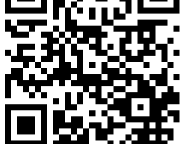
CARES Act
Provider Relief Funding and Documentation

February 19, 2021



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Disclosures

- The content in this presentation is focused primarily on hospitals
- The information is current to on or about February 19, 2021, including HHS's revised CARES Public Health and Social Services Emergency Fund (PHSSEF) reporting guidance from January 15, 2021
- To date, the portal for reporting CARES PHSSEF amounts is open for registration only, the reporting portal is not open; HHS will announce a new deadline:
  - …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
- Subsequent details related to COVID-19 funding and documentation are not included in this presentation

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Agenda

- CARES Provider Relief Funding (PRF) Allocations
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- CMS Flexibilities and Medicare Cost Reporting
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About Our Speaker

- Frequent speaker on regulatory issues
- Practice Line Leader for Toyon's CARES Documentation and Funding Services and Uncompensated Care Recognition Services
- Experience with regulatory changes, uncompensated care reporting and the Medicare Inpatient Prospective Payment System (IPPS)
- Former VP of Finance for the Hospital Alliance of New Jersey with a continued focus on evaluation of state and federal financing programs

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CARES PRF Allocations

General and Targeted Provider Distributions

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CARES Funding Allocations

Allocation	Amount ($ in Billions)
Phase 1 Initial Allocation (MCR FFS Claims)	$30.00
Phase 1 Additional Allocation to 2% Net Patient Service Revenue (NPSR)	20.00
Phase 2 General (2% NPSR)	18.00
Phase 3 (Round 1) General Pmts and Add-On	24.50
Targeted High Impact (Rounds 1 and 2)	22.00
Targeted Safety Net (Rounds 1 and 2)	14.70
Targeted Rural (Rounds 1 and 2)	11.30
Targeted Skilled Nursing Facility (SNF)	7.40
Consolidated Appropriations Act, 2021	3.00
HRSA Uninsured Claims est. YTD	1.70
Indian Health Service (IHS)	0.50
Grand Total*	**$153.10****
- - - -	
Total Appropriated Funding	**$178.00**
Est. Amount of Remaining Funds	**$24.90**

*Does not require repayment; subject to attestation of terms and conditions. PRF amounts do not account for providers returning funds.

** As of February 18, 2021 providers have attested to $106 billion in payments.

$178 billion* in total Provider Relief Fund (PRF) Payments

- **$100 billion** Public Health and Social Services Emergency Fund *(PHSSEF, a Section of the CARES Act H.R. 748)*
- **$75 billion** Paycheck Protection Program & Health Care Enhancement Act *(PL 116-139)*
- **$3 billion** Consolidated Appropriations Act, 2021

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CARES Funding Allocations

Other Coronavirus Funding (*does not require repayment)*

Medicare Relief

Sequestration Suspension *(CARES Act, Appropriations Act)*

20% increase to MS-DRG for COVID-19 inpatients *(CARES Act)*

Families First Coronavirus Response Act (H.R. 6201)

$1bn Testing for Uninsured

Federal Medicaid match increase of 6.2%

(certified public expenditures and intergovernmental transfers)

Public Health Emergency Funding Grants

Federal Emergency Management Agency (FEMA)*

$250m Hospital Preparedness Program

$50m Hospital Associations for Hospital Preparedness

FEMA cost share is 100% retroactive to January 2020.

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CARES Funding Allocations

Medicare Prospective Payment System (PPS)

Capital Extraordinary Circumstances Exception Payment

Intention	Criteria	Eligible Hospitals	Funding
Loss on disposal of depreciable assets (Involuntary conversion of a depreciable asset)	1) Capital loss must be greater than $5M; 2) File request per 42 CRF 412.348 with CMS Regional Office 180 days after the "extraordinary circumstance"	1) Sole community hospitals; 2) Urban Hospitals > = 100 beds and at least 20.2% DSH; 3) Hospitals with a combined inpatient MCR and MCD utilization > = 70%	85% of the determined capital costs (sole community hospitals receive 100% of cost)

Observations

- Medicare payments are determined after 180 days after the close of an extraordinary event.
- How does this funding align with a "payor of last resort" given CARES PRF and FEMA?

Source: 42 CRF 412.348 and FAQs per: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf

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CARES Funding Allocations – Use of the Medicare Cost Report

General Fund **$20 billion of $50 billion related to Net Patient Care Revenue***	- 2% of Net Patient Service Revenue (NPSR) from Medicare cost report Worksheet (WS) G-3 Line 3 (2018/2019)
	- Supported by Tax Returns or Audited Financial Statements (if no tax returns)
High Impact **Rd 1: $12 billion; $2 billion DSH related**	- $2bn safety net add on to Round 1 of High Impact Payments
	- Payment equals % to total of all Disproportionate Share (DSH) Payments of Round 1 High Impact Providers - DSH payments are based on Medicaid eligible and total days (S-2, S-3 Pt. I) and Uncompensated Care (S-10)
	- Toyon estimates HHS used cost reports from Federal Fiscal Year (FFY) 2018 to makes this determination

*Initial 1st tranche of $30bn used Medicare claims as Proxy to Expedite Payments. Total Phase 1 General Fund is $50bn.

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CARES Funding Allocations – Use of the Medicare Cost Report

Safety Net **$14.7bn** **3 "Gates"** **($5M to $50M per hosp.)**	- *Gate 1:* Two consecutive years of 3% or less profit margin from past five years - Medicare cost report WS G-3 Line 29 / (Line 3+Line 25)
	- *Gate 2:* Medicare DSH Percentage (DPP) from WS E Pt A Line 32 > = 20.2% - Childrens hospitals use Medicare cost report WS S-3 Pt I (Medicaid Utilization Calc.) > = 20.2%
	- *Gate 3:* Uncompensated Care Cost per bed > = $25,000 (N/A for childrens hospitals) - Medicare cost report WS S-10 Line 30 / WS S-3 Pt I L 14 C 2
Rural **$11.3bn** **($100K to $4.5M per hosp.)**	- Qualifying hospitals include rural hospitals (e.g., Critical Access), hospitals in small metro areas, sole community hospitals (SCH) and Medicare Dependent Hospitals (MDH) - Payments of 1% to 1.97% of Operating Expenses from Medicare cost report WS G-3 Line 4
	- Add on for Rural Days Percentage of Total Patient Days (CMS Patient Day File)

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CARES Funding Allocations – Use of the Medicare Cost Report

Phase 3 (Rd 1) **$24.5bn**	- 2% of NPSR for certain providers (not yet in receipt of this amount)
	- Providers receive at least 88% of net operating losses comparing the first and second quarter of CY 2020 to the first and second quarter of 2019, if losses exceeded 2 percent of annual revenue from patient care
	- HHS capped amounts for any hospital reporting non-patient care revenue and expenses, amounts were not reported in the financial detail, and other outliers
Phase 3 (Rd 2) **TBD**	- 85% of all remaining PRF amounts
	- The amounts in the third and fourth quarter of CY 2020, as well as the first quarter of CY 2021 will likely be compared against these same periods in CY 2019

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Coronavirus Expenses Net of Revenue

Phase 3 Payment Methodology - January 28, 2021 FAQ

Q: What is the payment amount that an applicant should expect to receive from Phase 3 of the General Distribution?

