TASC FEDERAL POLICY UPDATE – MAY 12, 2020, 2:00 P.M C

DECLARATION OF COVID-19 AS A NATIONAL EMERGENCY, MARCH 1, 2020
COVID-19 EMERGENCY BLANKET WAIVERS

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Emergency Waivers

- **CAHs**
  - Capacity: 25 bed limit; 96 hour LOS; rural location (for CAH surge sites)
  - Workforce: deference to state law for staff licensure; personnel qualifications
- **Post-acute**
  - 3-day SNF waiver, also applies to swing beds
  - Renewed SNF coverage without new benefit
- **Workforce**
  - Out-of-state providers; NP practice flexibility
- **RHCs/FQHCs**
  - MD supervisions & staffing flexibilities
  - Service location expansion
  - NEW: (4/30) Rural hospitals with provider-based RHCs can increase bed capacity without impact to payment

CMS Releases Additional Waivers for Hospitals and Other Facilities (see addendum)

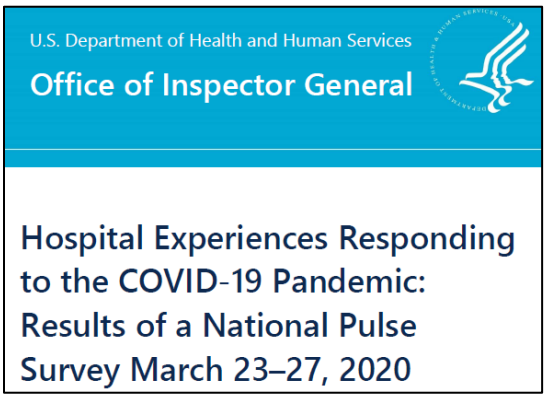
CMS continues to release waivers for the healthcare community that provide the flexibilities needed to take care of patients during the COVID-19 public health emergency (PHE). CMS recently provided additional blanket waivers for the duration of the PHE that:

- Expand hospitals' ability to offer long-term care services ("swing beds");
- Waive distance requirements, market share, and bed requirements for Sole Community Hospitals;
- Waive certain eligibility requirements for Medicare-Dependent, Small Rural Hospitals (MDHs); and
- Update specific life safety code requirements for hospitals, hospice, and long-term care facilities.

Hospital Guidance

- The Interim Final Rules and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf
- CMS has released guidance to describe standards of practice and flexibilities within the current regulations for hospitals (including critical access hospitals and psychiatric hospitals) at https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2
- CMS guidance also addresses hospital flexibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to establish alternate testing and triage sites to address the pandemic at https://www.cms.gov/files/document/qso-20-15-hospitalcahemtala.pdf
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19 https://www.cms.gov/files/document/covid-rural-health-clinics.pdf

COVID-19 LEGISLATION



- **Phase 1 (3/6)**: Coronavirus Preparedness and Response Supplemental Appropriations (H.R. 6074)
- **Phase 2 (3/18)**: Families First Coronavirus Response Act Becoming Law (H.R.6201)
- **Phase 3 (3/27)**: Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748) created the $2T emergency fund for providers: Fact Sheet: Provisions to Help Rural Hospitals
- **Phase 3.5 (4/24):** Paycheck Protection Program and Health Care Enhancement Act (H.R. 266) replenished emergency fund by $75B and PPP by $310B

Next COVID-19 Relief Package

- Federal support for healthcare heroes
- Accelerated payment forgiveness for hospitals
- Increase health insurance coverage
- Liability relief
- Hospital heroes
- Coverage for the uninsured

Looking Ahead: Phase 4 and Beyond

- **Phase 4**
  - Rural priorities
  - Loan forgiveness
- **Non-COVID-19 Priorities**
  - Rural Emergency Hospital designation
  - Reopen necessary provider designation
  - Telehealth
  - More

Rural Distribution Methodology $10 billion allocation to rural hospitals and providers
This funding recognizes that rural hospitals, health clinics, and health centers function with lower operating margins than urban and suburban providers and thus are at greater risk of closure as a result of reduced volumes attributable to the coronavirus. Targeted distributions to rural hospitals, health clinics, and health centers were made according to the following methodology.
Recipients fall into three categories:

- Rural acute care general hospitals and Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Community Health Center sites located in rural areas

Definition of Rural HHS utilizes the following definition of rural to identify general acute-care hospitals for these targeted funds:

- All non-metro counties;
- All census tracts within a metro county that have a Rural-Urban Commuting Area (RUCA) code of 4-10;

Details of distribution here and below as an endnote.

The **Emergency COVID Telehealth Response Act**, legislation that would extend the Department of Health and Human Services' waiver authority for telehealth services to include physical therapists, occupational therapists, speech language pathologists and certain other providers during the COVID-19 emergency. The agency last month used its waiver authority to broaden access to telehealth services for Medicare beneficiaries during the emergency.

The **Healthcare Workforce Resilience Act**, a targeted allocation of recaptured visas to these health care professionals will have a tremendous impact on the ability to care for patients with COVID-19, and it will have a lasting impact on the overall health of our communities.

