



Provider Relief Fund Updates: Phase 3 Application and Reporting Updates

October 26, 2020

GOAL: Support community providers (you!) in applying for new funding and knowing what to do once funding is received

Today, we will discuss:

- **New \$20 Billion General Distribution Phase 3 Funding Opportunity**

- What is the opportunity and should I apply?
- How do I apply?

The answer is very likely YES, you should apply!

- **Provider Relief Fund Reporting Requirements**

- How can I use the Provider Relief Fund payments?
- What do I need to report back to HHS and is there a risk I need to return money?

- **Next Steps**

- **Questions**

Upcoming Deadlines to Keep In Mind

- **November 6:** Deadline to submit Phase 3 application
- **January 15, 2021:** HHS plans to launch reporting system
- **February 15, 2021:** First reporting deadline for all providers on use of funds in 2020
- **June 30, 2021:** Provider Relief Fund payments must be expended in full
- **July 31, 2021:** Second and final reporting deadline

Get started ASAP by submitting your Tax ID number to HHS!

Start documenting now to get ahead of any surprises

New \$20 Billion General Distribution Phase 3 Funding Opportunity

Questions for the Group

1. **Prior to the announcement of this webinar, had you heard of the Phase 3 General Distribution?**
 - a. Yes, I am at least somewhat familiar with it
 - b. No

2. **Have you received any Provider Relief Fund money thus far?**
 - a. Yes
 - b. No

3. **Does the amount of funding you received feel significant?**
 - a. Yes
 - b. No



What is the New Funding Opportunity and Should I Apply?

HHS Has, Over Time, Developed a Structure Through Which Providers Receive Base and Additive Payments

<p>GENERAL DISTRIBUTION Providers receive a minimum 2% of patient revenue</p>	<p>Phase 1: Medicare Providers (<i>providers that bill FFS Medicare</i>) received an automatic payment based on their share of total Medicare FFS revenues in 2019. Providers with cost reports on file (generally hospitals) received an automatic second payment that—when combined with the first payment—would bring their total payment to at least 2% of net patient revenue. All other providers (those that received a first payment but did not automatically receive a second payment) were required to apply by June 3.</p> <p>Phase 2: Medicaid, CHIP, dental, and assisted living facility providers that did not receive <i>any</i> Phase 1 payment <u>plus</u> providers that did not receive their full 2% of patient revenue payment in Phase 1</p> <p>Phase 3: NEW OPPORTUNITY</p>
<p>TARGETED DISTRIBUTIONS These are additive to General Distribution payments</p>	<p>High-Impact Distribution (<i>hospitals in “hot spots,” determined based on number of COVID-19 inpatient admissions in January-June</i>)</p> <p>Safety Net Hospitals Distribution (<i>hospitals that meet certain patient percentage, uncompensated care, and profitability measures; acute care facilities; and free-standing children’s hospitals</i>)</p> <p>Rural Distribution (<i>hospitals in rural/small metropolitan areas or with rural Medicare designations, health centers located in rural areas</i>)</p> <p>Skilled Nursing and Long-Term Care Facilities Distributions (<i>CMS-certified facilities with 6+ beds</i>)</p> <p>Tribal Hospitals, Clinics, Urban Health Centers Distribution</p>



The Provider Relief Fund also funds payments to providers via the [HRSA COVID-19 Uninsured Program](#), for claims for COVID-19 treatment and COVID-19 vaccine administration (pending approval) to uninsured individuals (testing claims are separately financed).

Phase 3 of the General Distribution is designed to accomplish two things:

1

Ensure all eligible providers receive a payment of at least 2% of annual revenue from patient care

2

Use remaining funding to issue “add-on” payments—above and beyond 2% of net patient revenue—to selected providers
(formula TBD)

Providers are eligible for Phase 3 regardless of whether they have already received some PRF payments, rejected prior payments, or received no payments at all

New \$20 Billion Funding Opportunity is Now Open to Nearly All Providers of Patient Care

HHS defines **patient care** as health care, services and support provided in a medical setting, at home, or in the community.