In addition to this amount (2% of NPSR), **providers will be paid up to 88 percent of their reported losses** (both lost revenue and health care-related expenses attributable to coronavirus incurred during the first half of 2020) **if losses exceeded 2 percent of annual revenue from patient care**

Some applicants may not receive this proportion of the losses reported on their applications, because HHS determined the reported revenues and operating expenses from patient care were not exclusively from patient care (as defined in the instructions) or because reported figures were not reflected in submitted financial documentation

Additionally, 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

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Coronavirus Expenses Net of Revenue

Phase 3 Hypothetical Calculation

	January 1, 2019 - June 30, 2019			January 1, 2020 - June 30, 2020			Variance	
	A	B	C = B-A	D	E	F = E-F	G = F-C	
Description	HY 2019 Revenue	HY 2019 Expense	HY 2019 Gain/Loss	HY 2020 Revenue	HY 2020 Expense	HY 2020 Gain/Loss	HY 2020 vs. 2019 Gain/Loss	
Total Revenue and Expenses	**$102,000,000**	**$106,000,000**	**($4,000,000)**	**$72,975,000**	**$100,000,000**	**($27,025,000)**	**($23,025,000)**	
Non-Patient from Prior Year Settlements	(1,200,000)			(1,300,000)				
Non-Patient from Innovation Revenue (PRIME)	(1,700,000)			(1,800,000)				
Non-Patient from Whole Person Care	(2,000,000)			(2,200,000)				
Non-Patient from Quality Incentive Program*	(1,500,000)			(1,600,000)				
Non-Patient from Misc. | Other	(1,000,000)			(1,100,000)				
Total Non-Patient Care Revenue	**(7,400,000)**			**(8,000,000)**				
Adjusted Total Revenue and Expenses	**$94,600,000**	**$106,000,000**	**($11,400,000)**	**$64,975,000**	**$110,000,000**	**($45,025,000)**	**($33,625,000)**	**H**
88% of HY 2020 vs. HY 2019 Rev Loss - Absolute Value							**$29,590,000**	**I = absval(H)*88%**
2% of Net Patient Service Revenue							**$2,000,000**	**J= Hospital NPSR * 2%**
Does 88% Revenue Loss Exceed 2% NPSR?							**Yes; Qualify**	**K= If I>J, "Yes; Qualify", else "Does Not Qualify"**

*Qualify Incentive Program (QIP) is like PRIME, and more aligned with “settlement” revenue representing base year claims outside of the reporting period of 2019 and 2020.

**Global Payment Program (GPP), Enhanced Payment Program (EPP) and Rate Range Intergovernmental Transfers (IGT) relate to services provided during 2019 and 2020 and are recommended to be reported as patient care.

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CARES Funding Allocations

Targeted PRF Allocations and Reporting

Per January 15, 2021 Guidance (resulting from H.R. 133 Consolidated Appropriations Act, 2021)

- "Reporting Entities that received a Targeted Distribution and are a subsidiary of a parent organization must report on the use of each Targeted Distribution received, consistent with the instructions above.
- However, **the subsidiary's parent organization may transfer the subsidiary's Targeted Distribution to another subsidiary of the parent organization, to be used by that other subsidiary**.
- The subsidiary that is the Reporting Entity must indicate the amount of any of the Targeted Distributions it received that were transferred to the parent entity. Transferred Targeted Distributions face an increased likelihood of an audit by HRSA."

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Targeted PRF Allocations and Reporting - January 28, 2021 FAQ

Q: Can a parent organization with a direct ownership relationship with a subsidiary that received a Provider Relief Fund Targeted Distribution payment control and allocate that Targeted Distribution payment among other subsidiaries that were not themselves eligible and did not receive a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment?

A: **Yes,** in accordance with the Coronavirus Response and Relief Supplemental Appropriations Act **the parent organization may allocate the Targeted Distribution up to its pro rata ownership share of the subsidiary to any of its other subsidiaries that are eligible health care providers**. To determine whether an entity is the parent organization, the entity must follow the methodology used to determine a subsidiary in their financial statements. If none, the entity with a majority ownership (greater than 50 percent) will be considered the parent organization.

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CARES Funding Allocations

Medicare's Accelerated and Advance Payment (AAP) Program

- **The Accelerated and Advance Payment (AAP) Programs** increased cash flow to Medicare providers and suppliers impacted by COVID-19 by approximately **$100bn**
  - **Toyon estimates the amounts to hospitals at $82bn**
- Providers have 29 months to repay these advances
  - Acute care hospitals received a 6-month advance and non-hospitals received a 3-month advance
- 25% recoupment one year from the date the payment was issued, continuing for 11 months
- 50% recoupment for another 6 months
- After the 6 months end (totaling 17 months inclusive of the first 11 months), a letter for any remaining balance of the accelerated or advance payment(s) will be issued
- If payment is not received within 30 days, simple interest (not compounded or an annual rate) will accrue at the simple interest rate (non-compounding) of 4% from the date the letter was issued and will be assessed for each 30-day period that the balance remains unpaid
- **Medicare is not currently allowing hospitals to apply for hardships under 42 CFR § 401.607; claims collection (Extended Payment Schedule)**

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PRF Reporting Step 1

Coronavirus Expenses Net of Revenue

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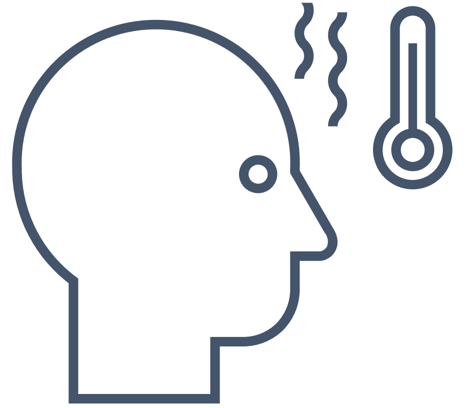
Coronavirus Expenses Net of Revenue



HHS states in many FAQs it broadly views every patient as a possible case of COVID-19.

