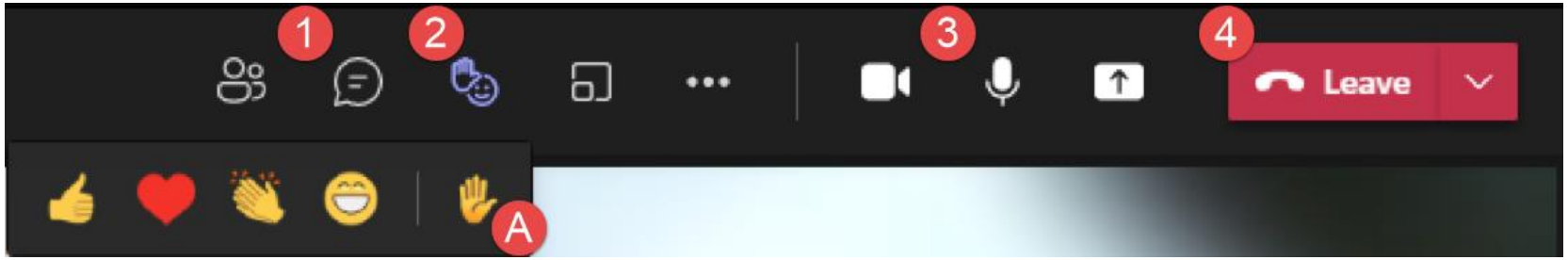
Welcome! The COVID Update: ARP Funding & HHS PRF Reporting Update will begin momentarily.



Overview of Teams Meetings (connecting via PC is preferred)

1. Chat – use the chat to ask a question
2. If you have been muted, you can request an unmute by clicking the Raise Hand
3. You can mute/unmute using the mic icon
4. You can leave the meeting by clicking the Leave button

If you have issues during the meeting, please send a message to ahiggins@shpllc.com

This meeting will be recorded.

SHP
Strategic Healthcare Partners

HHS Provider Relief Fund Future Payments Walkthrough

HHS PRF Reporting Reminder

- Reminder……HHS PRF Reporting is due September 30, 2021
  - PRF recipients are required to report for each “payment received period” in which they received one or more payments exceeding, in the aggregate, $10,000 (rather than $10,000 cumulatively across all PRF payments).
- HHS has announced reporting grace period
  - Although the U.S. Department of Health and Human Services (HHS) deadline to report on payments received between April 10 and June 30, 2020, is still officially September 30, 2021, HHS recently announced that it would not seek recoupment or initiate enforcement actions for noncompliance until November 30, 2021.

HHS Future Payments

- Total Funding Opportunities: $25.5B
  - ***CARES Act Phase 4 General Distribution: $17B available***
    - Broad range of providers with changes in operating revenues and expenses.
  - ***American Rescue Plan Rural Relief Distribution: $8.5B***
    - Providers who serve rural patients covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)
- Application Cycle:
  - Application Cycle Opens on September 29, 2021
  - ***Applications Must Be Submitted by October 26 at 11:59 P.M. ET.***
- Where to Apply:
  - Applications will be submitted through HRSA's Provider Relief Fund Application & Attestation Portal
    - https://cares.linkhealth.com/#/
  - Most providers will have an active account for this portal; through previous PRF Attestations or Phase 3 Application Cycle but if your have not logged in for more than 90 days, you will need to first reset their password before starting a new application.
- In order to streamline the application process and minimize administrative burdens, providers will apply for both programs in a single application and HRSA will use existing Medicaid, CHIP, and Medicare claims data in calculating portions of these payments.

HHS Phase 4 General Distribution

- $17 billion based on providers' changes in operating revenues and expenses from ***July 1, 2020 to March 31, 2021***.
- To promote equity and to support providers with the most need, HRSA will:
  - ***Reimburse smaller providers for changes in operating revenues and expenditures at a higher percentage compared to larger providers.***
  - ***Provide "bonus" payments based on the amount of services they provide to Medicaid, CHIP, and Medicare patients, priced at the generally higher Medicare rates.***

How Will Phase 4 Payments Be Calculated?

