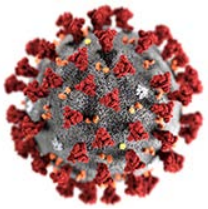
COVID-19 Statewide Hospital Huddle Summary Tuesday, July 7, 2020



Tom Bell welcomed everyone to the call. He hopes everyone is doing well, and that their facilities and communities are doing well also.

Spark Update

Tom Bell gave an update on the SPARK Task Force. The task force was formed to delineate funds from the federal government to the state with regards to the CARES Act. A little over $1.5 Billion has been provided to the state. The bureaucracy has been a little difficult to navigate. Currently, Round 1 is being implemented now to distribute around $400 million to Kansas counties. The counties have been sent resolutions to sign and return by July 13 (resolution says country will act to share that money with entities in their county). At this point 27 counties have returned their resolutions. Hospitals may reach out to their county to ask if they have sent the resolution back to the state. Funds will be distributed on July 15. Money must be incurred (for all rounds) between March 1-Dec. 31, 2020. But they do not have to be spent by then ... they could be spent in the first quarter next year. Round 2 will be targeted funds (determined by a process not directly to counties) determined by the SPARK Steering Committee, Spark Executive Committee, the State Finance Council and in Round 2 also a group of state agency heads. Four areas will be targeted in Round 2: health, education, economic development and connectivity. Round 2 funds will also be around $400 million. The Steering Committee has looked at priorities in each area - Health: COVID preparedness, public health issues, contact tracing, PPE supplies, and nursing homes. Economic Development: protecting small businesses. Connectivity: broadband and telehealth. Education: online learning and getting kids K-12 back in the classrooms this fall. It is expected that more movement on the process and Round 2 will take place the week of July 20.

Myron Gunsalus, Director Kansas Health and Environment Laboratories

Myron first gave an overview of the two types of COVID-19 testing. The first type is diagnostic, and is split into two categories of PCR and antigen. These tests look for the actual active virus or RNA of the virus. The antigen test looks for unique proteins of the virus and uses a nasal pharyngeal swab. The most well-know, gold standard or main testing platform is a PCR test (also known as a molecular test or a nucleic acid test). These tests relate to the RNA and DNA of the virus itself. We are looking for the actual thing that makes it a virus, and what makes it unique to SARS COVID-2. You are looking at an actual copy of the RNA, extracting it out and copying it. The test is repeated over and over until it is concentrated. If it's detected early in the process then the virus is present, but if it takes forever and none is found then the virus is not there. The theory of PCR is that you are looking at how much is there, and how quickly it concentrates. The benefit of this is that you are actually looking for the RNA you are trying to find. There are a wide variety of PCR platforms that your hospital lab or the commercial labs are using. Antigen tests creates an antibody that looks for antigens. If the virus is found then it triggers. Those are the diagnostic tests, and he really wants to emphasize rural hospital have been desperate for testing. It is better than it was a month and a half ago, and this is what the goal is, to test diagnostically. At this time, there are no diagnostic tests that have been approved by the FDA for asymptomatic individuals to be surveillance or to screen everyone. That being said, many of you are using these tests for pre-surgery screening. Hopefully these people are asymptomatic, because if they were symptomatic they wouldn't be having surgery. We do use these for asymptomatic, but they are not technically geared toward broad testing. The real caution here is to purchase a test and test everyone and have some false conclusions. This leads to false information about what is happening in the community. There are five of these tests that moderate or waived labs can purchase and use under CMS guidelines. For a high complexity

lab, there are around 70-80 platforms. Some of the tests are automated and others are sequential pieces of equipment.

Serology testing is the other form of testing. This gets a lot of traction because it is inexpensive, easy to do and widely available through a blood test. The sampling technique, although it's invasive, you get whatever is there, as opposed to the nasal-pharyngeal where you don't know if you got enough of the sample. It looks at seroprevalance, how many people in a community are carrying antibodies against this. You might be looking for donor studies through blood banking, for plasma donors, to help fight the infection in another person. You will get told by certain labs that if you do serological testing, it purports to know who is immune. If they tell you that, then you should ask them where they justify that, because it has not been approved by the CDC at all. There is no official stance on immune response and immunity from having had COVID. It may be there, but we don't know how good it is. There are some studies that say it could fade immunity response and IGG antibodies as soon as a month or two after you contract it and then you no longer have immunity. Other studies say it can last a long time. All of this relates to the potential for a vaccine. The immune response is a qualitative. Right now there are a few place doing a titer looking at how much immune response you have. Others are just looking at a yes or no situation. It is all retrospecitive. It's not looking at infections you have today. The infection could have happened a week ago, or longer. Antibodies can still be detected after the infection has passed.

