Provider Relief Funds and Cost Reports
New Funding Opportunities for RHCs
May 5, 2021

HBS
Healthcare Business Specialists

HBS
Healthcare Business Specialists

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Please join our Facebook Group with over 2,300 RHCs
https://www.facebook.com/groups/1503414633296362

HBS
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RHC Information Exchange Group on Facebook

- *"A place to share and find information on RHCs."*

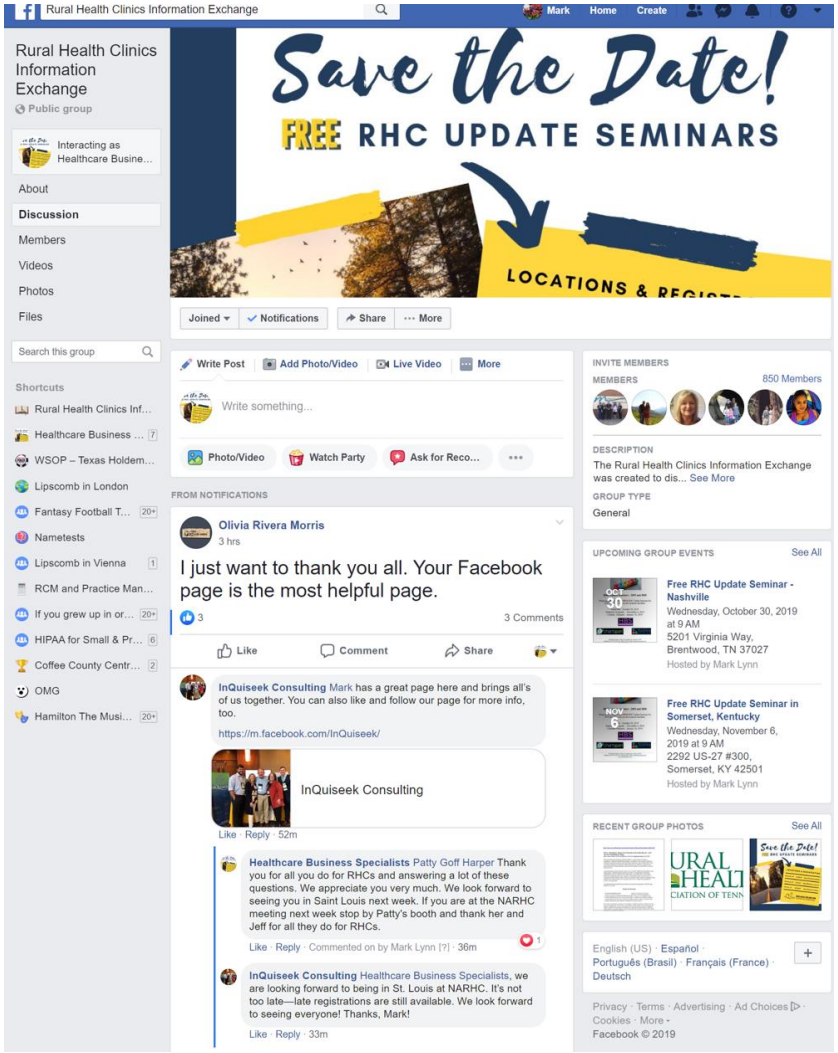
HBS

Healthcare Business Specialists

- What does Healthcare Business Specialists do?
- Listing of Services

https://tinyurl.com/w63xbp9

- We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
- We prepare Program evaluations of RHCs.
- We help clinics startup as RHCs.
- Emergency Preparedness for RHCs.
- We prepare Tenncare Quarterly Reports
- Our Cost Reporting Brochure can be found at the following link:
- RHC Cost Report Brochure



RHC Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs

https://www.facebook.com/groups/1503414633296362/

Preparing for the RHC Certification and Recertification Survey

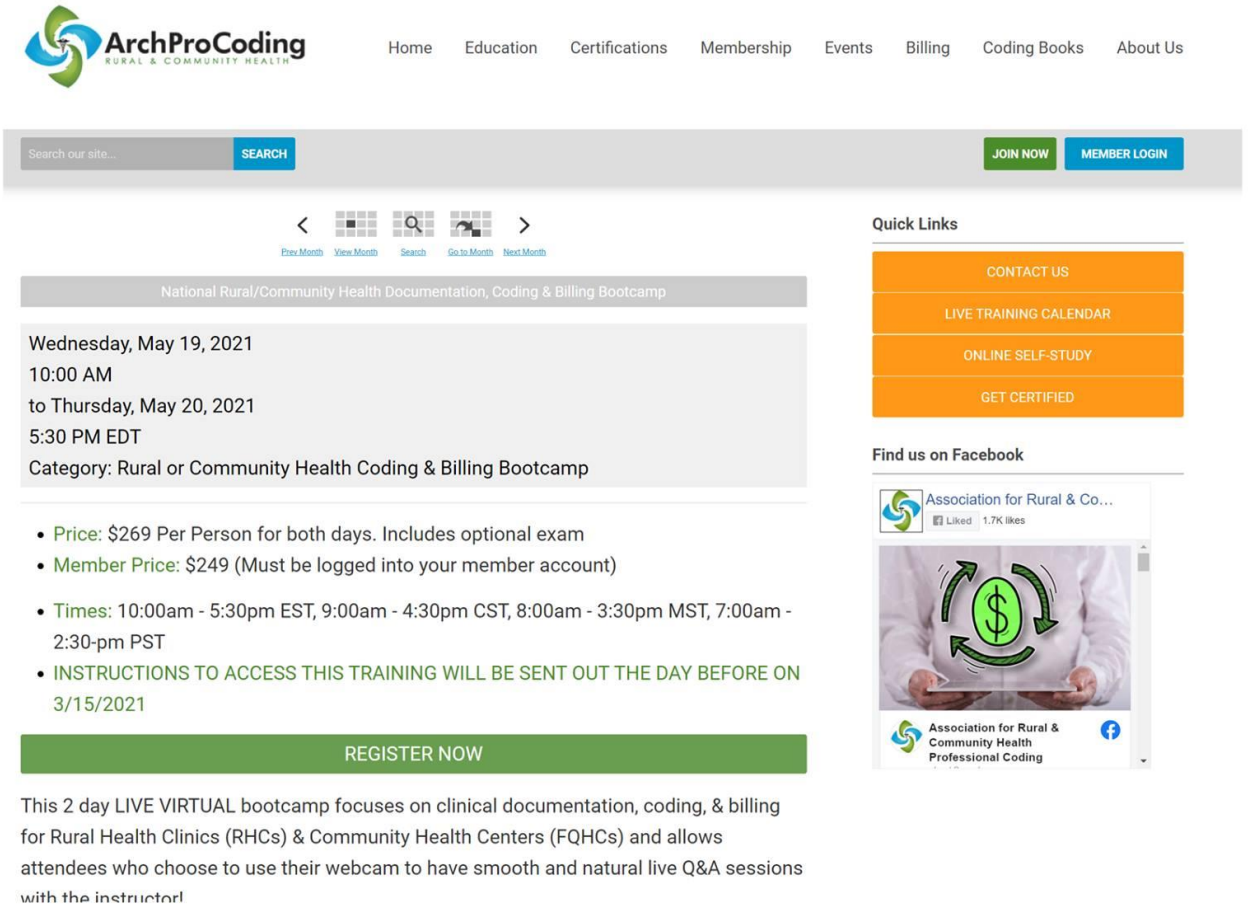
In this webinar, Mark Lynn, CPA and Dani Gilbert, CPA will go over the steps to become a rural health clinic or prepare for the program evaluation from a Mock Inspection standpoint or recertification of the clinic. We will go over procedures needed, steps to take, policies to update and provide tools to help with the inspection. We will focus on getting the clinic inspection ready and go over the importance of having an Evidence Binder for the inspector and tools to help document compliance with the nine conditions of participation for rural health clinics.

Please register for Preparing for the RHC Certification and Recertification Survey on May 13, 2021 12:00 PM CDT at:

https://attendee.gotowebinar.com/register/1124892069129855755

The recording of these sessions and slides will be available in the RHC Information Exchange Facebook Group with 2,300 members and our website at www.ruralhealthclinic.com.

RHC Billing Training



https://mailchi.mp/archprocoding.com/evaluation-management-auditing-bootcamp-271586?e=20a5fea402

Disclaimer

- Information is current as of 5/5/2021.
- We will supply general information. All situations are specific so refer to specific guidance as necessary. HHS & CMS Guidance regarding Provider Relief Funds & Cost Reporting is everchanging.

Questions or Comments?

- **Please type your questions in the Questions area of Go To Webinar. Additionally, we will open up the lines for questions at the end of the webinar.**

- **This session is being recorded and the slides will be available in the RHC Information Exchange Facebook Group, on our website, and will be emailed to you.**

MEET OUR SPEAKERS 

Meet the Speakers

Nathan Baugh, ***BS, Director of Government Affairs, NARHC, Alexandria, VA***

Nathan Baugh is the Director of Government Affairs for the National Association of Rural Health Clinics (NARHC) where he has worked since April of 2015. Nathan works on both regulatory and legislative policy at the federal level. He has been involved in issues such as the CPT reporting policy, the Chronic Care Management benefit, and the Emergency Preparedness rules.

Agenda

1	**American Rescue Plan Provider Relief Funding Opportunity and recent announcements of New Funding to RHCs – Nathan Baugh, NARHC**
2	Provider Relief Fund Reporting Non-Update
3	Summary of Relief Funds Table
4	Provider Relief Funds Portal
5	Provider Relief Expenses
6	Provider Relief Lost Revenues
7	Cost Reporting Update
8	Upper Payment Limit Increased
9	Extended Cost Report Deadline
10	Covid Vaccine Reimbursement
11	Productivity Standards
12	Telehealth


THE AMERICAN RESCUE PLAN
AMERICAN RESCUE PLAN
ACT OF 2021

Biden Sets New Goal: At Least 70% Of Adults Given 1 Vaccine Dose By July 4

Updated May 4, 2021 · 3:43 PM ET

ALANA WISE

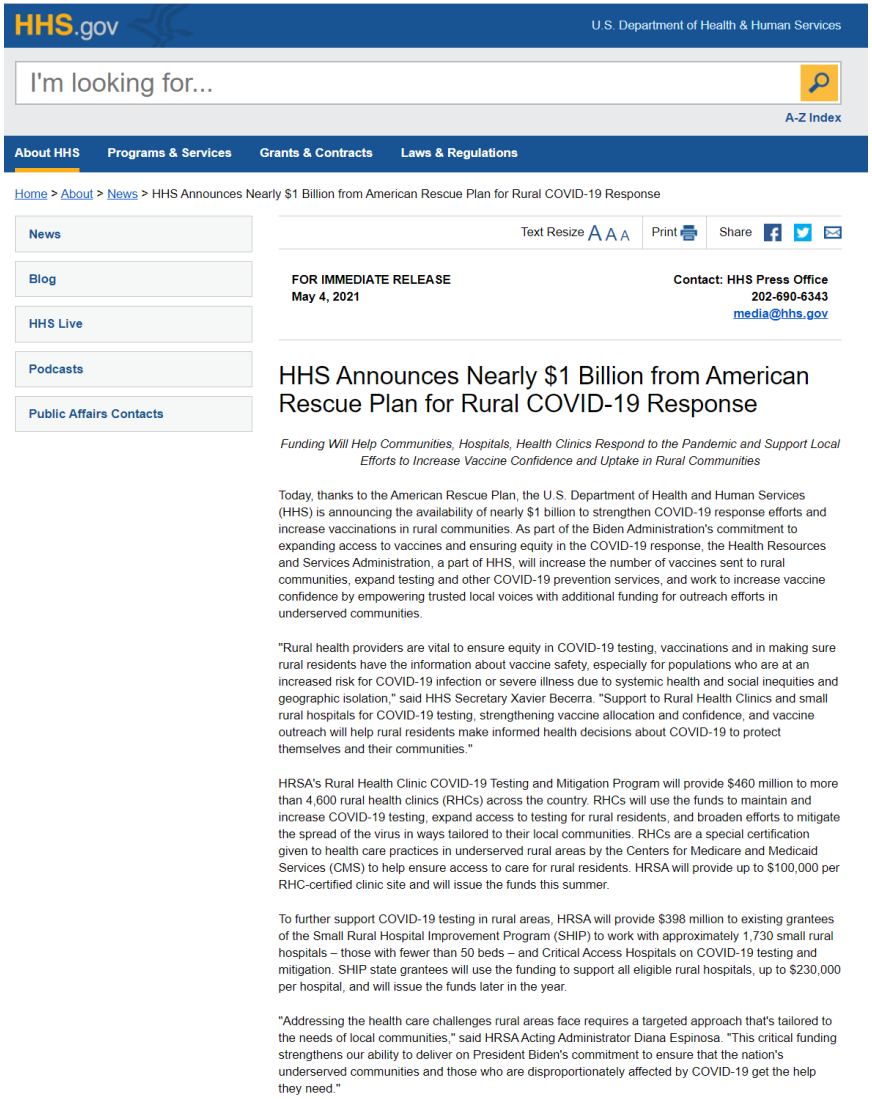
President Biden speaks about the COVID-19 vaccination program Tuesday in the White House. Biden has set a goal of seeing 160 million adults fully vaccinated by July Fourth.

Evan Vucci/AP

President Biden on Tuesday announced a new goal to administer at least one dose of a COVID-19 vaccine to 70% of American adults by the Fourth of July.

The administration also aims to have 160 million adults fully vaccinated by then, a push to improve the level of immunity in the country to the point where the coronavirus has less of an opportunity to spread and so that more public health

HHS Announces Nearly $1 Billion from American Rescue Plan for Rural COVID-19 Response



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FOR IMMEDIATE RELEASE
May 4, 2021

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Announces Nearly $1 Billion from American Rescue Plan for Rural COVID-19 Response

Funding Will Help Communities, Hospitals, Health Clinics Respond to the Pandemic and Support Local Efforts to Increase Vaccine Confidence and Uptake in Rural Communities

Today, thanks to the American Rescue Plan, the U.S. Department of Health and Human Services (HHS) is announcing the availability of nearly $1 billion to strengthen COVID-19 response efforts and increase vaccinations in rural communities. As part of the Biden Administration's commitment to expanding access to vaccines and ensuring equity in the COVID-19 response, the Health Resources and Services Administration, a part of HHS, will increase the number of vaccines sent to rural communities, expand testing and other COVID-19 prevention services, and work to increase vaccine confidence by empowering trusted local voices with additional funding for outreach efforts in underserved communities.

"Rural health providers are vital to ensure equity in COVID-19 testing, vaccinations and in making sure rural residents have the information about vaccine safety, especially for populations who are at an increased risk for COVID-19 infection or severe illness due to systemic health and social inequities and geographic isolation," said HHS Secretary Xavier Becerra. "Support to Rural Health Clinics and small rural hospitals for COVID-19 testing, strengthening vaccine allocation and confidence, and vaccine outreach will help rural residents make informed health decisions about COVID-19 to protect themselves and their communities."

HRSA's Rural Health Clinic COVID-19 Testing and Mitigation Program will provide $460 million to more than 4,600 rural health clinics (RHCs) across the country. RHCs will use the funds to maintain and increase COVID-19 testing, expand access to testing for rural residents, and broaden efforts to mitigate the spread of the virus in ways tailored to their local communities. RHCs are a special certification given to health care practices in underserved rural areas by the Centers for Medicare and Medicaid Services (CMS) to help ensure access to care for rural residents. HRSA will provide up to $100,000 per RHC-certified clinic site and will issue the funds this summer.

To further support COVID-19 testing in rural areas, HRSA will provide $398 million to existing grantees of the Small Rural Hospital Improvement Program (SHIP) to work with approximately 1,730 small rural hospitals – those with fewer than 50 beds – and Critical Access Hospitals on COVID-19 testing and mitigation. SHIP state grantees will use the funding to support all eligible rural hospitals, up to $230,000 per hospital, and will issue the funds later in the year.

"Addressing the health care challenges rural areas face requires a targeted approach that's tailored to the needs of local communities," said HRSA Acting Administrator Diana Espinosa. "This critical funding strengthens our ability to deliver on President Biden's commitment to ensure that the nation's underserved communities and those who are disproportionately affected by COVID-19 get the help they need."

HRSA will also support RHCs to increase the availability of COVID-19 vaccines in rural communities and expand outreach to build vaccine confidence. Working in partnership with the Centers for Disease Control and Prevention (CDC), HRSA is inviting Medicare-certified RHCs to join the new Rural Health Clinic COVID-19 Vaccine Distribution (RHCVD) Program to directly receive vaccines from the Biden Administration. HRSA and CDC will continue to enroll interested RHCs to receive COVID-19 vaccines, the allocation for which is separate from jurisdictions' weekly allocations.

In addition, through the Rural Health Clinic Vaccine Confidence (RHCVC) Program, HRSA will make nearly $100 million available in grants to eligible RHCs nationwide to address health equity gaps by offering support and resources to medically underserved rural communities where COVID-19 vaccine uptake lags in comparison to more populated areas. HRSA will fund all eligible RHCs that apply. The RHCVC Program is the first targeted RHC grant since the passage of the Rural Health Clinic Service Act in 1977.

RHCs will be able to use the funds to increase vaccine confidence, improve health care in rural areas, and reinforce key messages about prevention and treatment of COVID-19 and other infectious diseases. Implementation efforts in rural communities will include disseminating information to rural residents about how and where to get vaccinated, and coordinating with existing vaccination sites and public health partners to identify strategies to increase vaccine confidence among key populations. RHCs may also use funding to promote vaccination and bolster patient literacy in rural areas on the benefits of broad vaccination and vaccine safety in support of continued efforts to return to a more normal lifestyle.

For more information about HRSA's rural programs, visit the Federal Office of Rural Health Policy website: https://www.hrsa.gov/rural-health/index.html

To learn more about HRSA's allocation to Rural Health Clinics for COVID-19 testing visit: https://www.hrsa.gov/rural-health/coronavirus/rural-health-clinics-covid-19-testing-fy20-awards

To learn more about the Small Rural Hospital Improvement Program (SHIP), visit https://www.hrsa.gov/rural-health/rural-hospitals.

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news. Like HHS on Facebook, follow HHS on Twitter @HHSgov, and sign up for HHS Email Updates.
Last revised: May 4, 2021

https://www.hhs.gov/about/news/2021/05/04/hhs-announces-nearly-1-billion-from-american-rescue-plan-for-rural-covid-19-response.html

HHS Announces Nearly $1 Billion from American Rescue Plan for Rural COVID-19 Response

•**Provide up to $100,000 to each of more than 4,600 Rural Health Clinics (RHCs)** across the country through the Rural Health Clinic COVID-19 Testing and Mitigation Program, which follows the success of the Rural Health Clinic COVID-19 Testing Program. Send questions about the Rural Health Clinic COVID-19 Testing and Mitigation Program to RHCCOVID-19Testing@hrsa.gov.

•Further expand COVID-19 testing in approximately **1,730 small rural hospitals – Critical Access Hospitals and other rural hospitals with fewer than 50 beds – with up to $230,000 each** through the Small Rural Hospital Improvement Program (SHIP). Hospitals that are interested should contact their state's SHIP grantee.

