hfma
healthcare financial management association

September 25, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3401 IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS Advanced and Accelerated Loan Repayment, Coding Policy Change Related to Medicare 20% Operating Payment Increase for COVID-19, and Changes to Medicare Conditions of Participation Related to Hospital and Critical Access Hospital (CAH) Reporting of COVID-19 Data

Dear Administrator Verma:

On behalf of the Healthcare Financial Management Association's (HFMA's) 56,000 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.

I write on behalf of HFMA's members to express concern about three issues related to the COVID-19 pandemic.

- Timing of Payment Recoupment for Providers Who Received Advanced or Accelerated Payments (AAP) from CMS
- CMS's Recent Revisions to Coverage/Payment Policy Related to the 20% Add-on Payment for Medicare Discharges When the Patient Has COVID-19
- Changes to the Medicare Conditions of Participation Related to Hospital and Critical Access Hospital (CAH) Reporting of COVID-19 Data

Timing of Payment Recoupment for Providers Who Received Advanced or Accelerated Payments from CMS: Since expanding the AAP programs on March 28, 2020, CMS has approved over 21,000 applications totaling $59.6 billion in payments to Part A providers, including hospitals. For Part B suppliers, including doctors, nonphysician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing $40.4 billion in payments.[1] In total, CMS has loaned $100B to 45,000 hospitals, physicians and other providers since expanding the program.

HFMA is concerned about the ability of some recipients, particularly independent physician practices, to repay these loans. We believe that loan forgiveness is the most appropriate way to ensure access to

[1]CMS. MLN Connects, "COVID-19: CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program," April 27, 2020.

care. Therefore, HFMA has asked Congress to forgive amounts loaned to providers through the Advanced and Accelerated Payment program[2]. If Congress does not forgive the loans, we believe it will be necessary to modify the terms of the loan. These modifications include:

- *Extend initiation of recoupment timeframe*: Extend the period before repayment begins from four months to at least 12 months.

- *Reduce recoupment percentage*: Reduce the amount of the Medicare claim reduction during repayment from 100% to no more than 25%.

- *Waive or reduce interest*: Waive the interest rate (or the collection of interest).

- *Extend Repayment Period*: Extend the repayment period before interest begins to accrue from 12 months to a minimum of 36 months.

The current terms of the loan, as hospitals, physicians, and other providers understand them based on CMS guidance, are summarized in Table 2.[3] CMS has stated that it will start withholding 100% of recipients' Medicare allowable payments 120 days from when the recipient received the loan. As of April 26, 2020, CMS did not accept any new applications for the Advance Payment Program, and CMS stated it was reevaluating all pending and new applications for accelerated payments. Furthermore, at that time, CMS confirmed its Medicare Administrative Contractors (MACs) will issue letters demanding repayment from physicians after 210 days and from hospitals after 365 days. Physician practices that received an APP Program loan will have a 9.625% interest rate applied to the outstanding balance of the loan by November 23, 2020. The corresponding date for hospitals is April 27, 2021.

Table 2: CMS AAP Program Loan Terms

	Hospitals	Physicians and Other Providers
Amount of Payment Advanced/Accelerated[1]	6 Months of Medicare Allowable	3 Months of Medicare Allowable
Interest Rate Applied	Currently 9.625%	Currently 9.625%
Time from Receipt of Advanced/Accelerated Payment to Repay Before Recoupment Begins	120 Days	120 Days
Latest Date for Recoupment to Begin	**8/24/2020**	**8/24/2020**
% of Medicare Claims Recouped after 119 Days	100%	100%
Time from Receipt of Advanced/Accelerated Payment to Repay Before Interest Imposed	365 Days	210 Days
Imposition of Interest Begins	**4/27/2021**	**11/23/2020**

1. Critical Access Hospitals (CAHs) May Request 125% of Medicare Allowable

[2] HFMA Comments on the Medicare Accelerated and Advanced Payment Programs

[3] CMS. "Fact Sheet: Expansion of the Accelerated and Advance Payments Program and Suppliers During COVID-19 Emergency."

