PYA Webinar: **"COVID-19 Provider Relief Fund Payments — Filling in the Gaps"**

Presenters: PYA Principals Martie Ross and Lori Foley, and Dan Huffman, Director of Financial Strategy and Revenue Innovation at Northside Hospital in Atlanta, GA.

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0:05
Good morning, everyone and welcome to today's webinar hosted by PYA **"COVID-19 Provider Relief Fund Payments—Filling in the Gaps."** PYA is a leading professional services firm providing expertise in health care tax management consulting and audit and Assurance. We are pleased to offer you our spot leadership on this important topic.
0:33
All attendees have been placed in listen-only mode. You may submit written questions using the question pane of the control panel will collect these after the webinar and do our best to respond accordingly. Please be aware with more people using online platforms outages can occur should the webinar be paused we will work to restore it as quickly as possible and all of our webinars are recorded and released.
1:02
a copy of the slides after the event with that, I would like to introduce our presenters Lori Foley and Martie Ross, PYA Consulting Principals, and Dan Huffman, Director of Financial Strategy and Revenue Innovation at Northside Hospital in Atlanta, Georgia.
1:26
Good morning, everyone. This is Lori Foley. I am a Principal as Laura mentioned with PYA in Atlanta and joined today by my fellow PYA Principal Martie Ross, and we're pleased to have Dan Huffman join us. Then is the Director of Financial Strategy and rent revenue Innovation at Northside Hospital here in Atlanta. We were excited to see over 350 registrants for today's webinar, which tells us that the topic is a hot one. We were also pleased to find that HHS.
1:56
did not drop any regulation late Friday night or over the weekend that we needed to incorporate though they did update some FAQ on the sixth, that was after the announcement of our webinar, so we have included those in our discussion for today.
2:13
Starting off just at the high level talking about the 100 billion dollar Provider Relief Fund. Obviously, we have the 50 billion dollars that came through the General Distribution including the Round 1 distribution of 30 billion dollars.

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And then the secondary rebalancing distribution of 20 billion dollars were going to spend some time digging into those including some gaps that we have identified at least some areas that are causing some consideration in this Some a month with money and with our client will also spend a little bit of time on the COVID-19 Hotspot Hospitals in the 12 billion dollars that was located to that initiative as well as the ten billion dollars for rural providers and then the additional COVID testing and treatment for uninsured. Additional information has come forward with that. So, we will walk through that process. It's important to note that they also have identified another 75 billion dollars added in the paycheck.
3:13
protection program and the health care enhancement act that we don't have details yet on that allocation. So obviously more funding is to be coming in more details coming forth. But for now, let's just dive on in. Martie, do you want to dig into the General Distribution round1? Sure, thanks Lori. Back on April 10, many of us looked in our bank accounts and were surprised to find money's having been deposited by Optim. This was our first General Distribution around 130 billion dollars.
3:43
That were allocated to all that had billed Medicare part A or Part B in 2019. And if you did the math it was roughly the amount you receive was roughly equal to six point two percent of that 10 2019 Medicare payments those distributions ended by April 24th, which set the stage then for the Round 2 distributions. This was the 20 billion dollars that HHS explained was being allocated to augment Round 1 allocations, so that the entirety of the 50 billion in General Distributions, would be in back allocated proportional to Providers share a 2018 net patient revenue the explanation being is that we wanted to get the 30 billion out as quickly as possible. So, we used the most reliable data available, which was the 2019 Medicare part A Part B payment, but in fact our intent HHS has its intent is to distribute base.
4:43
2018 net patient revenues, we'll talk about in a minute the potential confusion that creates what also is confusing is Round 1 payments were made by individual TIN Round 2 payments are being made to the parent organization IE The Entity that files the tax return and the payment would subsume all TINs that are under that tax return that do not file their own separate tax return for a Round 2 payments there are two methods for making these distributions for those providers that's been a cost report they received automatic what they HHS refers to advance payments despite the fact you've received the payment you are still obligated as the recipient upload your most recent IRS tax filings as well as your estimate of March and April lost revenue that needs to be completed according You current language on the HHS website within 30 days for verification purposes know that they refer to this as an advance payment, indicating that there may be adjustments made to that automatic distribution, based on this data submitted for verification. In addition, if you are a Round 1 recipient that did not receive an automatic ground to payment IE. You don't file a cost report, or your cost report data was insufficient for HHS.
6:13
to make that determination, you still have the opportunity to submit an application to receive Round 2 payments. You will not receive any more automatic payments, and you would have to submit applications. Keep in mind that if you did not receive a Round 1 payment, you are not eligible for Round 2 payments.
6:30

