CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 10, 2021

Norris Cochran
Acting Secretary
Department of Health and Human Services
503H-3
200 Independence Ave. S.W.
Washington, D.C. 20201

Via Email: norris.cochran@hhs.gov

Subject: Clarifications of Provider Relief Fund Reporting Instructions and Phase 3 Distribution

Dear Acting Secretary Cochran:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) greatly appreciates the support the Department of Health and Human Services (HHS) and other federal agencies have provided to hospitals and other providers during the COVID-19 pandemic. We are especially grateful for expedited funds so hospitals across the U.S. can continue providing urgently needed care to Americans suffering from COVID-19 while maintaining access for all who need care.

Realizing that hospital finances are complex, we appreciate the agency's prior clarifications through updated Provider Relief Fund (PRF) reporting instructions and the frequently asked questions (FAQs) document. These and future clarifications will help ensure that providers are able to accurately report their expenses and lost revenue attributed to COVID-19. This will ensure that PRF recipients are able to retain the funds necessary to offset the financial losses caused by the pandemic and continue serving their communities as Congress intended when it passed the CARES Act and appropriated additional funding in subsequent legislation.

To that end, CHA asks the department to provide additional clarification in the following areas related to the PRF:

- Aligning the timeframe to use PRF funds with the public health emergency (PHE)
- Determining lost revenue reporting for hospitals with a non-calendar fiscal year (FY)
- Preventing "double counting" of health care claims-based COVID-19 relief payments
- Reporting marginal COVID-19 expenses net of revenue for COVID-19 relief payments
- Defining COVID-19 relief payments that must be offset against expenses[1]
- Clarifying the requirement to offset Medicaid disproportionate share hospital (DSH) payments against COVID-19 expenses

[1] Including the scenario whereby a hospital applied for but did not yet receive FEMA relief.

- Removing Medicaid supplemental payments from the determination of lost revenue attributable to COVID-19
- Providing additional detail on provider specific decisions for the Phase 3 distribution

CHA's specific concerns and recommendations include:

Aligning the Timeframe to Use PRF Funds: HHS' PRF reporting instructions and FAQs state that providers must expend provider relief funds no later than June 30, 2021. Based on current caseloads, projected vaccination rates, and the current trajectory of the disease, it is likely that hospitals and other providers will incur expenses and lost revenue related to COVID-19 beyond that date. In addition to providing direct care to patients with COVID-19, CHA's members are incurring considerable expenses in developing and supporting vaccination clinics. CHA's members report that these clinics are operating at considerable losses per day. Additionally, even after the PHE has ended, hospitals and other PRF recipients will likely incur expenses related to the pandemic from unwinding emergency operations.

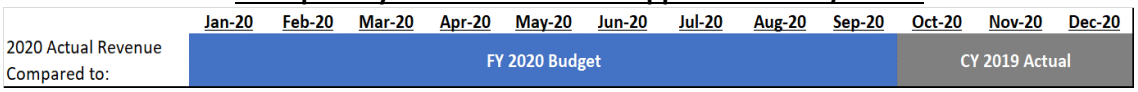
- ✓ *Solution*: CHA asks HHS to align the time period in which providers can use PRF funding (and related reporting timeframes) with the duration of the PHE. This time period should include a reasonable "tail period" to offset any costs related to unwinding emergency operations. CHA believes that allowing providers to use PRF funds for an additional 90 days after the PHE terminates would provide an appropriate amount of time to cover the costs of unwinding emergency operations.

Lost Revenue Reporting: CHA greatly appreciates HHS' recent clarification that PRF recipients may now calculate their lost revenue attributed to COVID-19 using either a comparison of 2020 actual to 2020 budgeted revenue or "any reasonable method of estimating revenue." However, even with this clarification there are still a number of issues — discussed below — that HHS must address in the PRF FAQs or reporting instructions to ensure that all PRF recipients are able to report their lost revenue consistently and in a manner that reduces administrative burden for both HHS and the PRF recipient.

