



Charles N. Kahn III  
President and CEO

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The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Verma:

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.

On Friday, President Trump signed the *Coronavirus Aid, Relief, and Economic Security Act (CARES Act)*, H.R.748, into law. The FAH applauds the Centers for Medicare & Medicaid Services' (CMS) efforts to move immediately to implementation, and we are appreciative of the guidance shared to date. **As you continue these efforts, we want to draw to your attention several key implementation issues for your urgent consideration. In summary, FAH urges CMS to:**

- Implement the recently adopted National Uniform Billing Committee (NUBC) recommendations below to explicitly define COVID 19-related discharges for purposes of the MS-DRG add-on payment.
- Apply its existing policy such that additional beds placed into service as a result of the COVID-19 public health emergency are *not* counted in the denominator of the interns and residents to beds (IRB) ratio, negatively impacting indirect medical education (IME) payments.
- Provide leadership in working with the Office of the Assistant Secretary for Preparedness and Response (ASPR) to ensure that the agency is 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).

- Work with the Department of Labor, to the extent applicable, to appropriately define “cash price” as “standard charge” for hospital lab tests as required under Section 3203 of the *CARES Act* and ensure that insurance plans appropriately reimburse providers for COVID-19 tests.
- Ensure that health plans incorporate the applicable waived cost-sharing for COVID-19 testing and related services into their reimbursement to health care providers.

### ***Medicare Accelerated Payment Program Expansion***

**The FAH deeply appreciates CMS’s recent announcement, so soon after the passage of the *CARES Act*, streamlining and expanding the accelerated payment program. We are especially grateful that the Agency exercised its authority to expand the program to providers and suppliers not specifically addressed in the *CARES Act*.** This action vividly demonstrates CMS’s ongoing commitment to taking actions that support hospitals and other provider efforts to combat the COVID-19 crisis. The ability to access in advance 100 percent of Medicare payment over six months, and the promise of receiving these funds within seven days of a request, is vital to assisting hospitals in securing the equipment and resources they need to sustain operations as the number of COVID cases and hospitalizations escalates at the same time that revenues hospitals normally count on disappear.

As the expanded program launches this week, a number of operational questions have arisen. For example, it is our understanding that some Medicare Administrative Contractors (MACs) are using existing forms that ask time-consuming questions regarding hospital finances that are no longer relevant in light of the new qualifying criteria spelled out in the [CMS’s Fact Sheet](#). Completing this additional information will impose an unnecessary burden and significantly slow the process, undermining the expanded program’s potential benefit. As such, if these forms or instructions for completing them are not quickly updated, we would ask that you instruct MACs not to collect data inconsistent with CMS’ intent. As of this writing, several MACs have conforming applications. We will alert you to this or any other difficulties that might arise, and again thank you for helping hospitals meet these new and unprecedented financial challenges.

### ***MS-DRG Add-On Payment***

The additional costs that providers incur while treating COVID-19-related patients are unprecedented and will be borne by all hospitals, especially those that serve a high percentage of Medicare and Medicaid patients. We appreciate that Congress has taken swift action to recognize these additional costs for diagnosis and treatment and look forward to working with the Department of Health and Human Services (HHS) and CMS to ensure that those provisions are implemented with minimal burden and maximum effect.

Specifically, Section 3710 of the *CARES Act* requires the Secretary to increase the weighting factor applied to the MS-DRG by 20 percent for COVID-19 discharges effective for the duration of the public health emergency declared by the Secretary on January 27, 2020. To meet Congressional intent, **the FAH urges CMS to swiftly take the following actions:**

- **Implement the recently adopted NUBC recommendations below to explicitly define COVID 19-related discharges for purposes of the MS-DRG add-on payment to include:**
  - a. Condition code “DR” (i.e., disaster related) to identify claims that are or may be impacted by specific polices related to COVID-19 emergency; and
  - b. Any of the following diagnosis codes in any position on the claim.
    - U07.1 (COVID-19) for services provided on or after April 1, 2020
    - B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for services provided before April 1, 2020
    - Z03.818 (Encounter for observation for suspected exposure to other biological agents ruled out)
    - Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases)
- Ensure the Fiscal Intermediary Standard System (FISS), used for Medicare Part A claims processing, is updated as soon as possible to reflect the above referenced needed changes, and **reconsider the proposed 15-day hold on claims for system updates. Claims should not be delayed any longer than necessary to preserve hospital cash flow.**
- Update the MS-DRG grouper in a timely manner to ensure accurate grouping and payment of the identified COVID-19-related patients. In addition, CMS should work with its contractors to ensure the 3M APR-DRG grouper, used by many Medicaid agencies and Medicare Advantage plans, is also updated so that data can be captured accurately across all government payors.
- Apply the Section 3710 add-on for any patient that received care consistent with a diagnosis of COVID-19. Especially during this extended period of limited testing availability, hospitals must treat every patient with COVID-19-like symptoms as a suspected positive case and incur the same extraordinary costs as a patient who may ultimately test positive and receive a final diagnosis of COVID-19. Doing so is not only the standard of care that is in the patient’s best interests, but also helps to limit community spread.

