Session 2 – COVID and Reimbursement Issues

Speakers:

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Objectives

Explore COVID-19 impact on hospital margin

Discuss how COVID related issues may impact different providers differently

Outline additional COVID-19 related cost reporting considerations

COVID-19 Testing and Vaccination Update

COVID-19 Testing Update

- FDA Emergency Use Authorizations
  - Molecular – 269 authorizations, inclusive of saliva, pooling and all CLIA complexities (but exclusive of Lab Developed Tests)
  - Antigen – 45 authorizations
  - Antibody – 85 authorizations
  - OTC/Home – 16 Antigen, 3 Molecular

COVID-19 Testing Update

- Reimbursement
  - Medicare – Must be medically necessary and prescribed by a practitioner (except 1 test is covered without an order)
  - Other Payers – CARES Act requires payment for COVID tests furnished by licensed or authorized providers without medical screening by the payer as the individualized assessment for medical necessity is presumed
  - OTC tests – historically not covered; recent Biden Administration pronouncements require Medicare and private payers to cover tests after Jan. 15, 2022

CMS Mandate – Dates to Know (States that Did Not Sue or Lost)

- On Dec. 28, 2021, CMS issued new guidance for the facilities in about 25 states not subject at that time to a federal court injunction
- These states include

STATES THAT DID NOT SUE OR HAVE LOST INJUNCTION BID* SO FAR					
California	Hawaii	Michigan	New York	Tennessee	District of Columbia
Colorado	Illinois	Minnesota	North Carolina	Vermont	Territories
Connecticut	Maine	Nevada	Oregon	Virginia	
Delaware	Maryland	New Jersey	Pennsylvania	Washington	
Florida*	Massachusetts	New Mexico	Rhode Island	Wisconsin	

CMS Mandate – Dates to Know (States that Did Not Sue or Lost)

- By **Jan. 27, 2022**, workers in covered health care facilities in these states must have (a) obtained the first dose of a COVID-19 vaccine, (b) a pending request for, (c) been granted qualifying exemption, or (d) been identified as having a temporary delay as recommended by the CDC
  - Facilities with >80% vaccination rates and have a plan to meet 100% within 60 days of the date of guidance will not be subject to enforcement action
  - After 60 days, facilities with >90% vaccination rates and a plan to meet 100% by 90 days of the date of the guidance will not be subject to enforcement actions

CMS Mandate – Dates to Know (States that Sued)

- On Jan. 14, 2022, CMS issued guidance for the facilities in the 24 states "newly" subject to the Mandate following the SCOTUS decision
- These states include

STATES THAT SUED AND LOST INJUNCTION BID AT SUPREME COURT				
Alabama	Idaho	Louisiana	New Hampshire	South Dakota
Alaska	Indiana	Mississippi	North Dakota	Utah
Arizona	Iowa	Missouri	Ohio	West Virginia
Arkansas	Kansas	Montana	Oklahoma	Wyoming
Georgia	Kentucky	Nebraska	South Carolina	

CMS Mandate – Dates to Know (States that Sued)

- By **Feb. 14, 2022 (Feb. 19 for Texas)**, workers in covered health care facilities in these states must have (a) obtained the first dose of a COVID-19 vaccine, (b) a pending request for, (c) been granted qualifying exemption, or (d) been identified as having a temporary delay as recommended by the CDC
  - Facilities with >80% vaccination rates and have a plan to meet 100% within 60 days of the date of guidance will not be subject to enforcement action
  - After 60 days, facilities with >90% vaccination rates and a plan to meet 100% by 90 days after the date of the guidance will not be subject to enforcement actions

CMS Mandate – Compliance Dates

- Based on the Dec. 28, Jan. 14 and Jan. 20 guidance documents

	25 States that Did Not Sue or Lost Suit	24 States That Sued	Texas
Phase 1 (First dose of 2, 1 dose of 1, or applied for exemption)	Jan. 27, 2022	Feb. 14, 2022	Feb. 22, 2022
Phase 2 (2nd dose of 2, granted an exemption)	Feb. 28, 2022	March 15, 2022	March 21, 2022
Full Enforcement (subject to the partial compliance provisions)	March 28, 2022	April 14, 2022	April 20, 2022

CMS Mandate

- Overarching Requirements – A facility must have:
  1. A plan or process in place for vaccinating all staff by the required deadlines
  2. A plan or process for providing exemptions and accommodations for those staff who are exempt from the vaccination requirement (medical and religious)
  3. A plan or process for tracking and documenting staff vaccinations

CMS – Who is Covered?

