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NATIONAL RURAL HEALTH ASSOCIATION

HHS Provider Relief Fund Reporting Requests

The National Rural Health Association (NRHA) urges you to address the following policy and reporting concerns to ensure the Provider Relief Funds (PRF) fully aid rural providers combatting the COVID-19 pandemic.

While we acknowledge and appreciate the important role of program integrity in implementation of the PRF, many of the policies and reporting guidelines during the previous Administration have significant implications for rural safety-net providers. COVID-19 cases have hit rural communities particularly hard, with higher death rates and a larger percentage of rural counties in the "red zone", as compared to their urban counterparts. This, coupled with the fact that rural providers operate on slim-to-negative margins, means that many rural providers are struggling to keep their doors open.

Absent these changes, many rural providers serving low-income, elderly, and severely ill patients, may be required to return much needed PRF funds to HHS. We encourage the Department to comply with the Congressional intent to assist hospitals and other providers on the front lines of the coronavirus response.

Issue #1: The FAQs (page 19) indicate that the cost of capital items may only be used as COVID related expenses if directly related to…coronavirus and must be completed by June 30, 2021.

- **Background:** Many rural hospitals have embarked on capital projects, including construction or remodeling facilities, to meet the needs of COVID. In many instances these projects require planning, bidding and lengthy construction or implementation phases. Some of the projects will not be completed by the end of the final reporting period of June 30, 2021.

- **Requested Change:** Please clarify when project cost may be included in the expenses related to COVID. Given that many hospitals will still be struggling with the pandemic after June 30, 2021, NRHA requests that project costs be included when the project is put under contract in order to accommodate those essential activities that may not be complete by the current deadline. Additionally, NRHA requests that HHS extend the current completion end date beyond June 30, 2021, ideally to December 31, 2021 or later.

- **Requested Change:** NRHA requests HHS allow the total cost of capital items (items over $5,000 each and useful life exceeding 12 months) as a permitted COVID related expense, unless reimbursed by other sources. The total capital project cost should be reported in the period during which the provider entered into a contract for the project regardless of when the project will be completed or when payment is made. Future estimated cost-based reimbursement for capital related costs should not be used to offset the cost of the capital project.

- **Requested Clarification:** Cost-based providers (like critical access hospitals) will depreciate the capital cost and claim the expense for cost reimbursement in future periods. How does future estimated cost-based reimbursement of depreciation impact the capital expense that can be claimed for PRF?

Issue #2: HHS must allow flexibility in the reporting of lost revenues. Providers across the country lost revenues over varying time periods, based on state and local conditions. Calendar year 2020 is an arbitrary period to use as a measurement period for lost revenues.

- **Background:** Allowing providers to be flexible in using their selection of time periods would allow providers to more accurately account for their revenue fluctuations that resulted from COVID. Providers across the country experienced varying degrees of economic disruption from COVID, therefore allowing flexibility in the determination of lost revenue will allow a more accurate representation of their experience.

- **Requested Change:** HHS should not require providers to use all of 2020 or 2021 in the lost revenue calculations, instead using whatever period of time is involved where providers lost revenues, whether that be only a few months in spring 2020 when elective services were suspended or whatever period is relevant. Providers should report lost revenues based on their unique circumstances, including varying time periods, and document the methodology, rationale, calculations, etc. This may be used in the option "any reasonable method" and will be subject to potential audit and review by HRSA.

Issue #3: Providers, particularly hospitals, have had a significant surge in COVID patients during the last half of 2020, into early 2021. It appears the related patient revenues for this surge in patients may have a doubly-negative impact on providers under current guidance.

- **Background:** HHS thus far has provided guidance that lost revenues must be measured for all of calendar year 2020, comparing 2020 revenues to 2019 revenues (or to a budget approved before March 27, 2020). These calendar year 2020 revenues are abnormally high in the latter part of the year due to COVID inpatients admitted at hospitals across the country. HHS has also provided guidance that, in the calculation of COVID expenses, such expenses are reduced by the related revenues (reimbursement received for services to these patients).

- **Requested Change:** Covid revenues used to reduce Covid expenses are NOT to be included in 2020 or 2021 revenues for any lost revenue calculations.

- Reimbursement for services to COVID patients logically would reduce the related COVID expenses. However, such reimbursement should not also be included in overall patient revenues for 2020 or 2021 when compared to 2019 or budget revenues. Including COVID revenues (i.e. reimbursement) in the lost revenue calculation inappropriately doubles the impact on providers if that reimbursement has already been included in the COVID expense calculation. This COVID reimbursement would include both claims-based reimbursement as well as cost report reimbursement for cost-based providers such as critical access hospitals and rural health clinics.

