HHS - Phase 2 FAQs

Overview and Eligibility

Who is eligible for Phase 2 – General Distribution?

To be eligible to apply, the applicant must meet all of the following requirements:

1. Either
    a. Must have either (i) directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018, to December 31, 2019, or (ii) own (on the application date) an included subsidiary that has either directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for health care-related services during the period of January 1, 2018, to December 31, 2019; or
    b. Must be a dental service provider who has either (i) directly billed health insurance companies for oral health care-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for oral health care-related services; or
    c. Must be a licensed dental service provider who does not accept insurance and has either (i) directly billed patients for oral health care-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for oral health care-related services;
    d. Must have billed Medicare fee-for-service during the period of January 1, 2019 and December 31, 2019;
    e. Must be a Medicare Part A provider that experienced a change in ownership and billed Medicare fee-for-service in 2019 and 2020 that prevented the otherwise eligible provider from receiving a Phase 1 - General Distribution payment; or
    f. Must be an state-licensed/certified assisted living facility.
2. Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or health care clinic); and
3. Must have provided patient care after January 31, 2020; and
4. Must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
5. If the applicant is an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

Providers who have received a payment under Phase 1 of the General Distribution are no longer prohibited from submitting an application under Phase 2 of the General Distribution. Providers who received a previous Phase 1 – General Distribution payment are eligible to apply and, if they have not yet received a payment that is approximately 2% of annual revenue from patient care, may receive additional funds.

How were assisted living facilities determined to be eligible for this Distribution?

Some assisted living facilities have already successfully applied for funding under Phase 2 of the General Distribution. To support payments to assisted living facilities who may not bill Medicare or Medicaid, HHS has developed a curated list of assisted living facility TINs from third party sources and HHS datasets. Providers with TINs on the curated list must meet other eligibility requirements including operating in good standing and not be excluded from receiving federal payments. As a next step, HHS will work with states and its partners to authenticate assisted living facilities not on the curated list. Please note that it may take additional time to validate an applicant's TIN. If they receive the results of that validation after September 13, they will still be able to complete and submit their application.

What data sources did HRSA use to identify assisted living facilities on the curated list?

HHS developed the curated list of assisted living facilities from state licensing boards/organizations, American Seniors Housing Association (ASHA), American Health Care Association (AHCA), National Center for Assisted Living (NCAL), Argentum, Brookdale, Leading Age, and other assisted living groups.

What was the methodology/formula used to calculate provider payment?

The Phase 2 – General Distribution methodology will be based upon 2% of (revenues * percent of revenues from patient care) from the applicant's most recent federal income tax return for 2017, 2018 or 2019 and with accompanying submitted tax documentation. Payments will be made to applicant providers who are on the filing TIN curated list submitted by states to HHS or whose applications underwent additional validation by HHS.

Tax Identification Number (TIN) Validation Process

How can a health care provider find out if they are on the curated list?

When a health care providers applies, the first step of the application process is to validate that their TIN is on curated lists of providers known to be in good standing and eligible under this phase. Applicants that are not on that list will be validated through an additional process with the state or other third party sources to determine if the provider is a known provider that was not captured initially. HRSA will be working directly with states and third party sources to authenticate providers not on the curated list and will not be reaching out to individual providers for validation. Please note that it may take additional time to validate an applicant's TIN. If they receive the results of that validation after August 28, they will still be able to complete and submit their application.

What if an applicant's TIN is flagged as invalid because it is not on the filing TIN list submitted by states to CMS or the curated list of dental providers?

Payments will be made to applicant providers who are in the filing TIN curated list from CMS if they are a Medicaid or CHIP provider. If a TIN is not on the curated list of state-submitted eligible Medicaid/CHIP providers or T-MSIS, it will be flagged as invalid. In these cases, HHS will work with the states to verify whether the TIN should be included as a valid Medicaid or CHIP provider in good standing.

If a TIN is not on the curated list of dental providers, HHS will conduct additional analysis related to the TIN and any active dental providers associated with the TIN.

If a TIN is not on a curated list of assisted living facilities, HHS will conduct additional analysis related to the TIN and any currently operating assisted living facilities associated with the TIN.

If the TIN is subsequently marked as valid, the provider will be notified to proceed submitting data into DocuSign even if validation occurs after the September 13, 2020 deadline. TINs that cannot be validated will not receive funding. Please note, the additional TIN validation may result in a delay in processing the application.

Application Process

How should a parent organization that files taxes on behalf of its subsidiaries report NPIs if the NPIs are associated with the subsidiaries' TINs, not the filing TIN? (Modified 9/4/2020)

If the parent organization does not have an NPI, the applicant should insert the subsidiary Group NPI that is best representative of the health care services delivered by the parent organization's subsidiaries. If the parent organization and its subsidiaries do not have an NPI, the applicant should enter "not applicable." The field cannot be left blank.

An organization has prescription sales as part of its revenue. Can these sales be captured in the data submitted as a part of revenue from patient care? (Added 9/3/2020)

Generally no. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included. Patient care revenues do include savings obtained by providers through enrollment in the 340B Program. HHS is still reviewing potential exceptions to the rule as related to providers who provide unreported health care services as a part of the furnishings of pharmaceuticals.

How should assisted living facilities calculate revenue from patient care?

"Patient care" means health care, services and supports, as provided in a medical setting, at home, or in the community to individuals who may currently have or be at risk for COVID-19, whereby HHS broadly views every patient as a possible case of COVID-19. Assisted living facilities that are applying for Phase 2 – General Distribution funds may include patient care revenue that supports residents' nutritional, housing, activities of daily living, and medical needs, including purchased services.

The application instructions indicate that "real estate revenues" should be excluded from revenues from patient care. For residents that live in skilled nursing or assisted living facilities, are resident fees that cover their accommodations considered service revenue or real estate revenues?

Resident fees that cover their accommodations can be considered patient service revenue.

Many assisted living and memory care communities also offer independent living units within the same community and those independent living residents benefit from services and supports offered by the community. Does the revenue from independent living units fits within the definition of "patient care?"

Yes. The revenue from independent living units as a part of larger assisted or skilled nursing facilities fits within the definition of "patient care" applying for the Phase 2 – General Distribution.