PERSPECTIVE

COVID-19 CARES ACT: HOSPITALS MUST PROCEED CAREFULLY

Jerilyn Morrissey, MD
Medical Director, Physician Executive Division - Client Performance & Revenue Integrity

Jay Ahlmer, CFA
Senior Vice President, Strategic Advisor

As COVID-19 case volumes continue to grow and hospitals prepare for an anticipated patient surge, the stress on healthcare facilities to weather an unprecedented health and financial crisis has skyrocketed. While the $2 trillion *Coronavirus Aid, Relief, and Economic Security (CARES) Act* includes more than $100 billion in aid for healthcare organizations, it is incomplete as a viable solution to offset the projected revenue loss that hospitals will face. Hospital executives need to consider the amount, timing, and mechanisms of proposed relief packages and how these available dollars can best address the multitude of potential financial challenges they face.

Analysis of the Initial Financial Impact of COVID-19 on Hospitals

In anticipation of the expected surge in patients and to keep patients safe from exposure, hospitals deferred elective services to create capacity under guidance from the Centers for Medicare and Medicaid Services (CMS) issued in mid-March.

> *"To aggressively address COVID-19, CMS recognizes that conservation of critical resources such as ventilators and Personal Protective Equipment (PPE) is essential, as well as limiting exposure of patients and staff to the SARS-CoV-2 virus. Attached is guidance to limit non-essential adult elective surgery and medical and surgical procedures, including all dental procedures. These considerations will assist in the management of vital healthcare resources during this public health emergency."*

Source: March 15, 2020, *CMS Adult Elective Surgery and Procedures Recommendations: Limit all non-essential planned surgeries and procedures, including dental, until further notice,* CMS.

Elective procedures are not only a major source of revenue in many hospitals, but also a primary driver of profitability. This revenue is critical to the viability of many hospitals.

In addition, healthcare facilities have invested heavily in responding to and preparing for the pandemic by training additional staff, increasing staffing levels, securing supplies, constructing or retrofitting additional facilities to increase beds, modifying electronic medical records, and expanding telehealth capabilities. These activities require significant upfront financial outlays against which no or very small revenues have been received to date.

Finally, the reimbursement of services delivered to a patient with COVID-19 will fall within established DRGs. While the Act includes a DRG premium for patients with COVID-19 diagnoses, the true cost to care for these patients remains unknown and may not be consistent with the traditional MS-DRG payment methodologies that match historical cost and reimbursement. The length of stay and the impact on hospital capacity is also unknown, requiring preparation for a worst-case scenario. The triad of unknown cost of care and commensurate reimbursement, unknown expected length of stay, and unknown volume of admissions creates financial and operational uncertainty.

What Are the Financial Provisions in the CARES Act for Healthcare Facilities?

The CARES Act, signed into law on March 27, 2020, was developed to provide financial support and resources to individuals and businesses affected by COVID-19 and has a variety of provisions designed to provide an influx of money to hospitals and other healthcare entities. While the CARES Act attempts to alleviate some of the current financial strain on hospitals, many questions remain. Elements of the Act that temporarily "boost" Medicare and Medicaid reimbursement include:

A Suspension of the 2% Medicare Sequester through the end of the year.

> *"During the period beginning on May 1, 2020 and ending on December 31, 2020, the Medicare programs under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall be exempt from reduction under any sequestration order issued before, on, or after the date of enactment of this Act." (H.R. 748 Section 3709).*

As a result, the annual 2% cut in Medicare payments to hospitals, physicians, and other providers is cancelled for the rest of calendar year 2020. While this will have a positive financial impact, with the growing number of Medicare beneficiaries that are managed under Medicare Administrative Organizations (MAO), the question remains, how much of this portion of the bailout results in a financial boost for MAOs and never makes its way to intended providers? Holding MAOs accountable will likely require that providers develop individual tactics for each payer (resulting in yet further unexpected costs for healthcare facilities).

A 20% add-on payment for COVID-19 patients

> *"For discharges occurring during the emergency period described in section 1135(g)(1)(B), in the case of a discharge of an individual diagnosed with COVID–19, the Secretary shall increase the weighting factor that would otherwise apply to the diagnosis-related group to which the discharge is assigned by 20 percent. The Secretary shall identify a discharge of such an individual through the use of diagnosis codes, condition codes, or other such means as may be necessary." (H.R. 748,Section 3710)*

By amending section 1886(d)(4) of the Social Security Act, the CARES Act provides that the Secretary will increase the weighting factor that would otherwise apply to the diagnosis-related group (DRG) to which the COVID-19 patient discharge is assigned by 20%. The add-on payment will be available for the duration of the COVID-19 emergency period, which the Secretary initiated on January 27, 2020. It remains to be seen if a patient that is COVID-19-positive will only require 20% greater hospital cost under the current circumstances. It is possible that costs to care for COVID-19 patients may very well exceed the additional DRG payment provided. In addition, the COVID-19 coding rules have yet to be clarified. For example, CMS has not indicated if the add-on payment will apply to encounters in which patients either did not receive a COVID-19 test, expired before the test was completed, or were treated presumptively for COVID-19 and ended up with a negative test. Thus, it is possible that hospitals end up receiving no additional DRG payments for many patients whose cost of care is dramatically increased due to COVID-19.

