Responding to the COVID-19 Crisis: How to Ensure Your Share of Relief Funding

April 3, 2020

Presenters

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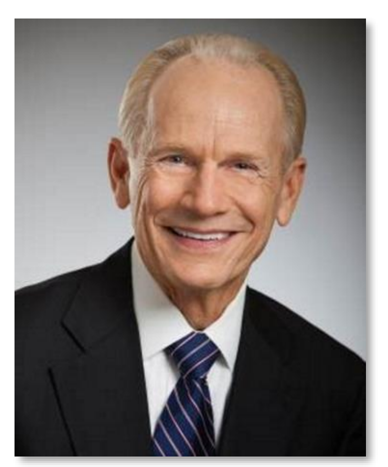

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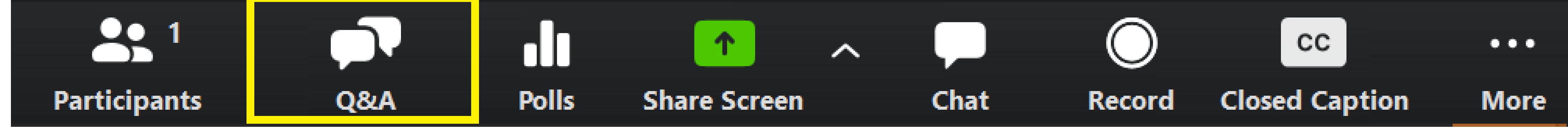
Housekeeping

- Please enter questions through the Q&A feature in Zoom (screenshot below) and we will answer questions at the end
  - You may also email questions directly at info@copehealthsolutions.com
- Attendees will receive a pdf copy of the presentation, a link to the recording and a written Q&A



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Agenda

1. Introduction
2. CARES Act & Distribution of Funds
3. What Should Providers Do Now to Prepare?
4. Additional Considerations
5. Questions & Answers

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CARES Act & Distribution of Funds

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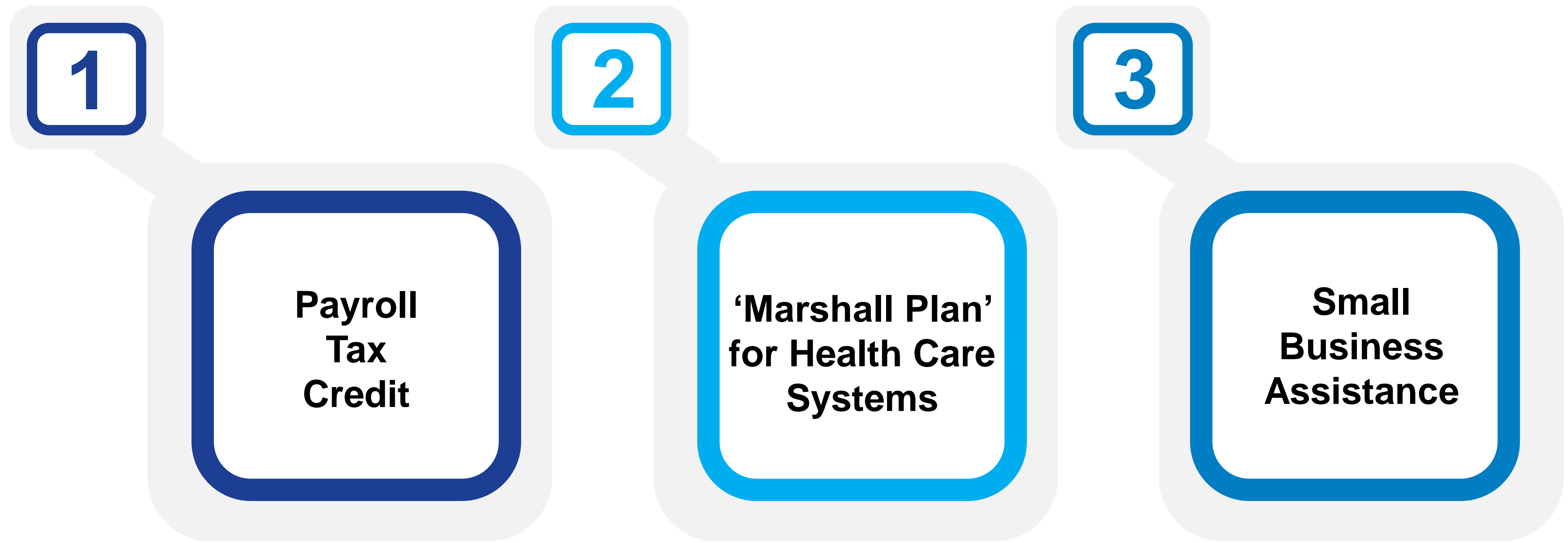
CARES Act – Mandatory Spending



