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## **Federal Funding Considerations and Data Capture – Loss of Revenue, Increased Costs, and Other Matters**

Webinar Hosted by



Presented on April 24, 2020

*Responses are based on information available as of April 24, 2020*

### **Topic: HHS Payment**

1. I am interested in today's expected CARES Act payment to allocate the \$20B. This is based on Medicare cost report data Net Patient Revenue. Can you confirm this number comes from the Medicare cost report Schedule G-3? Is the formula the hospital's Net Patient Revenue from 2018 Medicare cost report divided by \$2.5T multiplied by \$20B? Should it be the aggregated net patient service revenue amount from all the submitted 2018 Medicare cost reports?

***We presume schedule G-3 is used for providers for which that data is available, i.e. a cost report for 2018 has been filed. All providers are being asked to submit net patient revenue information from tax returns or audited financial statements if tax returns are not available along with copies of source documents for verification of the amounts. There are other submission requirements as well. See: <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>.***

### **Topic: Hot Spot Reporting**

2. On the \$10B Hot Spot CARES Act Funding, can you elaborate on the definition of the ICU Beds as of April 10, 2020? We believe this should be our ramped up - surge planned number of ICU beds. If we normally have 50 licensed ICU beds, but we restructured units to serve as ICU beds, our understanding is that we should report this new ramped up number of ICU beds. Can you confirm?

***We followed up with the TeleTracking Technical Support hotline, and the hotline representative said to report the number (capacity) of ICU beds you had available to treat (COVID-19) patients on April 10, 2020. We take this response to mean you can report your increased ICU bed total after you have converted other Acute type beds for COVID-19 purposes. Simply document how you arrived at your count in case it is ever questioned. We would suggest documenting the beds you claim as "ICU" meet Medicare regulation requirements for a Special Care/Intensive Care Unit.***

3. If you are a hospital that does not have ICU beds or had any COVID cases, are we required to do the portal log-in by the April 25<sup>th</sup> deadline?  
***Department of Health and Human Services (HHS) communicated that the targeted distribution and request for the ICU bed count and number of admissions with a positive diagnosis for COVID-19 patients is to compensate providers for the "...increased burden of caring for those with the coronavirus." In your example, we do not believe the hospital would qualify for a targeted distribution unless it treated a COVID-19 patient; therefore, the hospital is not required to submit any information under this request. It is noted that submission of data does not guarantee receipt of these targeted funds.***
4. We had empirically a number of ER cases and admissions that we treated as COVID but later tested negative. Should we count these "possibles" on the surge report?  
***The HHS communication describing the data request clearly states to report the "Total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020". Without calling the TeleTracking Technical Support hotline number for further confirmation, we would assume this would rule out anyone who did not test positive.***
5. Our surge of COVID positive began on April 13th. We are a southwest state. So we had zero then. Now we are at 5. Was this arbitrary selection of this date purely political to help NYC and large Eastern cities at the expense of central states?  
***According to HHS, this targeted allocation is attempting to provide funding as quickly as possible to healthcare providers in those areas that have been particularly impacted by the COVID-19 outbreak. We cannot speak to the selection of the reporting dates. Also, it is unclear at this time if HHS has plans to provide funding to those facilities that began treating COVID-19 patients after the reporting date of April 10<sup>th</sup>.***

#### **Topic: Lost Revenue**

6. Do we have a definition of how "lost revenue" should be calculated? For federal funding, is it possible that "lost revenue" will be defined when the reporting requirements are released?  
***At the time of the presentation, specific guidance had not been released on how to compute lost revenue, so all we could offer was our opinion which was to consider specific indicators (such as statistics and individual department variances) and compare revenues per the internal financial statements to previous periods or to budget. Subsequent to the presentation, HHS released information on estimating lost revenue. The guidance states "you may use a reasonable method of estimating the revenue during March and April compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted***

**revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year." The HHS FAQ document that includes this information can be found at <https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf>**

7. You mentioned offsetting the 20% Medicare increased reimbursement for COVID patients against Lost Revenue. What about the stop of the Sequestration funds? ***At the time of the presentation, specific guidance had not been released on how to compute lost revenue so we offered our opinion and ideas to consider specific indicators (such as statistics and individual department variances) and compare revenues per the internal financial statements to previous periods or to budget. Subsequent to the presentation, HHS released information on estimating lost revenue. The guidance states "you may use a reasonable method of estimating the revenue during March and April compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year." We believe that if you consider the 20% add-on and the stop of sequestration funding in your allowance for doubtful account consideration when booking your monthly entries for financial statement purposes, you will have considered both of these (and other relevant changes) when comparing your current revenues to those of a prior period or budget. The HHS FAQ document that includes this information can be found at <https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf>.***