- *Issue – Non-Calendar FY End*: "Method B" in the January 15, 2021, PRF reporting instructions allows for reporting lost revenue attributed to COVID-19 based on a comparison of budgeted 2020 revenue to actual revenue if the budget was approved prior to March 27, 2020. This method works for PRF recipients whose fiscal year ends on December 31 and follows a calendar year (approximately 33% of hospitals). However, for PRF recipients that have non-calendar FY ends — commonly June 30 (31%) and September 30 (18%), with the remaining hospital FY ends spread across other months — reporting using budgeted revenue may require "hybrid approaches."

  One example of a hybrid approach that CHA's members are considering is using both Methods "A" and "B." PRF recipients using a hybrid approach would report based on a comparison of budgeted revenue for the months in 2020 for which they have a budget approved by March 27, 2020, to actual 2020 performance and the remaining months, reporting based on a comparison of 2019 actual compared 2020 actual. Below is an example of what this might look like for a September 30 FY-end PRF recipient.

Example "Hybrid" Lost Revenue Approach for a 9/30 FYE



- ✓ *Solution*: CHA asks that HHS clarify in the PRF FAQs that using a hybrid approach will not automatically subject PRF recipients to additional audit scrutiny. Given the number of hospitals that have non-calendar FY ends, failing to do so will significantly (and unnecessarily) increase the administrative burden for both HHS and PRF recipients.

- *Issue – "Double Counting" Claims-Based Payments Related to COVID-19*: The current instructions require PRF recipients to "report health care related expenses attributable to coronavirus, net of other reimbursed sources (e.g., payments received from insurance and/or patients, and amounts received from federal, state, or local governments, etc.) …" However, doing so will reduce the COVID-19 expenses that need to be reimbursed by PRF funds.

  The instructions also require providers to report "Total Revenue/Net Charges from Patient Care Related Sources in 2020: Revenue/net charges from patient care (prior to netting with expenses) for the calendar year 2020." Doing this inflates 2020 actual revenue related to patient care compared to either the 2020 budget or 2019 actual revenue, as any increase in claims-based payment to compensate providers for costs associated with COVID-19 from health plans and other payers was not included in budgets finalized by March 27, 2020, nor received from payers in 2019.

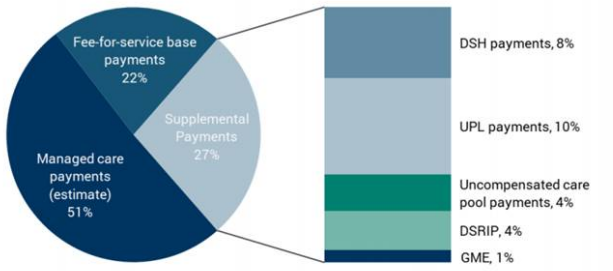
  By requiring PRF recipients to offset additional claims-based payments related to COVID-19 from health plans and other payers (e.g., the 20% increase in Medicare MS-DRG payments for COVID-19-related discharges) that are intended to help cover providers' increased COVID-19 costs and counting them as increased revenue in 2020, HHS is "double counting" claims-based revenue associated with COVID-19 and artificially reducing the amount of PRFs recipients are entitled retain to offset their expenses and lost revenue attributed to COVID-19. Quite simply, when HHS uses one dollar that a provider received from the PRF to both reduce a dollar's worth of COVID-19-related expenses and reduce a dollar's worth of COVID-19 lost revenue, it is spending the same dollar twice.

  - ✓ *Solution*: HHS should clarify that claims-based payments meant to cover the increased costs of caring for COVID-19 patients (like the 20% Medicare MS-DRG add-on payment) should not be offset against COVID-19-related expenses. The increase in 2020 patient care revenue specifically for payments intended to offset increased costs related to COVID-19 will be captured in the lost revenue attributed to COVID-19 calculation and will appropriately reduce lost revenue related to COVID-19 to account for the COVID-19 expenses this increased revenue was intended to cover. Taking this approach will have the added benefit of not requiring PRF recipients and HHS to determine whether a claims-based payment needs to be offset on a case-by-case basis. Based on conversations with CHA's members, while there are some instances where determining whether an increased claims-based payment is COVID-19-related is straightforward, many others are subject to interpretation and less clear as to whether they should be offset against expenses.