So if you have not seen anything in your bank account by April 24th, you have not met the qualification requirements to receive Brown won or around to funding you cannot submit an application and the system will not allow you to do so ,as you go there to do your application. Let's talk about that verification application process. This is completed online utilizing the Provider Relief Fund payment portal. As you go to the HHS Provider Relief Fund website, you'll appreciate there are two portals. There is a portal that is used for attestation.
7:08
And there is a portal that is used for this verification of Application process which is referred to as the payment portal. There are four pieces of information that you will need to submit as an applicant to receive Round 2 funds, or you received your automatic payment you're going to be supplemented by submitting this information as well. First of all, it's gross receipts or sales that the provider has received or program service revenue as submitted on the federal income tax return. You will find a very useful General Distribution portal FAQ on the
7:43
HHS Provider Relief Fund website. It directs you to specific line items on the tax return to identify the relevant data points to submit here. Secondly, you need to submit an estimated revenue loss for March and April due to COVID-19. The HHS advised that a provider may use any reasonable.
8:13
Method to estimate revenue during March and April compared to a same period had COVID-19 not appeared. And the two examples they provide here if either comparison of revenue to budget, or comparison to Prior Year's performance with any necessary adjustments. Third, you will need to submit a copy of the providers most recently filed tax return, and here making sure you have a complete picture of the provider entity.
8:43
May require a complete and accurate submissions at this point. And finally, number four. You're going to need to provide a list of TINs of any subsidiary organizations that received Round 1 Funds, but do not file a separate tax return again. This is that potential confusion between Round 1 and Round 2 Round 1's going out by individual TIN Round 2 instead.
9:08
It's looking for that parent organization and subsumed within that parent any entity that does not file its own separate tax return. So that is the property entity to either be submitting the verification for automatic funds or the application for additional Round 2 funds.
9:28
As Lori referenced, we've identified some critical gaps around General Distribution that require your attention and the first concerns
9:39
if you are receiving a payment that you believe is greater than expected is the May 6th FAQs the update to the to the provider District General Distribution FAQ's HHS tells us that if a provider or does not have or does not anticipate having COVID related lost revenues or increased expenses. They should return the funds. Key here is the word anticipated.
10:10
These relief funds are intended to address ongoing expenses and losses, thus make a forward looking projection on those expenses and anticipated losses and determine whether it's appropriate to retain the funds. If in fact you cannot anticipate any such expenses would then be appropriate to return the funds.
10:40

So, here's our first significant Gap if for example you receive 3 million, but your best math says the most you'll incur an additional expenses and lost revenue is 2 million going forward. What do you do with the other 1 million and we don't have an answer to that question yet. We'll need additional HHS guidance, but at this point the guidance is through the attestation process that if you don't expect any losses or any additional expenses it would then be appropriate to return the amount.
11:15
If another issue here is when we have moving TINs as organizations acquire new provider TINs or they have sold off certain TINs it may be that these payments have not kept up with those mergers and Acquisitions.
11:35
And so, if you're receiving funds for an entity that is no longer part of your parent organization, that would also be a trigger for a Repayment to be made through the portal.
11:50
The other question ,the other side of the coin, is what do you do if you believe that you have been underpaid, in this case you would repay the payment that you did receive but then submit through the portal your revenues as well as your anticipated losses to the portal to determine the correct payment. HHS has been very clear that it's mode of communication here is the portal that they have not offered other vehicles
12:20
to address these questions through HHS. Finally, the third Gap, is tying 2018 net patient revenue, which is intended to be the basis for the entirety of the distribution of the 50 billion with the 2019 Medicare payment that were the basis for the initial 30 billion dollars. And how does that an entity reflect it current 20/20 structure for purposes of these payments.
12:50
So here I'd like to turn it over to tan to talk about the experience nor side has facing as IT addresses this particular issue.
13:01
Hi Martie. Yes, you did a great job there. So, my perspective will really be from one of a provider's perspective. So, as we move through cares act funding we from a provider perspective are mixing multiple years and data sources for payment determination. As you said the Medicare fee-for-service payments with fiscal year 2019 was used in Round 1 funding for us. We received an automatic distribution.
13:29
so fiscal year 2018 Medicare cost reporting was the source of our Round 2 funding and then as part as part of what is occurring now is we're caught kind of calling that a rebalance process. So, we're being asked to use our most current tax return information, which we assume is to basically validate initial payments and in our case, for example, it would be the 990 form for 2017 which represents fiscal year.
13:59
2018 for Northside Hospital as you know, the healthcare industry is dynamic. So how does one treat ongoing changes like mergers and Acquisitions. For many of us between 2018 which is the cost report period that we received our second round of funding for and the use of fiscal year 2019 Medicare fee-for-service payments. The basis for rounds one initial distribution. And then also, how are we carrying four?
14:29
Our COVID patients today in 2020. We're using three different years of trying to look at structure and make determinations as to how to pay. So basically, from our perspective. We

