ALSTON & BIRD

COVID-19 Provider Relief Fund – Distributions to Date and Upcoming Disbursements

The Provider Relief Fund (PRF) was established through the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* (enacted March 27, 2020). Pursuant to the CARES Act, $100 billion in grants will be disbursed from the Office of the Assistant Secretary for Preparedness and Response (ASPR) Public Health and Social Services Emergency Fund (PHSSEF). The *Paycheck Protection Program and Health Care Enhancement Act* (PPPHCEA) (enacted April 24, 2020), added $75 billion to the PRF, totaling $175 billion. General information on the PRF, including eligibility requirements, Terms and Conditions, and relevant attestation and data submission portals, is available here.

On July 20, 2020, HHS released a Notice of Reporting Requirement. All PRF recipients will be required to report within 45 days of the end of calendar year 2020 on expenditures through December 31, 2020 via a reporting system that will open on October 1, 2020. Recipients with funds unexpended by December 31, 2020 must submit a "second and final report" no later than July 31, 2021. According to an HHS update, detailed instructions will "soon be made available."

On July 31, 2020, HHS announced that the Medicare General Distribution will be reopened the week of August 10 for: (1) eligible providers that did not apply for Round 2 payment; and (2) providers that experienced a change in ownership in 2020. On August 10, 2020, HHS announced a "Phase 2 General Distribution", which is open for eligible Medicaid, CHIP, dental, and certain Phase 1 General Distribution providers.

On August 7, 2020, HHS announced the intended allocation methodology for the $5 billion nursing home distribution.

On August 14, 2020, HHS announced a $1.4 billion a third Safety Net Hospital Targeted Distribution to certain children's hospitals.

Overall, the distributions fall under the following categories as of August 23, 2020 (updates from the prior version are highlighted)[1]:

1. **Phase 2 General Distribution to Medicaid/CHIP/Dental/Phase 1 Providers** – $15 billion[2]
2. **Targeted Allocations**
    a. **Treatment for Uninsured** – portion of remaining $53.414 billion plus $1 billion[3]
    b. **Safety Net Hospitals (Round 3)** – $1.4 billion
    c. **COVID-19 High Impact Areas (Round 2)** – $10 billion total

[1] Funding opportunities that are no longer available are italicized. These distributions are grayed out in the table below.
[2] HHS has reframed this distribution as a Phase 2 General Distribution.
[3] The *Families First Coronavirus Response Act* (enacted March 18, 2020) appropriated $1 billion for COVID-19 testing and related visits for the uninsured. While this is separate from the PRF, HRSA, the administering agency, will distribute these funds through the same HRSA portal (here) and methodology.

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d. **Nursing Homes** – $5 billion
e. ***Safety Net Hospitals*** *– $10.213 billion*[4]
f. ***Safety Net Hospitals (Round 2)*** *– $3 billion*
g. ***COVID-19 High Impact Areas (Round 1)*** *– $12 billion total*[5]
h. ***Rural Providers*** *– $10 billion*
i. ***Rural Providers (Round 2)*** *– $1 billion*
j. ***Indian Health Service (IHS)*** *– $500 million*
k. ***Skilled Nursing Facilities (SNFs)*** *– $4.873 billion*

3. ***Phase 1 General Distribution to Medicare Facilities and Providers*** *– $50 billion total*[6]

For additional details, please view the HHS Provider Relief Fund FAQs (here) (***last updated through 8/18/2020***).

PRF Attestations

This dataset lists providers who have attested to receiving one or more payments from the Phase 1 (and eventually Phase 2) General Distributions and High Impact Area, Safety Net Hospital, Rural Provider, IHS, and SNF Targeted Distributions ($116.586 billion total). This currently does not include the expected $5 billion distribution to nursing homes.

