actual losses.

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## EXAMPLE

Pediatric Partners grosses \$1,000,000 in patient care revenue in a typical year. Their March revenue decreased by 20% and their April revenue decreased by 60%. They also spent

\$10,000 in COVID-related expenses (pricey PPE, an outside triage tent, and laptops for staff to work from home).

	typical year	2020	loss
January	100,000	100,000	
February	95,000	95,000	
March	90,000	72,000	-18,000
April	80,000	32,000	-48,000
May	60,000		
June	50,000		
July	70,000		
August	80,000		
September	90,000		
October	90,000		
November	95,000		
December	100,000		

Pediatric Partners' reduced revenue for March and April is \$66,000. Adding in the \$10,000 for increased COVID expenses, their total loss and extra expenses comes to \$76,000.

This is much more than 2% of \$1,000,000, which is \$20,000. Pediatric Partners can expect about \$20,000 from the Medicaid support fund.

Because actual losses will almost always exceed 2%, it's not a good use of the practice's time to log every last dollar spent on actual losses. That is to say, Pediatric Partners could keep spending time looking for lost revenue. They might even be able to justify raising their total losses from \$76,000 to \$85,000, but it will not increase their payment from the Medicaid distribution.

On the other hand, practices who can document that their actual losses (from reduced revenue and increased expenses) definitely exceed 2% of their patient-care receipts can be confident that they will easily meet the Terms and Conditions of the grant.

Again, according to The FAQ, "providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment, that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment."

## How will I get the money?

Most providers will receive money through EFT (bank transfer). You enter this information in Questions 33-36 of your application.

## What is the deadline for my submission?

July 20, 2020. (From The FAQ.)

## Do I have to apply?

Yes and no:

- No, in the sense that this is an optional program, and in the sense that some practices are ineligible to apply.
- Yes, if you want to get money. Unlike the first distribution of Medicare payments, which CMS sent to providers whether they requested them or not, this money is distributed only after an application is submitted successfully.

## Do I have to pay this money back? Is it an advance?

This money is a grant. It does not need to be repaid. It is not an advance on future-earned funds. You do have to agree to the Terms and Conditions.

## Is this grant taxable?

Yes.

## If I got a PPP loan/EIDL loan/EIDL grant, can I still apply?

Yes. SBA programs for coronavirus relief (Paycheck Protection Program, Economic Impact Disaster Loan) do not make you ineligible for this program. You do need to report funds you've received from these programs in your application in Question 25.

## What if I changed practices?

Note that, other than clinicians who are sole proprietors (i.e., who billed Medicaid using their Social Security Numbers and filed their business revenue under IRS Schedule C), it is only practices, not clinicians, who can apply. That is, four clinicians in one group practice can only apply once as a practice, not four times individually. The legal right to apply for monies rests with the owner(s) of the tax ID in question on January 31, 2020.

## What if I changed practice management systems halfway through the reporting year?

A practice may have left EMR system “A” in August 2018 and started on EMR system “B” that same month. Assuming that their practice’s last filed income tax return was in 2018, the practice needs to report revenue by payer for 2018. This may be very difficult for practices who switched EMR systems who can no longer get financial data out of their old systems.

The practice may have recorded the payer of deposits in its accounting system (e.g., Quickbooks.) If not, one strategy would be to obtain 12 months of bank statements for 2018 and review the deposits. Insurance EFTs are usually labeled by the depositor and easily classified into payer type:

05-19	Preauthorized Credit UNITEDHEALTHCARE HCCLAIMPMT 1	453.13
05-19	Preauthorized Credit Amerigroup TN5C HCCLAIMPMT 597\	803.32
05-19	Preauthorized Credit VSHP VOL II FUND SPLTYPYMT	7,309.80
05-20	Preauthorized Credit CIGNA HCCLAIMPMT	98.77
05-20	Preauthorized Credit InstaMed PLATEAU PE	120.91
05-20	Preauthorized Credit MERCHANT SERVICE MERCH DEP 2	350.00
05-20	Preauthorized Credit CIGNA EDGE TRANS HCCLAIMPMT	614.46

It is more difficult to determine payer type for deposits of patient cost share: cash, checks, and credit cards. However, typically practices have extremely low cost share for Medicaid and CHIP plans, with the vast majority (90%+) of cost share being paid by commercial plans, with smaller amounts in the government and self-pay categories.

If you use an alternative method like this to compute your percentages by payer for Questions 17-24, save and document your method in case you need to explain it later.

## What can I spend this grant money on?

The Terms and Conditions state that you, 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.*
- *...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 HHS FAQ has a great answer found at

<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html#terms-conditions>  
under this question:

**The Terms and Conditions state that Provider Relief Fund payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the Recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus. What expenses or lost revenues are considered eligible for reimbursement?**

In particular, this part of the answer suggests that there's no end date to when you can use the funds:

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus.

Providers who are concerned about “double dipping” (i.e. using this money for purposes that have already been covered by the PPP act or an SBA loan) can be assured that they can use the revenue for any unreimbursed COVID-related expenses that arise. It may be helpful to create an expense category or class in your accounting software with which you can tag all these items.

The FAQ also clearly permits application of funds more generally to cover lost revenue:

Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover...