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COVID-19
Funding and Requirements

Presented by Toyon University

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About Our Speaker

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- Frequent speaker on regulatory issues
- Industry leader in interpretation, financial analysis, and strategy for regulatory and reimbursement issues
- Experience with Medicare cost reporting, regulatory changes, organ acquisition reporting, and value-based purchasing
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About Our Speaker

- Frequent speaker on regulatory issues
- Practice Line Leader for Toyon's Uncompensated Care Recognition Services
- Experience with regulatory changes, uncompensated care reporting and the Medicare Inpatient Prospective Payment System (IPPS)
- Former VP of Finance for the Hospital Alliance of New Jersey with a continued focus on evaluation of state and federal financing programs

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Disclosures

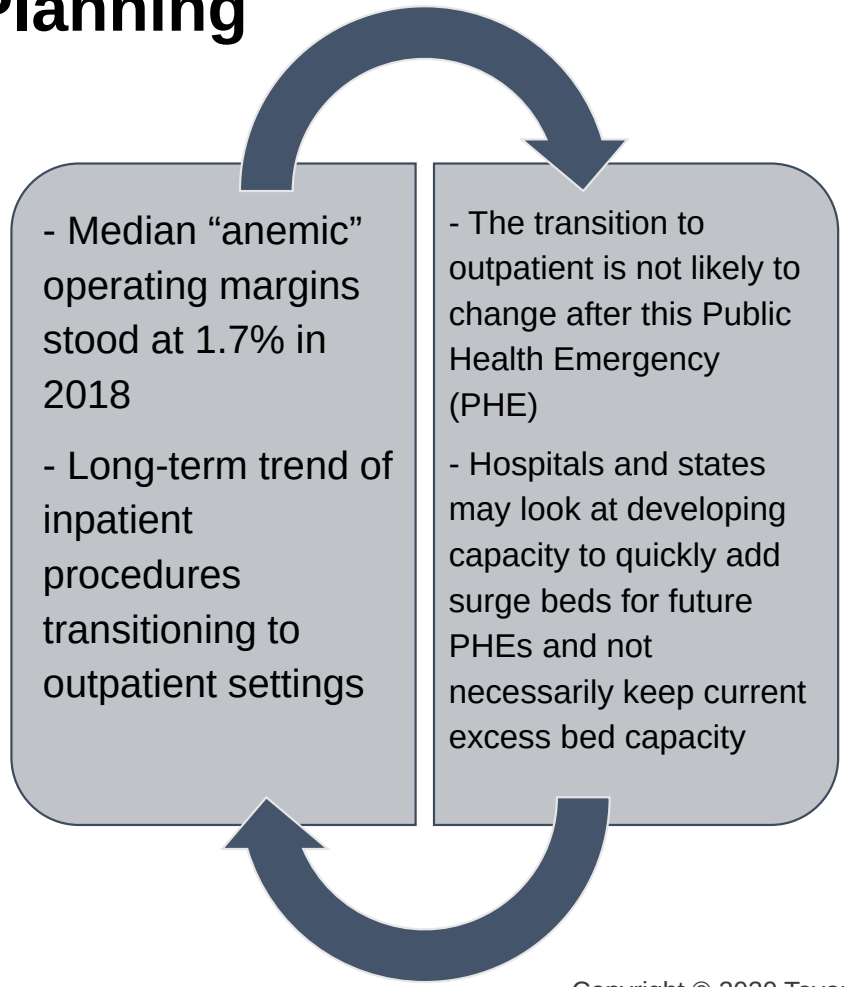
- The content in this presentation is focused primarily on hospitals.
- The information in this presentation is current to May 19, 2020. Therefore, subsequent details related to COVID-19 funding and documentation are not included in this presentation.
- Please visit https://www.toyonassociates.com/latest-covid-19-resources/ for updates, summaries, supporting details and COVID-19 funding models.

Agenda

- Funding and Methods
- Attestation | Terms and Conditions
- Reporting Revenue Loss
- Impacts on Medicare Cost Reporting
- Q&A

Hospital Pandemic Planning

Hospital Performance Prior to COVID-19



Funding and Methods

Medicare's Accelerated and Advance Payment (AAP) Program

- **The Accelerated and Advance Payment (AAP) Programs** increased cash flow to Medicare providers and suppliers impacted by COVID-19 by over **$100bn**.
- However, the AAP programs are **not a grant and require recoupment** within one year, or less, depending on provider or supplier type.
- CMS suspended advance Medicare payments on April 26, 2020.
  - CMS is assessing the funding to recipients, and how funds are being used before making future disbursements.

