Idaho Hospital Association

COVID-19 Report to Members - October 8, 2020

*Reports are sent on Mondays and Thursdays, unless there's breaking news.*

# Reimbursement & Policy

## Data reporting guidance issued

On October 6th, CMS published **guidance** on how the September 2 interim final rule will be implemented which makes reporting COVID-19 data a condition of participation in the Medicare and Medicaid programs. The guidance outlines the enforcement process and steps by which hospitals can be terminated from Medicare and Medicaid participation should they be deemed non-compliant.

In addition to outlining how the rule will be enforced, the guidance also included six additional influenza-related fields that are to be reported daily. These fields are optional starting October 19 and will become mandatory in the near, but currently unspecified, future.

Idaho hospitals should have received letters describing their compliance status from HHS via email or postal mail this week. Three weeks after the initial letter, a warning letter will be sent if hospitals remain non-compliant, followed by a notice of termination.

HHS, IDHW and IHA have noted several areas that continue to impact 100% COVID-19 reporting compliance by Idaho hospitals.

- Facilities must report on most fields every day. If facilities are unable to report on actual weekend days or other days when the facility is not staffed, they may make up this reporting in **TeleTracking**. This back-reporting can only be done in TeleTracking.
- Facilities must complete every required field for every reporting day. This includes fields that are not applicable to their facility either regularly or for a given day. For example, instances when they don't admit patients in the prior 24 hours, they still need to enter "0" for all age strata to assure complete reporting.
- Facilities that are part of health systems with centrally managed supplies cannot skip PPE related fields. They should – according to the most recent guidance – report some portion of the centrally managed supplies. This allocation can be determined by the hospital system and HHS has not offered formal guidance on this point.
- Facilities using IRTS to upload the data to HHS must mark "yes" on the Opt-In field on Hospital Capacity to facilitate the data push. These facilities must report daily on: Hospital Prev Day, Hospital Capacity, Hospital Patients, and Hospital PPE & Supplies tabs and meet the frequency reporting requirements noted on each page. The daily push from IRTS to TeleTracking happens at 2:30pm, so updates should be completed before that time to be included. IRTS has noted that the new flu data elements are coming soon.

IHA has contacted hospitals with <90% compliance rates to offer additional guidance so that they remain in compliance and are able to continue caring for their communities. We will continue to track this story and provide updates and guidance as it becomes available. In the meantime, feel free to contact **Nicole Hernandez** or **Bozena Morawski** with data reporting questions.

Other changes that will occur with the implementation of the rule include:

- mandatory supply data reporting is being reduced to once per week;
- staffing and remdesivir data reporting will be optional beginning November 1; and
- psychiatric and rehabilitation hospitals will only have to report once per week.

## Idaho Senators share concerns on CARES Act reporting

At the urging of Idaho hospitals, Idaho Senators Crapo and Risch have joined Republican colleagues on a letter to HHS Secretary, Alex Azar, to express concerns over the Post-Payment Notice of Reporting Requirements published on September 19th. The letter states, "We have grave concerns over the changes to the reporting requirements for funds received from the Provider Relief Fund will create uncertainty and financial hardship for hospitals in our states, particularly in rural areas. In the midst of the COVID-19 pandemic, our health care providers need more certainty, not less."

The CARES Act increased funding for eligible providers for healthcare-related expenses and lost revenues attributable to COVID-19. The law specified that recipients of this funding must submit reports and maintain documentation to ensure compliance with payment. In June, HHS stated that hospitals could use any reasonable method of estimating the revenue compared to the same period had COVID-19 not appeared. For example, if hospitals had prepared a budget without taking into account the impact of the pandemic, the estimated lost revenue could be the difference between budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

However, on September 19, HHS issued a new definition of lost revenue, stating that it was represented as a negative change in year-over-year net patient care operating income. It specified that after covering the cost of COVID-19 related expenses, hospitals generally only will be able to apply PRF payments toward lost revenue up to the amount of their 2019 net patient operating income.

