



Charles N. Kahn III
President & CEO

April 3, 2020

The Honorable Alex Azar
Secretary
The U.S. Department of Health and Human Service
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201

Dear Secretary Azar:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH and our members deeply appreciate the efforts across the Department of Health and Human Services (HHS) to provide support to hospitals and health care providers in response to the novel coronavirus (COVID-19) pandemic. As you implement these critical funds, we would like to provide recommendations for and seek clarity regarding three recently enacted policies:

- Ensure the Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Medicare & Medicaid Services (CMS) are ready to efficiently and promptly pay claims for uninsured individuals covered by Title V of the *Families First Coronavirus Response Act (Families First Act)* (Public Law 116-127).
- Clarify that no additional rulemaking or regulatory actions are necessary in order to effectuate the statutory changes making nurses employed at tax-paying entities and tax-paying entities eligible for the Nurse Corps Loan Repayment Program; the Telehealth Network and Telehealth Resource Centers Grant Programs; and the Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs.

- Update relevant web pages and literature to reflect the statutorily updated eligibility criteria for these programs.
- Reopen and extend the 2020 deadline for nurses to apply for the loan forgiveness program for an additional 60 days.

Funding for Testing and Related Services for the Uninsured

Both Congress and the Administration recognize the critical importance of ensuring that all individuals needing a test for COVID-19 receive one, regardless of insurance status. Despite early delays in test availability, we are now seeing increased testing in communities, and we anticipate this will grow exponentially in the coming days. Hospitals and health systems, alongside their community partners, are leading efforts to ensure that every individual experiencing symptoms gets the testing and treatment needed.

Title V of the *Families First Act* provides \$1 billion for the Public Health and Social Services Emergency Fund (PHSSF) to cover COVID-19 testing and testing-related services provided to uninsured and certain underinsured individuals. The law defines an uninsured individual as one who is not enrolled in a federal health care program or a plan on the group or individual market. Further, the law references the National Disaster Medical System (NDMS) with regard to the types of activities the Secretary can undertake to reimburse providers for the testing and testing-related services.

In addition to the funding allocated for the testing of the uninsured, the *Families First Act* also creates the option for states to cover COVID-19 testing and testing-related services for uninsured individuals through Medicaid at 100 percent federal match during the emergency period. We expect some states will move quickly to adopt this option, while others will not.

As the COVID-19 pandemic response is continually evolving, hospitals are currently holding claims for services, including testing, that have been delivered to uninsured patients while several policy questions remain unanswered. **The FAH urges you to ensure that CMS and ASPR work collaboratively to ensure that the Secretary is ready to efficiently and promptly pay claims for uninsured individuals covered by Title V of the *Families First Act*.**

Moreover, in examining the current NDMS Definitive Care Reimbursement Program, we are concerned that the current Program requirements are not in alignment with the language and intent of the *Families First Act*. The FAH recommends several amendments to the current Program guidance and Memorandum of Agreement (MOA) to prevent administrative burden and claims processing delays. Please see the attached recommendations for updating and waiving current Program guidance so that the NDMS reimbursement process can function efficiently for all hospitals providing testing and testing-related services to uninsured individuals. **In addition, the FAH recommends that you consider the following actions in moving forward toward implementation:**

- Distribute the \$1 billion proportionately to the number of uninsured in each state. COVID-19 is currently affecting every corner of the country, however, resources to pay for testing must be appropriately allocated to those states with the greatest number of uninsured individuals to ensure that funds are available to continue that testing uninterrupted.

- Quickly identify an experienced claims processor to pay claims electronically to ensure prompt payment. One national claims processor with experience serving as a CMS Medicare Administrative Contractor (MAC) will allow for streamlined and efficient adjudication of claims. In addition to the NDMS system, you may wish to consider the model adopted by CMS in implementing Section 1011 of the *Medicare Modernization Act of 2003*. CMS contracted with Trailblazer to administer and process claims for funds available under that program.
- Allow providers to attest to the individual being uninsured. Currently, there is no way for an independent claims processing contractor to easily check eligibility across all 50 states. Providers will do their due diligence in checking for Medicaid, Medicare, and other private insurance but must be allowed to attest that the individual is uninsured to prevent an unnecessary delay in claims processing.

