NATIONAL RURAL HEALTH RESOURCE CENTER

Delta Region Community Health Systems Development Hospital and Clinic Webinar Series - COVID Financial Recovery Part III: Operational Considerations

Speakers:

- Kevin Rash, Director, BKD
- Jaimie Pham, Senior Consultant, BKD
- Eric Rogers, Director, BKD

This webinar does qualify for ACHE credits, if you are a member of the American College of Healthcare Executives and would like to receive the 1 hour of credit, please reach out to Program Coordinator, Synneva Hackman.


Kevin Rash


Jaimie Pham


Eric Rogers

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $8,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

NATIONAL RURAL HEALTH RESOURCE CENTER

COVID Recovery Series

Financial Recovery Part III: Operational Considerations

7.31.2020

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Delta Region Community Health System Development (DRCHSD) Program Supported By:

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Agenda

1. Reopening and Realigning Hospital Service Lines
2. Monitoring Labor Productivity and Realignment Post Pandemic
3. Waivers, Quality and ACO Implications

Speakers

1 Kevin Rash

2 Jaimie Pham

3 Eric Rogers

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Reopening and Realigning Hospital Service Lines

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Hospital Operational Response to COVID Pandemic

Crisis Management

Hospital Incident Command
- Sections & Chiefs
- *Incident Action Plan*
- Command Staff

Community Health Needs

Hospital Health Needs

Endure Crisis

Hospital Incident Command
- *Incident Action Plan*
- *Demobilization Plan*

Community Health Needs
- Delaying Care
- Declining Needs

New Delivery methods
- Telehealth

Regulation Changes
- Requirement waivers

Financial
- CARES Act
- Decline of Revenue

Hospital Health Needs

Strategic Assessment & Alignment

Hospital Incident Command
- *Incident Action Plan*
- *PDSA Plan*
- *Open*
  - *– CDC & CHD*

Hospital Health Needs
- Reduce workforce
- Provider Agreements
- Service Lines
- Delayed Care Now

Community Health Needs

New ERA of Care

Being defined for next 6-18 months

How do we assist now and in the future

Strategic Operating Planning

Revenue Optimization

- Securing Federal Cares Act Funds
  - Use Of Federal Cares Act Funds
- Reimbursement
- Payer Contract Management
- Billing & Collection
- Denials & Bad Debt
- CDM Management
- Documentation & Coding

Cost Management

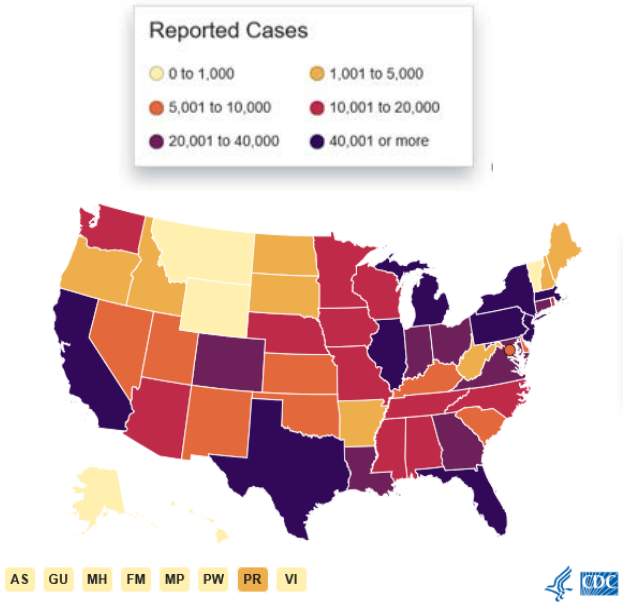
- Management Structure
  - Span Of Control
- Departmental Staffing
  - Labor Benchmarking, Fixed Positions
- Supply Chain
  - Supply Cost, Vendor Contract Management, Process: P2P
- Drug Utilization & Cost
- Provider Contract Review & Restructuring