looked at the use of the cost report and schedule G3 line 3, which state it indicate the hospital of net patient revenue, but our general knowledge.
14:49
It's not been used for reimbursement purposes in the past and it's not typically reviewed or generally audited by the MAC. This could result in a Disparity and what providers would pour here relative to physician and other provider revenues for our purposes at least at this time? And as we know things are changing as we see from the FAQ is more information is becoming available but using the current tax return should really serve as a validation of reasonableness for the funds that were distributed, and it should take into account the issues that we've identified as mergers Acquisitions Etc. It should not and probably cannot be used as an exact value.
15:29
Station it's very likely many Hospital providers may have acquired other providers. They the start of the fiscal year 2019 that would result in a Round 1 funding the Medicare fee-for-service payment portion of the program, but it would not be reflected in it either our fiscal year cost report for 18 or would also not be reported in our fiscal year 2018 990. So, as a result our current position, is this rebalance
15:59
Service a reasonableness test by HHS when looking at the amount of distribution funding received by providers? That said it would be very smart for providers to make sure that they document and maintain records of any issues identified in this review process. So, they surface at some point in the future. So again, as you said Martie, I'm sure there will be more to come in FAQs. Thank you.
16:27
Thanks, Dan turning now to the COVID Hotspot Hospitals the HHS by the April 25th. Deadline may have received if you're with us ability.
16:39
The notification that needed to reports the number of admission that the facility experienced in addition to the number of ICU beds by September, excuse me by April 25th that deadline five thousand five hundred and ninety eight hospitals had ported almost a hundred and eighty-five thousand COVID-19 admissions through the April 10th deadline that they were using for data aggregation. Through that reporting, and HHS at the time just said that they were seeking that information in order to determine an appropriate distribution formula, since then HHS has indicated that they are allocating that 12 billion dollars to 395 hospitals that have 100 or more admission through April 10th related to the COVID-19 diagnosis and that they were paying that at a rate of seventy six thousand nine hundred and seventy-five dollars per admission that 395 hospitals represent 71 percent of all reported COVID-19 Admissions and not surprisingly the top five States including New York, New Jersey, Illinois, Michigan and Massachusetts all states that were very well known to have a significant.
17:57
influx of COVID cases. There was a bit of a flurry of activity coming around that is 25th deadline. In fact, it got extended from like Thursday to Saturday is people were aggregating the information and then I know we had had some conversation about some of the challenges. That sounds very straightforward.
18:16
How many ICU beds do you have and how many COVID diagnosis do you did you incur but in reality there was some issues or debate and discuss and I think that a lot of Systems had related to reporting that information he share a little bit about that.

