Provider Relief Fund Payments — Filling in the Gaps

May 11, 2020 | Webinar Questions & Answers

Disclaimer: To the best of our knowledge, these answers were correct at the time of publication. Given the fluid situation, and with rapidly changing new guidance issued daily, be aware that these answers may no longer apply. Please visit our COVID-19 hub frequently for the latest information, as we are working diligently to put forth the most relevant helpful guidance as it becomes available.

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PYA Webinar: "COVID-19 Provider Relief Fund Payments — Filling in the Gaps" | 05-11-20 Martie Ross, Lori Foley	
Question Asked	**Answer Given**
When CMS states "2018 cost report" is that the hospital's cost report that ends in FFY2018 or begins in FFY2019 or does it literally mean the cost report that the hospital submitted for its unique fiscal year?	HHS has not stated publicly which cost reports on which it relied in calculating the Round II automatic payments.
What should a provider do if in Round 1 [it] received an amount and using the mathematical equation in HHS FAQ [it] gets a negative amount? Should the funds from Round 1 that it is over be returned?	A TIN's payment should roughly approximate 6.2% of Medicare fee-for-service payments for 2019. We are aware of a number of organizations that have not been able to tie the Round I payment amount directly to the information in their billing systems. Unless the "overpayment" is due to a change in billing TINs where you received funds to which you clearly are not entitled, we believe it is reasonable to rely on HHS' calculation using CMS-provided data in making the Round I payments. A provider that receives a Round II payment is required to submit additional information to verify that payment amount, but there is no similar requirement associated with Round I payments. It is still necessary to track COVID-related expenses and lost revenues to justify retention of and appropriate use of the funds received.
Regarding "March and April losses" ... because providers were still receiving money from January-February (and early March) claims, most providers will have little to no loss until May or June. How are we supposed to calculate a "loss" for March and April? Is it the anticipated loss based on lower patient claims filed for March and April dates of service?	HHS is asking a provider to estimate its losses in March and April in a reasonable manner. It would be reasonable to base this estimate on lost volume during this two-month period, as opposed to receipts. Additionally, it is reasonable to expect, at least for a number of providers, that May and possibly even June and July will be similarly impacted. For purposes of tracking retention and use of funds, documenting these losses/increased expenses for the trailing months will be important.
I noticed on slide 4 in your presentation that you mentioned a 30-day deadline for receipients of automatic tranche 2 general allocations - how does the attestation extension play into deadlines for portal 2 submissions?	As of the date of the webinar, the HHS website states a Round II recipient must submit **financial information within 30 days of receipt, although the deadline for attestation was changed from 30 to 45 days on May 7.**
When you refer to COVID-19 admissions, do you mean inpatient admissions? Is observation incluced in the count?	HHS directed hospitals to submit by April 25 "Total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020" for purposes of calculating the COVID-19 hot spot payments. Obervation counts were not referenced in the HHS request.
Will the specific amounts of these various forms of payment by provider be available to view by the public? Where (site) might they be viewed?	https://data.cdc.gov/Administrative/HRSA-Provider-Relief-Fund-General-Allocation/kh8y-3es6
We received an automatic Round I payment, but not Round II. We submitted an application for the Round II payments but nothing received to date. Is it possible that CMS will take-back any Round I payments if the allocation from Round II shows an organization might have been overpaid?	HHS has reserved the right to recoup funds if a payment was made in error. However, HHS to date has made no mention of adjusting Round I payments based on financial information submitted by the provider for Round II.

