hfma
healthcare financial management association

December 4, 2020

Eric Hargan
Deputy Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CARES Act Provider Relief Fund (PRF) Compliance Questions

Dear Deputy Director Hargan:

On behalf of the Healthcare Financial Management Association's (HFMA's) 56,000 members, I would like to thank you for your team's leadership during the COVID-19 Public Health Emergency (PHE). We greatly appreciate the work HHS's staff has undertaken to quickly distribute CARES Act Provider Relief Funds (PRFs) to caregivers at the frontline who are playing a key role in fighting this pandemic and protecting their communities. The speed with which the agency has moved to distribute funds is both unprecedented and impressive.

While the speed has been impressive, the agency's responsiveness to technical compliance questions about the PRFs presents an opportunity for improvement. HFMA members appreciate the diligent efforts HHS staff have made to update the PRF FAQs and provide answers through the Provider Support Line. Specifically, HFMA's members greatly appreciate the additional detail provided in the October 28th update to the FAQs and the November 2 revisions to the PRF reporting instructions. However, we are concerned that the current reporting requirements continue to conflict with the prior FAQs issued by HHS and do not provide sufficient detail to PRF recipients so that they can ensure they are reporting their expenses and lost revenue attributed to the coronavirus accurately. Furthermore, the requirements deviate from the initial intent of supporting American families, workers and the heroic healthcare providers in the battle against the COVID-19 outbreak.

HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry. Therefore, we have convened a task force of HFMA members consisting of accountants who provide audit services to healthcare providers, attorneys, and healthcare finance consultants. Based on their work with hospitals, health systems, post-acute providers, and physician practices, they have identified key questions related to the November 2 reporting requirements that must be clarified. Given the technical nature of these questions, in addition to identifying them, the task force has also developed suggested clarifications based on their understanding of the CARES Act, Financial Accounting Standards Board (FASB) /Governmental Accounting Standards Board (GASB) accounting standards, the myriad of laws and regulations that govern the healthcare industry and common provider practice. These are included for your review in Attachment 1.

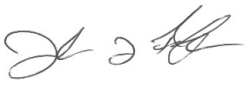
We ask that you and your staff review the issues raised and provide clarifications as quickly as possible. HFMA members are concerned that continued ambiguity on these issues makes it challenging for their

organizations to accurately recognize revenue, understand their financial position and communicate that position to capital markets. This ambiguity is impacting staffing decisions (increasing the likelihood of furloughs and layoffs of caregivers and support staff) and investment decisions (causing many providers to freeze capital projects) and increasing financing costs for both short-term liquidity and long-term capital as investors demand additional higher risk premiums, given the uncertain environment.

Beyond the immediate impact on operations and financial statements, the lack of clarity presents potential compliance issues. While HFMA members are making every effort to provide HHS with accurate data as requested and comply with the terms and conditions as they understand them, the ambiguity increases the risk that well-meaning providers may be found, after the fact, not to have reported data accurately or fully complied based on HHS's evolving data definitions and terms. HFMA members note that time is of the essence as we are less than 60 days away from the date HHS intends to open the reporting portal and less than 90 days away from the initial reporting deadline.

We would like to meet with you and your staff to discuss the questions and responses in Attachment 1. My staff will follow up to schedule a conference call. HFMA looks forward to any opportunity to provide additional assistance or comments to HHS to further their efforts to help providers respond to the COVID-19 pandemic, provide HHS the necessary data it needs to coordinate response efforts and comply with the various PRF terms and conditions. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal agencies and advisory groups. In the meantime, if you have questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you to provide clarity on these important questions.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
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About HFMA

HFMA is the nation's leading membership organization for more than 56,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant. HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.

Attachment 1: Questions Related to HHS's November 2 General and Targeted Distribution Post-Payment Notice of Reporting Requirements

1) Clarifications requested on Step 1 (also noted as item 2 in list of required data elements}, calculating "expenses attributable to coronavirus not reimbursed by other sources (2020 only)."

   a. *Confirm Definition of Expenses Attributable to Coronavirus Not Reimbursed by Other Sources related to "maintaining healthcare delivery, etc.*: The instructions state, "Expenses attributable to coronavirus may be incurred both in treating confirmed or suspected cases of coronavirus, preparing for possible or actual coronavirus cases, *maintaining healthcare delivery capacity*, etc.".