Issue #4: Cost reporting is quite complex and presents several challenges in determining expenses attributable to COVID related to use of PRF funds, as well as the determination of lost revenue. NRHA has several issues to raise related to cost reporting clarification in the FAQs.

- **Background:** The FAQ modified on 1/28/2021 (page 16) indicates that interest earned on unspent PRF funds must be used as a revenue source and returned to HHS. CMS generally requires that interest income be used to offset interest expense in cost reports.

- **Requested Change:** The FAQ should clarify that any interest reported as other assistance and/or returned to HHS should be net after any cost reimbursement impact.

- **Background:** The FAQ added on 10/28/2020 (page 21) indicates that the cost-reimbursement impact of including COVID related expenses must be used to reduce the COVID related expenses reported for PRF. This requirement creates an unreasonable and burdensome calculation requirement on cost-based providers, especially critical access hospitals and rural health clinics. The timing of the calculations required will be difficult to attain for the specified reporting periods established in the Post-Payment Notice. Cost reports are completed based on the provider's fiscal year and generally filed 5 months after the end of the provider's fiscal year (CMS has extended the due dates during the Public Health Emergency to 7 months). Cost reports will not be available for all providers for a calendar year reporting period.

- **Requested Change:** Providers should be allowed to make a reasonable estimate of the cost reimbursement impact of COVID expenses when calculating the net unreimbursed COVID expenses.

Issue #5: Can decreases in tax receipts, state grants, other grants that were directed to fund operations (not COVID-related), be used in the lost revenue calculations?

- **Background:** Although these receipts may not be directly related to patient care they are necessary to provide income for the provider to maintain capacity. Including them in the lost revenue calculation would allow the PRF to cover decreases that were caused by COVID.
    - As an example, tax receipts are based on local sales tax which has been negatively impacted because of the economic disruption caused by COVID, therefore the abnormal decrease from 2019 to 2020 was caused by COVID. Can the decreased sales tax receipts be used in the lost revenue calculations?
    - As an example, state grants for school-based clinics have been terminated early and/or funding amounts reduced because of state budgets cuts attributed to COVID. Can the decreased grant funding be used in the lost revenue calculations?

- **Requested Change:** Allow any reduction of tax receipts, grants, etc. that can be documented as tied to COVID as lost revenue.

Issue #6: How are one-time revenue adjustments (positive or negative), such as income from a Medicare appeal, handled in reporting revenue for any period?

- **Requested Clarification:** Should revenue that is attributable to a specific prior year, be adjusted out of either 2019 or 2020? If the income was received in 2020 and was directly attributable to 2019, should the amount be deducted from 2020 and added to 2019? If the income was received in 2020 and attributable to 2018, should the amount be excluded completely?
- **Requested Clarification:** Can net patient revenue be adjusted for documented changes in income for any period (2019, 2020 and 2021) for amounts unusual from period to period such as price increases, increased per unit payments from payers (like Medicare DRG, APC, RHC changes), changes in physician staffing, starting or ending specific services or clinics, etc.?

- **Requested Clarification:** Can revenue be adjusted to remove the COVID related payments for patients that are required to be used as reductions of COVID-related expenses in Section 2. As specified in FAQ page 17, payments for COVID direct billing must be used to reduce COVID expenses. Using paid amounts to reduce expenses and also including the payments in net patient revenue will create a duplicate "credit" which cannot be covered with PRF funds. Reimbursement for direct billing to cost-based providers should not be used to reduce permitted COVID expenses.

- **Requested Change:** Providers should be allowed to "normalize" net patient revenue for the lost revenue calculation by documented amounts that are unique for any period used in the derivation of lost revenue. This "normalization" of revenues, including the elimination of Covid-related patient revenue if also used to reduce Covid expenses, may be used in the "any reasonable method" of reporting and may be subject to audit or review by HRSA.

Issue #7: Why are 2020 personnel and patient metrics required by calendar quarter?

- **Background:** Quarterly reporting, if not needed for a purpose of the calculations of COVID expenses or lost revenue, will be a burdensome requirement for small rural providers and should be eliminated.

- **Requested Change:** The quarterly reporting should be eliminated due to burden. Annual reporting should be allowed.

