

August 5, 2020

Liz Richter
Deputy Center Director
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Department of Health and Human Services
Baltimore, MD 21244-1850

Re: Acute Hospital Medicare Cost Report Issues Created by COVID-19

Dear Deputy Center Director Richter:

On behalf of the Healthcare Financial Management Association's (HFMA's) 56,000 members, I would like to thank you for your team'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.

While the initial waivers have given providers the necessary regulatory flexibility to respond quickly to the COVID-19 pandemic, HFMA members are concerned the pandemic and associated relief efforts have created a number of technical Medicare cost report issues that need to be addressed. Otherwise hospitals may owe (or be due) a significant payable due to circumstances beyond their control and have future rates set too high (or low). Both situations will further jeopardize the financial sustainability of many hospitals that have seen their income statements and balance sheets weakened by the pandemic at a time when they are most needed by the communities they serve. Specifically, these issues include:

- Intern and resident counts for Indirect Medical Education (IME) /Direct Graduate Medical Education (DGME) payment calculation
- Medicare ratio for DGME payment calculation
- Uncompensated care claimed on worksheet S-10
- Medicaid and Supplemental Security Income (SSI) volumes for DSH-eligible hospitals
- Ratio of costs to charges
- Worksheet A-8 treatment of COVID-19 expenses
- Worksheet A-8 treatment of Payment Protection Program (PPP) loan forgiveness
- Medicare Accelerated Payment Program cost report treatment – Worksheet A-8
- Rural health clinic (RHC) productivity standards
- Medicare transplant volumes and survival rates – conditions of participation
- Worksheet G-3: Reporting Revenues Associated with CARES Act Grants and Loan Forgiveness

Below, please find specific comments on the items above. HFMA has worked closely with members of its [Principles and Practices Board](#) and Governmental Reimbursement Executive Council in drafting these recommendations, given their deep technical expertise in cost reporting issues.

Intern and Resident Counts for IME/DME Payment Calculation

CMS, in the April 30, 2020, “Interim Final Rule 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,” clarifies that it will not count beds added during the PHE in the calculation of IME payments. HFMA members thank CMS for using its waiver authority to ensure that teaching hospitals are not penalized for ensuring their communities have adequate inpatient capacity to meet demand driven by the pandemic and save lives.

HFMA has heard concerns from its members that some residents’ rotation schedules have been disrupted by the pandemic. This will reduce their resident count for the period impacted by the PHE. As a result, this will decrease the teaching hospital’s three-year rolling average that determines Medicare IME and DGME payments for the three-year period in which data from fiscal years impacted by the PHE is used. HFMA members believe that if a teaching hospital’s resident count from a **cost report whose timeframe overlaps the PHE is lower than in the last full cost reporting period prior to the PHE, CMS should allow the hospital to substitute the resident count from a prior cost report period that does not include the PHE.** The three-year rolling average used to determine IME and DGME payments should be calculated using the highest resident count from among the three cost reports filed prior to the pandemic.

Medicare and Medicare Advantage Day Counts for DGME Payment Calculation

Hospitals across the country are reporting significant changes in volume because of the pandemic. As you are aware, CMS asked hospitals to cancel nonemergent procedures to reduce the risk of community spread of COVID-19 and preserve scarce supplies of personal protective equipment.¹ Hospitals have overwhelmingly and unhesitatingly complied even as many hospitals in areas of the country that have not yet experienced a surge in COVID-19 cases sit mostly idle. As a result, approximately 50% of hospital revenue is nonemergent and has been postponed or deferred. In addition, our members report seeing a significant decrease in emergency department (ED) visits attributable to Americans sheltering in their homes. As a result, hospital revenues have decreased dramatically. Total revenues are down 40%-60%, with ED visits down 25%-30%, inpatient surgical volumes down 30%-50%, outpatient surgical volumes and procedures down 50%+, and ambulatory surgery center procedures down 70%+.²

Medicare uses the ratio of Medicare and Medicare Advantage (MA) inpatient days to total inpatient days (hereafter the Medicare day ratio) to calculate a teaching hospital’s DGME payment. HFMA members are concerned that due to changes in volume resulting from the pandemic, a hospital’s Medicare day ratio may decrease, reducing the payments that support critical programs training the physicians who will help our country respond to the next pandemic or public health crisis. HFMA members believe that if a teaching hospital’s Medicare day ratio from a **cost report whose timeframe overlaps the PHE is lower than in the last full cost reporting period prior to the PHE, CMS should allow the hospital to substitute the Medicare day ratio from a prior cost report period that does not include**

¹ [CMS Guidance on Elective Procedures](#)

² J.P. Morgan, “[The stimulus bill isn’t enough: Hospital revenues are declining much faster than anticipated](#),” March 26, 2020.

the PHE. The Medicare day ratio used to determine payments should be calculated using the highest ratio from among the three cost reports filed prior to the pandemic.