HHS states it “broadly views every patient as a possible case of COVID-19; therefore, care does not have to be specific to treating COVID-19.”

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Coronavirus Expenses Net of Revenue

$10,001 and $499,999

Two broad categories:

(1) General & Administrative (G&A); and

(2) Healthcare

$500,000+

Greater detail in each subcategory of G&A and healthcare expenses:

1) G&A (seven categories)

2) Healthcare (five categories)

Healthcare Related Expenses Attributable to Coronavirus Not Reimbursed by Other Sources

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Coronavirus Expenses Net of Revenue

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Personnel
Training, staffing, temporary employee or contractor payroll, overhead employees, or security personnel.*

Fringe Benefits
Extra benefits supplementing an employee's salary, hazard pay, travel reimbursement, health insurance, etc.

Lease Payments
New equipment or software lease.

Insurance
Premiums paid for property, malpractice, business insurance, or other operation insurance relevant.

Utilities/Operations
Lighting, cooling/ventilation, cleaning, or additional third-party vendor services not included in "Personnel."

Mortgage/Rent
Monthly payments related to mortgage or rent for a facility.

Other
Costs not captured above that are generally considered part of overhead structure.

General & Administrative (G&A)

*Not to exceed $197,300 per employee.

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Coronavirus Expenses Net of Revenue

Patient Care Healthcare Expense

Facilities
…Such as lease or purchase of permanent or temporary structures, or to modify facilities to accommodate patient treatment practices revised due to coronavirus.

Supplies
…Such items could include personal protective equipment (PPE), hand sanitizer, or supplies for patient screening.

Information Technology (IT)
Expenses paid for IT or interoperability systems such as electronic health record licensing fees, telehealth infrastructure, increased bandwidth, and teleworking to support remote workforce.

Equipment
…Such as ventilators, updates to HVAC systems, etc.

Other
Any other actual expenses, not previously captured above, that were paid to prevent, prepare for, or respond to the coronavirus.

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Coronavirus Expenses Net of Revenue

Interpretation: Reporting Coronavirus Expenses by HHS Category (Net of Revenue)

Description	Expenses	
I. CY 2020 General and Administrative (G&A) Expenses		
Mortgage/Rent: Monthly payments for mortgage or rent for a facility	$1,500,000	
Insurance: Premiums paid for property, malpractice, business insurance, or other operations insurance	1,000,000	
Personnel: Workforce-related actual expenses paid to prevent, prepare for, or respond to the coronavirus	2,500,000	
Fringe Benefits: Extra benefits supplementing salary, e.g., hazard, travel, health ins, malpractice, etc.	500,000	
Lease Payments: New equipment or software lease	300,000	
Utilities/Operations: Lighting, cooling/ventilation, cleaning, or additional third-party vendor services	80,000	
Total G&A Attributable to Coronavirus	**$5,880,000**	**A**
II. CY 2020 Healthcare Related Expenses Attributable to Coronavirus		
Supplies: To prevent, prepare for, or respond to the coronavirus	$1,200,000	
Equipment: To prevent, prepare for, or respond to the coronavirus	1,700,000	
Information Technology (IT): IT or interoperability systems to expand or preserve care	800,000	
Facilities: Facility-related costs used to prevent, prepare for, or respond to the coronavirus	420,000	
Total Healthcare Related Expenses Attributable to Coronavirus	**$4,120,000**	**B**
Total	**$10,000,000**	**C=A+B**
Coronavirus Revenue	**$3,000,000**	**D**
Total Expenses Net of Coronavirus Revenue	**$7,000,000**	**E = C-D**

Providers may have established cost centers to track incremental expenses related to coronavirus, which is useful under this reporting approach.

- Toyon recommends providers evaluate the HHS FAQ on Commercial Payors reimbursing at the increased cost amount
- Providers still report coronavirus G&A and healthcare expenses, and other statistical data
- Coronavirus related reimbursement may include FEMA, payor specific COVID relief payments made on a per claim (i.e., Medicare 20% DRG add-on), business insurance, SBA and PPP assistance, local | State | Tribal assistance

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Coronavirus Expenses Net of Revenue

Issue: The "$85 FAQ"; Reporting Marginal Coronavirus Expenses Net of Revenue

- **There are material COVID-19 costs, like excessive patient length of stay, that are indirect and not captured in a general ledger of expenses.**
- This is like recognition of costs for Indirect Medical Education (IME)
- HHS has an FAQ stating 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
- The 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

Recommended Solutions for HHS

- **Develop a template** available to providers to execute the calculation representing a marginal increase in cost from 2019 to 2020, per the "$85 FAQ". This would eliminate any variation in how providers determine their marginal increase
- **Clarify the circumstances** when providers can determine their coronavirus expenses using the $85 FAQ marginal reporting approach vs. reporting specific coronavirus expenses net of reimbursement should be clarified
- **Explain PRF reporting "options"** under the marginal expense method vs. reporting coronavirus expenses per the general ledger (net of reimbursement)
- *It is not recommended 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

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Coronavirus Expenses Net of Revenue