•**Invite RHCs to join the new Rural Health Clinic COVID-19 Vaccine Distribution Program** – a joint effort with the Centers for Disease Control and Prevention to increase COVID-19 vaccine supply in rural communities. Send questions about the Rural Health Clinic COVID-19 Vaccine Distribution Program to ruralpolicy@hrsa.gov with RHC Vaccine Distribution in the subject line.

•**Make nearly $100 million available in grants through the Rural Health Clinic Vaccine Confidence (RHCVC) Program.** ***HRSA will fund all eligible RHCs that apply*****.** Rural Health Clinics participating in the RHCVC program will be able to use the funds to increase patient and community confidence in COVID-19 vaccination and to address equity gaps by bolstering patient literacy on the benefits of broader vaccination for other infectious diseases. Send questions about the Rural Health Clinic Vaccine Confidence Program to RHCVaxconfidence@hrsa.gov. **$21,739.13 per RHC if everyone applies**

President Biden Announces Trio of RHC COVID-19 Initiatives

RHC COVID-19 Testing and Mitigation Program to Allocate $100,000 per RHC

05/04/2021

Today, President Biden announced in a White House press release a trio of COVID-19 initiatives involving rural health clinics. They are as follows:

Shipping New Allocations of Vaccine to Rural Health Clinics*: The Administration will send vaccines directly to rural health clinics in some of our most underserved communities. This initiative will include clinics in areas with a limited number of other vaccination sites, and enhance vaccine access in rural communities across the country.*

While formal details are still to be determined, last Friday we asked RHCs to fill out a quick form if they were interested in receiving a direct allocation of vaccines supply from the federal government. We recommend that you fill out **this form**, at your earliest convenience, if your RHC is interested in receiving this supply.

Increasing Vaccine Education and Outreach Efforts in Rural Communities*: The President announced over $100 million in American Rescue Plan (ARP) funding to approximately 4,600 rural health clinics across the country to support vaccine outreach in rural communities. This funding will be used to assist rural residents in accessing vaccinations as well as education and outreach efforts around the benefits of vaccination.*

It is NARHC's understanding that this funding will be made available through a Health Resources and Services Administration (HRSA) grant program and that interested RHC will have to apply for this funding. The purpose of the grant will be to help pay for vaccine outreach and/or overcoming vaccine hesitancy in the population. We plan to work closely with HRSA on this initiative and will keep the RHC community apprised as more details are made available.

***Increasing Funding for Rural Health Clinics and Hospitals to Respond to COVID-19 with Testing and Mitigation Measures**:*

The Health Resources and Services Administration (HRSA) is providing nearly $860 million in ARP funding to help rural health clinics and rural hospitals broaden their COVID-19 testing and mitigation to slow the spread of the virus in their communities. HRSA will provide up to $100,000 per clinic to each of the 4,600 federally designated rural health clinics and up to $230,000 per hospital to 1,730 small rural hospitals to increase COVID-19 testing, expand access to testing in rural communities, and broaden efforts to respond to and mitigate the spread of the virus in ways tailored to community needs.

This program will be very similar to the $49,461.42 RHCs received last May for COVID-19 Testing, as this funding will be allocated directly to each and every RHC with no application necessary. However, a key difference between this forthcoming allocation and the funding from last year (besides the amount) is that this year's funding can be used for COVID-19 Testing *and Mitigation* expenses, not just testing.
As many of you know, NARHC has been working with the Federal Office of Rural Health Policy (FORHP), NOSORH and the State Offices of Rural Health to provide technical assistance on the RHC COVID-19 Testing Program. We hope that we will be able to provide technical assistance for this forthcoming allocation as well. At this time, it is our understanding that RHCs will need to be properly registered on RHCcovidreporting.com in order to be eligible for this forthcoming allocation.

Like the RHC COVID-19 testing program this funding will be made directly to the banking information associated with each Tax Identification Number (TIN) organization that owns a rural health clinic. If the organization owns multiple RHCs, the organization will receive $100,000 per RHC.
We understand that many of you may have questions about what exactly COVID-19 *mitigation* entails and how the terms and conditions for this bucket of money may differ from previous (and other forthcoming) allocations. We have many of those same questions and we will be working to provide you with this crucial information as soon as it is available.

1. We were certified as an RHC in 2021 but did not receive the $49,000 in COVID-19 Testing monies. Will we get the $100,000 and do we need to sign up for the COVID-19 Testing portal?
2. We are awaiting our RHC inspection as of May 5, 2021. We have an approved 855A but need the state inspection to officially be an RHC. Do we qualify for the $100,000?

COVID-19 Coverage Assistance Fund

On May 3 the US Department of Health and Human Services, through the Health Resources and Services Administration (HRSA) announced a new program covering costs of administering COVID-19 vaccines to patients enrolled in health plans that either do not cover vaccination fees or cover them with patient cost-sharing. Since providers cannot bill patients for COVID-19 vaccination fees, this new program, the COVID-19 Coverage Assistance Fund (CAF), addresses an outstanding compensation need for providers on the front lines vaccinating underinsured patients.

www.hrsa.gov/covid19-coverage-assistance

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Get reimbursed for COVID-19 testing and treatment of uninsured individuals. Learn more »

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COVID-19 Coverage Assistance Fund

Technical Assistance

HRSA will be hosting two webcast sessions to provide an overview and orient health care providers to the program by covering information such as enrolling as a provider participant, submitting patient information, submitting claims, and receiving payment via direct deposit:

- Register for the Thursday, May 6 webcast
- Register for the Wednesday, May 12 webcast

Update: The HRSA COVID-19 Coverage Assistance Fund (CAF) Portal is now open.

For more information about the program, access:

- Program Fact Sheet (PDF - 218 KB)
- Educational Toolkit (PDF - 1.88 MB)
- Clearinghouse Fact Sheet (PDF - 389 KB)
- Provider Portal Guide (PDF - 1.45 MB)

The Biden-Harris Administration is providing free access to COVID-19 vaccines for every adult living in the United States. Accordingly, the Health Resources and Services Administration's (HRSA) COVID-19 Coverage Assistance Fund (CAF) will cover the costs of administering COVID-19 vaccines to patients whose health insurance doesn't cover vaccine administration fees, or does but typically has patient cost-sharing. While patients cannot be billed directly for COVID-19 vaccine fees, costs to health care providers on the front lines for administering COVID-19 vaccines to underinsured patients will now be fully covered through CAF, subject to available funding. As vaccination efforts accelerate, patients will increasingly gain access to COVID-19 vaccines at locations near where they live with providers they trust.

Providers who have administered Food and Drug Administration (FDA) authorized COVID-19 vaccines under an Emergency Use Authorization (EUA) or FDA-licensed COVID-19 vaccines under a Biologics License Application (BLA) to underinsured individuals, on or after December 14, 2020 (the first date of vaccine distribution in the United States), may now submit their COVID-19 vaccine administration fee claims for reimbursement consideration to the CAF. To be eligible for reimbursement, the provider must have first submitted the claim to the individual's health plan for payment and had the claim denied or only partially paid.

Providers can access the CAF Portal

View Frequently Asked Questions

Note that providers who have administered COVID-19 vaccines to uninsured patients on or after December 14, 2020 are eligible to submit claims for reimbursement to the HRSA COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment and Vaccine Administration for the Uninsured (HRSA Uninsured Program).

About the Program

HRSA will provide claims reimbursement to eligible health care providers at the national Medicare rate for administering Food and Drug Administration (FDA) authorized COVID-19 vaccines under an Emergency Use Authorization (EUA) or FDA-licensed COVID-19 vaccines under a Biologics License Application (BLA) to underinsured individuals.

CMS Updates Transmittal to MACs Regarding New RHC Upper Payment Limits

On May 4th, the Centers for Medicare and Medicaid Services (CMS) updated Change Request 12185, which is the main document from CMS implementing the new RHC Upper Payment Limits from the Consolidated Appropriations Act of 2021.
As many of you are aware, the Consolidated Appropriations Act of 2021 contained a drafting error regarding the grandfathering date which NARHC worked swiftly to correct. On April 14th, President Biden signed the grandfathering fix into law, simultaneously fixing the grandfathering date and creating a mechanism for entities that had submitted an application to become a RHC by the end of 2020 to also be considered grandfathered.

However, because payment limits technically took effect on April 1, 2021, CMS had to issue guidance implementing the law on the books at the time. As a result, the initial Change Request 12185 did not include the updated grandfathering date, and until now, was all the instruction the MACs had in regards to the new upper payment limits.

As a result, MACs were applying $100 upper payment limits to RHCs that opened in 2020 not yet reflecting the grandfathering fix President Biden signed into law. Now, however, the guidance *does* reflect the April 14th statutory fix and the MACs have the instruction they need to properly pay those RHCs that were established in 2020.
We suspect that an updated MLN Matters Article will also be posted soon. The full change request can be read **HERE**.
Nathan Baugh
Director of Government Affairs

https://www.cms.gov/files/document/r10780otn.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10780	**Date: May 4, 2021**
	Change Request 12185

Transmittal 10679, dated March 16, 2021, is being rescinded and replaced by Transmittal 10780, dated, May 4, 2021 to revise the background and policy sections. This correction also revises Business Requirement (BR) 12185.2 and adds BR 12185.2.1. All other information remains the same.

SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

I. SUMMARY OF CHANGES: This Change Request updates the payment limit for Rural Health Clinics (RHCs) in Chapter 9, Section 20.2 - "Payment Limit under the AIR" of the Claims Processing Manual effective April 1, 2021.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 10780	Date: May 4, 2021	Change Request: 12185

Transmittal 10679, dated March 16, 2021, is being rescinded and replaced by Transmittal 10780, dated, May 4, 2021 to revise the background and policy sections. This correction also revises Business Requirement (BR) 12185.2 and adds BR 12185.2.1. All other information remains the same.

SUBJECT: Update to Rural Health Clinic (RHC) Payment Limits

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

I. GENERAL INFORMATION

A. Background: As authorized by section 1833(f) of the Social Security Act (the Act), Medicare Part B payment to independent RHCs is 80 percent of the All-Inclusive Rate (AIR), subject to a payment limit for medically necessary medical, mental, and qualified preventive face-to-face visits with a RHC practitioner and a Medicare beneficiary for RHC services. The payment limits for subsequent years are increased in accordance with the rate of increase in the Medicare Economic Index (MEI).

In addition, under section 1833(f) of the Act, an RHC that is provider-based to a hospital with fewer than 50 beds is exempt from the statutory payment limit per visit. That is, a provider-based RHC's AIR (also referred to as per visit payment amount) is based on their average allowable costs determined at cost report settlement.

In the interim final rule (IFC) with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27569), CMS implemented a policy that excludes temporarily added surge capacity beds due to the Public Health Emergency (PHE) for the COVID–19 pandemic (defined at § 400.200) from a hospital's bed count (discussed at § 412.105(b)) for the purposes of determining whether an RHC that is provider-based to that hospital is exempt from the statutory payment limit per visit.

Effective January 1, 2021, the RHC payment limit per visit for Calendar Year (CY) 2021 is $87.52. This payment limit applies to independent RHCs and RHCs that are provider-based to a hospital with 50 or more beds. This payment limit was implemented through Change Request 12035, Transmittal 10413, entitled "Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2021".

Division CC, section 130 of the Consolidated Appropriations Act of 2021(P. L. 116-260), signed December 27, 2020, updated §1833(f) of the Act by restructuring the payment limits for RHCs beginning April 1, 2021.

Section 2 of H.R.1868 (P. L. 117-7), signed April 14, 2021, provided a technical correction to §1833(f). The amendments made by this technical correction take effect as if included in the enactment of the Consolidated Appropriations Act of 2021(P. L. 116-260).

B. Policy:
1. Independent RHCs and provider-based RHCs in a hospital with 50 or more beds

Beginning April 1, 2021, in accordance with section 1833(f)(2) of the Act, RHCs will begin to receive an increase in their payment limit per visit over an 8-year period, with a prescribed amount for each year from 2021 through 2028. Then, in subsequent years, the limit is updated by the percentage increase in MEI applicable to primary care services furnished as of the first day of that year.

More Provider Relief Funds

- President Biden signed the **American Rescue Plan Act of 2021 (the "ARP")** into law on March 11, 2021. Included in the massive $1.9 trillion relief package was an additional **$8.5 billion for rural hospitals and providers**. (there is still $25 billion left over from CARES Act funding in 2020)

- The $8.5 billion **creates a new relief fund for certain eligible rural health care providers** ("Rural Relief Fund"). This new Rural Relief Fund **is separate from the existing Department of Health and Human Services ("HHS") $178 billion Provider Relief Fund** created by the Coronavirus Aid, Relief and Economic Security Act ("CARES Act"), though the two are structured nearly identically.

Who Qualifies

The definition for the new Rural Relief Fund requires providers to be considered a rural provider or supplier.

1. A provider or supplier located in a rural area (i.e., outside of a Metropolitan Statistical Area);
2. A provider treated as located in a rural area (i.e., is reclassified as rural under 42 CFR 412.103);
3. A provider or supplier located in any other area that serves rural patients (as defined by HHS), which may include a Metropolitan Statistical Area with a population of less than 500,000;
4. **Rural Health Clinics;**
5. A provider or supplier that furnishes home health, hospice or long-term services and supports in an individual's home located in a rural area (outside of a Metropolitan Statistical Area); and
6. Any other rural provider or supplier as defined by HHS.

You must apply for ARP funds

- Funds will be distributed based on applications that must include

1. a statement justifying need,
2. documentation of expenses and lost revenues,
3. tax identification number,
4. other items as determined by HHS.

https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html

Provider Relief Funds Reporting Non-Update

Question: Provider Relief Funds must be Reported by this date?

A. August 2, 2021

B. June 30, 2021

C. July 31, 2021

D. We still do not know.

Summary of Possible Distributions to RHCs

	Type	Date*	Amount	Report in PRF Portal	Subject to Single Audit
RHC Distribution	Targeted	5/6/2020	$103,000 +	Yes	Yes
RHC COVID-19 Testing	Not an HHS Distribution	5/20/2020	$49,461.42	No	Yes
Phase I, II, III	General	4/2020, 9/2020, 12/2020	% of Medicare Revenues/Total Expenses	Yes	Yes
COVID Uninsured Claims	Allocation	As Claimed	Medicare Fee Schedule	No	Yes
Medicare Advanced Payments	Loan	As Requested	% of Medicare Revenue	No	No
PPP Loan	Forgivable Loan	As Approved	2 ½ Months of payroll initially	No	No

*Your date may be different. Most RHCs received monies on these dates.

TABLE OF RELIEF FUNDS FROM THE NARHC

Tranche	Date	Amount	Purpose	Reporting
Phase 1 General Distribution	April 10, 2020	6.2% of 2019 Medicare Reimbursement	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
Phase 2 General Distribution	April 24, 2020	2% of 2018 revenue minus phase 1 distribution	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
Phase 3 General Distribution	December 15, 2020	Variable	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
Rural Targeted Allocation	May 6, 2020	$103k + 3.6% operating expenses (Ind), Graduated Base Payment + 1.97% of operating expenses (PB)	Lost Revenue and Unreimbursed COVID Expenses	Provider Relief Fund Portal
RHC COVID-19 Testing Program	May 20, 2020 + later dates	$49,461.42 per RHC	Unreimbursed COVID testing expenses	www.RHCcovidreporting.com
American Rescue Plan	TBD – Will have to apply	TBD	Lost Revenue and Unreimbursed Covid Expenses	TBD
ARP – Agriculture Grants	TBD – Will have to apply	TBD	COVID or Expand Services/Telehealth	TBD
Others?	TBD	TBD	TBD	TBD

Source: Nathan Baugh, NARHC

Do Not include RHC Covid-19 Lab Testing in the HHS Provider Relief Funding Reporting

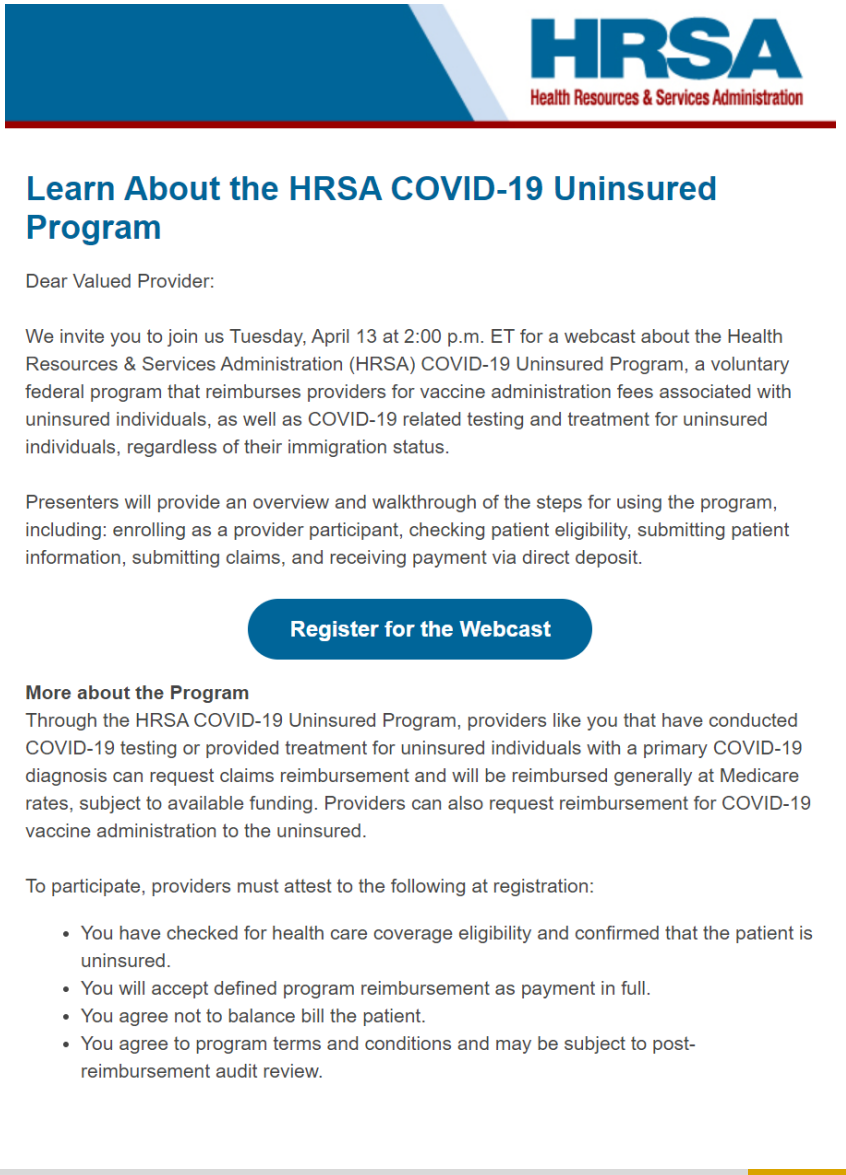
- Rural Health Clinic Testing distribution. If your only PRF payment was the Rural Health Clinic Testing Distribution, you should not register in the PRF Reporting Portal. For information about the Rural Health Clinic Testing reporting requirements, contact RHCCOVID-19Testing@hrsa.gov and learn more at the Rural Health Clinic Testing website.