Funding and Methods

Medicare AAPs

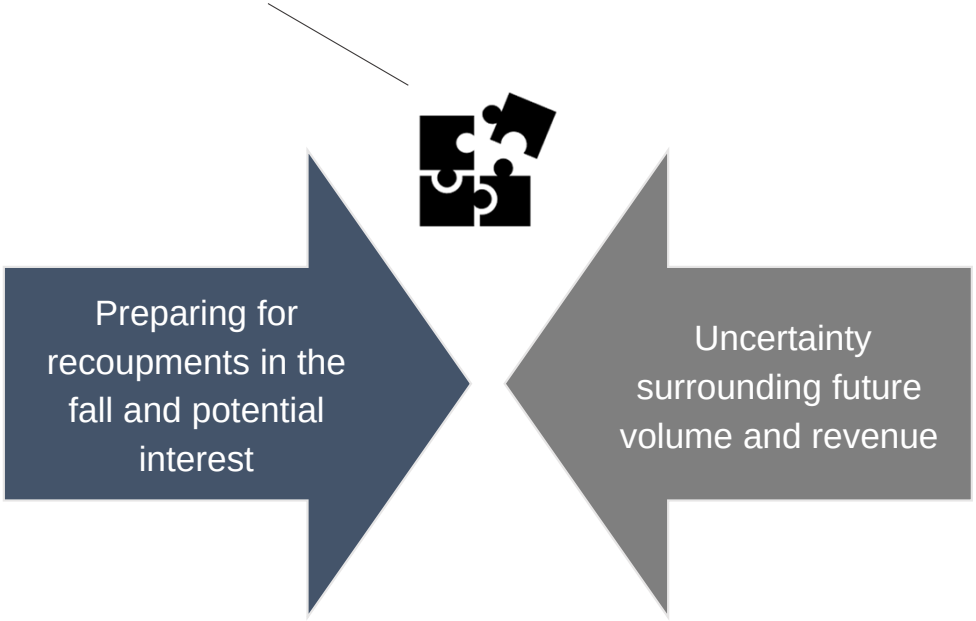
Category	Hospitals		Non-Hospital Providers | Suppliers		Grand Total	
Region	Count	AAP Amount	Count	AAP Amount	Count	Total
East North Central	919	13,583,627,695	6,123	2,811,350,734	7,042	16,394,978,429
East South Central	486	4,766,337,581	2,671	1,019,225,098	3,157	5,785,562,679
Middle Atlantic	524	12,784,308,199	5,277	2,610,084,098	5,801	15,394,392,297
Mountain	528	4,854,927,623	1,904	821,382,943	2,432	5,676,310,566
New England	242	5,807,862,781	2,601	1,745,962,155	2,843	7,553,824,936
Pacific	625	9,816,248,517	4,762	2,465,073,821	5,387	12,281,322,338
South Atlantic	901	15,775,232,936	7,697	3,511,991,313	8,598	19,287,224,249
US Province	64	115,046,487	138	22,354,938	202	137,401,425
West North Central	764	6,129,465,437	2,307	1,236,316,528	3,071	7,365,781,965
West South Central	1,067	8,419,771,405	5,148	2,040,592,950	6,215	10,460,364,355
Grand Total	**6,120**	**82,052,828,661**	**38,628**	**18,284,334,577**	**44,748**	**100,337,163,238**
Percentage of Total	**13.68%**	**81.78%**	**86.32%**	**18.22%**	**100.00%**	**100.00%**

*Hospitals include acute care, psychiatric, rehabilitation, childrens, cancer, long term care.

Funding and Methods

Medicare AAP Program Provider Concerns

Projecting future volumes (i.e., fall and winter) under extraordinary and emerging circumstances



Tips

- Hospital and patient care professionals establish short-term indicators, such as patient visits and consultations against various long-term goals and projections
- Process coordination involving finance working closely with revenue cycle tracking withhold amounts against actual and budgeted projections
- Running a Provider Statistical & Reimbursement (PS&R) report based on specific paid dates can assist with these efforts

Funding and Methods

Provider Relief Funding: *Does not require repayment**

$100bn from PHSSEF CARES Act (H.R. 748)

Administered by the Department of Health and Human Services (HHS) and Health Resources and Services Administration (HRSA)

Funds apportioned from the Public Health and Social Services Emergency Fund (PHSSEF)

$75bn Paycheck Protection Program & Health Care Enhancement Act (PL 116-139)

HHS has not provided details on how this will be distributed to hospitals

Medicare Relief

Est. $2.8bn Sequestration *(CARES Act)*

20% increase to MS-DRG for COVID-19 inpatients *(CARES Act)*

Families First Coronavirus Response Act (H.R. 6201)

$1bn Testing for Uninsured

Federal Medicaid match increase of 6.2%

(certified public expenditures and intergovernmental transfers)

Public Health Emergency Funding Grants

Federal Emergency Management Agency (FEMA)

$250m Hospital Preparedness Program

$50m Hospital Associations for Hospital Preparedness

*Subject to attestation of terms and conditions

Funding and Methods

CARES Act

How Providers Are Funded

Provider IDs

Provider must send HHS the following information:

- Billing Tax ID number(s)
  - Some system providers have hundreds of tax IDs
  - Tax IDs can be regional and some hospitals may have more than one ID
- Last six digits of deposit bank acct #
- Exact amount of relief payment(s)

Attestation

- Providers have 45 days to attest after receipt of CARES funding
- There are **two separate attestation portals**
  1. First tranche attestation requires confirmation of receipt and acceptance of terms and conditions
  2. Second tranche attestation is also applied if a first payment was received