- **75% of the Phase 4 allocation will be calculated based on changes in operating revenues and expenses:**
  - Large providers will receive a minimum payment amount that is based on a percentage of their changes in operating revenues and expenses.
  - Medium and small providers will receive a base payment plus a supplement, with small providers receiving the highest supplement, as smaller providers tend to operate on thin margins and often serve vulnerable or isolated communities.
  - HHS will determine the exact amount of the base payments and supplements after analyzing data from all the applications received to ensure they stay within their budget and funds are distributed equitably.
  - No provider will receive a Phase 4 payment that exceeds 100% of their losses and expenses
  - ***Key Remaining Questions:***
    - ***How will HHS define Large vs. Medium/Small Providers?***
    - ***What is the calculation to translate changes in revenue/expenses for the 9 month period into funding?***

How Will Phase 4 Payments Be Calculated?

- **25% of the Phase 4 allocation will be put towards bonus payments that are based on the amount and type of services provided to Medicaid, CHIP, and Medicare patients.**
  - HHS will price Medicaid and CHIP claims data at Medicare rates, with some limited exceptions for some services provided predominantly in Medicaid and CHIP.
  - Some remaining questions:
    - ***For Hospitals, cost based Medicaid is many times higher than Medicare, no additional reimbursement?***
    - ***What is the definition of services "provided predominantly in Medicaid"? Will this harm pediatricians/OB?***

How Will Phase 4 Payments Be Calculated?

- **Step 1: Calculating Base Payment**
  - After the payment adjustments are calculated, HRSA will calculate the ***Base Payment, which is a percentage of a provider's change in quarterly operating revenues and expenses.*** Provider size categories (Small, Medium, and Large) will be based on annual net patient care revenues, and will be established after the close of the Phase 4 application and any payment adjustments are made.
    - Large providers will receive a Base Payment amount that is X%* of the change in their operating revenues and expenses summed across all three quarters (after payment adjustments have been considered). For example, in Phase 3, that amount was 88 percent.
    - Base Payments for medium and small providers will include X% of the change in their quarterly operating revenues and expenses (after payment adjustments have been considered) plus a supplement payment equivalent to an additional percentage (to be determined) of the sum of their change in revenues and expenses for the three quarters, ***with small providers receiving the greatest amount.***
  - No provider will receive a Base Payment that exceeds 100% of their change in quarterly operating revenues and expenses.
  - ** Percentage will be determined after analysis of applicants received during the application period.*
  - **Base Payment for New Applicants:** New applicants are defined as having no TINs, including at the subsidiary level, that have received a General Distribution payment in any of the previous three phases or a Targeted Distribution payment. ***New applicants will receive a payment that is the greater of:***
    - ***2% of Annual Net Patient Care Revenues, or***
    - ***Their calculated Base Payment.***
- **Step 2: Deductions of Prior PRF Payments From Base Payments**
  - HRSA will deduct prior Provider Relief Fund payments that were not previously deducted in Phase 3. This will allow providers that have never benefitted from the Provider Relief Fund to receive greater financial support.

How Will Phase 4 Payments Be Calculated?

- **Step 3: Calculating Bonus Payments**
- Approximately 25% of the Phase 4 funding will be used to make Bonus Payments to providers based on Medicare, Medicaid, and CHIP administrative claims data from January 1, 2019 through September 30, 2020.
  - ***To reduce administrative burden and streamline application processing, providers will not provide claims data in the application. HRSA will use data to which it already has access.***
- ***HRSA will price Medicaid and CHIP claims data at Medicare rates, in order to promote equity between Medicare and Medicaid/CHIP reimbursement rates.*** There will be some limited exceptions for certain services provided predominantly in Medicaid and CHIP, when those services are not typically provided (and therefore not priced) by Medicare.
- HRSA will calculate the number and type of Medicare, Medicaid, and CHIP claims per billing TIN, and multiply them by the relevant prices from Step 1.
- HRSA will adjust the Bonus Payments to the portion of funding set aside for bonus payments.
  - HRSA will then aggregate billing TINs' payments to the filing TIN (i.e., the applicant).

Who is Eligible to Apply for Phase 4?