Alternatively, if HHS continues to insist on offsetting increased payments that are intended to cover increased COVID-19 costs and are paid on claims, CHA requests that HHS clarify that claims-based payments that are offset against COVID-19 expenses should be removed from PRF recipients' 2020 actual revenue.

- *Issue – Medicaid Supplemental Payments*: The Centers for Medicare & Medicaid Services (CMS) grants states considerable flexibility to design Medicaid programs that meet the needs of the state, including supplemental payments. The 2016 Medicaid managed care final rule has created situations where Medicaid supplemental payment programs operate in a retroactive manner. **Per the terms and conditions for receiving CMS approval**, states collect encounter data and outcomes and calculate directed payments. These are lump sum payments 18-24 months after the actual time of service. As a result, these infrequent lump sum payments will create distortions in actual year-to-year revenue comparisons if not properly isolated and excluded. When HHS collects total revenue, it is imperative to isolate and exclude Medicaid supplemental payments, which play a significant role in reimbursement for all Medicaid programs as demonstrated in a recent MACPAC report[2].

FIGURE 1. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2018



✓ *Solution*: CHA asks that HHS exclude Medicaid supplemental payments from the baseline and 2020 actual data used to calculate lost revenue related to COVID-19. As discussed above, Medicaid supplemental payments are not based on data from either calendar year 2019 or 2020.

If HHS does not allow providers to remove supplemental Medicaid payments from the calculation of lost revenue attributed to COVID-19, CHA asks that HHS make two edits to the existing PRF FAQ from November 18, 2020[3], or issue a new FAQ. The revised or new FAQ should clarify that:

1) Medicaid supplemental payments received in 2019 or 2020 — that are based on care rendered in prior periods should be reclassified back to the year in which the care was provided.
2) Any Medicaid supplemental payment revenue should be considered on a net revenue basis only.

[2] https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf
[3] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf, 2/24/21, pg. 29

Due to significant underfunding of Medicaid and state budget limitations, the Medicaid program nationwide reflects a patchwork of permissible funding mechanisms to support each state's program. One of the largest non-state general fund sources is from Medicaid providers (hospitals, nursing facilities, transportation providers, etc.) that contribute the non-federal share associated with the Medicaid supplemental payments. In California, six CMS-approved provider taxes support the Medicaid program, along with a heavy reliance on governmental entities (e.g., 21 public hospitals and health systems) that are responsible for the non-federal share of Medicaid payments. Making these two adjustments will allow hospitals that received a Medicaid supplemental payment in 2020 for care provided in 2019 or prior periods to accurately reclassify the payment to the proper year and account for the proper net patient revenue that HHS seeks to compare. Failing to do both distorts patient revenue comparisons and will not provide HHS with an accurate understanding of the negative impact of COVID-19 on the PRF recipient's revenue.

Reporting COVID-19 Expenses Net of Revenue: HHS' Post-Payment Notice of Reporting Requirements[4] instructs PRF recipients to report "Healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which includes General and Administrative (G&A) and/or other healthcare related expenses…" However, neither the notice nor the related FAQs provide sufficient detail on how providers should report direct and indirect expenses and which payments from third-party payers must be offset. Below, please find a specific discussion of clarifications necessary to ensure PRF recipients are able to accurately report their expenses associated with COVID-19 to HHS.

- *Issue – Marginal Coronavirus Expenses Net of Revenue*: Some material COVID-19 costs, such as excessive patient length of stay, are indirect and captured in a general ledger of expenses. An HHS FAQ (below) states the PRF permits reimbursement of marginal increases related to coronavirus. This FAQ then provides an example of pre- and post-pandemic cost, going from $80 per patient in 2019 to $85 per patient in 2020[5].

  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 12/11/2020) 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*

[4] https://www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements-january-2021.pdf
[5] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf, 02/24/21, pg. 18

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. 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)

This FAQ recognizes the marginal $5 increase in cost, net of any COVID-19 reimbursement. This reporting approach (the marginal increase in cost per patient) is vastly different than reporting COVID-19 expenses, net of reimbursement — primarily because the marginal "$85 FAQ" captures the indirect costs not assigned to any cost center or general ledger account.