- Start with the facility type, then consider staff type
- Facilities

ASC	Home Health Agencies
Hospices	Comprehensive Outpatient Rehabilitation Facilities
Psychiatric Residential Treatment Facilities	Critical Access Hospitals
PACE Providers	Clinics, Rehab Agencies and Public Health Agencies as Providers of Outpatient Therapy Services
Hospitals	Community Mental Health Centers
Long Term Care Facilities	Home Infusions Therapy Suppliers
ICFs-IID	Rural Health Clinics/Federally Qualified Health Centers
ESRD Facilities	

  - CMS Requirement does not include non-certified facilities (physician offices, DME, labs, IDTFs, etc.); but consider if physician group has ASC

CMS – Who is Covered?

- All facility “staff” must be vaccinated (or have an exemption)
- Staff include:
  - Employees, licensed practitioners, volunteers, students and trainees
    - Includes non-clinical personnel such as administrative personnel, housekeeping, food service and volunteer and other fiduciary board members
  - Anyone who provides care, treatment, or other services for the facility under contract or other arrangement
    - Includes many vendors (clinical and others, such as construction personnel)
    - Location my include those outside of a clinical setting (e.g., a patient’s home)
    - FAQs suggest staff who help or have contact with staff are included

CMS – Who is Not Covered?

- Vaccination requirement does not apply:
  - Even if someone falls within the “staff” definition, the vaccination requirement does not apply to those who exclusively provide telehealth, telemedicine or support services remotely who do not have any direct contact with patients or other staff
    - Telehealth and remote staff who do interact with other staff (on-site meetings, etc.), likely must comply with the vaccine requirement
  - Vendors who provide infrequent and ad-hoc non-health care services
    - Delivery personnel, repair personnel and others
  - Patients and their visitors

CMS – How is Compliance Enforced?

- Survey process (revalidation, complaint) for conditions of participation/conditions for coverage
  - Deficiencies cited with plan of correction opportunity, possible CMPs
  - Recent survey guidance does not add to or explain how “staff” is to be interpreted, but does explain what surveyors will look for in the survey process

CMS – Survey Guidance

- Based on Guidance issued Dec. 28 and Jan. 14, CMS will request that the facility provide a list of all staff and their vaccine status:
  - Including the percentage of unvaccinated staff, excluding those staff that have approved exemptions
  - If any concerns are identified with the staff vaccine status list, surveyors should verify the percentage of vaccinated staff.
  - The provider or supplier must identify any staff member remaining unvaccinated because it's medically contraindicated or has a religious exemption.
  - The facility must also identify newly hired staff (hired in the last 60 days).
  - The facility must indicate the position or role of each staff member

CMS – Survey Guidance

- Includes document review guidelines which instruct surveyors to obtain a sample of staff documentation and do a deeper dive
  - Direct care staff (vaccinated and unvaccinated), contracted staff and direct care staff with an exemption to obtain:
    - proof of vaccination
    - proof of exemption
    - employee records to determine if unvaccinated staff were offered vaccination and education about the same
  - Surveyors will look for proof of medical exemption requirement
  - Surveys will not evaluate or review religious exemption requests or approvals; review only that the facility has an effective process for staff to request a religious exemption for a sincerely held religious belief

The Joint Commission

- For facilities accredited by The Joint Commission, a recent webinar deck raises concerns about documentation that may be required on survey:

CMS – Interplay with State Law?

