

Submitting HHS Claims for Uninsured COVID-19 Care

The U.S. Department of Health and Human Services' Health Resources and Services Administration will reimburse for COVID-19 testing and related treatment of uninsured patients, using the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program. The fund for the program includes at least \$2 billion; \$1 billion was allocated through the Families First Coronavirus Response Act, and another \$1 billion was allocated through the Paycheck Protection Program and Health Care Enhancement Act. An unspecified amount was also allocated through the CARES Act, which states a portion of the \$100 billion total allocation for healthcare cost relief will be used to cover uninsured claims. However, as shown in HBI's **Promoting COVID-19 Provider Relief Fund Compliance** ([click here](#)), most of that \$100 billion is already either spent or earmarked for specific uses, leaving roughly \$29.6 billion for providing relief (through as yet undefined methodologies) to skilled nursing facilities, dentists, and providers that exclusively bill Medicaid, in addition to covering care for uninsured patients.

Kaiser Family Foundation estimated in April 2020 that as many as 2 million uninsured patients could be hospitalized for COVID-19. KFF also calculated estimated payment for that care based on Medicare rates, yielding a range of \$13.9 billion to \$41.8 billion. Note that this was estimated reimbursement (and that Medicare rates are typically about half of what private payers reimburse) and did not reflect providers' estimated costs of providing that care. However, KFF's estimate incorrectly anticipated that the 20% DRG add-on payment would be applied to these claims (HRSA later announced it would not pay the add-on for facility IPPS claims) and is therefore higher than the rates HRSA ultimately will pay.

The difference between the current allocations and estimated need is clear. Claims will be reimbursed on a rolling basis and based on date of service. Providers should not delay submitting claims through this program; if no additional funds are set aside, the fund could be quickly exhausted.

The following Q&A summarizes additional key points of the claim submission and reimbursement process.

Q: What services are covered?

• Covered Services:

- COVID-19 diagnostic and antibody testing (including specimen collection and the related telehealth service or in-person visit if was conducted in an office, urgent care, or ED)
- COVID-19 treatment provided via telehealth or in-person; eligible in-person service settings include an office, ED, hospital (for any level of care, including observation), SNF, acute inpatient rehabilitation facility, the patient's home (including both home health and DME)
- Ambulance transport, both for emergent reasons and for non-emergent transfers
- COVID-19 vaccine, once available and approved by the FDA
- FDA-approved drugs for COVID-19 treatment, if provided during an inpatient stay

• Noncovered Services:

- Outpatient prescription drugs (with the exception of a vaccine)
- Hospice services
- Services generally not covered by Medicare

Outpatient claims must have a date of service and inpatient claims must have an admission date of February 4, 2020, or later. To be eligible, claims must include a COVID-19 diagnosis code as the primary diagnosis; the only exception is for pregnant patients, in which case a COVID-19 diagnosis code can be the secondary diagnosis. [Click here](#) for a list of covered codes from HRSA.

Q: What are the reimbursement rates?

Professional and facility claims will be reimbursed at current Medicare fee schedules, including applicable geographic adjustments for professional fees. If codes are added and CMS reimbursement rates have not yet been set, claims using those codes can be submitted but will be held until those rates are determined. As explained in the terms and conditions, providers cannot balance bill the uninsured individuals; however, HRSA reimbursement will include the amounts Medicare beneficiaries generally are required to pay out of pocket.

There are a few additional caveats specific to this program:

- HRSA will freeze fee schedule rates for non-IPPS hospitals as of February 4, 2020
- HRSA will not pay IPPS hospitals the 20% DRG add-on for inpatient COVID-19 care
- HRSA will limit facility fee payments for ambulance claims
- HRSA will set per-visit limits on home health reimbursement

[Click here](#) for more information from HRSA.

Q: How do we submit claims and receive reimbursement?

UnitedHealth Group is managing the claim submission and remittance process for HRSA. Claims must be submitted electronically, and all remittances will be electronic. They can be submitted beginning on May 6, 2020, and HRSA anticipates the first remittances will be made on May 18, 2020.