Date	Amount Attested To
5/13/2020	$34.09 billion
5/29/2020	$45.874 billion
6/1/2020	$48.518 billion
6/3/2020	$49.875 billion
6/10/2020	$52.983 billion
6/18/2020	$54.769 billion
6/22/2020	$56.606 billion
6/25/2020	$57.154 billion
6/29/2020	$59.115 billion

[4] The Safety Net Hospital distribution state-by-state breakdown is available here (***last updated 6/11/2020***).
[5] Initially $10 billion, HHS added $2 billion that will be distributed to the eligible hospitals based on Medicare and Medicaid disproportionate share and uncompensated care payments.
[6] HHS released a CARES Act PRF Distribution Summary, available here.

Date	Amount Attested To
7/1/2020	$60.035 billion
7/6/2020	$60.720 billion
7/8/2020	$61.206 billion
7/14/2020	$62.275 billion
7/20/2020	$64.135 billion
7/27/2020	$66.971 billion
8/5/2020	$72.723 billion
8/10/2020	$73.546 billion
8/17/2020	$74.665 billion

Uninsured Treatment and Testing Claims Reimbursement

This dataset lists the health care entities that have agreed to the Terms and Conditions and received reimbursement for COVID-19 testing and/or COVID-19 treatment for uninsured individuals.

Date	Treatment Claims Paid	Testing Claims Paid
5/26/2020	$2.08 million	$2.04 million
6/2/2020	$81.963 million	$10.839 million
6/12/2020	$130.030 million	$23.605 million
6/18/2020	$154.975 million	$31.569 million
6/26/2020	$171.176 million	$36.970 million
7/1/2020	$201.648 million	$48.997 million
7/10/2020	$265.464 million	$82.607 million
7/15/2020	$288.336 million	$93.476 million
7/23/2020	$309.612 million	$109.490 million
7/29/2020	$348.329 million	$137.203 million
8/5/2020	$382.410 million	$167.670 million
8/12/2020	$407.971 million	$194.826 million
8/19/2020	$470.100 million	$235.501 million

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Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
Phase 2 General Distribution ($15 billion)[7]	Eligible entity types: • Must have either (i) directly billed their state Medicaid/CHIP programs or Medicaid managed care plans for health care-related services during the period of January 1, 2018, to December 31, 2019; or (ii) own (on the application date) an included subsidiary that meets this requirement; **or** • Must be a dental service provider who has either (i) directly billed health insurance companies for oral health care-related services, or (ii) owns (on the application date) an included subsidiary that meets this requirement; **or** • Must be a licensed dental service provider who does not accept insurance and has either (i) directly billed patients for oral health care-related services, or (ii) who	• Providers may receive a payment up to a total of 2% of reported revenue from patient care • Payments will be made to the Filing/Organizational TIN and not directly to subsidiary TINs • Payments will be disbursed on a rolling basis as information is validated (HHS may seek additional information from providers as necessary) • The majority of payments will be made through bank transfer and may require some providers to set up ACH accounts	• **The deadline to apply has been extended to 8/28/2020[8]** • The application portal is available here • Application instructions are available here • The application form is available here • Applicants must provide: ○ Most recent federal income tax return (2017, 2018, or 2019) or a written statement explaining why it is exempt ○ If required by Field 15, the applicant's Gross Revenue Worksheet (here) • If a provider does not have a federal tax form to submit, it must upload a statement explaining why and submit the most recent audited financial statements • Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

[7] HHS is held webinars on the original (i.e., Medicaid/CHIP/Dental provider) application process on June 23 at 2PM ET, June 25 at 2PM ET, and July 8 at 4PM ET (a recording is available here). HHS held a webinar on the Phase 2 General Distribution application process on August 13 at 3pm ET.

[8] HHS announced this extension on July 31.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
	owns (on the application date) an included subsidiary that meets this requirement; • Must have billed Medicare fee-for-service during the period of January 1, 2019 and December 31, 2019; **or** • Must be a Medicare Part A provider that experienced a change in ownership and billed Medicare fee-for-service in 2019 and 2020 that prevented the otherwise eligible provider from receiving a Phase 1 General Distribution payment. In addition, eligible entities: • Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 or (ii) be a tax-exempt entity and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or health care clinic); **and** • Must have provided patient care after January 31, 2020; **and**		

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
	• Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; **and** • Must not have received a Phase 1 General Distribution payment totaling 2% of annual patient revenue; **and** • If the applicant is an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.		
Uninsured (portion of remaining $52.014 billion plus $1 billion)	Every health care provider who has tested, provided testing-related visits, and provided treatment for uninsured COVID-19 patients after February 4	• Based on requested claims reimbursement • Will be reimbursed at Medicare rates (subject to available funding) • Payment disbursed via direct deposit • Qualifying COVID-19 testing and treatment services (when COVID-19 is the primary diagnosis) include: ○ Specimen collection, diagnostic, and antibody testing ○ Testing-related visits in the following settings: office, urgent care, emergency room, or via telehealth	• Providers can register for this program **on April 27** (here) and begin submitting claims in May • The provider portal is available (here) • HRSA released FAQs (here) • Providers will have to: ○ Enroll as a participant ○ Check patient eligibility and benefits ○ Submit patient information ○ Submit claims ○ Attest to Terms and Conditions for Testing and Treatment

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
		○ Treatment[9] ○ FDA-approved vaccine (when available)	
Safety Net Hospitals ($1.4 billion)	Free-standing children's hospitals that are either: • IPPS-exempt; or • HRSA-defined Children's Hospital Graduate Medical Education facility[10] Eligibility determined by the most recent CMS cost report	• 2.5% of net patient revenue ○ Minimum $5 million and maximum $50 million payments • Payment amount determined by Worksheet G-3, line 3 • For hospitals that do not file cost reports, net patient revenue calculated from tax information and audited financial statements • Funds distributed as early as the week of August 17	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)
COVID-19 High Impact Areas – Round 2 ($10 billion)	• Hospitals: ○ With more than 161 COVID-19-positive inpatient admissions between 1/1/2020 through 6/10/2020; or ○ With one admission per day; or	• Hospitals paid $50,000 per eligible admission • Funding from the prior round ($76,975 per eligible admission) were taken into account when determining each hospital's payment from this distribution	• Upload COVID-19-positive inpatient admissions using the CSV document via the TeleTracking portal • **Information must be submitted by 9PM ET on 6/15/2020** • Within 90 days of receipt of payment, acknowledge receipt and attest to

[9] According to HRSA, treatment is defined as: office visit (including via telehealth); emergency room; inpatient; outpatient/observation; skilled nursing facility: long-term acute care; acute inpatient rehab; home health; durable medical equipment (e.g., oxygen, ventilator); emergency ambulance transportation (any type); non-emergent patient transfers via ambulance; and FDA approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay.
Services **not** covered include: services not covered by traditional Medicare; any treatment without a COVID-19 primary diagnosis (except for pregnancy when the COVID-19 code may be listed as secondary); hospice services; outpatient prescription drugs.
[10] Preliminary state-by-state breakdown (reflecting 56 hospitals receiving $1.009 billion) is available here.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
	○ That experienced a "disproportionate intensity of COVID admissions (exceeding the average ratio of COVID admissions/bed)"[11] • Recipients of the first High Impact Area distribution are still eligible for this new distribution		Terms and Conditions at the "Attestation Portal" (here)
Nursing Homes ($5 billion)	Medicare-certified long-term care facilities and state veterans' homes (nursing homes)	• $2.5 billion upfront to support increased testing, staffing, and PPE needs ○ Expected to be distributed in mid-August • Funding for COVID isolation facilities • Performance-based distributions that will consider COVID-19 prevalence in the local geography, and recipient's ability to minimize spread and COVID-19-related fatalities among residents ○ Expected to occur throughout the fall	• Nursing homes must participate in the Nursing Home COVID-19 Training to be qualified to receive this funding ○ Nursing homes in states with a 5% positivity rate or greater will be required to test all nursing home staff each week ○ Training will be available to all 15,400 nursing homes nationwide and more than 15,000 testing devices will be deployed to help support the mandate • Attestation requirements TBD
Phase 1 General	*Note: HHS will reopen this distribution the week of August 10 for certain providers that did not apply to Round 2 and those that were unable to access this distribution due to a change in ownership in 2020. Eligible providers will have to apply for this distribution by August 28.[12] See "Phase 2 General Distribution" row.*		

