

Provider Relief Fund Phase 3: Payment Calculation Methodology

The Health Resources and Services Administration (HRSA) began making payments under the Phase 3 General Distribution in November 2020 and the majority of payments (80 percent) were made in 2020. Phase 3 payment calculations have generally been completed with limited exceptions. In light of these payment calculations and distributions coming to a close and in the interest of transparency, HRSA is publishing the methodology used to determine the payment amounts issued to providers within this distribution.

Phase 3 Payment Calculation: Summary

Processing Phase 3 applications involved determining the greater of 88 percent of losses (i.e., losses in revenue net of expenses) for the first and second quarters of 2020 or 2 percent of net patient revenue from a provider's application submission, minus prior Provider Relief Fund (PRF) payments made to that provider and its listed subsidiaries, and applying risk mitigation/cost containment safeguards in order to ensure the adequate stewardship of funds appropriated to support health care providers in the prevention, preparation and response to the global COVID-19 pandemic. This approach reflected a decision to take self-reported revenue losses and expenses into account, while also ensuring, for consistency and fairness, that applicants that had not received the 2 percent of annual patient care revenue figure that had been used in the first two phases of the General Distribution had the opportunity to do so in Phase 3.

HRSA employed several pre-payment risk mitigation/cost containment safeguards. These safeguards included adjusting payments to providers where applications triggered a flag for concerns, such as significant deviations between claimed quarterly and annual revenues or expenses, reporting figures outside of the expected range related to similar providers, or, for applications that needed manual review or offered insufficient financial documentation.

The full calculation methodology comprised the following seven steps, described in detail below:

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

Phase 3 Payment Calculation: Step-by-Step Details

A. Calculation of 2 percent of Annual Patient Care Revenue

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

Annual Patient Care Revenue. Both the Annual Patient Care Revenue and 2 percent Annual Patient Care Revenue figures were used in later steps.

For pharmacies and durable medical equipment (DME) suppliers, whose annual revenue is predominantly non-patient care, HRSA capped Annual Patient Care Revenue at 10 percent of their claimed Annual Gross Revenue based on industry estimates of revenue and operating expenses from patient care.

B. Calculation of Initial Loss Ratio and Provider-Type Loss Ratios

Initial Loss Ratio

For each application, an initial Loss Ratio was calculated using the 2019 and 2020 first and second quarter revenues and expenses entered on the application. The initial Loss Ratio was defined as Losses divided by Annual Patient Care Revenue (i.e., (Lost Revenue minus Change in Expenses)/Annual Patient Care Revenue). The calculation is defined below:

$$\begin{aligned} \text{Lost Revenue} &= [Q1Revenue_{20} - Q1Revenue_{19}] + [Q2Revenue_{20} - Q2Revenue_{19}] \\ \text{Change in Expenses} &= [Q1Expenses_{20} - Q1Expenses_{19}] + [Q2Expenses_{20} - Q2Expenses_{19}] \\ \text{Losses} &= \text{Lost Revenue} - \text{Change in Expenses} \\ \text{Loss Ratio} &= (\text{Losses} / \text{Annual Patient Care Revenue}) \end{aligned}$$

Provider-Type Loss Ratio

The Phase 3 application included a field for self-selected provider-type. For each provider-type, the mean, median, and mean plus one standard deviation of the loss ratio was calculated from applicants in that provider-type. The provider-type loss ratio was used to calculate payment adjustments. Table 1 includes the mean, mean plus one standard deviation and median loss ratio for each provider-type.

Table 1. Provider-Type Loss Ratios¹

Provider-Type	Mean Loss Ratio	Mean Loss Ratio + one standard deviation	Median Loss Ratio
Ancillary Services - Chiropractors	4.83%	14.97%	11.91%
Ancillary Services - Dental Service Providers	7.08%	16.55%	18.98%
Ancillary Services - Diagnostics	4.65%	14.44%	10.12%
Ancillary Services - Eye and Vision Service Providers	6.50%	15.98%	14.97%
Ancillary Services - Other Ancillary Service Providers	5.43%	16.39%	12.66%
Ancillary Services - Respiratory, Developmental, Rehabilitative and Restorative Service Providers	6.81%	18.14%	14.80%
DME/ Suppliers	2.92%	13.90%	5.48%
Emergency Medical Service Providers	3.68%	13.39%	9.15%
Facilities - Acute Care Hospital	5.26%	11.17%	11.69%
Facilities - Assisted Living Facilities	1.23%	9.29%	2.68%
Facilities - Hospice Providers	2.21%	13.82%	2.35%

¹ Table 1. Provider-Type Loss Ratios is reflective of Phase 3 data.