Funding and Methods

CARES Act

How Providers are Funded

Other Data to HHS	Confirmation	Repayments	Application Process
• Most recent filed tax return (2017, 2018, or 2019), and estimated lost revenue for March/April 2020. • If the entity is not required to file a tax return, then most recent AFS. • If the entity files a consolidated tax return or AFS, then only one attestation is required. However, the TINs and payment information are required in the submission.	• Email from HHS when application is completed. • No HHS notification on status of application once submitted. • Inquiries from HHS are not anticipated; if additional information is requested, HHS will use the email used to access the Provider Portal.	• If a provider meets certain terms and conditions, the payments received do not need to be repaid at a later date. • Retention and use of funds are subject to certain terms and conditions. If these terms and conditions are met, payments do not need to be repaid at a later date. • There is no appeals or dispute process.	• HHS is processing applications in batches every Wednesday at 12:00 noon ET. • Funds are not disbursed on a first-come-first-served basis. Applicants are given equal consideration regardless of when they apply.

Funding and Methods

CARES Act

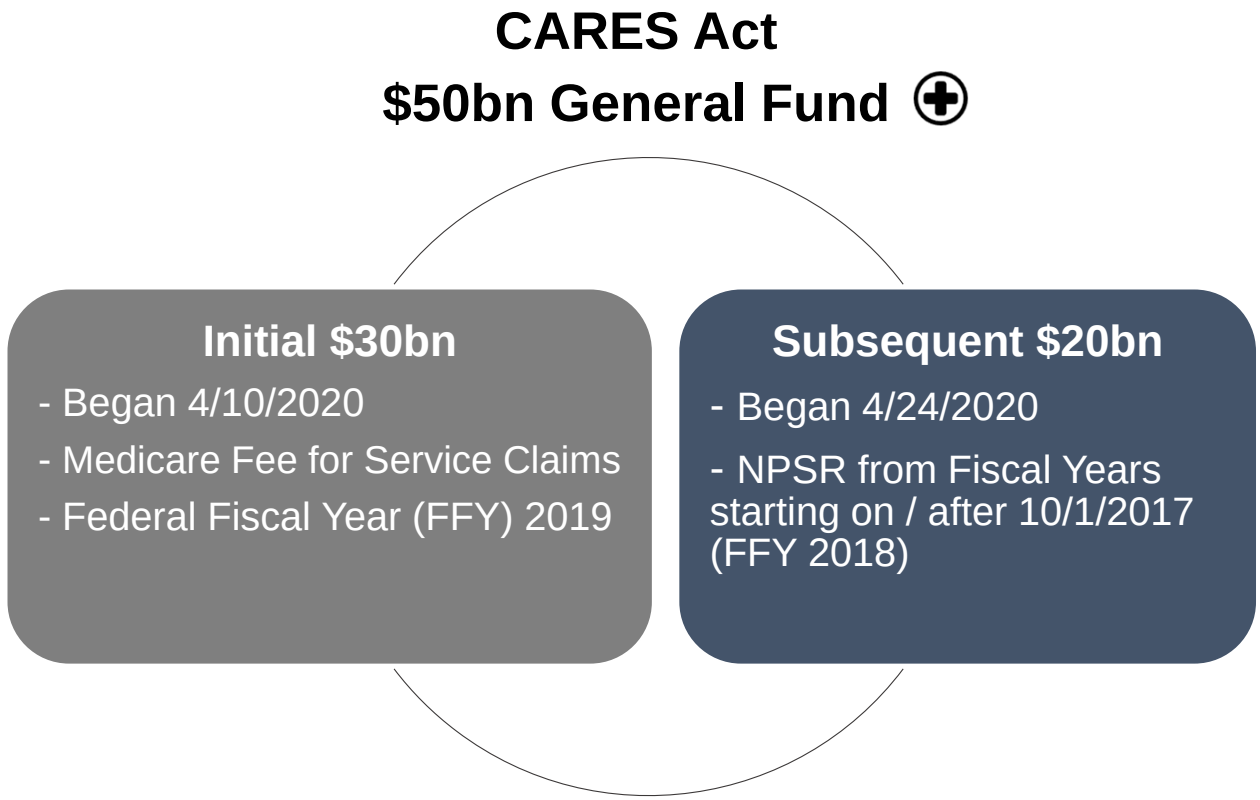
$100bn Estimated Funds Allocated to Eligible Hospitals