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CARES Act – Emergency Funding

$100 billion "until expended" to reimburse eligible health care providers for health care related expenses or lost revenues

- Defines eligible providers
- Requires submission of reports and documentation
- Must deduct any payments from other providers
- The Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) has 3 years after last payment to present audit findings to Congress

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CARES Act – Emergency Funding

- Public Health and Social Services Emergency Fund - $275 million distributed across various entities until Sept. 30, 2022
- $185 million to Health Resources and Services Administration (HRSA) for critical access hospitals, telehealth and tribal health
- $4 billion for homelessness assistance programs
- $200 million - Assistance for nursing homes
- $45 billion to FEMA disaster relief fund
- $25 billion for food assistance
- $4 billion to Centers for Disease Control (CDC)

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CARES Act – Emergency Funding

$27 billion available through FY 2024 for prevention and preparation

- Workforce modernization, telehealth access and other preparedness response activities
- For developing vaccines, purchasing vaccines, diagnostics and medical surge capacity
- $250 million for entities that are part of the Hospital Preparedness Program
- $16 billion for the Strategic National Stockpile

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Medicaid Financing

Several of the provisions will increase Medicaid financing for states, including:

Medicaid Disproportionate Share Hospital (DSH) Payments

Delay Premium Maintenance of Effort (MOE) Requirement

Clarification of State Medicaid Option to Cover the Uninsured

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Medicare Payment Improvements and Flexibilities

The bill provides additional funds to providers who are caring for Medicare beneficiaries

1

Sequestration (2%)

Eliminates the 2% Medicare sequester from May 1 through Dec. 31, 2020. During the emergency period, the legislation provides a 20% add-on to the DRG rate for patients with COVID-19. This add-on will apply to patients treated at rural and urban inpatient prospective payment system (IPPS) hospitals.

2

20% add-on for COVID-19 codes (DRG,CPT, Etc.)

During the emergency period, the legislation provides a 20% add-on to the DRG rate for patients with COVID-19. This add-on will apply to patients treated at rural and urban inpatient prospective payment system (IPPS) hospitals.

3

Expanded Option (accelerated payment)

There will be expansion of the Medicare hospital accelerated payment program during an emergency. All eligible providers are able to request accelerated payments for inpatient services that cover a time period of up to six months. The bill also extends the timeframe for recoupment of the accelerated payment.

Flexibilities (increasing post-acute access)

The legislation provides flexibility for post-acute care (PAC) providers so they are able to increase the capacity of the health care system, without penalty, during the emergency period. This includes waiving: the inpatient rehabilitation facility (IRF) 3-hour rule, LTCH site-neutral payment policy, and the LTCH “50% Rule.”

