hfma
healthcare financial management association

June 30, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1744-IFC/CMS-5531-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

File Codes: CMS-1744-IFC/CMS-5531-IFC

Re:

- Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency
- Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

Dear Administrator Verma:

On behalf of the Healthcare Financial Management Association's (HFMA's) 58,000 members, I would like to thank you for CMS's leadership during the COVID-19 Public Health Emergency (PHE). We greatly appreciate the work CMS's staff has undertaken to use its waiver authority to expand access to care via telehealth, allow for hospitals to expand capacity, reduce unnecessary administrative burden, and support providers who are participating in alternative payment models (APMs). The speed and responsiveness with which the agency has moved to address provider concerns is both unprecedented and impressive, as evidenced by both recent interim final rules.

HFMA members believe there are additional steps that CMS must take to ensure access to care, further reduce administrative burden and support health systems and providers as they respond to the pandemic. We ask that CMS use its waiver authority to address the following issues:

- *Ensure Medicare COVID-19 Patients with Sepsis MS-DRGS Receive Payment Increase*: Accurately calculate payment for Sepsis discharges when the patient has COVID-19 to include the 20% Congressionally mandated payment increase.
- *Suspend Transfer Payment Policies for COVID-19 Discharges*: Suspend CMS's acute and post-acute transfer policies in recognition of the high cost of COVID-19 discharges.
- *Support Provision of Uncompensated Care to Eligible Patients*: Clarify its rules around Allowable Medicare Bad Debt and Uncompensated Care audits to ensure that hospitals are not penalized for supporting their communities during the pandemic.
- *Waive Rural Health Clinic (RHC) Productivity Standard*: Waive the RHC productivity standard during the PHE.

- *Provide Certainty for Telehealth Investments*: Use CMS's existing regulatory authority, where possible, to make changes related to providing expanded telehealth services permanent.
- *Relocating a Provider-Based Department (PBD) to a Patient's Home*: Clarify its requirements for registering patients' homes as excepted or non-excepted PBDs under the extraordinary circumstances policy for payment purposes.
- *Extend the Timeframe to File a First Level Appeal*: During the PHE, extend the timeframe to request an appeal of a Medicare Administrative Contractor's initial determination to 180 days.

Below please find HFMA members' specific comments on these issues.

Ensure Medicare COVID-19 Patients with Sepsis MS-DRGS Receive Payment Increase: HFMA's members report that payments for COVID-19 positive patients whose inpatient stay results in a sepsis MS-DRG (871 or 872) do not include the Congressionally mandated 20% increase in the Medicare operating payment included in the CARES Act. Additionally, neither MS-DRG is included in tables illustrating the increase in IPPS operating payments included on pages 18 – 21 of the May 27th update of CMS's COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing[1].

HFMA's members ask that CMS instruct the MACs to accurately calculate IPPS operating payments for Sepsis discharges when the patient has COVID-19 to include the 20% Congressionally mandated payment increase. Further, for all qualifying COVID-19 discharges that have not included the 20% payment increase and therefore been inaccurately paid, HFMA's members ask that CMS instruct the MACs to proactively reprocess those claims and make the legally required additional payment without the hospital having to file an appeal or request additional reimbursement. This will avoid an unnecessary administrative expense.

Suspend Acute and Post-Acute Transfer Payment Policies for COVID-19 Discharges:
Medicare reduces payment in some cases when a patient has a short length of stay (LOS) and is transferred to another acute care hospital, or in certain circumstances, to a post-acute care setting. In response to the COVID-19 pandemic, HFMA members in areas that have experienced surges in COVID-19 admissions report frequently needing to transfer COVID-19 cases to other hospitals to balance the case load and ensure adequate inpatient capacity of medical-surgical and ICU beds.

HFMA members report that the costs per case for COVID-19 admissions are considerably higher than non-COVID-19 discharges that result in the same MS-DRGs. While the CARES Act increased the weighting factor that would otherwise apply to the MS-DRG for COVID-19 cases by 20 %, analysis suggests this payment increase is insufficient,[2] as average hospital losses are projected to be $2,800 per case on an all-payer basis. Furthermore, we understand from hospitals in COVID-19 surge areas that they have needed to transfer patients to other hospitals or discharge them to appropriate post-acute settings to rebalance patient loads and create capacity. Therefore, HFMA members ask CMS to use its section 1135 waiver authority to suspend the CMS acute and post-acute transfer payment policies during the PHE to reduce the loss hospitals are experiencing when providing medically necessary care to Medicare beneficiaries suffering from COVID-19.