   HFMA members interpret the instructions to mean that Provider Relief Funds (PRF) recipients are to report all patient care-related operating and capital expenses incurred during 2020, which would then be offset by the incremental revenue related to COVID-19 received from various sources (see request for clarification below). For example, these expenses would include those for the patient accounting department, health information management department and patient food services for a hospital PRF recipient.

   Specifically, HFMA members ask that HHS clarify the general and administrative expenses that can be claimed. The November 2 PRF reporting instructions defines "expenses attributed to coronavirus, not attributed to other sources" conceptually as, "expenses attributable to coronavirus may be incurred both in treating confirmed or suspected cases of coronavirus, preparing for possible or actual coronavirus cases, maintaining healthcare delivery capacity, etc.".

   These expenses include "general and administrative" expenses (G&A) which are defined as follows:

   > General and Administrative Expenses Attributable to Coronavirus
   > The actual G&A expenses incurred over and above what has been reimbursed by other sources.
   >
   > a. Mortgage/Rent: Monthly payments related to mortgage or rent for a facility.
   > b. Insurance: Premiums paid for property, malpractice, business insurance or other insurance relevant to operations.
   > c. Personnel: Workforce-related actual expenses paid to prevent, prepare for, or respond to the coronavirus during the reporting period, such as workforce training, staffing, temporary employee or contractor payroll, overhead employees or security personnel.
   > d. Fringe Benefits: Extra benefits supplementing an employee's salary, which may include hazard pay, travel reimbursement, employee health insurance, etc.
   > e. Lease Payments: new equipment or software lease.
   > f. Utilities/Operations: Lighting, cooling/ventilation, cleaning, or additional third party vendor services not included in "Personnel."
   > g. Other General and Administrative Expenses: Costs not captured above that are generally considered part of overhead structure.

   Based on this definition, HFMA members believe that all general and administrative expenses, net of incremental revenue related to COVID-19, are eligible for PRF reimbursement. These expenses are necessary to "maintaining healthcare delivery capacity."

However, the 10/28 FAQ below seems to contradict the November 2 PRF Reporting Instructions.

> *When reporting my organization's G&A expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? (Added 10/28/2020)*
>
> *Providers should calculate incremental G&A expenses incurred that were attributable to coronavirus and then estimate the portion of those expenses that were not covered through operational revenues, other direct assistance, donations or other sources. Examples may include expenses such as: Hiring additional security personnel, increased hazard pay, increased cost of utilities to operate temporary facilities, or similar items attributable to the coronavirus that were not normally incurred.*

HFMA members strongly encourage HHS to revise the 10/28 FAQ to clarify that all general and administrative expenses – not just incremental general and administrative expense – are eligible for PRF reimbursement. As discussed above, these expenses are necessary to maintain care delivery capacity. If this interpretation is not accurate, HHS must provide examples of the types of general and administrative expenses that are both eligible and ineligible for PRF payment related to "maintaining healthcare delivery capacity" and how those expenses should be offset (reduced) by COVID-19 related payments.

b. <u>*Clarify Expenses Included in Calculation of Those Related to Coronavirus*</u>: On pages 3 and 4, the instructions provide a partial list of "general and administrative expenses attributable to coronavirus" and "healthcare related expenses attributable to coronavirus."

- *Other Expenses*: HFMA members note that each category of expenses includes an "other" category. We ask that HHS confirm that the following expense categories are included in "other" and have not been explicitly excluded.

    1. *Depreciation*: Amortized capital expenses for property, plant and equipment.
    2. *Financing expense*: Includes increased interest expense for lines of credit or other short-term loans to ensure liquidity, fees for breaching debt covenants and other financing costs.
    3. *Property and Other Taxes*: Taxes and assessments paid to state, local or the federal government based on assessments on property value, number of beds or other non-revenue related taxes.
    4. *Professional Services*: Includes but is not limited to consulting support, financial advisory services, legal services and audit services.

- <u>*Expense Recognition*</u>: Do other healthcare expenses incurred for the coronavirus include incremental COVID-19 expenses incurred even if total expenses in that category went down from 2019 to 2020? Asked differently, are PRF recipients allowed to claim any COVID-19-related expenses or is it the change in expenses between 2019 to 2020?