Rural Health Clinic COVID-19 Testing Program Data Report (RHC CTR)
The Department of Health and Human Services (HHS) announced $225 million for rural health clinics (RHCs) to provide COVID-19 testing as authorized by the Paycheck Protection Program and Health Care Enhancement Act. This program resulted in an amount of **$49,461.42** for each eligible RHC.

https://www.rhccovidreporting.com/

Learn about the HRSA COVID-19 Uninsured Program

https://webex.webcasts.com/starthere.jsp?ei=1450127&tp_key=f386ea0ee0



HRSA
Health Resources & Services Administration

Learn About the HRSA COVID-19 Uninsured Program

Dear Valued Provider:

We invite you to join us Tuesday, April 13 at 2:00 p.m. ET for a webcast about the Health Resources & Services Administration (HRSA) COVID-19 Uninsured Program, a voluntary federal program that reimburses providers for vaccine administration fees associated with uninsured individuals, as well as COVID-19 related testing and treatment for uninsured individuals, regardless of their immigration status.

Presenters will provide an overview and walkthrough of the steps for using the program, including: enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit.

Register for the Webcast

More about the Program

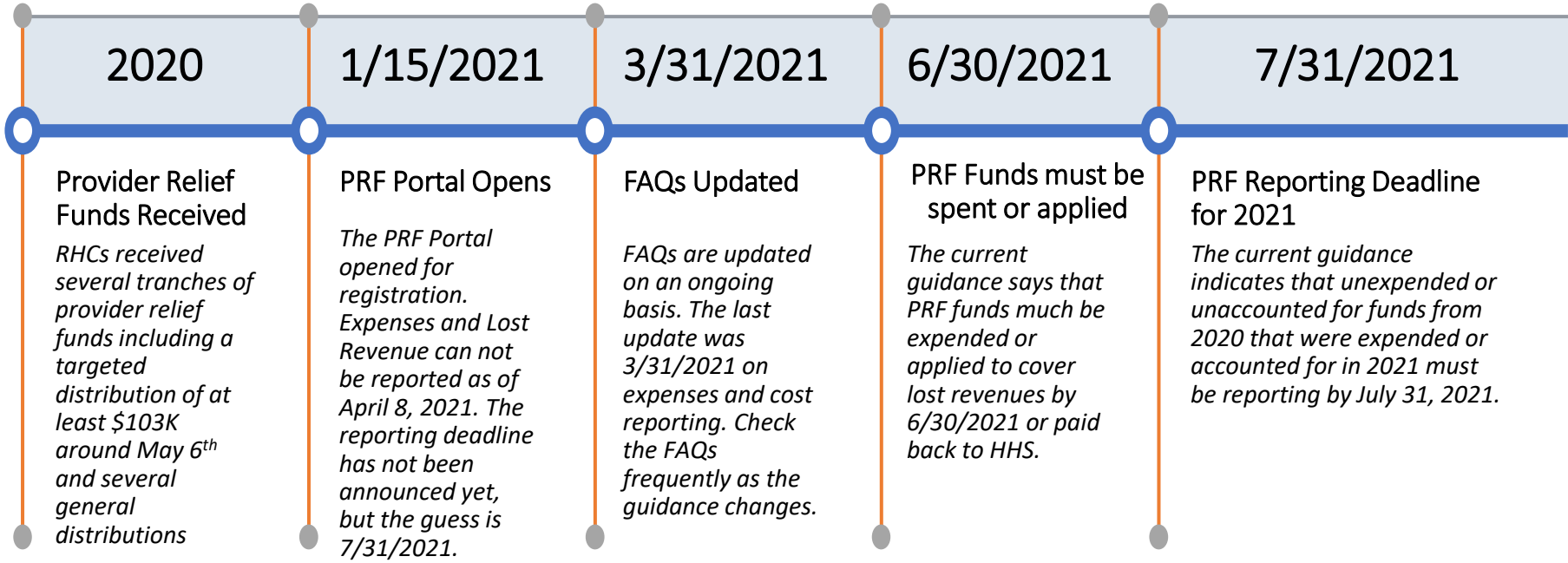
Through the HRSA COVID-19 Uninsured Program, providers like you that have conducted COVID-19 testing or provided treatment for uninsured individuals with a primary COVID-19 diagnosis can request claims reimbursement and will be reimbursed generally at Medicare rates, subject to available funding. Providers can also request reimbursement for COVID-19 vaccine administration to the uninsured.

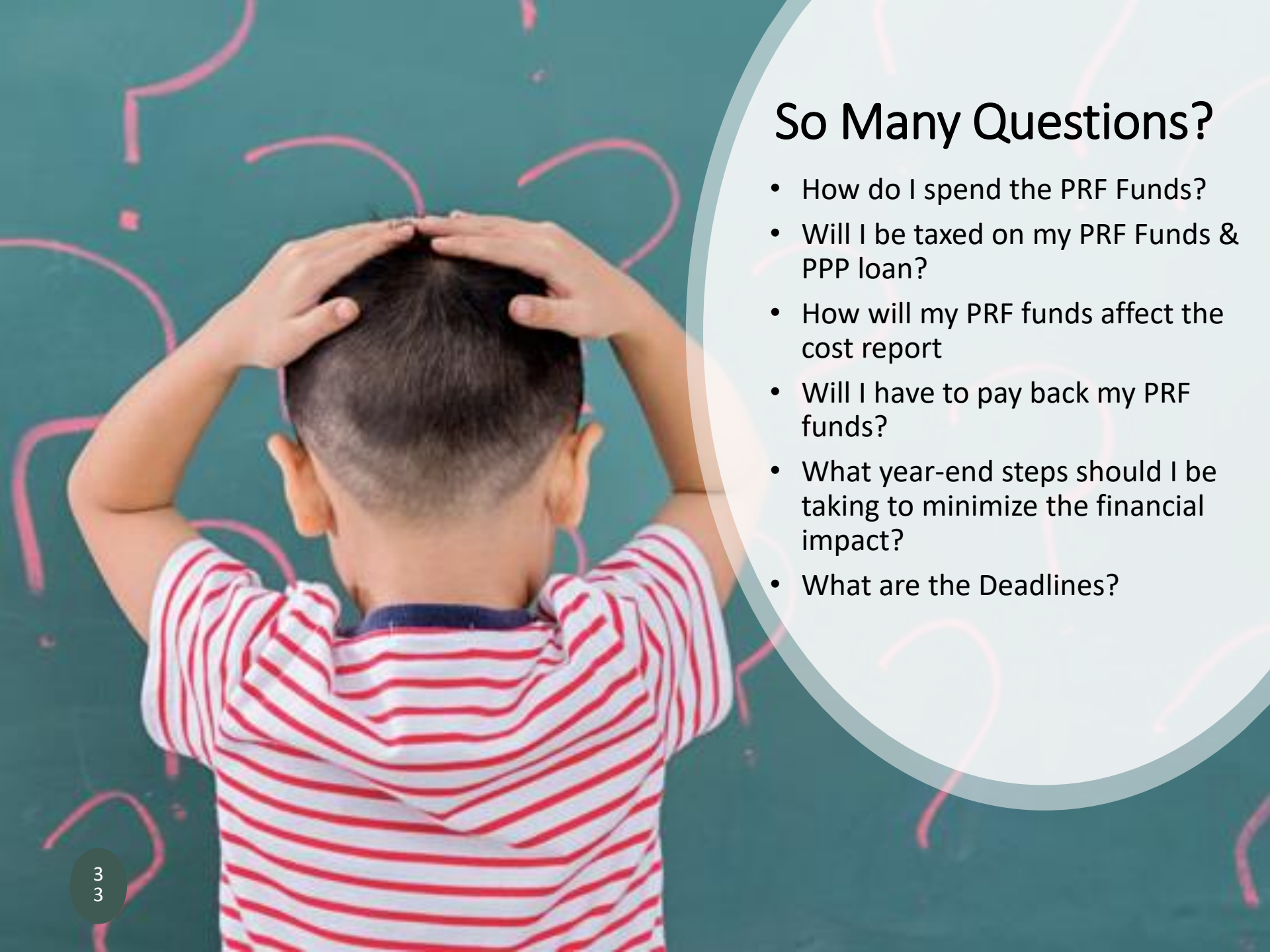
To participate, providers must attest to the following at registration:

- You have checked for health care coverage eligibility and confirmed that the patient is uninsured.
- You will accept defined program reimbursement as payment in full.
- You agree not to balance bill the patient.
- You agree to program terms and conditions and may be subject to post-reimbursement audit review.

Provider Relief Funds Timeline
As of May 5, 2021
(Subject to Change)

Timeline





So Many Questions?

- How do I spend the PRF Funds?
- Will I be taxed on my PRF Funds & PPP loan?
- How will my PRF funds affect the cost report
- Will I have to pay back my PRF funds?
- What year-end steps should I be taking to minimize the financial impact?
- What are the Deadlines?

Quick Answers without Context
Consult Appropriate Professionals

Question	Answer
Should we try to spend as much of my PRF funds as possible by 12/31?	Yes
Should we pay hazard pay using my PRF funds before 12/31 6/30/21	Yes
How long do we have to spend PRF funds	6/30/2021
Will we have to pay back unused PRF funds	Yes
Are PRF funds taxable?	Yes
Are PPP loan proceeds taxable?	No
Are expenses paid with PPP loan proceeds deductible?	1. ~~No~~ Yes
Are expenses reimbursed with PRF funds allowable expenses on the CR?	Yes
Are these answers subject to change?	Yes

1. The appropriations act includes the COVID-related Tax Relief Act of 2020, which provides for the full deductibility of ordinary and necessary business expenses that were paid with a forgiven or forgivable PPP loan.

The Bad News – PRF Funds are Taxable

Frequently Asked Questions about Taxation of Provider Relief Payments

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted on March 27, 2020, appropriated $100 billion for the Public Health and Social Services Emergency Fund (Provider Relief Fund). The Paycheck Protection Program and Health Care Enhancement Act, enacted on April 24, 2020, appropriated an additional $75 billion to the Provider Relief Fund. This funding will be used to reimburse eligible health care providers for health care-related expenses or lost revenues that are attributable to the COVID-19 pandemic. See https://www.hhs.gov/provider-relief/index.html for more information about the Provider Relief Fund.

Q1: May a health care provider that receives a payment from the Provider Relief Fund exclude this payment from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code (Code)?

A: No. A payment to a business, even if the business is a sole proprietorship, does not qualify as a qualified disaster relief payment under section 139. The payment from the Provider Relief Fund is includible in gross income under section 61 of the Code.

Q: Is a tax-exempt health care provider subject to tax on a payment it receives from the Provider Relief Fund?

A: Generally, no. A health care provider that is described in section 501(c) of the Code generally is exempt from federal income taxation under section 501(a). Nonetheless, a payment received by a tax-exempt health care provider from the Provider Relief Fund may be subject to tax under section 511 if the payment reimburses the provider for expenses or lost revenue attributable to an unrelated trade or business as defined in section 513.

https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments

The Good News – You can use the additional taxes as a use of your PRF Funds

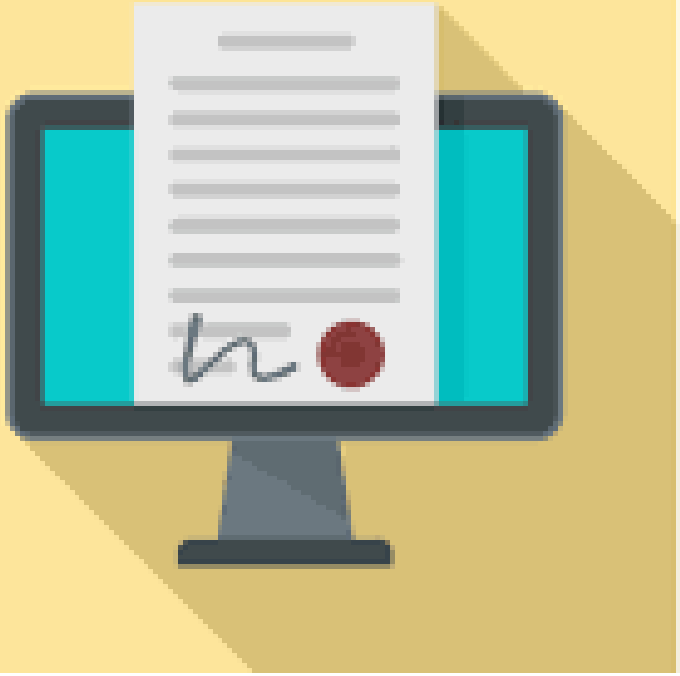
Can providers use Provider Relief Fund payment to pay taxes? *(Added 12/11/2020)* −

Yes. HHS considers taxes imposed on Provider Relief Fund payments to be "healthcare related expenses attributable to coronavirus" that are reimbursable with Provider Relief Fund money, except for Nursing Home Infection Control Distribution payments.

How to compute the additional Tax Burden
Call your Tax Person

1. Prepare the tax return without the PRF funds reported
2. Prepare the tax return with the PRF funds included in revenue
3. Compute the difference.

CARES Act Provider Relief Fund Attestation Portal is Live



Key Dates for Provider Relief Funding Reporting
Updated per January 15, 2021 Guidance
As of May 5, 2021 this slide is accurate

What was supposed to Happen

- January 15, 2021: Portal opens for providers
- February 15, 2021: first reporting deadline for all providers on funds spent during 2020
- **June 30, 2021: All Funds must be expended by this date.**
- July 31, 2021: final reporting deadline for providers who did not fully expend PRF funds prior to December 31, 2020. Spending from January 1, 2021 to June 30, 2021.

What Happened

January 15, 2021: Portal opened for registration only. No reporting is available at this time.

The reporting deadline has been revised and will be in the future. We have not been told what the deadline will be.

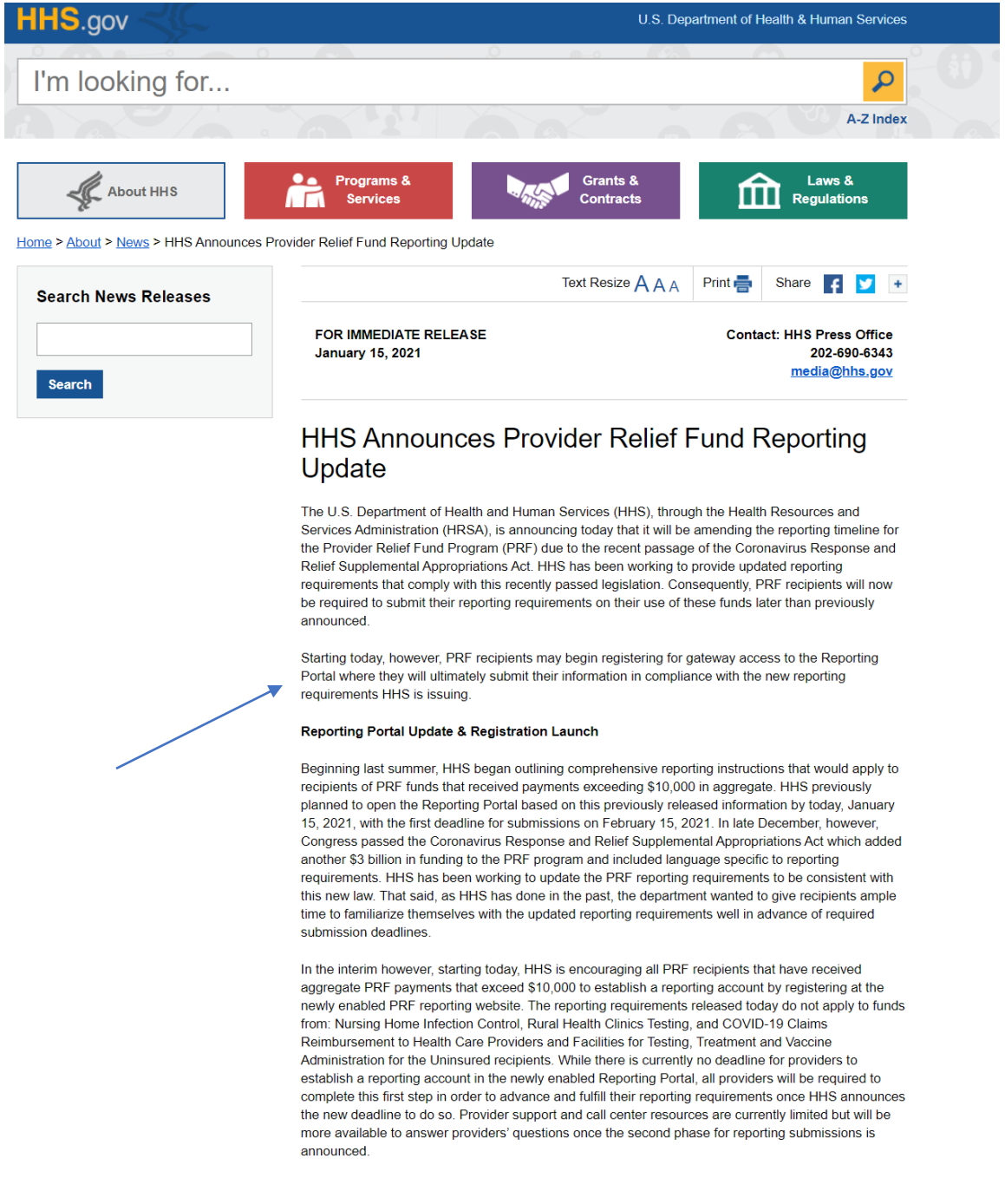
No Changes in the January 15 Update

No Changes in the January 15 Update

January 15, 2021 HHS Press Release on Provider Relief Funding

Source:

https://www.hhs.gov/about/news/2021/01/15/hhs-announces-provider-relief-fund-reporting-update.html



HHS.gov U.S. Department of Health & Human Services

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Home > About > News > HHS Announces Provider Relief Fund Reporting Update

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FOR IMMEDIATE RELEASE
January 15, 2021

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Announces Provider Relief Fund Reporting Update

The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is announcing today that it will be amending the reporting timeline for the Provider Relief Fund Program (PRF) due to the recent passage of the Coronavirus Response and Relief Supplemental Appropriations Act. HHS has been working to provide updated reporting requirements that comply with this recently passed legislation. Consequently, PRF recipients will now be required to submit their reporting requirements on their use of these funds later than previously announced.

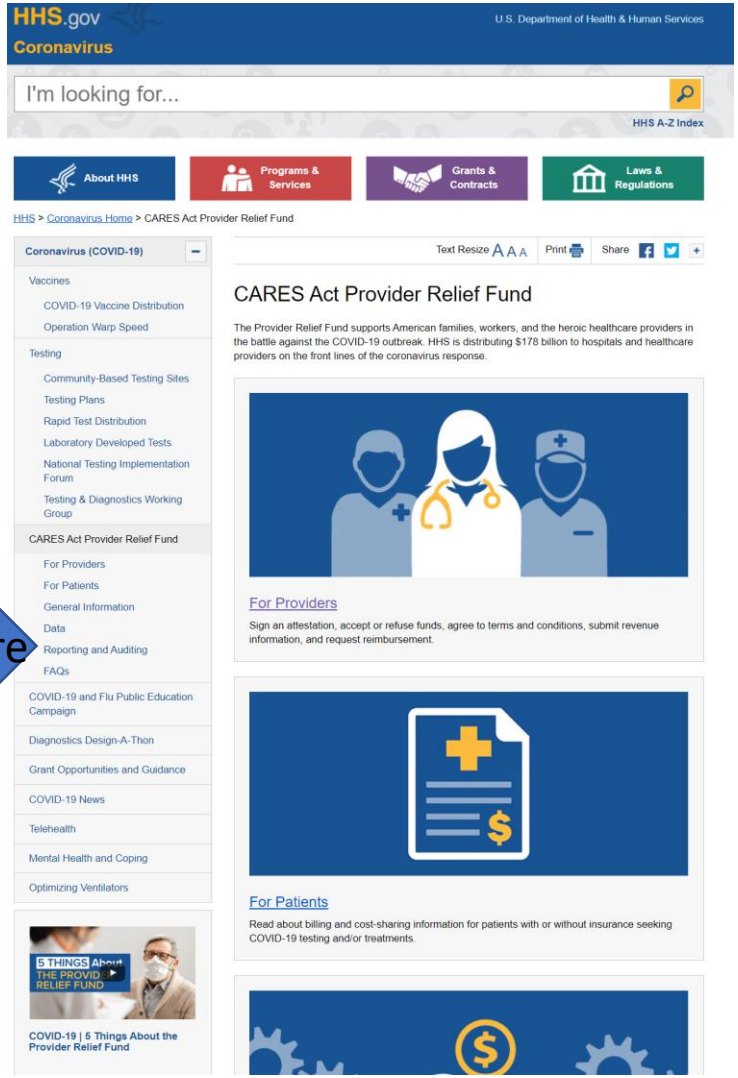
Starting today, however, PRF recipients may begin registering for gateway access to the Reporting Portal where they will ultimately submit their information in compliance with the new reporting requirements HHS is issuing.