Based on CMS guidance, HFMA believes that CMS should have instructed the MACs to withhold 100% of payments for over 45,000 hospitals and providers by August 24, 2020. However, HFMA members report that, as of September 2, 2020 the various MACs have not started withholding payments. Given the financial stress withholding 100% of Medicare payments would cause some hospitals, physician practices and other providers given the well documented revenue and cost challenges posed by the pandemic, HFMA members appreciate this temporary flexibility. And we continue to urge Congress to forgive or modify the terms of the AAP loans as described above.

However, we ask that CMS communicate to AAP loan recipients, through public subregulatory guidance, its intentions related to AAP loan recoupment. Specifically, we ask that CMS immediately communicate its timeline for making decisions related to AAP recoupment. Additionally, we ask that CMS provide the following information to AAP loan recipients at least two weeks in advance of initiating recoupment:

- Date recoupment will begin
- Percentage of payments that will be withheld
- Confirmation of loan amount to be recouped
- Remittance advice codes that will be used to identify AAP recoupment amounts
- Description of recoupment process for providers on Periodic Interim Payments
- Amount of time before MACs will issue a demand letter (followed by provider-specific information from MACs)
- Interest rate CMS will charge for providers who have not repaid their outstanding loan balance after they receive a demand letter

HFMA believes it is necessary for CMS to take these steps to eliminate the ongoing uncertainty that AAP recipients face regarding their balance sheets.

Recent Revisions to Coverage/Payment Policy Related to the 20% Add-on Payment for Medicare Discharges When a Patient Has COVID-19: On August 17, CMS updated its guidance[4] related to the DRG add-on payment, adding the requirement to have a positive COVID-19 laboratory test documented in the patient's medical record in order for the claim to be eligible for the 20% increase in operating MS-DRG payment for inpatient discharges. The new requirement would apply to inpatient admissions occurring on or after Sept. 1, 2020. CMS states that it is modifying current policy to "address potential Medicare program integrity risks."

The guidance explains that positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), and that the test generally must be performed during, or up to 14 days prior to, the hospital admission. A test performed by an entity other than the hospital (e.g., a local government-run testing center) would satisfy the requirement if the result is manually entered into the patient's record. HFMA has heard from its members that it is often time consuming and difficult to get documentation from testing sites that are not affiliated with the hospital where the patient is admitted. In many communities this information is not in a health information exchange and requires staff to manually track down the results.

[4] *MLN Matters*, "New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act."

HFMA members are concerned about the undue burden that this new requirement will put on hospitals, and we urge the agency to continue providing flexibility in eligibility for the DRG add-on payment – as has been the policy since the beginning of the COVID-19 public health emergency.

Importantly, coding rules have allowed application of available codes on the basis of provider documentation that the patient had COVID-19. Per official ICD-10-CM coding guidance, only confirmed diagnoses may be coded with U07.1 (COVID-19) on the claim. Recently released[5] guidance specifically states that, "In this context, 'confirmation' does not require documentation of a positive test result for COVID-19; the provider's documentation that the individual has COVID-19 is sufficient." Basing the COVID-19 diagnosis code on clinical judgment alone – in line with coding rules – continues to be an important approach given that test accuracy may not be reliable, retesting is unnecessarily onerous and some communities face persistent testing shortages, as described below.

Moreover, current coding guidance further instructs that code U07.1 may not be assigned when the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19. As a result, the usage of the code U07.1, which identifies COVID-19 claims, would be limited only to confirmed cases. **The U07.1 diagnosis code therefore remains sufficient for identifying COVID-19 cases for the DRG add-on policy.**

HFMA members are concerned that requiring a positive test will lead to unnecessary additional testing and administrative burden. We have heard from our hospital members that acquiring test results from other healthcare providers, local testing centers and other third party entities can be a burdensome process, sometimes resulting in long delays or unobtainable results. In order to receive the add-on payment, hospitals would have to dedicate considerable time and effort to obtain a patient's third party result to manually add into the medical record, and in some cases would ultimately have to retest the patient. And, because some labs continue to experience protracted turnaround times, ordering a retest may still not guarantee timely results for the hospital to include in the medical record.