Markets & Opportunity

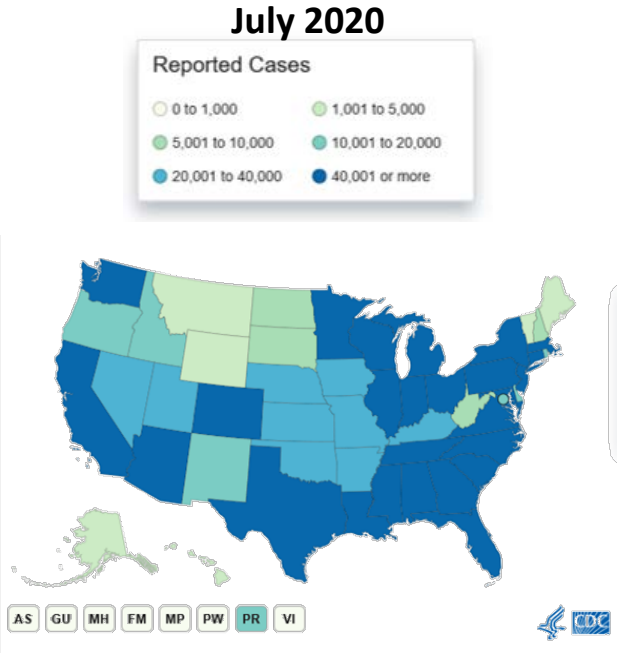
- Volume Projections
- Physician Needs
- New Services
- Services To Reduced Or Eliminate

COVID-19 Reported Cases Timeline

May 2020



July 2020



Guidance Considerations for Reopening

- Center of Disease Control and Prevention
- State
- City
- County
- Health Organizations

For more information: Visit CDC Guidelines

Healthcare Associations Joint Statement
ASC, ASA, AORN, AHA

"Hospitals are carefully considering options to restart elective surgeries and medical care. Unfortunately, reopening won't be as simple as leaving where we left off before the SARS-CoV-2 virus and the incidence of COVID-19 occurred."

Summation Check List for Procedural Areas:

Timing for Reopening of Elective Surgery
COVID-19 Testing Within a Facility
Case Prioritization & Scheduling
Post-COVID-19 Issues for the Five Phases of Surgical Care
- Phase 1: Preoperative
- Phase II: Immediate Preoperative
- Phase III: Intraoperative
- Phase IV: Postoperative
- Phase V: Post Discharge Care Planning

Collection & Management of Data, Financial, Operational and Safety/Quality
COVID-19 Related Safety & Risk Mitigation Surround Second Wave
Additional COVID-19 Related Issues

Reopening & COVID-19 Testing

- COVID-19 Testing Within a Facility
  - Be prepared with available testing kits and/or rapid testing whenever available
  - Establish process flow that screens patients by survey to alleviate testing constraints
  - Continue to support staff and patients by implementing daily temperature checks at entrance, complimentary masks, and testing support for needed staff
- COVID-related Safety and Risk Mitigation surround Second Wave
  - Update and implement social distancing, mask wearing, and other safety policies for staff, patients and visitors
  - Restrict number of persons that can accompany the procedural patient to the facility

Reopening Service Lines Focuses

- Case Prioritization, Scheduling, Service Lines Opening:
  - Gather list of all previously **cancelled/postponed and new cases**
  - Create clinically led task force to review elective cases and surgical plans to move forward
  - Develop strategy for phased opening of operating rooms, which include capacity goals, outpatient versus inpatient case composition and prioritization
  - Ensure adequate availability of inpatient and ICU beds and **supplies** for postoperative care
  - Ensure **supply chain** reliability, with emphasis on surgical supplies, implants, and anesthesia support. This includes verification of expiry products and incoming shipment tracking for COVID-related delays.
  - Determine policy and guidelines for COVID-19 positive procedural candidate, which includes treatment, postponement of procedure, and further timelines

Monitoring Labor Productivity and Realignment Post Pandemic

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Labor Productivity:
Pre COVID-19 & Post COVID-19

- Establish labor productivity baseline Pre COVID-19
  (3-6 Months, August 2019 through February 2020)
- Understand COVID-19 Impact
  (March 2020 through May 2020)
- Develop Productivity Standard Going Forward:
  Worked Hours per Unit of Service

Labor Productivity:
COVID-19 Timeline, No-Flex Staff Departments

Baseline

Pre COVID-19

COVID-19 Impact

Time Frame By Pay Period	Department Name	Unit of Service	UOS Volume	Total Productive Hours	Total Paid Hours	Total Productive Hours Per UOS	Benchmark	Variance Range		Total Paid FTE
12/01/2018 - 11/30/2019	Lab 1	Procedures	174,268	45372.74	48961.20	0.260	0.130	5.9	11.8	23.5
12/01/2018 - 11/30/2019	Lab 2	Procedures	209,664	33031.48	35850.73	0.158	0.115	2.3	4.7	17.2
12/07/2019 - 02/29/2020	Lab 1	Procedures	50,302	12502.15	13253.69	0.249	0.130	5.6	11.3	23.7
12/07/2019 - 02/29/2020	Lab 2	Procedures	54,759	9305.18	10320.51	0.170	0.115	3.0	6.0	18.4
03/14/2020 - 05/23/2020	Lab 1	Procedures	32,291	9909.93	10937.43	0.307	0.130	6.6	13.1	22.8
03/14/2020 - 05/23/2020	Lab 2	Procedures	45,813	7610.83	8136.38	0.166	0.115	2.6	5.2	17.0

Time Frame By Pay Period	Department Name	Unit of Service	UOS Volume	Total Productive Hours	Total Paid Hours	Total Productive Hours Per UOS	Benchmark	Variance Range		Total Paid FTE
12/01/2018 - 11/30/2019	Emergency Department	Visits	18,716	82511.36	86688.96	4.409	2.230	10.3	20.6	41.7
12/07/2019 - 02/29/2020	Emergency Department	Visits	4,727	20504.01	21974.43	4.338	2.230	9.5	19.1	39.2
03/14/2020 - 05/23/2020	Emergency Department	Visits	3,111	15930.27	16787.71	5.121	2.230	9.9	19.7	35.0

Labor Productivity:
COVID-19 Timeline, Flex Staff Department, continued

Baseline

Pre COVID-19

COVID-19 Impact

Time Frame By Pay Period	Department Name	Unit of Service	UOS Volume	Total Productive Hours	Total Paid Hours	Total Productive Hours Per UOS	Benchmark	Variance Range		Total Paid FTE
12/01/2018 - 11/30/2019	Behavioral Health	Equivalent Patient Days	4,280	67087.58	71774.86	15.675	9.542	6.8	13.5	34.5
12/07/2019 - 02/29/2020	Behavioral Health	Equivalent Patient Days	1,156	16313.50	17937.83	14.112	9.542	5.2	10.4	32.0
03/14/2020 - 05/23/2020	Behavioral Health	Equivalent Patient Days	912	13047.38	14025.92	14.306	9.542	4.9	9.7	29.2

Waivers, Quality, and ACO Implications

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Diagnostic Testing

Supervision of Testing	Ordering of Labs	Coverage		Payment
Expanded to Non-Physician Practitioners • NPs • CNSs • PAs • CNMs	• Applies to COVID-19, Influenza, and RSV Testing • Removes requirement that order comes from a treating provider *For influenza and RSV only- applies if in conjunction with a COVID-19 diagnostic test	Medicaid coverage: • COVID-19 testing provided in non-office settings • Lab processing for self-collected COVID-19 tests (FDA-Approved)	Antibody Serology: • Interim coverage for antibody serology testing during PHE • Developing coverage criteria to be used after the PHE	COVID-19 testing • Additional payment for assessment and specimen collection • Expands use of 99211 (assessment and specimen collection) for new patients, not just established patients

Healthcare Workforce Augmentation

- CMS' Goals for Workforce Augmentation During the PHE:
  1. Remove barriers to keeping staffing levels high at hospitals and other healthcare settings
  2. Cutting red tape for professionals to work at top of license
- Home health services can be ordered by non-physician providers along with certification of eligibility and review of home health care plan
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Physician Assistants can now provide home health services, as mandated by the CARES Act.
- Teaching hospitals can shift residents to other hospitals without reduction in Medicare payments or penalties

Healthcare Workforce Augmentation (continued)

- Physical and Occupational Therapists (PT and OT) can now delegate maintenance therapy services to PT and OT assistants in outpatient settings
- Ambulatory Surgery Centers (ASC)- Waiving requirement for ASCs to periodically reassess medical staff privileges allowing providers with expiring privileges to continue taking care of patients
- Rural Health Clinics (RHC)- Waiving requirements for nurse practitioner, physician assistant, or certified nurse-midwife is available to furnish care at least 50% of the RHC operation time

Patients over Paperwork

- CMS' Goal- Decrease paperwork and administrative burden!
- Mental Health- Allowing payment for some partial hospitalization services delivered in temporary expansion locations including patient's home
  - Individual psychotherapy
  - Patient education
  - Group psychotherapy
- Hospital Value-Based Purchasing (VBP) Program-
  - Extraordinary Circumstance Exception (ECE) Policy from 2014
  - Mitigates adverse impact on quality performance and resulting payments as a result of unforeseen circumstances outside of the hospital's control
  - CMS is updating the ECE policy to include exceptions for all hospitals located in hard hit COVID-19 regions without hospitals submitting requests

ACO Flexibilities

- Calculation of Shared Losses:
  - Extreme and Uncontrollable Circumstances Policy began January 2020
  - Shared losses mitigated based on length of the PHE
    - Ex. PHE lasts from January through June 2020 means shared losses could be halved

- Quality Reporting for 2019 PY:
  - Reporting period was extended to April 30th
  - ACOs who did not report will receive the Nat'l mean score
  - ACOs that did complete will receive the higher of the Nat'l mean or their own score
  - Impact to 2020 reporting is ongoing

Participation in Shared Savings Program

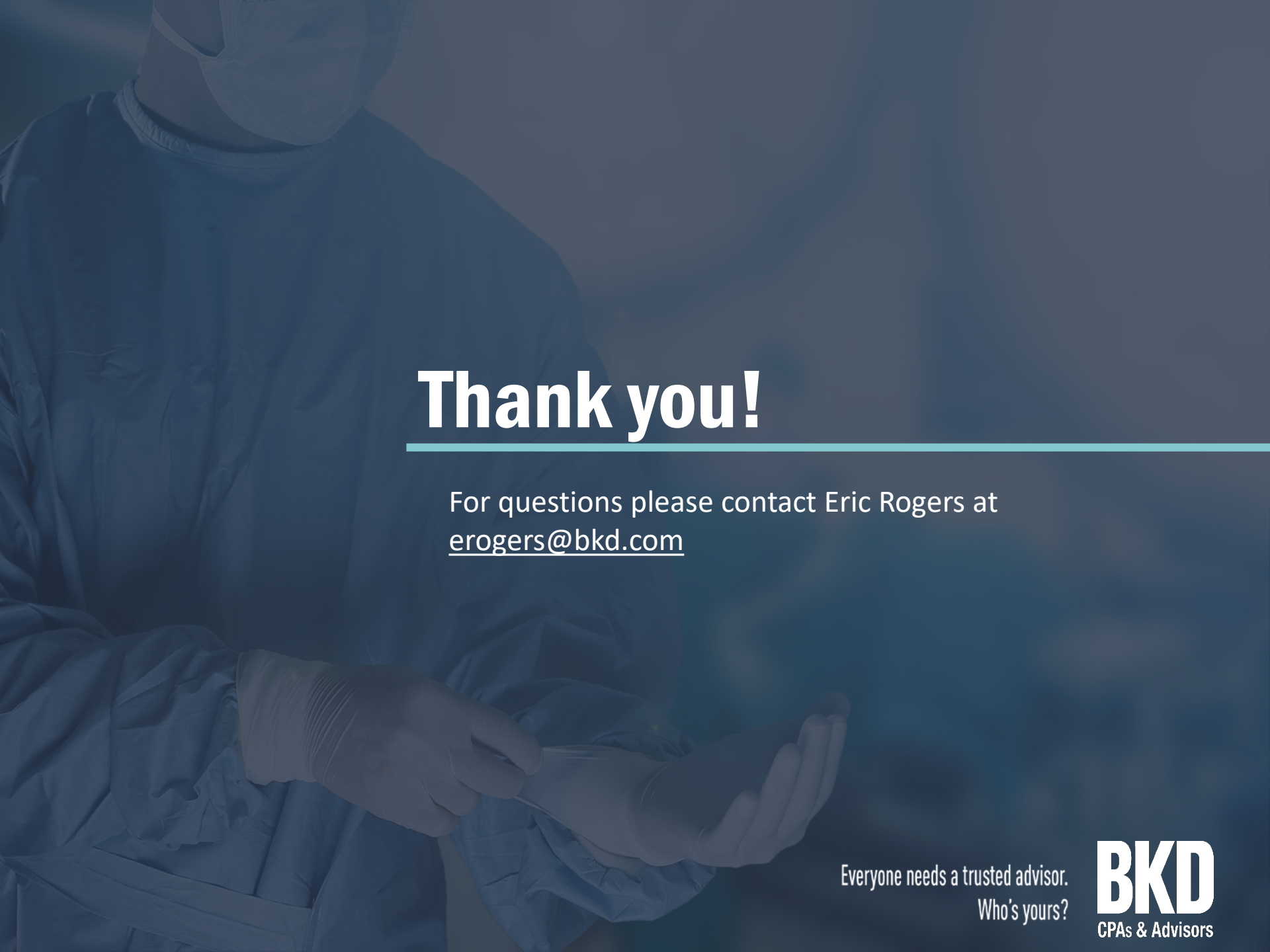
- No application cycle in 2020 for PY 2021
- Voluntary options for 2021:
  - Voluntary elect to extend period for agreements ending 2020
  - Option to forgo automatic advancement in BASIC track
  - For current ACOs, still have option to:
    - Apply for SNF 3-day and/or Beneficiary Incentive Program,
    - Select beneficiary assignment methodology, and
    - Make changes to Participant or SNF Affiliates
- Initial election/change request available from 06/18 – 07/20
  - RFI rounds from early August through September
  - Final Disposition 10/20
  - Annual Participant Certification 10/27 – 11/09

Financial Methodology Flexibilities

- All COVID episodes of care (EoC) removed for:
  - Part A and B benchmark and performance year expenditures
  - National/Regional trend update factors
  - Truncation factors
  - Revenue-based loss recoupments
  - Low/High revenue ACO participation determination
- EoCs are triggered by inpatient services for treatment of COVID:
  1. IP discharges eligible for 20 percent DRG adjustment
  2. IP CAH discharges

Telehealth and Beneficiary Assignment

- 2020 and subsequent PYs starting during PHE
- Additional codes added to primary care list for beneficiary assignment:
  - Remote evaluation of patient video/images (G2010)
  - Virtual check-ins (G2012)
  - Online digital E&M services (CPTs 99421-99423)
  - Telephone evaluation and management services (CPTs 99441-99443)



Thank you!

For questions please contact Eric Rogers at erogers@bkd.com

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