- To be eligible to apply, the applicant must meet all of the following requirements:
  - Must fall into one of the following categories:
    - Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, their state/territory ***Medicaid*** program (fee-for service or managed care) or Children's Health Insurance Program (CHIP) for health care-related services during the period of January 1, 2019 to December 31, 2020; or
    - Must have either directly billed, or owns (on the application date) an included subsidiary that has directly billed, ***Medicare*** fee-for-service (Parts A and/or B) or Medicare Advantage (Part C) for health care-related services during the period of January 1, 2019 to December 31, 2020;
    - Must be a ***dental service provider*** who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for oral health care-related services during the period of January 1, 2019 to December 31, 2020;
    - Must be a ***state-licensed/certified assisted living facility*** on or before December 31, 2020;
    - Must be a behavioral health provider who has either directly billed, or owns (on the application date) an included subsidiary that has directly billed, health insurance companies or patients for health care-related services during the period of January 1, 2019 to December 31, 2020;
    - Must have received a prior Targeted Distribution payment.
  - Must have either (i) filed a federal income tax return for fiscal years 2018, 2019, or 2020, 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 health care clinic); and
  - Must have provided patient care after January 31, 2020; and
  - Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
  - If the applicant is an individual that was providing patient care, 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.

What is ARP Rural?

- ARP Rural is intended to help address the disproportionate impact that COVID-19 has had on rural communities and rural health care providers, and funding will be available to providers who serve patients in these communities.
- ***ARP Rural payments will be determined based on the location of the patients, not the provider.***
  - Applicants do not need to verify whether their patients live in an area that meets the definition of rural, and ***can select whether their organization (including any included subsidiaries) would like to be considered for ARP rural payments during the application process.***
- ***HRSA will base payments on data already available to it on the amount and type of Medicare, Medicaid, and CHIP services provided to rural patients.***
- HRSA will use the Federal Office of Rural Health Policy definition of Rural and can be searched through the Rural Health Grant Eligibility Analyzer.
  - https://data.hrsa.gov/tools/rural-health

Who is Eligible to Apply for ARP Rural Payments?

- In accordance with the statutory requirements, to be eligible to apply for ARP Rural Payments, the applicant or at least one subsidiary TINs must be:
- A rural health clinic as defined in section 1861(aa)(2) of the Social Security Act; or
- A provider treated as located in a rural area pursuant to section 1886(d)(8)(E), such as **critical access hospitals;** or
- A provider or supplier that:
  - Has directly billed for health care-related services between January 1, 2019 and September 30, 2020:
    - **Medicare fee-for-service** (Parts A and/or B);
    - **Medicare Advantage** (Part C)
    - Their state/territory **Medicaid program (fee-for service or managed care); or**
    - Their state/territory Children's Health Insurance Program **(CHIP)**; and
  - Operates in or serves patients living in the HHS Federal Office of Rural Health Policy's (FORHP) definition of a rural area:
    - All non-Metro counties;
    - All Census Tracts within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties;
    - 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile; and
    - 295 outlying Metropolitan counties with no Urbanized Area population.

How Will ARP Rural Payments Be Calculated?

- Similar to Phase 4 methodology, HHS will make payments to providers based on the ***amount and type of Medicare, Medicaid, and CHIP services*** provided to rural patients from Jan. 1, 2019 through Sept. 30, 2020.
  - HHS will price Medicaid and CHIP claims data at Medicare rates, with some limited exceptions for some services provided predominantly in Medicaid and CHIP.
  - ***Providers who serve any patients living in Federal Office of Rural Health Policy-defined rural areas with Medicaid, CHIP, or Medicare coverage, and who otherwise meet the eligibility criteria, will receive a minimum payment.***

How Will ARP Rural Payments Be Calculated?

- Payments will be based on Medicare, Medicaid, and CHIP administrative claims data from January 1, 2019 through September 30, 2020. To reduce administrative burden and streamline application processing, providers will not provide claims data in the application. HRSA will use data to which it already has access.
  - **Step 1**. ***HRSA will price Medicaid and CHIP claims data at national Medicare rates***, to eliminate any impact from the disparities between Medicare and Medicaid/CHIP reimbursement rates. There will be some limited exceptions for certain services provided predominantly in Medicaid and CHIP, when these services are not typically provided (and therefore not priced) by Medicare.
  - **Step 2**. HRSA will calculate the number and type of Medicare, Medicaid, and CHIP claims per billing/subsidiary TIN from January 1, 2019 through September 30, 2020, and multiply them by the relevant prices from Step 1.
  - **Step 3**. HRSA will adjust the claims-based payments to the amount of funding available for ARP Rural (approximately $8.5 billion).
  - **Step 4**. HRSA will then aggregate billing TINs' payments to the filing TIN (i.e., applicant).