Launched in 2016, the Frontier Community Health Integration Project aims to better integrate and coordinate care, and reduce avoidable hospitalizations, admissions and transfers to distant providers. **The FCHIP Demonstration Extension Act** (S. 3399) would renew for five years a demonstration project that tests new models of health care delivery for critical access hospitals in the most sparsely populated states.

CARES ACT TELEHEALTH PROVISIONS

- $200 million to the Federal Communications Commission to enable provision of telehealth services.
- Medicare Telehealth Flexibilities.
- Enhancing Medicare Telehealth Services for Rural Health Clinics and FQHCs.
- Using Telehealth for Hospice Recertification.

Telehealth Waivers and Flexibilities

- Originating and geographic site restrictions on telehealth services – all areas, all settings
- Use of everyday communication technologies (FaceTime, Skype)
- Practitioners providing telehealth services from home
- Additional services reimbursement when furnished via telehealth, including ED visits
- E/M services via audio-only communications
- Remote patient monitoring for acute conditions
- Virtual check-ins for new & established patients

- Direct supervision via telecomm technology
- Agreements w/distant site providers
- Hospitals can bill for certain outpatient services furnished remotely to Medicare patients at home
    - e.g., Counseling and educational service, therapy services
- HOPDs can bill originating site facility fee when patient is at home
- More practitioners able to provide telehealth service
    - Physical therapists, occupational therapists, and speech language pathologists
- Expansion of audio-only services, including behavioral health counseling and educational services
    - Increased payment for audio-only E/M services

RE-OPENING FACILITIES TO PROVIDE NON-EMERGENT NON-COVID-19 HEALTHCARE: PHASE I

The White House Guidelines for Opening Up America Again can be found at the following link: https://www.whitehouse.gov/openingamerica/#criteria.
If states or regions have passed the Gating Criteria (symptoms, cases, and hospitals) announced on April 16, 2020, then according to CMS, they may proceed to Phase I.
Centers for Medicare & Medicaid Services (CMS) Recommendations
https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf

General Considerations

- In coordination with State and local public health officials, evaluate the incidence and trends for COVID-19 in the area where re-starting in-person care is being considered.
- Evaluate the necessity of the care based on clinical needs. Providers should prioritize surgical/procedural care and high-complexity chronic disease management; however, select preventive services may also be highly necessary.

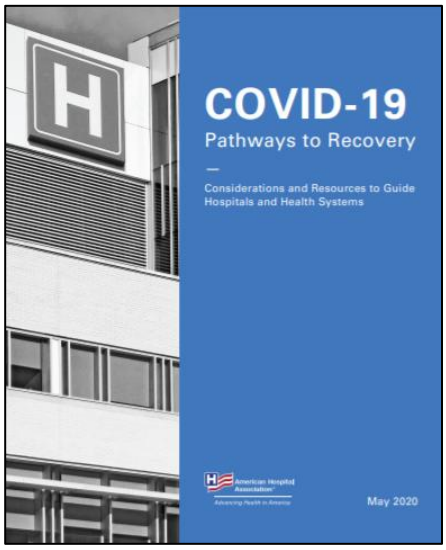
- Consider establishing Non-COVID Care (NCC) zones that would screen all patients for symptoms of COVID-19, including temperature checks. Staff would be routinely screened as would others who will work in the facility (physicians, nurses, housekeeping, delivery and all people who would enter the area).
- Sufficient resources should be available to the facility across phases of care, including PPE, healthy workforce, facilities, supplies, testing capacity, and post-acute care, without jeopardizing surge capacity.

Safely resuming elective surgery as COVID-19 curve flattens

A joint statement, developed by American College of Surgeons (ACS), American Society of Anesthesiologists (ASA), Association of peri-Operative Registered Nurses (AORN) and American Hospital Association (AHA), provides key principles and considerations to guide health care professionals and organizations regarding when and how to do so safely. The statement notes facilities should not resume elective procedures until there has been a sustained reduction in the rate of new COVID-19 cases in the area for at least 14 days. The facility also should have adequate numbers of trained staff and supplies, including personal protective equipment (PPE), beds, ICU and ventilators to treat non-elective patients without resorting to a crisis-level standard of care.
https://www.asahq.org/about-asa/newsroom/news-releases/2020/04/joint-statement-on-elective-surgery-after-covid-19-pandemic

CDC Guidance for Reopening Buildings after Prolonged Shutdown or Reduced Operation

- Added guidance for mold awareness, monitoring, and remediation during and after prolonged building shutdowns
- Updated Legionella guidance for people with weakened immune systems and the use of respiratory protection when flushing water systems



AHA has developed a new resource, **COVID-19 Pathways to Recovery**. Development of this compendium has been led by an AHA Board Task Force with input from many members of the association. While it is not intended to be an all-inclusive resource and will evolve over time as we learn more, it provides important questions and checklists to consider moving forward.
The first part of this resource covers critical areas, including workforce considerations, testing and contract tracing, internal and external communications, and the supply chain. It outlines some areas for hospital and health system leaders to consider as they work toward a safe, orderly return to providing comprehensive health care services to their communities, while continuing to care for their workforce and begin longer-range planning. These sections will continue to be updated as new information develops, and additional focus areas will be added to the resource soon.