Uncompensated Care Claimed on Worksheet S-10:

HFMA members are concerned that uncompensated care claimed on Worksheet S-10 during the pandemic may not be representative of a hospital's actual burden of uncompensated care under normal circumstances. Additionally, HFMA members ask CMS to clarify how it will treat unpaid amounts for uninsured patients who receive testing or treatment services that are covered by the Health Resources & Service Administration (HRSA) COVID-19 Claims Reimbursement for testing and treatment of the uninsured.

Uncompensated Care During the Pandemic

HFMA members are concerned that the significant changes in volumes at many hospitals as a result of the pandemic could skew future allocations of uncompensated care as the data for the time period covered by the PHE is not representative of levels of uncompensated care typically provided. HFMA members believe CMS needs to provide a mechanism to prevent significantly decreasing a hospital's uncompensated care DSH payments as a result of anomalous data. **For hospitals whose total uncompensated care (as defined in the calculation of Factor 3 for uncompensated care DSH) is 20% lower than the prior year, HFMA recommends that CMS substitute the cost of uncompensated care from a historical period for the cost of uncompensated care for the current period that has been impacted by the PHE.**

To do this, CMS should calculate the average daily cost of uncompensated care for the current period cost report. This would then be multiplied by the number of days included in the cost report period that are covered by the PHE and subtracted from the uncompensated care expense claimed on the current period cost report to calculate the "non-PHE current period uncompensated care expense." CMS would calculate the inflation-adjusted³ average daily cost of uncompensated care from the two most recently audited Medicare cost reports and multiply this amount by the number of days during the cost reporting period impacted by the PHE to determine the "current period PHE compensated care proxy." This amount would be added to the "non-PHE current period uncompensated care expense" to determine the adjusted uncompensated care expense for current period cost report.

Additionally, HFMA members do not support the use of one year's worth of audited data as is currently proposed in the 2021 Inpatient Prospective Payment System (IPPS) rule. Given the inadequacies of the audit process ([discussed in our letter in response to the 2021 proposed rule](#)) and the potential for random swings in uncompensated care volumes from year to year (particularly as a result of COVID-19), HFMA members strongly recommend that CMS use multiple years of audited S-10 data to calculate Factor 3. While we believe that three years is optimal, we ask that for FY21, CMS use FY15 and FY17, given that both years have been subject to some degree of Medicare Administrative Contractor (MAC) audit. For FY22, we ask that CMS use FY15, FY17 and FY18. As stated in our 2021 IPPS proposed rule comment letter, we strongly believe CMS should ensure that 100% of hospital uncompensated care data is audited moving forward to ensure a level playing field and accurate allocation.

³ CMS could use the average estimated increase in Medicare hospital expenditures from the two prior periods to adjust these amounts for inflation.

Treatment and Testing for Uninsured COVID-19: HFMA members appreciate the administration using a portion of the CARES Act Provider Relief Fund (PRF) to provide payment for treatment, testing and related services delivered to uninsured individuals stricken with COVID-19. Furthermore, we would like to thank HHS for clarifying that these funds are to act as a payer of last resort⁴ for care provided to qualifying patients. Unfortunately, HHS has not specified the funding level for the program. HFMA members ask CMS to clarify that if the program runs out of money, any claims that are submitted to the fund but are unpaid due to insufficient funding may be claimed as charity care on worksheet S-10 if the patient otherwise meets the hospital's criteria for charity care. If the patient does not qualify for full charity care and the provider elects to bill the patient, we also ask that CMS allow hospitals to claim any uncollected amounts that have been deemed bad debt as a result of the account resolution actions allowed by the hospital's collections policy to be claimed as non-Medicare bad debt on the S-10 for purposes of calculating Factor 3.

Finally, HFMA members encourage CMS to allow hospitals to count the shortfall between the payment a hospital receives for testing, treatment and related services provided to uninsured COVID-19 patients and the cost of providing care to those patients in the calculation of Factor 3 used to allocate the pool of uncompensated care DSH payments.