Myron's advice to hospital regarding what to use and what to buy depends on the situation. Diagnostics should be the main goal, to know if someone has the virus or not. Serological testing can give you an idea of prevalence, and is more for surveillance. It's not ideal for detecting infection. Diagnostic should be most of the work you all would do, where serological is used for research. Five of the diagnostic tests that are approved for waived or moderate, the rest are PCR tests. All the rest are high complexity. When would you use these together? The rapid tests, such as the Abbott ID Now is an isothermal PCR test. It is cartridge based. And you may want to use that for screening such as pre-op. If you get a negative, it's a presumptive negative but if you get a positive it's pretty likely it is a positive. The same holds true for the Sofia by Quidel Company. It is also a presumptive negative and is an antigen test, so it is not as sensitive. Both of these tests are fast and easy and can be done in any facility that has a CLIA waive certificate. We don't recommend for asymptomatic testing as they are not as sensitive and should be paired with molecular tests. You should do a percentage of the samples reflected over to a more sensitive test. Symptomatic individuals who come up negative should reflect and have performed again on a higher sensitivity platform. Some long-term care facilities have opted for serological assay for screening, but none of the serologicals are approved for waive testing. LTC facilities would not be qualified to do that test. The rapid test might be a better tool. You might want to combine tests. If you do a serological, reflect them to a PCR if you get any hits, to see if there is an active infection. One question that comes up a lot is the sensitivity of the tests. PCR testing has the most sensitivity with 96-100% accuracy depending on proper collection. The downside to PCR is that it will also detect dead RNA. The virus may no longer be viable but the RNA is still floating around. KSHE's guidance is that patients may be released after 10 days or 72 hours after last symptoms with no drugs to prevent symptoms.

Another question he gets asked is about pooling. Is it ok to pool samples? The FDA is working on a model. Nebraska used this method at the start of the pandemic when under restriction in being able to find kits and testing supplies. It will work if the prevalence of positives is low, around 10%. Myron's recommendation, based on what he has seen, is 3-5 samples would be most that should be used, expecting that most are non-detectable and this gives up some sensitivity. If 20% of patients might be detectable, then pooling does not make as much sense because he is going to retest all the samples individually. You are giving up sensitivity so you would not want to use a pool test on Abbott or Quidel, but instead use on a test with very good sensitivity like a traditional PCR where fewer levels of particles can be detected.

Myron's final topic was to request feedback from hospitals. He would like to hear from facilities that are having trouble getting supplies. KHEL is now able to support collection supplies. They received some every week from HHS and vendors and they have verified efficacy. The Cepheid test has dependable results, along with Bonfire. They don't have presumptive negatives. The commercial labs are struggling with manufacturing. Cepheid will not be able to increase allocations for the balance of the year. Abbott may expand a little bit, and may have some flexibility Roche platform is struggling with its supply chain and CDC has not been able to break that loose. Similarly, the Hologic Panther, which is a high throuput testing platform is having trouble getting supplies. KDHE is still getting collection kits and some supplies for testing. The Kansas Health and Environmental Lab can still test over 8,000 per day and is currently only doing around 2,300. Hospitals should reach out to Myron with their supply chain issues relative to testing and collection, and he will work with federal partners to help with allocations.

Statistics Relative to COVID – Sally Othmer
As reported on our KHA COVID Dashboard on Mondays, Wednesday and Friday, COVID cases continue to trend upward, up 16 percent or close to 2,500 since our huddle last week. All but seven counties in Kansas are reporting cases. The state reported 280 deaths as of yesterday, an increase of 10 since last week. With increased testing, the 14-day trend of infections by population continues to climb from .01 to .024 percent but it's important to note that hospitalizations per infection has remained steady at just over 8 percent. These measures demonstrate the impact on our hospitals and our communities. **At a regional level**, all KHA districts again indicated an increase in cases since last Monday and an increase in new cases as a percent of the region's population and all but the Southeast show a rise in infections per capita. See the KDHE Latest Public Update for additional information.

We have had some questions about statistics relative to recovered cases since there are some media outlets reporting this measure. We reached out to KDHE and because the CDC has not released a single definition for a "recovered" person. Each county has a slightly different definition for recovered. KDHE is working with the counties to see if they can get this in the near future. KHA will follow KDHE's lead on reporting this statistic and wait for a more standardized definition.

We have also had some questions come in about the availability of PPE and other supplies. We gather those counts from data submitted to the supply Module in NHSN. Now reported out on our dashboard at the state level, as participation picks up, I would like to report this at the district level as well so everyone's participation is greatly appreciated. You may have noticed additional items on the dashboard as we can now pull in some robust data from NHSN providing COVID hospitalizations and hospital capacity. Please also remember to join the KHA reporting group. The group ID is **60538** and the password is **Kansas*2020**.

Relative to Reporting - There are two repositories of COVID patient capacity and supply data that hospitals must report into to qualify for distributions of Remdesivir and for PPE.

COVID Data Collection - The Kansas Department of Health and Environment relies data reported through National Healthcare Safety Network (NHSN) for COVID reporting. KDHE has asked for KHAs assistance to encourage our hospitals to report this data to NHSN through the COVID-19 Patient Impact and Hospital Capacity Pathway module and to report on a consistent daily basis.

Teletracking - HHS Reporting Requirements for Remdesivir Distribution - Per the article in yesterday's daily update, Hospitals must report into Tele Track to qualify for the latest Remdesivir distributions from the Department of Health and Human Services. The first deadline was yesterday Monday, July 6. The next deadline will be Monday, July 20, at 7 pm CST. It is anticipated that this cycle will reoccur every two weeks

until the end of September, occurring every other Monday to inform allocation of the medicine. KHA is in regular communication with Region VII HHS officials to advocate for streamlined reporting and will continue to provide updated information to our members as it becomes available. We continue to work with both KDHE and HHS on ways to reduce confusion, burden and redundancies relative to COVID-19 reporting.

COVID-19 Preparedness and Response Update – Ron Marshall

ASPR Grant Update

The first quarter expenditure report for the ASPR grant is due on July 10. If the funds have not been spent, there is a section on the form (page 3) to indicate that you have not spent your funds and to specify what the funds will be spent on in the future. If you have not received the expenditure report, please reach out to Ron Marshall or Melissa Willey at KHA. It was originally sent on June 19 from Melissa.

PPE

Last week HHS Region 7 had a call with state hospital associations and state health departments and a member of the White House Task Force to share the challenges of obtaining PPE. We are sharing our member's letters on this challenges on obtaining PPE with the task force and KHA, KDHE and KDEM are working on a Kansas response to be submitted by July 16. Cotton face masks are in very low supply, but they are expecting more arriving soon. They do have KN95s, gowns and face shields. There have a low supply of N95 and gloves. Ron received information on the shortage of nitrile gloves and that information is in today's email. There is also a shortage of lab reagents. Please reach out to Myron Gunsalus at KHEL or Ron Marshall at KHA with your concerns.

Finance and Reimbursement Updates – Tish Hollingsworth

HHS Provides Additional Updates on the CARES Act Provider Relief Fund FAQs

On June 19, HHS added a bit more clarity on what to include in the lost revenue calculation and the attributable time frame for allowable expenses or lost revenue. According to the FAQs, lost revenue estimates should be based on budget-to-actual or year-over-year, and should include revenue from all sources that can be attributed to COVID-19. HHS acknowledges that "healthcare related expenses attributable to coronavirus" is a broad term that may cover a range of items and services purchased to prevent prepare for, and respond to coronavirus. (see FAQ under "Terms and Conditions").

In addition, the FAQs indicate, "HHS expects that providers will only use Provider Relief Fund payments for as long as they have eligible expenses or lost revenue. If, at the conclusion of the pandemic, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds." (see FAQ under "Terms and Conditions")

HHS added an FAQ on June 30 alerting that there will be significant anti-fraud monitoring of the money distributed from the Provider Relief Fund. The Office of the Inspector General will provide oversight as required in the CARES Act, and HHS will notify recipients of applicable audit requirements soon. (see FAQ under "Auditing and Reporting Requirements")

Medicare Accelerated and Advance Payments

To date, HHS has still not provided any information to the Medicare contractors regarding the pending Medicare Part A applications for Accelerated payments that were in process due to the April 26 cutoff. HHS has processed some additional Medicare Part B Advance Payments.

