Illinois Health and Hospital Association

March 12, 2021

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

Dear Acting Secretary Cochran,

On behalf of Illinois' more than 200 hospitals and nearly 40 health systems, we commend the U.S. Department of Health and Human Services (HHS) on actions taken thus far to support healthcare providers during the ongoing COVID-19 pandemic. From the earliest days of this pandemic, HHS provided information, guidance, and most importantly funding, without which our hospitals would be unable to continue serving the American people.

To that end, the single greatest source of federal financial support has been the Provider Relief Fund (PRF). We thank HHS for its support, and would like to take this opportunity to explore some outstanding questions from our members as they prepare to submit PRF reports and apply for additional potential funding in the coming months. In an effort to support the mission of HHS, as well as our members, we submit the following questions and issues concerning current PRF guidance:

Issue: PRF Timeline
Current PRF guidance indicates providers must spend or return all funds to HHS by June 30, 2021. However, the pandemic is far from over, with current predictions from the Biden administration indicating the pandemic will likely continue through the end of the calendar year. Additionally, the Consolidated Appropriations Act, 2021 (CAA) (HR 133) requires a fourth application-based PRF general distribution. HHS has yet to announce the application process for the fourth distribution, which must be based on COVID-related costs and lost revenues from the third and fourth quarters of 2020 or the first quarter of 2021. Given these requirements, it seems likely the application period will not open until the second quarter of 2021, making it difficult for providers to spend down needed funds by June 30, 2021.

Recommended Action: Extend the PRF utilization period through the end of the calendar year in which the public health emergency ends.

Issue: Calculating Lost Revenues based on the Calendar Year

The vast majority of not-for-profit healthcare providers do not have a December 31 fiscal year end. However, the current options for calculating lost revenues heavily rely on calendar year end scenarios. The January 15, 2021 reporting guidance provides three lost revenue calculation allowances:

1. *Reporting Entities electing to calculate lost revenues attributable to coronavirus using the difference between their 2019 and 2020 actual patient care revenue must also submit Revenue from Patient Care Payer Mix as outlined above for the 2019 calendar year (by quarter).*
2. *Reporting Entities electing to calculate lost revenues attributable to coronavirus using the difference between their 2020 budgeted and 2020 actual patient care revenue must submit their 2020 budgeted amount of patient care revenue. Recipients must also submit: 1) a copy of their 2020 budget, which must have been approved before March 27, 2020, and 2) an attestation from the Reporting Entity's Chief Executive Officer, Chief Financial Officer, or similar responsible individual, attesting under 18 USC § 1001 that the exact budget being submitted was established and approved prior to March 27, 2020.*
3. *Reporting Entities electing to calculate lost revenue attributable to coronavirus using an alternate methodology must submit a description of the methodology, a calculation of lost revenues attributable to coronavirus using that methodology, an explanation of why the methodology is reasonable, and a description establishing how lost revenue was in fact a loss attributable to coronavirus, as opposed to a loss caused by any other source.*

Based on current reporting guidance, the majority of not-for-profit providers would default to option 3, using an alternate methodology that better reflects their specific fiscal year. Option 3 requires additional paperwork and supporting documentation, and automatically exposes providers to enhanced audit scrutiny.

Recommended Action: Hospitals need maximum flexibility in calculating lost revenues as they could not have adequately prepared for the ongoing fiscal ramifications COVID has brought to their institutions. We suggest HHS either create an additional lost revenue calculation option that addresses alternate fiscal year end scenarios, or amend option 2 to address non-calendar year fiscal year ends. For example, HHS might specify that non-calendar year end providers may use 2020 actual to budget for approved budget periods, and 2020 actual to 2019 actual for budget periods not approved by March 27, 2020. Developing such guidance will not only offer additional details to providers attempting to comply with HHS reporting and audit requirements, but will also further standardize lost revenue calculations across providers, decreasing the number of alternate scenarios presented to HHS and auditors. Audits are expensive for both the auditor and auditee, and IHA would be happy to assist HHS in thinking through additional guidance that would mitigate this cost for the taxpayer and further streamline the reporting process.

Issue: January and February 2020 and Lost Revenues Calculations
The current guidance on calculating lost revenues looks at the entire 2020 calendar year, including January and February of 2020. However, the influx of COVID-19 patients and subsequent moratoriums on elective procedures and non-hospital based health services began in March 2020. Requiring providers to include January and February 2020 in their lost revenues calculations, regardless of provider type, is inappropriate because those two months are irrelevant to the economic ramifications of COVID-19. Including January and February 2020 in lost revenues calculations offsets the substantial economic losses experienced later in the pandemic.