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Home-Based Services

The bill makes a number of policy changes regarding the provision of home-based health care services, which seek to increase access and decrease patient risk during the emergency period; many of these policy changes also will apply to Medicaid home health services

This provision will reduce requirements during the COVID-19 emergency that pertain to face-to-face evaluations for home dialysis patients

Face-to-Face Visits Between Home Dialysis Patients and Physicians

This provision will expand the ability of physician assistants, nurse practitioners and certified nurse specialists to order home health services

Enabling Additional Health Professionals to Order Home Health Services

This provision will expand certain state and community-based service guidelines to include self-directed personal assistance services and attendant services

Facilitating Home and Community-Based Support After Hospital Stays

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Increasing Access

Post Acute	Nursing Home Infection Control Capabilities	3-day Rule Eliminated
Telehealth	Medicare Telehealth Flexibilities	Medicare Telehealth Enhancement
Testing	Coverage of Diagnostic Tests and Preventive Services	High Deductible Health Plan (HDHP) Exemption for Telehealth Service

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Who is Eligible to Receive Emergency Funds?

Suppliers and providers enrolled in Medicare or Medicaid are eligible

Examples include:

Health Systems

Physician Groups and Federally Qualified Health Centers (FQHC)

Hospitals

Individual Providers

Ambulatory Care Centers

Others

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How Will Funds Be Distributed?

The application, timing, and distribution process is still being constructed

What we currently know:

- There is consideration for a portion of the funding to be automatically distributed to hospitals via a formula
- Many of the allocations will "*remain available until fully committed and expended*"
  - This may mean **first come, first serve**
- To increase your chances of receiving funds, organizations need to
  - Start preparing now
  - Respond quickly when the federal government releases the application process
  - Be prepared for audits with documentation

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California

- Senate Bill 89 Enacted: Appropriates $500 million from the General Fund for purposes related to the COVID-19 Proclamation of Emergency. Allows the appropriation to be increased in $50 million increments up to a total to not exceed $1 billion.
- Pursuant to Governor Gavin Newsom's March 15th executive order, hospitals have been granted a temporary waiver of regulatory requirements due to the COVID-19 state of emergency.
- As of April 1st, Governor Gavin Newsom signed an executive order that allows for the immediate use of funds to support the state's continuing efforts to protect public health and respond to the COVID-19 crisis.
- Department of Managed Health Care (DHMC) All Plan Letter (3/18)
  - Health plans shall reimburse providers at the same rate, whether a service is provided in-person or through telehealth
  - For telehealth services, a health plan may not subject enrollees to cost-sharing greater than the same amount if the service was provided in-person

Total Allocation	$15,322,206,367
State Share	**$9,526,137,621**
Alameda County	$291,651,561
Contra Costa County	$201,293,497
Fresno County	$174,345,905
Kern County	$157,087,754
Los Angeles County	$1,751,852,108
Orange County	$554,167,091
Riverside County	$431,117,152
Sacramento County	$270,838,440
San Bernardino County	$380,430,899
San Diego County	$582,547,875
San Francisco County	$153,832,754
San Joaquin County	$132,996,947
San Mateo County	$133,769,122
Santa Clara County	$336,415,539
Stanislaus County	$96,091,702
Ventura County	$147,630,401

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What Should Providers Do Now to Prepare?

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Prompt Action and Documentation

- Begin documenting increased expenditures and revenue losses in a clear and systematic way
- Our experience in other disasters teaches us:

Thorough documentation leads to greater success in drawing down disaster-related funding

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Strategies to Maximize Access to Crisis Funds

Create a task force with C-suite plus others

Brief all critical staff and clinicians on new processes

Brief governance on the issue and strategy

Assign a person to be “on point” to collect the increased expenditures

Develop a strategy for documentation processes

Review expenditures by department on a weekly basis

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Strategies to Capture COVID-19 Expenditures

- Document costs in real-time; don’t wait
  - Be thorough – it is critical that all costs are captured
  - Unit price increase of basic supplies (e.g., food, housekeeping supplies, drugs)
- Review labor costs
  - Overtime and/or risk pay
  - Additional staff
  - Contract labor (e.g., registry, travelers, locums)
  - Sick time
- Review supply costs
  - Additional supplies
  - Increases in pricing based on demand
  - Delivery charges

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Strategies to Capture COVID-19 Expenditures