[1] https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[2] Strata Decision Technology. "Report: Hospitals face massive losses on COVID-19 cases even with proposed increase in federal reimbursement."

Support Provision of Uncompensated Care to Eligible Patients:
HFMA members are taking a variety of revenue cycle actions to support their patients and communities during the COVID-19 pandemic as it relates to patient responsibilities for uninsured individuals and patients who have balances after insurance payment (e.g., deductibles and coinsurance).

Medicare Bad Debt: There has been considerable ambiguity related to billing and coverage associated with COVD-19 testing and treatment for COVID-19 for Medicare, the commercially insured and uninsured patients. In response to this ambiguity, many HFMA members have elected to temporarily[3,4] hold bills and pause patient collections efforts for their portion of the balance until Medicare, commercial insurers (including Medicare Advantage plans) and the Department of Health and Human services clarify their policies around billing and coverage for their respective members or the uninsured. Additionally, HFMA is aware of at least one large health system that suspended billing and collections efforts for at least 30 days in response to the significant increase in the unemployment rate as a result of shelter-in place-restrictions to limit the spread of COVID-19.

The Provider Reimbursement Manual's (PRM's) provisions related to allowable Medicare Bad Debt[5] have a long history of inconsistent interpretation and uneven application across and within Medicare Administrative Contractors (MACs). HFMA members, who have proactively taken steps to minimize patient confusion, reduce administrative burden, and comply with recently enacted requirements to waive cost sharing for services related to COVID-19 and prohibitions on balance billing COVID-19 patients, are concerned that some MACs may misinterpret the PRM and disallow allowable Medicare bad debt based on actions that were intended to be responsive to the economic conditions in their markets, reduce administrative burden and comply with recently enacted laws.

HFMA members believe that section 310 is most likely to be misinterpreted. It states:

> *REASONABLE COLLECTION EFFORT*
> *To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)*

CMS's recently proposed 2021 Inpatient Prospective Payment System (IPPS) rule acknowledges the interpretation issues that have long proved problematic for MACs and providers and attempts to clarify their intent in the PRM. While HFMA is still reviewing the proposed rule with its members, we generally believe CMS's clarifications are helpful.

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[3] WGN Web Desk, March 12, 2020. "Advocate Aurora Health says it will temporarily halt patient billing related to COVID-19,"
[4] LaPointe, J. "CommonSpirit Health, others, suspend patient billing for COVID-19." *RevCycle Intelligence*, March 20, 2020.
[5] CMS, Provider Reimbursement Manual—Part 1.

Specific to COVID-19 and Section 310 of the PRM, HFMA asks that CMS issue the MACs clear guidance stating hospitals that suspended collection efforts for a specific population of patients (e.g., COVID-19 patients) or its entire patient population for a period of time are not automatically out of compliance with the reasonable collection effort requirements.

First, we note that if a hospital ceases collections efforts for a period of time, for its COVID-19 patients or all patients, its collection efforts for both Medicare and non-Medicare patients are similar and consistently treated and therefore meets the reasonable collection effort criteria.

Second HFMA members ask that CMS (as it proposes in the 2021 IPPS Rule) instruct MACs to allow providers to issue an initial bill on or before 120 days after: (1) the date of the Medicare remittance advice; or (2) the date of the remittance advice from the beneficiary's secondary payer, if any, whichever is latest, and remain in compliance with the reasonable collections efforts criteria.

Third, we ask CMS to instruct MACs to allow hospitals to cease "other actions" as defined in PRM 310 during the timeframe the hospital has elected to pause collections activities during the PHE and remain in compliance with the reasonable collection effort criteria.

Finally, we ask that CMS provide MACs clear instruction on how to account for the pause in collections activity as it relates to the Presumption of Noncollectibility requirements at PRM 310.2. This provision states, "If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

Unless the patient is deemed indigent or medically indigent based on the requirements of PRM 312, HFMA recommends CMS instruct MACs that if the cumulative period for which collections activity occurred on a patients account is more than 120 days, the presumption of noncollectibility at PRM 310.2 has been satisfied. Below in Exhibit 1 are several examples of how this would apply to specific situations.