Recommended Action: We ask HHS to amend lost revenues calculation guidance, instructing providers to begin calculating lost revenues with the month in which mitigation measures began for that particular provider. HHS might require specific documentation supporting the selection of that month. For many Illinois hospitals, the economic impact of COVID-19 began in March 2020, but the appropriate start point may vary nationally due to the fragmented, state-by-state response to COVID-19.

Issue: Defining and Measuring "Other Assistance Received"
In the October 28, 2020 version of the PRF FAQs, HHS included the following:

How does "other assistance received" factor into my reported expenses? (Added 10/28/2020).
Other assistance received is reported as operating revenue and used in the calculation of year-over-year change in patient care related revenue.

This FAQ is not included in the current PRF FAQ document, though it does still appear on the HHS CARES Act PRF FAQ website. The treatment of "other assistance received" is integral to how providers calculate reported expenses. Without clear and consistent guidance, providers cannot accurately report operating revenue in their calculation of year-over-year change in patient care related revenue.

Recommended Action: We ask HHS to revisit and update both the PRF FAQ document and the HHS CARES PRF FAQ website, definitively indicating whether providers should include "other assistance received" in the calculation of operating revenues and, subsequently, patient care related revenue.

Issue: Reporting Entity for Transferred Targeted Distributions
The January 15, 2021 reporting guidance states that "*the original Targeted Distribution recipients, regardless of whether the parent or subsidiary received the payment and regardless of whether that original recipient subsequently transferred it, becomes the Reporting Entity and must report on the use of funds in accordance with the CRRSA.*" HHS also writes the following:

Transfer of Targeted Distributions
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.

This guidance raises a few potential concerns for providers. First, the guidance suggests that the original recipient of a Targeted Distribution must also be the Reporting Entity for those funds, even though the original recipient may not have ultimately utilized the funds. Our concern is that the original recipient would not be in a position to report on and provide supporting documentation for transferred Targeted Distributions, which may result in unnecessary questions and follow-up during the report review and audit processes.

Second, HHS states there is an increased likelihood of audit on transferred Targeted Distributions. It is unclear to us why these funds would be under increased scrutiny.

Recommended Action: Regarding which entity should report on the use of Targeted Distribution funds, we recommend that HHS modify the current reporting guidance to require that the entity that ultimately utilized Targeted Distribution funds be the Reporting Entity for those dollars. If the original recipient transferred Targeted Distribution funds, they should report how much of the Targeted Distribution was transferred and to whom (identified in the report by Tax Identification Number).

We believe this change will likely address issues that might lead to increased audit scrutiny for transferred Targeted Distributions. If it does not, then we ask HHS to provide justification for increased audit scrutiny of transferred Targeted Distributions.

Issue: Treatment of Claims Based Payments Related to COVID-19
Congress modified or increased many claims-based federal payments to assist healthcare providers with the cost of preparing for and responding to COVID-19. These include, but are not limited to, the 20% add-on payment to MS-DRGs for COVID-19 positive Medicare fee-for-service (FFS) patients, increased Federal Medical Assistance Percentage (FMAP) dollars that may flow through to hospitals treating Medicaid-enrolled patients, and suspended sequestration cuts on prospective payment system reimbursements. Additionally, hospitals have been providing COVID-19 tests and are now administering COVID-19 vaccines.

The reporting guidelines require PRF recipients to "*report healthcare related expenses attributable to coronavirus, net of other reimbursed sources (e.g., payments received from*

insurance and/or patients, and amounts received from federal, state, or local governments, etc.)…"

We agree that providers must first bill payers and account for that revenue in their total revenue calculations. However, when the Congress provided a 20% increase to Medicare FFS reimbursement for COVID-related MS-DRGs, increased the FMAP, and suspended sequestration, they took those actions in an effort to further increase the amount of dollars flowing to healthcare providers. If HHS requires providers to account for these increases in their calculation of "other reimbursed sources," it will count against their total reimbursable COVID-19 expenses and lost revenues under the PRF.

Additionally, including reimbursement for COVID-19 tests and COVID-19 vaccine administration artificially inflates 2020 and 2021 patient care revenue compared to either 2020 budget or 2019 actual revenue, as budgets or actual revenues realized prior to COVID-19 did not account for these services. In other words, accounting for revenue from the administration of COVID-19 tests and vaccines will actually penalize providers, as the inclusion of these services does not provide an apples-to-apples comparison when calculating lost revenues.

Recommended Action: We request HHS clarify that claims-based payments meant to help offset the increased costs of treating patients with COVID-19, such as the 20% MS-DRG add-on payment, should not be offset against COVID-19 related expenses. Additionally, we ask that HHS create similar guidance concerning reimbursement for the administration of COVID-19 tests and vaccines.

Alternatively, should HHS require that such reimbursement be included in a provider's calculation of total revenue, we request HHS clarify that claims-based payments that are offset against COVID-19 expenses be removed from PRF recipients' 2020 actual revenue calculation.