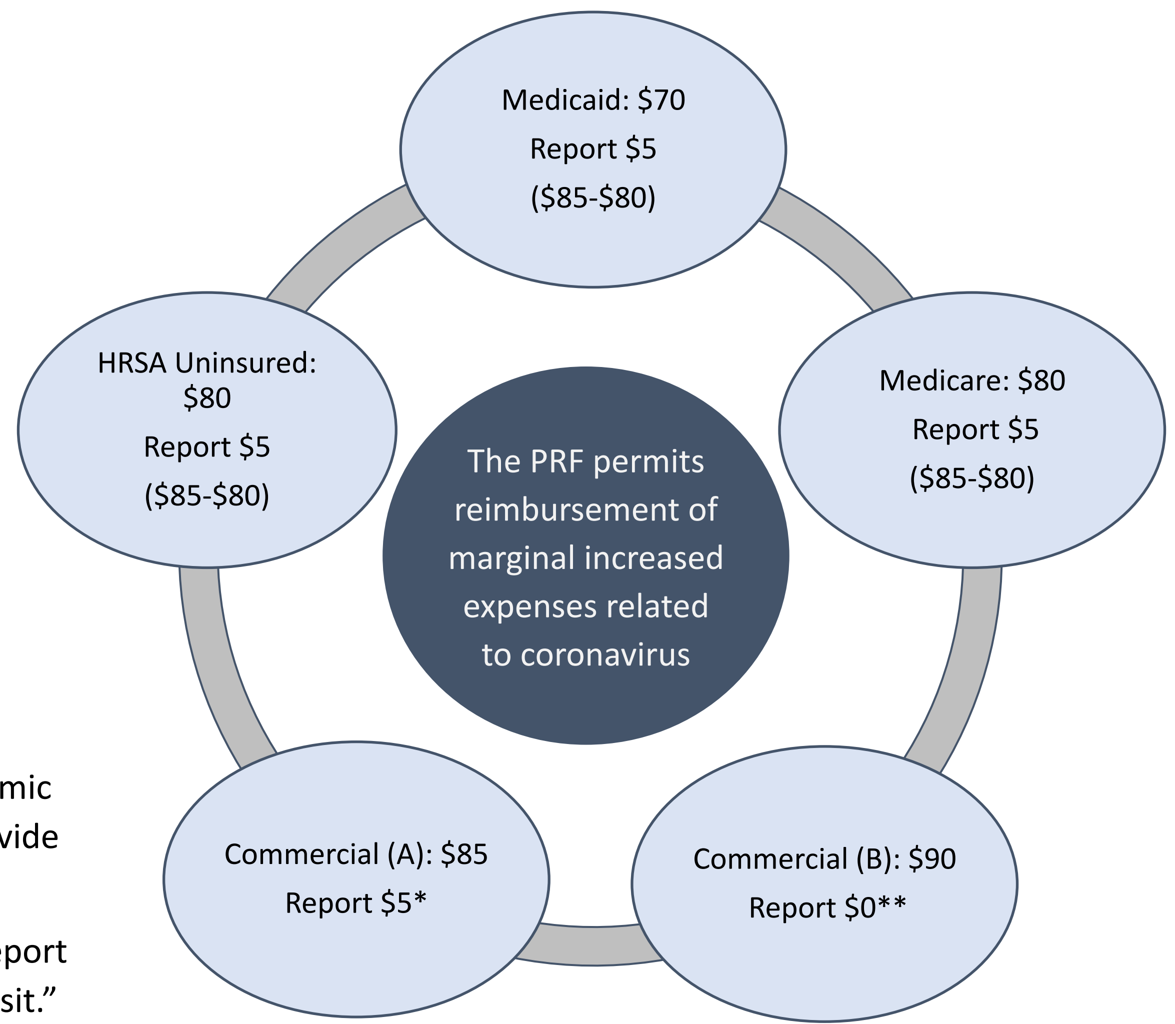
"The $85 FAQ"

FAQ: When reporting my organization's healthcare expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources?"

- **HHS:**…"Assume 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…"

*"Commercial insurer did not reimburse for $5 increased cost of post-pandemic office visit." Since the payor reimbursed at cost, it is recommended HHS provide further clarification on how this amount is determined."

**"$85 + $5 insurance supplemental coronavirus-related reimbursement. Report $0, since insurer reimbursed for $5 increased cost of post-pandemic office visit."



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Coronavirus Expenses Net of Revenue

Interpretation: Reporting Approach using “The $85 FAQ” Cost per Patient

	A	B	C = B-A	D	E = C*D	F	G = E-F	
Inpatient	**CY 2019 Cost per Patient Discharge**	**CY 2020 Cost per Patient Discharge**	**CY 2020 vs. CY 2019 Cost Change**	**2020 IP Discharges**	**Coronavirus IP Expense**	**Coronavirus IP Revenue**	**IP Expenses Net of Revenue**	
a. Medicare Part A+B	$26,000	$26,500	$500	2,200	$1,100,000	$330,000	$770,000	
b. Medicare Part C	25,000	25,200	200	4,200	840,000	252,000	588,000	
c. Medicaid	32,000	33,000	1,000	3,200	3,200,000	960,000	2,240,000	
d. Commercial Insurance	23,000	23,100	100	3,100	310,000	93,000	217,000	
e. Self-Pay (No Insurance)	35,000	37,500	2,500	804	2,010,700	603,210	1,407,490	
Total	**$27,273**	**$36,408**	**$9,135**	**13,504**	**$7,460,700**	**$2,238,210**	**$5,222,490**	**H**
Outpatient	**CY 2019 Cost per Patient Visit**	**CY 2020 Cost per Patient Visit**	**CY 2020 vs. CY 2019 Cost Change**	**2020 OP Patient Visits**	**Coronavirus OP Expense**	**Coronavirus OP Revenue**	**OP Expenses Net of Revenue**	
a. Medicare Part A+B	$1,900	$2,200	$300	1,200	$360,000	$108,000	$252,000	
b. Medicare Part C	1,900	2,100	200	2,500	500,000	150,000	350,000	
c. Medicaid	2,400	2,900	500	2,250	1,125,000	337,500	787,500	
d. Commercial Insurance	1,400	1,650	250	1,750	437,500	131,250	306,250	
e. Self-Pay (No Insurance)	3,700	3,846	146	800	116,800	35,040	81,760	
Total	**$2,007**	**$2,973**	**$966**	**8,500**	**$2,539,300**	**$761,790**	**$1,777,510**	**I**
Total Inpatient + Outpatient	**N/A**	**N/A**	**N/A**	**N/A**	**Total IP +OP Coronavirus Expense**	**Coronavirus IP + OP Revenue**	**Total Expenses Net of Revenue**	
a. Medicare Part A+B					$1,460,000	$438,000	$1,022,000	
b. Medicare Part C					1,340,000	402,000	938,000	
c. Medicaid					4,325,000	1,297,500	3,027,500	
d. Commercial Insurance					747,500	224,250	523,250	
e. Self-Pay (No Insurance)					2,127,500	638,250	1,489,250	
Total					**$10,000,000**	**$3,000,000**	**$7,000,000**	**J = H+I**

- Volume based payors only
- Toyon recommends providers evaluate the HHS FAQ on Commercial Payors reimbursing at the increased cost amount
- Providers still report coronavirus G&A and healthcare expenses, and **other statistical data**
- Coronavirus related revenue may include FEMA, payor specific COVID relief payments made on a per claim (i.e., Medicare 20% DRG add-on), business insurance, SBA and PPP assistance, local | State | Tribal assistance

In this **hypothetical example**; coronavirus related expenses, net of reimbursement are approx. $7m

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Coronavirus Expenses Net of Revenue

FAQ: When reporting my organization's healthcare expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources?"

