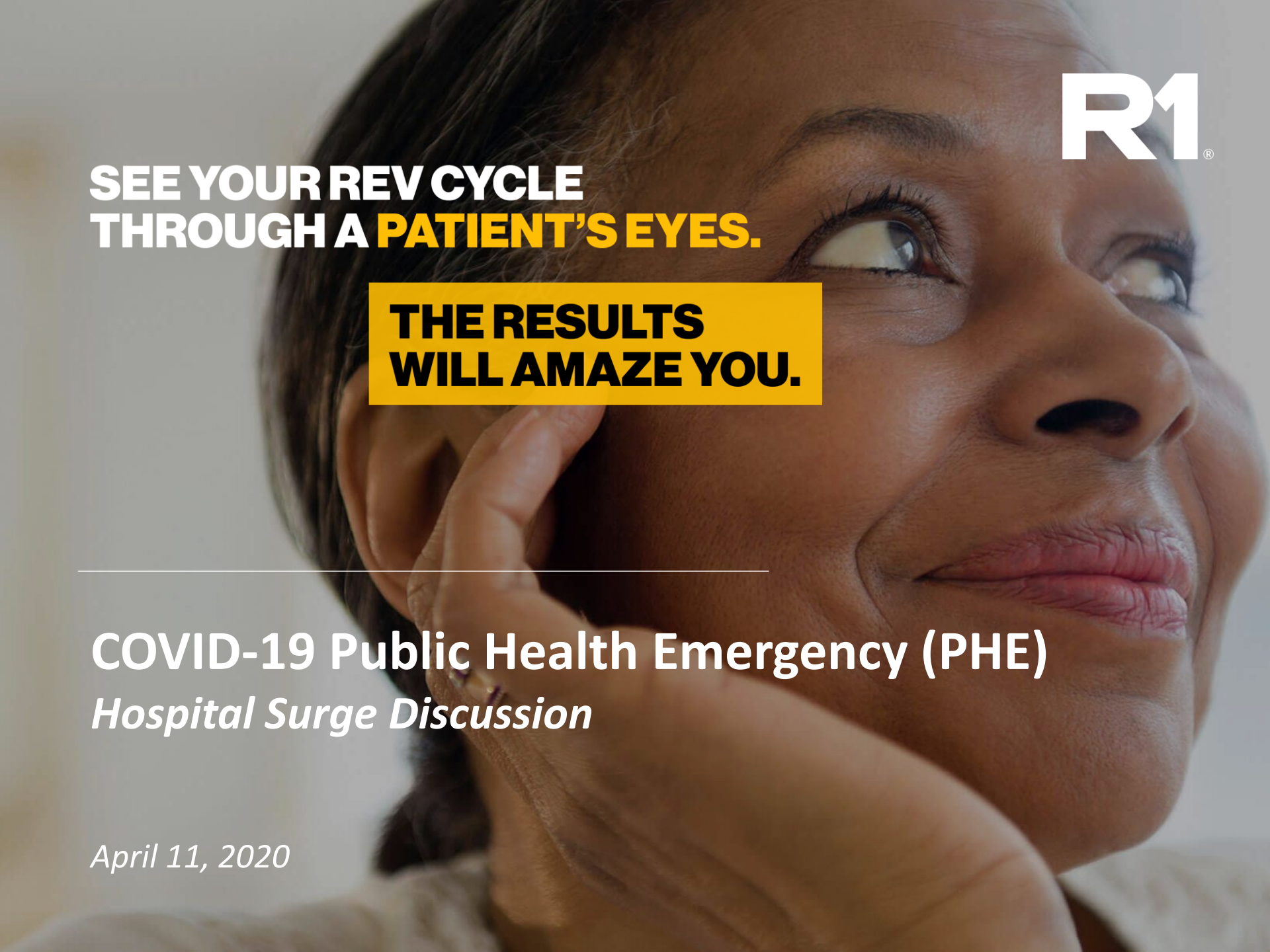

COVID-19 Public Health Emergency (PHE)

Hospital Surge Discussion

April 11, 2020

Today's R1 Regulatory Team

Amber Thomas, JD – Vice President, Regulatory Compliance & Operational Audit

Amber has been leading the regulatory advisory and guidance function at R1 RCM since 2015. Prior to joining R1, Amber was the compliance officer for the largest public hospital in the United States, Jackson Memorial Hospital & Holtz Children's Hospital in Miami, Florida. Amber began her career as a regulator at the Centers for Medicare & Medicaid Services, Division of Technical Payment Policy and then served in the Office of General Counsel for CMS's Program Integrity Division. Amber also practiced law at a mid-size regional law firm where she focused on legal and regulatory issues in health care transactions between physician groups and hospitals.

Andrew Leibfried, JD – Director, Regulatory & Billing Compliance

Andrew has 7+ years of healthcare regulatory & compliance experience. As the Director, Regulatory & Billing Compliance for R1, he primarily focuses on government payer reimbursement issues, claims processing and payment, and fraud & abuse laws and investigations. Prior to joining R1, Andrew worked as an attorney in the Office of the Secretary for the Department of Health and Human Services (HHS) in Washington, D.C., where he worked primarily on Medicare policy. Prior to his time in the Secretary's office, Andrew also worked as a regulatory counsel for the Food and Drug Administration (FDA) and as a compliance attorney for a regional health insurance company.