[11] Updated state-by-state breakdown available here; list of Round 2 recipients available here.
[12] HHS announced this on July 31.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
Distribution ($50 billion)	In general • Medicare facilities and providers impacted by COVID-19	In general • All payments are made to the billing organization according to its Taxpayer ID Number (TIN)	In general • Within 90[13] days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here) • Providers who have already received payments will need to upload their most recent IRS tax filings as well as estimates of lost revenues for March and April 2020 at the "Revenue Information Portal" (here) • See the Revenue Information Portal User Guide and General Distribution FAQs for additional information
	$30 billion • All facilities and providers that received Medicare FFS reimbursements in 2019	$30 billion • Based on share of total Medicare FFS payments in 2019 • Distributed via automatic payments or mail ($26 billion distributed on April 10, $4 billion on April 17)	$30 billion • Acknowledge receipt of payment and attest to Terms and Conditions (specific to the $30 billion) (here) • This step must be completed before moving on to the Revenue Information Portal
	$20 billion • It appears that all facilities and providers eligible to receive the initial $30 billion will be eligible for this distribution	$20 billion • Allocated to ensure entire $50 billion General Distribution is allocated proportional to recipients' share of 2018 net patient revenue[14]	$20 billion • All providers must submit revenue information, acknowledge receipt of payment, and attest to Terms and Conditions (specific to the $20 billion)

[13] HHS extended the deadline from 30 days to 90 days on May 22.

[14] HHS indicated that moving to an overall revenue model should address concerns from providers in high Medicare Advantage penetration areas. The expected distribution methodology is as follows: (Gross Receipts or Sales/$2.5 Trillion) X $50 Billion = Expected Combined General Distribution

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
		• Some providers (those with adequate cost report data) will receive automatic payments • Payments started to go out on April 24 and will continue on a weekly, rolling basis based on provider submissions and data validation	• Eligible providers may request payments and providers who received automatic payments must submit the required information through the Revenue Information Portal (here) • Revenue information must be submitted by June 3, 2020 to be eligible for this payment
Safety Net Hospitals ($10.213 billion)	Acute care facilities and children's hospitals must meet each of the following criteria, respectively. The information was extracted from CMS Hospital Cost Reports and Provider Specific Files. Acute care facilities: • A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater; • Annual uncompensated care per bed of at least $25,000;[15] and • Net Operating Margin of 3% or less Children's hospitals: • Medicare DPP of 20.2% or greater; and	• Payments will begin the week of 6/8 • Eligible hospitals will receive a minimum of $5 million and a maximum of $50 million Methodology: • HHS determined each acute care facility's bed-weighted DPP score by performing the following calculation: *Acute Care DPP Score X Number of facility beds* • HHS determined each children's hospital's bed-weighted Medicaid Only Days score by performing a similar calculation: *Medicaid Only Ratio X Number of facility beds* • Each acute care facility or children's hospital's individual score was expressed as a percentage of the total sum of bed-weighted facility DPP scores and Medicaid Only ratios	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

[15] For example, a hospital with 100 beds would need to provide $2,500,000 in Uncompensated Care in a year to meet this requirement.