18:31
Sure, I think for Northside our biggest challenge, you know, certainly there were two key stats or part of that submission those two key stats included the number of COVID-19 admissions from January 1 through April 10th and Reporting the correct number of ICU beds the challenge with the first one was certainly the fact of ensuring that we were capturing and counting all of our COVID cases and the main issue at that point in time and things have certainly improved since then was the return of COVID of the COVID.
19:01
Testing results. So again, making sure that we were counting the correct number of COVID tests, you know, really dependent upon how quickly we were getting that turnaround for those tests. Like as I said that's improved significantly and we believed we were accurate in counting our COVID admissions. And as it relates to ICU beds, I think like all hospitals around the country. We were preparing for the surgeon COVID cases also like most hospitals we're recording information and data.
19:31
around things like ICU beds to multiple reporting sources, and these multiple reporting sources do have some variation in the reporting requirements.
19:41
So, as our Hospital chose to do we basically knew that we wanted to meet some of the surge capacity. So, we certainly focus on expanding Ric capacity in a variety of ways. We wanted to make sure that we were preparing for that search.
19:58
So, we did things like certainly upgrading our intermediate ICU beds to full-blown ICU beds with negative pressure rooms as well as converted some of our anticipated med-surg beds that we were no longer using We weren't doing a lot of surgeries at that time also converting to ICU. That's again very important that all of this information be documented for future use because there certainly was a lot of expense associated with in with doing that in preparing for this particular surge.
20:29
So we basically got there and said, okay all of the ICU beds that we currently have all of the intermediate ICU beds that we created another med-surg beds that we got upgraded to be I see you've had would be the number that we would submit It from that particular perspective. It's also important to note though, like many hospitals and large Healthcare Systems, we also had additional plans to move forward there and those plans really had to do with things like using recovery rooms and using ORs as additional ICUs. One other comment there Lori that you've made is you know, I kind of again when these funds came out I know ultimately became a twelve billion dollar program, but initially it was a ten billion dollar COVID.
21:13
admission program so to speak and then the two billion dollar ad on basically which I believe all of us Hospital share two billion dollars released on add-on payments for providers based upon dish and Total uncompensated Care my understanding at least at this point is I'm not aware of what that exact calculation was. Back to you Lori. Thanks Dan, you’re right. We're hoping for some additional information on that as we move forward and seek to tie down some of those numbers Martie. Will you share more about the rural providers?
21:50
Sure, so our third bucket of provider relief fund payments is for rural providers and HHS has noticed that these providers which were already operating on thin margins before the pandemic

have been particularly devastated as Result of delays in care and cancelled elective surgeries as well as the expense they've incurred in preparing their communities to respond to COVID-19. I've so rural providers share ten billion dollars. Most of this money has now it is now in process many facilities have received These funds others are still waiting to receive these funds. We don't have a specific timeline on when that will be completed.
22:33
So, this the third bucket really divides into four sub buckets depending on the provider type beginning with rural PPS hospitals, as well as critical access hospitals. They are receiving a graduated base Payment of approximately 2% of their operating expenses based on their most recently filed cost report. Second category are provider-based rural health clinics.
23:00
They are not receiving separate payment because their expenses are being included within the Hospital operating Expenses and so a critical access hospital that has two or three rural health clinics that are provider-based clinics May likely have received a provider relief on payment that seemed higher than the cause own operating expenses, but appreciate that in making these calculations HHS rolled up those provider-based RHC expenses into the overall payment amount received by that hospital.
23:38
Third category are the independent rural health clinics. Those clinics are receiving a hundred thousand dollars per Clinic site + 3 .6 the RHCs operating expenses again as reflected on its most current cost report.
23:57
Finally those federally qualified Health Centers located in rural areas are receiving a payment of $100,000 per rural clinic site and know This is an addition to other payments that rural FQHC have received beginning with dollars were allocated out of the first COVID legislation all the way to dollars that were just released on last Thursday relating to COVID-19. Testing back. That was the first allocation.
24:30
We saw out of the health care enhancement act 25 million dollars earmarked for COVID testing.
24:41
It was at half a billion dollars that went to the FQHCs last week, but for rural FQHCs, you're going to see even a sweetener with this additional $100,000 So, rural providers most likely will have received Round 1 payments Round 2 payments or have the opportunity to apply for around due payments, and then are receiving these additional funds. You are of course entitled to Pots of money the key here is going to be your ability to demonstrate that the funds are necessary either to cover increased costs associated with responding to COVID-19, or lost revenue as a result of the decline in electives and other procedures and activity in your organization. That will be critical because you have to spread that across all of the funds received.
25:37
Let's stop here with those first three buckets and talk about the attestation process because for each payment your organization receives, it will need to complete the online attestation form. Critical change here is the last Thursday HHS announced that it was extending the period for submitting the attestation from 30 days following receipt of payment to 45 days receipt of payments.
26:06
Last week we had the folks that received the initial Round 1 funding on April 10. We're looking at a deadline by Saturday to complete their attestation with the with keeps things CMS, but I