		A	B	C	D = A+B+C
Region	**Number of Hospitals**	**$50bn General Funds**	**$12bn High Impact Funds**	**$10bn Rural Funds**	**Total Est. Determined Funding**
East North Central	919	3,481,766,473	1,923,007,963	1,570,080,859	6,974,855,296
East South Central	486	1,102,517,448	110,703,177	999,041,852	2,212,262,476
Middle Atlantic	524	2,994,096,069	6,998,414,379	586,574,918	10,579,085,366
Mountain	528	1,379,694,223	141,554,570	982,745,687	2,503,994,480
New England	242	1,158,060,608	805,161,294	367,290,536	2,330,512,438
Pacific	625	3,776,753,157	334,089,012	793,322,322	4,904,164,491
South Atlantic	901	3,781,699,806	1,054,504,100	1,148,268,033	5,984,471,939
US Province	64	61,584,664	0	22,299,662	83,884,327
West North Central	764	1,577,037,357	150,473,024	1,950,077,914	3,677,588,295
West South Central	1,067	2,137,581,501	482,092,481	1,384,120,179	4,003,794,161
Hospital Total	**6,120**	**21,450,791,307**	**12,000,000,000**	**9,803,821,962**	**43,254,613,270**
Total Determined Funding		**50,000,000,000**	**12,000,000,000**	**10,000,000,000**	**72,000,000,000**
Hospital %		**42.90%**	**100.00%**	**98.04%**	**60.08%**

*Hospitals include acute care, psychiatric, rehabilitation, childrens, cancer, and long-term

Funding and Methods

Full allocation rebased at approximately 1.97% of Net Patient Service Revenue (NPSR). Providers that received more than this percentage in the first $30bn did not receive additional funding during the second tranche of $20bn.



Funding and Methods

CARES Act

$50bn General Fund (Est. Amounts to Eligible Hospitals)

		A		B	C = A+B
Region	Number of Acute Care Hospitals	Est Amt in $50bn General Funds	Number of all Other Hospitals	Est Amt in $50bn General Funds	Total Est. Determined Funding
East North Central	504	3,032,913,731	415	448,852,743	3,481,766,473
East South Central	302	1,025,291,093	184	77,226,354	1,102,517,448
Middle Atlantic	368	2,843,814,092	156	150,881,978	2,994,696,069
Mountain	244	1,196,079,495	284	183,614,728	1,379,694,223
New England	133	1,019,153,289	109	138,907,319	1,158,060,608
Pacific	406	3,452,303,637	219	324,449,520	3,776,753,157
South Atlantic	580	3,531,962,788	321	249,737,017	3,781,699,806
US Province	56	59,041,144	8	2,543,520	61,584,664
West North Central	258	1,278,124,028	506	298,913,329	1,577,037,357
West South Central	542	1,836,996,200	525	300,585,301	2,137,581,501
Hospital Total	**3,393**	**19,275,679,498**	**2,727**	**2,175,711,809**	**21,451,391,307**
Total Determined Funding					**50,000,000,000**
Hospital % of General Funding					**42.90%**

*All other hospitals include psychiatric, rehabilitation, childrens, cancer, long term care

Funding and Methods

CARES Act
$12bn COVID-19 High Impact Fund

Eligibility
395 hospitals with 100 or greater COVID-19 patients through 4/10/2020

Admissions
High Impact Provider total admissions are 129,911 (70% of total reported by 5,598 hospitals)

$10bn Allocation
Each hospital received $76,975 per admission totaling $10bn in base allocations

$2bn Allocation
Each hospital received a proportion of $2bn in funding based on Disproportionated Share (DSH) payments

Funding and Methods

CARES Act

$12bn COVID-19 High Impact Fund

		A	B = A*$76,975	C	D = B+C	E = D/A
Region	**Count**	**Est. # of COVID Admissions through 4/10/2020**	**Est Amt at $76,975 per Admission**	**Est. DSH Add-On to Payment**	**Grand Total High Impact Payments**	**Est Adj Per Admission Amount with DSH**
East North Central	77	20,169	1,552,538,527	370,469,437	1,923,007,963	95,343
East South Central	7	787	60,600,526	50,102,651	110,703,177	140,616
Middle Atlantic	144	80,924	6,229,103,277	769,311,102	6,998,414,379	86,482
Mountain	8	1,250	96,190,667	45,363,903	141,554,570	113,277
New England	34	8,281	637,418,501	167,742,793	805,161,294	97,232
Pacific	20	2,888	222,316,372	111,772,640	334,089,012	115,675
South Atlantic	55	9,271	713,642,371	340,861,729	1,054,504,100	113,741
US Province	0	0	0	0	0	0
West North Central	9	1,178	90,697,715	59,775,309	150,473,024	127,706
West South Central	20	5,164	397,492,044	84,600,438	482,092,481	93,358
Total Hospitals by PTAN	**374**	**129,912**	**10,000,000,000**	**2,000,000,000**	**12,000,000,000**	**92,370**

*Although 395 hospitals qualify for payment, these hospitals roll into 374 unique PTAN numbers.

Funding and Methods

CARES Act

$10bn Rural Fund

Rural Hospitals, Provider-based Rural Health Clinics (RHC), Independent RHCs and Critical Access Hospitals (CAH).

Rural areas defined per HRSA Rural-Urban Community Area (RUCA).

Rural hospitals receive tiered base payments from $1M to $3M based on NPSR + 1.97% op. exp.

Independent RHCs receive $100,000 per clinic site + 3.6% of the RHC's op. exp. (adjusted for budget neutrality).
Rural Community Health Centers receive $100,000 per site (adjusted for budget neutrality).

Funding and Methods

CARES Act

$10bn Rural Fund – Est. Eligible Amounts for Rural Providers

			A	B	C	D = A+B+C	E
Region	**Rural Hospitals and CAHs**	**Provider Based RHCs**	**Est. Total Rural Funding**	**Est. From $50bn General Fund**	**Est. From $12bn High Impact Fund**	**Grand Total**	**Advanced Medicare Payments**
East North Central	376	343	1,570,080,859	541,232,571	22,422,233	2,133,735,662	1,887,803,924
East South Central	271	219	999,041,852	252,926,839	8,700,862	1,260,669,553	1,260,606,563
Middle Atlantic	115	40	586,574,918	246,861,962	26,864,546	860,301,426	1,202,650,573
Mountain	262	160	982,745,687	217,498,848	8,703,109	1,208,947,643	649,546,513
New England	70	38	367,290,536	157,886,867	0	525,177,403	838,553,472
Pacific	178	229	793,322,322	260,347,279	0	1,053,669,601	1,157,200,657
South Atlantic	279	143	1,148,268,033	386,980,026	42,999,133	1,578,247,192	1,592,624,594
US Province	6	0	22,299,662	6,130,410	0	28,430,073	4,501,120
West North Central	549	611	1,950,077,914	386,938,883	0	2,337,016,797	1,513,691,353
West South Central	400	347	1,384,120,179	325,529,848	18,999,531	1,728,649,557	1,181,952,493
Total Rural Hospitals	**2,506**	**2,130**	**9,803,821,962**	**2,782,333,532**	**128,689,414**	**12,714,844,907**	**11,289,131,263**

*Does not include estimates for community health centers, federally qualified health centers and independent RHCs.

Funding and Methods

CARES Act

Est. Eligible Amounts to Critical Access Hospitals (CAH)

		A	B	C = A+B	D
Region	**CAHs**	**Est. Rural Funding**	**Est. From $50bn General Fund**	**Grand Total**	**Advanced Medicare Payments**
East North Central	215	814,095,402	178,244,276	992,339,678	523,940,667
East South Central	79	261,764,908	27,176,480	288,941,388	83,600,606
Middle Atlantic	34	119,854,242	19,880,292	139,734,534	70,841,798
Mountain	169	587,775,049	87,408,355	675,183,404	260,443,627
New England	42	202,969,227	66,175,982	269,145,209	401,678,615
Pacific	126	478,146,748	102,590,377	580,737,125	450,653,275
South Atlantic	98	338,100,359	49,360,469	387,460,829	146,884,548
West North Central	420	1,414,760,416	183,554,874	1,598,315,289	667,729,219
West South Central	180	589,919,084	56,416,499	646,335,583	136,382,200
Total CAHs	**1,363**	**4,807,385,434**	**770,807,604**	**5,578,193,038**	**2,742,154,555**

Funding and Methods

$100bn CARES Appropriation

Undetermined | Unallocated Funds

Fund Description	Amount
Total PHSSEF (CARES Act) Allocation	$ 100,000,000,000
Less: General Allocation	(50,000,000,000)
Less: COVID-19 High Impact Areas	(12,000,000,000)
Less: Rural Providers	(10,000,000,000)
Less: Indian Health Services (IHS)	(400,000,000)
Unallocated Funds	**$ 27,600,000,000**

COVID-19 Funding | Methodologies

CARES Act

HRSA's Uninsured Payment Program (P.L. 116-136)

Reference	Funding Description
COVID-19 Uninsured Program Portal https://coviduninsuredclaim.linkhealth.com/	• Hospitals providing COVID-19 testing/treatment to uninsured patients will be reimbursed at Medicare rates for service dates on or after 2/4/2020. • These payments do not include the 20% increase to the DRG weight for COVID-19 diagnoses U07.1 and B97.29 authorized by Section 3710 of the Cares Act."
Notable from Terms and Conditions https://www.hhs.gov/sites/default/files/terms-and-conditions-uninsured-relief-fund.pdf	• *"The Recipient will not include costs for which Payment was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received."*

Tip: Establish new payor code associated with HRSA's Uninsured Program

Tip: Follow established procedures per patient financial assistance policy(s) to determine the insurance status of a patient at the time services were provided. This may include checking for patient eligibility based on information obtained from the patient.

COVID-19 Funding | Methodologies

CARES Act

$200M Telehealth Funding Program (H.R. 748)

Reference	Funding Description
Telehealth Public Notice (4/2/2020) https://docs.fcc.gov/public/attachments/DA-20-394A1.pdf	Three steps to apply for the COVID-19 Telehealth Program: (1) obtain an eligibility determination from the Universal Service Administrative Company (USAC); (2) obtain an FCC Registration Number (FRN); and (3) register with System for Award Management.
Notable from FAQs https://www.fcc.gov/covid-19-telehealth-program-frequently-asked-questions-faqs	• Non-grant reimbursement program for non-profit health care providers rural or non-rural areas or U.S. territories for eligible services and devices purchased on or after March 13, 2020. • **Telecommunications Services and Broadband Connectivity Services** - Voice services, for health care providers or their patients. • **Information Services** - Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation. • **Connected Devices/Equipment** - Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.

Funding and Methods

FEMA

Reference	Funding Description
COVID-19 Pandemic: Eligible Emergency Protective Measures (3/19/2020) https://www.fema.gov/news-release/2020/03/19/coronavirus-covid-19-pandemic-eligible-emergency-protective-measures	Governments and certain private not-for-profits including hospitals and related facilities, clinics, long-term care facilities, and outpatient facilities. FEMA assistance will be provided at a 75 percent federal cost share and will not duplicate assistance provided by HHS, CDC or other federal agencies. The Public Assistance application is simplified online at www.grantee.fema.gov.
	Management – Emergency Operation Center costs | Training | Disinfection of eligible public facilities | Technical assistance to governments on emergency management **Emergency medical care** – Medical treatment (and supplies) of infected persons in a shelter or temporary medical facility | Temporary medical facilities and/or enhanced medical/hospital capacity | Access to specialized medical equipment | Medical waste disposal | Emergency medical transport **Medical sheltering** – Purchase and distribution including personal protective equipment (PPE) | Communications of general health and safety information to the public | Reimbursement for government force account overtime costs Examples of emergency eligible overtime costs include (per AHA): overtime labor for budgeted employees and straight-time and overtime labor for unbudgeted employees, backfilled employee labor, call-back pay, night-time pay, weekend differential pay, stand-by time, necessary equipment supplies and materials.

Attestation | Terms and Conditions

Terms and Conditions for Provider Relief Fund Distributions

Terms and Conditions
Relief Fund Payment from $20 Billion General Distribution - PDF
Relief Fund Payment from $30 Billion General Distribution - PDF
FFCRA Relief Fund Payment Terms and Conditions - PDF
Uninsured Relief Fund Payment Terms and Conditions - PDF
High Impact Relief Fund Payment Terms and Conditions - PDF
Rural Provider Relief Fund Payment Terms and Conditions - PDF

https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/terms-conditions/index.html

Attestation | Terms and Conditions

Healthcare Entity Identifiers

- Tax ID Number (TIN)
- National Provider Identifier (NPI)

- Provider Transaction Access Number (PTAN)
- Medicare Certification Number (CCN)
- State Medicaid Provider Number

Additional IDs for Telehealth Funding:

- Business Type (Data Accountability and Transparency (DATA) Act Business Types)
- Data Universal Number System Number (DUNS)
- FCC Registration Number (FRN)

Attestation | Terms and Conditions

CARES Funding – Notable T&Cs

Quarterly Reports	Recipients submit a report within 10 days after each calendar quarter regarding the use of the funds.	HHS shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.
Out of Network Patients	Recipients agree to not balance bill any patient for out-of-network services (i.e., the amount above if in-network) during the public health emergency period.	**Tip**: Hold patient bills during the PHE; pro-actively writing off patient copayments as underpayments; and/or applying new payer and transaction codes.

Attestation | Terms and Conditions

CARES Funding – Notable T&Cs continued

Avoiding Funding Duplication

"*The Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.…The Recipient will not include costs for which Payment was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.*"

Tip: Identify and delineate items reimbursed in current and future legislation during the emergency period. Consider funds from the Payroll Protection Program, FEMA assistance, additional COVID-19 expense reimbursement, uninsured and indigent reimbursement (Medicare Empirical DSH, UC DSH, State 1115 Reimbursement Programs). Additional considerations for Volume Decrease Relief Adjustments for certain hospitals are pending.

Reporting Revenue Loss

PHE Impact

- Lost revenue (i.e., higher-margin elective and ambulatory services on hold)
- Less favorable payer mix (i.e., COVID patients are largely Medicare and Medicaid)
- Increased bond interest rates (i.e., rating agencies have lowered outlook for not-for-profits)
- Higher labor costs (i.e., overtime, more contract labor, additional sick time)
- Higher supply costs (i.e., shortages, significant price mark-ups)

Recommendations

- Collaborate with advocates and states to continue to relax or suspend regulatory requirements
- Document increased costs and lost revenue attributed to the pandemic
- Use standard templates for statewide reporting and capturing of data
- Apply for all relief funds now, future tranches are likely to be politically challenging
- Develop monthly management reports or dashboards to track COVID-19 impacts

Reporting Revenue Loss

CARES Funding Data Collection

NPSR Collection*

- Understanding of a provider's usual operations.
- Revenue loss for COVID impact.
- Tax forms to verify the self-reported information.
- Organizational structure and subsidiary TINs**

Submission of Revenue Loss Data

Before application in the Provider Relief Fund Application Portal, collect and provide estimated organizational lost revenue for March 2020 and April 2020***.

*This information may also be used in allocating other Provider Relief Fund distributions.

*** For April 2020, an estimate of the total monthly loss based on data from the first few weeks in April or by extrapolation from March data is acceptable.

***To ensure providers who file tax returns covering multiple legal entities (e.g., consolidated tax returns) are not over/under paid.

