hfma™
healthcare financial management association

August 7, 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 Compliance Questions

Dear Deputy Director Hargan:

On behalf of the Healthcare Financial Management Association's (HFMA's) 58,000 individual professional members, and the members of the American Health Care Association & National Center for Assisted Living, American Medical Rehabilitation Providers Association, LeadingAge, National Association for Home Care & Hospice, and National Association of Long-Term Hospitals, we 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, many of whom work in the provider settings represented by the associations that are co-signatories to this letter, appreciate the diligent efforts HHS staff have made to update the PRF FAQs and provide answers through the Provider Support Line. However, many questions are not addressed in the FAQs. Or if they are addressed in the FAQs, the answers are insufficiently detailed to enable providers to ensure they are in full compliance with the terms and conditions. Furthermore, while provider support line staff are unfailingly polite, it is clear they are reading from scripts based on the FAQs and unable to answer detailed technical questions. In the best cases, questions about PRF payments or compliance issues take multiple calls to resolve, while often questions are left unresolved.

As a group, our organizations are committed to helping our members improve the management of and compliance with the numerous rules and regulations that govern healthcare providers. 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 and physician practices, they have identified key questions related to the CARES Act PRFs that remain unanswered or have been answered but with insufficient detail. Given the technical nature of these questions, in addition to identifying them, the task force has also developed suggested answers based on their understanding of the CARES Act, Financial Accounting Standards Board/Governmental Accounting Standards Board 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 questions and provide answers as quickly as possible. The individual members and groups represented by the signatories to this letter 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), 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 data definitions and terms.

We would like to meet with you and your staff to discuss the questions and responses in Appendix 1. My staff will follow up to schedule a conference call. We look 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 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,

/s/Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

/s/ Michael W. Cheek
Senior Vice President
American Health Care Association & National Center for Assisted Living

/s/Kate Beller, Esq.
Executive Vice President for Policy Development and Government Relations
American Medical Rehabilitation Providers Association

/s/Ruth Katz
Senior Vice President for Policy
LeadingAge

/s/William A. Dombi, Esq.
President
National Association for Home Care & Hospice

/s/Lou Little
President
National Association of Long-Term Hospitals

Cc:
Alexander Azar, Secretary of Health and Human Services
Seema Verma, Administrator, Centers for Medicare & Medicaid Services

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

1. **When can providers anticipate specific guidance on Provider Relief reporting requirements? Are there any guiding principles that providers can implement now to prepare for reporting?**

   The current PRFs FAQs state that "HHS will be requiring recipients to submit future reports relating to the recipient's use of its PRF money." HFMA members ask that HHS provide clear, specific guidance on what they will be required to report, the frequency of required reporting, when the first report will be due and how long PRF recipients will need to report. Providers, at a minimum, need to know the following items:

   a. What data will be required?
   b. What are the specific definitions for each of the required data elements?
   c. Can PRF recipients report on a consolidated basis (e.g., file one report for multiple tax identification numbers (TINs) owned or controlled by the same parent entity)?

   HFMA members strongly encourage HHS to align reporting with existing requirements (e.g., use data definitions from the Medicare cost report where applicable) and use templates that providers and the agency are already familiar with (e.g., CDC Disaster Preparedness Budget Model). We believe HHS should limit the reporting time frame to the period in which PRF can be used to reimburse providers for lost revenue and expenses related to COVID-19. Therefore, if PRF could be used to cover lost revenue and expenses related to COVID-19 for calendar year 2020, then providers would be required to file their final report during the first quarter of 2021. Please see question 3 below for HFMA members' recommendation related to the time frame that should be covered by PRF.

2. **Will HHS be providing more clarity on the definition for "lost revenues"? There is confusion among providers on the calculation of lost revenues, and the differences between "lost revenues" and "lost margin."**

   HFMA members appreciate the guidance HHS has made available through the PRF FAQs. It appears the existing FAQs will allow providers to use both comparisons to budgeted revenue and prior year actual revenue to current period actual revenue.