Expansion of Eligibility Criteria for Title VIII Nurse Loan Repayment Program

Section 3404, Nursing Workforce Development, of the *Coronavirus Aid, Relief, and Economic Security Act (CARES Act)* (P.L. 116-136) contained a key provision amending Section 846 of the *Public Health Service Act (PHSA)*. The amendment expands eligibility criteria for nurses participating in the Nurse Corps Loan Repayment Program to allow for employment at a for-profit health care facility that otherwise falls within a Health Resources & Services Administration (HRSA) designated shortage area. This provision will ensure that the significant number of communities in HRSA designated shortage areas served by for-profit hospitals have access to the same recruitment and retention tools as other vulnerable communities.

In order to ensure nurses are informed and able to take advantage of this change in eligibility, we request HHS direct HRSA to take the following actions:

- Clarify that no additional rulemaking or regulatory actions are necessary in order to effectuate this statutory change to eligibility
- Update relevant web pages and literature to reflect the statutorily updated eligibility criteria (i.e., make clear that nurses employed by for-profit health care facilities are eligible)
- The *CARES Act* had an effective date of March 27, 2020, but the deadline for applications to the Nurse Corps Loan Repayment Program was March 12, 2020. **The FAH urges you to reopen and extend the deadline for nurses to apply for the loan forgiveness program for an additional 60 days.** As the legislation was passed as part of an effort to confront COVID-19, nurses currently serving these communities should be given the opportunity to benefit from this program.

Expansion of Eligibility Criteria for HRSA Grant Programs

Similar to the aforementioned Title VIII Nurse Loan Repayment Program, the *CARES Act* modified and expanded eligibility requirements for several other HRSA administered programs, specifically:

- Sec. 3212. Telehealth Network and Telehealth Resource Centers Grant Programs
- Sec. 3213. Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs.

As a result of the *CARES Act*, such programs are no longer restricted only to public and non-profit entities. **The FAH urges HHS to clarify that no additional rulemaking or regulatory actions are necessary in order to effectuate this statutory change to eligibility, and to update relevant web pages and literature to reflect the statutorily updated eligibility criteria.** These clarifications should be made immediately, and certainly prior to the public posting of any new funding opportunities.

We thank you and the dedicated staff across HHS for your efforts to support communities across the country during this national emergency. If you have any questions, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Hahn". The signature is fluid and cursive, with a large initial "A" and "M".

cc:

Thomas J. Engels, Administrator, Health Resources & Services Administration
Dr. Robert Kadlec, Assistant Secretary for Preparedness and Response

ATTACHMENT

National Disaster Medical System (NDMS) Definitive Care Reimbursement Program

In examining the NDMS statute ([42 USC 300hh-11](#)), the [Memorandum of Agreement](#) (MOA), [frequently asked questions](#) (FAQ), and other web-based NDMS guidance, the Federation of American Hospitals (FAH) has identified several policy changes that would be needed to quickly and efficiently reimburse all hospitals and other providers for testing and testing-related services for uninsured and underinsured patients with COVID-19 should the NDMS program be utilized in implementing Title V of the *Families First Coronavirus Response Act* (Public Law 116-127).

- **Transportation of Patients and FCC Coordination.** Guidance currently links reimbursement through the NDMS to the transportation of the patient coordinated through a Federal Coordinating Center (FCC). FCC involvement in transportation appears to be the primary method by which the NDMS tracks patients to facilitate payment. Thus, operationalizing the NDMS for all hospitals requires:
 - Waiving the transport requirement as this is a national, not regional emergency
 - Developing an alternative process for onboarding patients into the NDMS system (other than transportation)

- **MOA Preparedness Provisions & 10 Percent Administrative Fee.** The Agency should implement the NDMS provisions related to COVID-19 in such a way as to waive the preparedness obligations in the MOA such that any hospital can receive the 10 percent administrative fee.
 - ***Preparedness Obligations.*** A quick summary of MOA provisions related to preparedness planning and coordination activities:
 - 4(A)—Provider agrees to “plan together” with the agencies concerning transportation, admission, treatment, transfer, and discharge/return of patients.
 - 4(B)—Participation in scheduled annual VA and DoD FCC exercises.
 - 4(C)—Reporting on available beds on request during exercises.
 - 4(C) and (D)—Reporting on available beds on request during response operations, which will be used by FCCs before distributing inbound patients.
 - 4(E)—Tracking, decontaminating, and returning patient movement items (PMI).
 - ***Waive the MOU Requirement.*** To avoid any concerns about executing an MOA – due to the required obligations and the ability of hospitals and the Agency to execute and process the MOAs – it is preferable to suspend the need for the MOA during the pandemic and still provide access to the 10 percent administrative fee.
 - *If such suspension is not possible, then the Agency must facilitate swift execution of the MOAs, with an assurance that the drills/exercises listed above do not occur during a public health emergency.*
 - ***Retroactive Effective Date.*** Our understanding is that around 1,000 hospitals currently have MOAs with the Agency. As that is less than 20 percent of the total hospitals in the United States, there could be a significant backlog for the NDMS Federal Partners to execute the agreements for all hospitals. As such, we recommend making the MOA retroactive (e.g., retroactive to the date the public

health emergency was declared; or the date the agreement was signed by the NDMS hospital and sent to the NDMS Federal Partners for execution).