- CMS states the Mandate preempts any inconsistent state law
  - State laws that prohibit employers from requiring vaccination
  - State laws that would limit the types of exemptions available under state law
- The Mandate will be unlikely to preempt state law with more requirements where employers/facilities can comply with both
  - State laws that require testing of unvaccinated staff
  - State laws that also require booster shots to meet vaccine requirements

COVID-19 Margin Impact

COVID-19 Margin Impact

- Has COVID-19 impacted hospitals' margins?
- Will the extra costs incurred ever be reflected in reimbursement paid by governmental and commercial payers?
- Will the spiraling labor costs be the new reality or just a temporary hiccup?
- Can hospitals survive without the extraordinary cash infusions provided by the government?
- What lessons have been learned to prepare, prevent and respond to the next pandemic event?

COVID-19 Margin Impact Discussion

- Has COVID-19 impacted hospitals' margins?
  - *Yes, in different ways, across different time frames*
- Will the extra costs incurred ever be reflected in reimbursement paid by governmental and commercial payers?
  - *Not likely. Hospitals will need to make sure their cost reports tell the right story and be very assertive in negotiations with commercial payers.*
- Will the spiraling labor costs be the new reality or just a temporary hiccup?
  - *Somewhere in between. Current trends will level out gradually.*
- Can hospitals survive without the extraordinary cash infusions provided by the government?
  - *Yes, for the majority of organizations, but not for all.*
- What lessons have been learned to prepare, prevent and respond to the next pandemic event?
  - *May be too soon to tell.*

Facility Trend: Statistics

Fauci Hospital COVID-19 Trends				
	Before	During		
	6/30/2019	6/30/2020	6/30/2021	COVID-19
Patient Statistcs				
Medicare Statistics				
Medicare Patient Days	65,597	63,488	66,400	
Medicare Discharges	11,890	11,111	11,282	
Medicare ALOS	5.52	5.71	5.89	
Medicare Utilization				
Days	34.81%	35.01%	35.26%	
Discharges	35.31%	35.72%	36.96%	
Medicaid Statistics				
Medicaid Patient Days	56,408	51,835	51,729	
Medicaid Discharges	7,732	9,470	8,924	
Medicaid ALOS	7.30	5.47	5.80	
Medicaid Utilization				
Days	29.94%	28.59%	27.47%	
Discharges	22.96%	30.44%	29.23%	
Total Patient Days	188,423	181,324	188,327	
Total Discharges	33,676	31,107	30,529	
Total ALOS	5.60	5.83	6.17	

Data precedes full impact of Delta and Omicron variants.

How much is COVID related?

Does extra COVID payment cover increased costs related to LOS?

Impact on GME & Allied Health Reimbursement?

Is this decline only temporary?

How much will Medicaid shortfall increase with ALOS?

Impact on Medicare and State DSH payments?

How will increase in ALOS impact long term cost structure?

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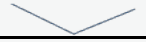
Facility Impacts: Financial

Fauci Hospital COVID-19 Trends				
	Before	During		
	6/30/2019	**6/30/2020**	**6/30/2021**	COVID-19
Financial				
Overall Cost/Charge Ratio	0.2763	0.3007	0.2777	
Unadjusted Average Hourly Wage	45.43	45.91	49.09	
Adusted Hourly Wage	53.28	52.53	54.39	
Net Patient Service Revenue	1,850,000,000	1,730,000,000	1,990,000,000	
Operating Expenses	2,180,000,000	2,260,000,000	2,390,000,000	
Operating Margin	(330,000,000)	(530,000,000)	(400,000,000)	
Other Revenue	390,000,000	480,000,000	460,000,000	
Net Income	60,000,000	(50,000,000)	60,000,000	
Net Income excluding COVID funds	60,000,000	(120,000,000)	30,000,000	

Impact on Uncompensated Care Pool Payments?

When will payments catch up?

Long term impact on operations

How much of cost increase and rebound in revenue is COVID-19 related?

Many organizations may not be able to rely on substantial “other revenue”.

