October 13, 2020

- **HCA Healthcare's announcement that it will be returning $1.6 billion in Provider Relief Funds ("PRFs") illustrates the challenges facing providers in accounting for PRFs under shifting guidance from the Centers for Medicare and Medicaid Services ("CMS").**
    - In a prior issue, we discussed how the PRF reporting requirements published by CMS on September 19 made material changes to prior reporting guidance from CMS, most notably by switching from a measure of lost revenues to lost profits. We also noted that providers may have to revisit their historical accounting for the "earned" portion of Provider Relief Funds that may have relied on prior guidance from CMS.
    - In its October 8 press release on preliminary results of operations for the third quarter, HCA not only modified its prior accounting for the earned portion of PRFs but also announced it would be returning the full amount of $1.6 billion in PRFs received from CMS.
        - In its 10Q for the second quarter, HCA reported that it had received a total of $1.42 billion in PRF during the second quarter and treated $822 million of that amount as earned. Excluding the PRFs, HCA's revenue for the second quarter was $1.5 billion lower than the prior year but its adjusted EBITDA was only $449 million lower than the prior year.
    - HCA's decision to return the full amount of PRFs may be due in part to the change in CMS reporting guidance given that HCA's lost profits have been significantly less than its lost revenues as a result of its effective management of expenses during the period in which states imposed restrictions on elective procedures.
        - Nonprofit health systems may be somewhat less impacted by the shift from lost revenues to lost profits given that few if any nonprofit systems were as effective as HCA in managing expenses during pandemic.
    - HCA's decision may also have stemmed from concerns about the challenges in accounting for and reporting on use of PRFs under the shifting CMS guidance as well as the risk of potential qui tam lawsuits attempting to allege that HCA improperly reported or retained PRFs in violation of the False Claims Act.
        - The challenges around accounting and reporting on use of PRFs and the associated risk related to potential qui tam lawsuits is something that faces all health systems, regardless of how successful they may have been in managing expenses during the pandemic.
    - **Key Takeaway:** It is unlikely that many other health systems will find themselves in the position of returning all or substantial portions of PRFs to CMS like HCA, but the recent announcement by HCA serves to highlight the challenges that these other health systems will be facing in accounting for and reporting on their retention of PRFs.
- **Providers should expect continued acceleration in the shift of procedures from hospital outpatient departments ("HOPDs") to ambulatory surgery centers ("ASCs") given recent studies on cost savings.**
    - In a previous issue, we discussed the Calendar Year 2021 Outpatient Prospective Payment System/Ambulatory Surgery Center Payment System proposed rule, in which CMS proposes to phase out the Medicare Inpatient Only List by CY 2024 and expand the types of procedures eligible for reimbursement when performed in ASCs.

- The push to expand the scope of procedures eligible for Medicare reimbursement when performed in ASCs is not new. In recent years, CMS has added many new complex procedures to the ASC covered procedures list, particularly notable are total knee replacements and coronary interventions.
- The continued focus on facilitating the shift of procedures to the ASC setting should also come as no surprise. A 2014 report from the Office of Inspector General estimated that Medicare saved almost $7 billion from 2007 to 2011 and could potentially save $12 billion from 2012 to 2017 due to the lower rates for procedures performed in ASCs as compared to HOPDs.
- A new 2020 study from the Ambulatory Surgery Center Association ("ASCA") estimates that the actual Medicare savings from 2012 to 2017 exceeded $21 billion. The ASCA also projects that, during the ten-year period from 2019 to 2028, total Medicare savings generated by ASCs could reach $73.4 billion. The savings could be even higher as more procedures are added to the ASC covered procedures list.
- The magnitude of cost savings for private health plans are even greater. A 2016 study from the ASCA found that utilizing ASCs rather than HOPDs for outpatient procedures reduces private health care costs by an estimated $37.8 billion annually. Private health plans are generally less conservative than CMS in approving procedures for ASC reimbursement since they have lower-risk beneficiary pools and have greater flexibility to incentivize patients to choose ASCs with lower co-pays.
- **Key Takeaway:** As health care costs continue to rise, providers should expect that both CMS and private payors will continue efforts to accelerate the shift of procedures from HOPDs to ASCs given the enormous potential for cost savings.

- **More than a month after the CMS bypassed the normal process and revised regulations to tie Medicare participation directly to mandatory COVID-19 reporting, CMS issued guidance laying out the specifics and the agency's enforcement process.**
  - In a prior issue, we reported on CMS's interim final rule ("IFR") that incorporated into the Medicare conditions of participation ("CoPs") for hospitals subject to 42 CFR Part 482 and critical access hospitals ("CAHs") mandatory COVID-19 reporting requirements. The amended CoPs went into effect September 2, 2020.
  - On September 24, NPR reported on an impending crackdown on hospitals failing to provide complete COVID-19 reporting. NPR's reporting was based on internal CMS documents, including draft guidance obtained by NPR, which in part described mandatory, daily reporting on COVID-19 patients, remdesivir drug inventory and influenza, which repeatedly has been cited as a basis for concern for the compounding effect it could have on the COVID-19 pandemic as the United States approaches flu season.
  - On October 6, more than one month after the IFR's effective date, CMS formally issued guidance in furtherance of the IFR, detailing required COVID-19 reporting and the agency's enforcement process for hospitals and CAHs that fail to comply. In total, the agency guidance reflects 38 separate data elements, many of which most hospitals and CAHs must report on a daily basis. Consistent with the draft guidance obtained by NPR, CMS's October 6 guidance includes data elements for remdesivir (required to be reported until November 4, but then optional thereafter) and influenza, among others.

- The CMS guidance also details a multi-step enforcement process for hospitals and CAHs that fail to comply with reporting requirements. Commencing October 7, the initial enforcement process initially provides for up to two reminder notifications, followed by up to four enforcement notifications. The fourth enforcement notification will be a notice of termination from Medicare program participation to be effective 30 days following the date of the notice if the hospital or CAH remains noncompliant. Notably, after November 18, CMS will cease providing reminder notifications and noncompliant hospitals and CAHs will immediately be subject to enforcement. The guidance also explains hospital and CAH appeal rights.
- **Key Takeaway:** While the CMS guidance includes measures designed to facilitate compliance in recognition that hospitals and CAHs may experience issues with data transmission or otherwise meeting the reporting requirements, many hospitals and CAHs will need to act promptly to avoid becoming subject to enforcement. According to an internal Centers for Disease Control and Prevention presentation cited by NPR, only 24% of hospitals satisfied United States Department of Health and Human Services reporting requirements as of the week of September 14.

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