   We ask that HHS also confirm the following:

   a. HHS will allow PRF recipients to calculate lost revenue by comparing projected revenue absent the pandemic using data from the period immediately prior to the pandemic (i.e., average daily revenue based on the three months prior to March 1, 2020, multiplied by the number of days included in the "pandemic

period") to actual revenue during the pandemic. ***HFMA members believe this is necessary to allow PRF recipients the flexibility to use a methodology that incorporates unanticipated changes in operations (e.g., retirement of a key physician or acquisition of a new physician practice) or payer mix that may not be reflected in budgeted numbers or prior year performance.***

b. The definition of revenue. While we believe the CARES Act only intends to compensate PRF recipients for lost net patient service revenue and other operating revenue, we continue to receive questions about including lost investment income and decreased donations. Further, HHS's FAQs state that generally, prescription sales cannot be captured in the data submitted as gross receipts or program service revenue. HFMAs members ask that HHS provide specific examples of when it is appropriate to include prescription sales in revenue data and when prescription sales should be excluded.

c. The period of time in which PRF recipients may accrue lost revenue and increased expenses related to COVID-19 that will be netted against PRF grants. ***At a minimum, we believe this time frame should span the PHE and include a tail period to allow for a return to normal operations (e.g., costs incurred in converting surge capacity back to normal operations, increased PPE costs while demand backlogs outstrip manufacturer production capacity, decreased revenue resulting from patient/consumer reluctance to seek care due to concerns of contracting COVID-19 in a healthcare setting).*** HFMA members believe it is appropriate for the tail period to cover 30 days for each 90-day period included in the PHE. Therefore, if the total PHE is 365 days, providers would be able to accrue lost revenue and increased expenses related to COVID-19 for 485 days (365 days covered under the PHE with 120 additional "tail" days).

a. Will HHS reconcile accrued lost revenue and expenses related to COVID-19 against just the General Distribution grants or will the reconciliation include both General Distribution and Targeted Distribution grants?

3. **Will HHS release a definition of "health care related expenses" which can be applied to the provider relief funding? Can providers claim an allocation of administrative overhead or consultant/legal fees for planning, documentation and reporting for PRFs?**

   HFMA members appreciate HHS's broad definition for healthcare expenses related to COVID-19 that are eligible for reimbursement included in the PRF FAQs. However, we ask that HHS provide additional granular detail. We believe the following should be included in the definition, at a minimum:

   a. Equipment
   b. Staffing (including overtime expense, temporary labor expense and employees hired to respond to the crisis, and additional staff retained on the payroll – though not required due to the significant decrease in patient volumes – to

provide immediate clinical and administrative surge capacity should volumes increase as a result of COVID)

c. PPE (including both PPE used to respond to the crisis and the increased expense for PPE used with non-COVID-19 patients due to shortages of critical materials)
d. Facilities, office space, "field" hospital/clinic expense (including construction costs to build new facilities, retrofit existing facilities, and lease or purchase costs for space to expand capacity, establish field clinics, field testing sites or hospitals).
e. Housing expenses (including housing for temporary caregivers, or contract labor; providing housing for employed caregivers who elect not to live in their homes to avoid infecting family/roommates; and quarantine quarters for individuals who have tested positive, are asymptomatic and have no alterative options for quarantining).
f. Pharmaceuticals
g. IT (including costs related to moving workers to home settings, infrastructure for telehealth, additional bandwidth – e.g. due to increased virtual patient load, the need to support virtual visits by patients and their families (particularly in long-term care settings), and teleworking – and workstations to support increased surge capacity).
h. Consulting support/legal fees to support pandemic response (including determining which sources of funding providers are eligible to receive and compliance efforts related to those funds).
i. Professional audit fees associated with any audits (including but not limited to single audits) required for CARES Act funding
j. Financing expense (including increased interest expense for lines of credit or other short-term loans to ensure liquidity, fees for breaching debt covenants and other financing costs).

4. **Are providers allowed to share and use general distribution PRFs among multiple TINs within the same organization? Are providers allowed to share PRFs between related-party/common ownership health care providers? How do you share funds across an entity?**

   HFMA members appreciate HHS's efforts to respond to this question in the existing FAQs. However, the current answer is worded so that it only addresses situations where multiple hospitals are owned by the same corporate entity. We ask that HHS confirm the following:

   a. That if multiple hospital TINs are subject to common control (e.g. a governmental authority exercises control over multiple TINs) that the controlling entity can allocate PRF funds amongst the entities it controls (including physician practices) as the controlling entity determines is necessary.
   b. The ability to reallocate funds amongst TINs with common corporate ownership/control extends to the Targeted Distribution funds (in addition to the General Distribution funds).
   c. What documentation (if any) does HHS require a corporate entity with ownership/controlling interest in multiple TINs that reallocates PRF among its

facilities/provider groups to file (or maintain)? Will this have any impact on attestation/reporting?