Providers must enroll ([click here](#) for more information from HRSA), which includes creating an Optum ID if they do not already have one, providing the Taxpayer Identification Number for the facilities where care was provided (which will take one to two days to verify), and a provider roster of clinicians conducting COVID-19 testing and treatment if they are not already contracted with UnitedHealthcare (which will take five to seven days to verify and requires a W-9 form, in addition to other information). If a provider is already contracted with UnitedHealthcare, many of these steps will be performed automatically with existing information; note, however, that completing this process does not mean a provider that does not have a contract with UnitedHealthcare becomes contracted for purposes outside HRSA reimbursement. Providers on the roster cannot be excluded from Medicare participation or on the List of Excluded Individuals/Entities from HHS. Additionally, only one Optum ID can be associated with a Taxpayer Identification Number, meaning one individual must submit all claims for that provider. Before a claim can be submitted, the patient must be added to a patient roster.

Providers must be set up to use UnitedHealth Group's Optum Pay automated clearinghouse; claims will be submitted through Optum Pay, and remittances will be direct deposited through it as well. If not already set up, this process will take about seven to 10 days to complete.

Providers must submit a patient roster listing the uninsured individuals who received COVID-19 testing and/or treatment. The following information must be provided for each individual on the patient roster:

- First and last name (middle initial is optional)
- Date of birth
- Gender
- Social Security number
- State of residence (full address is optional)

- Outpatient date of service or inpatient dates of admission and discharge
- An attestation from the healthcare provider that they ran insurance eligibility checks and confirmed the patient is uninsured

If the patient did not provide their Social Security number and state of residence, the roster can instead include their driver's license number or other state ID number. If that information also was not provided by the patient, the roster will need to include an attestation that the healthcare provider attempted to collect that information; because that information is necessary to confirm the patient does not have health insurance, a patient added without them will take longer to process. A patient account number also can be included but is not required.

After receiving the roster and confirming eligibility, UnitedHealth Group will assign each eligible uninsured patient a temporary member ID that will remain valid for the 30-day period following the outpatient date of service or the inpatient date of discharge. That temporary member ID will then be used on the HRSA claim. The payer name for HRSA claims is COVID19 HRSA Uninsured Testing and Treatment Fund, and the payer ID is 95964. This new payer ID must be used on all HRSA claims, even if the provider was already contracted with UnitedHealth Group. If a claim is approved, direct deposit remittance should be expected in seven to 10 business days.

Q: What if we have to correct a claim or want to appeal a denial?

That will not be possible. HRSA requires all claims to be complete at the time of submission, and all reimbursement is final. There is no process to submit a corrected claim, bill late charges, or appeal a denial or underpayment.

However, if the clearinghouse rejects the claim, it can be repaired and resubmitted. [Click here](#) for more information from HRSA.

Q: What if we already billed the patient?

Providers who have billed uninsured patients for COVID-19 testing and/or treatment can still submit an HRSA claim. They must inform the patient they do not owe any money, regardless of any statements they were sent, and any amounts the patient paid for that testing and/or treatment must be refunded.

Q: What are the terms and conditions?

[Click here](#) for the full terms and conditions for testing claim reimbursement from HRSA. [Click here](#) for the full terms and conditions for treatment claim reimbursement.

The main points are:

- Testing and/or treatment must have been medically necessary
- No other payer or source of funding was obligated to cover those claims
- Providers must accept reimbursement as payment in full and cannot balance bill the uninsured patient
- Additional documentation and other requirements outlined for other Provider Relief Fund grants also apply and are described in HBI's **Promoting COVID-19 Provider Relief Fund Compliance** ([click here](#))

COVID-19 is an ongoing situation and organizations' processes are changing daily to adapt to various needs during this crisis. As such, this information is up-to-date as of May 5, 2020. HBI is continually monitoring the situation and updating material as we gather additional information. While HBI has attempted to ensure the accuracy of research provided in this document, the information has been obtained from numerous resources. Therefore, HBI cannot guarantee its accuracy and is not liable for any claims or losses that arise from errors or omissions within this document.