COVID-19: New and Expanded Flexibilities for RHCs & FQHCs during the Public Health Emergency

On July 6, CMS updated MLN Matters Article SE20016 to clarify how Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can apply the Cost Sharing (CS) modifier to preventive services furnished via telehealth. This update includes some additional claims examples for billing staff. In addition, MLN SE20016 includes a new section concerning the exception to the productivity standards for RHCs. The article indicates that exceptions to the productivity standard may be granted by our Medicare Administrative Contractor, Wisconsin Physician Services (WPS), and additional information should be released from WPS soon. Some information on the productivity standards exception can be found on the WPS website.

Provider Relief Fund Medicaid and Children's Health Insurance Program Distribution Webinar -- July 8
HHS recently announced the additional distributions from the Provider Relief Fund to eligible Medicaid and Children's Health Insurance Program (CHIP) providers that participate in state Medicaid and CHIP programs. HHS expects to distribute approximately $15 billion to eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Distribution. Eligible providers must submit their data by July 20.

Before applying through the Enhanced Provider Relief Fund Payment Portal, applicants can watch a recording of the June 25 webinar or you can register for a live webinar which is scheduled for **Wednesday, July 8 at 3:00 pm CDT.** You can review the most recent FAQs on the Medicaid/CHIP targeted distribution here.

Member Questions – All Topics

Q1: Regarding Spark: It was mentioned there are three rounds, what is entailed with Round 3? Is there recoupment? And just clarify, the funds received in Round 1 alone must be spent within March 2020-Dec 31, 2020?
A1: All of the money ($1.25 billion dollars the state sends out) needs to *incurred* between March-December 31, 2020. Round 3 details are still pending, but funding available depends on how much is allocated in Round 2. Round 2 funds may be more than Round 1. As far as recoupment, it is expected that there will be some sort of audit. The state is responsible for the funds, but counties will have to account for the spending on COVID-19 related expenditures.

Q2: We have been struggling with "re-opening" our nursing homes and the issue of baseline testing of residents and staff. KDADS is absolutely no help as they recommend baseline testing. Our medical staff is opposed to baseline testing however from a liability standpoint there is some thought that if we don't we may open ourselves to liability if we do experience an outbreak. Does the State Lab has an opinion on baseline testing?
A2: KHEL gave input to KDADS regarding the LTC testing. In a community with widespread community transmission, it's probably a good idea to test everyone and do ongoing monitoring. In a community with low to moderate transmission, one positive case in a facility should be the trigger to test all staff and residents and follow up with a second test in 5-7 days. Facilities should work with their local health department, as there is no definition of "widespread."

Q3: Does the state have a shortage of lab collection supplies? Should the hospital reach out through the local health department?
A3: There is no guarantee of what the state receives each week from HHS. Yes, do reach out to the local health department or county emergency manager for collection supplies.

Q4: What do you think of the new COVID/Flu combo test approved by the FDA for emergency use authorization?
A4: We have not run it yet, but anticipate this will be what is used in the future. The CDC Assay is the first one that will come out, other vendors will follow. It is the way to go, it is not uncommon; we do other combination tests quite frequently. It should be a good system.

Q5: In Kansas how much of the increased positive cases is due to increased testing versus more actual COVID-19 cases?
A5: There is an increase in cases. It's important to look at the rate of positives, not just the number of cases. The rate went up last week for the first time in a long time, from 8% to 8.2%. It had been as high as 10-12 percent statewide. Some counties are as high as 20-30% of people testing found positive.

Q6: How do I get a CLIA certificate?
A6: To ask questions about CLIA certification, learn about the application process or questions about CMS requirements on COVID, contact: Jennifer Evans - Phone: (785) 291-3162, KDHE.CLIA2@ks.gov; General Lab number (785) 296-1620

Q7: What is the current turnaround time for COVID testing?
A7: KHEL generally turns around tests in 24-48 hours, but there are reports that the larger commercial labs are overwhelmed and could be longer. We are looking into testing turnaround times. K-State has capacity for testing and are turning around in 1-2 days.

Next Hospital Huddle Call

Please continue to share your COVID-19 questions with us by emailing Cindy Samuelson. Our next call will be Tuesday, July 14 at 10:00 a.m.