- **Other MOA Provisions.** HHS has the necessary flexibilities to accommodate the needs of the COVID-19 pandemic (e.g., broadening the definition of “NDMS patient” through guidance without amending the MOA). However, there are several provisions in the MOA we recommend amending to make the program work for all hospitals:
 - ***Reimbursement Tables 1 to 3.*** The current reimbursement tables do not address underinsured individuals (e.g., insured but not covered for those services) or those with unaffordable cost-sharing.
 - The Agency should amend the tables or issue other guidance clarifying that individuals will be treated as uninsured with respect to care that is not covered by their insurance.
 - ***Section 5(E)-(F), 30 Day Limit & Transport References.*** The agreement only covers care within 30 days after transport, with reimbursement for care beyond 30 days subject to approval by NDMS through an appeal.
 - **30-day Limit.** A 30-day limit is problematic given the nature of this emergency. And the appeals process will be an unnecessary and time-consuming administrative burden.
 - We recommend amending the MOA to eliminate the 30-day limit, particularly given that the NDMS agencies have the authority to adjust coverage via guidance.
 - **Transport.** As Section 5(E) does not define “patient transport to the Provider facility,” we recommend the Agency amend the FAQs to interpret it as the date of arrival at the facility.
 - ***Section 5(I), International Patients and Undocumented Aliens.*** Under the MOA, Section 5(I), coverage for these patients is “subject to authority, available appropriations, and NDMS approval.”
 - The NDMS guidance should explicitly address reimbursement for COVID-19 treatment of undocumented aliens.
- **Other Issues**
 - ***Only hard-copy claims.*** Per FAQ 22, only hard copy claim forms are accepted, which are both slow, costly, and administratively burdensome.
 - The program should be amended to utilize electronic claims submission, and the contractor administering the claims should utilize electronic claims submission.
 - ***Timely payment.*** Neither the MOA nor the FAQs address timely payment, and the use of paper claims will make payment significantly slower than current payment processes for Medicare and private insurance.
 - The contractor administering the claims process should have the necessary capabilities to effectively implement a nationwide NDMS process, and its contract with the NDMS Agencies should include timely payment metrics. In particular, the NDMS Agencies should consider utilizing an entity that has experience as a CMS Medicare Administrative Contractor (MAC).

- ***What is a “hospital”?*** Neither the FAQ nor the MOA addresses the definition of a “hospital.”
 - The interpretation of “hospital” must encompass LTCHs, IRFs, and IPFs (as well as other non-IPPS hospitals (e.g., CAHs)). This will be particularly important should Congress extend the funding for testing and testing-related services to treatment-related services.
- ***What is the “Medicare Rate”?***
 - **Under Medicare.** Clarity if needed regarding the “Medicare Rate.” The [reimbursement rates](#) website page focuses on “the amount the facility would be paid” under Medicare, which we interpret to mean that the rate is based off of what Medicare would pay (including outliers, etc.).
 - To ensure appropriate payments, the interpretation must be specific to the individual hospital (i.e., account for area wage index, non-IPPS/OPPS payment methodologies, etc., as applicable) and include outlier payments, etc.
 - **Sequestration.** The MOA references Medicare rates and methodologies, which should not be reduced by sequester.
 - To ensure appropriate payments, the interpretation should not include a sequester reduction.
 - **Adjustment Factor.** The MOA, section 5(H), addresses a FFS adjustment factor that can be applied to approximate total Medicare reimbursement where the FFS amount doesn’t capture full reimbursement (e.g., waivers, bundled pricing arrangements, ACOs, and other APMs).
 - To ensure appropriate payments, this adjustment factor should be included if the FFS amount does not capture the full reimbursement.
- ***High Cost-Sharing Plans.*** The FAQ should be amended to provide coverage for patients that might be considered underinsured due to their high deductibles and other cost-sharing obligations. (In 2020, the out-of-pocket maximum is \$8,150 for an individual and \$16,300 for a family).
 - Reimbursement should be available for all cost-sharing obligations during this emergency without any means testing.