Reporting Portal Update & Registration Launch

Beginning last summer, HHS began outlining comprehensive reporting instructions that would apply to recipients of PRF funds that received payments exceeding $10,000 in aggregate. HHS previously planned to open the Reporting Portal based on this previously released information by today, January 15, 2021, with the first deadline for submissions on February 15, 2021. In late December, however, Congress passed the Coronavirus Response and Relief Supplemental Appropriations Act which added another $3 billion in funding to the PRF program and included language specific to reporting requirements. HHS has been working to update the PRF reporting requirements to be consistent with this new law. That said, as HHS has done in the past, the department wanted to give recipients ample time to familiarize themselves with the updated reporting requirements well in advance of required submission deadlines.

In the interim however, starting today, HHS is encouraging all PRF recipients that have received aggregate PRF payments that exceed $10,000 to establish a reporting account by registering at the newly enabled PRF reporting website. The reporting requirements released today do not apply to funds from: Nursing Home Infection Control, Rural Health Clinics Testing, and COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment and Vaccine Administration for the Uninsured recipients. While there is currently no deadline for providers to establish a reporting account in the newly enabled Reporting Portal, all providers will be required to complete this first step in order to advance and fulfill their reporting requirements once HHS announces the new deadline to do so. Provider support and call center resources are currently limited but will be more available to answer providers' questions once the second phase for reporting submissions is announced.

Provider Relief Funds Landing Page (Google Provider Relief Funds)



Click Here

Page was updated 1/15/2021

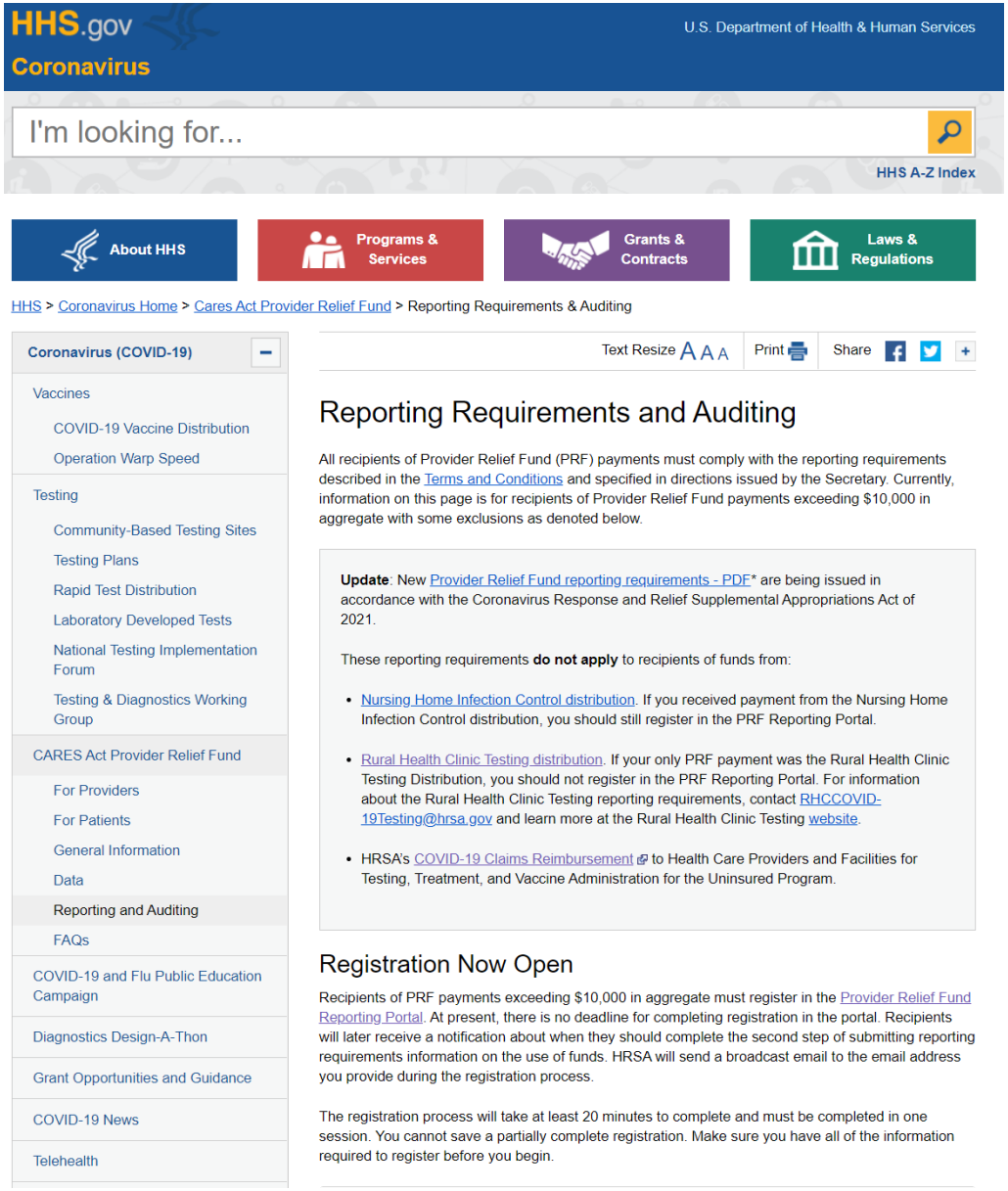
Reviewed on 3/23/2021 but did not change from 1/15/2021

https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

Reporting and Auditing Landing Page

Source:

- https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html



Portal Registration Now Open

- **Provider Relief Fund (PRF) Reporting Portal**
- This portal is for recipients exceeding $10,000 in PRF payments to complete post-payment reporting requirements. The portal is **currently only open for registration**, not reporting.
- **At present, there is no deadline for completing registration in the portal**. Recipients will later receive a notification about when they should complete the second step of submitting reporting requirements information on the use of funds**. HRSA will send a broadcast email to the email address you provide during the registration process.**
- For more information about the registration process, refer to the PRF Reporting Portal User Guide ___ and the Reporting Portal FAQs ___.
- Assistance via phone is limited to basic questions about the registration process at this time. For those basic inquires, call the Provider Support Line at (866) 569-3522; for TTY dial 711. Hours of operation are 7 a.m. to 10 p.m. Central Time, Monday through Friday.

Portal Registration Now Open (2)

The registration process will take at least 20 minutes to complete and must be completed in one session. **You cannot save a partially complete registration. Make sure you have all of the information required to register before you begin.**

The portal is only compatible with the most current version of Edge, Chrome, and Mozilla Firefox.

Do this First before entering the portal

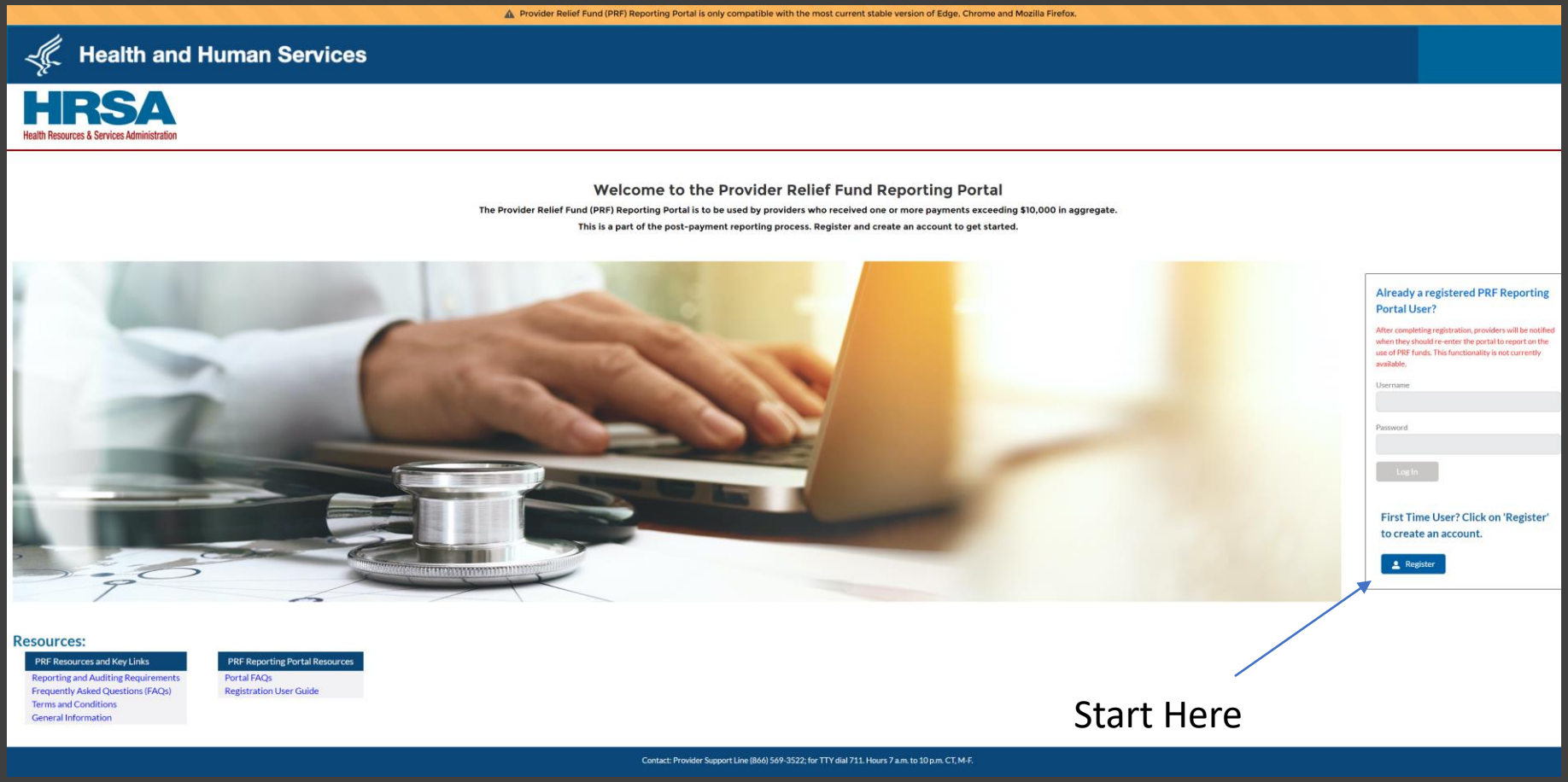
What information do I need to complete the registration process in the PRF Reporting Portal?

Information required to register is as follows:

- Tax ID Number (TIN) (or other number submitted during the application process (e.g., Social Security Number, Employer Identification Number (EIN))
- Business name (as it appears on a W-9) of the reporting entity 1.
- Contact information (name, phone number, email) of the person responsible for submitting the report
- Address (street, city, state, five digit zip code) of the reporting entity as it appears on a W-9)
- TIN(s) of subsidiaries (if a provider is reporting on behalf of subsidiary(ies) - in a list delimited by commas, e.g.,123456789,987654321,135791357)
- Payment information (for any of the payments received) 2.
  - TIN of entity that received the payment
  - Payment amount
  - Mode of payment (check or direct deposit ACH)
  - Check number or ACH settlement date

You will also need to create a username (in the form of an email) and a password during the registration process.

1. Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service. (Think CP-575)
2. **You only have to report one of the payments to register**. I would use the targeted Rural Distribution that was at least $100,000 and paid around May 6, 2020. (Provider-based RHCs were paid through the hospital distribution)



Start Here

This is what the portal looks like

Link

https://prfreporting.hrsa.gov/s/

Already a registered PRF Reporting Portal User?

After completing registration, providers will be notified when they should re-enter the portal to report on the use of PRF funds. This functionality is not currently available.

User Guide

USER GUIDE - REGISTRATION

PROVIDER RELIEF FUND REPORTING PORTAL

Date: January 15, 2021

https://hrsac19.my.salesforce.com/sfc/p/#t00000004XgP/a/t0000001FIcy/yU0WSf98g33mM6OuwWS2OK0mNwKY8cYwBK9PhP.2GoA

FAQs

Provider Relief Fund (PRF) Reporting Portal

Frequently Asked Questions (FAQs)

Last Updated: 1/15/2021

Disclaimer: Some PRF recipients may not need to report on the use of their funds. Only PRF recipients who need to report must register in the PRF Reporting Portal. PRF recipients should refer to information on the PRF webpage and the most recently issued Post-Payment Notice of Reporting Requirements *for additional information.*

Table of Contents

General Questions

1. **Do I need to register for an account in the PRF Reporting Portal?**

   PRF recipients who received one or more payments exceeding $10,000 in the aggregate are required to report on several required data elements as part of the post-payment reporting process and therefore must register for an account.

2. **I only received funds from the Rural Health Clinic Testing Distribution. Am I required to register in the PRF Reporting Portal?**

   If your only PRF payment was the Rural Health Clinic Testing Distribution, you do not need to register in the PRF Reporting Portal. You should contact 'RHCCOVID-19Testing@hrsa.gov' for information about the Rural Health Clinic Testing reporting requirements and learn more at the Rural Health Clinic Testing website.

3. **I am a recipient of a Nursing Home Infection Control Distribution and we have not been informed of the reporting requirements. Should I register in the PRF Reporting Portal?**

   Recipients that meet the conditions for reporting on use of funds must register in the PRF Reporting Portal before they can begin reporting. Although HRSA has not yet announced the reporting requirements for the Nursing Home Infection Control Distribution, providers that otherwise meet reporting eligibility should complete registration. More information will be made public as soon as it becomes available.

4. **How do I access the PRF Reporting Portal?**

   The PRF Reporting Portal is accessible at: *https://PRFReporting.hrsa.gov*.

1

https://hrsac19.my.salesforce.com/sfc/p/#t00000004XgP/a/t0000001FId8/wN.4dTa.NRiNhwh_0CBblH6gvvedhqOt7_.5OS7rP6U

Revised Notice of Reporting Requirements

In addition to opening the portal for registration, HHS released yet another set of Provider Reporting Requirements with additional information on how to compute lost revenue. This seven-page document dated January 15, 2021 **replaces the three previous versions** and can be found here.

Source

https://www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements-january-2021.pdf

General and Targeted Distribution

Post-Payment Notice of Reporting Requirements

January 15, 2021

Purpose

The purpose of this notice is to inform Provider Relief Fund (PRF) recipients, who received one or r payments exceeding $10,000 in the aggregate, of the data elements that they will be required to repc part of the post-payment reporting process. This document supersedes the November 2, 2020 Post-P Notice of Reporting Requirements.

Please note that these reporting requirements do not apply to the Nursing Home Infection Control distributions or the Rural Health Clinic Testing distribution. Separate reporting requirements will be been announced for these distributions. These reporting requirements also do not apply to reimburse from the Health Resources and Services Administration (HRSA) COVID-19 Claims Reimbursemen Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Un Program and the HRSA COVID-19 Vaccine Administration Assistance Fund. Additional reporting announced in the future for these reimbursements.

Overview

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), the Paycheck Protection Program (PPP) and Health Care Enhancement Act (P.L. 116-139), and the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act (P.L. 116-123) appropriated funds reimburse eligible healthcare providers for healthcare related expenses or lost revenues attributable coronavirus. These funds were distributed by HRSA through the PRF program. Recipients of these agreed to Terms and Conditions, which require compliance with reporting requirements as specified Secretary of Health and Human Services in program instructions.

Purpose

This notice informs recipients of the categories of data elements that they must submit as part of the reporting process. HRSA has amended this notice to reflect changes to the reporting process in acco with the CRRSA. HRSA plans to offer Question and Answer Sessions via webinar in advance of th reporting deadline, and as needed, HRSA will also issue Frequently Asked Questions to provide gre clarity about the reporting process.

Reporting Instructions on Use of Funds

Recipients will report their use of PRF payments using their normal method of accounting (cash or a basis) by submitting the following information:

1. Healthcare related expenses attributable to coronavirus that another source has not reimbursed a not obligated to reimburse, which includes General and Administrative (G&A) and/or other hea related expenses (further defined within the data elements section below).
2. PRF payment amounts not fully expended on healthcare related expenses attributable to coronav then applied to patient care lost revenues. Documentation requirements for lost revenue calculat further defined within the data elements section below.

1

Provider Relief Funds

The PRF distributes funds "...to **prevent, prepare for, and respond to coronavirus**, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus."