- ✓ *Solution*: CHA recommends that HHS develop and make available a template to providers to execute the calculation representing a marginal increase in expenses from 2019 to 2020, per the "$85 FAQ." This would eliminate any variation in how providers determine their marginal expense increases. The circumstances when providers can determine their COVID-19 expenses using the $85 FAQ marginal reporting approach vs. reporting specific COVID-19 expenses net of reimbursement should be clarified. CHA also recommends that HHS clarify any PRF "options," reporting under the marginal expense method vs. reporting COVID-19 expenses per the general ledger (net of reimbursement). We do not recommend that providers report a mix of direct (from the general ledger) and marginal expenses, as this would be difficult to standardize, and there would be a high risk of duplicating expenses.

- *Issue – COVID-19 Payments that Must be Offset Against COVID-19 Related Expenses*: HHS' current reporting instructions require that PRF recipients report their COVID-19 expenses net of other reimbursed sources – including amounts from insurance and/or patients. However, the PRF reporting instructions and associated FAQs provide limited guidance as to what types of payments specifically should be offset. The "$85 FAQ" indicates that only increased payments specifically intended to compensate providers for COVID-19-related costs should be offset from the increased cost associated with COVID-19.

    - ✓ *Solution*: If HHS does not clarify that payments from insurance and/or patients that are intended for the increased expenses associated with delivering care to COVID-19 patients do not need to be offset from COVID-19 expenses, it must provide additional conceptual guidance with specific examples of the types of payments that need to be offset against COVID-19-related expenses.

- *Issue – Requirement to Offset Medicaid DSH Payments Against COVID-19 Expenses*: On February 24, 2021, HHS added the FAQ below requiring PRF recipients to offset Medicaid DSH payments against their COVID-19-related expenses.

    > ***Are there any restrictions on how hospitals that receive Medicaid disproportionate share hospital (DSH) payments can use Provider Relief Fund General and Targeted Distribution payments?***[6] *(Added 2/24/2021) Yes. Providers may not use PRF payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if a hospital has received Medicaid DSH payments for the uncompensated costs of furnishing inpatient and/or outpatient hospital services to Medicaid beneficiaries and to individuals with no source of third - party coverage for the services, these expenses would be considered reimbursed by the Medicaid program and would not be eligible to be covered by money received from a General or Targeted Distribution payment. For more information on the calculation of the Medicaid hospital-specific DSH limit, see www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.*

    As discussed above, the "$85 FAQ" clarifies that PRF recipients are only required to offset the increased incremental revenue received from third-party payers that is specifically intended to pay for costs associated with COVID-19 against COVID-19 expenses. CHA strongly supports this clarification, as we believe it is consistent with the longstanding accounting principle that requires expenses to be matched with related revenue.

    CHA is concerned the recently added FAQ could be misinterpreted to require all Medicaid DSH payments to be offset against COVID-19 expenses associated with Medicaid and uninsured patients. This interpretation would be inappropriate. It would confiscate funds intended by states and the federal government to reimburse safety net hospitals for a portion of their unreimbursed costs for providing care to Medicaid patients and the uninsured and use those funds to pay for costs associated with COVID-19. Congress intended for the PRF to cover

[6] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf, 02/24/21, pg. 16

incremental, increased COVID-19 costs, not existing costs for providing care to Medicaid and uninsured patients.

In addition to clarifying that it is only the incremental increase in Medicaid DSH revenue specifically intended to pay for COVID-19 costs, HHS must also clarify what portion of the increased Medicaid DSH revenue associated with COVID-19 costs should be offset against expenses. As discussed above, most Medicaid DSH payments are funded by provider intergovernmental transfers, certified public expenditures, or even private providers' contributions through provider taxes. Offsetting 100% of the incremental Medicaid DSH COVID-19-related revenue would inappropriately recoup funds paid by PRF recipients to support state DSH programs, further exacerbating losses for safety net hospitals.

- ✓ *Solution*: CHA recommends that HHS clarify in an updated FAQ that PRF recipients are only required to offset any net incremental Medicaid DSH revenue received by providers to cover costs associated with COVID-19 against COVID-19-related expenses for Medicaid and uninsured patients.