  As an example, a large academic medical center has set aside a wing of the hospital solely to treat COVID-19 patients. Typically, that wing of the hospital is 90% occupied on average. Thus far, the COVID-19 wing has an average occupancy of 60%. HFMA members believe it is Congress's intent that the PRF funds be used to reimburse hospitals for maintaining COVID-19-specific wings to allow the hospital to better

respond to the pandemic. However, due to the lower occupancy level in 2020 of the COVID-19 wing, if the analysis of expenses reimbursed by PRF funds is based on the incremental difference in 2020 expenses relative to 2019, net of any incremental revenue related to COVID-19, this provider will not be able to claim PRF for this crucial element in its community's PRF response plan.

Further, we ask that HHS confirm that only incremental revenue related to COVID-19 (e.g., 20% increase in Medicare operating MS-DRG payments, a specific COVID-19 payment increase from commercial payers, state-specific recovery funds) should be offset from costs attributable to COVID-19.

c. *PRF Expenses for Cost-Based Providers*: An FAQ posted on 10/28/20 states that COVID-19-related expenses reimbursed by cost-based payers are not covered by PRF funds. Specifically, the FAQ states:

How does cost reimbursement relate to my Provider Relief Fund payment? (Added 10/28/2020)

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.

Typically cost-based payers require the provider to submit a cost report. This cost report is used to calculate the allowable expenses that the payer is responsible for reimbursing the provider. While time frames for filing cost reports differ by payer, they are typically filed many months after the end of the provider's fiscal year. For example, the Medicare cost report is due five months after the end of a provider's fiscal year.

If HHS maintains its current policy promulgated in this FAQ, cost-based providers (even those with a calendar fiscal year end (FYE) whose FYE20 cost reports will not be due until May 31, 2021) will need to make a reasonable estimate of their cost-based reimbursement for expenses attributable to COVID-19 that were covered by cost-based payers like Medicare.

HFMA members ask that HHS clarify that a good faith estimate of these costs is acceptable. We also ask that HHS clarify whether or not there will be a subsequent reconciliation process for calendar FYE providers.

Additionally, not all PRF recipients who receive cost-based payments are on a calendar FYE. (See discussion below for additional details.) This adds significant complexity as these PRF recipients will need to create a synthetic cost report from two "stub -periods." For example, a 9/30 FYE's PRF reporting will consist of nine months from its FY20 cost reporting period and three months from its FY21 cost reporting period. HFMA asks that HHS provide PRF recipients who receive cost-based payments from some payers with a specific template that calculates the COVID-19 related expenses that were reimbursed under cost-based payment for reporting that addresses this issue. Further, we are concerned that critical access hospitals may not be

able to prepare this reporting within 45 days. Many of these hospitals outsource cost report preparation and there may not be enough consultants to meet the demand for preparing calendar year-end cost reports for hospitals that are non-calendar year-end FYEs.

Finally, we ask that HHS confirm that any expenses incurred by non-calendar year-end providers in the preparation of a calendar year-end cost report will be covered by PRF funds.

d. *Timing of Payments vs. Application to Expenses*: How are skilled nursing facilities (SNFs) that received targeted distributions for infection control required to apply expenses to each layer of funding? For example, if a SNF incurred infection control expenses in March through July – prior to targeted SNF infection control funding being announced – would the SNFs apply infection control expenses incurred in April to the General Distribution payments to justify those expenses? Or should they apply infection control expenses incurred in April to the infection control targeted distribution even though that funding was not received until August?

HFMA members believe it was HHS's intent to allow SNFs to apply the specific infection control funds to expenses incurred for infection control, regardless of when those expenses were incurred during the PHE. Therefore, the SNF targeted relief funds for infection control can be applied to infection control expenses incurred prior to the distribution. HFMA members ask HHS to confirm this interpretation.

2) Clarifications requested on Step 2 (also noted as item 3 in list of required data elements}, calculating "lost revenues attributable to coronavirus."

a. *Normalizing Revenues Between 2019 and 2020*: On June 19, HHS released an FAQ defining lost revenue as "any revenue that … a health care provider lost due to coronavirus." It stated that hospitals could "use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if [hospitals had prepared a budget] without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between … budgeted revenue and actual revenue. It also would be reasonable to compare the revenues to the same period last year."