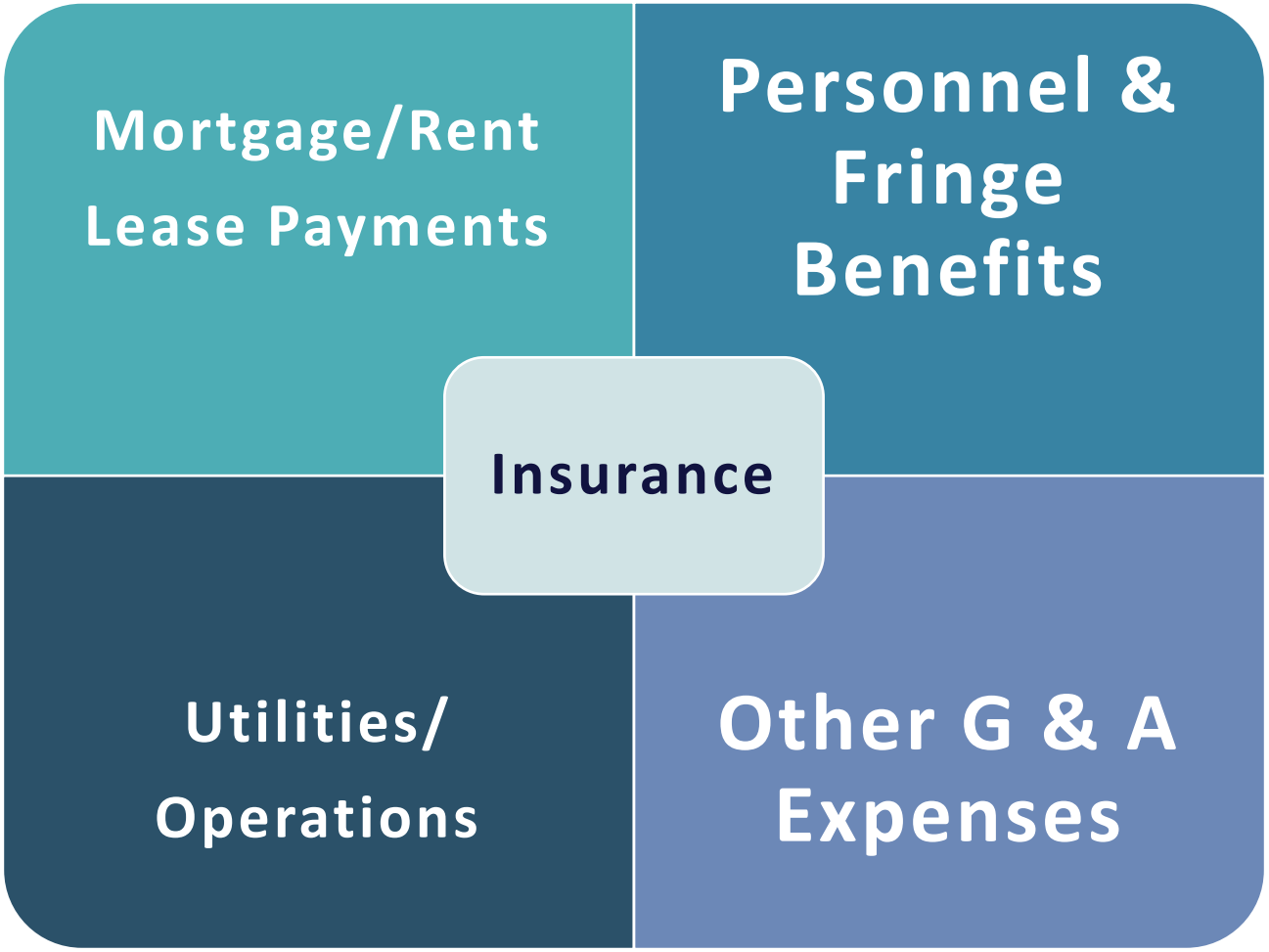
RHCs receiving less than $500,000 in PRF Funds

Healthcare Related Expenses Attributable to Coronavirus Not Reimbursed by Other Sources
Healthcare related expenses are limited to costs incurred to prevent, prepare for, and/or respond to coronavirus. Reporting Entities that received **between $10,001 and $499,999** in aggregated PRF payments are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed 4 sources (e.g., payments received from insurance and/or patients, and amounts received from federal, state, or local governments, etc.) in two categories: **(1) G&A expenses and (2) other healthcare related expenses**. **These are the actual expenses incurred over and above what has been reimbursed by other sources.**

RHCs Receiving $500,000 or more must report expenses in more detail

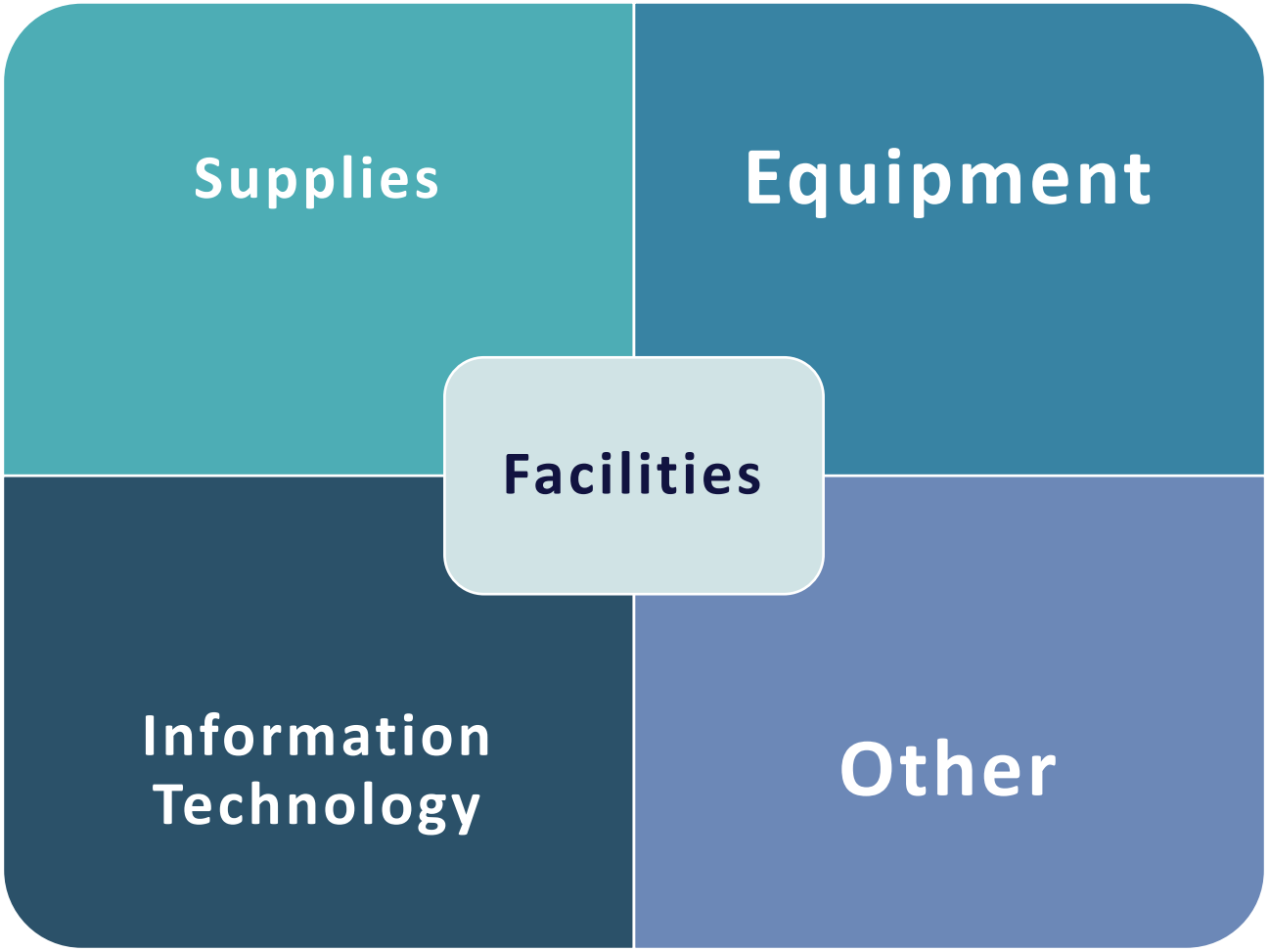
Reporting Entities that received $500,000 or more in PRF payments are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed sources, in greater detail then the two categories of G&A expenses and other healthcare related expenses, according to the following subcategories of expenses: General and Administrative Expenses Attributable to Coronavirus1 The actual G&A expenses attributable to coronavirus that were incurred over and above what has been reimbursed by other sources.

Healthcare Expenses for PRF Reporting
General & Administrative Expenses



Healthcare Expenses for PRF Reporting

Healthcare Expenses



FAQs from HHS

1. FAQs are updated and changed regularly. From May 2020 to January 2021 HHS updated the FAQs 50 times.
2. **The answers did substantially change over time. If you rely on the FAQ to make a decision, take a screenshot of the guidance.**

HHS FAQs	https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/provider-relief-fund-general-info/index.html#auditing-reporting-requirements
CMS FAQ (174 pages)	https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Can Reporting Entities claim the time spent by staff and director-level resources on COVID-19-specific matters, such as participating in task forces or preparing their health care organization's COVID-19 response, that they would not have otherwise spent time on in the absence of the pandemic? *(Added 2/24/2021)*

Time spent by staff on COVID-19-specific matters may be an allowable cost attributable to coronavirus so long as it was not reimbursed or obligated to be reimbursed by other sources. If the personnel salaries are reimbursed by any other source of funding they cannot be also reimbursed by the Provider Relief Fund. In addition, no one individual may be allocated as greater than one full-time equivalent (FTE) across all sources of funding. All costs must be tangible expenses (not opportunity costs) and must be supported by documentation.

The Reporting Entity must maintain appropriate records and cost documentation including, as applicable, documentation described in 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient must promptly submit copies of such records and cost documentation upon the request of the Secretary, and the Reporting Entity agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

How does cost-based reimbursement relate to my Provider Relief Fund payment?

(Modified 3/31/2021)

Recipient must follow CMS instructions for completion of cost reports available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935

Under cost-based reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. In these instances, if the full cost was reimbursed based upon this method, there is nothing eligible to report as an expense attributable to coronavirus because the expense was fully reimbursed by another source. Provider Relief Fund payments cannot be used to cover costs that are reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if Medicare or Medicaid makes a payment to a provider based on the provider's Medicare or Medicaid cost, such payment generally is considered to fully reimburse the provider for the costs associated with providing care to Medicare or Medicaid patients and no money from the PRF would be available for those identified Medicare and Medicaid costs. However, in cases where a ceiling is applied to the cost reimbursement or the costs are not reimbursed under cost-based reimbursement (such as costs for care to commercial payer patients) since the reimbursed amount by Medicare or Medicaid does not fully cover the actual cost, those non-reimbursed costs are eligible for reimbursement under the Provider Relief Fund.

Use your cost report to compute your cost per visit in 2019 and 2020 and claim the difference if you are above the RHC Upper Payment Limit

	Medicare	Medicaid	Commerical	Self
Cost per visit 2020	$ 130	$ 130	$ 130	$ 130
Cost per visit 2019	$ 115	$ 115	$ 115	$ 115
Variance	$ 15	$ 15	$ 15	$ 15
Payment per visit 2020	$ 87	$ 106	$ 102	$ 65
Payment per visit 2019	$ 85	$ 103	$ 99	$ 65
Payment Increase	$ 2	$ 3	$ 3	$ -
Net Increase in Expense	$ 13	$ 12	$ 12	$ 15
Visits	1,000	2,000	2,000	200
Increased Expense due to Covid	$ 13,000	$ 24,000	$ 24,000	$ 3,000
Total PRF Fund use reportable				$ 64,000

Remember to apply any amounts received from other sources

When reporting my organization's healthcare expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? *(Modified 3/31/2021)*

Healthcare related expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, employees, and other healthcare related costs/expenses for the calendar year. The classification of items into categories should align with how Provider Relief Fund recipients maintain their records. Providers can identify their healthcare related expenses, and then apply any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance Program (CHIP), or other funds received from the Federal Emergency Management Agency (FEMA), the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, and the Small Business Administration (SBA) and Department of Treasury's Paycheck Protection Program (PPP) that offset the healthcare related expenses. Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting the other funds received or obligated to be received which offset those expenses. The Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse. For example, assume the following:

A $5 increase in expense or cost to provide an office visit is calculated by pre-pandemic cost vs. post-pandemic cost, regardless of reimbursement source:

- Pre-pandemic average expense or cost to provide an office visit = $80
- Post-pandemic average expense or cost to provide an office visit = $85

Examples of reimbursed amounts may include, but not be limited to:

- **Example 1**
  Medicaid reimbursement: $70 (Report $85-$80 = $5 as expense attributable to coronavirus but unreimbursed by other sources)
- **Example 2**
  Medicare reimbursement: $80 (Report $85-$80 = $5 as expense attributable to coronavirus but unreimbursed by other sources)
- **Example 3**
  Commercial Insurance reimbursement: $85 (Report $5, commercial insurer did not reimburse for $5 increased cost of post-pandemic office visit)
- **Example 4**
  Commercial Insurance reimbursement: $85 + $5 insurer supplemental coronavirus-related reimbursement (Report zero since insurer reimbursed for $5 increased cost of post-pandemic office visit)
- **Example 5**
  COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured: $80 (Report $5 as expense attributable to coronavirus but unreimbursed by other sources)

FAQS Hiring and Vendor Costs

Are expenses related to securing and maintaining adequate personnel reimbursable expenses under the Provider Relief Fund? *(Added 12/11/2020)*

Yes, expenses incurred by providers to secure and maintain adequate personnel, such as offering hiring bonuses and retention payments, child care, transportation, and temporary housing, are deemed to be COVID-19-related expenses if the activity generating the expense was newly incurred after the declaration of the Public Health Emergency and the expenses were necessary to secure and maintain adequate personnel.

Are outsourced or third-party vendor services that enable access to health care services reimbursable expenses under the Provider Relief Fund? *(Added 12/11/2020)*

Yes, outsourced or third-party vendor services that enable sustained access to health care services and daily operations, such as food/patient nutrition services, facilities management, laundering, and disinfection/anti-contamination services, are considered reimbursable expenses if they are attributable to coronavirus.

Increased Hazard Pay is an allowable use of PRF Funds

When reporting my organization's G&A expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*

Providers should calculate incremental G&A expenses incurred that were attributable to coronavirus and then estimate the portion of those expenses that were not covered through operational revenues, other direct assistance, donations or other sources.

Examples may include expenses such as:

Hiring additional security personnel, increased hazard pay, increased cost of utilities to operate temporary facilities, or similar items attributable to the coronavirus that were not normally incurred.

https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/provider-relief-fund-general-info/index.html#use-of-funds

Capital Expenditures

Will the Provider Relief Fund limit qualifying expenses for capital equipment purchases to 1.5 years of depreciation, or can providers fully expense capital equipment purchases? *(Added 11/18/2020)*

Expenses for capital equipment and inventory may be fully expensed only in cases where the purchase was directly related to prevent, prepare for and respond to the coronavirus. Examples of these types of equipment and inventory expenses include:

- Ventilators, computerized tomography scanners, and other intensive care unit- (ICU) related equipment put into immediate use or held in inventory
- Masks, face shields, gloves, gowns
- Biohazard suits
- General personal protective equipment
- Disinfectant supplies

Can providers include the entire cost of capital facilities projects as eligible expenses, or will eligible expenses be limited to the depreciation expense for the period? *(Added 11/18/2020)*

Expenses for capital facilities may be fully expensed only in cases where the purchase was directly related to preventing, preparing for and responding to the coronavirus. Examples of these types of facilities projects include:

- Upgrading a heating, ventilation, and air conditioning (HVAC) system to support negative pressure units
- Retrofitting a coronavirus unit
- Enhancing or reconfiguring ICU capabilities
- Leasing or purchasing a temporary structure to screen and/or treat patients
- Leasing a permanent facility to increase hospital or nursing home capacity

Question: How can an RHC Compute Lost Revenue when reporting on the HHS Portal?

A	**Actual 2020 Net Patient Service Revenue to Actual 2019 Net Patient Service Revenue**
B	Actual 2020 Net Patient Service Revenue to Budgeted 2020 Net Patient Service Revenue (Budget approved March 26, 2020 or earlier)
C	Any Reasonable method of calculating Lost Revenue
D	All of the Above

Lost Revenue Update – Three Ways to now compute Lost Revenue

Recipients may choose to apply PRF payments toward lost revenue using one of the following options, up to the amount:

a) of the difference between 2019 and 2020 actual patient care revenue;

b) of the difference between 2020 budgeted and 2020 actual patient care revenue. If recipients elect to use 2020 budgeted patient care revenue to calculate lost revenue, they must use a **budget that was established and approved prior to March 27, 2020.** Providers using 2020 budgeted patient care revenue to calculate the amount of lost revenues they may permissibly claim will be required to

c) See next slide

Note: a) And b) were from previous guidance. C) is new.

Lost Revenue Update – The New Way to now compute Lost Revenue (Continued)

- c) **calculated by any reasonable method of estimating revenue.** If a recipient wishes to use an alternate reasonable methodology for calculating lost revenues attributable to coronavirus, the recipient must submit a **description of the methodology, an explanation of why the methodology is reasonable, and establish how the identified lost revenues were in fact a loss attributable to coronavirus, as opposed to a loss caused by any other source.** All recipients seeking to use an alternate methodology face an **increased likelihood of an audit by HRSA.** HRSA will notify a recipient if their proposed methodology is not reasonable, including because it does not establish with a reasonable certainty that claimed lost revenues were caused by coronavirus. **If HRSA determines that a recipient's proposed alternate methodology is not reasonable, the recipient must resubmit its report within 30 days** of notification using either 2019 calendar year actual revenue or 2020 calendar year budgeted revenue to calculate lost revenues attributable to coronavirus.

Lost Revenue Update – Three Ways to now compute Lost Revenue (Continued)

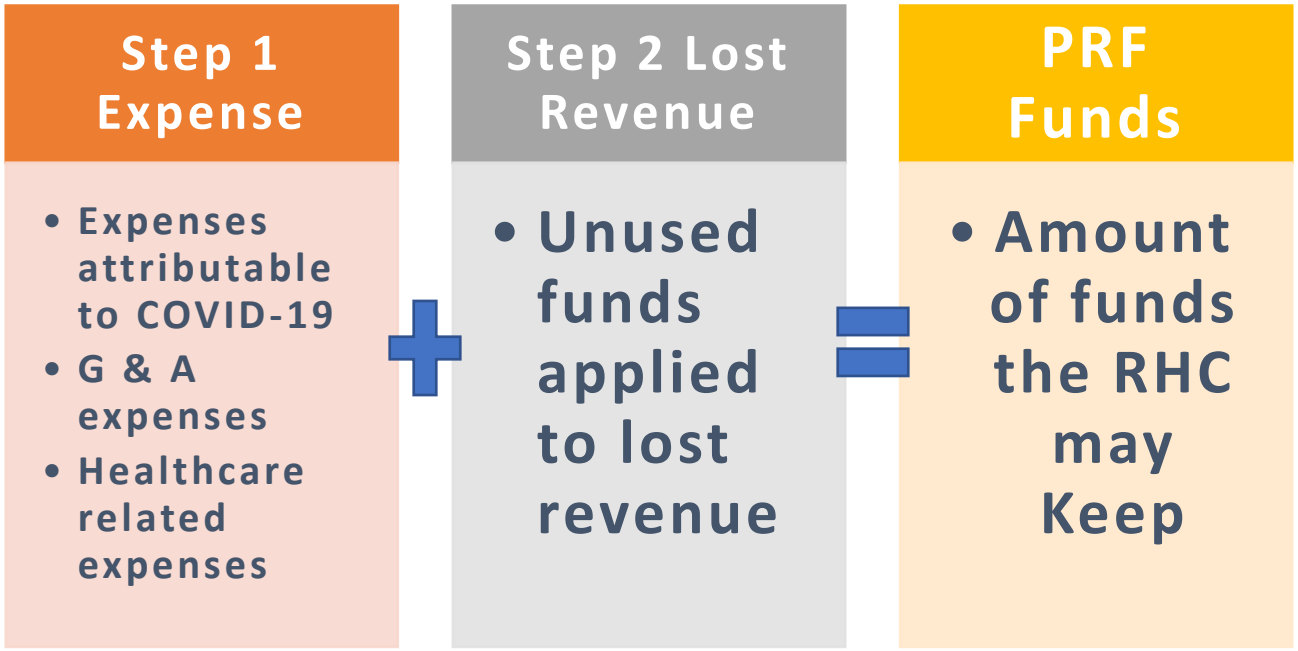
Method c) may provide relief to RHCs which did not have a budget established on or before March 26, 2020 or did not experience the loss of net patient revenue in 2020 as compared to 2019. This provision could benefit RHCs that added providers or services in 2020 or may have been in the startup phase in 2019.