5. **Is there any further guidance on the taxation of PRFs? Will there be any guidance from HHS and the IRS regarding the reduction of taxable income through "lost revenues"?**

HFMA appreciates HHS's guidance (provided July 10, 2020) related to the taxable nature of the HHS PRF grants. While we generally agree with HHS's stance that PRF grants are not taxable for tax-exempt providers, we question the HHS/IRS determination that PRF grants *are* taxable for for-profit providers. HFMA members believe that the HHS PRF grants should be excluded from the calculation of gross income as a qualified disaster relief payment under 26 U.S. Code § 139(b)(4). Under 139(b)(4):

> ***QUALIFIED DISASTER RELIEF PAYMENT DEFINED*** *For purposes of this section, the term "qualified disaster relief payment" means any amount paid to or for the benefit of an individual—if such amount is paid by a Federal, State, or local government, or agency or instrumentality thereof, in connection with a qualified disaster in order to promote the general welfare, but only to the extent any expense compensated by such payment is not otherwise compensated for by insurance or otherwise.*

HFMA members note that the statute does not limit payments only to individuals as the definition of Qualified Disaster Relief Payment includes any amount paid for the benefit of an individual. In the case of the HHS PRF, payments to hospitals, health systems and physician practices are for the benefit of protecting individuals from COVID-19 in the communities where these providers operate.

Furthermore, HFMA members believe that Congress intended for the PRF grants to be exempt from the calculation of taxable income. The appropriation legislation included in the CARES Act that provided the initial $100B for the PRF states:

> *For an additional amount for ''Public Health and Social Services Emergency Fund'', $100,000,000,000, to remain available until expended, to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus: Provided, that these funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse…*

Based on the language in the appropriation, it's clear that Congress's intent was providing funds to promote the general welfare. We also note that similar to the language of 26 U.S. Code § 139(b)(4), the appropriation prevents the PRF grants from being used to reimburse for expenses or losses that have been paid for by other sources.

If Congress had, for some reason, wanted to reduce the appropriation available to for-profit providers, it could have reduced the amount by 21% (U.S. corporate tax rate, simplified example) and lowered its financing and transaction costs by reducing the amount of debt issued

by the U.S. Treasury. Instead, under the HHS/IRS's current interpretation, the U.S. government is essentially paying disaster relief funds to for-profit providers only to recoup them as taxes in an inefficient and expensive for the taxpayer, and circular transaction. **We ask HHS and the IRS to reconsider their stance on the taxable nature of PRF for for-profit providers in light of Congress's clear intention that these funds be nontaxable.**

6. **Is there any specific guidance on the level of detail to be used to document COVID-19-related expenses for reporting requirements?**

   Providers vary in their ability and reaction time to organize and track qualified COVID-19-related expenses. Many organizations were either unable to create designated cost centers or have difficulty retroactively allocating expenses from a delayed response created by a myriad of reasons. Additionally, the different categories of qualified expenses also vary in ease of isolating COVID-19-related, incremental expenses. For example, it is more difficult to isolate overhead and labor expenses that are qualified COVID-19-related expenses, especially for salaried employees who do not enter time or have the ability to flag their related activities.

   HFMA members strongly encourage that HHS accept documented, consistent, reasonable and defensible methodologies for identifying and reporting qualified COVD-19-related expenses. Organizations must be able to provide support that expenses are incremental and would not have been incurred without the pandemic. Support could include narratives, invoices and reasonable methodology to compare expenses to a pre-pandemic environment (i.e., expenses as a percentage of net revenue).

7. **Should providers document separate financial impacts among the various funding sources (Paycheck Protection Program [PPP], Small Business Administration [SBA], provider relief, fee-for-service COVID-19 add-ons, etc.)?**

   HFMA members strongly encourage single financial reporting across all federal COVID-19 relief programs to reduce unnecessary administrative burden and expense related to duplicative burden. **As such, HFMA members ask HHS (including CMS) and the SBA to develop a single reporting template with requirements that will meet the needs of each program.** Specific questions that should be considered include:

   a. What format should providers use to document the offset of funding sources against lost revenue and COVID-19-related expenses?
   b. Will separate reporting be required for each source of funding under different rules or will it be possible to use one reporting format for all CARES Act funding sources?
   c. Would general ledger detail coding be required or is summary reporting of compliance with terms and conditions adequate?
   d. Would separate departmental-type reporting for each tranche of funding be required or helpful (i.e., allocating lost revenues and expenses to each funding tranche to demonstrate degree of compliance with each funding type) or is a

high-level summary of total funds received and total lost revenues and COVID-19-related expenses be sufficient?