Medicaid and SSI Patient Volumes for DSH Eligibility

HFMA members have expressed concern that the changes in volume and case mix due to the pandemic (described above) may impact their ability to qualify for Medicare DSH payments⁵ (traditional and uncompensated care) and, as a result, the HRSA 340B program. **If a hospital that previously qualified for DSH on one of its three prior cost reports fails to qualify for DSH on a cost report whose timeframe overlaps the PHE, HFMA members strongly recommend that CMS allow the hospital to qualify for DSH based on having qualified on one of its three prior cost reports.** Traditional DSH payments should be calculated using the highest disproportionate patient percentage from among the three prior period cost reports.

Ratio of Costs to Charges

HFMA members are concerned about the impact that changes in volume and expenses as a result of COVID-19 will have on the calculation of ratios of cost to charges for cost reporting periods that overlap the PHE. As described above, overall volumes for most providers are much lower than in prior periods. This reduction in volumes is not only for delayed/canceled nonemergent procedures but also reductions in admissions for emergent conditions like stroke, heart attack⁶ and trauma. Given the circumstances of the reduction in volume of care, we believe any services that did occur during March, April, May and June will likely be of much higher acuity than average. Further, we will continue to see high volatility in volume and acuity in some markets during the remainder of the PHE as hospitals have to adjust access to nonemergent procedures to reflect both the current and anticipated volume of COVID-19 cases and their capacity to meet the needs of a surge (acute and ICU beds, personal protective equipment, or PPE, and staffing).

⁴ HRSA. ["FAQs for COVID-19 claims reimbursement to health care providers and facilities for testing and treatment of the uninsured"](#)

⁵ CMS. MLN Fact Sheet: ["Medicare Disproportionate Share Hospital."](#)

⁶ ["Cigna claims data show declines in hospitalizations for serious conditions,"](#) *Modern Healthcare*, April 24, 2020.

At the same time that hospitals have seen significant reductions in volume and revenue, many have seen increases in expenses related to COVID-19. Many hospitals have responded to the urgent need to create additional ICU beds. Because of these heroic efforts, we have not experienced the need to ration care that, sadly, other countries have. Nevertheless, it can cost as much as \$45,000⁷ per bed to convert a general acute bed to an ICU bed.

Hospitals have also incurred significant expenses related to increased clinical staffing to actually deliver lifesaving care to afflicted patients. Average weekly pay for temporary registered nurses has nearly doubled from \$1,700 in January to more than \$3,000 in March.⁸ Caring for COVID-19 patients (or suspected COVID-19 patients) has significantly increased the demand and use rate for PPE given the communicable nature of the disease. In some hospitals with significant COVID-19 patient loads, our members have reported that PPE usage has increased six-fold. This has driven well documented shortages and commensurate increases in prices for PPE of all types. For example, HFMA members' organizations spent approximately \$.50 per N95 mask in January. Now it is not uncommon for members to report N95 masks selling for more than \$5 per mask.

As a result of rapid and abnormal changes in both the numerator and denominator of the cost-to-charge ratio (CCR), HFMA members believe that CMS should not use cost or charge data from cost reports that overlap with the PHE to rebase MS-DRG weights, calculate payments or reconcile outliers. **Instead, HFMA members believe that CMS should use cost and charges from the most recent cost report filed prior to the PHE to calculate CCRs used in MS-DRG and ambulatory payment classifications weight rebasing, outlier reconciliation and hospital-specific calculations like outlier payments, new technology payments (in- and outpatient), critical access hospital (CAH) outpatient payments, organ acquisition costs and uncompensated care costs.**

Cost Report Treatment of COVID-19 PRF Grants for Lost Revenue and Expenses Related to COVID-19
HFMA members request CMS provide hospitals and MACs with specific guidance for the various rounds of relief funding from the CARES Act PRF and subsequent legislation. HFMA members believe these funds (apart from the amounts paid on a per-claim basis for care provided to uninsured COVID-19 patients) are grants. We do not believe the Medicare Statute or Provider Reimbursement Manual requires the funds or the associated expenses they relate to be offset on Worksheet A-8.

First, the emergency appropriation language⁹ associated with CARES Act states:

*“For an additional amount for “Public Health and Social Services Emergency Fund,” \$100,000,000,000, to remain available until expended, to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, **through grants** (emphasis added) or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus:...”*

⁷ Neighmond, P., “[Growing costs and shrinking revenues squeeze hospitals as they brace for coronavirus](#),” NPR, April 6, 2020.

⁸ “[COVID-19 poses long-term impact to not-for-profit hospitals](#),” Modern Healthcare, March 19, 2020.