Issue: Capturing Marginal Costs Related to COVID-19

The PRF FAQ document instructs hospitals to calculate marginal expenses related to COVID-19, indicating that these costs are permissible under the PRF. The document then provides examples on how to calculate marginal increased costs under the following 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?" (Modified 12/11/2020)

Unfortunately, there remains significant confusion regarding how providers should capture marginal costs related to COVID-19. Much of this confusion stems from how different providers capture costs within their systems. Marginal costs include indirect costs that are not associated with a specific cost center or general ledger account, meaning absent further guidance there will be significant variability in how incremental costs are calculated across providers.

Recommended Action: We recommend HHS create a template for providers, demonstrating how HHS wants providers to calculate the marginal increase in costs from 2019 to 2020. Providing specific guidance via a template will mitigate variation in how providers determine their marginal increased costs, decreasing confusion for providers as well as minimizing HHS' and auditors' potential need for follow-up clarification.

Additionally, we ask that HHS clarify circumstances when providers may determine marginal expenses versus reporting specific coronavirus expenses net of reimbursement. Being clear on when providers should report marginal expenses versus coronavirus expenses per the general ledger will provide further clarity, as reporting a mix of direct and marginal expenses will be difficult to standardize and there is a high risk of inadvertent duplication of expenses.

Issue: Treatment of Medicaid Disproportionate Share Hospital (DSH) Payments
HHS added the following FAQ related to Medicaid DSH payments on February 24, 2021:

Are there any restrictions on how hospitals that receive Medicaid disproportionate share hospital (DSH) payments can use Provider Relief Fund General and Targeted Distribution payments? (Added 2/24/2021)

Yes. Providers may not use PRF payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if a hospital has received Medicaid DSH payments for the uncompensated costs of furnishing inpatient and/or outpatient hospital services to Medicaid beneficiaries and to individuals with no source of third party coverage for the services, these expenses would be considered reimbursed by the Medicaid program and would not be eligible to be covered by money received from a General or Targeted Distribution payment. For more information on the calculation of the Medicaid hospital-specific DSH limit, see https://www.medicaid.gov/state-resourcecenter/downloads/covid-19-faqs.pdf.

We agree that providers should not use the PRF to pay for COVID-related costs reimbursed by or obligated to be reimbursed by other sources. However, we find this FAQ and how it relates to the appropriate use of PRF payments confusing.

Recommended Action: We ask HHS to provide additional context and guidance around why this FAQ was added. Specifically, we ask HHS to clarify whether they are referencing annual Medicaid DSH audits and potential paybacks. If not, we ask HHS to provide additional insight around why they included this FAQ so providers are best positioned to comply with DSH-related requirements.

Issue: Treatment of Eliminations
Many hospitals include business lines that may earn revenue in one arm of the organization that displays as a cost in another arm of the organization. For example, many not-for-profit

hospitals self-insure their employees. In 2020, these hospitals incurred COVID-related expenses because the cost to insure and provide healthcare to their employees went up as their staff contracted and sought treatment for COVID-19. However, because many of those same employees sought care at a hospital-affiliated provider group or the hospital itself, the organization is also making money that somewhat offsets these costs. Hospitals are not sure how HHS wants them to treat these eliminations: should they be included in the calculation of COVID-related costs and lost revenues, or not?

Recommended Action: Provide clear guidance on how PRF recipients should treat eliminations in the calculation of COVID-related costs, patient revenue and lost revenues.

Issue: PRF Reporting Process
Providers are attempting to adequately prepare to comply with imminent PRF reporting requirements, but lack adequate guidance on what the report will look like or what documentation HHS will require.

Recommended Action: HHS provided guidance and sample applications during previous PRF application general distributions, which simplified and streamlined the application process for providers. Such documentation is important in allowing providers to work with their financial partners to accurately and thoroughly prepare and execute applications, or in this case reports, in an effort to provide all information HHS requires and minimize errors. We request that HHS distribute report templates and guidance to providers prior to opening the PRF reporting portal. The provision of these materials would be advantageous to both Reporting Entities and HHS, allowing time to seek additional guidance and clarification before reports are due and minimizing reporting errors and audit costs across Reporting Entities.

Issue: Supporting Providers that are Treating COVID "Long-Haulers"
As we learn more about the myriad ramifications of contracting and surviving COVID-19, it is clear that some patients suffer from COVID-19 side effects long after the virus is active. These so-called COVID "long-haulers" continue to require medical care, often from long-term care hospitals (LTCHs). LTCHs report COVID long-haulers often require lengths of stay (LOS) upwards of 40 days. Congress could not anticipate the medical and financial challenges that accompany COVID long-haulers when it initially passed legislation increasing reimbursement and creating policies specific to covered services, prior authorization, and patient cost sharing.