Changes to the reporting requirement would result in significant financial losses for numerous Idaho hospitals. IHA and the AHA continue to advocate to go back to the previous reporting model. Retaining these funds under the criteria identified in June will help hospitals to continue to serve the patients and communities who depend on them.

# Quality & Patient Safety

## CDC guidance notes possibility of airborne spread

There are three principle modes of transmitting respiratory viruses, including SARS-CoV-2:

1. through direct **contact** with an infectious person or with a contaminated inanimate object (fomite transmission);
2. through exposure to respiratory **droplets** exhaled by an infectious person; or
3. through **airborne transmission** of smaller droplets and particles that can remain suspended in the air.

A person infected with SARS-CoV-2 can infect others via all three modes of transmission. "Close contact" refers to transmission that can occur from contact or droplet transmission, within about 6 feet of an infected person.

On October 5th, the CDC updated its **How COVID Spreads** webpage to include information describing instances where SARS-CoV-2 transmission apparently occurred between people that were >6 feet from each other or instances where people were infected with SARS-CoV-2 after visiting an area that was recently vacated by another infected individual. These circumstances describe what is referred to as **airborne transmission**, infection that is spread through exposure to small respiratory droplets and particles that can remain suspended in air over longer periods of time (typically hours) or travel over longer distances (usually >6 feet) than the larger respiratory droplets associated with droplet transmission.

Although the updated guidance emphasized that close contact – i.e. either contact or droplet transmission – were the most common ways that SARS-CoV-2 is transmitted from person to person, it outlined conditions under which airborne transmission is more likely to occur:

1. In enclosed spaces where "an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space."
2. With prolonged exposure to respiratory particles, particularly when they are generated through expiratory exertion, for example when shouting, singing, or exercising.
3. In spaces with inadequate ventilation, which allows higher concentrations of small respiratory droplets and particles.

At present, it is not known what proportion of SARS-CoV-2 infections are acquired through airborne transmission versus other routes, though fomite transmission thought to be the least common route. Adherence to existing public health recommendations, which include proper ventilation of indoor spaces and avoiding crowded indoor spaces, will mitigate the potential for airborne transmission.

More information about these updates can be on the link above or on the **Scientific Brief: SARS-CoV-2 and Potential Airborne Transmission**, also published on October 5th.

# Resources & Equipment

## FDA issues guidance on vaccine safety, efficacy

This week, the FDA released both **guidance** and a **briefing document** outlining the data needed to support an emergency use authorization (EUA) for a COVID-19 vaccine candidate. The document also explains the approval process and how they expect pharmaceutical companies or others working on vaccines to demonstrate safety and effectiveness. With a significant amount of attention being paid by the public on when and how safe a vaccine or vaccines will be, the FDA is also holding an **open session** of its vaccine advisory committee to discuss development, authorization and other information related to the approval process.

## Report ~ Revenue management strategies

As hospitals and health systems evaluate the financial impacts of COVID-19, the Healthcare Financial Management Association (HFMA) offers management strategies to explore:

- **Dynamic budgeting**: Health care financial leaders will need to use rolling forecasts of revenue mix and growth and continuously track revenues by payer class and contract. This will become more important as employer-based insurance and public finance programs come under greater economic stresses.
- **Aggressive cost management**: Reducing fixed costs and managing variable costs based on timely estimates of expected revenue are musts. Costs and overhead must reflect the reality of interrupted service volume and an uncertain recovery, the authors note. Variable expenses should be adjusted in real time to fit with actual realized revenues.
- **Telehealth and telework**: Telehealth volumes have increased substantially and are expected to continue once the pandemic ebbs. A significant portion of visits could be virtualized which would make a reduction to clinical space a possibility. Additionally, virtual work arrangements could grow incrementally providing opportunities to reduce office space and fixed expenses.
- **Focus on managing contracts**: The report encourages on-going monitoring of individual contracts and payment variances as well as responding to underpayment and machine-driven denials.

For more information, review HFMA's report **Four Crucial Health System Responses to the Revenue Impact of COVID-19**.

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