HHS: ...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 CHIP
- Other Funds Received from FEMA
- HRSA PRF Payments for the Uninsured
- SBA and Treasury's Paycheck Protection Program (PPP)

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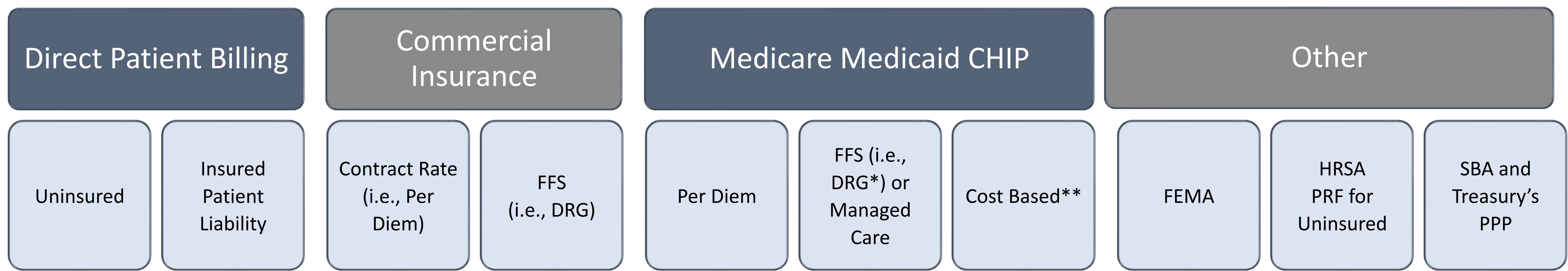
Coronavirus Expenses Net of Revenue

Reimbursement Types by Payor

Payments to net against coronavirus expenses another source has not reimbursed and is not obligated to reimburse.



*Including the 20% increase to DRG payments for Medicare FFS beneficiaries. Is not expected providers will have to report savings from the Medicare sequester relief

**The amount of revenue offset against expenses will depend on how providers choose to report coronavirus expenses

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Coronavirus Expenses Net of Revenue

Reporting of Patient Care Revenue and Expenses

Remove revenue and expenses related to the following

Expense from any rental property (exception for nursing and assisted living facilities' real estate costs where resident costs are allowable), contributions made, and gains and/or losses on investments

Revenue related to insurance, retail, real estate (exception for nursing and assisted living facilities' real estate revenue where resident fees are allowable), pharmacy (except 340B); grants or tuition; contractual adjustments, charity care adjustments, bad debt, any gains and/or losses on investments, and any PRF received

Revenue related to cost report settlement/appeals

Consideration of revenue and expense from provider tax programs for care outside of reporting period

Per terms and conditions remove Executive Level II salary expense in excess of $197,300

Providers must also report coronavirus G&A and healthcare expenses, and other statistical data.

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Coronavirus Expenses Net of Revenue

Notable Updated FAQs from January 28, 2021

COVID-19 Vaccine Distribution and Administration

Q: If a provider administers a COVID-19 vaccine to a patient that has Medicare Part A, but not Part B, coverage, can the provider use Provider Relief Fund payments to cover the unreimbursed costs associated with vaccine administration?

HHS: Yes. The costs associated with administering a vaccine to a patient with Medicare Part A, but not Part B, coverage would be considered unreimbursed under the Provider Relief Fund, and payments could be used to cover incurred expenses.

Q: Can Provider Relief Fund payments be used to support COVID-19 vaccine distribution?

HHS: Provider Relief Fund payments may be used to support expenses associated with distribution of a COVID-19 vaccine licensed or authorized by the Food and Drug Administration (FDA) that have not been reimbursed from other sources or that other sources are not obligated to reimburse. Funds may also be used ahead of an FDA-licensed or authorized vaccine becoming available. This may include using funds to purchase additional refrigerators or freezers, personnel costs to provide vaccinations, and transportation costs not otherwise reimbursed.

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Other PRF Reporting

Interest Earned on PRF Payment

For Reporting Entities that held the PRF payment(s) being reported on in an interest-bearing account, the dollar value of interest earned on those PRF payment(s) must be reported. The total reportable use of PRF distributions will be inclusive of the interest earned on those PRF distributions.

January 28, 2021 FAQ Update:

Q: Is interest earned on Provider Relief Fund funds considered a reportable revenue source to HHS?

HHS: Yes, **if funds were held in an interest-bearing account, they would be considered reportable revenue**. Interest earned would then be reported in "**Other Assistance**." If interest is earned on Provider Relief Fund disbursements that the Reporting Entity expended in full, the interest amounts may be retained and applied toward a reportable use of funds. If interest is earned on funds that are only partially expended, the interest on remaining unused funds must be calculated, reported, and returned.

CY 2020 and CY 2019 Facility, Staffing and Patient Care (per quarter)

a. Personnel Metrics: Total personnel by labor category (e.g., full-time, part-time, contract, other: recipient must define), total rehires, total new hires, and total personnel separations by labor category.

b. Patient Metrics: Total number of patient visits (in-person or telehealth), total number of patients admitted, and total number of resident patients.

c. Facility Metrics: Total available staffed beds for medical/surgical, critical care, and other beds.

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OMB Single Audit Guidance

2 CFR PART 200, APPENDIX XI | COMPLIANCE SUPPLEMENT | ADDENDUM

December 2020

NOTE: Auditors must use this 2020 Addendum and the 2020 Compliance Supplement together

Applies to providers with $750,000+ in aggregated federal financial assistance during their fiscal year

DEPARTMENT OF HEALTH AND HUMAN SERVICES CFDA 93.498 PROVIDER RELIEF FUND

Other sections of the OMB addendum discuss cost principles, however for the PRF it states:

- "At the time of issuance of this addendum, the report and reporting portal were under development and not expected to be available before January 15, 2021.
- By February 1, 2021, a notice will be placed on OMB's Office of Federal Financial Management website (https://www.whitehouse.gov/omb/management/office-federal-financial-management/) providing key line items and other information from the report that are subject to audit for audits of fiscal years ending on or after December 31, 2020.
- Auditors performing audits of December 31, 2020 year-ends are expected to test this special reporting even though it will not be able to be submitted by recipients until early in the next fiscal year…
- ***Extensions***…recipients and subrecipients that received COVID-19 funding with original due dates from **October 1, 2020, through June 30, 2021**, **an extension for up to three (3) months beyond the normal due date**…"

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OMB Single Audit Guidance

2 CFR PART 200, APPENDIX XI | COMPLIANCE SUPPLEMENT | ADDENDUM

December 2020

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Applies to providers with $750,000+ in aggregated federal financial assistance during their fiscal year

APPENDIX VII OTHER AUDIT ADVISORIES | I. Novel Coronavirus (COVID-19)

Agency Guidance Document References for Programs in the Addendum

- "The COVID-19 pandemic has led many federal agencies to issue implementing guidance (e.g., frequently asked questions, memos) outside of the normal regulatory process for new and existing programs receiving COVID-19 funding.
- **Such guidance [FAQs] is issued to communicate an agency's understanding of how the relevant statutes, regulations, or the terms and conditions of the federal awards to the extent they exist and apply to a particular circumstance, but it does not create new compliance requirements. Due to the evolving nature of the pandemic environment, it has been common for federal agencies to update, change, or delete their specific guidance over time**..."
- …When citing criteria for audit findings, 2 CFR 200.516(b)(2) indicates the following information must be included in finding detail: "The criteria or specific requirement upon which the finding is based, including the Federal statutes, regulations, or the terms and conditions of the Federal awards." **Therefore, auditors should refer to a statute, regulation, or term and condition as criteria for the audit finding**.