Application Rules

- The applicant must adhere to the requirements following:
  - **Filing TIN and Subsidiaries:** In general, applications must be submitted at the parent or filing tax identification number (TIN) level (i.e., the entity that files federal income taxes). In some cases, entities that are within a parent entity's filing TIN may wish to apply. These entities must include additional requirements at Field 17 Annual Revenues from Patient Care Worksheet and Field 18 Organizational Structure Documentation. HRSA will review these exceptions on a case-by-case basis.
  - **Multiple Applications:** Applicants **must not submit** multiple applications with the same filing TIN(s). HRSA will not pay duplicate providers.
  - **Comprehensive Listing of Billing and Subsidiary TINs:** Applicants must include all billing TINs under the filing TIN that provide patient care.
    - Applicants must include an exhaustive list of TINs and must ensure that all TINs included in the application belong to the filing TIN that is applying.
    - HRSA will calculate the ARP Rural and a portion of Phase 4 payments based on the submitted billing TINs.
    - Failure to include an exhaustive list of billing TINs that provide patient care will affect the amount of the applicant's ARP Rural payment and Phase 4 bonus payment.
- ***Failure to adhere to these requirements and the following instructions may result in HRSA deeming your application ineligible for payment.***

Application Flowchart

Sample Application Form

This Form is Provided for Information Only **Reference ID**_____

HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP)
Rural Distribution Revenue Application

Tax ID Number: _____

Name as shown on your income tax return: _____

Federal Tax Classification: _____

Business Name (if different): _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Registration Type: _____

NPI: _____

(1) Contact Person Name: _____

(2) Contact Person Title: _____

(3) Contact Person Phone Number: _____

(4) Contact Person Email: _____

(5) Applicant/Provider Type: _____

Fields 6 - 8 have been intentionally removed

(9) CMS Certification Numbers (CCNs), if applicable: _____

Sample Application Form

REVENUES

(10) Revenues: $ _____

(11) Fiscal Year of Revenues: _____

(12) Revenue from Patient Care: $ _____

(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: _____

13. OPERATING REVENUES FROM PATIENT CARE

(13.1) 2019 Q1 (Jan 1 – Mar 31): _____ (13.2) 2019 Q3 (July 1 – Sept 30): _____

(13.3) 2019 Q4 (Oct 1 – Dec 31): _____ (13.4) 2020 Q3 (July 1 – Sept 30): _____

(13.5) 2020 Q4 (Oct 1 – Dec 31): _____ (13.6) 2021 Q1 (Jan 1 – Mar 31): _____

14. OPERATING EXPENSES FROM PATIENT CARE

(14.1) 2019 Q1 (Jan 1 – Mar 31): _____ (14.2) 2019 Q3 (July 1 – Sept 30): _____

(14.3) 2019 Q4 (Oct 1 – Dec 31): _____ (14.4) 2020 Q3 (July 1 – Sept 30): _____

(14.5) 2020 Q4 (Oct 1 – Dec 31): _____ (14.6) 2021 Q1 (Jan 1 – Mar 31): _____

Sample Application Form

SUPPORTING DOCUMENTATION: Total Annual Revenues and Annual Revenues from Patient Care

(15) *Autopopulated based on Field 12.1* _____

(16) Upload Annual Revenues Adjustments Worksheet (if required): _____

(17) Upload Annual Revenues from Patient Care Worksheet (if required): _____

(18) Upload Organization Structure Documentation (if required): _____

SUPPORTING DOCUMENTATION: Operating Revenues and Expenses from Patient Care

(19) Upload 2020 Q3 and Q4 and 2021 Q1 operating revenues and expenses from patient care documentation: _____

(20) Upload 2019 Q1,Q3,Q4 operating revenues and expenses from patient care documentation: _____

RURAL PROVIDERS

(21) Select "Yes" if your organization would like to be considered for an additional ARP rural payment. Yes No

Fields 22 - 32 have been intentionally removed

BANKING INFORMATION

(33) Bank Name: _____

(34) ABA Routing Number: _____

(35) Account Holder Name: _____

(36) Account Number: _____

Terms and Conditions

If a payment is issued, all recipients must agree to its distribution's Terms and Conditions within 90 days.