Exhibit 1: Example Collection Efforts Scenarios

	Collection Pause		Patient	Statement Dates								
Patient	Start Date	End Date	Discharge Date	1st Bill	2nd Bill	3rd Bill	4th Bill	5th Bill	Write Off Date	Days from First Stmt to Write Off	Collection Pause Period	Total Collections Activity Days	Meets Presumed Non-Collectible Criteria
A	3/27/2020	4/27/2020	2/2/2020	2/20/2020	3/21/2020	4/28/2020	5/28/2020	6/27/2020	7/27/2020	158	31	127	Yes
B	3/27/2020	4/27/2020	4/4/2020	5/24/2020	6/23/2020	7/23/2020	7/26/2020	8/25/2020	9/24/2020	173	N/A	123	Yes
C	3/27/2020	4/27/2020	1/2/2020	2/1/2020	3/2/2020	4/28/2020	5/28/2020		6/27/2020	147	31	116	No

Determination of Uncompensated Care for Calculation of Uncompensated Care Disproportionate Share Hospital (DSH)[6,7,8,9]: Currently, there are no published audit instructions for Medicare contractors to follow when reviewing non-Medicare charity care and non-Medicare bad debt. In this vacuum, our members who have undergone audits of their worksheet S-10 for "meaningful use" or "Uncompensated Care DSH" report that MACs have disallowed charity care, citing

[6] HFMA, "HFMA Comments on 2020 IPPS Proposed Rule."
[7] HFMA, "HFMA comments on FY2018 IPPS proposed rule."
[8] HFMA, "HFMA comments on FY18 IPPS proposed rule."
[9] HFMA, "HFMA comments on CMS's FY17 IPPS proposed rule."

justifications ranging from arbitrary federal poverty limits to inappropriately citing section 312 of the PRM, which pertains to determining indigence for purposes of identifying Medicare bad debt. Further, one of the common issues experienced by hospitals during "meaningful use" audits is the disallowance of charity care granted using a presumptive eligibility tool.

In communications with HFMA, CMS has stated that its position on charity care is as follows:

> *Hospitals provide varying levels of charity care, which must be budgeted for and financed by the hospital depending on the hospital's mission, financial condition, geographic location and other factors. In advance of billing, hospitals typically use a process to identify who can and cannot afford to pay in order to anticipate whether the patient's care needs to be funded through an alternative source, such as a charity care fund.*
>
> *Depending on a variety of factors, including whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt; however, a provider MAY NOT write off an account as charity care and also claim it as a Medicare bad debt. If the provider writes the account off as bad debt, Medicare has guidelines that they must follow including section 312 "Indigent or Medically Indigent Patients." If the provider writes the account off as charity care they must follow their charity care policy. Medicare does not dictate or have requirements for the hospital's charity care policies because charity care is not reimbursable by Medicare.*

CMS has further clarified that it interprets the above to mean that if a presumptive methodology is part of a hospital's charity care policy, it may be used in identifying amounts reported on S-10. CMS indicates that it has provided this guidance to its contractors and is in the process of updating the PRM to reflect this position.

In light of the increased need for charity care due to the spike in unemployment resulting from the COVID-19 pandemic, HFMA strongly supports CMS's position on identifying charity care for reporting on the S-10. We encourage CMS to expedite its updating of the PRM to clarify this position. Further, we suggest that, until the PRM is updated, CMS should provide continuous education to its contractors, as it appears that some MACs may not be aware of its position. We would encourage CMS to make those education materials available to providers so there is a clear and consistent understanding of the definitions and criteria related to non-Medicare charity care and non-Medicare bad debt.

Finally, given some MACs' continued mistreatment of charity care on the S-10, HFMA believes that CMS must allow hospitals a mechanism to appeal adjustments to the S-10. Currently, hospitals are only allowed to appeal adjustments that have a material settlement impact on the cost report. While the data used to calculate the uncompensated care payment will have a significant reimbursement impact on hospitals in the future, it does not "settle" on the cost report that it is reported on.