The FAQ referenced for the $50M stated that if you do not have losses the "entire" amount should be repaid. Is this correct? Or do you only need to refund the difference b/w your losses and the amount received?	We understand there is presently no vehicle to make a partial refund. We anticipate HHS will issue clarifying guidance on this matter in the near future. For now, the FAQ states, " If a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment."
We are a state entity with a single TIN and many separate providers (mental health institutes, veterans centers, etc.). Will we receive an EOB for the first payment to allocate the amount to each center?	No, you will not. COVID-related expenses and losses will be evaluated at the TIN level, as opposed to separately for each provider billing under the TIN.
How long does a hospital have to expend funds for COVID related purposes (ie, remodel facility to enhance treatment of pandemic related patients)?	HHS has not placed a time limit on COVID-related expenses or losses. One should be prepared to demonstrate any identified expense or loss that ties back to COVID.
Were Rural Referral Centers in Urban areas included in the Rural Hospital payments?	Please see the Eligiblity section of this document detailing the COVID-19 hot spots and rural allocations - https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/payment-allocation-methodology/index.html
We might calculate a loss from April and March that is LESS than the first round of auto payments, but when we consider May (and even June) lost revenue, that is not the case. Can we consider further lost revenue past April in ensuring we were not overpaid in the first round of auto payments?	HHS is asking a provider to estimate its losses in March and April in a reasonable manner. It would be reasonable to base this estimate on lost volume during this two-month period, as opposed to receipts. Additionally, it is reasonable to expect, at least for a number of providers, that May and possibly even June and July will be similarly impacted. For purposes of tracking retention and use of funds, documenting these losses/increased expenses for the trailing months will be important.
If we got a Round 1 payment automatically because we file cost reports but haven't yet received our Round 2 payment, do we need to go into the portal and enter our information first? Because the Round 2 calc indicates we should get additional payment in Round 2.	Not all providers that submit cost reports received an automatic Round II payment. HHS may have determined that the cost report did not include the specific information needed to calculate the Round II payment. In this case, you should apply for Round II funding.
We have received 2 payments and attested to both. However, when I try to go in to enter revenue information, I get a message that we haven't attested yet. I've tried calling the phone number provided on the website and they could not help.	Unfortunately, we do not have any additional information. Be sure to maintain a screen shot of the error message you have received.
What about government agencies who do not file an income tax return?	Here's the relevant FAQ: "Which information should be submitted by a state-run entity (e.g. state university medical center) that has no parent organization that files a federal income tax return? The applying state entity should select “Tax-Exempt Organization” in the dropdown menu for “Federal Tax Classification.” The state entity should use Net Patient Revenues from its most recent audited annual financial statements as a substitute for “Program Services Revenue” when prompted. Further, the state entity should submit its most recent audited financial statements as a substitute for the federal income tax return Form 990 requested."

What happens if we used an incorrect billing address in the attestation. Can we revise that somehow?	To our knowledge, neither HHS nor Optum have provided direction on how to correct inaccurate information included in an attestation. We recommend calling the help line.
How do you access the public information of the facilities and the amounts received?	https://data.cdc.gov/Administrative/HRSA-Provider-Relief-Fund-General-Allocation/kh8y-3es6
Many small healthcare providers are LLCs taxed as a partneship. The owners also provide services to patients of the LLC. To be clear, they are not employees. May the funds be used to pay the owners' compensation that was lost as a result of the COVID-19 pandemic?	Yes, subject to the $197,300 annual compensation limitation. The entity may also need to consider limitations imposed by other funding mechanisms such as Payroll Protection Program loans.
What if you are a private act authority and do not have a tax return, how do you apply for Round 2 payments? We did receive funds for Round 1 distribution.	Here's the relevant FAQ: "Which information should be submitted by a state-run entity (e.g. state university medical center) that has no parent organization that files a federal income tax return? The applying state entity should select “Tax-Exempt Organization” in the dropdown menu for “Federal Tax Classification.” The state entity should use Net Patient Revenues from its most recent audited annual financial statements as a substitute for “Program Services Revenue” when prompted. Further, the state entity should submit its most recent audited financial statements as a substitute for the federal income tax return Form 990 requested."
Is there a visit or E/M that can be charged in conjunction with drive thru testing for COVID-19?	The American Medical Association has published comprehensive materials on coding and billing for COVID-19 testing, available at https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance