

March 30, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to make recommendations regarding two Coronavirus Aid, Relief, and Economic Security (CARES) Act provisions. **Specifically, regarding the expansion of Medicare’s accelerated payment program and creation of an add-on payment for Medicare patients with COVID-19, we urge the Centers for Medicare & Medicaid Services (CMS) to provide as much flexibility as possible with implementation in order to maximize the program’s effectiveness in supporting providers during the crisis related to COVID-19. For example, we urge the agency to eliminate interest on monies owed until at least a 12-month period has elapsed, and to reduce the withhold for recoupment.**

Financial struggles continue to mount as providers prepare and care for the influx of patients with suspected or diagnosed COVID-19. Many of our member hospitals, especially those in rural areas, continue to share serious concerns about a lack of cash flow, and thus the ability to keep their doors open. **Several providers – including rural hospitals – are already forecasting near-term closure if they do not obtain financial relief very soon.**

Congress recently passed legislation that provides funding to hospitals to help them continue to care for patients. Specifically, it expanded the current Medicare accelerated payment program by allowing hospitals – including children’s, cancer and critical access hospitals – to receive accelerated Medicare payments covering up to six months of services. We greatly appreciate this provision, as well as CMS’s further expansion of accelerated payments to all Medicare providers and suppliers. The CARES Act also created a 20% add-on payment under the inpatient prospective payment system for all COVID-19 cases. The following describes our recommendations to make these provisions actionable and effective for providers grappling with the challenges of the current pandemic.



Improving the Accelerated Payment Program

We appreciate Congress's and CMS's expansion of the Medicare accelerated payment program and urge CMS to make sure it is as flexible as possible during the current public health emergency. Specifically, we ask CMS to:

Eliminate interest on the money owed. The current program subjects providers to interest on their accelerated payment amount after they are considered delinquent in repayment and the Medicare Administrative Contractor (MAC) sends a demand letter. Specifically, interest accrues beginning on the 31st day after the demand letter. The interest rate is set at "the prevailing rate set by the Treasury Department," which can vary over time and thus put even more financial strain on hospitals as they work through the uncertainty of the COVID-19 crisis. *While the legislation and CMS expansion allow at least 12 months for certain providers to repay in full, they do not remove the application of interest on monies owed.* Moreover, while CMS has communicated to us that interest would not begin to accrue until after the 12-month mark, we have heard from several hospitals that some MACs are communicating that interest will begin to accrue after 120 days. Notably, the Federal Reserve recently dropped interest rates to nearly zero as a way to support borrowing for a wide variety of commercial businesses. **CMS should extend similar flexibilities and waive any interest on repayment of accelerated payments, until at least the 12-month period has elapsed. Doing so would help hospitals continue to provide much-needed patient care without assuming additional financial risk. CMS should provide guidance to the MACs to clarify and communicate this as soon as possible.**

Reduce the withhold for recoupment. Currently, accelerated payments are recouped via a 100% withhold on all payments until the amount is repaid. However, in these circumstances, this policy would again render hospitals without incoming funds and cause further financial instability as the emergency continues. **As such, we urge CMS to reduce the withhold when recouping accelerated payments and allow providers to make good faith payments over time.** For example, a smaller withhold – e.g., 25% – would allow the provider to get back on its feet while making good faith payments. Another possibility would be to have graduated withholds whereby a small amount is withheld early on, with larger withholds as the provider becomes more financially stable.

Make repayment timeframe longer and based on conclusion of the public health emergency. Based on the CARES Act and recent CMS announcement, recoupment begins after 120 days and, according to the CMS [fact sheet](#) and Medicare Financial Management Manual, the "clock" for this 120 days starts the day the accelerated payment is issued. The date of issuance also starts the "clock" for the 12-month timeframe to repay any balance owed. However, the COVID-19 crisis and related financial distress for hospitals are not short-term emergencies. Hospitals likely will not be able to begin repayment just four months after receiving the payment, as they still will be grappling with the pandemic. **CMS should direct the MACs to begin the repayment "clock" upon conclusion of the public health emergency or the issuance of the payment, whichever is latest.**

Ensure that accelerated payments include both inpatient and outpatient services. The cash flow problem that hospitals, particularly those in rural areas, are experiencing is driven by

halting both inpatient and outpatient procedures in order to prepare for the medical surge. **CMS should make explicit the inclusion of both Medicare Part A and Part B hospital services so that hospitals can have a meaningful funding cushion.**

Base the accelerated payment amount on last year's reimbursements. Currently, the amount of the accelerated payment is computed as "a percentage of the net reimbursement for unbilled or unpaid covered services" (42 CFR 413.64(g)). However, services in this circumstance are not unbilled or unpaid covered services; rather, accelerated payment is being furnished for services that were delayed or cancelled to prepare for COVID-19 patients. In CMS's expansion [announcement](#), the agency states that accelerated payments are "based on historical payments." **CMS should clarify that MACs will base hospitals' accelerated payment amounts on what providers would have expected to be paid under non-emergency circumstances, such as their previous year's reimbursements.** For example, a six-month accelerated payment for January through June 2020 would be based on actual payments for January through June 2019. Per the CARES Act and CMS fact sheet, hospitals could then elect up to 100% (125% for CAHs) of this actual 2019 payment as their 2020 accelerated payment.

Make the request and approval process, simple, clear, transparent and swift. We have heard from some of our members that the request and approval process for accelerated payments can be unclear and cumbersome. Specifically, we have heard that communication with MACs about the accelerated payment process has been limited, and that the paperwork to be completed is unnecessarily time consuming. Any delays in approval elongate hospitals' financial uncertainty, especially during an emergency. **We appreciate CMS's guidance to MACs to issue payments within seven days of the request. CMS should continue to instruct MACs to provide clear and transparent information, implement a simplified and streamlined request process, and issue immediate approval of accelerated payment requests.**

Allow providers to request more than one accelerated payment. The longer-term outlook for this pandemic still remains unclear. Since waves of widespread illness are plausible, **we urge CMS to allow hospitals to request additional accelerated payments – at the six-month mark for example – in order to maintain crucial financial support for this unprecedented public health emergency.**

Outside of accelerated payments, CMS also allows most providers to elect to receive periodic interim payments (PIP) for Medicare Part A services. As we shared in our recent [letter](#) to the agency, we continue to recommend that: PIP be broadly and immediately available for providers that elect the option; reconciliation and cost settlement be delayed until after the public health emergency has subsided; and leniency be given related to reporting criteria and other administrative requirements. **We appreciate CMS's extension of accelerated payment eligibility to PIP hospitals.**

Operationalizing the COVID-19 Add-on Payment

We appreciate Congress's action to provide additional hospital payments for COVID-19 patients. **In order to direct these payments accurately and efficiently, we urge CMS to**

employ a multi-pronged approach to identify patients with COVID-19. First, it should use the new ICD-10 code for COVID-10, U07.1, which will be available for services provided on or after April 1, 2020. However, in the case that the ICD-10 code is not present, CMS should identify COVID-19 patients using the following combination of codes:

- **ICD-10 code B97.29 or B34.2** – while these codes are not exclusive to the SARS-CoV-2/2019-nCoV virus responsible for the COVID-19 pandemic, the AHA’s Central Office on ICD-10-CM/PCS and the American Health Information Management Association (AHIMA) have issued [guidance](#) to providers on March 20, 2020 urging them to consider developing facility-specific coding guidelines that limit the assignment of code B97.29, Other coronavirus as the cause of diseases classified elsewhere, to confirmed COVID-19 cases and preclude the assignment of this code for any other coronaviruses. However, hospitals also may have utilized code B34.2, Coronavirus infection, unspecified to identify patients with the novel coronavirus as the [supplement](#) to the *Official Guidelines for Coding and Reporting* advising against the use of code B34.2 for COVID-19 wasn’t released until Feb. 20, 2020. Both clinical codes, when paired with the condition code below, would indicate a COVID diagnosis.
- **“DR” condition code** – the National Uniform Billing Committee (NUBC) recently [approved](#) the use of the “DR” (disaster related) condition code to flag COVID-related care. This code is retroactive to January 27, 2020, the date the Department of Health and Human Services declared the COVID-19 crisis to be a public health emergency.

Thank you for considering these recommendations. We continue to appreciate the efforts that CMS and others have taken to support hospitals and health systems during this unprecedented crisis. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President