8. **How will relief funds impact charity care on the Medicare Cost Report?**

   Treatment and Testing for Uninsured COVID-19: HFMA members appreciate the Administration using a portion of the CARES Act PRF to provide payment for treatment, testing and related services delivered to uninsured individuals stricken with COVID-19. Furthermore, we would like to thank HHS for clarifying that these funds are to act as a payer of last resort[1] for care provided to qualifying patients. Unfortunately, HHS has not specified the funding level for the program.

   HFMA members ask CMS to clarify that if the program runs out of money, any claims that are submitted to the fund but are unpaid due to insufficient funding may be claimed as charity care on worksheet S-10 if the patient otherwise meets the hospital's criteria for charity care. If the patient does not qualify for full charity care and the provider elects to bill the patient, we also ask that CMS allow hospitals to claim any uncollected amounts that have been deemed bad debt as a result of the account resolution actions allowed by the hospitals collections policy be claimed as non-Medicare bad debt on the S-10 for purposes of calculating Factor 3.

   Finally, HFMA members encourage CMS to allow hospitals to count the shortfall between the payment a hospital receives for testing, treatment and related services provided to uninsured COVID-19 patients and the cost of providing care to those patients in the calculation of Factor 3 used to allocate the pool of uncompensated care DSH payments.

9. **What cost report and reimbursement implications should we be thinking about?**
   HFMA members ask HHS to work with CMS staff on the following issues.

   Ratio of Costs to Charges (RCC): HFMA members are concerned about the impact changes in volume and expenses as a result of COVID-19 will have on the calculation of RCCs for cost reporting periods that overlap the PHE. As described above, overall volumes for most providers are much lower than in prior periods. This reduction in volumes is not only for delayed/canceled nonemergent procedures but also reductions in admissions for emergent conditions like stroke, heart attack[2] and trauma. Given the circumstances of the reduction in volume of care, we believe any services that did occur during March, April, May and June will likely be of much higher acuity than average. Furthermore, we will continue to see high volatility in volume and acuity in some markets during the remainder of the PHE as hospitals have to adjust access to nonemergent procedures to reflect both the current and anticipated volume of COVID-19 cases and their capacity to meet the needs of a surge (acute and ICU beds, PPE and staffing).

   At the same time that hospitals have seen significant reductions in volume and revenue, many have seen increases in expenses related to COVID-19. Many hospitals have responded to the urgent need to create additional ICU beds. Because of these heroic efforts, we have not

[1] HRSA, "FAQs for COVID-19 claims reimbursement to health care providers and facilities for testing and treatment of the uninsured"
[2] "Cigna claims data show declines in hospitalizations for serious conditions," *Modern Healthcare*, April 24, 2020.

experienced the need to ration care that, sadly, other countries have. Nevertheless, it can cost as much as $45,000[3] per bed to convert a general acute bed to an ICU bed.

Hospitals have also incurred significant expenses related to increased clinical staffing to actually deliver lifesaving care to afflicted patients. Average weekly pay for temporary registered nurses has nearly doubled from $1,700 in January to more than $3,000 in March.[4] Caring for COVID-19 patients (or suspected COVID-19 patients) has significantly increased the demand and use rate for PPE, given the communicable nature of the disease. In some hospitals with significant COVID-19 patient loads, our members have reported that PPE usage has increased six-fold. This has driven well documented shortages and commensurate increases in prices for PPE of all types. For example, HFMA members' organizations spent approximately $.50 per N95 mask in January. Now it is not uncommon for members to report N95 masks selling for more than $5 per mask.

As a result of rapid and abnormal changes in both the numerator and denominator of the cost to charge ratio, HFMA members believe that CMS should not use cost or charge data from cost reports that overlap with the PHE to rebase MS-DRG weights, calculate payments or reconcile outliers. **Instead, HFMA members believe that CMS should use cost and charges from the most recent cost report filed prior to the PHE to calculate CCRs used in MS-DRG and ambulatory payment classification weight rebasing, outlier reconciliation and hospital-specific calculations like outlier payments, new technology payments (in- and outpatient), critical access hospital (CAH) outpatient payments, organ acquisition costs and uncompensated care costs.**

Cost Report Treatment of COVID-19 PRF Grants for Lost Revenue and Expenses Related to COVID-19: HFMA members request CMS and HHS provide hospitals and Medicare Administrative Contractors (MACs) with specific guidance for the various rounds of relief funding from the CARES Act PRF and subsequent legislation. HFMA members believe these funds (apart from the amounts paid on a per claim basis for care provided to uninsured COVID-19 patients) are grants. We do not believe the Medicare statute or Provider Reimbursement Manual requires the funds or the associated expenses they relate to be offset on Worksheet A-8.