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COVID-19 Medicare Margin Impact

Fauci Hospital				
FYE 06/30/2019 to FYE 6/30/21				
	Medicare Cost Report Comparison			
	6/30/2019	6/30/2020	6/30/2021	Trend
Total Medicare Charges	**1,214,000,000**	**1,151,000,000**	**1,199,000,000**	
Total Medicare Contractual Allowances	**850,000,000**	**797,000,000**	**817,000,000**	
Total Medicare Reimbursement	**364,000,000**	**355,000,000**	**382,000,000**	
Total Medicare Costs	**376,000,000**	**391,000,000**	**384,000,000**	
Total Medicare Margin	**(12,000,000)**	**(36,000,000)**	**(2,000,000)**	
		(24,000,000)	**34,000,000**	
Memo: Total Sequestration Included Above:	(7,000,000)	(6,000,000)	0	
	(6,875,263)	(5,600,354)	0	

How much of cost increase and rebound in revenue is COVID-19 related?

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COVID-19 Medicare Margin Impact

Fauci Hospital
FYE 06/30/2019 to Fye 6/30/21

	Variance Analysis	
	06/30/2019 vs 6/30/2020	06/30/2020 vs 6/30/2021
Total Charges	**(63,000,000)**	**48,000,000**
Total Reimbursement	**(9,000,000)**	**27,000,000**
Total Medicare Costs	**15,000,000**	**(7,000,000)**
Total Medicare Margin-	**(24,000,000)**	**34,000,000**
Reimbursement Drivers		
Operating Paymens (all components)	**(15,000,000)**	**16,000,000**
Indirect Medical Education	**4,000,000**	**7,000,000**
Pass through costs	**1,000,000**	**(2,000,000)**
Sequestration	**1,000,000**	**6,000,000**
	(9,000,000)	**27,000,000**

How much of cost increase and rebound in revenue is COVID-19 related?

How much of this favorability is related to normal rate increases and clinical improvements unrelated to COVID-19?

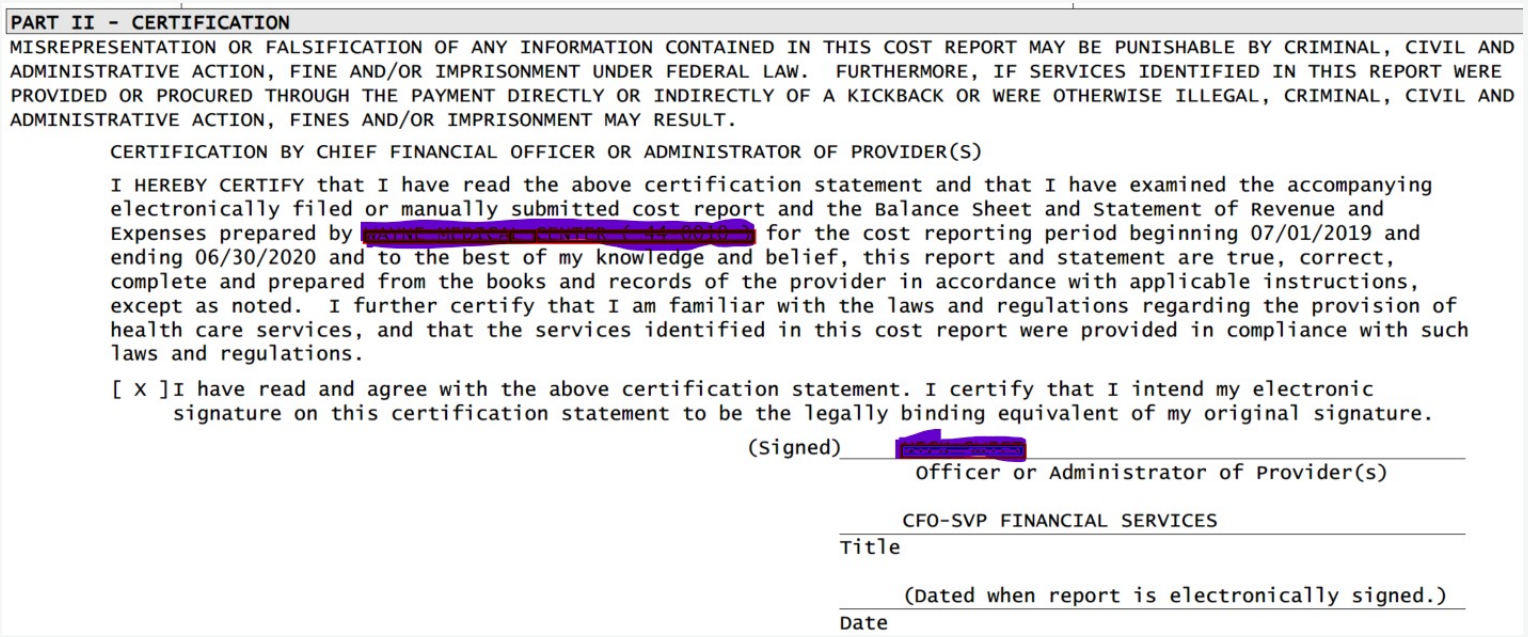
How significant is the current suspension of the sequester?