know it's HHS issue 8 those additional FAQs on May 6. They made the decision to extend the attestation period of 45 days.
26:35
So now You'll be pushed out to May 24th to submit that attestation. If you receive funds on April 10, we're also hoping that it's not only indicative of affording providers additional time to digest the May 6th epic you updates, but also hope that we have additional guidance coming here in the short-term.
26:58
I guess was mixed feelings when we didn't see that guidance drop over the weekend that we didn't have to update the slides, but at the same time would want to Why do with the most recent information on this and certainly as that data becomes that information does become available? We'll update our website to provide that information. When you go online through the attestation portal and remember to portals one for payment one for attestation. You'll be led through a process of providing certain information to verify the receipt of payment. So, Dan. I know North Side last week not appreciating the deadline. That was to be expected.
27:36
Attended that they're attestation. Can you give us some experiences from that Round 1 attestation process? Sure, Martie be happy to as you said, you know north side. We were very anxious to get our at septation done given the fact that the deadline was rapidly approaching. Basically. What we did is we created a what I'll call a data input sheet for attestation.
28:01
So, what's extremely key here is that that information was provided by HHS to the hospital when their electronic remittance of those funds to the hospital, please make sure you keep all of those because the information and data that you need to attest to must match that information exactly. So even if you think you have a different 10 number for some reason, and you try to put in a different 10 number with the information that was provided from HHS or originally that attestation will not process.
28:33
So basically, what we did is we created a sheet input sheet that basically had the TIN description or TIN name the tax ID number remember you need to include the last six digits of the bank account that was in that HHS transmittal. You also need to include the exact amount of the payment down to the sense. So, if it was X number of dollars and one cent you needed to make sure that you put that 1 cent in there and then last but not least. We were a little surprised.
29:06
The fact that we also had to provide service rendering address for those particular for a 10 and we may have a 10 that might have 30 different locations. We use the primary service addressed in identifying that particular 10, and then you also have to include the billing address as part of that submission.
29:26
Other than that, it just requires a signature of the we use the CMS officer of our organization, but it should be usually they're asking for or either the CMS officer or the CFO to do those SS stations, I believe that's it. We're anxiously looking to into the detail Martie of what's going to be required in the Round 2 at the stations. That be you and me both Dan, but we don't we do know that HHS has is posting all TINs that have completed the attestation. There's a data set available on the HHS website a hundred and forty-two thousand TINS have done.
30:05

So thus far. It was interesting that there were ten providers that attested to receiving $1 in Provider Relief Fund payments. Currently the amounts go much much higher than that but appreciate that as you do receive these funds these funds are going to be publicly reported as required under the cares act. So, there will be some financial information about your organization, which typically you would be keep we would treat as a trade secret that in fact is going to be made public because of the receipt of these funds to avoid that,
30:36
One option is to reject all of the funding that would take you out of that reporting requirement. And in fact, that's your option today. You either a test return or returned the funds if you take no action within 45 days CMS, one more time, if I had a quarter for every time I did that in this webinar, but HHS has made clear that if you do not attest within 45 days that will be considered deemed acceptance.
31:05
So, this is one we're doing nothing in fact, means something, because you will still be obligated under the terms and conditions and let's talk about those terms and conditions which are quite a read to say the very least. Oops. I got too anxious there and went one slide too fast back up. Okay, the terms and conditions. There are a different set of terms and conditions for Round 1, Round 2, the COVID hotspot funding, and the rural provider funding. They are effectively the same, but they are different documents and you will have to complete the attestation and the acceptance of the terms and condition for each of those payments that you receive the Round 1, Round 2, COVID hotspot, rural. You potentially could be filing four of these attestations. But the terms and conditions begin with a certification that the provider that the recipient provider does.
32:01
in fact, diagnose, treat, or care for individuals with possible or actual cases of COVID-19. That language created a great deal of consternation. HHS came back and said it doesn't have to be specific to COVID-19, and in fact, we view every patient as they possible COVID-19 patient. So, if you've treated a Medicare beneficiary in this time period you can make that Certification Number 2. And this is critical, that you certify that the funds will only be used to prevent, prepare for respond to the coronavirus,
32:36
or to reimburse the recipient for health care expenses or lost revenue that's attributed to the coronavirus. So, this is the beginning of that that obligation that the funds have restricted use, and you have to be prepared to demonstrate that you in fact utilize the funds consistent with those restricted uses. And finally, the recipient must agree that the funds will be used to reimburse your expenses or losses, will not use the funds, excuse me, to reimburse.
33:06
expenses or losses that are reimbursed from a different Source. This immediately runs into one of our other favorite programs under the cares act, the Payroll Protection Program. So, if you receive funding under PPP, and for example use those dollars to pay payroll, you could not intern claim that as a COVID related expense for purposes of demonstrating the use of funds appropriately under the Provider Relief Fund.
33:36
So, let’s make sure we are not double dipping. The exception here, we believe is the Medicare Advanced and accelerated payments. For those of you that got onto your MAC website and submitted your application and have since received the advance payment on your Medicare charges, that money is in fact an advance, that you would receive those payments subsequently and you're going to have to repay those amounts,