⁹ Division B—Emergency Appropriations for Coronavirus Health Response and Agency Operations, March 25, 2020, p. 141.

CMS Pub. 15-1 Section 600 (Principle) states:

*For cost reporting periods **beginning on or after October 1, 1983, grants, gifts, and income from endowments, whether or not the donor restricts the use for a specific purpose, are not deducted from a provider's operating costs** (emphasis added) in computing reimbursable cost. For periods beginning prior to October 1, 1983, restricted grants, gifts, or endowment income designated by a donor for paying specific operating costs were deducted from the particular operating cost or group of costs.*

Because Congress, in the appropriation, intended for the CARES Act PRF to be a grant, it would be inappropriate to offset the funds based on CMS Pub. 15-1 Section 600.

Second, in accordance with CMS Pub. 15-2, §4016, HFMA members do not believe the CARES Act PRF grants are considered a “recovery of expenses through sales, charges, fees, etc.” Therefore, there is no need to adjust expenses.

We ask CMS to confirm our interpretation that COVID-19 PRF Grants for Lost Revenue and Expenses Related to COVID-19 do not need to be offset on Worksheet A-8 and communicate it broadly to both hospitals and MACs through an MLN Matters article or other sub-regulatory vehicle. We are deeply concerned that inconsistent treatment among MACS, or auditors within a MAC, will result in inconsistently defined allowable costs which could skew CCRS, impacting MS-DRG weight setting, the calculation of Medicare cost-based payment items (e.g., outliers, CAH outpatient payments), determination of uncompensated care costs for DSH Factor 3 and certain states’ Medicaid cost reports.

Cost Report Treatment of Small Business Administration (SBA) Loans

HFMA members ask CMS to clearly describe how it intends for MACs to treat forgiveness of Small Business Administration (SBA) loans like the Paycheck Protection Program (PPP) on the Medicare Cost Report. If SBA forgiveness is considered a grant, cost reporting instructions (please see above) do not require the offset of grants or contribution against the allowable costs of the provider. However, if the amount of the PPP forgiven is required to be offset against allowable costs on the cost report, this will have settlement implications for cost-based providers (e.g., CAHs) that many are not anticipating.

If CMS determines that the forgiven amount of the loan is not a grant, HFMA requests that CMS clarify the timing on when the loan amount is forgiven. Specifically, is the amount considered forgiven when the loan is received or when the provider has satisfied the conditions for the loan to be forgiven? Or is the loan forgiven after the provider has received confirmation from the SBA that a portion of the loan has been forgiven?

Medicare Accelerated Payment Program Cost Report Treatment

Since expanding the Accelerated and Advanced Payment (AAP) programs on March 28, 2020, CMS approved over 21,000 applications totaling \$59.6 billion in payments to Part A providers, which includes hospitals. For Part B suppliers, including physicians, nonphysician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing \$40.4 billion in payments. The AAP programs are not a grant, and providers and suppliers are typically required to pay back the

funding within one year or less, depending on provider or supplier type. However, CMS has not released guidance to providers or MACs on how these payments should be treated on the Medicare cost report.

HFMA members ask that CMS issue guidance to the MACs and hospitals clarifying the treatment of AAP on the cost report. Given that this is an advance on expected payments, we do not believe these payments should be entered into the cost report as a lump sum payment or an interim payment at the time the lump sum payment was received. Given this loan will be paid back by offsetting claims for services provided, we believe these AAP amounts should be reported in the cost reporting period during which the claim was offset and the provider issued a “zero-pay” remittance advice.

Rural Health Clinic (RHC) Productivity Standards

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 July 6, 2020) 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

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.

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.

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 $((1-(9/12))*4,200)$.

Medicare Transplant Volume and Survival Rates – Conditions of Participation

The Medicare program's conditions of participation (CoP) for certain transplant programs require new and existing programs to meet minimum clinical experience (volume) and outcomes criteria.¹²

The clinical experience requirements of the transplant program CoPs are as follows:

- Section 42 CFR 482.80(b) requires certain transplant programs to have performed 10 transplants over a 12-month period to be considered for initial approval.
- Section 42 CFR 482.82(b) requires certain transplant programs to have performed an average of 10 transplants during the reapproval period to be considered for reapproval.

The regulation specifies a transplant program's 1-year post-transplant patient and graft survival rates to be unacceptable if the observed survival is lower than the expected survival to such an extent that (1) the one-sided p-value is less than .05; (2) the number of observed events minus the expected events is greater than 3; and (3) the number of observed events divided by the number of expected events is greater than 1.5.