Lost Revenue FAQ on 1/28

Can I use 2020 budgeted revenues as a basis for reporting lost revenues? *(Modified 1/28/2021)*

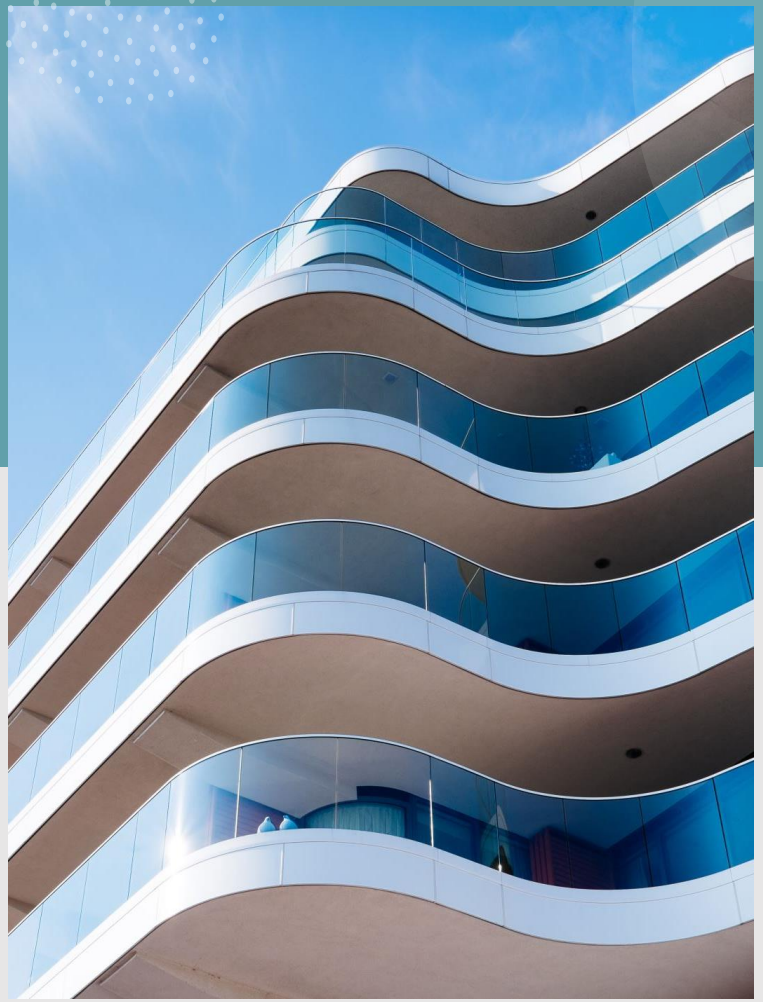
Yes. When reporting use of Provider Relief Fund money toward lost revenues attributable to coronavirus, Reporting Entities may use budgeted revenues if the budget(s) and associated documents covering calendar year 2020 were established and approved on or before March 26, 2020. To be considered an approved budget, the budget must have been ratified, certified, or adopted by the Reporting Entity's financial executive or executive officer as of that date, and the Reporting Entity will be required to attest that the budget was established and approved on or before March 26, 2020. Documents related to the budget, including the approval, must be maintained in accordance with the Terms and Conditions.

PRF Use of Funds



Question: I am a provider-based RHC. Will I have to register our RHC and the other RHCs in the system?

Yes, you will report , but in most cases the hospital received Provider Relief Funds in bulk. The average Rural distribution was $4 million per hospital and distributions were not specific for each RHC. Your CFO or Controller will most likely be handling the reporting of these funds. I would discuss with them what information they would like for you to gather for reporting.



•Cost Reporting Update

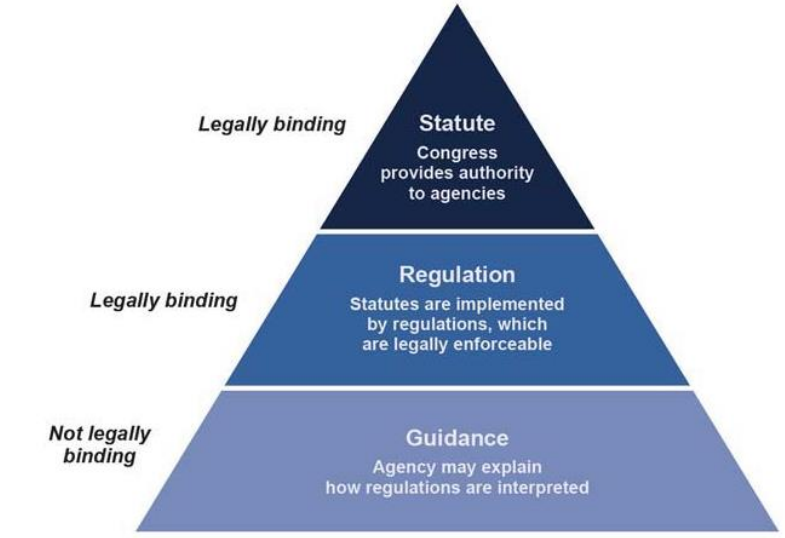
Where can you find guidance specific to RHCs? NARHC has the answers at the click of a button!

RHC Federal Statute, Regulation, and Guidance

Review RHC Statute

Review RHC Regulation

Review RHC Guidance

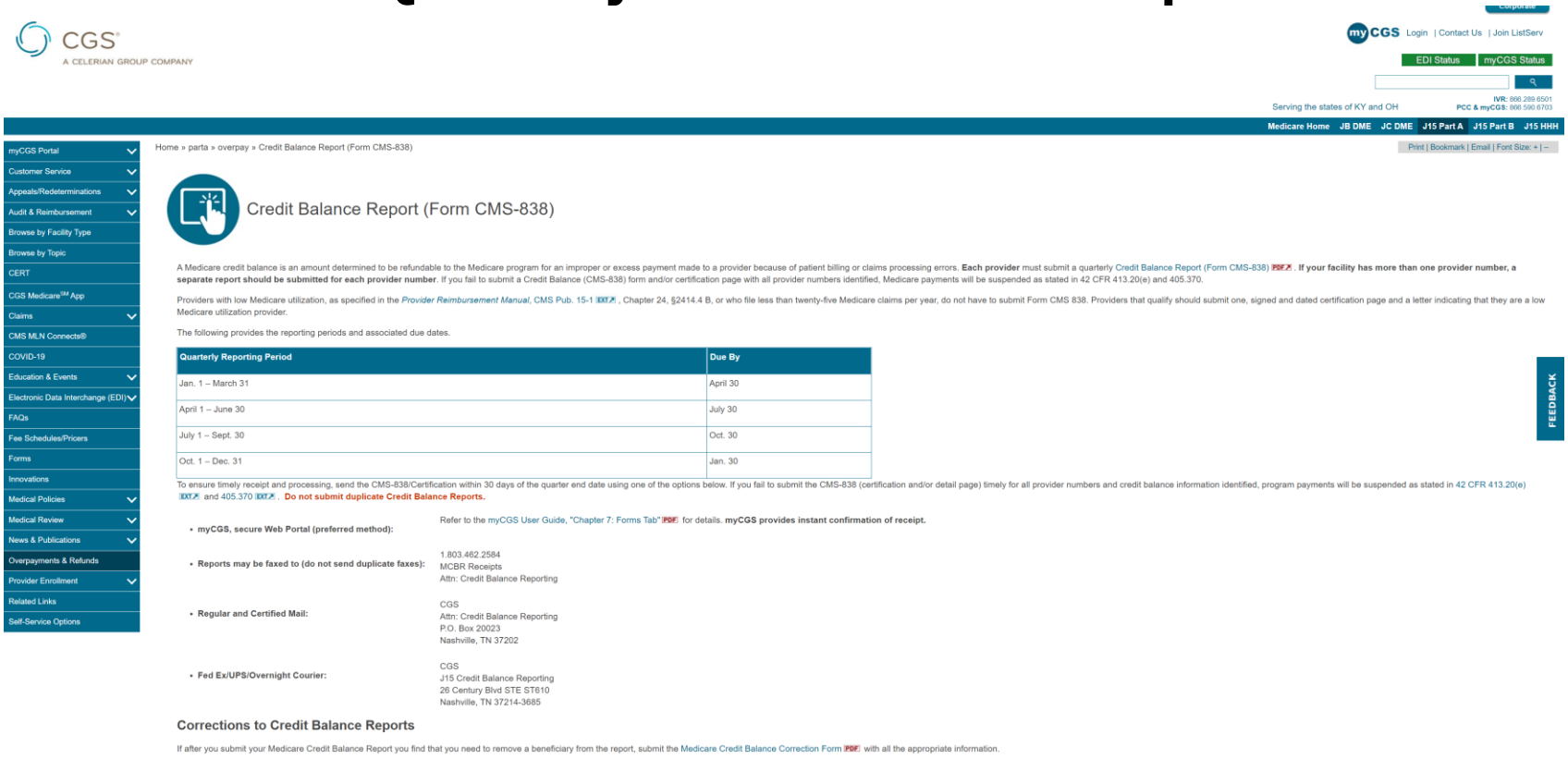


Source: GAO analysis of agency authority. | GAO-15-368

(Hierarchy of Statutory and Regulatory Authority)

https://www.narhc.org/narhc/RHC_Statute__Regulation__and_Guidance.asp

Quarterly Credit Balance Report



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Related Links
Self-Service Options

Home » parta » overpay » Credit Balance Report (Form CMS-838)

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Credit Balance Report (Form CMS-838)

A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors. **Each provider** must submit a quarterly Credit Balance Report (Form CMS-838) PDF. **If your facility has more than one provider number, a separate report should be submitted for each provider number**. If you fail to submit a Credit Balance (CMS-838) form and/or certification page with all provider numbers identified, Medicare payments will be suspended as stated in 42 CFR 413.20(e) and 405.370.

Providers with low Medicare utilization, as specified in the *Provider Reimbursement Manual*, CMS Pub. 15-1 EXT, Chapter 24, §2414.4 B, or who file less than twenty-five Medicare claims per year, do not have to submit Form CMS 838. Providers that qualify should submit one, signed and dated certification page and a letter indicating that they are a low Medicare utilization provider.

The following provides the reporting periods and associated due dates.

Quarterly Reporting Period	Due By
Jan. 1 – March 31	April 30
April 1 – June 30	July 30
July 1 – Sept. 30	Oct. 30
Oct. 1 – Dec. 31	Jan. 30

FEEDBACK

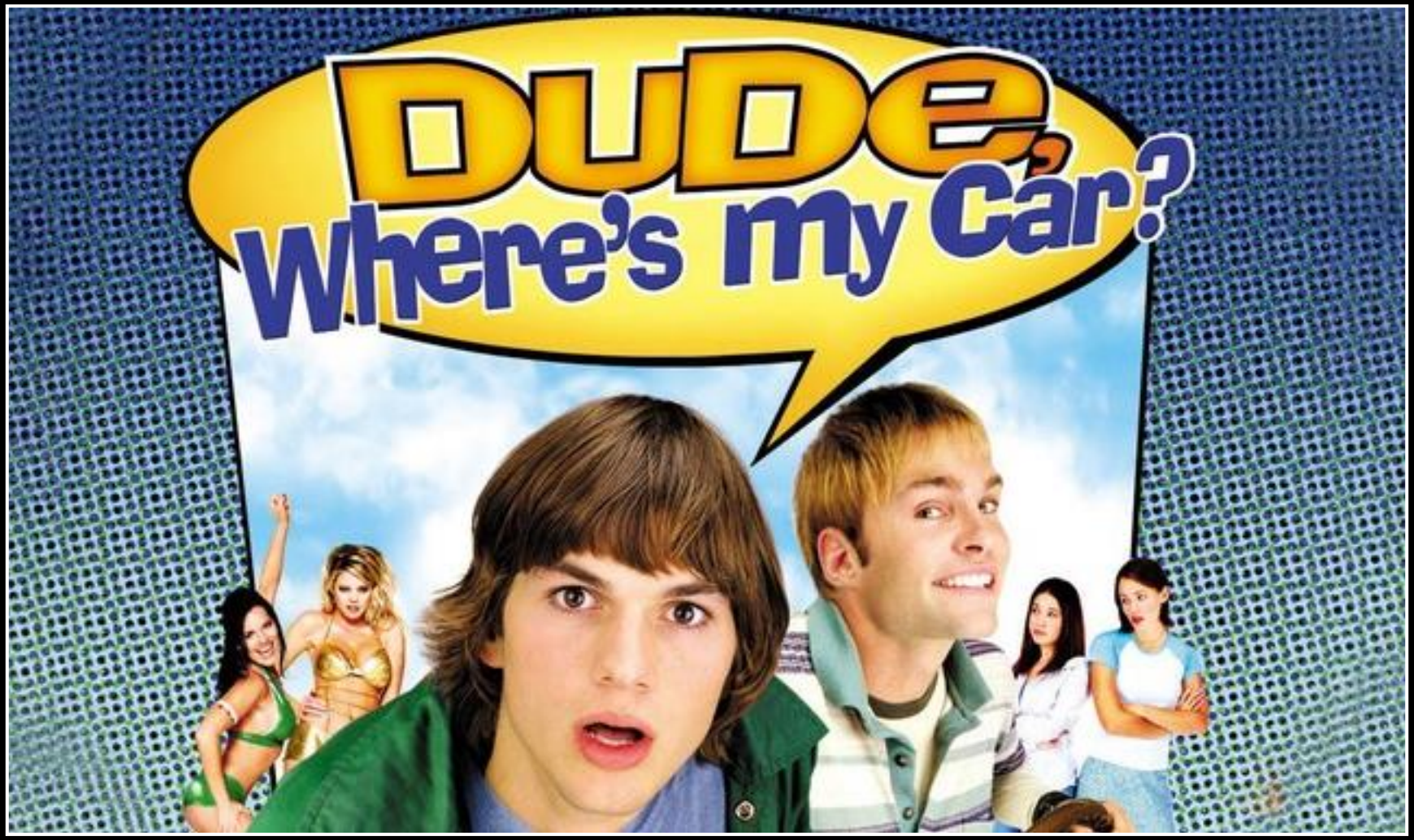
To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below. If you fail to submit the CMS-838 (certification and/or detail page) timely for all provider numbers and credit balance information identified, program payments will be suspended as stated in 42 CFR 413.20(e) EXT and 405.370 EXT. **Do not submit duplicate Credit Balance Reports.**

- **myCGS, secure Web Portal (preferred method):** Refer to the myCGS User Guide, "Chapter 7: Forms Tab" PDF for details. **myCGS provides instant confirmation of receipt.**
- **Reports may be faxed to (do not send duplicate faxes):** 1.803.462.2584
MCBR Receipts
Attn: Credit Balance Reporting
- **Regular and Certified Mail:** CGS
Attn: Credit Balance Reporting
P.O. Box 20023
Nashville, TN 37202
- **Fed Ex/UPS/Overnight Courier:** CGS
J15 Credit Balance Reporting
26 Century Blvd STE ST610
Nashville, TN 37214-3685

Corrections to Credit Balance Reports

If after you submit your Medicare Credit Balance Report you find that you need to remove a beneficiary from the report, submit the Medicare Credit Balance Correction Form PDF with all the appropriate information.

https://cgsmedicare.com/parta/overpay/credit_balance.html



Dude, where is my $100 rate?

New Upper Payment Limits Begin April 1st

RHC Grandfathering Fix Expected to Pass the House Soon

04/01/2021

April 1st, 2021, the Rural Health Clinic (RHC) per visit upper payment limit increases from $87.52 to $100. The increased upper payment limit is a direct result of the payment changes included in Section 130 of the Consolidated Appropriations Act of 2021. Some Medicare Administrative Contractors have already sent out letters to RHCs informing them of the increased upper limit and how it will affect their All-Inclusive Rate payments.

Meanwhile, on Capitol Hill, the House is expected to pass legislation after they return from recess (April 12th) that includes a grandfathering fix for RHCs and delays the resumption of a 2% Medicare sequestration cut until the end of 2021 that affects all providers.

NARHC has been advocating for a grandfathering fix ever since the Consolidated Appropriations Act of 2021 passed Congress because the clear intent of Congress to protect existing provider-based RHCs was not fully realized. A drafting error in that legislation meant that RHCs that opened in the calendar year 2020 would not be grandfathered in as intended. We are happy to see that Congress moved swiftly to include a technical correction in this legislation.

While H.R. 1868 is not yet law, the expectation that this bill will pass is so strong that CMS announced that they will temporarily hold claims with dates of service on or after April 1, 2021, pending Congressional Action. This includes RHC claims that would have otherwise been subject to the 2% sequester reduction.

For context, when COVID-19 began last year, Congress temporarily waived the standing 2% across-the-board reduction in Medicare reimbursement (the sequester) until the end of 2020, and then later through March 31, 2021. H.R. 1868 will now extend this waiver through the end of 2021.

Specifically, section 2 of the Senate-passed version of H.R. 1868 contains the RHC grandfathering fix which will:

– Fix the grandfathering date for under 50-bed hospital RHCs from December 31, 2019, to December 31, 2020;

– Allow under 50-bed hospital entities that submitted applications to become an RHC by December 31, 2020, to be grandfathered-in; and

– Establish a methodology for setting the upper payment limits for grandfathered RHCs that did not have reimbursement in 2020.

Sequestration and Claims are being held starting April 1st, 2021

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Back to MLN Connects® Newsletter

2021-03-30-MLNC-SE

Date 2021-03-30

Subject Special Edition - Temporary Claims Hold Pending Congressional Action to Extend 2% Sequester Reduction Suspension

mlnconnects
Official CMS news from the Medicare Learning Network®

SPECIAL EDITION

Tuesday, March 30, 2021

Temporary Claims Hold Pending Congressional Action to Extend 2% Sequester Reduction Suspension

In anticipation of possible Congressional action to extend the 2% sequester reduction suspension, we instructed the Medicare Administrative Contractors (MACs) to hold all claims with dates of service on or after April 1, 2021, for a short period without affecting providers' cash flow. This will minimize the volume of claims the MACs must reprocess if Congress extends the suspension; the MACs will automatically reprocess any claims paid with the reduction applied if necessary.

Will the American Rescue Plan Trigger PAYGO?

The $1.9 trillion **American Rescue Plan,** enacted March 11, 2021, sets in motion PAYGO reductions in Medicare spending of 4 percent next year, totaling $36 billion.

Sequestration under PAYGO can be avoided if Congress passes legislation that offsets the deficit increase, waives the bill's effects on the federal spending scorecard, or otherwise mitigates or eliminates the statutory PAYGO requirements.