First, the emergency appropriation language[5] associated with CARES Act states:

> *"For an additional amount for ''Public Health and Social Services Emergency Fund'', $100,000,000,000, to remain available until expended, to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, **through grants** (emphasis added) or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus:…"*

CMS Pub. 15-1 Section 600 (Principle) states:

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[3] Neighmond, P., "Growing costs and shrinking revenues squeeze hospitals as they brace for coronavirus," NPR, April 6, 2020.

[4] "COVID-19 poses long-term impact to not-for-profit hospitals," Modern Healthcare, March 19, 2020.

[5] Division B—Emergency Appropriations for Coronavirus Health Response and Agency Operations, March 25, 2020, Pg 141.

For cost reporting periods ***<u>beginning on or after October 1, 1983, grants,</u>*** *gifts, and income from endowments, whether or not the donor restricts the use for a specific purpose,* ***<u>are not deducted from a provider's operating costs</u>*** *(emphasis added) in computing reimbursable cost. For periods beginning prior to October 1, 1983, restricted grants, gifts, or endowment income designated by a donor for paying specific operating costs were deducted from the particular operating cost or group of costs.*

Because Congress, in the appropriation, intended for the CARES Act PRF to be a grant, it would be inappropriate to offset the funds based on CMS Pub. 15-1 Section 600.

Second, in accordance with CMS Pub. 15-2, §4016, HFMA members do not believe the CARES Act PRF grants are considered a "recovery of expenses through sales, charges, fees, etc." Therefore, there is no need to adjust expenses.

We ask CMS and HHS to confirm our interpretation that COVID-19 PRF grants for lost revenue and expenses related to COVID-19 do not need to be offset on Worksheet A-8 and communicate it broadly to both hospitals and MACs through an *MLN Matters* article or other subregulatory vehicle. We are deeply concerned that inconsistent treatment among MACs or auditors within a MAC will result in inconsistently defined allowable costs which could skew CCRs, impacting MS-DRG weight setting, the calculation of Medicare cost-based payment items (e.g., outliers, CAH outpatient payments), determination of uncompensated care costs for DSH Factor 3, and certain states' Medicaid cost reports.

Cost Report Treatment of SBA Loans: HFMA members ask CMS and HHS to clearly describe how it intends for MACs to treat forgiveness of SBA loans like the PPP on the Medicare Cost Report. If SBA forgiveness is considered a grant, cost reporting instructions (please see above) do not require the offset of grants or contribution against the allowable costs of the provider. However, if the amount of the PPP forgiven is required to be offset against allowable costs on the cost report, this will have settlement implications for cost-based providers (e.g., CAHs) that many are not anticipating.

If CMS determines the forgiven amount of the loan is not a grant, HFMA requests that CMS clarify the timing on when the loan amount is forgiven. Specifically, is the amount considered forgiven when the loan is received or when the provider has satisfied the conditions for the loan to be forgiven? Or is the loan forgiven after the provider has received confirmation from the SBA that a portion of the loan has been forgiven?

10. **Can providers send back a portion of relief funds as they determine needs to offset lost revenues and incremental expenses related to COVID-19?**

Many providers have received unexpectedly large relief funds. These funds coupled with rebounded volumes and revenues have caused providers pause regarding whether they can support the use of the recent large lump sums. With that said, the same

organizations could justify a portion of the funds today and/or are unsure of future exposure to additional surges, regulatory mandates or patient behavior shifts.

HFMA members recommend that HHS allow providers to return a portion of relief funds if they determine they are uncertain about offsetting the entire amount with lost revenues and qualified expenses. If this is administratively burdensome and logistically unlikely, HFMA members would recommend that HHS provide clarity on the reconciliation and recoupment of funds at the end of the pandemic. This clarity may allow organizations to make a business decision on whether they attest to the amount and manage the relief funds accordingly, or deem that it is in their best interest to return all of the funds.