- *Issue – FEMA Revenue to Offset Against COVID-19 Expenses*: Providers may have applied for Federal Emergency Management Agency (FEMA) relief not received by the PRF reporting date but at a later date. Under "Other Assistance Received," the January 15, 2021, PRF instructions state to report:

  "*Total amount of coronavirus-related relief received from FEMA by the Reporting Entity* ***as of the reporting period end date.*****"**

  However, if providers report FEMA payments received as of the close of the reporting period (December 31, 2020), any FEMA funding received after this date may duplicate payments for the same COVID-19-related expenses claimed as PRF.

  Conversely, in an FAQ modified December 11,2020[7] (below), HHS states providers are to report the FEMA funding obligated to be received.

  > ***Funds from the Federal Emergency Management Administration (FEMA) are generally intended to be the last source of reimbursement, however, the Post-Payment Notice of Reporting Requirements indicates that FEMA funds would be applied prior to the Provider Relief Fund distributions. In which order should governmental funding sources be applied and reported?*** *(Modified 12/11/2020) As it relates to expenses, providers identify their health care-related expenses, and then apply any amounts received through other sources (e.g., direct patient billing, commercial insurance, Medicare/Medicaid, reimbursement from the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, or funds received from FEMA or SBA/Department of Treasury's Paycheck Protection Program) that offset the health care-related expenses. Provider Relief Fund payments may be applied to the remaining*

[7] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf, 12/11/20, pg. 19

expenses or cost, after netting the other funds received or obligated to be received which offset those expenses.

- ✓ *Solution*: HHS should clarify that providers are to offset COVID-19 expenses by FEMA funding they have applied for and are obligated to receive. HHS should also clarify how PRF recipients should report FEMA funds applied for but not yet received. The guidance must address the uncertainty of FEMA's approval during the PRF reporting period.

Phase 3 Provider Relief Funding: The Phase 3 distribution is intended to pay providers the greater of up to 88% of their reported losses (both lost revenue and health care-related expenses attributable to COVID-19 incurred during the first half of 2020) or 2% of annual revenue from patient care. HHS states some applicants will not receive an additional payment, either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88% of reported losses or 2% of revenue from patient care.

- *Issue – "Black Box" Decisions Related to Phase 3 PRF Distributions*: A number of California hospitals incurred expenses and lost revenue attributable to COVID-19 in Q1 and Q2 of 2020 that exceed 2% of revenue from patient care and existing distributions of PRFs (both general and targeted distributions). HHS' PRF FAQ dated January 28, 2020, states[8]:

  Certain applicants may not receive these full amounts because HHS determined the revenues and operating expenses from patient care reported on their applications included figures that were not exclusively from patient care (as defined in the instructions), reported figures were not reflected in submitted financial documentation, or reported figures were extreme outliers in comparison to other applicants of the same provider type; instead, HHS capped the amount paid to these provider types based on industry estimates of revenue and operating expenses from patient care."

  However, the denial notices (or payment notices in cases where payment is less than anticipated) received by these providers do not provide detail on adjustments HHS staff made to reported revenue and expense data or caps based on HHS' subjective determination of an "extreme outlier" in reported values.

  - ✓ *Solution*: CHA asks that HHS provide details of any adjustments or caps it applied to the data submitted by a Phase 3 PRF applicant in determining whether an applicant qualifies for a Phase 3 distribution and the amount of that distribution. Further, HHS must create a process where applicants who were denied a Phase 3 distribution or received less than what the applicant believed they were due based on HHS' formula can appeal adjustments to the revenue and expenses reported. CHA does not believe it is appropriate for HHS staff to make arbitrary adjustments to data submitted by applicants for PRF funds without the applicant having the opportunity to provide additional support for the data that were submitted.

[8] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf, 022421, pg. 42

CHA appreciates the opportunity to offer comments on necessary clarifications to the PRF reporting instructions. If you have any questions, please contact me at (202) 270-2143 or cmulvany@calhospital.org.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy

cc: Caryn Marks, Office of Intergovernmental and External Affairs, U.S. Department of Health and Human Services