National Rural Health Association

*Rural COVID-19 Response Update*

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October 14, 2020
Panelists

• Tommy Barnhart, NRHA TA Specialist
• Alan Morgan, NRHA CEO
• Brock Slabach, NRHA Sr. Vice-President
Session Details

• Description: provide an overview of NRHAs Covid-19 Response specifically addressing financial and operational issues for rural hospitals and clinics.

• Agenda:
  • Introductions and overview, Alan Morgan
  • Financial/Reimbursement Activities, Tommy Barnhart
  • Operations/Supplies Activities, Roger Masse
  • Summary and Q/A, Brock Slabach and group
Financial/Reimbursement Activities

Tommy Barnhart
CMS 1135 Waivers (partial list)

- SNF/Swing Bed waiver of 72 hour qualifying hospital stay
- Waived CAH bed limit of 25
- Waived CAH 96-hour average length of stay
- Telehealth waivers
  - RHC/FQHC distant site status during Public Health Emergency (PHE) in CARES Act, push to extend past PHE
  - Encounter rate $92.03 per visit
  - Guidance issued by CMS on billing
    - Billed to Part B
    - Caution: costs associated with this service should be carved out of RHC cost reports and these encounters would NOT count toward provider productivity

- Check CMS COVID website for all & updated information
Medicare Accelerated/Advanced Payment Program

• CMS advanced billions of dollars based on 2019 Medicare payments
• Continuing Resolution:
  • Payback starts with claims processed after 1 year from receipt of payments
  • Beginning one year after receipt for 11 months – claims withheld at 25%
  • After 11 months end, withholding will be 50% of 6 months
  • Following withholding period (29 months from receipt of funds):
    • Provider can pay outstanding balance in full, OR
    • Extended payment plan –interest rate of 4%
CARES Act Funding Provisions - PHSSEF

• Public Health and Social Services Emergency Fund (PHSSEF) or Provider Relief Fund (PRF)
  • $100B in original CARES Act – plus $75B from COVID 3.5

• $50 billion general allocation was allocated in proportion to each healthcare provider’s share of 2018 total patient revenue
  • First $30B was distributed based on 2019 Medicare revenue only
  • Second tranche of $20B distributed based on total 2018 revenue and reconciled with the first phase.
  • Some only got from $30B

• Treatment of uninsured COVID-19 patients at Medicare rates. Providers must register for this reimbursement program and submit claims
CARES Act Funding Provisions - PHSSEF

- Targeted distributions:
  - $22B COVID-19 High Impact
  - Rural:
    - $10.2B Rural hospitals, RHCs and FQHC rural sites
    - $1.1B Rural hospitals, certain urban hospitals in rural areas and hospitals in small metropolitan areas
  - $7.4B Skilled nursing facilities
  - $500M Tribal hospitals, clinics and urban health centers
  - $14.7B Safety net and children's hospitals
- $15B Medicaid providers
- About $50B remaining to be distributed
• About $50B remaining to be distributed
  • Uninsured portion?
  • Phase 3 - $20B
    • Announced October 1
    • Providers must apply by November 6
  • 2% of net revenue – if not already received in 1\textsuperscript{st} and 2\textsuperscript{nd} round
  • Additional amount – change in operating revenues and/or expenses
    • Calculation uncertain – pending applications received
CARES Act Funding Provisions - Other

- Sequestration abatement for services 5/1 – 12/31/20
- Payroll Protection Program
- Employee Retention Credit – if not eligible for PPP
- Community Health Centers (CHC) - $1.32B
- Telehealth flexibilities
- Other rural funding through HRSA

**Additional CARES COVID 3.5**
  - Community Health Centers (CHC) - $600M
  - Rural Health Clinics - $225M
HHS & HRSA Distributions

- Attestations required for each distribution
- Purpose - COVID expenses & lost revenue
- Will be subject to single audit requirements – guidance is not available yet (consult your auditors)
- Follow HHS FAQs – updated frequently
HHS Distributions - Reporting