Eligible provider types include, for example:

- ✓ Behavioral health providers
- ✓ Allopathic & Osteopathic Physicians
- ✓ Dental Providers
- ✓ Assisted Living Facilities
- ✓ Chiropractors
- ✓ Nursing Service and Related Providers
- ✓ Hospice Providers
- ✓ Residential Treatment Facilities
- ✓ Respiratory, Developmental, Rehabilitative and Restorative Service Providers
- ✓ Hospital Units
- ✓ Laboratories
- ✓ Eye and Vision Service Providers
- ✓ Physician Assistants & Advanced Practice Nursing Providers
- ✓ Nursing & Custodial Care Facilities

HHS has indicated that it wants to use this distribution to fill in the gap between the payments received and the financial impact of COVID

Factors HHS Will Assess to Determine Add-on Payments:

- Financial impact of COVID-19 in Q1-Q2 (January-June) 2020
 - Operating revenues from patient care in Q1-Q2 2020 compared to Q1-Q2 2019
 - Operating expenses from patient care in Q1-Q2 2020 compared to Q1-Q2 2019
- Other Provider Relief Fund payments received to date

Example of Providers that May Receive Largest Add-on Payments (as share of patient revenue)*

- Providers that have significant lost revenues and expenses that exceed Provider Relief Fund payments to date; for example:
 - Dental providers that halted operations for some period of time
 - Ambulatory care centers that halted elective procedures for some period of time
 - Pediatric providers that have seen dips in well child visits
 - Providers with significant operating expenses from patient care, such as assisted living facilities with high PPE costs and testing costs not reimbursable by insurance/HRSA Uninsured Fund

One pediatric provider reported a 60% dip in visits – resulting in revenue losses far exceeding their 2% payment

*The payment methodology is not yet available

How Do I Apply?

Start the Application Process by Submitting Your Tax ID Number ASAP



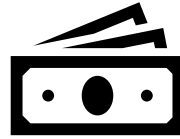
Confirm eligibility by reviewing criteria in the application instructions



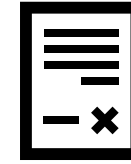
Submit Tax ID Number to HHS for validation via the Provider Relief Fund Application and Attestation Portal



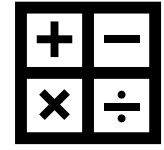
Submit application via the Provider Relief Fund Application and Attestation Portal by November 6 at 11:59 pm ET



Receive payment



Accept payment terms and conditions via the Provider Relief Fund Application and Attestation Portal



Document use of funds

It may take a couple of weeks for HHS to validate Tax ID numbers – and you must receive validation before you can complete and submit your application. You will be best positioned to submit your application on time by submitting your TIN *as soon as possible*, and while awaiting TIN validation, beginning to prepare the information that will be needed for the application.

HHS published application instructions and a sample application form that you can use to prepare your application

Necessary Documentation:

- Most recent federal income tax return for 2017, 2018, or 2019
 - *Or*, if operations began after January 1, 2020, quarterly tax returns for 2020
 - *Or*, if the applicant is exempt (e.g., a state-owned healthcare clinic), a written explanation
- *IF* entering an adjusted revenue number from the number shown on the most recent federal income tax return, a completed revenue worksheet (Excel template provided by HHS)
- Supporting documents for operating revenues and expenses from patient care in Q1-Q2 2019 and Q1-Q2 2020 (these should substantiate the information provided in the application and may be internally-generated financial statements)

Provider Relief Fund Reporting Requirements

How can I use the Provider Relief Fund payments?

**Expenses Attributable to
COVID-19 Not Reimbursed by
Other Sources**

Lost Revenues

Expenses attributable to COVID-19 include those incurred treating confirmed or suspected cases of COVID-19, preparing for possible or actual COVID-19 cases, and maintaining healthcare delivery capacity

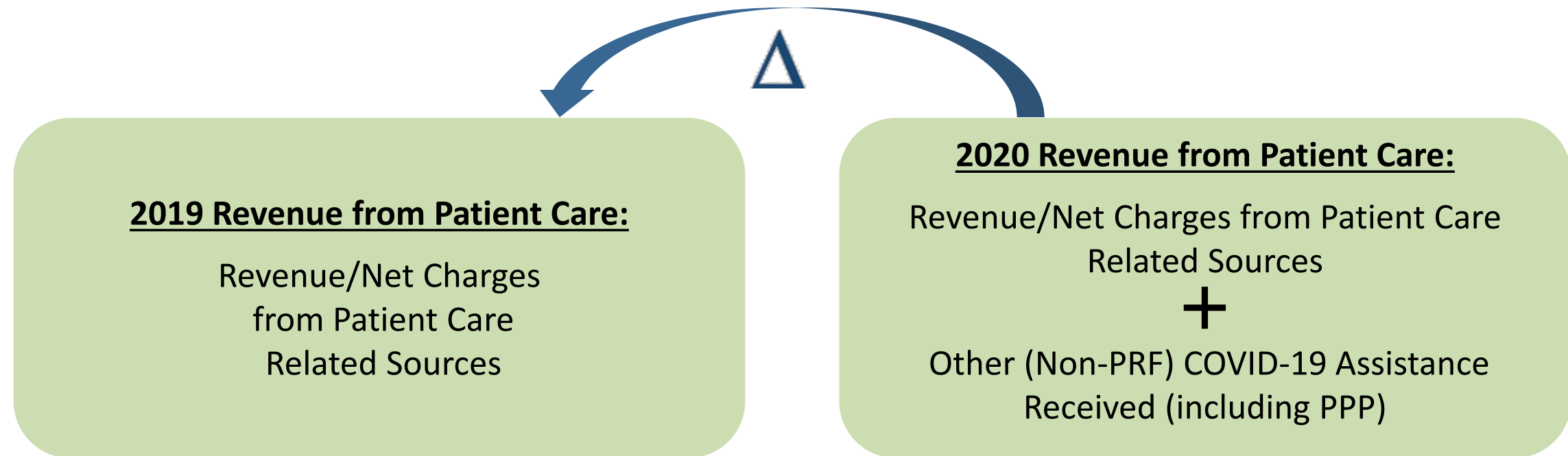
- **General and administrative expenses** such as:
 - Personnel
 - Fringe benefits
 - Utilities/operations (e.g., cleaning or ventilation costs)