<table>
<tr><th>Distribution</th><th>Eligible Entities</th><th>Distribution Methodology</th><th>Required Provider Action</th></tr>
<tr><td></td><td>• Net Operating Margin of 3.0% or less

Hospitals no longer operational or without 2018 cost report information are not eligible</td><td>• This percentage was multiplied by $10 billion

Definitions and Data Sources – Medicare Cost Report:<table>
<tr><td>DPP</td><td>W/S E Part A Line 32, Column 1</td></tr>
<tr><td>UCC</td><td>W/S S-10, Line 30, Column 1</td></tr>
<tr><td>Hospital Beds</td><td>W/S S-3 Part I, Line 14, Column 2</td></tr>
<tr><td>Net Patient Revenue</td><td>W/S G-3, Line 3, Column 1</td></tr>
<tr><td>Total Other Income</td><td>W/S G-3, Line 25, Column 1</td></tr>
<tr><td>Total Revenue</td><td>Net Patient Revenue + Total Other Income</td></tr>
<tr><td>Net Income</td><td>W/S G-3, Line 29, Column 1</td></tr>
<tr><td>Profit Margin</td><td>Net Income / Total Revenue</td></tr>
<tr><td>Medicaid-Only Days</td><td>Worksheet S-3, Part I, Column 7, Line 14, plus Line 2 and Line 32, minus the sum of Lines 5 and 6</td></tr>
<tr><td>Total Days</td><td>Worksheet S-3, Part I, Column 8, Line 14; plus Line 32; minus the sum of Lines 5 and 6; plus</td></tr>
</table></td><td></td></tr>
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Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
		employee discount days reported on Line 30 Medicaid-Only Ratio: Medicaid Only Days / Total Days	
Safety Net Hospitals ($3 billion)	Revised profitability threshold for acute care facilities (the other requirements remain the same): • Less than 3% averaged consecutively over two or more of the last five cost reporting periods HHS expects 215 acute care facilities will receive payment.[16]	• HHS used the same formula for determining payments • For newly eligible entities, HHS used the acute care facility's last two to five Medicare Cost Report filings to determine eligibility based on profit margin and the latest Medicare Cost Report to determine annualized UCC per bed and Medicare DPP	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)
COVID-19 High Impact Areas – Round 1 ($12 billion)	• 395 hospitals that provided inpatient care for 100 or more COVID-19 patients through April 10, 2020	• $10 billion distributed to the eligible entities based on a fixed amount per COVID-19 inpatient admission[17] ○ 395 hospitals received $76,975 per COVID-19 admission • $2 billion distributed to these hospitals in proportion of each facility's share of Medicare Disproportionate Share funding • Distributions began May 7[18]	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here) • Providers should update their capacity and COVID-19 census data and can use the "same method they used previously" to update this information[19]

[16] A state-by-state breakdown is available here.

[17] Hospitals were required to submit information via an authentication portal before 3pm ET on April 25. Hospitals were required to provide: TIN; National Provider Identifier; the total number of ICU beds as of April 10, and the total number of COVID-19 positive admissions from January 1 to April 10.

[18] A state and county breakdown is available here.

[19] In an FAQ modified 5/19, HHS states: *Providers should update their capacity and COVID-19 census data to ensure that HHS can make timely payments in the event that the provider becomes a high-impact provider. Providers can continue to update their information through the same method they used previously.*

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
Rural Providers ($10 billion)	• Rural acute care general hospitals • Critical Access Hospitals (CAHs) • Rural Health Clinics (RHCs) • Rural Community Health Centers (CHCs) • Must be located in in a rural location defined as: ○ All non-Metro counties ○ All Census Tracts within a Metro county that have a Rural-Urban Commuting Area (RUCA) code of 4-10 ○ 132 large area Census Tracts with RUCA codes 2 or 3 ○ Independent RHCs – Census Bureau definition ○ CAHs – all designated CAHs • Facilities were identified from the December 2019 CMS Provider of Services file	*Per Hospital Allocation = Graduated Base Payment + (1.97% X Operating Expenses)* • Graduated base payment (minimum $1 million) = (50% of first $2 million of expenses) + (40% of next $2 million) + (30% of next $2 million) + (20% of next $2 million) + (10% of next $2 million) • Provider-based RHCs (i.e., connected with rural hospitals) have allocation included with the hospital's allocation *Per Independent RHC Allocation = $100k + (3.6% X Operating Expenses)* *Per FQHC Allocation = $100k per site* Payments were multiplied by a modifier to ensure the total value of distributions equaled $10 billion.[20] Distributions began May 6 based on the facility's physical address as reported to CMS and HRSA, regardless of affiliation with urban-area organizations[21]	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