COVID-19 Cost reporting Considerations

COVID-19 Cost Reporting Considerations

- COVID has changed many things about hospital operations, including cost reporting.
- Some of the changes will be short term, and others may have longer term implications.
- Additional “due diligence” around the entire cost reporting process may be required.
- The changes may result in permanent changes to the regulations and cost report instructions.

“S” Certification: *Considerations*



PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by [redacted] for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) [redacted]
Officer or Administrator of Provider(s)

CFO-SVP FINANCIAL SERVICES
Title

(Dated when report is electronically signed.)
Date

- Chief Financial Officer or Administrator reads, prepares, and signs this certification after cost report completion.
- May be beneficial to complete an “independent” cost report review prior to filing or prior to MAC audit as part of overall compliance plan.

Statistics

- Impact of Volume Changes (short & long-term):
  - DSH (Disproportionate Share Hospital) adjustment,
  - Medical Education reimbursement
  - Cost based (CAH; TEFRA) reimbursement amounts

- Changes in available beds:
  - IME (Indirect Medical Education) payments,
  - Special payment provisions (Medicare Dependent Hospital; Rural Referral Center; Sole Community Hospital)

- Modified use of observation services captured in revenue accumulation and statistical measures.

Reporting Wages Benefits

- Additional labor costs
  - Special payments and pay raises
  - Reliance on temporary or contracted labor
  - Impact on benefit costs (health insurance and retirement obligations)
- Capture costs where they were actually incurred, especially direct patient care related costs.
- Long-term consequences in reported wage index values due to aberrant patient care volumes (increases and decreases) and extraordinary labor economics.

Expenses

- PRF funds treated as grants for cost reporting purposes. These amounts should not reduce allowable costs.
- Capture of all COVID-19 related expenses in correct period properly align with related revenues (if any).
- Capital equipment purchased with Provider Relief Fund grants (or other donations) should be treated as donated. Depreciation on these assets is allowable, based on appropriate AHA useful lives.
- COVID-19 related bonuses paid to physicians (or other Part B practitioners) should be evaluated for commercial reasonableness and fair market value?

Cost Report Financial Statements

- Any remaining Medicare Advance or Accelerated Payments (MAAP) should be treated as a liability.
- PRF amounts should be separately reported on the cost report income statement. These should not be reported within net patient service revenue.
- HRSA Uninsured Patient program revenue should be included in net patient service revenue.
- Any adjustments (differences between gross charges and payments) for HRSA uninsured patients should not be included in uncompensated care.

Conclusion

- COVID-19 has impacted hospitals' operations and margins, but not all hospitals will be impacted the same way at the same time.
- There will be both short term and long-term impacts and additional cost reporting guidance may be required.
- Isolate any temporary COVID-19 reimbursement impacts for reporting, planning, and due diligence (acquisitions/dispositions).
- Cost finding and reporting may be different for GAAP, IRS, Medicare and HRSA/PRF reporting purposes.
- Use extra "due diligence" regarding cost reporting process.

Additional Resources

- https://www.pyapc.com/insights/a-checklist-for-successful-hospital-cost-reporting-in-the-time-of-covid-19/
- https://www.pyapc.com/insights/cost-reporting-in-the-time-of-covid-19-could-have-an-impact-on-hospital-payment/

Thank You

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