What Documentation Do I Need to Apply?

- Supporting documentation and information needed to complete an application will include:
  - Applicant TIN and TINs for any subsidiaries included in the applicant TINs IRS tax filing.
  - Internally-generated financial statements that substantiate operating revenues and expenses from patient care in:
    - 2019 Q1, Q3, and Q4
    - 2020 Q3 and Q4
    - 2021 Q1
  - Federal income tax return, audited financial statements, or internally-generated financial statements submitted in their entirety.

What Documentation Do I Need to Apply?

If the applicant for tax purposes is:	They must provide:
Sole proprietor or disregarded entity owned by an individual	Form 1040 including Schedule C
Trust or Estate	Form 1041 including Schedule C
Partnership	Form 1065
C Corporation	Form 1120
S Corporation	Form 1120-S
Tax-Exempt Organization	Form 990
Not required to file federal income taxes (e.g. government entities)	Internally generated financial statements (or management prepared financial statements) and a statement explaining why the entity if not required to file a federal tax form.

HRSA Technical Webcasts Announced

- HRSA will be hosting webinar sessions for Phase 4 and ARP Rural applicants, featuring guidance on how to navigate the application portal.
  - Thursday, September 30 from 3:00-4:00 p.m. EST: https://webex.webcasts.com/starthere.jsp?ei=1498144&tp_key=a107a70478
  - Tuesday, October 5 from 3:00-4:00 p.m. EST: https://webex.webcasts.com/starthere.jsp?ei=1497665&tp_key=df7fdbdc74

Phase 3 General Distribution Reconsiderations

- HHS has finally released exact methodology/formula that they used to calculate Phase 3 General Distribution Payments.
  - As a reminder, Phase 3 Funding was based on an application submitted by provider by November 2020.
- Providers who believe their Phase 3 payment was not calculated correctly according to this methodology will now have an opportunity to request a reconsideration.
  - Providers who did not submit an application for Phase 3 cannot request to be considered for a payment now.

Phase 3 Reconsideration

- HRSA is developing a structured process to review and reconsider applications and payment determinations.
- Any corrections to payment determinations are subject to the availability of funds.
- If after reviewing the above methodology you believe your payment was calculated incorrectly, or if you would like to be notified when more information becomes available regarding the reconsiderations process, please contact PRFReconsiderations@hrsa.gov

Phase 3 General Distribution Reconsiderations

- HHS processed Phase 3 applications by generally determining:
  - The greater of 88 percent of losses (i.e., losses in revenue net of expenses) for the first and second quarters of 2020 **or**
  - 2 percent of net patient revenue from a provider's application submission **minus**
  - Prior Provider Relief Fund (PRF) payments made to that provider and its listed subsidiaries **and then**
  - Applying risk mitigation/cost containment safeguards in order to ensure the adequate stewardship of funds.
- HHS is just now releasing the risk mitigation/cost containment methodologies that they used for these payments.

Phase 3 General Distribution Reconsiderations

- The full calculation methodology comprised the following seven steps:
  - A. Calculating 2 percent of Annual Patient Care Revenue
  - B. Calculating initial Loss Ratio and Provider-Type Loss Ratios
  - C. Capping Loss Ratios and other pre-payment value adjustments
  - D. Calculating 88 percent of Adjusted Losses
  - E. Selecting the greater of calculated A or D
  - F. Deducting all prior PRF payments from result of E
  - G. Flagging and conducting manual review of flagged potential payments

Phase 3 General Calculations

- Calculation of 2 percent of Annual Patient Care Revenue
  - Each application required the applicant to supply the Annual Gross Revenues for the most recent complete tax year and the percent of that revenue (in whole numbers) that was attributed to patient care (Percent Patient Care).
  - The Annual Gross Revenue was then multiplied by the reported Percent Patient Care to determine the Annual Patient Care Revenue for the application.
  - ***The Annual Patient Care Revenue was then multiplied by 0.02 to calculate the dollar value for 2 percent of Annual Patient Care Revenue. Both the Annual Patient Care Revenue and 2 percent Annual Patient Care Revenue figures were used in later steps.***