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OMB Single Audit Guidance

For-profit providers (commercial) that receive $750,000 or more in annual awards have two options under 45 CFR 75.216(d) and 75.501(i):

1) a financial related audit of the award or awards conducted in accordance with Government Auditing Standards; or

2) an audit in conformance with the requirements of 45 CFR 75 Subpart F

HHS Single Audit Information:

https://www.hhs.gov/about/agencies/asfr/data-act-program-management-office/single-audit/index.html

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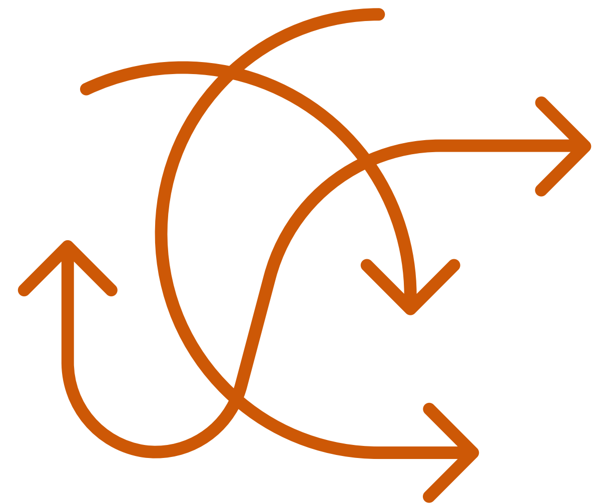
PRF Reporting Step 2



Patient Care Lost Revenues

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Patient Care Lost Revenues

PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues

Method 1
CY 2019 and CY 2020 Actual Patient Care Revenue

- Actual Patient Care Revenue Before Expenses
- Include 340B
- Exclude non-patient care and payments from care not provided in 2019 or 2020

Method 2
CY 2020 Budget and CY 2020 Actual Patient Care Revenue

- Actual Patient Care Revenue Before Expenses
- Include 340B
- Exclude non-pat. care and pmts from care not in '19 or '20
- Budget Established and Approved prior to 3/27/2020

Method 3
Any Reasonable Method of Estimating Revenue
Increased likelihood of an audit by HRSA

- Description of the methodology
- Explanation why methodology is reasonable
- Define how lost revenues were attributable to coronavirus, as opposed to by any other source

Method 3 examples | observations: 1) Irregular Revenue in 2019 (Implementation of New Patient Accounting Software); 2) Closure of Neighbor Hospital, resulting in both increase in revenue and expenses: Would HHS allow the impact shown as the difference in net losses from CY 2019 to CY 2020?

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Patient Care Lost Revenues

Issue 1:

Hospital Patient Care Revenue is Complex, Especially for Public Hospitals

Provider Relief Fund recipients shall exclude from the reporting of net patient revenue payments received or payments made to third parties relating to care not provided in 2019 or 2020.*

Conflicting Concepts

To calculate lost revenues attributable to coronavirus, providers are required to report revenues received from Medicare, Medicaid, commercial insurance, and other sources for patient care services. **Other source**s include fundraising revenues, **grants** or donations if they contribute to funding patient care services.

***Medicaid supplemental revenue may not be related to care provided in 2019 and 2020**

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Patient Care Lost Revenues

Issue 1: Potential Solution | Comment to HHS

Include	Exclude
Medicaid GME	University CA DSH**
IGT Rate Range Transfer*	PRIME and Whole Person Care
GPP	Prior year Settlements
EPP	QIP** and QAF

Based on interpretation without clear guidance from HHS

It is recommended HHS provide clear and concise guidance articulating the variables to consider for patient care vs. non-patient care revenue in PRF reporting of Medicaid Supplement payments.

- Reimbursement for care provided during CY 2020 and CY 2019

Vs.

- Reimbursement associated with base-year "add-ons", etc. that are determined from years prior to 2019 and 2020

*For IGT programs it is recommended providers record total computable revenue, not as the Federal Financing Participation (FFP).

**There is industry uncertainty regarding the treatment of this revenue as patient care.

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Patient Care Lost Revenues

Issue 2:

Duplication reporting revenue in step 1 related to coronavirus expenses and again in step 2 as revenue loss

In **step 1**, providers already report coronavirus expenses net of reimbursement

For instance, consider the following relief payments: FEMA, Cost Based, Medicare 20% DRG add-on, HRSA Uninsured Program

In **step 2**, HHS requests hospitals to report lost revenue from CY 2020 vs. CY 2019, including revenue from all payors and "other"

This step duplicates the revenue already accounted for in step 1.

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Patient Care Lost Revenues

Issue 2: Potential Solution | Comment to HHS

Report Coronavirus Revenue in Step 1 or Step 2, Not Both

Report Coronavirus Revenue Against Expenses Only (Step 1)*

Report Coronavirus Revenue in Determination of Revenue Loss Only (Step 2)

*Added benefit of not requiring PRF recipients and HHS to determine if claims-based payment needs to be offset on a case-by-case basis.

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Patient Care Lost Revenues

Issue 3: Reporting budgets established and approved prior to March 27, 2020

- Providers that are non-December 31 fiscal year are concerned with 2020 budgets not approved by March 27, 2020.
- HHS has not clarified if providers may adjust and/or prorate budgets for other fiscal periods.

Month/Year	FYE March 31, 2020		FYE June 30, 2020		FYE Sept. 30, 2020		FYE December 31, 2020	
Apr-19	2020	1	2019		2019		2019	
May-19	2020	2	2019		2019		2019	
Jun-19	2020	3	2019		2019		2019	
Jul-19	2020	4	2020	1	2019		2019	
Aug-19	2020	5	2020	2	2019		2019	
Sep-19	2020	6	2020	3	2019		2019	
Oct-19	2020	7	2020	4	2020	1	2019	
Nov-19	2020	8	2020	5	2020	2	2019	
Dec-19	2020	9	2020	6	2020	3	2019	
Jan-20	2020	10	2020	7	2020	4	2020	1
Feb-20	2020	11	2020	8	2020	5	2020	2
Mar-20	2020	12	2020	9	2020	6	2020	3
Apr-20	2021		2020	10	2020	7	2020	4
May-20	2021		2020	11	2020	8	2020	5
Jun-20	2021		2020	12	2020	9	2020	6
Jul-20	2021		2021		2020	10	2020	7
Aug-20	2021		2021		2020	11	2020	8
Sep-20	2021		2021		2020	12	2020	9
Oct-20	2021		2021		2021		2020	10
Nov-20	2021		2021		2021		2020	11
Dec-20	2021		2021		2021		2020	12