- Think beyond cost accounting for labor and supplies
  - Equipment purchases (e.g., additional ventilators, beds, oximeters)
  - Repurposing and modification of space, federal medical stations (32 total; 8 in CA)
  - Hard to discharge patients
  - Increased length of stay and demand for ICU beds due to COVID-19 diagnosis
  - Revenue cycle efficiency (e.g., billing codes, appeals, collection reconciliation)
  - Delayed impacts:
    - Leases
    - Transportation
    - Delays in projects (construction in progress)
    - Increases in insurance premiums (health insurance, workers comp, unemployment, liability)
    - Future financing costs
    - Litigation

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Reassignment of Physicians, Other Providers and Staff

Role changes during crisis

Cross utilization

Medical Staff/Residents

Labor contracts

Off-campus sites

Competency assurance

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Document Increased Expenditures in a Clear and Systematic Way

Recommendations:

- If it is an option, dedicate a person exclusively to these efforts
- Take a wide-ranging view – be inclusive not exclusive
- Implement and refresh weekly COVID-19 dashboards to track added disaster costs
- Sort out duplication costs prior to submission
- Avoid allocating fixed General and Administrative costs as additional COVID-19 costs
- Quantify price increases triggered by the crisis, even for basic items
- Prepare for an audit and gather supporting documentation that supports increased costs

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Loss of Revenue – Analysis is Key

- **The finance department should choose an approach to document lost revenue**
  - When did the disaster hit? (e.g., January 1 or February 1)
  - What is an appropriate base period for comparison of revenue?
    - Two or three months prior to the disaster start
    - The prior year period or seasonal shift period

- **May require advanced modeling techniques**
  - Shift in DRG and CPT acuity
  - Shift in payor line of business volume
  - Analyze paid claims information versus expected payments/revenue

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Loss of Revenue – Analysis is Key

- **For hospitals/other healthcare organizations, top to bottom revenue stream review:**
  - Emergency and inpatient departments
  - Inpatient surgery and inpatient interventional departments
  - Sub-acute and transitional care
  - Ambulatory services/post-acute services and home care
    - Outpatient surgery
    - Clinics
    - Physician practices
    - Outpatient diagnostics
    - Home Health
    - Hospice
    - Behavioral Health
    - Long-term acute care hospitals and acute rehabilitation hospitals
    - Other

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Additional Considerations

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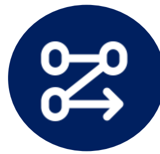
Charting Unknown Territory

Most government agencies and providers have never faced a crisis like this; everyone needs to work together. Providers should:

Collaborate with agencies to design reasonable processes to facilitate funding and payments

Work through advocacy groups with the government, if regulatory requirements need to be relaxed or suspended, to obtain executive orders, emergency legislation and other changes



Work with the regulatory agencies and formulate standardized logic, processes, audit trails and reporting COVID-19 costs/losses

Monitor health plan payments to ensure additional compensation during the crisis

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Call to Action

Orientation, training and staff support

Cost capture and financial modeling

Validation of submission for COVID-19 relief funding

Loans, grants and small business administration interruption funds

Reconciliation, audit preparation and review - **document now**

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Q&A

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Appendix

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CARES Act

Among other health care-related provisions, the package[1]:

Increases funding to the Public Health and Social Services Emergency Fund by almost **$127 billion** to reimburse hospitals for COVID-19 expenses

Creates Medicare add-on payment of **20%** for rural and urban inpatient hospital COVID-19 patients

Removes the **2% Medicare sequester** from May 2020 through December 2020

Expands the existing option for hospitals to receive **"accelerated" Medicare payments**, including by ensuring Critical Access Hospitals (CAH) can access this option

Eliminates **$8 billion** in total Medicaid DSH cuts over FY 2020 and FY 2021

[1] https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act

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CARES Act

Among other health care-related provisions, the package[1]:

Provides **flexibility** to post-acute care providers, including waiving long-term care hospital (LTCH) site-neutral policy

Takes steps to improve the **supply chain**, including access to masks and drugs, among other items

Takes steps to expand **coverage** for COVID-19 testing and testing-related services

Provides new **telehealth** flexibilities, including expanding access in rural areas

[1] https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act

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Small Businesses in Health Care

The legislation includes several other provisions relevant for hospitals and health systems, including:

Small Business Loans via the "Paycheck Protection Program"

- Make available loan opportunities for organizations with less than 500 total employees
- May be up to $10 million and may be forgivable
- Can use to pay salaries, leave and health benefits, rent, and/or retirement obligations, among other uses
- Both for-profit and non-profit hospitals will be eligible for these loans; however, affiliation rules will apply

Net Operating Losses

- According to a Senate Finance Committee, the Act's changes to the Code's NOL provisions "will allow companies to utilize losses and amend prior years' returns, which will provide critical cash flow and liquidity during the COVID-19 emergency."

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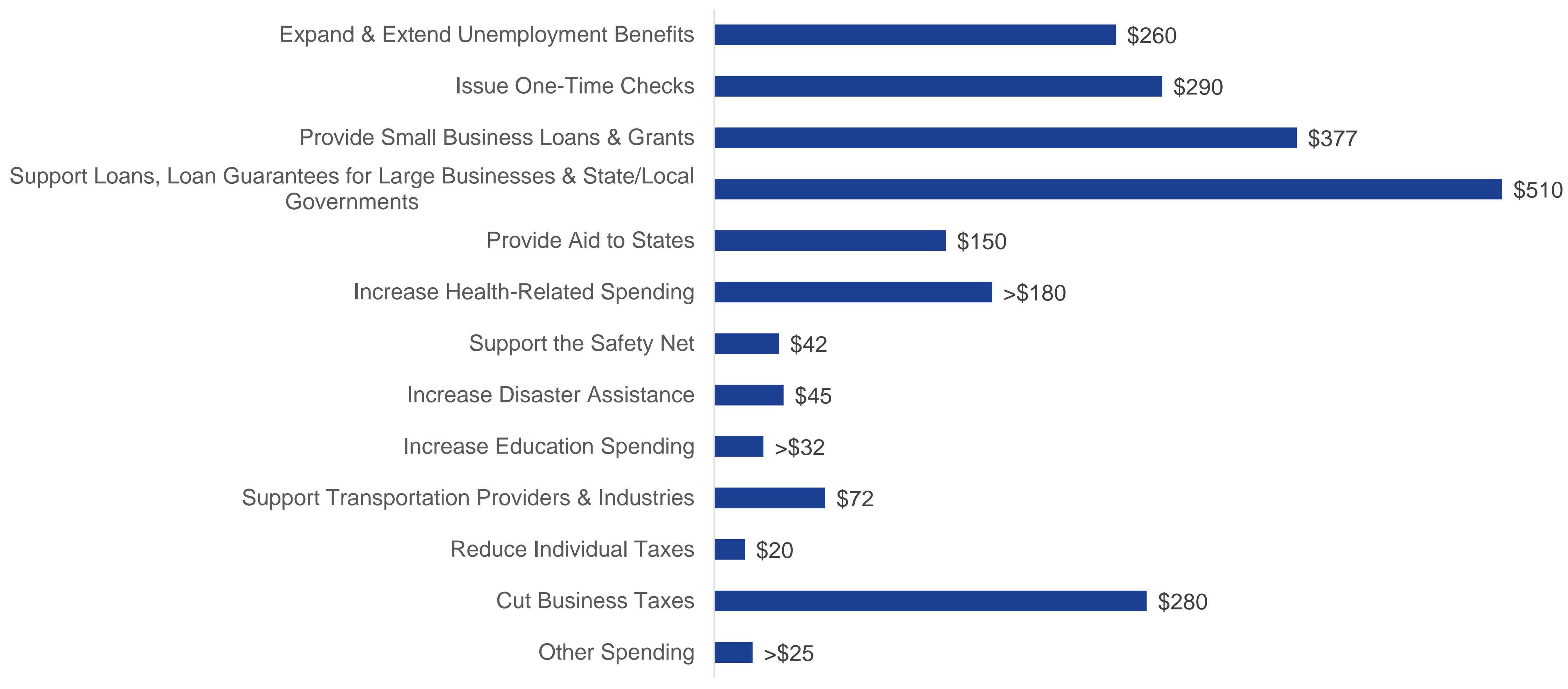
CARES Act