Expansion of the Medicare Accelerated Payments Program:

> *"(B) Upon the request of the hospital, the Secretary may do any of the following:*
>
> *(i) Make accelerated payments on a periodic or lump sum basis.*
> *(ii) Increase the amount of payment that would otherwise be made to hospitals under the program up to 100 percent (or, in the case of critical access hospitals, up to 125 percent).*
> *(iii) Extend the period that accelerated payments cover so that it covers up to a 6-month period.*
>
> *(C) Upon the request of the hospital, the Secretary shall do the following:*
>
> *(i) Provide up to 120 days before claims are offset to recoup the accelerated payment.*
> *(ii) Allow not less than 12 months from the date of the first accelerated payment before requiring that the outstanding balance be paid in full."*
> *(H.R. 748, Section 3719)*

Section 1815 of the Social Security Act provides for an accelerated Medicare payment program in circumstances where a hospital is experiencing financial difficulty due to delays in receiving payment for Medicare services provided. The CARES Act attempts to accelerate payments

to hospitals by revising the Medicare Accelerated Payment Program as outlined above. Advance payments will allow providers that are losing revenue to apply to CMS to accelerate Medicare payments, essentially as an advance payment on future Medicare billing.

While this measure can temporarily relieve the financial pressure providers are experiencing due to delays in payments, it does nothing to address the revenue lost during this period. The Act assumes that, after the COVID-19 crisis, hospitals will experience a massive catch-up of lost revenue that will allow them to pay back these cash advances within a year. Considering the fact that, in normal times, hospitals are operating near capacity, the ability to "backfill" this lost revenue will come at the cost of foregoing future revenue. Hospital beds are like airplane seats – once the seat (or hospital bed) "takes off" for the day, the revenue for that period in time is lost forever. Thus, while hospitals may have additional unused bed capacity moving forward that allows some previously delayed elective procedures to be rescheduled, the revenue realized from these rescheduled procedures will be small compared to the current revenue that will have been previously lost, resulting in a net loss of revenue that will NEVER be recouped. As well, many of these delayed elective procedures will end up being performed at non-hospital sites. Prior to COVID-19, 50% of hospitals already had little to no operating margin. Thus, because hospitals will experience a loss of hospital revenue as opposed to a delay in revenue, repayment of these cash advances will only send hospital financials further into the red at a time when uncompensated charity care will probably be greatest as the economy tries to get back on its feet (think post 2008).

Delaying Medicaid Disproportionate Share Hospital Reductions

The Act delays scheduled reductions in Medicaid disproportionate share hospital (DSH) payments. Specifically, it eliminates the $4B in Medicaid DSH cuts in FY 2020 and reduces the DSH cut for FY 2021 from $8B to $4B. (*H.R. 748*, Section 3813).

This measure will provide needed relief for many hospitals across the country that provide a critical service to those most in need. While this is an important step, it is mostly a reversal of payment cuts that were put into place in October 2019 and set for October 2020. This doesn't address the lost revenue hospitals are facing today and the likely increase in uncompensated charity care that hospitals will deliver during the post-COVID-19 economic recovery.

Next Steps in this Uncertain Time

This third phase of COVID-19 legislation likely will not be the last. The fact is a simple analysis of all the elements impacting hospitals demonstrates that the current measures aren't enough. With that in mind, hospitals need to proceed with caution. While the cash advances provided by the Accelerated Payment Program might help bailout today's immediate hospital cash flow crisis, the other financial components of the Act do little or nothing to ensure the future stability and growth of our nation's hospital system.

If you are interested in learning how this works, contact us at 1.866.299.3301 or send us an email at covid-19@versalushealth.com.

Questions? Contact Dr. Joseph Zebrowitz at drjoe@versalushealth.com or call 484.766.1606.

Versalus Health provides hospitals with comprehensive solutions focused on the intersection of utilization management, revenue cycle, and compliance. By combining advanced analytics with clinical, regulatory, billing/reimbursement, and provider-payer relationship expertise, Versalus Health optimizes utilization management's role in the revenue cycle. Our solutions enhance compliance, increase efficiency, ensure appropriate reimbursement, and improve results across all payer types. For more information about Versalus Health, visit www.versalushealth.com.