Medicare RHC Cost Report Upper Limits

Begin Date	End Date	Medicare Upper Limit
1/1/2020	12/31/2020	$ 86.31
1/1/2021	3/31/2021	$ 87.52
4/1/2021	12/31/2021	$ 100.00
1/1/2022	12/31/2022	$ 113.00
1/1/2023	12/31/2023	$ 126.00
1/1/2024	12/31/2024	$ 139.00
1/1/2025	12/31/2025	$ 152.00
1/1/2026	12/31/2026	$ 165.00
1/1/2027	12/31/2027	$ 178.00
1/1/2028	12/31/2028	$ 190.00
1/1/2029	12/31/2029	MEI

MEI = Medicare Economic Index

Provider-based RHC certified on or before 12/31/2019 are grandfathered and are not subject to these Medicare Upper Limits. Consult your cost report preparer for an explanation of the new system.

https://www.narhc.org/News/28696/Rural-Health-Clinic-Modernization-Included-in-Final-COVID-Package

Random selection of 20 cost reports from 2019 to see the impact of the new payment system

Six clinics will get no increase

Three clinics will get an increase, but not up to $100

Eleven clinics will get an increase to $100 per visit

Sample of 20 Cost Reports Cost Per Visit from 12/31/2019				
				Projected
		Cost	Variance	Care Rate
Number	State	Per Visit	from $100	1-Apr-21
1	KY	$ 81.55	$ (18.45)	$ 81.55
2	NC	$ 84.70	$ (15.30)	$ 84.70
3	FL	$ 84.84	$ (15.16)	$ 84.84
4	Il	$ 85.55	$ (14.45)	$ 85.55
5	SC	$ 85.55	$ (14.45)	$ 85.55
6	MS	$ 87.14	$ (12.86)	$ 87.14
7	KY	$ 91.08	$ (8.92)	$ 91.08
8	TN	$ 92.40	$ (7.60)	$ 92.40
9	NC	$ 94.84	$ (5.16)	$ 94.84
10	MO	$ 100.47	$ 0.47	$ 100.00
11	AR	$ 102.51	$ 2.51	$ 100.00
12	AR	$ 104.96	$ 4.96	$ 100.00
13	CA	$ 105.15	$ 5.15	$ 100.00
14	IN	$ 106.84	$ 6.84	$ 100.00
15	GA	$ 127.66	$ 27.66	$ 100.00
16	PA	$ 131.10	$ 31.10	$ 100.00
17	LA	$ 136.36	$ 36.36	$ 100.00
18	WY	$ 138.95	$ 38.95	$ 100.00
19	AL	$ 205.63	$ 105.63	$ 100.00
20	OH	$ 249.97	$ 149.97	$ 100.00

V. Cost Reporting

1. **Question:** Will CMS delay the filing deadline for cost reports impacted during the COVID-19

Updated: 1/7/2021 pg. 105

PHE?

Answer: Yes, 42 CFR 413.24 (f)(2)(ii) allows this flexibility. CMS will delay the filing deadline of Fiscal Year End (FYE) 10/31/2019 and FYE 11/30/2019 cost reports until June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports until August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020. **For any cost reporting period not previously identified and ending on a date falling in the period of March 1, 2020 through December 31, 2020, providers are granted an additional 60 days from the initial due date to file their cost reports.**

In summary the extension impacts the following cost reporting fiscal year ends for all provider types (hospitals, SNFs, HHAs, hospices, ESRDs, RHCs, FQHCs, CMHCs, OPOs, histocompatibility labs and home office cost statements):

Cost Reporting Period Ending	Initial Due Date	Extended Due Date	Revised Due Date
10/31/2019	03/31/2020	06/30/2020	
11/30/2019	04/30/2020	06/30/2020	
12/31/2019	05/31/2020	07/31/2020	08/31/2020
01/31/2020	06/30/2020	08/31/2020	
02/29/2020	07/31/2020	09/30/2020	
For any cost reporting period not previously identified and ending on a date falling in the period of March 1, 2020 through December 31, 2020, providers are granted an additional 60 days from the initial due date to file their cost reports.			

Revised: 1/5/21

Automatic 60-day extension for cost report filing.

12/31/2020 Cost Reports are due August 2, 2021

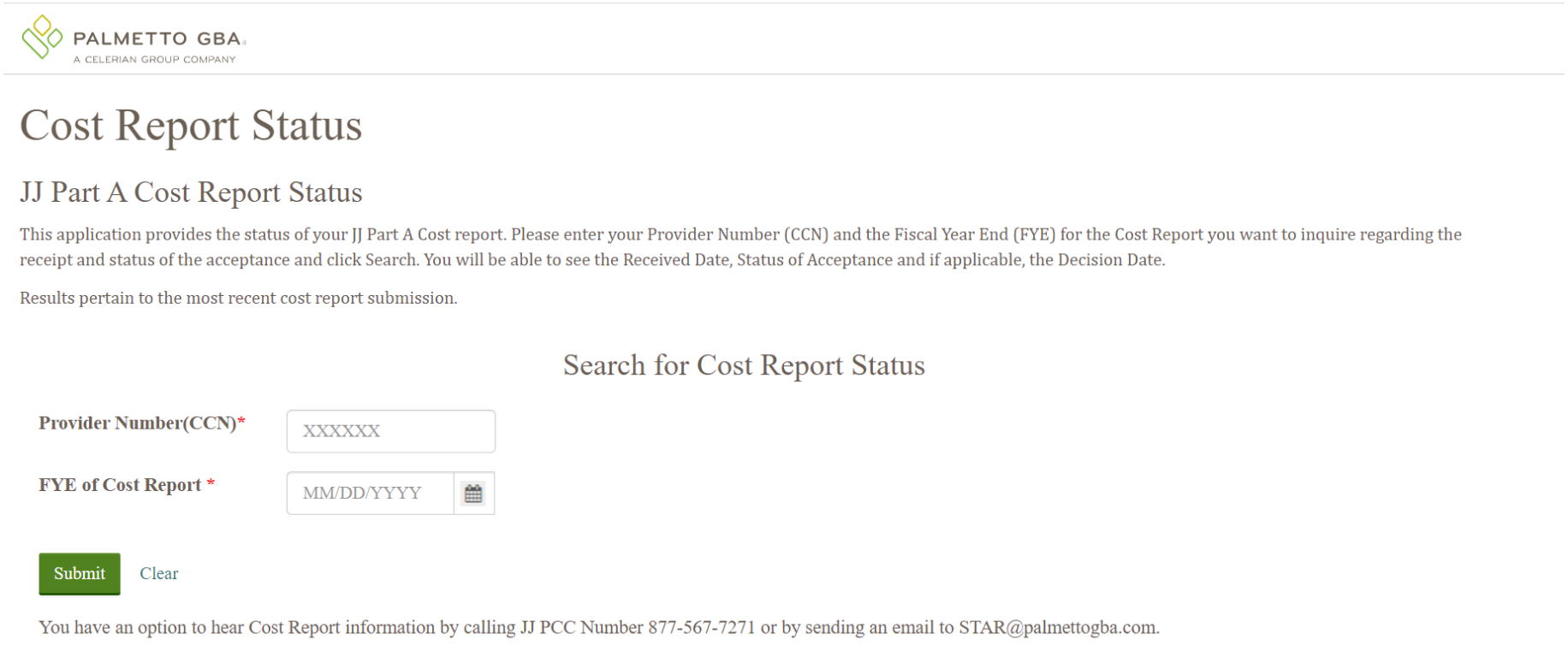
Period Ending	Initial Due Date	Extended Due Date	Revised Due Date
10/31/2019	03/31/2020	06/30/2020	
11/30/2019	04/30/2020	06/30/2020	
12/31/2019	05/31/2020	07/31/2020	08/31/2020
01/31/2020	06/30/2020	08/31/2020	
02/29/2020	07/31/2020	09/30/2020	
03/31/2020	08/31/2020	10/31/2020	
04/30/2020	09/30/2020	11/30/2020	
05/31/2020	10/31/2020	12/31/2020	
06/30/2020	11/30/2020	01/31/2021	
07/31/2020	12/31/2020	03/01/2021	
08/31/2020	01/31/2021	03/31/2021	
09/30/2020	03/01/2021	04/30/2021	
10/31/2020	03/31/2021	05/31/2021	
11/30/2020	04/30/2021	06/30/2021	
12/31/2020	05/31/2021	07/31/2021	

https://www.palmettogba.com/palmetto/jja.nsf/DIDC/BX3TL21233~Audit%20and%20Reimbursement~Cost%20Report%20Filing

Question: Is the Extension Automatic or do we have to apply for it?

The Extension is automatic. No need to apply.

Cost Report Status Tool from Palmetto



https://www4.palmettogba.com/provider_cr_status/costreportstatus?region=JJ%20Part%20A

Question: How are RHCs Paid for COVID-19 vaccine administration

A	**Bill to Medicare B and receive fee for service**
B	Bill to Medicare Part A as an Incident to service
C	Include on the Cost Report like Flu and Pnu shots
D	Bill the Uninsured Portal from reimbursement

Medicare COVID-19 Vaccine Shot Payment

On March 15, 2021, CMS updated the Medicare payment rates for COVID-19 vaccine administration. Effective for services furnished on or after March 15, 2021, the new Medicare payment rate for administering a COVID-19 vaccine is approximately $40 to administer each dose of a COVID-19 vaccine. This means that starting on March 15, 2021, for single dose COVID-19 vaccines, Medicare pays approximately $40 for its administration. Starting on March 15, 2021, for COVID-19 vaccines requiring multiple doses, Medicare pays approximately $40 for each dose in the series. This rate reflects updated information about the costs involved in administering the COVID-19 vaccine for different types of providers and suppliers, and the additional resources necessary to ensure the vaccine is administered safely and appropriately. The rate is geographically adjusted based on where the service is furnished.

While CMS generally implements changes to Medicare payment rates for specific services through notice and comment rulemaking, the payment rate changes for these specific services were implemented to respond quickly to new information during the COVID-19 public health emergency.

For COVID-19 vaccine administration services furnished before March 15, 2021, the Medicare payment rate for a single-dose vaccine or for the final dose in a series is $28.39. For a COVID-19 vaccine requiring a series of two or more doses, the payment rate is $16.94 for the initial dose(s) in the series and $28.39 for the final dose in the series. These rates are also geographically adjusted.

Note: these rates do not apply for entities that are paid for preventive vaccines and their administration at reasonable cost, such as Federally Qualified Health Centers, Rural Health Clinics, and Hospital-Based Renal Dialysis Facilities. We also note that, as indicated in the 2021 Medicare Physician Fee Schedule Final Rule, CMS continues to seek additional information from the public for our further consideration as we review and establish payment rates for vaccine administration services during the public health emergency and on a longer term basis.

Get the most up to date list of billing codes, payment allowances and effective dates.

Related Links

CMS COVID-19 webpage
CMS COVID-19 FAQs
CMS COVID-19 toolkits
CDC COVID-19 website

Page Last Modified: 04/02/2021 01:45 PM
Help with File Formats and Plug-Ins

https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment

COVID-19 Vaccine Administration goes on the Cost Report Including Medicare Advantage Patients

NARHC-News
Column for COVID Vaccine Administration to be Added to Cost Report

2/17/2021 @ 3:52:00 PM

Contributor: Nathan Baugh, National Association of Rural Health Clinics

Add Your Response

The Centers for Medicare and Medicaid Services (CMS) confirmed to NARHC today that they are "in the process of modifying the Worksheet B-1, to add an additional column for the COVID vaccines and administration and we are also including a subscripted line to report MA patients in addition to traditional Medicare [we] hope to have a revised cost report out within the next 30 days."

This modification will allow RHCs to separate out COVID vaccine costs from the influenza and pneumococcal costs and it will ensure that RHCs are paid their full Medicare costs for all three vaccines.

Because reimbursement for the administration of the COVID vaccination is to be made through the cost report for both *Medicare Advantage* patients as well as traditional Medicare patients, it was imperative for CMS to break out COVID vaccine administration costs from the influenza and pneumococcal columns.

As a reminder, RHCs will be reimbursed a lump sum amount for COVID-19 vaccine administration based on costs as reported on the cost report. Here is the policy as articulated on the CMS website:

COVID-19 vaccines and their administration will be paid the same way influenza and pneumococcal vaccines and their administration are paid in RHCs and FQHCs. Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived. RHCs and FQHCs should include COVID-19 vaccines and their administration costs for patients enrolled in Medicare Advantage on the cost report as well. For additional information, please see https://www.cms.gov/covidvax.

COVID Vaccine Log for the Cost Report

InQdocs 600-I

COVID-19 VACCINE LOG

Facility Name: _____

Date	Patient Name and/or Identifier (MBI or Acct/MR#)	Insurance or Financial Class	Pfizer Dose 1 0001A	Pfizer Dose 2 0002A	Moderna Dose 1 0011A	Moderna Dose 2 0012A	Astra Zeneca Dose 1 0021A	Astra Zeneca Dose 2 0022A	Jannsen J&J One Dose 0031A	Consent	Staff Initials

Page _____ of _____

Source: Patty Harper, InQuiseek

COVID-19: RHC and FQHC Lump Sum Payments

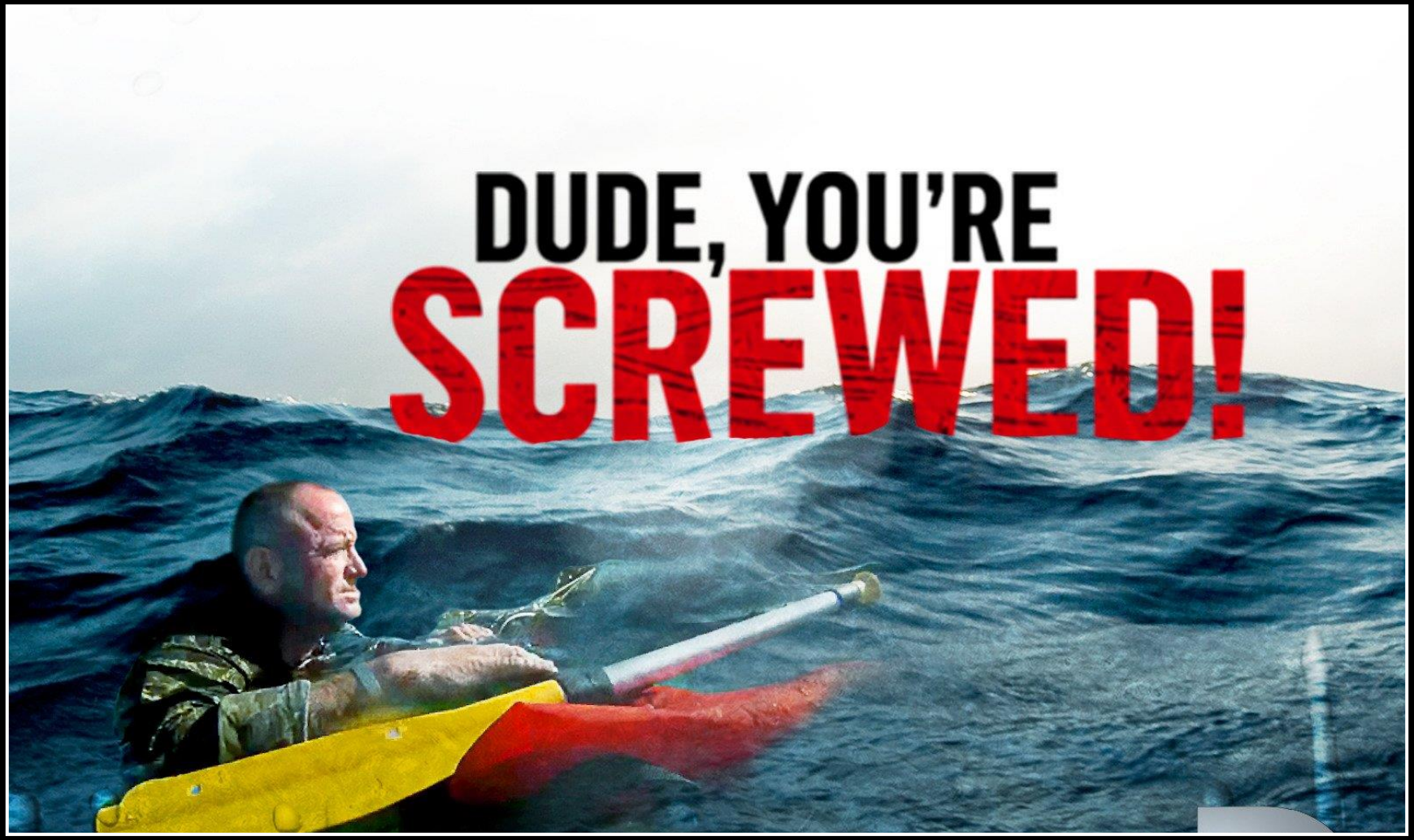
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) may request lump sum payments for administering COVID-19 vaccines in advance of cost report settlement. CMS will pay you for COVID-19 vaccines and administration at 100 percent reasonable cost like influenza and pneumonia vaccines.

CMS direction to Palmetto GBA is to, upon request from the provider, calculate a lump sum based on either:
1.Data from the RHC's or FQHC's most recently submitted cost report, specifically, flu and pneumococcal vaccine costs; or

2.60–90 days of actual COVID-19 vaccine and administration data, including, but not limited to: invoices for vaccines, payroll data for the staff providing the administration of the vaccines, and billing rosters that include all vaccines given and the payor for each vaccine given
The request for the lump sum can be submitted to: JJIRR@palmettogba.com. The request should indicate the basis requested, as noted above, and documentation if requesting actual COVID-19 vaccine and administration cost reimbursement. Lump sums should be processed within 30 days of receipt.

If you have questions about this lump sum payment, please contact Medicare Reimbursement at JJIRR@palmettogba.com.

https://palmettogba.com/palmetto/jja.nsf/DID/JFKE7AMC72



What if I file a No or Low-Utilization Cost Report?

Threshold for Filing a Medicare Low Utilization Cost Report

The Centers for Medicare & Medicaid Services (CMS) has instructed the Medicare Administrative Contractors (MACs) to use the following defined "Low Medicare Utilization Thresholds," compared to total reimbursement amounts, to determine whether a provider qualifies to file a low utilization cost report. This directive is effective for all cost reports received on or after June 19, 2020.

- Federally Qualified Health Clinics (FQHCs) = $50,000
- Rural health clinics (RHCs) = $50,000
- Community Health Mental Health Clinics (CMHCs) = $15,000. CMHCs with no outlier payments reported on the PS&R qualify for low utilization.
- All other providers (hospital and non-hospital provider types) = $200,000

Note 1: Total reimbursement is the sum of the current interim payments on the PS&R, total bi-weekly payment (including periodic interim payments) and total lump sum adjustments.

Note 2: The above thresholds will be applied to the cost report being submitted for the entire provider complex (family). This means if a hospital cost report is being submitted with a provider-based FQHC, the Low Medicare Utilization threshold used will be the $200,000 hospital threshold amount; it will not be $250,000 (which would be the hospital $200,000 plus the FQHC $50,000 threshold).

For mailed-in submissions: if a low Medicare cost report is filed that is above these thresholds, the submission will be rejected and request that the provider file a full Medicare cost report.

Cost Reports submitted via the MCRef system on or after June 19, 2020, will receive a new error message on the eFile Cost Report Materials screen when a provider attempts to submit a cost report with "Medicare Utilization" of "Low" where the amount of total reimbursement exceeds the threshold (defined above).