Provider-Type	Mean Loss Ratio	Mean Loss Ratio + one standard deviation	Median Loss Ratio
Facilities - Inpatient Behavioral Health Facilities	1.80%	11.16%	3.59%
Facilities - Nursing Homes	1.09%	6.73%	2.26%
Facilities - Other Inpatient Facilities	1.57%	10.30%	3.23%
Facilities - Residential Treatment Facilities	2.37%	14.52%	2.91%
Home and Community - Home and Community-based Support Providers	3.00%	14.48%	3.39%
Home and Community - Home Health Agencies	2.80%	13.81%	4.75%
Home and Community - Other Services	3.70%	13.47%	4.95%
Other	3.64%	14.13%	6.40%
Outpatient and Professional - Ambulatory Surgical Center	6.36%	15.45%	18.20%
Outpatient and Professional - Behavioral Health Providers	3.71%	17.57%	6.27%
Outpatient and Professional - Multi-specialty Practice	4.59%	14.46%	10.16%
Outpatient and Professional - Other Outpatient Clinic	5.71%	16.28%	13.87%
Outpatient and Professional - Other Single Specialty Practice	5.87%	16.25%	13.50%
Outpatient and Professional - Pediatrics Practice	4.29%	13.60%	10.18%
Outpatient and Professional - Podiatric Medicine and Surgery Practice	6.15%	16.81%	14.91%
Outpatient and Professional - Primary Care Practice	4.49%	15.61%	10.25%

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

As part of the pre-payment risk mitigation/cost containment safeguards employed by HRSA, payments were capped for a number of reasons, including the three below:

1. If one of the reported quarter revenues or expenses was greater than 50 percent of Annual Patient Care Revenue, then the application was flagged and the initial Loss Ratio was adjusted to the mean loss ratio for the provider-type that the applicant self-selected. This affected approximately 7.8 percent of all applications.
2. If the initial Loss Ratio was found to be above the mean loss ratio plus one standard deviation relative to the self-selected provider-type, then the Loss Ratio was identified as outside the expected range. The initial Loss Ratio was adjusted down to the mean plus one standard deviation of the same provider-type. This affected approximately 9.1 percent of all applications.
3. HRSA also calculated payments for new providers that began operations in 2019 or 2020 based on the applicant's available financial data and data from providers of the same type. The loss ratios for these new providers were capped at the median loss ratio for their provider-type.

Table 2. Payment Calculation Adjustments

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

D. Calculation of 88 percent of Adjusted Lost Revenues and Expenses

After determining if an application's Loss Ratio should be capped, HRSA applied the capped Loss Ratio to the Annual Patient Care Revenue to determine the application's Adjusted Lost Revenue and Expenses. In the case where no capping was required, the initial Loss Ratio was used to calculate the Adjusted Lost Revenue.

$$\text{Adjusted Lost Revenue and Expenses} = \text{Annual Patient Care Revenue} * \text{Adjusted Loss Ratio}$$

To determine the potential payment based on lost revenues and expenses, the Adjusted Lost Revenues was multiplied by 0.88 to determine 88 percent of Adjusted Lost Revenues and Expenses. This figure was determined based on the available budget for Phase 3.

E. Select the greater of calculated A or D

The greater amount of 2 percent of Annual Patient Care Revenue and 88 percent of Adjusted Lost Revenues and Expenses was used when calculating payment. This ensured that providers received at least the same amount as if they had applied to Phase 1 or 2.

F. Deduction of all prior PRF payments

All prior PRF payments, including General and Targeted Distributions, received by both filing taxpayer identification number (TIN) organization and its listed subsidiaries were deducted from the amount in Step E. This step aimed to ensure that PRF payments were prioritized for providers who had not received funding or as much funding during earlier phases. As a result of this and prior steps, the payment calculation for approximately 31 percent of applicants was \$0.

G. Flagging and manual review of flagged potential payments

By law, PRF payments were considered "emergency payments" to be distributed to eligible health care providers quickly and efficiently. In order to distribute funds quickly, the majority of payment

calculations (approximately 95 percent) for Phase 3 were determined using the aforementioned prepayment process. The remaining approximately 5 percent of applications were sent for further review if they were flagged for one of the following reasons:

- Separate applications from related providers
- Incomplete information
- High-dollar applications

If applications were flagged for one or more of these reasons, a manual review of supporting documentation was conducted.

If during the manual validation the documentation did not support the application revenues and expenses, then the payment was subject to further adjustment or deemed ineligible for payment.

Reconsiderations

If you have general questions about the PRF, please contact the Provider Support Line at 866-569-3522.

HHS recognizes that providers may have questions regarding their Phase 3 payment determinations. If after reviewing the above methodology you believe your payment was calculated incorrectly, you may now request reconsideration. Information about the reconsideration process is available at www.hrsa.gov/provider-relief/payment-reconsideration. You must submit the [completed online form](#) by the **submission deadline – 11:59:59 pm EST on November 12, 2021**.