However, in the current instructions released on November 2, HHS will now base this analysis on the difference between calendar years (CYs) 2019 and 2020 actual results. We appreciate HHS's clarification. However, this change will inappropriately reduce the amount of PRF that recipients will retain because annual increases in payment rates and changes in operations that would have resulted in increased volume will not be factored into the analysis of lost revenues attributed to COVID-19. HFMA members strongly encourage HHS to revert to the June 19, 2020, FAQs and allow providers to compare their actual lost revenue for 2020 to their budgeted numbers.

If HHS does not revert to the June 19 guidance and allow for a comparison to budgeted revenues, HHS will need to provide guidance to PRF recipients as to how they should treat changes between 2019 and 2020 revenues and expenses as a result of rate increases and changes in operations. Specifically, HHS's instructions must address:

- *Provider Rate Increases*: Typically, providers receive annual increases in payment rates from commercial payers (e.g., negotiated rate increases) and governmental payers (e.g., Medicare market basket update, changes in wage index) to compensate them for increases in the year-over-year cost to provide healthcare services. If 2019 results are

not "grossed up" to account for annual increases in payment rates, it will artificially (and inappropriately) decrease PRF that providers can claim to replace lost revenue.

If HHS does not revert to the June 19 guidance and allow PRF recipients to use either CY19 actual performance or 2020 budgeted, it must allow PRF recipients to standardize (gross-up) CY19 payment rates so that they are "apples-to-apples" comparable to 2020 payment rates. HFMA recommends that if HHS elects to allow providers to gross-up their revenue, they instruct PRF recipients to use an all-payer, case mix and volume-adjusted mechanism.

- *Supplemental Payments*: Many providers, especially safety net hospitals, receive supplemental payments that are not tied to direct patient care. Payments are typically made on a monthly or quarterly basis. In some instances, these payments are tied to patient volume, but they are based on prior period patient volume. In other instances, the revenue is not correlated to patient volume in any period. Typically, this revenue is included in net patient revenue on financial statements.

  Currently, "operating revenues from patient care" is defined (as added on 10/28) in the current FAQs as "gross charges for patient services delivered, minus contractual adjustments from all third party payers, charity care adjustments, bad debt, and any other discounts or adjustments necessary to arrive at net patient service revenue."

  HFMA members ask HHS to exclude these supplemental payments from the definition of "operating revenues from patient care" in instances when the payment is not based on patient volume or other (PRF recipient-specific) characteristics attributable to the time period impacted by the PHE. As an example, if the monthly Medicaid disproportionate share hospital (DSH) payments in 2020 payment are based on the PRF recipient's Medicaid volume in 2018, HFMA members believe that Medicaid DSH payments should be excluded from 2019 and 2019 "operating revenues from patient care" in the calculation of "lost revenues attributed to coronavirus."

- *Changes in Operations*: Many PRF recipients have made changes in operations and/or investments in expanded services/capacity that would have increased patient volumes beyond those reflected in their CY19 financial results. A few examples, which are not intended to be exhaustive, include:

  - A skilled nursing facility that downsized in 2020 from 200 beds to 100 beds
  - A hospital that opened a new patient tower in 2020 to increase volume
  - A hospital that had a significant business stoppage in 2019 due to adverse hurricane exposure, reducing 2019 patient care revenue in comparison to normal business operations
  - A market that saw a hospital closure, resulting in reallocated services that are not accounted for in a year-over-year comparison and ultimately all providers in that market not being made "whole" for the lost revenue that occurred in the community

  How should the PRF recipient adjust the 2020 numbers for these types of change so they are comparable to 2019? HFMA recommends that HHS revert to its June 19 guidance and allow PRF recipients to use recipients to use either CY19 actual performance or 2020 budgeted. It must allow PRF recipients to standardize (gross-up)

CY19 payment rates so that they are "apples-to-apples" comparable to 2020 payment rates.

- *Other Operating Revenue*: The requirements appear to imply that activity considered "other operating revenue" (e.g., revenue from a retail pharmacy in the hospital lobby, premium revenue from a health plan owned by a hospital) should not be included in the lost revenue analysis. HFMA members generally agree with this approach.

  Additionally, we ask for clarification of how revenue and expenses related to 340B drugs sold to hospital patients at hospital-owned pharmacies should be treated. Given that revenue and expense is related to the providers' patients, HFMA members believe it should be included in the analysis of lost revenue attributed to COVID-19.