Taking these immediate and necessary steps will help ensure that CMS accurately captures and pays for the unprecedented costs of both suspected and diagnosed COVID-19 patients – many of whom are Medicare and Medicaid beneficiaries.

### ***Hospital IME Payment Adjustment***

Hospitals are paid for IME based on the ratio of interns and residents to beds (IRB). During the COVID-19 public health emergency, most hospitals across the United States, including teaching hospitals, are placing more beds into temporary service to treat the surge of

patients with COVID-19. Many are doing so in consultation with state and local authorities to prepare to meet the needs of their community.

As these efforts continue, teaching hospitals are concerned that CMS could count these temporary beds in the IRB ratio, which would inappropriately lower their IME payments. 42 CFR section 412.105(b) defines “beds” for the IME adjustment as “available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.” Specific types of beds are excluded (i.e., beds in rehabilitation and psychiatric units among others). “Available” beds for IME purposes is defined in Part I of the Provider Reimbursement Manual, section 2405.3G as:

To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.

**We urge CMS to apply its existing policy such that additional beds placed into service as a result of the COVID-19 public health emergency are not counted in the denominator of the IRB ratio. Otherwise, CMS would be imposing a payment penalty on teaching hospitals for taking the very actions needed to treat additional patients during the emergency.** There is ample support in CMS’s manual provision for the position we are urging you take.

The additional beds being placed into service are not the types of beds that will be “permanently maintained for lodging inpatients.” Rather, these beds are being temporarily placed into service as a result of the public health emergency. In some cases, the additional beds being placed into service are of the type that would qualify as alternative care site beds through a waiver under section 1135 of the *Social Security Act* (see Q/A 1135M-4 at: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>) For instance, the state of California is currently planning to expand inpatient hospital capacity by 40 percent across the state. It seems clear that these beds do not meet the criteria to be counted as beds for the IRB ratio because they are not beds “permanently maintained for lodging inpatients” and are only being placed into service as a result of this unprecedented public health emergency.

In addition, many states have waived all licensure requirements for the period of the public health emergency. We believe it would be impossible for CMS to accurately count and validate the attributable beds to each provider to appropriately make such payment adjustments.

## *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 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 CMS to work collaboratively with ASPR 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 CMS and ASPR 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 MAC will allow for streamlined and efficient adjudication of claims. In addition to the NDMS

system, CMS and ASPR may wish to consider the model adopted by CMS in implementing Section 1011 of the Medicare Modernization Act of 2003. CMS contracted with Trailblazer for claims processing to administer those funds.

- 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.

### ***Diagnostic Testing “Cash Price”***

Section 3202 of the *CARES Act* puts forth the parameters for health insurance plans to reimburse entities providing COVID-19 tests. Under the statute, insurers must reimburse the test provider either the rate negotiated between the provider and the insurer or the “cash price.” **In implementing this provision, the FAH urges CMS, and the Department of Labor, to the extent applicable, to appropriately define “cash price” as “standard charge” for hospitals and utilize their enforcement discretion to provide hospitals time to incorporate COVID-19 tests in their online chargemasters. In addition, the FAH urges CMS and the Department of Labor to ensure that insurance plans are providing appropriate reimbursement for COVID-19 tests.**

The term “cash price” is not defined in the *CARES Act* and, to our knowledge, is not defined elsewhere. In addition, as of January 1, 2019, hospitals are required to post online a list of their current standard charges, which represent the hospitals’ chargemasters. To limit the burden associated with complying Section 3202, the FAH urges CMS to define “cash price” to be the “standard charge” of the COVID-19 test for hospitals and provide time for hospitals to reflect this new test in their online chargemasters.

As COVID-19 testing is still ramping up, most entities have not yet sought reimbursement for tests already performed. While FAH members strive to be in-network and will thus primarily seek in-network negotiated rates for the tests they perform, the national scope of this pandemic will lead to out-of-network laboratory tests as well. As such, we urge CMS and the Department of Labor to use their authority to ensure that insurance plans fulfill their responsibilities to provide coverage and appropriate reimbursement for these vital COVID-19 tests.

### ***Waived Cost-Sharing for Testing and Testing-Related Services***

The FAH applauds Congress for waiving enrollees’ cost-sharing for COVID-19 testing and testing-related services in the *Families First Act* and applauds CMS for urging Medicare Advantage plans to waive enrollees’ cost-sharing for these services. No individual should hesitate to seek testing due to concerns about the cost-sharing required by their insurance plan.

As plans have increased enrollees’ out-of-pocket responsibilities over the years, patient cost-sharing has unfortunately made up a larger proportion of hospitals’ and other health care providers’ reimbursement for services. **As insurance plans now waive sometimes substantial**

**cost-sharing for COVID-19 testing and testing-related services, the FAH urges CMS and the Department of Labor, as applicable, to ensure that hospitals and health care providers are made whole. Specifically, plans should incorporate the waived cost-sharing into their reimbursement to health care providers for COVID-19 testing and testing-related services. To do otherwise would deny hospitals and other health care providers appropriate payment for these necessary services and further strain already fragile health provider finances.**

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We appreciate your prompt attention to these important implementation issues and look forward to working with you and your team. If you have any questions, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to be "Andrew M. ...". The signature is fluid and cursive, written over a horizontal line.

## 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.