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Patient Care Lost Revenues

Issue 3 Potential Solution | Comment to HHS: Hybrid Loss Approach of Methods 1 and 2

- Comparison of budgeted 2020 revenue for the months in 2020 with a budget approved by March 27, 2020
- Comparison of Actual 2019 to Actual 2020 Actual revenue for the remaining months

Example "Hybrid" Revenue Loss Approach for a 6/30 FYE

Month Year	2020 Actual Revenue Compared to:
January 2020	FY 2020 Budget
February 2020	
March 2020	
April 2020	
May 2020	
June 2020	
July 2020	FY 2019 to FY 2020 Actual
August 2020	
September 2020	
October 2020	
November 2020	
December 2020	

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Patient Care Lost Revenues

Reporting Coronavirus Expenses and Revenue Loss

Step 1: Coronavirus Expenses Net of Reimbursement

Description	Amount	Key
PRF Allocation	$25,000,000	A
Coronavirus Exp. Net of Pmt.	7,000,000	B ("$85 FAQ" Interpretation)
Residual Amount*	**$18,000,000**	**C = A –B**

Step 2: Revenue Loss

CY 20 Actual Patient Revenue vs. CY 19 Actual Patient Revenue

Payor	CY 20 vs. CY 19 Variance	Key
Medicare Part A+B	($6,100,000)	D
Medicare Part C	(6,000,000)	E
Medicaid	(2,800,000)	F
Commercial Insurance	(8,000,000)	G
Self-Pay (No Insurance)	(725,000)	H
Total	**($23,625,000)**	**I = Sum(D:H)**

Excess PRF over Expenses and Lost Revenue*	**$5,625,000**	**J = C+I**

*If the Provider's revenue loss did not cover the remaining PRF allocation, the Provider has the option to calculate revenue loss comparing CY 2020 actual patient care revenue vs. CY 2019 patient care revenue or use an alternative method

Providers also have additional six months to use remaining amounts toward expenses attributable to coronavirus but not reimbursed by other sources, and/or lost revenues in an amount not to exceed the difference between:

1) 2019 Quarter 1 to Quarter 2 and 2021 Quarter 1 to Quarter 2 actual revenue, or
2) 2020 Quarter 1 to Quarter 2 budgeted revenue and 2021 Quarter 1 to Quarter 2 actual revenue

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Patient Care Lost Revenues

Reporting Expenses and Revenue Loss

January 28, 2021 FAQ

Q: If all funds are expended to cover unreimbursed healthcare related expenses attributable to coronavirus, are Reporting Entities still required to submit lost revenue information?

HHS: Reporting Entities are required to submit actual patient care revenue for calendar years 2019 and 2020 in order to inform program integrity and HRSA's audit strategy.

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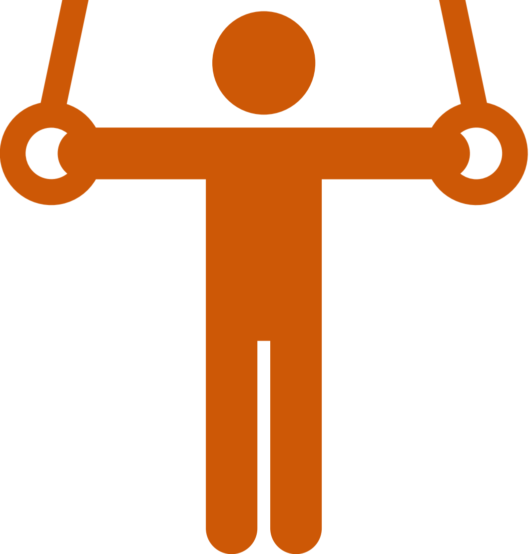
CMS Flexibilities and Medicare Cost Reporting



Considerations and Guidance

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CY 2020 Year End Reporting

FAQ: How does cost reimbursement relate to my Provider Relief Fund payment?

HHS: "Recipient must follow CMS instructions for completion of cost reports. Under cost 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. In cases where a ceiling is applied to the cost reimbursement and the reimbursed amount does not fully cover the actual cost due to unanticipated increases in providing care attributable to coronavirus, those incremental costs that were not reimbursed are eligible for reimbursement under the Provider Relief Fund."

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

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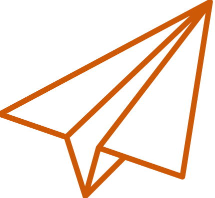
Medicare Cost Reporting

“[Hospital Name] respectfully requests data from the fiscal year ending (FYE) *June 30, 2020* Medicare cost report is evaluated with Centers for Medicare and Medicaid Services (CMS) and other industry stakeholders before it is used for hospital reimbursement and rate setting. As recorded in [Hospital Name]’s accompanying cost report, the COVID-19 public health emergency (PHE) may have resulted in irregular data as compared to normal years of operation. We strongly encourage CMS to assess the financial implications of using this data before it is applied towards any Medicare and Medicaid reimbursement and rate setting.”



Cover Letter to MAC

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Medicare Cost Reporting

On the other hand…

- While months during the PHE may not be reflective of a "normal" year, Statute takes precedence with how the payments are determined
- CMS has offered some flexibilities, and the agency may be held to standards ensuring payment closely resembles current activity
  - For example, if the provider has lower Medicare bad debts than in prior years, the bad debt reimbursement will be less

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Medicare Cost Reporting

COVID-19 revenue is not offset on WS A-8

Payment Protection Program (PPP) loan forgiveness amounts are not offset on WS A-8

For hospitals: reporting Revenues Associated with CARES Act Funds on WS G-3, Line 24.50 (only for the 2552-10 form for hospitals)

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Medicare Empirical DSH

- Issues, such as the cancelations of elective procedures, impact the proportion of inpatient care provided to Medicaid eligible patients to total patients

- DSH ratios are not likely representative of a typical year

- DSH qualification and payments as well as qualification for discounts under the 340B program should be evaluated

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Medicare Uncompensated Care DSH

- Issues, like stay-at-home mandates, impacted the volume of charity care provided this year	- Rising unemployment rates from the PHE have an exponential impact on: 1) the amount of charity care provided 2) hospital financial assistance policies (FAP) 3) national funding needed for future UC DSH	- Updates to FAPs are also recommended so that charges not reimbursed by HHS/HRSA are considered for financial assistance (WS S-10 reporting)

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Medical Education (IME) and Direct Graduate Medical Education (DGME)