34:06
out of subsequent billing. Thus you have more leeway in the use of those funds for and the counting of the purposes since again, you're going to be on the hook for those payments. Yes.
34:18
There's been murmurings in Washington to potentially forgiving those amounts, but I certainly wouldn't be betting on that right now as things stand. But appreciate you do have more flexibility today, as those are an advance on payments that you will in fact have to return in the future the it's wouldn't fall into this categorie of reimbursed from other sources for purposes of calculating Provider Relief Fund, lost revenues, or COVID expenses.
34:48
Now the wrong way, there we go. The issue of recoupment, of course is always of concern, when you talk of receiving quotes around it “free money” from the federal government the FAQs the again the May 6 FAQ's, provide the most complete guidance we have today on this issue and here on the screen.
35:12
You see the direct quotes from the FAQs making it clear that you, as the recipient, will have the burden of proof to demonstrate you have the Lost revenues or increased expenses attributed to COVID-19 and must exclude those that are reimbursed or funded through other sources. So, you have to be able to demonstrate that those losses or those expenses exceed the amount you receive from all sources in the Provider Relief Fund.
35:42
If it just takes the position that they do not intend to recoup on so long as lost revenue plus increase expenses exceeds the amount that you received, that in that extent it is a grant to the provider. However, as you would expect HHS reserves the right to audit releif fund recipients to ensure that the requirements and the terms and conditions have been met and to collect any relief fund amounts that were either paid in error,
36:13
or were not used by the provider to cover lost revenue or increased expenses. And in addition, as we'll here soon highlight, there are other requirements within the terms and conditions and violation of those terms may be a basis for some amount of recoupment by the government. What they do not address here in the FAQs is the interest charge associated with recoupment.
36:40
And those of you that have had the unfortunate experience of having gone through some form of recoupment on Medicare payments, know that it comes with a very high interest rate associated with it. Here HHS has not made any statement with regard to the specific statutory authority under which it would pursue recoupment, and thus we can't exactly get point to an interest rate, but simply be aware that if you find yourself in a recruitment position with That they're most likely will be higher than market rate interest charges associated with that. So again, the theme you're hearing here is you better be well prepared to demonstrate that lost revenue or expenses associated with COVID.
37:29
Other terms and conditions to which you will sign up or be inferred to agree to if you don't attest within 45 days are the restriction on executive level two salaries IE. You cannot use the money to pay any individual an amount in excess of a 197,300 per year. You can pay up to that amount.
37:52
So, if you have an individual whose salary would be three hundred thousand dollars you can count as an expense up to 197,300 of that person's salary if you're only claiming half of that FTE you would not use a hundred fifty thousand instead. You would have to use the 98 thousand

ninety eight thousand five hundred and fifty not $98 and 655 sensed misplaced period there that should be a comma but be careful that you have processes in place when you are claiming employee salaries, especially these highly compensated employees that you are making those appropriate.
38:29
Adjustments you here? It's here on the screen other limitations on the expenditure of funds. These are all actually taken out of the Cares Act statute, that are actually applicable to federal agencies as they expend Cares Act dollars, the restrictions placed on them. HHS swept those up into the terms and conditions. That's why the document is 10 pages long is because it is referencing these. Some are certainly remote.
38:58
Can't imagine most Bills would have a reason to be procuring chimpanzees from the wild. But certainly you cannot claim any relief fund dollars for that purpose. They're also of course restrictions on dealings with corporations that have been excluded from participation in federal programs or have had any other conviction of federal criminal activity within the last 24 months.
39:21
So again, be careful, you've got those compliance processes in place to ensure that any of those types of payments would not be included. Then we have the issues around balance billing. Very clear that the administration wants to use the Provider Relief Fund as a vehicle to prevent balance billing for individuals who are seeking care for COVID-19 that they do not end up paying more than they would pay a provider who is in network for their insurance plan. Some creation of issues here, because of that this the original language here said possible cases of COVID-19 as we discussed above. CMS has issued separate guidance saying well, I anyone's a possible COVID-19 issue. So not surprisingly we read this initially to say this means you can't balance Bill anyone during the pandemic because anyone is a potential as a possible case of COVID-19, but HHS has since gone back in change the language in the terms conditions to refer to presumptive or actual case.
40:31
COVID-19 and there you see on the side the clarification of the FAQs indicating that no the balance billing restriction is truly limited to a patient who may potentially who is viewed as a potential COVID patient. Interesting question here is whether we can treat the balance between what you were paid as an out of debt as a pseudo in-network Provider by the payer and what you would have been able to balance bill in any other circumstance can we treat eat that as The COVID-19 expense or lost revenue that's I think is one of the issues we hope HHS will address in subsequent FAQs. It's also made clear by HHS the terms and conditions don't in any way restrict you from billing Insurance even if you are not in network provider for that insurance and in fact they're relying on that process as a way in which you can determine what the in Network payment would have been and that's allowing you to charge the patient any co-payment that they owe as an in-network provider. And finally keep in mind that the terms and conditions do not address the responsibility to diagnose or treat the uninsured. Lori here will talk a few minutes about the opportunity you have through provide the fourth bucket of the Provider Relief Fund to recover that money through special reimbursement.
41:56
Finally, the terms and conditions go into a great deal of detail on your reporting requirements. In short.
42:02