- *Payments Related to Risk-Based Contracts*: It is unclear from HHS's November 2 PRF reporting guidance whether or not providers should include payments from (revenue) or payments to (expenses) payers (e.g., Medicare, commercial insurers, Medicaid) related to risk-based contracts. As an illustrative example, a primary care practice receives $100,000 in risk-sharing revenue from a health plan in CY19 for participating in a shared savings contract for Medicare Advantage patients. This is a "bonus" payment that is separate from patient care revenue paid on individual claims. Due to increased ED utilization, the primary care practice only receives $50,000 in risk- sharing revenue from participating in the contract in CY20. Is the risk- sharing revenue in 2019 and 2020 considered patient care revenue?

  The risk-sharing payment represents a "stand ready obligation," not patient care. We recommend that HHS clarifies that, in this example, the $100,000 received in 2019 and $50,000 received in 2020 should be removed from the analysis of lost revenues attributed to coronavirus.

b. <u>*Calendar Year Reporting*</u>: In the November 2 reporting requirements, the calculation of lost revenues/margin attributed to coronavirus appears to be based on a calendar year versus a quarter-by-quarter analysis. Based on the statute and HHS's FAQs, providers initially interpreted that the calculation of expenses and lost revenue attributed to coronavirus would occur on a quarter-by-quarter basis. If HHS does not revert to a quarter-by-quarter analysis, the following questions will need to be addressed:

- *Non-Calendar Year End Fiscal Years*: If compliance will be required on an annual (or cumulative) basis and a healthcare provider has a non-calendar-year-end FYE (e.g., common FYEs are 6/30 and 9/30), how does HHS recommend the provider prepare the analysis of lost revenues?

  These providers will need to create calendar-year- end financial statements to support this analysis. While this in and of itself is not difficult, HFMA asks HHS to clarify what type of documentation non-calendar-year-end FYE PRF recipients will be asked to provide to support the expenses and revenues reported in both CY19 and CY20. These providers will not have audited financial statements for the calendar years on which HHS is basing its analysis. Additionally, based on page 2 of the November 2 reporting guidance, if recipients do not expend PRF funds in full by the end of CY20, they have an additional six months in which to use remaining amounts. What information will PRF recipients need to provide HHS to document that these expenses and lost revenue reported were for that six-month period? Providers whose fiscal year-ends are

December 31 and September 30 will not have audited financial statements for that period. And providers whose fiscal year ends on June 30 would have audited financial statements but these statements would cover a 12-month period, not just that six-month period.

c. *Double Counting Revenue Related to COVID-19*: The instructions for calculating expenses attributable to COVID-19 are defined as:

> *Healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or healthcare related operating expenses (further defined within the data elements section below).*

Additionally, the 10/28 FAQs[1] that provide examples of how a PRF recipient could report their expenses states:

> *Providers can identify their healthcare related expenses, and then apply any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance Program (CHIP), or other funds received from the Federal Emergency Management Agency (FEMA), the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, and the Small Business Administration (SBA) and Department of Treasury's Paycheck Protection Program (PPP) that offset the healthcare related expenses.*

The instructions for calculating "lost revenues attributable to COVID-19" instruct providers for 2020 to report the following as revenue:

> *Revenue from Patient Care Payer Mix (2019 and 2020)*
> a. *Medicare Part A+B: Actual revenues/net charges received from Medicare Part A+B for patient care for the calendar year.*
> b. *Medicare Part C: Actual revenues/net charges received from Medicare Part C for patient care for the calendar year.*
> c. *Medicaid: Actual revenues/net charges received from Medicaid/Children's Health Insurance Program (CHIP) for patient care for the calendar year.*
> d. *Commercial Insurance: Actual revenues/net charges from commercial payers for patient care for the calendar year.*
> e. *Self-Pay (No Insurance): Actual revenues/net charges received from self-pay patients, including the uninsured or individuals without insurance who bear the burden of paying for healthcare themselves, for the calendar year.*
> f. *Other: Actual gross revenues/net charges from other sources received for patient care services and not included in the list above for the calendar year.*
>
> *Other Assistance Received (2020)*
> a. *Treasury, Small Business Administration (SBA) and the CARES Act/Paycheck Protection Program (PPP): Total amount of coronavirus-related relief received from Treasury, SBA, and CARES Act/PPP by the Reporting Entity as of the reporting period end date.*

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

b. *FEMA CARES Act: Total amount of coronavirus-related relief received from FEMA by the Reporting Entity as of the reporting period end date.*
c. *CARES Act Testing: Total amount of relief received from HHS for coronavirus testing-related activities.*
d. *Local, State, and Tribal Government Assistance: Total amount of coronavirus-related relief received from other Local, State, or Tribal government sources by the recipient and its included subsidiaries as of the reporting period end date.*
e. *Business Insurance: Paid claims against insurance policies intended to cover losses related to various types of healthcare business interruption as of the reporting period end date.*
f. *Other Assistance: Total amount of other federal and/or coronavirus-related assistance received by the recipient and the other TINs included in its report as of the reporting period end date.*

The current instructions require PRF recipients to both offset any COVID-19 attributable expenses with incremental revenue related to COVID-19 (e.g., 20% increase in operating MS-DRG payments for Medicare discharges with a diagnosis of COVID-19 on the claim) and report that same revenue as an increase to its 2020 revenue when it calculates lost revenue attributable to COVID-19. This "double-counts" the same dollar as both covering COVID-19 attributable expenses and replacing lost revenue attributable to COVID-19. The reality is the dollars associated with the 20% increase in Medicare operating MS-DRG payments for discharges with a COVID-19 diagnosis on the claim can only be spent once by the PRF recipient to respond to the COVID-19 PHE.

Therefore, HFMA members strongly recommend that HHS clarify its reporting instructions to require revenue specifically attributable to COVID-19 be reported only once. For administratively simplicity, we recommend that it be reported with 2020 revenue in the calculation of lost revenue attributable to COVID-19. HFMA members believe this is less administratively burdensome than having to segregate specific portions of payments from payers like Medicare to calculate the incremental increased payment attributable to COVID-19, which is then used to reduce the cost of expenses attributable to COVID-19.

d. <u>*Continued Reporting of Expenses in Lost Revenue Calculation*</u>: The November 2, 2020, instructions no longer require PRF recipients to net their lost revenue attributed to coronavirus by the expenses calculated in Step 1. HFMA greatly appreciates and supports this clarification.

However, the current PRF reporting instructions still include expenses in Step 2. The instructions direct PRF recipients to "provide information used to calculate lost revenues attributable to coronavirus, represented as a negative change in year-over-year actual revenue from patient care related sources. Revenues and expenses in this section include all lost patient care revenues and patient care cost/expense impacts."

The instructions specifically define expenses as:

> *General and Administrative Expenses (2019 and 2020) G&A expenses may include items such as monthly payments related to mortgage or rent for facility where reporting entity provides patient care services, other monthly finance charges for real property and/or property taxes, insurance premiums for property, employee health insurance, or malpractice insurance, overhead salaries, healthcare and contractor salaries, fringe benefits, lease payments, lighting, cooling/ventilation, cleaning, vendor services*

purchased from third party vendors, consulting support, legal fees, audit and accounting services, food preparation and supplies, logistics and transport or other costs not captured above, such as debt financing, for the relevant calendar year.

Healthcare Related Expenses (2019 and 2020) Healthcare related expenses may include items such as supplies, equipment, IT, facilities, employees, and other healthcare related costs/expenses for relevant calendar year.

HFMA members request that HHS further clarify their reporting instructions by removing any references to expenses in the instructions for step 2 and remove the lists of general and administrative and healthcare-related expenses from the instruction in step 2. If expenses are not netted against lost revenue, we question why, during the middle of a pandemic, HHS would require PRF recipients to take the administratively burdensome step of reporting data that is unnecessary to administer the PRF program.

e. <u>*Clarifying Calculating Lost Revenue for PRF Recipients Closed as A Result of COVID*</u>: If a PRF recipient closed due to state mandate in mid-March and does not reopen until Q3 of 2021, would it be entitled to claim PRF for lost revenue for all of the months it was closed?

HFMA members believe, based on the FAQ below, that in this example the PRF recipient would be entitled to claim lost revenue for the months it was closed.

