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# Revenue Cycle Update: CARES Act Suspends Sequestration and Increases Inpatient DRG Weight for Services provided to COVID-19 Patients

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# Anticipating Payer Denials and Other Revenue Cycle Issues or COVID-19 related Services

Healthcare providers are facing the additional pressures of providing care to COVID-19 patients on top of their normal patient load. The CARES Act, signed into law on March 27, 2020, contains significant positive changes to the manner in which providers will be reimbursed under both original Medicare, as well as by commercial plans that pay providers based on a Medicare Allowed amount. This Client Alert addresses two of those changes – the suspension of the 2% sequestration reduction and the 20% increase in reimbursement for inpatient treatment provided to COVID-19 patients. It also sets out a "watch list" of issues that may arise in the revenue cycle over the coming weeks and months related to the COVID-19 pandemic.

## SUSPENSION OF 2% SEQUESTRATION

Payments by the Medicare program to providers and Medicare Advantage Organizations have been subject to a 2% sequestration reduction since 2013. The CARES Act suspends this sequestration reduction for the period May 1, 2020 through December 31, 2020. In addition to changing payments under original Medicare, this will likely change payments from commercial plans in the following ways:

- Providers that have contracts with Medicare Advantage plans tied to the amount the providers would be paid under various Medicare payment systems, and/or tied to a portion of the plan's capitation payments, generally should receive a 2% increase from the plans.
- Providers that are not contracted with a Medicare Advantage plan also should receive at least a 2% increase because they are supposed to be paid at least what the provider would have received under original Medicare.

The suspension of the sequestration reduction comes as welcome news to providers. To maximize the revenue opportunities created by the suspension, providers should keep the following in mind:

1. **Medicare Advantage ("MA") Contracted.** Many MA plans have been applying sequestration reductions to payments where the contract rates are based on Medicare rates. There may be reasons the plans never should have applied those reductions. But even if allowed before the CARES Act, the suspension should result in these reductions being turned off during the suspension time period. However, we foresee that some of the plans will 'forget' to turn it off or try to argue that they do not have to do so under the contract terms. You'll want to make sure to timely appeal and push back if that happens.
2. **Non-Contracted MA.** Sequestration applies to non-contracted MA plans because the rule is that non-contracted MA plans get to pay what the provider would collect from Original Medicare. Now with sequestration suspended that rule works in reverse to your favor. MA plans typically implemented a 2% reduction for all non-contracted claims. If any non-contracted MA plans 'forget' to turn that off, there is a process for appealing to the plan, and then to CMS if the plan fails to correct it. But the process has especially short deadlines and formalities after the underpayment occurs – e.g., 60-day periods, etc.
3. **Commercial Plans Using Medicare-Based Rates.** Some commercial contracts use Medicare-based rates. If the commercial plans using Medicare-based rates are applying sequestration on commercial claims, they may 'forget' to turn off these edits. You'll want to be alert to any applicable contractual appeal deadlines.
4. **Checking Contracts and Reimbursement Systems.** You may want to double check your contracts for what they require and check your payment systems to make sure that any sequestration related 'expected reimbursement' fields are set and adjusted correctly.
5. **Prior Sequestration Settlements.** If you had prior sequestration settlement agreements, or related agreements or amendments flowing from them, you may want to check to see what they require in the event that sequestration changes. We hear from other providers that they are checking these documents for language to accommodate getting the extra 2% coming from the suspension if the settlement had agreed to allow some reduction.
6. **Affects All Providers.** This sequestration suspension affects all types of healthcare providers that receive payments of these types. There had been pre-passage rumors that it might be for only for certain types of providers.

Of course, there can be nuances in a provider's specific contracts that dictate otherwise. Contracts with Medicare Advantage plans can vary about what is or is not counted in calculating IPPS/DRG payments and capitation payments. Some contracts set grace periods for plans to load new rates. More importantly, some contracts set short deadlines to contest/appeal/raise underpayments. Providers should be mindful of these provisions and the effect they may have on their right to pursue full payment from Medicare Advantage plans. Although there are legal theories that can overcome appeal deadlines, such as the anti-forfeiture doctrine, equitable tolling, etc., it is better not to have to invoke those doctrines.

## 20% INCREASE ON WEIGHTING FACTOR FOR INPATIENT DRGS FOR COVID-19 PATIENTS

In a change that is targeted at the care providers render for COVID-19 patients, the CARES Act increases the weighting factor that will be applied to inpatient DRGs for patients whose primary or secondary diagnosis is COVID-19. This will affect payments to providers rendering services to patients covered under original Medicare, as well as payments for patients covered by Medicare Advantage plans, for all of the same reasons that the suspension of sequestration will affect payments from Medicare Advantage plans.

King & Spalding's healthcare practice will be monitoring these developments and will pass on any additional guidance we receive from CMS or other sources.

## MOVING FORWARD IN THE REVENUE CYCLE

As the healthcare industry settles into what is expected to be a protracted fight against the COVID-19 pandemic, healthcare providers are moving quickly to adapt their services and processes to meet the needs of this unprecedented healthcare emergency. CMS and state regulators have issued waivers and guidance giving providers latitude to provide services in a manner that otherwise would have been impermissible under the law. Amid all of these changes, hospitals and other providers must continue to operate their revenue cycle processes by submitting claims and pursuing payment. However, it remains to be seen whether the commercial health plans that receive these claims will be nimble enough to revise their claims processing and utilization management systems to adapt to dynamic, wide-scale, simultaneous changes. In this challenging environment, many health plans will struggle to pay claims timely or accurately. Providers will want to be ready for this and implement strategies both now and down the road in the revenue cycle to overcome these hurdles. To help lay the groundwork for providers to receive the payment they are entitled to receive, it will be helpful to maintain a "watch list" of issues that may arise in the revenue cycle over the coming weeks and months, so that revenue cycle teams can identify potential problems and disputes as claims are adjudicated and returned and strategizing about proactive solutions. Set forth below is a preliminary watch list of the issues that King & Spalding's healthcare team anticipates arising during the coming revenue cycle:

1. **Denials of Telemedicine Services.** In an effort to keep patients out of facilities where they can infect or be infected by other patients, many providers are rapidly moving a variety of services onto telemedicine platforms. We expect that health plans will deny claims for telemedicine services with explanations and queries that may be unclear. For example, services may be denied as non-covered when the issue is actually that the plan cannot determine whether the services were appropriately provided via telemedicine or in a real-time audio/video communication. Health plans may also delay paying claims by asking for more information about the transmissions and locations of the provider and patient. Advance documentation of certain touchstone factors like these is critical to prompt and appropriate adjudication of claims.
2. **Incorrect Calculation of Copayments for COVID-19 Testing.** CMS and some state regulators have directed plans to cover COVID-19-related testing without copayments -- irrespective of whether the services are provided in or out of network. But there will be a significant lag in most health plans' ability to conform their systems to adjudicate claims correctly. This makes it likely that health plans will continue to direct providers to seek copayments for COVID-19 testing, when in fact all amounts due for those services should be paid by the health plans.
3. **Delayed Authorizations for Post-Stabilization Services at Out-of-Network Emergency Departments.** Epidemiologists are now predicting a surge in COVID-19 patients will occur in the next 2-3 weeks. When this occurs, emergency departments will struggle to timely request authorization to provide post-stabilization services. On the other hand, many health plans will struggle to provide timely responses to providers' requests for post-stabilization services. Some state regulators, like California's Department of Managed Health Care,

have directed health plans to be more lenient with prior authorization requirements. The DMHC went so far as to say that health plans regulated by the DMHC in California should "waive prior authorization requests for services related to COVID-19…" While this may alleviate some health plan-issued denials when a COVID-19 patient is admitted without authorization, regulators have not yet made the waiver of prior authorization requirements mandatory. Nor does this address the overall effect that COVID-19 will have on an emergency department's ability to contact a health plan and request authorization for non-COVID-19 related post-stabilization services. This will lead to disputes over payment for all types of post-stabilization services, not just those related to COVID-19. We recommend that providers document the date and time they make the requests for post-stabilization services, and the reasons for any delay.

