



CARES Act Provider Relief Fund – Medicaid, CHIP & Dental Distribution

***NEW** The application deadline for both non-Medicaid and Medicaid/CHIP providers has been extended to August 3, 2020.

Dental Distribution (Non-Medicaid Providers)

On July 10, The U.S. Department of Health & Human Services (HHS) announced that the CARES Act Provider Relief Fund application would expand to include eligible, non-Medicaid dentists. 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.

To be eligible to apply for the dental distribution relief funds, a dental provider must meet all of the following requirements AND must attest to the associated [Terms and Conditions](#):

1. must not have received payment from the initial \$50 billion Medicare-focused General Distribution; and
1. must not have received payment from the \$15 billion Medicaid and CHIP Distribution; and
2. 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
3. must have provided patient dental care after January 31, 2020; and
4. must not have permanently ceased providing patient dental care directly, or indirectly through included subsidiaries; and
5. if the applicant is an individual, have gross receipts or sales from providing patient dental care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

If you are concerned you were not on the curated provider list, please ensure you have an active, verifiable dental provider TIN and submit your information to the Provider Relief Fund application portal. Any eligible dental providers not on the curated list will undergo additional review and if validated will be permitted to apply for funding.

HHS published a series of [FAQ's](#) on the Provider Relief Fund's dental distribution.



Medicaid and CHIP Provider Distribution

HHS is distributing Provider Relief Funds to assist providers and clinicians who treat our most vulnerable populations, including low-income and minority patients. Providers that participate in state Medicaid/CHIP programs or Medicaid managed care plans and have not yet received a payment from the Provider Relief Fund General Distribution may be eligible for Medicaid and CHIP Provider Distribution funds.

To be eligible to apply for the Medicaid/CHIP relief funds, a dental provider must meet all of the following requirements AND must attest to the associated [Terms and Conditions](#):

1. Received no payment from the \$50 billion General Distribution to Medicare providers
2. Billed Medicaid/CHIP programs or Medicaid managed care plans for health care-related services between Jan. 1, 2018 – Dec. 31, 2019
3. Filed a federal income tax return for fiscal years 2017, 2018 or 2019; or be exempt from filing a return
4. Provided patient care after January 31, 2020
5. Not permanently ceased providing patient care directly, or indirectly
6. Reported on Form 1040 (or other tax form) gross receipts or sales from providing patient care

An HHS fact sheet for Medicaid and CHIP Providers overviewing provider eligibility, uses of funds, attestation requirements, and other important information can be found [HERE](#).

You may find many answers to your questions by reviewing the HHS [Medicaid and CHIP Provider FAQs](#).

General Information/Resources – ALL PROVIDERS

Eligible providers will receive a reimbursement of two percent of their annual reported patient care revenue. It is suggested to review all pertinent information on the [HHS Provider Relief Fund](#) website.

Many resources, guidance and specific information can be found on the HHS Provider Relief Fund, [Page for Providers](#), including:

- [Instructions for the Medicaid/CHIP and Dental Application – PDF](#)
- [Enhanced Provider Relief Payment Portal](#) (Apply for/attest to funds, agree to Terms and Conditions and more)
- [FAQs](#)

Clarification Regarding Terms and Conditions

Providers must agree to the [Terms and Conditions](#) in the [Enhanced Provider Relief Payment Portal](#) within 90 days of receiving payment. If a provider chooses not to accept the Terms and Conditions, all



funds must be returned. If no attestation is made within the portal after 90 days, it will be assumed that the provider has accepted all Terms and Conditions.

One of the terms and conditions states a provider must have, "provided, on or after Jan. 31, 2020, diagnosis, testing or care for actual or possible COVID-19 patients." (p. 1) To clarify this requirement, HHS specified the following:

Unless the payment is associated with specific claims for reimbursement for COVID-19 testing or treatment provided on or after February 4, 2020 to uninsured patients, under the Terms and Conditions associated with payment, providers are eligible only if they provide or provided after January 31, 2020, diagnoses, testing or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.

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

The only time "presumptive" is used in the Terms and Conditions is with the following term:

"The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient." (p. 2-3)

Therefore, the above term related to balance billing is only applicable for an out-of-network patient who is a presumptive or actual case of COVID-19 as defined by HHS and with supporting medical record documentation. If the patient does not fit this definition, the provider may collect all applicable out-of-network expenses, including those greater than what the patient would pay in-network.

If the patient does meet the definition of a presumptive or actual case of COVID-19 as defined by HHS:

Providers accepting the Provider Relief Fund payment should submit a claim to the patient's health insurer for their services. Most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer's prevailing in-network rate. If the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.



Should providers choose to accept new, out-of-network patients, we recommend documenting all applicable information of the patient including any appropriate medical records. HHS will provide information related to the audit of Provider Relief Funds, so it is important to keep record of eligible expenses and proof of abiding by all Terms and Conditions.

Funds may be used for as long as providers need to cover permissible expenses (i.e. if the pandemic ends and the provider still has remaining funds, HHS will issue guidance for returning these funds.)

If you have general questions or inquiries related to this information, you may contact advocacy@agd.org or call the HHS Provider Support Line at (866) 569 -3522.