[20] See the payment allocation methodology for more details.
[21] A state-by-state breakdown is available here (pages 5-6).

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
Rural Providers ($1 billion)	Hospitals with certain rural Medicare designations • Sole Community Hospitals (SCHs) • Medicare Dependent Hospitals (MDH) • Rural Referral Centers (RRCs) 10 isolated urban hospitals • 40 or more miles away from another hospital open to the public Small Metropolitan area hospitals • Without a special Medicare designation • In metro areas with less than 250,000 people as identified by the county-level Rural-Urban Continuum Codes Rural specialty hospitals • Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Acute Care Hospitals (LTACHs) • Must meet be in a location that meets the following rural definition: ○ All non-Metro counties	SCHs, MDHs, and RRCs • Payment based on 1% of operating expenses (calculated based on the most recent Medicare Cost Report) plus a supplement of $50 per rural inpatient day • Payments range from $100,000 to $4.5 million Isolated Urban Hospitals • Supplemental payment of $1 million • Inpatient days provided to rural residents estimated by the proportion of patient days attributed to Medicare patients from rural zip codes from the 2018 Hospital Service Area File multiplied by the total number of patient days reported in the Medicare Cost Report Small Metro area hospitals without a special Medicare designation • Payment based on 1% of operating expenses (calculated based on the most recent Medicare Cost Report) • Payments range from $100,000 to $2 million Rural IPFs, IRFs, and LTACHs • Used previous methodology adjusted for rural patient share (calculated as	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
	○ All Census Tracts 1 within a Metropolitan county with a RUCA code of 4-10 ○ 132 large area census tracts with RUCA codes 2 or 3 HHS expects nearly 500 providers will receive payment.[22]	percent of inpatient days provided to rural patients from the Hospital Service Area File) ○ Graduated base payment + approximately 2% of operating expenses (determined by the most recent Medicare Cost Report) • Payments range from $100,000 to $4.5 million	
IHS ($500 million)	• IHS and tribal hospitals, clinics, and urban health centers • Allocations determined based on December 2019 Provider of Service Files, 1/17/2020 HCRIS, and Worksheet B PART I COL 26 of the cost report	• Payments distributed via ACH through Optum Bank to central billing office based on billing organization's TIN • **IHS and tribal hospitals:** $2.81 million base payment plus 3% of total operating expenses • **IHS and tribal clinics and programs:** $187,000 base payment plus 5% of estimated service population multiplied by average cost per user • **IHS urban programs:** $181,000 base payment plus 6% of estimated service population multiplied by average cost per user • **Estimated operating cost per person:** $3,943 (based on actual IHS spending per user from 2019 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita report)	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

[22] A state-by-state breakdown is available here.

Distribution	Eligible Entities	Distribution Methodology	Required Provider Action
SNFs ($4.873 billion)	• All certified SNFs with six or more certified beds are eligible (more than 13,000 SNFs) • State-by-state breakdown available here	• $50,000 fixed distribution per SNF; $2,500 distribution per bed • Distributions ranged from $65,000 to $3,255,500; average distribution of approximately $315,600 per SNF • Payments distributed electronically based on banking account information associated with billing TIN (or paper check)	• Within 90 days of receipt of payment, acknowledge receipt and attest to Terms and Conditions at the "Attestation Portal" (here)

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