#### **Topic: Capital Costs**

8. What if capital spend or renovating areas was anticipated for a surge, but now are not expected to be needed? ***You should capture and document the information and reasoning for the capital spend. While we can't tell you with certainty which programs will allow or will not allow each specific spend, we recommend capturing the data to support the reasoning in anticipation of pursuing reimbursement with the understanding that certain programs may not allow reimbursement.***

#### **Topic: Paycheck Protection Program (PPP)**

9. Is there any clarity for banks to approve loaning money from the PPP to hospital authorities from the new funding package? ***The SBA issued an updated interim final rule that states "a hospital that is otherwise eligible to receive a PPP loan as a business concern or nonprofit organization (described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code) shall not be rendered ineligible for a PPP loan due to ownership by a state or local***

**government if the hospital receives less than 50% of its funding from state or local government sources, exclusive of Medicaid. The Administrator, in consultation with the Secretary, determined that this exception to the general ineligibility of government-owned entities, 13 CFR 120.110(j), is appropriate to effectuate the purposes of the CARES Act.”**

10. Under the PPP program, is the 500 employee limit absolute or FTE?  
**SBA Regulation Section 121.106 provides guidance on counting employees. The Section describes the size standard as the average number of U.S.-based employees for each pay period for the preceding completed 12 calendar months. It indicates to count part-time and temporary employees the same as full-time employees. This is essentially a headcount calculation, not a full-time-equivalent (FTE) calculation.**

**Topic: Requirements**

11. For the first round of \$30 Billion, we had to certify receipt. Will the same apply to the \$20 Billion?  
**We believe that the terms and conditions will apply to the additional \$20 billion in HHS funding as that amount is added to the \$30 billion to create the \$50 billion general allocation. The intent of the \$20 billion is to allow for a proportionate distribution of the entire \$50 billion based upon 2018 net revenue per eligible provider. On April 24<sup>th</sup>, a portion of providers was to receive an advance payment based off the revenue data submitted on CMS cost reports. For additional general distribution funds, providers without adequate cost report data on file will need to submit their revenue information to a portal opened on April 27<sup>th</sup> at the following location:  
<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>.  
Providers who receive their money automatically will still need to submit their revenue information so that it can be verified.**
12. In regard to non-cost report providers, how should that information be provided to HHS?  
**HHS will begin distribution of the remaining \$20 billion of the general distribution to these providers on April 24<sup>th</sup> to augment their allocation so that the entire \$50 billion general distribution is allocated proportional to providers' share of 2018 net patient revenue. On April 24<sup>th</sup>, a portion of providers was to receive an advance payment based off the revenue data submitted on CMS cost reports. For additional general distribution funds, providers without adequate cost report data on file will need to submit their revenue information to a portal opened on April 27<sup>th</sup> at the following location:  
<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>.  
Providers who receive their money automatically will still need to submit their revenue information so that it can be verified.**

## **Topic: Net Patient Revenue**

13. Any idea as to what Net Patient revenue for 2018 relates to? Is this for 12/31/2018, system fiscal year, cost reporting year? There are different year ends for a multitude of reasons.

***We presume the Medicare cost report schedule G-3 is used for providers for which that data is available, i.e. a cost report for 2018 has been filed.***

***Furthermore, all providers are being asked to submit net patient revenue information from tax returns or audited financial statements if tax returns are not available along with copies of source documents for verification of the amounts. There are other submission requirements as well. See:***

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

***This information will be used by HHS to allocate and validate the distribution of the remaining \$20 billion of the general distribution to these providers on April 24<sup>th</sup> to augment their allocation so that the entire \$50 billion general distribution is allocated proportional to providers' share of 2018 net patient revenue. On April 24<sup>th</sup>, a portion of providers was to receive an advance payment based off the revenue data submitted on CMS cost reports. For additional general distribution funds, providers without adequate cost report data on file will need to submit their revenue information to a portal opened on April 27<sup>th</sup> at the following location: <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>. Providers who receive their money automatically will still need to submit their revenue information so that it can be verified.***

## **Topic: Medicare Advantage Plans**

14. Are there any plans for CMS to compel Medicare Advantage plans to offer advance or accelerated payments? For many hospitals, Medicare Advantage plans are 50% of total Medicare utilization. As I understand, claim payments from Medicare Advantage plans are excluded from the advance/accelerated payments provided by CMS.