Reporting Revenue Loss

CARES Funding – Quarterly Reports

Quarterly Reports

T&Cs require quarterly reports for entities receiving more than $150K in CARES Funding (due 10 days after close of the quarter).

First reports are due July 10. Providers are awaiting further details from HHS.

Revenue Loss

Retention of funding is considered primarily related to the quantification of lost revenue.

Providers are evaluating reporting revenue loss using budget to actual, year over year, and/or hybrid methodologies.

Reporting Revenue Loss

CARES Funding – Quarterly Reports

Funding

- Total amount of funds received from HHS under the foregoing enumerated Acts
- The amount of funds received that were expended or obligated for each project or activity

Expenses

- A detailed list of all projects or activities for which the funds were expended or obligated, including:
  - The name and description of the project or activity
  - The estimated number of jobs created or retained by the project or activity
  - Where applicable; and detailed information on any level of subcontracts or subgrants awarded by the Recipient or its subcontractors or subgrantees

Data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the OMB.

Reporting Revenue Loss

CARES Funding – Quarterly Reports

Reporting Approaches

Budget to Actual

Budgeted revenue during March and April compared to the same actual period had COVID-19 not appeared

Year over Year

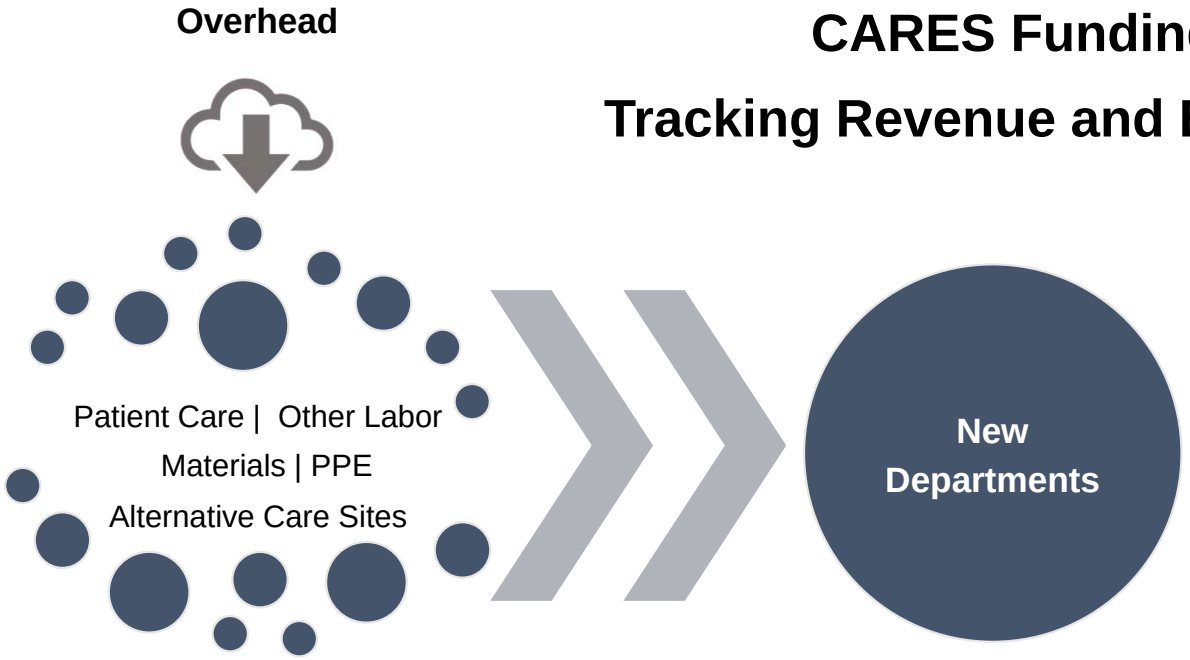
Actual revenue received during March and April compared to same period last year

Hybrid Methods

Assessment against unique activity for 2020 resulting in cost increase—for instance, purchases to prepare for COVID-19

Consideration of hospital region, insurance recoveries, additional staffing and retaining patients unable to discharge to post acute care

Reporting Revenue Loss



CARES Funding

Tracking Revenue and Expenses

Integrated cost accounting systems (with systems like payroll) help quantify time and resources allocated to COVID-19 time | patients.