• Reporting:
  • Guidance released 9/19 – link
    • https://www.hhs.gov/sites/default/files/post-payment-notice-of-reporting-requirements.pdf
  • Reporting portal apparently opens 1/15/21
  • Reporting periods:
    • 1st report covers calendar year 2020 – due 2/15/2021
    • 2nd and final report due 7/31/2021
  • Evaluation period for expenses & lost revenue – ends 6/30/2021
  • NRHA has submitted questions to HHS
  • See more details in separate break out session
Paycheck Protection Program

• Additional $321B to the SBA PPP program in H.R. 266
• H.R.7010, the Paycheck Protection Program Flexibility Act of 2020:
  • Increased the loan forgiveness period from eight weeks to 24 weeks;
  • Changed the 75/25 payroll / non-payroll requirement for loan forgiveness to 60/40
  • Increased the loan repayment period from two to five years;
  • Allowed payroll tax deferral for PPP recipients; and
  • Extended the June 30 rehiring deadline to December 31, 2020
• Forgiveness application and instructions on SBA/PPP website
• Follow SBA PPP FAQs
Cost Report Treatment

- CMS Issued FAQs on August 26
  - No offset for:
    - PPP loan forgiveness
    - Provider Relief Funds (PRF)
    - RHC distribution not mentioned but should follow PRF
  - FAQs include specific cost report guidance on how to report PPP forgiveness, CARES Act revenue, COVID payments for uninsured and other COVID funding.
  - Link for CMS FAQs including cost report guidance:
• RHC productivity:
  • NRHA requested national waiver of productivity standards
  • CMS FAQs leave the exception up to the MACs
Operational/Supplies Activities

Brock Slabach
Covid-19 in Rural America

- Thus far in 2020, twelve rural hospitals have closed – four during the pandemic (UNC Sheps Center).
- COVID-19 is growing faster in rural America in both number of cases and deaths (KFF). (As of 9/20/2020 CDC – 198,754 deaths total in U.S.)
- Due to COVID-19, an estimated 41% of U.S. adults had delayed or avoided medical care including urgent or emergency care (12%) and routine care (32%).
- The number of deaths in rural America from Covid now stands at 10,313 on Aug. 1
- Latest rural hotspots (as of 5/26/2020): Western KS and OK
- Emergency visits down 42% nationwide since PHE declared March 13, 2020
- Certain rural hotspots are getting new media coverage with focus on:
  - Prisons
  - Meatpacking Plants
  - Long-term Care Facilities
  - Schools/Universities
CoBank/NRHA TA Center

- Grant continued support for set-up of Rural Technical Assistance Center
- Areas of focus remain: Finance/Reimbursement and Operations/Supplies
- Operations and Supplies: rural hospitals
- Continuous review of current supply chain – sources, quality, costs
  - Emphasis on need to develop/expand domestic manufacturing
  - Looking for models for effective rural testing/contact tracing
  - Continue to cite importance and to encourage community collaboration
  - Remain updated on recent negative trends for Nursing Homes/School openings
  - Participate with government agencies/private entities in providing input and teaming to support effective new programs
CONTINUED REALITIES

• Significant geographic disparities (some spiking/some in large reductions)
• Population behaviors are affecting efficiency/failures of efforts
• Safety in re-opening inconsistent – example – schools and universities (parental and alumni pressure)
• Large challenges for surges due to increased social (sports) and other events (Sturgis)
• Seeming differences on treatment of next steps: testing/tracing, types of testing/vaccinations
Supply Chain Status

• Inconsistent data continues. Federal agencies report supply is OK and release of stockpile inventory (much of which they say is domestic production). Some states/industries continue to report shortages of PPE, testing supplies/turnaround times.
• Quantities reported as adequate, but users report numerous issues with sizing.
• State purchasing groups express frustration on seeming delays in use of stockpile inventory and domestically manufactured products.
• Volunteer organizations (Project N95 as an example) must vet supplies for quality.
• Costs remain at highly inflated levels.
Survey Summary
(conducted June/July 2020, includes formal survey and informal feedback)

• Strong concern expressed for lack of information on future supply chain capacity.
• Near 25% reported other providers in respective service areas experience shortages.
• Most noteworthy shortages include: Masks (inc. N95), Gowns, Face Shields, Test Kits/Supplies.
• Other items mentioned: Caps, Sanitizer, Shoe Covers, Goggles, Wipes. All are critical to meet need to treat COVID19 and routine care from re-opening.
• Noted many ongoing issues:
  • Price gouging and pre-payment problems
  • Sizing issues
  • Product quality
  • Uncertain delivery schedules.
Volunteer Groups

• Many remain available to meet needs. Continue to work on Production/Procurement/Manufacturing needs: Angel Flight, Project Cure, Heart4Heroes, Project N95

• Informational Assistance (NRHA assisted) – Susceptibility Index from Dr. Peters at University of Iowa. Each County in the country can access data that shows index for risk of surge and allows a drill down on factors contributing to the score (show access link)

• Public Health Foundation – providing certified training programs for contact tracing
Project N95 Collaborative Agreement Details:

- Just signed collaborative agreement
- NRHA to provide information to members of PPE available from Project N95
- Project N95 will provide vetting of products, source product, aggregate orders, purchase products.
- Purchasers pay for product by credit card to Project N95
- Each facility receives their individual order
Re-opening Elective/Non-Emergency Services

Key Elements to Control Community Spread

• Testing
• Tracing
• Treatment
• Vaccine

CMS on Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare:

• Patient perceptions of safety in visiting healthcare facilities
• Hospitals and Clinics are safe: Am. Heart Association’s “Don’t Die of Doubt” campaign and video
• Adequate workforce across phases of care (such as availability of clinicians, nurses, anesthesia, pharmacy, imaging, pathology support, and post-acute care)
• 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
Need for Continuous Assessment

• **Staff training** is an ongoing imperative. Increasing access to training/instruction:
  • Apps – available from public and private sources from the basics of proper application of PPE to certification as a contact tracer. And now, to do lab work in a nursing home!
  • Webinars and detailed instructions from numerous State/Federal agencies
• **Regulatory guidelines** are ever changing and ongoing
  • Waivers are maintained for the present – prepare for some to be eliminated
  • Access to financial support/reimbursement methodologies/repayment formulas remain unclear
• Infection Prevention Requirements in [State Operations Manual](#) dated March 20, 2020—checking/documenting temps of all HCP at start of each shift per [CDC Guidelines](#). Surveyors using this currently
Numerous areas of serious concern remain

- Testing/contact tracing – changing methods and priorities
- Supply chain remains uncertain – inconsistent feedback on domestic manufacturing
- Lack of staff in many forums/excess/unaffordable staff in others
- Significant geographic differences in pandemic impact/different timeframes
- No clear path! – philosophical/political variances in direction
Congregate population challenges have not changed

- Meatpacking plants – “Deal With It”, “Remain Open” – we need our meat
- Prisons – while there has been some reduction in inmates, internal programs seem to be reducing risk factors
- Nursing Homes – continue to face crisis level problems. HHS making changes to improve. HHS feels problem no longer PPE. Focus is on enforcement/training/technology/money.
  - New reporting requirements for NHs summary
  - New training manuals with focus on Infection Control guidelines – feel not done well now
  - Conditions of Participation/Deficiency Levels/Fines/Loss of Admission Rights
  - Placing laboratory equipment for employee testing in house with rapid antigen testing with improved reimbursement. Providers express concern but strong emphasis
  - CDC willing to release more stockpile PPE/more funds allocated from Provider Relief Funds
  - Continued emphasis on community collaboration for more effective local decisions and control
Conclusion, Recommendations and Next Steps

- Surges/waves will continue without geographic consistency, FLU SHOTS! Avoid twindemic
- Currently, a continued lack of cooperation at the national level
- Vaccination efforts must be monitored with strong emphasis by NRHA for a fair share access Trump Administration’s Vaccination Distribution Plan, rural is considered

- Need for:
  - Supply chain must continue to develop domestic manufacturing
  - Government openness on actions necessary. Continue with meetings to bring forth concerns/ideas.
  - Identify Best Practices. Suggest some that become evident. Find ways to implement – encourage demonstration projects and joint efforts
  - Don’t wait for national/state efforts!! Reach out locally to other providers and public health/emergency management participants. Include local business interest. Initiate local COLLABORATION/JOINT EFFORTS!!!
Summary

Brock Slabach
Summary

- Rural environment for hospitals/clinics
- Reimbursement/Operations
- Operations/Supplies
- Future plans for NRHA TA Center activities
National Rural Health Association

Q/A

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