Phase 3 General Calculations

- Calculation of Initial Loss Ratio and Provider-Type Loss Ratios
  - For each application, an initial Loss Ratio was calculated using the 2019 and 2020 first and second quarter revenues and expenses entered on the application.
  - The initial Loss Ratio was defined as Losses divided by Annual Patient Care Revenue (i.e., (Lost Revenue minus Change in Expenses)/Annual Patient Care Revenue).
  - The calculation is defined below:
    - ***Lost Revenue = [Q1Revenue20 – Q1Revenue19] + [Q2Revenue20 – Q2Revenue19]***
    - ***Change in Expenses = [Q1Expenses20 – Q1Expenses19] + [Q2Expenses20 – Q2Expenses19]***
    - ***Losses = Lost Revenue – Change in Expenses Loss Ratio = (Losses / Annual Patient Care Revenue)***

Phase 3 General Calculations

- C. Capping Loss Ratios and other pre-payment value adjustments

Adjustment	Actual Patient Care Revenue	Adjusted Lost Revenues
Single quarter revenue or expenses > 50 percent of total annual revenue	N/A	Annual Patient Care Revenue MULTIPLED BY Mean Loss Ratio for Applicant's Provider-Type
"Loss ratio" was greater than the mean plus one standard	N/A	Annual Patient Care Revenue MULTIPLED BY Mean plus one Standard Deviation Loss Ratio for Applicant's Provider-Type
New provider in 2019 or 2020	N/A for new 2019 providers 2 percent of sum of Quarters 1 and 2 revenues for new 2020 providers	Annual Patient Care Revenue MULTIPLED BY Median Loss Ratio for Applicant's Provider-Type (above)
Pharmacy & DME	Capped at 10 percent	N/A

Phase 3 General Calculations

- C. Capping Loss Ratios and other pre-payment value adjustments
  - Payments were capped for a number of reasons, including the three below:
    - If one of the reported quarter revenues or expenses was ***greater than 50 percent*** of Annual Patient Care Revenue, then the application was flagged and the initial Loss Ratio was adjusted to the mean loss ratio for the provider-type that the applicant self-selected. ***This affected approximately 7.8 percent of all applications.***
    - If the initial Loss Ratio was found to be above the mean loss ratio plus one standard deviation relative to the self-selected provider-type, then the Loss Ratio was identified as outside the expected range. The initial Loss Ratio was adjusted down to the mean plus one standard deviation of the same provider-type.
      - The mean, mean plus one standard deviation and median loss ratio for each provider-type can be accessed at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/phase-3-methodology-overview.pdf.
      - ***This affected approximately 9.1 percent of all applications.***
    - HRSA also calculated payments for new providers that began operations in 2019 or 2020 based on the applicant's available financial data and data from providers of the same type. ***The loss ratios for these new providers were capped at the median loss ratio for their provider-type.***

Phase 3 General Calculations

- E. Select the greater of calculated A or D
  - The greater amount of 2 percent of Annual Patient Care Revenue and 88 percent of Adjusted Lost Revenues and Expenses was used when calculating payment.
  - This ensured that providers received at least the same amount as if they had applied to Phase 1 or 2.
- F. Deduction of all prior PRF payments
  - All prior PRF payments, including General and Targeted Distributions, received by both filing taxpayer identification number (TIN) organization and its listed subsidiaries were deducted from the amount in Step E.
  - This step aimed to ensure that PRF payments were prioritized for providers who had not received funding or as much funding during earlier phases.
  - ***As a result of this and prior steps, the payment calculation for approximately 31 percent of applicants was $0.***

Phase 3 General Calculations

- G. Flagging and manual review of flagged potential payments
  - In order to distribute funds quickly, the majority of payment calculations (approximately 95 percent) for Phase 3 were determined using the aforementioned prepayment process.
  - The remaining approximately 5 percent of applications were sent for further review if they were flagged for one of the following reasons:
    - Separate applications from related providers
    - Incomplete information
    - High-dollar applications
  - If applications were flagged for one or more of these reasons, a manual review of supporting documentation was conducted.
  - ***If during the manual validation the documentation did not support the application revenues and expenses, then the payment was subject to further adjustment or deemed ineligible for payment.***

Wrap Up & Questions

Unmute using *6 or the mic icon in the app or use the chat to ask.