***Currently Medicare Advantage plans are excluded from the Advance Payment Program and Accelerated Payments Program. There is not any guidance available stating whether CMS will require the plans to provide this option to the providers they service. In a recent development, CMS has suspended its Advanced Payment Program due to the overwhelming requests and distribution of CARES Act funds to providers.***

15. I know Medicare Advantage plans are subject to pay 20% premium for COVID-19 diagnoses and elimination of 2% sequestration payment reduction but seems they should be required to offer some advance payment with the much lower volumes.

***Currently Medicare Advantage plans are excluded from the Advanced Payment Program and Accelerated Payments Program. There is not any guidance available stating whether CMS will require the plans to provide this option to the providers they service. In a recent development, CMS has***

***suspended its Advanced Payment Program due to overwhelming requests and distribution of CARES Act funds to providers.***

16. Can we confirm that Medicare Advantage plans are subject to paying the Medicare 20% premium for COVID-19 diagnoses and elimination of 2% sequestration payment reduction? We were not aware that they were subject to the Medicare case requirements.

***This will depend on a provider's Medicare Advantage contract. Many Medicare Advantage plans state reimbursement will be based on Medicare rates, and they have been applying the 2% sequestration adjustment. Therefore, if the sequestration is suspended, then the Medicare Advantage plans should cease applying it to claims. Likewise, they should follow the 20% add-on for COVID-19 claims. If they "forget" to follow these guidelines, then the claims should be appealed in a timely manner.***

**Topic: Telehealth**

17. Is the Telehealth \$200M a "grant" and thus be eligible for the separate A-133 audit, if we go over the threshold?

***The Federal Communications Commission (FCC) specifically states in its Frequently Asked Questions that it is not a grant. However, the FCC also states the funds may be subject to future compliance audits. We recommend keeping records that will facilitate preparation of any program expenditure audit documents.***

18. I signed in a little late. Did the discussion of earlier telehealth programs include other federal agencies funding to provider community such as FCC and the USDA (United States Department of Agriculture) for such?

***Currently, the COVID-19 telehealth program is being administered by the FCC. The FCC has \$200 million in appropriations to fund this program and has already awarded \$13.7 million in the first four rounds of awards. The FCC has stated that it does not plan on awarding more than \$1 million per applicant. Any costs not covered by this program could be consideration under other programs such as the Federal Emergency Management Agency's (FEMA) Public Assistance program.***

**Topic: Medicaid**

19. How would a provider who only has Medicaid patients be affected by these funding streams if it is all based on Medicare billing?

***HHS has requested Medicare providers submit additional data, such as 2018 net patient service revenue, to be used as a basis for future funding. This will ensure that those providers that do not have a significant Medicare payer mix still receive emergency funding to assist them during the COVID-19 pandemic. In addition, HHS has indicated there would be specific consideration given to organizations who solely take Medicaid. This is a summary of the additional***

**allocation description on HHS’s website: “There are some providers who will receive further, separate funding, including skilled nursing facilities, dentists, and providers that solely take Medicaid.” There are also other programs available to all providers, some dependent on certain metrics such as employee count. Some of these programs were discussed during the presentation such as Paycheck Protection Program, Main Street Lending Program, and FEMA Public Assistance Program.**

**Topic: Tax Credits**

20. Are you covering the employee retention tax credits? I would be interested to know more details about how to qualify and if actions taken by the hospital to create capacity for COVID-19 would meet the criteria for eligibility.

***The employee retention tax credit is eligible to a business that had to suspend operations due to governmental mandate limiting travel, commerce, or group meetings. This may be an option for some healthcare organizations but will only apply to those employees who are being paid and not providing services (not working). The available credit is up to \$10,000 per eligible employee per quarter. Also, this is not available for employees covered under the Paycheck Protection Program. More information about this program can be found at the following location: <https://www.irs.gov/newsroom/faqs-employee-retention-credit-under-the-cares-act>.***

For more information please visit our website at [www.Draffin-Tucker.com](http://www.Draffin-Tucker.com) or contact:

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