Specifically, LTCHs do not receive the 20% Medicare add-on payments on MS-DRG reimbursement provided to short-stay acute care hospitals treating Medicare FFS COVID-19 patients. LTCHs must also confront prior authorization challenges due to the abnormally long LOS required by many COVID long-haulers. Medicare Advantage plans and other private payers often require continuing stay authorizations every three to five days, yet the prior authorization process is fragmented, costly, and often results in inappropriate care denials that jeopardize the coverage of care required by COVID long-haulers.

Recommended Action: We ask HHS to examine its authority to grant additional financial support to LTCHs. Such support could be through a retroactive Medicare add-on payment, a targeted PRF distribution for entities providing long-term acute care, or some other action deemed appropriate by the Secretary. Additionally, we ask HHS to create guidance for private payers, including Medicare Advantage plans, to simplify and streamline prior authorization requirements for LTCH patients suffering from long-term effects of COVID-19.

Issue: Phase 3 PRF General Distribution

According to the PRF FAQ document, the Phase 3 general distribution formula was intended to pay providers the greater of up to 88% of their reported losses (both lost revenue and COVID-related expenses incurred during the first half of 2020) or 2% of annual revenue from patient care.

We understand that some applicants' financial situation does not meet the requirements to receive a Phase 3 general distribution payment. However, a number of Illinois hospitals incurred expenses and lost revenues attributable to COVID-19 in Q1 and Q2 of 2020 that exceeds 2% of annual revenue from patient care. Additionally, the sum of PRF dollars received thus far does not exceed the Phase 3 payment cap. Yet these hospitals have either not received a Phase 3 payment, received a payment that is less than anticipated, or received a denial notice. In all three scenarios, HHS has not provided detail as to why the provider did not receive expected application-based payments.

It would appear that such applicants did not receive Phase 3 payments based on issues referenced in the January 28, 2021 update to the PRF FAQs:
Certain applicants may not receive these full amounts because HHS determined the revenues and operating expenses from patient care reported on their applications included figures that were not exclusively from patient care (as defined in the instructions), reported figures were not reflected in submitted financial documentation, or reported figures were extreme outliers in comparison to other applicants of the same provider type; instead, HHS capped the amount paid to these provider types based on industry estimates of revenue and operating expenses from patient care."

However, HHS has not supplied provider-specific details on adjustments made to reported revenue and/or expense data, or how HHS determined provider-specific caps based on undisclosed "extreme outlier" values. The lack of explanation leaves providers without information necessary for current financial decisions, and may affect future application-based PRF distributions and PRF reporting.

Recommended Action: We ask that HHS provide details of any adjustments or caps it applied to the data submitted by a Phase 3 PRF applicant. Further, we ask HHS to create an appeals process for applicants that were either denied a Phase 3 payment or received a payment that was less than expected based on HHS' Phase 3 formula. Given the extreme losses hospitals

continue to experience and the intent of the PRF to help providers offset COVID-related costs and lost revenues, we believe it is appropriate and necessary for HHS to ensure providers receive the dollars to which they are entitled under the Congressional intent of the PRF.

Issue: Differing Definitions across Federal Guidance Documents
There are several documents from HHS regarding different aspects of the government's response to COVID-19, including general distribution application guidance, reporting guidelines, terms and conditions, daily COVID-19 data submissions, and the PRF FAQ document. Unfortunately, some of the definitions across these documents are inconsistent. For example, the latest PRF FAQ document includes the following:

What is considered a "staffed bed" for reporting KPI? (Added 10/28/2020)
A staffed bed is licensed and physically available with staff on hand to attend to patients; includes both occupied and available beds.

However, in the reporting guidelines, HHS defines "Facility Metrics" as "*Total available staffed beds for medical/surgical, critical care, and other beds.*"

In other words, the FAQ document points toward all licensed beds, while PRF reporting guidance appears to have a more specific definition. This not only introduces confusion, but may also result in the reporting of inconsistent numbers across different federal data systems.

Recommended Action: We recommend that HHS standardize terms and definitions across guidance documents and portals in order to streamline data reporting and mitigate confusion both in the reporting process, and during future federal audits.

Again, thank you for considering these issues and recommended actions Acting Secretary Cochran. We thank you for the work HHS has done thus far to guide the healthcare industry through these unprecedented times, and we look forward to continuing to partner with you and HHS in the future.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association

cc: The Honorable Dick Durbin
The Honorable Tammy Duckworth

The Honorable Bobby Rush (D-1-IL)
The Honorable Robin Kelly (D-2-IL)
The Honorable Marie Newman (D-3-IL)
The Honorable Jesús “Chuy” García (D-4-IL)
The Honorable Mike Quigley (D-5-IL)
The Honorable Sean Casten (D-6-IL)
The Honorable Danny K. Davis (D-7-IL)
The Honorable Raja Krishnamoorthi (D-8-IL)
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