RHC Productivity Standard:
Section 80.4 of Chapter 13 (RHC and Federally Qualified Health Center (FQHC) Services) of the Medicare Benefit Policy Manual applies a minimum productivity standard of 4,200 visits per full-time equivalent (FTE) physician and 2,100 visits per FTE nonphysician practitioner to the calculation of a RHC's All-Inclusive Rate (AIR). The manual states:

> *At the end of the cost reporting year, the A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the AIR.*

HFMA members who work in RHCs or have provider-based RHCs associated with their hospital report a significant drop-off in visits to RHCs as a result of COVID-19. Many clinics have transitioned some or all of their encounters to telehealth visits. Those RHCs that are maintaining in-clinic visits report volumes that are lower than prior years even after factoring in telehealth visits. This aligns with the general trend that has been reported across the country of patients avoiding hospitals and physicians' offices due to concern of contracting COVID-19 in a healthcare setting.[10]

Furthermore, based on current statute (42 CFR § 405.2463) and CMS instruction (MLN Matters Number: SE20016,[11] Revised April 30) telehealth visits cannot be included in the visit count on the Medicare Cost Report for RHCs. Given the significant decrease in in-person visits and the prohibition on including telehealth encounters in the visit count for RHCs on the Medicare Cost Report, HFMA members are concerned that applying the productivity standard during the period of the PHE will artificially lower an RHC's AIR, resulting in significant financial harm to these providers. This will limit access to care in areas served by some RHCs.

HFMA notes Section 80.4 of Chapter 13 of the Medicare Benefit Policy Manual states

> *The A/B MAC has the discretion to make an exception to the productivity standards based on individual circumstances. All visits (Medicare, Medicaid, Managed Care, etc.) are included in determining the productivity standards for the cost report.*

While MACs already have this discretion if RHCs request it, this requires RHCs to submit a request, which is administratively burdensome. It requires RHC staff to divert limited resources to requesting an exemption. This is time that could be better spent supporting patient care.

HFMA members ask CMS to instruct the MACs to waive the minimum productivity standard during the PHE and for a period of three months after that. We believe a tail period is necessary, as HFMA members are concerned that patients may initially be reluctant to re-engage with healthcare providers in-person for a period of time after the pandemic is over due to concerns about contracting COVID-19 in healthcare settings.

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[10] *Modern Healthcare*, "Cigna claims data shows declines in hospitalizations for serious conditions."
[11] *MLN Matters*, "New and expanded flexibilities for rural health clinics (RHCs) and federally qualified health centers (FQHCs) during the COVID-19 public health emergency (PHE)," April 30, 2020.

As an example, if the PHE lasts 6 months, the total period of time the productivity standard would be waived is 9 months. In this instance, the physician productivity standard for a provider with a 12/31 fiscal year-end would be 1,050 visits ((1-(9/12))*4,200).

Provide Certainty for Telehealth Investments:
In the Interim Final Rules released on March 30, 2020 and April 30, 2020 CMS used its waiver authority under the public health emergency to expand Medicare beneficiaries' access to telehealth services. These changes include, but are not limited to expanding reimbursable services that can be provided via telehealth, providing flexibility in supervision requirements to take advantage of telehealth, and expanding sites of service where telehealth can be used to treat Medicare beneficiaries.

HFMA's members greatly appreciate CMS's use of waivers to expand payment for telehealth services provided to Medicare beneficiaries. This expansion has allowed providers to safely deliver necessary care to Medicare beneficiaries while observing social distancing and preserving PPE. The experience has proven that telehealth is a convenient modality to deliver high quality care and support population health as Administrator Verma recently acknowledged[12]. **Given the significant investments physician practices and hospitals have made to rapidly expand these capabilities, HFMA's members ask CMS to use its existing regulatory authority, where possible, to make these changes permanent.** Failing to do so will waste an important opportunity to drive innovation in the way healthcare is delivered and reduce the total cost of care while improving patient access and convenience.