You're going to have to report what at HHS tells you you're going to have to report. But in addition if you are receiving more than a hundred and fifty thousand from any source, not just the provide a relief fund, but from the PPP, or the like you're going to find yourself subject to the requirement, the quarterly reporting requirements, to be established by the pandemic response and accountability committee or PRAC, as we now refer to it for they will have a special quarterly reporting system for those who have received cares act and other funding sources course PRAC is still in its infancy. We believe its membership is now set, but they have not yet issued any forms or guidance. So, we are to some degree, feeling in the dark as to what information we need to be collecting, and recording, and sorting for potential purposes of this reporting requirement.
42:54
There are also references in the terms of conditions that the specific provisions of the code of federal regulations with regard to reporting. These are the general Provisions that refer that apply when one receives Federal grant dollars, it is confusing here because these typically tie back to budgets and we don't have a budget per se to reference here. So again, we'll need some more HHS guidance around this particular issue. And at last, of course not least, is an agreement in the terms and conditions that you'll cooperate.
43:25
with any investigation or inquiry regarding the receipt of the funds of the spending of those funds may be issued by any federal agency.
43:36
Lori, I'm going to turn it over to you and let you bring it home. That sounds good. And I know we had indicated this would be a 45-minute webinar. We did get some additional information through those updated FAQ. So, if you are able to bear with us and stick with us for another five or ten minutes, we will wrap this up definitely within the 60 Minute time window apologies for the additional information, but hopefully you were finding it valuable.
44:00
So, turning for a moment to COVID testing and treatment for the uninsured HHS announced a portion of the Provider Relief Fund would be used for that purpose, to treat those patients, and that was in addition to the two billion dollars earmarked in the COVID legislation. The HRSA is taking the lead on these payments and they have in fact contracted with United Healthcare Group for adjudicating those claims and those payments will talk about that in just a moment providers could begin enrolling on April the 27th, claims could start being submitted last week on May the 6th, and provider should begin receiving direct deposit payments on May the 18th. Generally reimbursement will be based on the current year Medicare fee schedule rate for each of those Services qualifying test and services include the testing and treatment for primary COVID diagnosis including the specimen collection Diagnostic and antibody testing related visit, treatment including an FDA-approved vaccine when one becomes available services that are not covered by traditional Medicare will be exempt and that includes any treatment without a COVID-19 primary diagnosis Hospice Services or outpatient prescription drugs.
45:28
in order to submit claims, there are several steps that providers will go through if you already have an Optim ID, then you can use that as a starting point in the portal, but if not, there's an application where you can obtain one in order to receive to file claims and receive payments. You will enroll as a provider participant you're obligated to check patient eligibility and confirm that they are in fact uninsured.
46:01