Total Costs

Reporting Revenue Loss

CARES Funding

Tracking Revenue and Expenses

Other Considerations for New COVID-19 Departments

Funding Relationships and other Departments

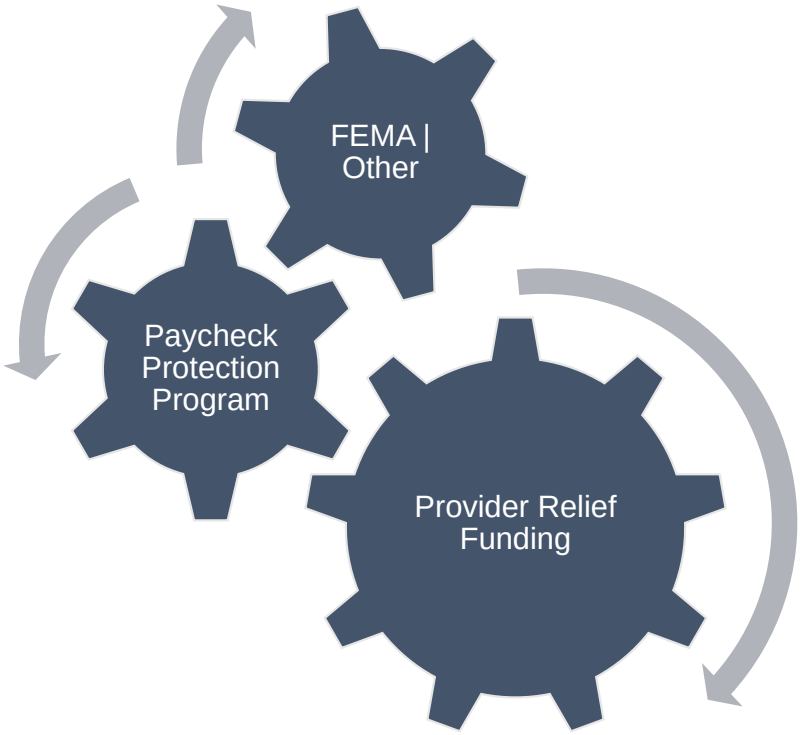
- Consideration of the extension of existing departments, like Emergency.
- Identification of costs and revenue from varying sources and funding programs. Reconciling FEMA revenue with other grants.
- Allocations for systems across multiple states and regions.
- Applied lessons learned from providers with experience from previous emergencies (e.g., hurricanes and earthquakes) help provide insight on funding and revenue loss.

PPE

- PPE may be currently sitting on the balance sheet, as it has not been used.
- PPE will be allocated to disaster response and providers are placing strict guidelines around what can be coded as PPE in these departments.
- When PPE is purchased in bulk, it may be attributed to disaster response | recovery vs. patient care.

Impacts on Medicare Cost Reporting

Other Government Revenue Considerations



Critical Access Hospitals and Rural Health Clinics

Is this considered "reimbursement from other sources that are obligated to reimburse"?

Impacts on Medicare Cost Reporting

Teaching Hospitals, Teaching Physicians, and Medical Residents

Claim residents' time in alternate locations (own home or patient's home) subject to supervision requirement

Claim GME training at other non-teaching hospitals if in response to COVID-19 (all three are met):

1. Training in lieu of training at teaching hospital
2. Training time was included in teaching hospital's
3. FTE count prior to and/or subsequent to the PHE

Hold harmless for temporary beds added during PHE

(added beds not considered for IME IRB ratio)

Impacts on Medicare Cost Reporting

Physician Time Studies

- During the PHE, any one of these time study options is acceptable:
  - One-week time study every 6 months (two weeks per year)
  - Time studies completed in the cost report period prior to January 27 (i.e., the PHE effective date)
    - For instance, a hospital with a 7/1/2019 - 6/30/2020 cost reporting period could use the time studies collected 7/1/2019 through 1/26/2020. No time studies needed for 1/27/2020 - 6/30/2020.
  - Time studies from the same period in CY 2019
    - For instance, if unable to complete time studies during February through July 2020, use time studies completed February through July 2019.

Impacts on Medicare Cost Reporting

CMS Waivers and Flexibilities

Temporary Expansion Sites (Surge Sites)

- Hospitals may change status of their current provider-based department locations to the extent necessary to address the needs of patients during the pandemic
- Includes remote locations, such as hotels or community facilities
- Provider-based outpatient departments
- Must still control and oversee services at alternative locations

CAHs:

- May expand beyond 25 beds
- May incur lengths of stay greater than 96 hours
- May open surge sites not in rural locations or regardless of location relative to other hospitals

Impacts on Medicare Cost Reporting

CMS Waivers and Flexibilities

Sub-acute Settings

- Acute care patients may be housed in excluded distinct part units (e.g., IPFs, IRFs)
- May still bill under excluded PPS
- IRF “60 Percent Rule” waived during PHE

Impacts on Medicare Cost Reporting

Other Considerations

- Providing subacute inpatient services in acute beds
- Telehealth services
- Impact on 340B eligibility

COVID-19 Other Issues

Homebound Definition
(for lab specimen collection)

Medically contraindicated for the patient to leave home safely and would require a considerable and taxing effort

Patients exercising "self-quarantine" are ***not*** considered homebound

Cost Reporting

ASCs that converted to hospitals will be deemed to have "no/low Medicare utilization" and will only be required to submit a signed certification page (Worksheet S) five months after their fiscal year end

Adjustments to Claims Processing

"DR" condition code for inpatient and outpatient temporary expansion sites

"CR" condition code for use by practitioners for patients treated in these expansion sites

May not charge a patient differential for a private room when medically necessary

Questions?

Thank you for your participation!

Please visit https://www.toyonassociates.com/latest-covid-19-resources/ for updates, summaries, supporting details, and COVID-19 funding models.

Contact Toyon Associates at 888.514.9312