The regulation requires that the outcome measures used for survey evaluation are from the most recent Center-Specific Report from the Scientific Registry of Transplant Recipients (SRTR). The "expected" patient and graft survival rate is calculated by the SRTR, which considers transplant patient and donor characteristics to establish a risk-adjusted outcome measure. A transplant program cannot calculate on its own what their "expected" survival rate should be.

Since the outcome measures are reported 1-year post transplant, the risk-adjusted outcomes that are published by the SRTR are based on transplants that were performed between 1 year and 3.5 years prior

¹² CMS, "[Transplant surveys: guidance for citing condition and standard-level deficiencies for certain regulatory requirements and allowing additional time to correct the deficiency](#)," April 4, 2008.

to the publication date of the most recent report. This has implications for a surveyor's assessment of the outcome requirements.

A provider that does not substantially meet the CoPs is considered to be limited in its capacity to furnish services at an adequate level or quality. CoPs (i.e., condition-level deficiencies) must be corrected before a transplant program can be approved or reapproved.

The termination process for currently participating organ transplant programs (i.e., programs previously approved by CMS that have not yet been approved under the CoPs) that do not comply with one or more CoP (i.e., has condition-level deficiencies) is generally consistent with the 90-calendar-day timeframe used for termination of other provider types; however, in two cases, the transplant programs should be allowed additional time for initial approval only under the CoPs to accomplish the corrective action necessary to attain compliance with the regulation. Please note that the termination would not affect the hospital's Medicare provider agreement; it would only apply to a hospital's Medicare approval for a given transplant program.

- 1) If the transplant program does not meet Condition 42 CFR §482.80 because of the clinical experience (volume) requirements outlined in (b) of this Section, the program will be given 210 days to come into compliance with this Condition, contingent upon CMS receipt of an acceptable and implemented plan of correction. This timeframe is derived from our experience with the corrective action plans (CAPs) recently undertaken by a number of transplant programs under auspices of the National Coverage Determination authority.
- 2) If the transplant program does not meet Condition 42 CFR §482.80 because of the outcome requirements outlined in (c) of this Section, the program will be given 210 days to come into compliance with this Condition, contingent upon CMS receipt of an acceptable and implemented plan of correction. This additional time will also allow for the release of the next SRTR Center-Specific Report which occurs every 6 months and sufficient time to provide the necessary steps regarding public notification, etc.

The additional time to come into compliance with the clinical experience or outcome requirements does not eliminate a transplant program's responsibility to immediately develop and implement a comprehensive plan of correction that addresses these issues. Similar to other types of deficiencies, this plan of correction should be submitted within 10 calendar days of the program's receipt of the CMS-2567 form. A plan of correction for these deficiencies must include an analysis of why the clinical experience and/or outcomes are not in compliance, an outline of the specific steps that the program will put in place to come into compliance and the timeframe for when these steps will be accomplished.

Given changes in program volume resulting from the pandemic, HFMA members believe that CMS needs to modify portions of the CoP related to programs that are found to be out of compliance with either the clinical experience or outcome requirements based on data from transplants performed during PHE. We ask that CMS allow new and existing programs at least 14 months from the end of the PHE to come into compliance with the CoP related to clinical experience and/or outcomes.

Worksheet G-3: Reporting Revenues Associated with CARES Act Grants and Loan Forgiveness
HFMA members ask that CMS create separate, specific lines in the "Other Income" section of worksheet G-3 for providers to report grants received from the HHS CARES Act PRF General

Distribution(s), HHS CARES Act PRF Targeted Distribution(s), and forgiveness of the Small Business Administration's Paycheck Protection Program loans.

HFMA members believe that separate lines are necessary to ensure these amounts are consistently reported by hospitals and the amounts are transparent to the public. Otherwise, we are concerned that when CMS, MedPAC, and private entities attempt to use the data on worksheet G-3 to understand hospitals' profitability during this time, inconsistent treatment of these funds will skew results.

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 Chad Mulvany, healthcare finance director, at HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Richard L. Gundling, FHFMA, CMA
Senior Vice President, Healthcare Financial Practices
Healthcare Financial Management Association

Cc:

Susan Burris, Director, Division of Cost Reporting, CMS
Deanna Rhodes, Deputy Director, Division of Cost Reporting, CMS
Donald Thompson, Director, Division of Acute Care, CMS

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.