- CMS is excluding beds added temporarily for the PHE when calculating available beds for IME reimbursement

- CMS is also permitting hospitals to report the time of interns and residents (I&R) trained at alternate locations (if in response to the PHE)

- Other disruptions may have an impact to the I&R count for IME and DGME, like cancellations of elective procedures, employee sick time issues, stay-at-home mandates

- *DGME Payments:* Payments determined by the proportion of inpatient Medicare Advantage (MA) days to total inpatient days may be impacted by the cancellation of nonemergent procedures from MA patients

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Cost to Charge Ratios

- Hospital services, and related expenses, provided during the PHE are not representative of a typical year and may result in an atypical CCR

- Notably, the CCR is used in Medicare outlier payments, and to determine UC costs for UC DSH reimbursement

- Other payers, like Medicaid, may utilize the cost to charge ratio for provider payments

- Also noted, providers may have created new departments or extensions of existing departments, like Emergency to track expenses

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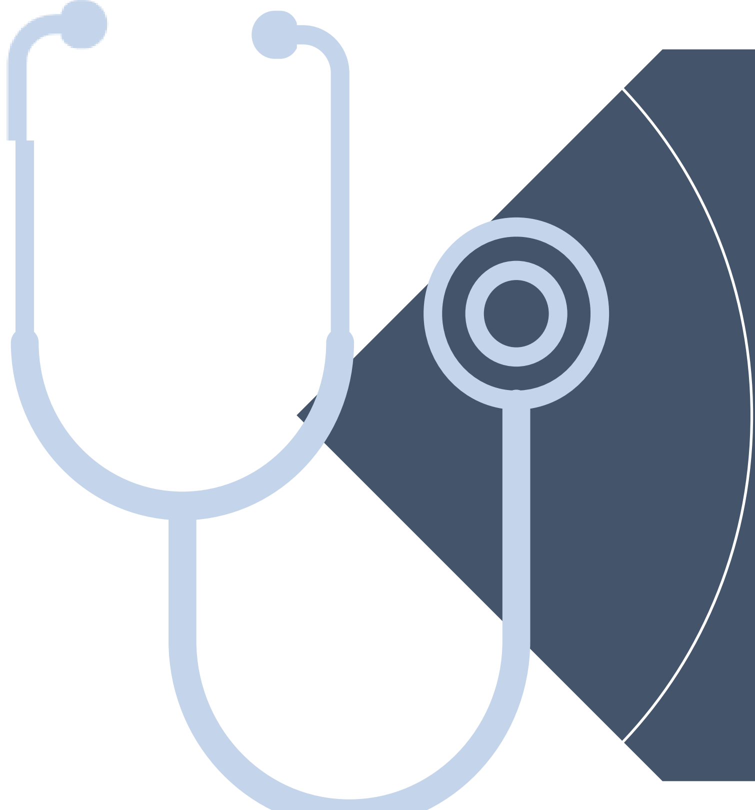
Medicare Cost Reporting



Rural Health Clinics

- Productivity Standards – The minimum productivity standards for physicians and non-physicians determining eligibility for the All-Inclusive Rate payments are not reflective of a usual year of operations for RHCs
- CMS states in an FAQ that an RHC can request exception to the productivity standards due to the PHE

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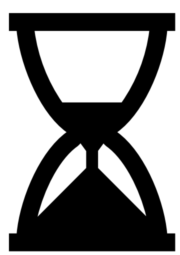
Medicare Cost Reporting

Physician Time Studies



- During the PHE, any one of these time study options is acceptable:
  - One-week time study every 6 months (two weeks per year)
  - Time studies completed in the cost report period prior to January 27 (i.e., the PHE effective date)
    - For instance, a hospital with a 7/1/2019 - 6/30/2020 cost reporting period could use the time studies collected 7/1/2019 through 1/26/2020. No time studies needed for 1/27/2020 - 6/30/2020
  - Time studies from the same period in CY 2019
    - For instance, if unable to complete time studies during February through July 2020, use time studies completed February through July 2019

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CMS Waivers and Flexibilities

Temporary Expansion Sites (Surge Sites)

- Hospitals may change status of their current provider-based department locations to the extent necessary to address the needs of patients during the pandemic
- Includes remote locations, such as hotels or community facilities
- Provider-based outpatient departments
- Must still control and oversee services at alternative locations

CAHs:

- May expand beyond 25 beds
- May incur lengths of stay greater than 96 hours
- May open surge sites not in rural locations or regardless of location relative to other hospitals

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CMS Waivers and Flexibilities

Sub-acute Settings

Acute care patients may be housed in excluded distinct part units (e.g., IPFs, IRFs)

May still bill under excluded PPS

IRF “60 Percent Rule” waived during PHE

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Consolidated Appropriations Act, 2021

Physician fee schedule increase by 3.75% for services provided in CY 2021

Suspension of the 2 percent Medicare payment cut through March 31, 2021

Increases payments for the work component of physician fees (wage index) in areas where labor cost is determined to be lower than the national average through December 31, 2023

New, voluntary Medicare payment CAH or a small, rural hospital with less than 50 beds to convert to a Rural Emergency Hospital (REH)* to preserve beneficiary access to emergency medical care in rural areas that can no longer support a fully operational inpatient hospital

*REHs can also furnish additional medical services needed in their community, such as observation care, outpatient hospital services, telehealth services, ambulance services, and skilled nursing facility services. REHs will be reimbursed under all applicable Medicare prospective payment systems, plus an additional monthly facility payment and an add-on payment for hospital outpatient services.

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Consolidated Appropriations Act, 2021

Beginning in fiscal year 2023, provides for the distribution of additional Medicare-funded graduate medical education (GME) residency positions.

Rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools, and hospitals that serve Health Professional Shortage Areas will be eligible for these new positions.

Phases-in steady increases in the RHC statutory cap beginning April 1, 2021 through 2028, bringing the RHC upper limit in line with the Federally Qualified Health Centers (FQHC) Medicare base rate*.

Allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full-time equivalent (FTE) resident cap or a Per Resident Amount (PRA).

Amends the current schedule of Medicaid Disproportionate Share Hospital (DSH) payment reductions to eliminate the reductions in effect for fiscal year 2021, eliminate the reductions for fiscal years 2022 and 2023, and add reductions to fiscal years 2026 and 2027.

*In each subsequent calendar year, starting in 2029, the new statutorily set RHC cap reverts to an annual Medicare Economic Index (MEI) inflationary adjustment.

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Questions?

Thank you for your participation!

Please currently visit https://www.toyonassociates.com/latest-covid-19-resources/ for updates, summaries, supporting details, and COVID-19 funding models

Contact Toyon Associates at 888.514.9312