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Telehealth

The legislation will make a number of policy changes regarding the provision of telehealth services, which may increase access during the emergency period, including:

Medicare Telehealth Flexibilities	Medicare Telehealth Enhancement
This section will eliminate the requirement included in the Coronavirus Preparedness and Response Supplemental Appropriations Act that providers or others in their group must have treated the patient in the past three years to provide them with a telehealth service during the ongoing public health emergency. The net result will be to **give the HHS Secretary authority to waive without restrictions** on the definition of "qualified provider."	This legislation will waive the restriction on FQHCs and RHCs that prohibits them from serving as distant sites. Specifically, during the emergency period, FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation will **reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services** under the physician fee schedule.

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Coverage of COVID-19 Testing and Other Services

The legislation will expand the types of diagnostic tests that must be covered by certain payers and clarifies several aspects of coverage reimbursement. These include:

Coverage of Diagnostic Tests and Preventive Services	High Deductible Health Plan (HDHP) Exemption for Telehealth Service
The legislation includes several provisions related to coverage and reimbursement for COVID-19 testing and testing-related services.	This section allows HDHPs with HSAs to cover telehealth services before a patient reaches his or her deductible amount.
This will expand the types of diagnostic tests that will be covered to include laboratory tests that have not been approved by the Food and Drug Administration (FDA) but meet certain conditions, including that the applicable state or territory has assumed responsibility for the validity of the tests. Certain commercial payers and public programs to cover this broader range of tests.	Health plans are directed to pay providers of laboratory services the full negotiated rate, or they must reimburse the provider the cash price for the service. Each provider of such laboratory services will be required to post a cash price for COVID-19 testing on a public website and failure to comply could result in civil monetary penalties. In addition, health plans are required to cover qualifying COVID-19 preventive services, such as an item, service or immunization recommended.

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CARES Act Funding: Where/How to Apply

- $100B Fund for Eligible Health Care Providers
  - Application: Eligible health care providers must submit an application to the Secretary (Alex Azar) of the Department of Health and Human Services (HHS) that includes their tax ID number and "a statement justifying the need of the provider for the payment." Applications will be reviewed on a rolling basis, and there is currently no further instruction on how to apply.
- $349B Small Business Loan Program (Paycheck Protection Program)
  - Eligible organizations can apply (link below) from the U.S. Small Business Administration
  - Nonprofits may apply at any lending institution that is approved to participate in the program through the existing SBA 7(a) lending program and additional lenders approved by SBA and the Department of Treasury. Nonprofits do not need to visit any government institution to apply for the program.
  - Starting April 3, 2020, small businesses and nonprofits can apply. Starting April 10, 2020, independent contractors and self-employed individuals can apply
  - https://home.treasury.gov/system/files/136/PPP%20Borrower%20Information%20Fact%20Sheet.pdf
  - https://www.sba.gov/document/sba-form--paycheck-protection-program-ppp-sample-application-form
- Individuals
  - Recovery Rebate: For most individuals, no action is required since the IRS will use a taxpayer's 2019 tax return, or, if not filed, their 2018 tax return. Payments will be distributed automatically beginning in mid-April, although some seniors and others who typically do not file returns will need to submit a simple tax return to receive the stimulus payment.
  - Unemployment: Expanded unemployment benefits are available through December 31, 2020. The additional $600 per week payments are available for up to four months. Unemployment claims must be filed in the state where you worked.

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