4. **Denials of Services being Provided in Unlicensed Spaces.** Most managed care agreements include a warranty or representation that all services provided under an agreement are being provided in a manner consistent with applicable law, and often require that a facility provide services in a manner consistent with the facility's license. As providers move patients to receive care in spaces that would normally be unlicensed to provide those services (previously closed facilities, dedicated units like mental health beds, hotels, tents) health plans may use these warranties and representations as a basis to deny claims for services provided in these spaces, arguing that compliance with these warranties/representations is a condition precedent to payment.

5. **Coverage Denials by Medicare Advantage Plans.** Before COVID-19, Medicare Advantage plans were required to cover services that original Medicare covers under Parts A and B. During this public health emergency, CMS has waived a number of requirements for coverage under original Medicare. Those waivers will also affect what Medicare Advantage plans must cover for their members. Some of the waivers include:

    - Waiver of the requirement for a 3-day inpatient hospital stay before admission to a skilled nursing facility;
    - Waiver of the requirement that acute care hospitals are not permitted to house acute care inpatients in excluded distinct part units (e.g. a psychiatric bed);
    - Waiver of requirements for replacement DME like the face-to-face requirement, a new physician's order, and new medical necessity documentation.

    If Medicare Advantage plans' systems are not revamped to recognize these changes, those systems will automatically deny many claims for services that should be considered covered benefits.

6. **Out-of-Network Denials by Medicare Advantage Plans.** CMS has directed Medicare Advantage plans to cover out- of-network services received by Medicare Advantage members during the public health emergency. Some Medicare Advantage payment systems are set up to automatically deny non-emergency claims submitted by out-of- network providers, so you can expect that as Medicare Advantage members seek services from out-of-network providers, many claims will likely be denied unless Medicare Advantage plans can quickly turn off these automatic adjudication functions. In addition to the normal appeal process, CMS has established a procedure for out-of- network providers to submit claims for these services directly to CMS through the Medicare Administrative Contractor if the Medicare Advantage plan fails to pay for out-of-network services as a covered benefit.

7. **Increased Capitated Provider Risk Caused by Copay Waivers.** While not strictly a revenue cycle issue, another issue many providers will be addressing is the increased financial risk being assumed by capitated providers as a result of the COVID-19 pandemic. While the requirement to waive copays described in No. 2 above may be beneficial to providers that are paid on a fee-for-service basis, it will hit capitated providers hard,

since they will no longer be able to pass on some of the cost of providing COVID-19 testing to patients. Providers should be mindful that some capitation agreements include “material change” language that give a provider relief - sometimes in the form of increased capitation -- if there is a change in coverage. These and other contract provisions may give providers an avenue to seek relief for this significant change.

8. **Denials for Failing to Comply With Deadlines.** Managed care agreements and plan policies contain a number of deadlines with which providers must comply in order to get their claims paid, such as timely filing, timely appeals, response to document requests, etc. Due to staffing and increased workloads during the COVID-19 crisis, providers may not be able to comply with these deadlines. Providers should consider sending a letter to their payors to inform the payors of the difficulties faced by the provider and to request exemptions from these deadlines while the pandemic persists.

This is not intended to be a comprehensive list of the potential revenue cycle issues presented by this pandemic. Events are occurring so rapidly that it is impossible to predict what other issues providers may encounter down the road. As new issues arise, we will continue to keep you informed. If you are facing difficulties that you would like to share or have questions about how to deal with particular problems, please let us know, and we will endeavor to provide you with a quick response. If your facility has developed solutions to any problems, let us know and we will share those solutions with the group.

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