You would submit patient information then submit claims and ultimately receive payment as and the other programs. There are some attestations that you would be agreeing to specifically that you have verified coverage on those patients that you would accept the program reimbursement of payment in full. So again, no balance billing for the patient and that you agree to post reimbursement audit review. As part of the process you would enter your tax ID number it takes one to two days
46:30
according to their website for that to be validated. Note that only one person can serve as the program administrator per tax ID. So, you need to identify who will be responsible for administration of this program. You would then set up an optim pay automated Clearinghouse transmission.
46:50
Again, if you are already enrolled with UnitedHealth Group, and that step can be expedited. You would add a provider roster and that may tie to a current chqh file if you that process. If you don't could take an additional five to seven days. So there is some lead time needed if you are not currently a United Healthcare provider. Then you would add in a test to the patient roster that can be done individually or through batch upload and it provides a temporary tax ID or temporary patient identifier for each patient. That's generally good for 30 days from the date of service. That process should take less than 24 hours for you to receive.
47:30
Save that patient temporary identifier and then once you've received that information and you are eligible to submit claims electronically then a via and 837 file. So there is a bit of a process that you would need to work through from a logistical perspective to determine which patients are completely uninsured, then some enrollment processes if you are not currently a UnitedHealth Group provider. Once those are all in place you can submit payment.
48:00
Receive the Medicare allowable for those know that the timely filing limits for the for regular CMS claims apply to these services. So it is not an open-ended discussion as far as following up in pursuing that option.
48:17
Shifting for just a moment on compliance and reporting considerations. Obviously, we've talked a good bit about the various terms and conditions that are being accepted and the tracking mechanism. It is important to establish a process to fully vet. All of the requirements The known, the implied, and the potential, because as we've noted information is coming out at a regular basis. So where we have gaps in questions now it is helpful to infer what you think. It might be and prepare for those.
48:47
Maybe and what if as you are evaluating those funding mechanism be sure to designate informed individuals within your organization to monitor them regularly for additional guidance rules and regulations. So for example, the May 6 FAQ update ,we did not see any outbound notification of that.
49:06
So make sure whoever's assigned is is regularly checking back into those program guidances to get any updates that they can find ,and then that that matriculate through this system to make sure that the teams that are working on those processes or any of the downstream effects are aware. It's important to also create a process to effectively and efficiently track those sources and uses of funds to ensure compliance with spending requirements and situations. Dan, can you tell

us just for briefly what you are seeing or Northside is considering as you were evaluating some of those segregations of expenses?
49:46
Sure, Lori, I'll do this quickly. We learned very quickly that it's very important to set up sub accounts were able to track various expenses. So we have a multitude of sub account set up to be able to track those say Supply expense, salary expense, Etc around individuals that have been assigned.
50:08
Let's say COVID responsibilities. And then also the other important thing, I believe that's important we capture to is capital expense again Capital expense that was planned versus Capital expense that was unplanned IE with COVID. So it's very important we make sure that we're capturing the capital expenses as well as the operating and salary expenses. And as I said, we're still going through an ongoing upgrade in that process to make sure that were capturing everything that needs to be captured because it's so important in all of these terms and conditions and reporting.
50:42
Thank you. Obviously a key piece there is to prepare in advance for an audit. We know that this could, this may take a year or two even to come back around where you have the opportunity or the request to provide additional information. So as you were going through these activities being prepared in creating essentially that book of evidence for each of the funds, each of the activities that were undertaken, the expenses were claimed, the lost revenue.
51:11
And then having to find usage rules for each of those additions. When you think about the portion related to the uninsured in particular, you may see that there are you know, you're going to have to put a new mechanism in in your operation to ensure and evaluate patients status in light of the various agreements and those terms and conditions of those funding mechanisms.
51:37
So for instance if the patient is out of network then and you accepted the Cares Act Relief Funds then you need to be able to identify that patient is out-of-network determine what their in-network obligation would have been and override perhaps a mechanism that's already set up to balance bill that patient. Conversely if the patient is self-pay and COVID and you accepted COVID testing and treatment for uninsured patients, then you also have to put in additional mechanisms to identify that they and confirm that they
52:11
are indeed self-pay. And so this may require some modifications to your default programming and your billing systems and it may be a little bit more than a back-end process.
52:21
It may be front-end related on diagnosis code and then some additional billing processes including payment posting balance billing and third-party collections activities obviously communication will be key throughout all of that and you will find that it will extend beyond the financial departments that may be on the front end evaluating the funds, the terms and conditions and the retention of payments and have to work its way through complete all the way through a billing system. For example to ensure that you are not accidentally running afoul of the obligations in areas that you have committed to you through this. Hopefully you have found today to be beneficial. I will turn it over to Laura to take us out.
53:04

Thank you and thanks to our presenters Lori Foley, Martie Ross, and Dan Huffman. If you have any questions, their presentation and contact information will be emailed to you along with a recording of today's webinar. Also, if PYA can provide assistance, please call or email us. You may also visit our website www.pyapc.com for more details about our specific areas of expertise or to subscribe to receive PYA Insights. On behalf of PYA, thank you for joining us and have a great rest of your day.