Last Updated: **01/26/2021**

Waiver of Productivity Standards

What is a waiver from Productivity Standards

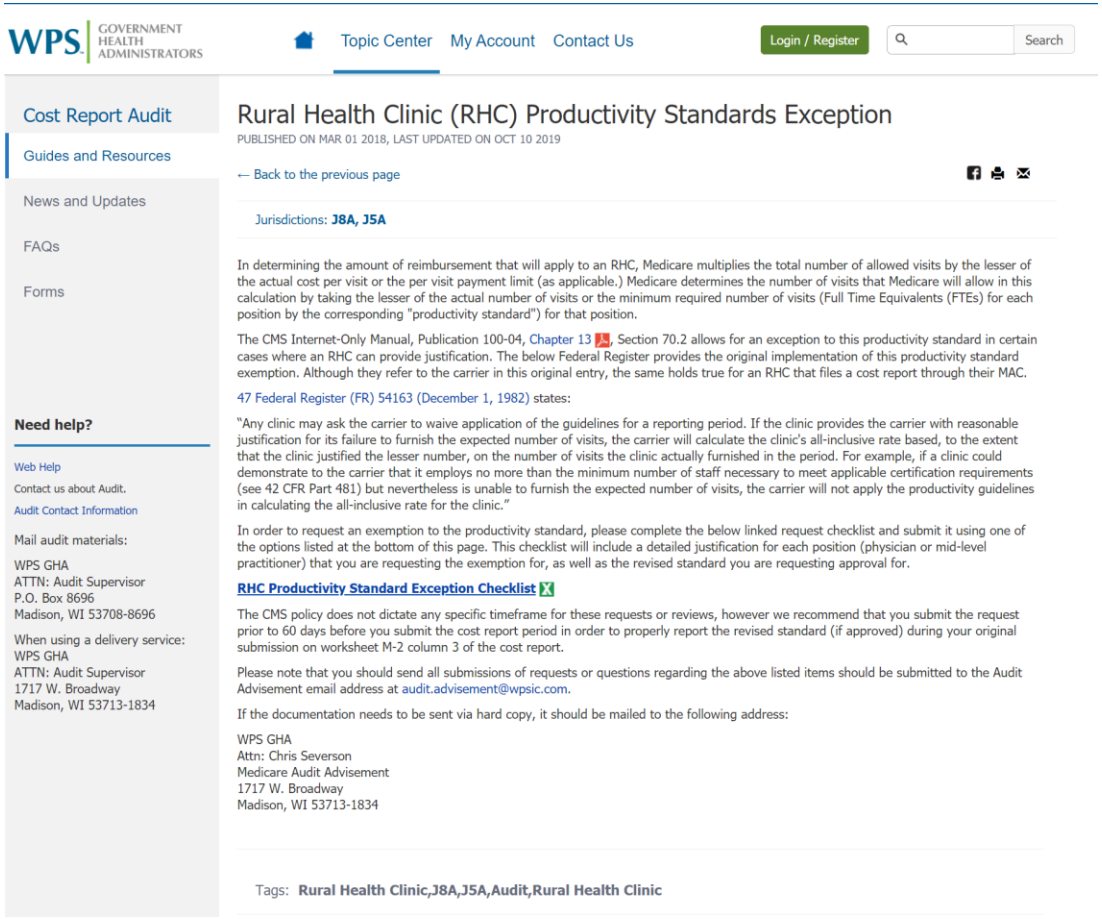
- Due to the impact of COVID-19 RHCs may not be able to meet minimum productivity standards because:
  - Drop in volume due to:
    - Shutdowns
    - Telemedicine visits (they do not count in this visit count)
    - Providers and staff having Covid or contact tracing
    - Patients unwilling to risk coming to the office
    - The drop in preventive visits due to COVID-19
- RHCs may request a waiver from Productivity Standards by submitting a request to the MAC.

The Provider FTE calculation is important For Productivity Calculations (based up a 2,080 Hour work year)

Provider	Visits
Physician	4,200
Physician Assistant	2,100
Nurse Practitioner	2,100

HBS
Healthcare Business Specialists

https://www.wpsgha.com/wps/portal/mac/site/audit/guides-and-resources/rhc-productivity-standards-exception/



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Audit Contact Information

Mail audit materials:

WPS GHA
ATTN: Audit Supervisor
P.O. Box 8696
Madison, WI 53708-8696

When using a delivery service:
WPS GHA
ATTN: Audit Supervisor
1717 W. Broadway
Madison, WI 53713-1834

Rural Health Clinic (RHC) Productivity Standards Exception

PUBLISHED ON MAR 01 2018, LAST UPDATED ON OCT 10 2019

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Jurisdictions: **J8A, J5A**

In determining the amount of reimbursement that will apply to an RHC, Medicare multiplies the total number of allowed visits by the lesser of the actual cost per visit or the per visit payment limit (as applicable.) Medicare determines the number of visits that Medicare will allow in this calculation by taking the lesser of the actual number of visits or the minimum required number of visits (Full Time Equivalents (FTEs) for each position by the corresponding "productivity standard") for that position.

The CMS Internet-Only Manual, Publication 100-04, Chapter 13, Section 70.2 allows for an exception to this productivity standard in certain cases where an RHC can provide justification. The below Federal Register provides the original implementation of this productivity standard exemption. Although they refer to the carrier in this original entry, the same holds true for an RHC that files a cost report through their MAC.

47 Federal Register (FR) 54163 (December 1, 1982) states:

"Any clinic may ask the carrier to waive application of the guidelines for a reporting period. If the clinic provides the carrier with reasonable justification for its failure to furnish the expected number of visits, the carrier will calculate the clinic's all-inclusive rate based, to the extent that the clinic justified the lesser number, on the number of visits the clinic actually furnished in the period. For example, if a clinic could demonstrate to the carrier that it employs no more than the minimum number of staff necessary to meet applicable certification requirements (see 42 CFR Part 481) but nevertheless is unable to furnish the expected number of visits, the carrier will not apply the productivity guidelines in calculating the all-inclusive rate for the clinic."

In order to request an exemption to the productivity standard, please complete the below linked request checklist and submit it using one of the options listed at the bottom of this page. This checklist will include a detailed justification for each position (physician or mid-level practitioner) that you are requesting the exemption for, as well as the revised standard you are requesting approval for.

RHC Productivity Standard Exception Checklist

The CMS policy does not dictate any specific timeframe for these requests or reviews, however we recommend that you submit the request prior to 60 days before you submit the cost report period in order to properly report the revised standard (if approved) during your original submission on worksheet M-2 column 3 of the cost report.

Please note that you should send all submissions of requests or questions regarding the above listed items should be submitted to the Audit Advisement email address at audit.advisement@wpsic.com.

If the documentation needs to be sent via hard copy, it should be mailed to the following address:

WPS GHA
Attn: Chris Severson
Medicare Audit Advisement
1717 W. Broadway
Madison, WI 53713-1834

Tags: **Rural Health Clinic,J8A,J5A,Audit,Rural Health Clinic**

Productivity Waiver – Palmetto

palmettogba.com / JJ Part A / Browse by Topic / Emergency and Disaster Instructions

RHC Productivity Standard Exceptions

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Per CMS Publication 100-02, Chapter 13 (PDF, 400 KB), Section 80.4, productivity standards require 4,200 visits per physician and 2,100 visits per practitioner.

If you are having difficulty meeting productivity standards as a result of COVID-19 PHE, you may request an exceptio the productivity standards. The following information is required.

- Visit count that you are requesting as an exception to the standard of 4,200 for physicians and 2,100 for mid-lev practitioners
- Documentation to justify an exception to the standard

A separate request is required for each facility/clinic, and we may ask for additional information after receipt of the request.

Last Updated: 07/21/2020

http://www.ruralhealthclinic.com/s/2020-Cost-Report-WPS-Productivity-Screen-Waiver-on-December-8-2020.xlsx

Source:	CMS Pub. 100-02, Chapter 13, §80.4
	47 FR 54163 (12/1/1982)
Main Hospital Name:	
Main Hospital Provider Number (CCN):	
RHC Provider Number (a separate tab should be completed for each clinic):	
Impacted FYE:	
RHC City:	
RHC County:	
Date of Submission of Request:	

1.) What is the current number of FTEs and visits for the RHC for this cost reporting period for each category of sta

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

2.) What was the number of clinic visits for the RHC in the prior year, and did the RHC request and receive approval for an RHC standard in that prior year?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

3.) What visit count are you requesting as an exception to the standards of 4,200 (Physicians) and 2,100 (Mid-Level Practitioners)?

For questions 4 through 8, you only need to complete the ones that relate to your request, and that you believe may help justify the request for an exception to the RHC Productivity Standards.

4.) Explain and demonstrate whether the clinic employs no more than the minimum number of staff (physician and mid-level practitioners) necessary to meet applicable certification requirements. Include details on what the current staffing level is for each type and what the minimum certification requirements are.

5.) Is the clinic listed in a Primary Care Health Professional Shortage Area (HPSA)? If so, provide documentation from the below link or another similar resource.
https://data.hrsa.gov/tools/shortage-area/hpsa-find

6.) Document how the population base of the service area is significantly lower than would be needed to generate sufficient visits meet the minimum number of visits required of the RHC Productivity Standards. This generally requires evidence for #4 as well.

7.) Document whether any new physicians or mid-level practitioners were added during the cost reporting period in question and when they started. Explain why you believe this may require a temporary reduction to the RHC Productivity Standards.

8.) Explain and document any other justification for an exception to the RHC Productivity Standards.

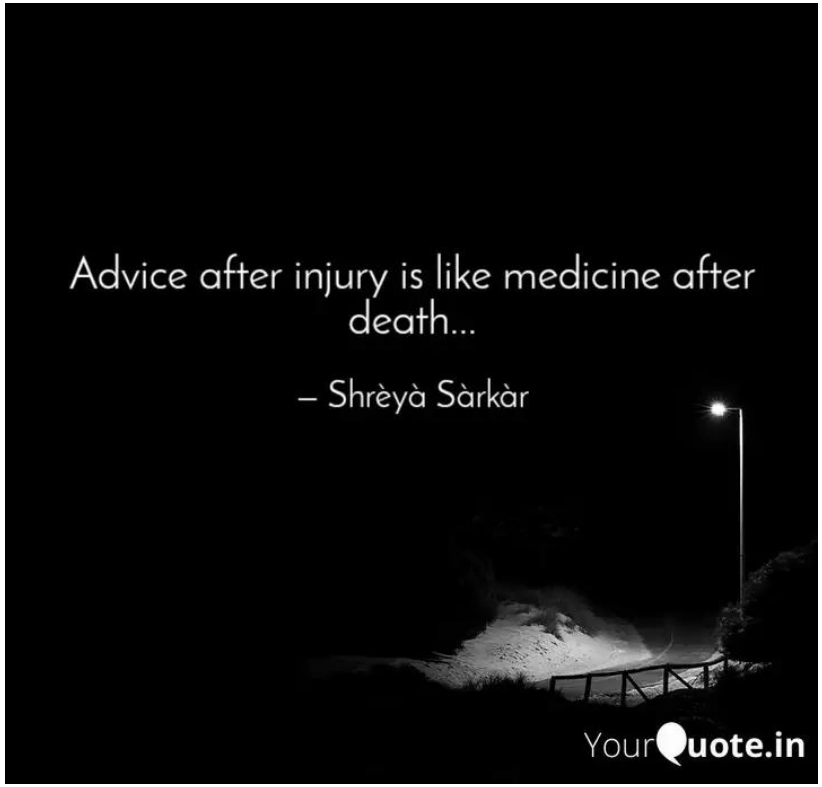
Name of Submitter:	
Title of Submitter:	
Date Submitted:	

Information to Submit in the Productivity Standard Waiver

- Available to provider-based RHCs not meeting standards due to circumstances beyond the clinic's control
- Submitted to Medicare Administrative Contractor (MAC) after fiscal year-end
- Include following elements
  - Clinic operating hours
  - Available hours & visits by provider
  - Productivity exception percentage requested
  - Any additional documentation that provides support

Telehealth Expenses are not included in the calculation of the All-Inclusive Rate

- We need to do the following:
  - Keep up with the number of Telehealth visits we performed
  - Determine the cost of providing Telehealth visits.
    - Typically, we will compute provider and nursing time based on CPT codes
    - If we can Identify any direct Telehealth expense, we may adjust or reclassify that expense
  - Keep Time Studies of the amount of time providers spent doing Telehealth and exclude that from your FTEs on Worksheet B.



Name of Clinic:

Worksheet B: Provider Time Study

FYE:

Purpose: To determine what activities the provider engages in during the day so the time may be properly allocated on the RHC Cost Report. Please conduct this study at least one week per quarter and preferably one week per month per provider. This page may be copied and reproduced as necessary to fit your needs. Please label each use of this table with its associated provider and the week that it references.

Provider Name:	
Week Ending	

Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total Weekly Hours**
Time In:								
Time Out:								
Total Hours Worked								
RHC Patient Care								
Clinic - RHC treating patients								
Nursing Home								
Other								
Total Clinical								
Administrative								
Medical Director								
Administrative								
CME								
Sick								
Vacation								
Total Admin								
Non- RHC Time								
Hospital								
Private Practice								
Telehealth								
Chronic Care Management								
Other:								
Total Non-RHC								
Sum of RHC, Admin, and Non-RHC								

The Sum of RHC, Administration and Non-RHC time should equal the Total Hours worked. Please sum each of the lightly shaded areas.

- The RHC receives a $32,000 Interim Settlement in July 2019 and does not report it to the cost report preparer.

- The receivable from Medicare is overstated by $32,000 on the cost report.

- The MAC sends out a Tentative Settlement overstated by $32,000.

- The NPR is completed and reconciled and the RHC has received $64,000 too much money and must pay it pack.

Cost Report Repayments to Medicare

- Many of the MACs did the following:
  - Increased the interim rate above the cap
  - Paid Interim Settlements during the year.
- This resulted in the following:
  - Much smaller settlements to RHCs
  - Some RHCs paying back monies to Medicare
  - RHC Consultants having to do a lot of explaining
  - **If you do not tell us you received an interim settlement, we will not know, and you may end up paying back Medicare money.**

Why are you having to payback Medicare on the cost report?
You did not give as many Medicare flu and pnu as the previous year.
Your Interim Rate was too high as estabilished by the MAC (above the cap)
Your Medicare visits increased substantially during the year.
You did not claim bad debts or have a smaller amount of bad debts.
You received an interim settlement and did not tell your CR preparer.

Report any Interim Payments to us so we can include on the cost report

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Worksheet C-1
Analysis of Payments to RHCs for Services Rendered

RHC Name	
CCN/PTAN Provider Number	
Fiscal Year End	

Interim Lump Sum Payments to RHCs

In recent years, the MACs are issuing interim lump sum payments (and occasionally a withhold of payment) to RHCs which are a part of the annual Medicare Cost Report Settlement. These payments or withholds must be recorded on Worksheet C-1 or it may result in a payback to Medicare on settlement of the cost report. If you received an interim payment or withhold please report this information to us below and provide the letter emailed to you documenting the payment or withhold.

Please provide the date and amount of Interim Payments or Withholds

Date of Interim Payments	Amount

Note: Failure to report these payments or withholds will affect the settlement of your cost report and may result in a payback to Medicare when the cost report is final settled. Please make an effort to identify any such payments to avoid the potential payback to Medicare.

Interim Payments to be reported on the Cost Report

P.O. BOX 100307 | COLUMBIA, SC 29202-3307 | PALMETTOGBA.COM/JJA | ISO 9001
AN MAC JURISDICTION J
Alabama, Georgia and Tennessee

PALMETTO GBA

October 9, 2018

[redacted]

Subject: YEAR END RATE REVIEW FOR FYE: December 31, 2018 FCR: [redacted] CCN: [redacted] NPI: [redacted]

Dear [redacted]

We have recently completed your Year End rate review for the year ending December 31, 2018. These reviews were based on previous audit history for your facility, the provider statistical and reimbursement report and the December 31, 2017 as-filed cost report.

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring across-the-board reductions in Federal spending. In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payments. Therefore, to prevent making overpayments, interim and pass-through payments related to the Medicare cost report will be reduced by 2 percent. Beginning April 1, 2013 the 2 percent reduction will be applied to Periodic Interim Payments (PIP), Critical Access Hospital (CAH) and Cancer Hospital interim payments, and pass-through payments for Graduate Medical Education, Organ Acquisition, and Medicare Bad Debts.

The results of these reviews are as follows:

Provider	Type of Review	New Rate $/Per Diem	New Biweekly	Effective Date	Lump Sum
	Cost Based Charges:				
[redacted]	RHC 1	96.38		1/1/2018	$36,798
	TOTAL:				$36,798

WKS C-1 Line 3

The net result of these reviews is a lump sum underpayment of $36,798. This amount will be issued on or before October 19, 2018. Enclosed are the computations and payment schedule(s) for your reviews.

If you have any questions please call me at (803) 763-1392 or e-mail me at brenda.williams@palmettogba.com.

Sincerely,

Brenda Williams

Brenda Williams
Accountant II, Provider Reimbursement
Provider Reimbursement

P S & R Reports

When requesting P S & R reports remember to ask for Summary Reports in PDF Format and ask for the following reports.

710 – RHC visits, deductibles, coinsurance, and net reimbursement use on the cost report.

711 – Ancillary RHC Charges. Not reported on the RHC Cost Report.

715 – RHC Fee Reimbursed (Telehealth/CCM) Not report as visits on the RHC cost report, but the expense must be excluded from the AIR calculation.

71A RHC MSP-LCC – Medicare Secondary Payer. This is not used or reported on the cost report.

71S RHC Preventive Services. The visits and net reimbursement in this report are included on the RHC cost report.

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RHC Cost Report Dashboard Report

Cost Report Reimbursement Dashboard

Sample RHC Dashboard Report
CCN: XX-XXXX
FYE: 6/30/2020

Cost Report Settlement	
Current Year	Previous Year
13,252	13,812

Medicare Cost Per Visit			Total Visits	
Current Year	Previous Year	Medicare Cap	Current Year	Previous Year
$ 121.32	$ 145.98	$ 86.31	6,592	7,395

Medicare Visits	
Current Year	Previous Year
455	436

Medicaid Visits	
Current Year	Previous Year
5,038	5,796

	Flu Shot Reimbursement		Pnu Reimbursement	
	Current Year	Previous Year	Current Year	Previous Year
Rate	$ 46.58	$ 189.71	NA	NA
Care Shots	$ 3.00	$ 6.00	NA	NA
Care Payment	$ 140	$ 1,138	NA	NA

Tentative Settlements		Interim Rates	
Current Year	Previous Year	Current Year	Previous Year
0	0	$50	$50

Medicare Bad Debts	
Current Year	Previous Year
None	None

Legend

Green: Numbers are consistent with prior year or can be explained based upon current conditions (ie. COVID)

Yellow: Numbers that may need addition in the future

Red: Numbers that may need attention or action.

Review Notes

1. Prior Year Flu shot reimbursement was $189.71 per shot. That is higher than the benchmarks we normally see for flu shots.

2. A Tentative Settlement was not reported to us this year. Normally we see tentative settlements from the MAC. This may reduce the final settlement or create a payback if not reported on the cost report.

3. The interim rates appear to still be set at $50 per visit. The clinic should request an increase to at least the Medicare Maximum of $86.31

4. The clinic may want to claim Medicare Bad Debts in the future. Medicare will reimburse 65% of the amount claimed for unpaid Medicare co-pays/deductible

Cost Report Files from Healthcare Business Specialists

http://www.ruralhealthclinic.com/rhc-cost-reporting

- RHC Cost Report Checklist and Forms for filing 12 31 2020 Cost Reports (22 page PDF)
- RHC Visit Count Worksheet for 12 31 2020
- MCReF User Manual (45 page PDF)
- MCReF FAQs (5 page PDF)
- Provider Reimbursement Manuals CMS Listing by Chapter
- The Maximum Rate for 2021 is $87.52 or a 1.40% increase from $86.31 in 2020 per MM12035
- Cost Report Waiver of Productivity Screen Worksheet from WPS (Excel Spreadsheet)

Questions?

Thank You!!!

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