Can providers who have ceased operation due to the COVID-19 pandemic still receive this funding? (Added 5/29/2020)

If a provider ceased operation as a result of the COVID-19 pandemic, they are still eligible to receive Provider Relief Fund payments so long as they provided on or after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19, therefore, care does not have to be specific to treating COVID-19. Recipients of funding must still comply with the Terms and Conditions related to permissible uses of Provider Relief Fund payments.

However, we ask HHS to clarify and provide an example to confirm.

f. *Amortization of Entrance Fees*: Based on the following FAQ, how does this impact the revenue and expenses that a continuing care retirement community entity may claim for its SNF, assisted living, and independent living entities/service lines in healthcare-related expenses or lost revenue:

Should entrance fee amortization be excluded from patient care? (Added 10/28/2020)

If the provider includes entrance fee amortization as operating revenue on its financial statements, it should be considered as revenue associated with patient services. Entrance fee amortization must be handled in a consistent manner in both 2019 and 2020.

HFMA members ask that HHS provide further clarification on this FAQ.

3. Clarification of other items in HHS's November 2 guidance/current FAQs.

    a. *Targeted Distributions*: HFMA members urge HHS to allow hospital systems to move targeted distributions to follow their patients treated for COVID-19 to hospitals within the system that are incurring the expenses and lost revenues directly attributable to the virus.

    Specifically, HHS has distributed each payment from the PRF to hospital systems or individual hospitals on the basis of a unique taxpayer identification number (TIN). For hospital systems whose corporate structure is composed of multiple hospitals under the control of a common parent and a single TIN, payments from both the general and the targeted distributions can be moved among those hospitals in proportion to their allowable expenses or lost revenues. By contrast, for hospital systems that operate under multiple TINs because of their corporate structure, targeted distribution payments cannot currently be moved among hospitals within the system to follow the patient or in proportion to the allowable COVID-19-related expenses or lost revenues.

    To better care for patients and more effectively manage scarce resources, many hospital systems will move a COVID-19 patient who needs intensive care from a smaller rural hospital to a larger hospital within their system where resources and experience caring for these patients are concentrated. Whether the funds from the PRF can be shared among the hospitals that incurred the expenses relating to care for the patient and the lost revenue that resulted from concentrating services in another location depends entirely on whether the rural and larger hospitals operate under the same TIN. We do not believe this is what Congress intended.

    Absent changes to the policies above, many hospitals, including many rural hospitals and those serving high numbers of low-income, elderly and severely ill patients, particularly in vulnerable communities, remain in the position of unfairly having to return substantial PRF funds to HHS when the system still has unreimbursed expenses attributable to COVID-19.

    b. *Reporting Template*: When does HHS plan to release a template of the information and the format that must be submitted? The reporting needs to be completed 45 days after year-end and the portal isn't scheduled to open until mid-January 2021.

    HFMA members ask that HHS provide this template and any related education no later than December 10, 2020, to give providers sufficient time to collect data and prepare their reports. If HHS cannot provide a template by December 10, 2020, HFMA members believe the reporting deadline needs to be extended.

    Calculating expenses attributed to coronavirus, not reimbursed by other sources will be complex. Determining the portion of expenses that are COVID-19-related, especially in situations where an organization has to determine just the proportionate amount that is not being reimbursed by another source, will be a time-consuming process. The simplistic example provided in the FAQ is straightforward enough. However, it does not reflect the reality that health systems have a vast array of services and a multitude of payers that pay on different terms. To compute all of this within 45 days of the end of the period will be incredibly challenging, even for PRF recipients with sophisticated financial management tools.

c. *Single Audit Extension*: Will the single audit requirement be extended given the lack of final guidance to date? As an example, providers who are 6/30/20 FYEs will need to have the audit completed by 3/31/21, which may not be practical, especially as they will be responding to meet the initial CARES Act reporting deadline in February 2021. Therefore, HFMA members strongly recommend that HHS provide an extension to the single audit requirement, particularly for June 30 year-end entities.

d. *Common Ownership*: Based on the most recent FAQs related to reallocating general distribution payments across commonly owned entities, HFMA members believe this ability extends to scenarios involving common ownership of multiple S-corporations. In this instance, the individual S-corporations that received the funds could pass them up to the entity that owns them. The entity that owns the various S-corporations could then reallocate the general distribution funds to the individual S-corporations based on their expenses attributed to coronavirus not reimbursed by other sources and lost revenues attributed to coronavirus. HFMA members ask that HHS confirm this interpretation.