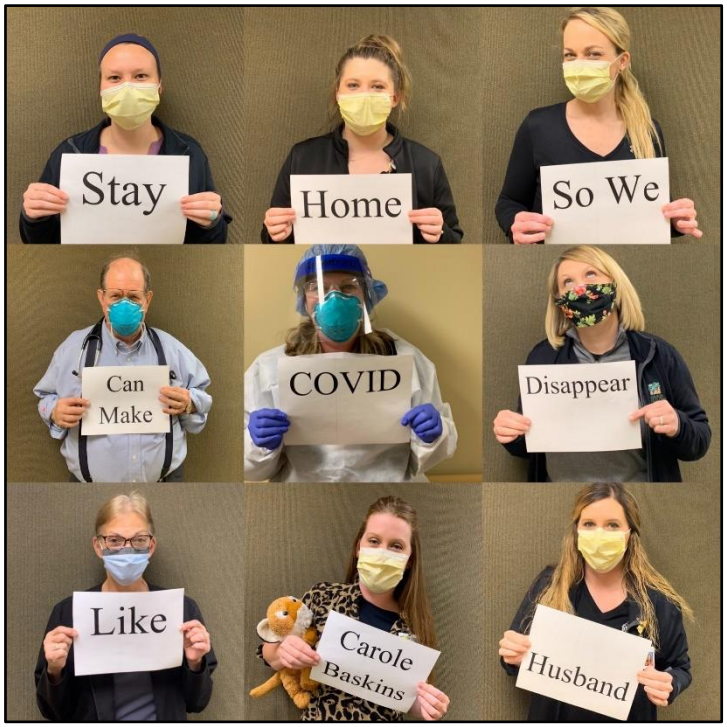
OTHER RESOURCES

American Hospital Association™
Advancing Health in America

Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19

This report attempts to quantify these effects over the short-term, which are limited to the impacts over a four month period from March 1, 2020 to June 30, 2020. Based on these analyses, the AHA estimates a total four month financial impact of $202.6 billion in losses for America's hospitals and health systems, or an average of $50.7 billion per month.

CDC: What Workers and Employers Can Do to Manage Workplace Fatigue during COVID-19
The coronavirus disease (COVID-19) pandemic has touched all aspects of society including how we work. Emergency responders, health care workers, and others providing essential services to the community have been especially stretched thin, working longer hours than usual, working more shifts or even over-night, and leaving less time to sleep and recharge. Long work hours and shift work, combined with stressful or physically demanding work, can lead to poor sleep and extreme fatigue. Fatigue increases the risk for injury and deteriorating health (infections, illnesses, and mental health disorders). While there is no one solution to fit everyone's needs, here are some general strategies from the CDC that workers and employers can use to manage workplace fatigue and work safely.



Rural Hospital Interventions for COVID-19
As the COVID-19 outbreak evolves, AHA has captured seven inspirational stories and lessons learned of how rural hospitals and health systems are working to increase access points, deliver care, improve safety and meet the needs of the residents of their communities. These form a growing compendium of case examples on rural hospital interventions for COVID-19.

In addition, we have interviewed the CEOs from some of these case examples and in their own words, they share their planning, implementation and lessons learned so that others may benefit from their experiences. They are provided as podcasts as part of the AHA Advancing Health series.

https://www.aha.org/resources/2020-05-01-rural-covid-19-resources

$10B Rural Provider Distribution Methodology

Rural acute care hospitals and Critical Access Hospitals (CAHs):
The methodology provides hospitals with supplemental funds based on a graduated base amount plus an additional amount to account for a portion of their usual operating costs and the volume of care they regularly provide, according to the following formula. The most recent, publicly available Medicare hospital cost reports were used to identify operating costs:

Per Hospital $ Allocation = Graduated Base payment + 1.97%* of the hospital's operating expenses
The graduated base payment is calculated as:

- 50% of the first $2 million of expenses (payment of up to $1,000,000)
- 40% of the next $2 million of expenses (payment of up to $800,000)
- 30% of the next $2 million of expenses (payment of up to $600,000)
- 20% of the next $2 million of expenses (payment of up to $400,000)
- 10% of the next $2 million of expenses (payment of up to $200,000)

Rural hospitals with annual operating expenses greater than $10,000,000 receive a base payment of $3,000,000.

Rural hospitals with no operating expense data receive a base payment of $1,000,000.

The total calculated amount was then multiplied by 1.03253231** to determine the actual payment per rural provider.

*The actual value used in the formula was 1.967728428%.

Rural Health Clinics (RHCs):

Provider-Based RHCs: RHCs connected with rural hospitals have their allocations included with their hospital's allocation, and the hospital is responsible for allocating dollars to support its RHC services.

Independent RHCs: A base amount plus a percentage of total operating costs were calculated for independent RHCs not associated with a hospital using RHC Cost Report data according to the following formula:

- Per Independent RHC $ Allocation = $100,000 per clinic site + 3.6% of the RHC's operating expenses