Issue #8: Guidance on reporting lost revenues (Section 4) requires providers to report revenues by quarter. Why is reporting by quarter necessary if only the annual comparison (or 6 months in 2021) is used?

- **Requested Change:** Remove the requirement to report revenues by quarter which will relieve rural providers which are stressed with limited human and financial resources.

Issue #9: Does the reporting of COVID revenue from other assistance received such as PPP loans, FEMA grants, etc. (as noted in the "Other Assistance Received" section of the Notice) need to be segregated by those amounts used to reduce expenses attributable to COVID and those that are not?

- **Requested Change:** Report amounts listed as "other assistance" segregated between amounts used to reduce COVID-related expenses and those that were not used (like PPP

forgiveness). Also clarify If such amounts were used to reduce COVID-related expenses those amounts will not be used in the lost revenue calculation.

Issue #10: Are amounts received from state Medicaid programs for uncompensated care included or excluded in the calculation of revenue from patient care for the determination of lost revenue?

- **Background:** Payment of these amounts comes in different forms depending upon the state plan such as: direct payments from the state, add-on payments to claims, grants from entities contracted by the state, etc. Funding is sourced by provider taxes, Medicaid DSH, state appropriations, etc. Most are based on uncompensated care experience of one or two prior years – not current year claims experience.

- **Requested Change:** Amounts received from state Medicaid programs or other sources to cover the cost of uncompensated care, regardless of the payer, should be used in the computation of patient revenue.

Issue #11: Can debt principal payments, along with interest, be included in expenses attributable to coronavirus if the loan was incurred to pay COVID expenses? Section 3(a) indicates "mortgage" payments are allowable – does that include principal and interest?

- **Requested Change:** Allow providers to include the total payment including principal.

Issue #12: Forgiveness from Paycheck Protection Program (PPP) loans must be offset against expenses directly attributable to COVID or used in the lost revenue (see #9 above). Is the reporting based on the respective underlying expenses in the reporting period? If so, in what period does the PPP forgiveness get reported: when the underlying expenses were incurred (such as during 2020) or when the loan is officially forgiven by SBA (such as 2021)? It would seem from the example on page 20 of the FAQs that the offset must be made in the period the expenses were incurred regardless of when the loan was forgiven.

- **Requested Change:** The revenue from PPP forgiveness should be used in the period during which the underlying expenses were reported. If the PPP amount is subsequently not forgiven, the reporting should be amended.

Issue #13: What is the impact of the FAQs related to "use of funds", especially lost revenue issued or modified after June 2020?

- **Requested Change:** HHS should republish or delete FAQs dated after June 2020 to confirm their continued applicability.

Issue #14: One of the lost revenue options is a comparison of budget to actual patient revenue if the budget was approved prior to March 27, 2020.

- **Background:** In most cases providers prepare and approve operating budgets based on their fiscal year. If the lost revenue calculation remains based solely on calendar year 2020 vs. 2019, how will fiscal year budgets be used in the comparison.
    - As an example, a hospital has a fiscal year ended September 30, 2020. The budget for the year October 1, 2019 – September 30, 2020 was approved in August 2019. The budget for the year October 1, 2020 – September 30, 2021 was approved in

August 2020. Certainly, the budget FY 2020 was approved prior to March 27, 2020. The budget FY 2021 was approved after March 27, 2020. What will the hospital use for the budget comparison for the period October 1 – December 31, 2020 since that budget period was approved after March 27, 2020?

- **Requested Change:** Providers whose fiscal year is other than December 31 should use an extrapolation of budget revenue based on the most recent budget approved prior to March 27, 2020. As an example, a provider with a September 30 year end should use the FY 2020 budget for the revenue comparison for the period January 1 – September 30, 2020. The provider should use the budget for the period October 1 – December 31, 2019 as a substitute for the budget October 1 – December 31, 2020 since the budget for that period was likely approved following March 27, 2020.

Issue #15: The use of "any reasonable method" is an option for the computation of lost revenue.

- **Background:** The Post-Payment Notice indicates that providers that use this method should document the method, etc. used for submission and that HRSA may review it. Upon review HRSA may determine it to be unreasonable. Are there pre-determined parameters that HRSA will use to judge the reasonableness of the lost revenue calculation? How will the HRSA review interact with any audit conducted under the single audit guidelines?

- **Requested Change:** HRSA should publish characteristics of the "any reasonable method" that will make it acceptable or unacceptable. In addition, if HRSA is accountable for review of this method, the provider should not be subject to the single audit.