Patient's Home as a Provider-Based Setting:
HFMA members strongly support CMS's use of its authority, due to the extraordinary circumstances posed by the COVID-19 pandemic, to temporarily waive provider-based rules, and some conditions of participation, to allow temporary expansion locations to become provider-based to the hospital. This policy allows hospitals to bill for medically necessary hospital outpatient therapeutic services furnished at those locations, assuming all other applicable requirements are met (including, to the extent not waived, the hospital conditions of participation). We believe this action is necessary to ensure that patients have access to medically necessary care delivered in a manner that allows them to avoid potential exposure to COVID-19. HFMA's members note that when care is delivered in a patient's home, the hospital still incurs the overhead expense related to the electronic medical record, clinical and administrative support staffing, revenue cycle staff and technologies, and facilities expense that is not being used during the pandemic. We note that when care is delivered via telehealth, it is likely the clinician is initiating the service from his/her office in the provider-based clinic. Therefore, HFMA's members believe it is appropriate that CMS cover the overhead expenses associated with delivering medically necessary care to Medicare beneficiaries.

One of the sites of service that hospitals may relocate a PBD to is patients' homes. In order to do this, CMS states in the Interim Final Rule Released on April 30, 2020 that:

> "…all hospitals that relocate excepted on- or off-campus PBDs to off-campus locations in response to the COVID-19 PHE should notify their CMS Regional Office by email of their hospital's CCN; the address of the current PBD; the address(es) of the relocated PBD(s); the date which they began furnishing services at the new PBD(s); a brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19; and an attestation that the

[12] https://www.statnews.com/2020/06/09/seema-verma-telehealth-access-covid19/

relocation is not inconsistent with their state's emergency preparedness or pandemic plan. We expect hospitals to include in their justification for the relocation why the new PBD location (including instances where the relocation is to the patient's home) is appropriate for furnishing covered outpatient items and services.

To the extent that a hospital may relocate to an off-campus PBD that otherwise is the patient's home, only one relocation request during the COVID-19 PHE is necessary. In other words, the hospital would not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient's home; a single submission per location is sufficient. Hospitals must send this email to their CMS Regional Office within 120 days of beginning to furnish and bill for services at the relocated on- or off-campus PBD."

HFMA members interpret this to mean that for each PBD whose physicians deliver care to patients in their homes, when the patients are registered in that PBD, the hospital would only need to file one relocation request with the regional office for the PBD (I.e., not for the individual patients).

As an example of this interpretation applied, a physician who practices at "on-campus clinic 1" provides care to Jane Doe, John Smith and Suzie Queue in their respective homes when they are registered as patients on the date of service in question of "on-campus clinic 1." Based on HFMA's interpretation of the interim final rule with comment period (IFC), the hospital would only need to file one relocation request for "on-campus clinic 1" to provide care in patients' homes. It *would not* need to file a unique location request for Jane Doe's, John Smith's and Suzie Queue's respective homes. Is this correct?

HFMA members strongly encourage CMS to require hospitals to file only one relocation request per PBD when a hospital elects to deliver care to patients who are registered to that clinic in the patients' home. We are deeply concerned that if hospitals must file a unique request for each patient, even if that request is good for subsequent visits during the duration of the PHE, it will be administratively burdensome and limit patient access to care in alterative settings during the COVID-19 pandemic.

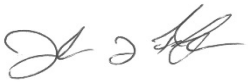
If, however, CMS intends for a PBD to file multiple relocation requests when it provides care to patients registered in the PBD on the given date of service, HFMA members ask that CMS clarify whether or not PBDs will need to register each unique address where care is provided or each unique patient. For example, Jane Doe and Jon Doe share a home address – 123 Main Street, Pleasant Town, VT. They are both registered as patients of "on-campus clinic 1" on the date of service when they receive care in their home. Would "on-campus clinic 1" need to submit a relocation request for the Doe's address– 123 Main Street, Pleasant Town, VT – or would it need to submit unique relocation requests for both Jane and Jon Doe?

Extend the Timeframe to File a First Level Appeal:
During the PHE, many providers have furloughed administrative staff and some clinical staff to reduce expenses in the face of declining volumes and revenues as a result of CMS's instructions to limit non-emergent procedures[13]. This has reduced providers' ability to file a first level appeal of a Medicare Administrative Contractors' initial claim determination within the allotted 120 days. In light of this, HFMA's members ask that CMS extend the timeframe to request a redetermination of a Medicare Administrative Contractor's initial determination to 180 days.

[13] https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf

HFMA looks forward to any opportunity to provide additional assistance or comments to CMS to further their efforts to help providers respond to the COVID-19 pandemic. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal agencies and advisory groups. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely.



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 56,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.