Moreover, the reliability of currently available COVID-19 tests is variable, with some experts highlighting a concerning frequency of false negative tests.[6] Less sensitive tests could demonstrate negative results despite an appropriate and accurate clinical diagnosis of COVID-19. This could similarly lead to unnecessary retesting until a test shows a positive result.

Because use of the COVID-19 ICD-10-CM code already requires clinical documentation of diagnosis as described above, retesting in these cases would have the sole purpose of including a positive result in the medical record. This is not only unduly burdensome and potentially wasteful, but it also may lead to longer hospital stays, higher costs and additional discomfort for patients who are already suffering.

Lastly, healthcare providers in many parts of the country continue to be saddled with shortages of testing supplies. A requirement to include a positive test result could have disproportionate impacts on

[5] CDC. "ICD-10-CM Official Guidelines for Coding and Reporting, FY 2021."

[6] Woloshin, S., Patel, N., and A.S. Kesselheim, "False negative tests for SARS-CoV-2 — infection challenges and implications," *New England Journal of Medicine*, Aug. 6, 2020.

lower-resourced providers, including small and rural hospitals, which may not have capacity and resources to test and retest when a patient is already diagnosed with COVID-19 by a clinician.

In light of these issues, we urge CMS to allow provider documentation of COVID-19 diagnosis to be sufficient for the DRG add-on if the test result is unavailable. While HFMA members can appreciate CMS taking proactive measures to ensure program integrity, we question the need to do so. First, the risks to program integrity are no greater than any other areas of fee for service. And, we would argue they are far lower, given that providers anticipate considerable scrutiny from both CMS and HHS of any inpatient discharge or outpatient service that is billed with a COVID-19 diagnosis code. Second, in the absence of any actual evidence of systemic program integrity issues related to the add-on payment we believe it is unnecessary for CMS to increase the administrative burden on providers, as discussed above, at this juncture.

Changes to the Medicare Conditions of Participation Related to Hospital and CAH Reporting of COVID-19 Data: On March 4, 2020, CMS issued guidance stating that hospitals should inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff, as appropriate, about the presence of a person under investigation for COVID-19. In this interim final rule with comment period, CMS is requiring hospitals and CAHs to report this information to HHS in accordance with a frequency, and in a standardized format, as specified by the Secretary during the COVID-19 PHE.

Examples of data elements[7] that may be required to be reported include, but are not limited to, the number of staffed beds in a hospital and the number of those that are occupied, information about supplies, and a count of patients currently hospitalized who have laboratory-confirmed COVID-19. CMS estimates that completing the reporting will require 90 minutes of a registered nurse's time.
In the interim final rule released on August 27, 2020 (display version), CMS states it will terminate a hospital or CAH's participation in Medicare for failure to consistently report test results throughout the duration of the PHE for COVID-19.

HFMA questions the need to threaten hospitals with expulsion from the Medicare program. Despite constantly evolving and onerous reporting requirements, 94% of hospitals are reporting data to the federal government.[8] And we are aware of ongoing efforts within the industry to increase compliance by addressing outdated contact information for some hospitals in HHS systems, identifying closed or merged hospitals in HHS's outdated data that would adversely affect its efforts, and reaching out to hospitals to help understand any barriers to participation. Furthermore, while we understand the need to collect robust data to help guide national COVID-19 response efforts, we question the wisdom in cutting off Medicare funding from a hospital that is unable to respond to the reporting requirements. Taking that action would only degrade that hospital's ability to protect and support its community during the pandemic. Therefore, we ask that CMS reverse this provision in the interim final rule immediately.

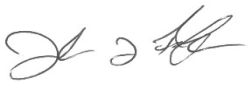
HFMA looks forward to any opportunity to provide additional assistance or comments to CMS to further their efforts to help providers respond to the COVID-19 pandemic. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal

[7] HHS, "Frequently Asked Questions: Laboratory Data Reporting for COVID-19 Testing."

[8] "AHA Statement on CMS Interim Final Rule on Data Collection and Medicare Conditions of Participation," August 25, 2020.

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.