- **Healthcare related expenses** such as:
 - Supplies (e.g., PPE)
 - Equipment (e.g., ventilators)
 - Information technology (e.g., IT/interoperability systems to expand/preserve care during the reporting period such as telehealth infrastructure)
 - Facilities (lease or construction/modification of facilities to separate patients, etc.)



Rule of Thumb: To avoid any question about whether expenses are indeed attributable to COVID-19, providers can think of expenses to include as expenses that—were it not for COVID-19—would not exist

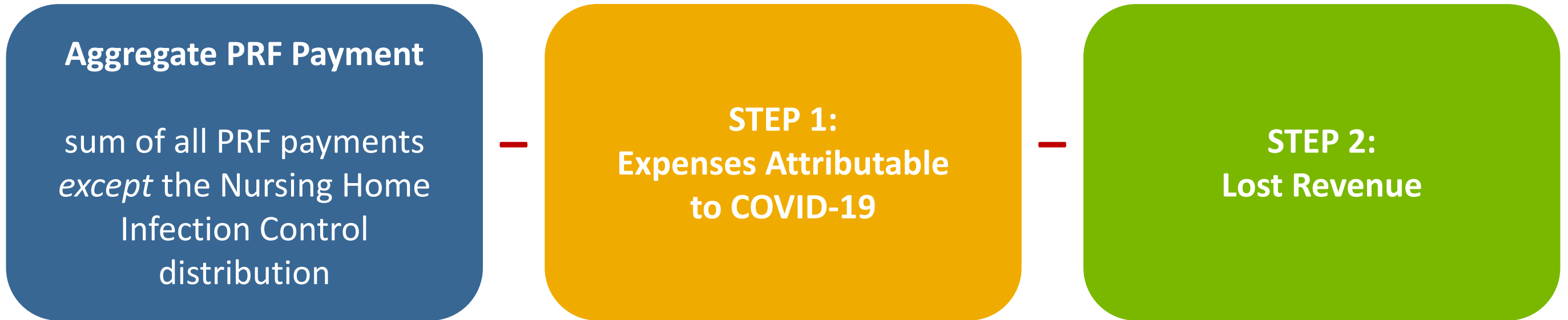
Lost Revenues Attributable to COVID-19 are defined as the 2020-to-2019 change in operating revenues



This includes Medicare Part A, B and C; Medicaid; commercial insurance; and self-pay revenues. It does not include bad debt and does not appear to include pharmacy revenues, except 340B revenues

What do I need to report back to HHS and is there a risk I need to return money?

Amount of funding that must be returned =



Providers most at risk for needing to return some portion of funding are those without significant revenue losses, such as high-risk providers that didn't see a drop in patient visits (and therefore revenue) but received large sums of financial assistance (via, for example, the PRF and/or PPP).

Careful accounting of COVID-19 expenses and lost revenues as defined by HHS will allow you to avoid any surprises in 2021

Upcoming Milestones:

- **January 15, 2021:** HHS plans to launch reporting system
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Following this webinar, we will distribute updated application instructions and information so that you can find all application and reporting resources in one place

- **Submit questions to COVIDProviderSupport@cityhall.nyc.gov**; we will circulate a frequently asked questions document based on submissions received
- **For challenges with completing your application, receiving TIN validation, etc. be in touch with the HHS Provider Support Line at (866) 569-3522. TTY dial 711. Hours of operation are 8:00 am to 11:00 pm ET, Monday through Friday.**

Remember, Step 1 is to submit your TIN for validation!

Questions?