Idaho Hospital Association

COVID-19 Daily Report to Members – April 10, 2020

Treasure Valley healthcare CEOs urge public to flatten the curve.

Today, Governor Brad Little took part in a conference call with IHA members to discuss the State's COVID-19 response, considerations for extending the stay-at-home order, the supply of PPE, and Federal relief money that will flow to the state later this month. State Budget Director Alex Adams told IHA members they expect to receive Idaho's share of the CARES Act relief - $1.25 billion – on April 24. Guidance from the Treasury Department on how that money can be expended has not been finalized. The Governor has appointed a committee that will meet Monday to begin discussions on how to allocate those funds. Administrator Adams did say that financial relief for healthcare providers – especially in rural settings – is a high priority for the Governor.

Mike Fenello, SLHS VP for Population Health, also gave hospital CEOs a very useful after-incident report on what they saw with the COVID-19 community spread in Wood River that led to a partial closure of the hospital. He shared some helpful action items that all hospitals should consider as they prepare for the unexpected.

Reimbursement & Policy

Initial hospital funding dispersed today

Today, Idaho's hospitals began receiving automatic, direct-deposit payments from HHS. These payments are part of the $100 billion in provider relief designated in the CARES Act passed by Congress. This initial distribution of $30 billion is based on each facility's share of the total 2019 Medicare FFS payments nationally. These payments are not loans and will not need to be repaid.

A **portal for signing an attestation** indicating receipt of the payment and agreeing to the **terms and conditions** will be open the week of April 13. If recipients do not wish to comply with the terms, they must contact HHS within 30 days of receipt of the payment and remit the full amount. HHS will be providing contact information for that course of action soon. IHA will share additional information on the portal availability as it becomes available.

HHS is still developing the process for distributing the remaining $70 billion but has indicated that they will be looking at some targeted relief for providers in areas hard hit by the outbreak, rural providers, and those with lower shares of Medicare FFS payments including children's hospitals or those with a high proportion of patients with Medicare Advantage plans.

Waiver updates

IHA continues working with members to determine what to include in a statewide 1135 Waiver which will be submitted by the Association. A review of requested and approved waivers by neighboring states is being conducted to see if those requests would also make sense for Idaho's providers. Before submission to CMS, the Association's waiver request will be shared with members. If you'd like to provide input, please contact Larry Tisdale (208.489.1402).

At CMS' behest, IHA needs to exclude any waivers already covered by the **Federal Blanket Waiver**. Yesterday, CMS added several additional waivers to the blanket waiver, including ones that will allow practitioners to work to the fullest extent of their license:

- Waiving the requirement that critical access hospitals (CAHs) have a physician physically present to provide medical direction, consultation and supervision. The requirement that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral" remains. CMS states that this action will allow the physician to perform responsibilities remotely, as appropriate, and also allow CAHs to use nurse practitioners and physician assistants to the fullest extent possible.
- Waiving the requirement that a nurse practitioner, physician assistant or certified nurse-midwife be available to furnish patient care services at least 50% of the time a rural health clinic (RHC) or federally qualified health center (FQHC) operates. The requirement that a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker or clinical psychologist to be available to furnish patient care services at all times remains. CMS states that this will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mix.
- Waiving the requirement that physicians must provide medical supervision of nurse practitioners at RHCs and FQHCs, to the extent permitted by state law. CMS states that this allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.
- Waiving regulations that prevent a physician at a long-term care facility from delegating a task when the regulations specify that the physician must perform it personally. Any task delegated under this waiver must continue to be under the supervision of the physician, and may not be delegated when prohibited under state law or by the facility's own policy.
- Waiving the requirement that all applicable required physician visits at a long-term care facility be made by the physician personally.
- Waiving the requirement that home health agency (HHA) occupational therapists (OTs) may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility for the patient to be receiving home health care. This allows OTs to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether occupational therapy is the service that establishes eligibility.
- Waiving the requirements that a nurse conduct an onsite supervisory visit every two weeks for patients under HHA care.
- Modifying the requirement that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient. CMS will instead allow hospices to utilize "pseudo patients," such as a computer-based mannequin device, instead of actual patients.
- Waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12-month period.

Corrected information on waiving cost-sharing

CMS clarified their policy on waiving cost-sharing (coinsurance and deductible amounts) under Medicare Part B for Medicare patients for certain COVID-19 testing-related services. For services provided on March 18, 2020 through the end of the Public Health Emergency, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under specific payment systems outlined in the **April 7 message** should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and to get 100% of the Medicare-approved amount. Additionally, they should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

Virtual Meetings, Education & Updates

Employment Law Webinar ~ Tuesday, April 14 @ 10a MT

In this complimentary webinar, IHA's legal counsel, Hawley Troxell, will provide legal and practical guidance on workplace COVID-19 issues, covering:

- Paid leave obligations under the Families First Coronavirus Response Act
- Navigating worksite closures, layoffs, furloughs and pay reductions
- Impact of workforce reductions on CARES Act PPP loan forgiveness
- What to do if an employee tests positive for COVID-19
- Key employee benefits provisions under the CARES Act

The session will conclude with a Q & A opportunity. **Registration** is now available.

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