Disclaimer

The purpose of this presentation is to briefly cover regulatory updates related to the CMS Hospital Without Walls Initiative. As hospitals continue implementing their COVID-19 patient surge plans, all decisions should be implemented with the assistance of your legal and compliance resources.

This presentation is not intended to supersede or replace any information you have received related to your specific facts and circumstances. The following information is current as of April 10, 2020 and applies to CMS waivers with an effective date of March 1, 2020. *CMS has stated that they continue to work on providing additional guidance to hospitals.*

CMS Hospital Without Walls Initiative

Overview

In order to give hospitals the flexibility to surge bed capacity, CMS is temporarily allowing the following:

- Hospitals may establish **temporary expansion sites** to provide inpatient and outpatient services
  - These can be internal and external to the hospital
  - **Examples**: Hotels, schools, convention centers, cafeterias, offices
- Temporary hospital enrollment for ambulatory surgical centers (ASCs) or temporary ASC enrollment for free-standing emergency departments
- Waivers for many hospital conditions of participation to ensure providers can focus more of their time on patient care

Note: *Despite certain CMS waivers, providers must still comply with state hospital and licensing rules*

CMS Hospital Without Walls Initiative

Temporary Expansion Sites and Provider-Based Waivers

Hospitals have wide latitude to provide hospital services in other internal or external temporary expansion sites **so long as sites meet Medicare Conditions of Participation that still apply during the PHE and the hospital complies with those.**

- Hospitals may also add new provider-based department locations
  - Hospitals may establish and operate as part of the hospital at any location irrespective of whether it satisfies the "provider-based status" requirements
  - This opens hospital expansion to site types normally excluded by regulation
  - Removes the restrictions such as the 35-mile requirement
- The hospital is expected to be operating under their State's emergency preparedness or pandemic plan and to control and oversee any services provided at temporary expansion sites

CMS Hospital Without Walls Initiative

Ambulatory Surgical Centers (ASCs) and Other Facilities

- ASCs may provide inpatient and outpatient hospital services by either:
  - Contracting with hospital systems, **in which case hospitals will be able to bill Medicare as if the services occurred within the hospital's main facility**;
  - Becoming provider-based to a hospital; or
  - Enrolling in Medicare and receiving temporary billing privileges as a hospital
- Other entities (e.g. freestanding emergency departments) may enroll as ASCs and then subsequently convert their enrollment to hospital during the public health emergency
- Hospitals may bill for routine services provided outside the hospital under arrangements during the PHE
  - Effective for services provided for discharges for patients admitted to the hospital during the PHE beginning March 1, 2020, if routine services are provided under arrangements outside the hospital to its inpatients, **these services are considered as being provided by the hospital**
  - **Note:** Hospitals need to continue to exercise sufficient control and responsibility over the use of hospital resources in treating patients regardless of whether that treatment occurs in the hospital or outside the hospital under arrangements.

Hospital Flexibility to Fight COVID-19

Additional Waivers

- Hospitals may house inpatients in distinct part units (DPU) to accommodate surge capacity during the emergency
  - *Billing:* The IPPS hospital should bill for the care
  - *Documentation*: Note in the medical record that the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the emergency.
- Inpatient psychiatric and rehabilitation patients (DPU) may also receive care in other areas of the hospital
  - *Billing:* The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System and rehabilitation services under the Inpatient Rehabilitation Facility Prospective Payment Systems
  - *Documentation*: Note in the medical record that the patient is a psychiatric or rehabilitation inpatient being cared for in an acute care bed because of issues related to the emergency

Key Conditions of Participation Waivers

- Emergency Medical Treatment & Labor Act (EMTALA)
  - CMS is waiving the requirement to provide a medical screening examination in the Emergency Department.
  - This will allow hospitals to screen patients at a location offsite from the hospital's campus

- Physical Environment
  - CMS will permit non-hospital buildings/space to be used for patient care and quarantine sites, provided that the location is approved by the state
  - Still need to ensure that safety and comfort for patients and staff are sufficiently addressed)

Inpatient Hospital Quarantine Billing

- A Medicare beneficiary with COVID-19 may remain in the hospital, quarantined in a private room, to avoid spreading the disease even **if they no longer meet the need for acute inpatient care**.
- Medicare will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, **including any the quarantine time** when the patient does not meet the need for acute inpatient care, until the Medicare patient is discharged.
  - The DRG rate (and cost outliers as applicable) includes the payments for when a patient needs to be isolated or quarantined in a private room.
  - Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary.
- In the event a patient is quarantined in an ambulatory setting, the existing Medicare payments for medically necessary services apply.

CMS Hospital Without Walls Initiative

Revenue Cycle Considerations

- Ensure that your revenue cycle lead for the hospital is aware of the hospital expansion sites or change in services, departments or locations
  - Important for hospital patient registration
  - May require updates to the chargemaster
  - Surge planning meetings can then discuss treatment of new sites

- Ensure that your hospital IT team(s) receive the request to build these additional “virtual beds” as soon as the temporary location and bed count is known
  - Allows billing to begin more quickly
  - For hospitals that have temporary expansion sites that do not have “virtual beds” due to tech backlog or otherwise, CDM may be able to add manual R&B charges (but not ideal)

Closing Remarks