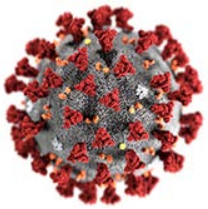
COVID-19 Statewide Hospital Huddle Summary Tuesday, April 6, 2021



Chad Austin welcomed everyone to the Hospital Huddle. We hope everyone had a nice Easter weekend and enjoyed some of the great weather this past weekend. We have seen the number of COVID-19 vaccines drastically increase over the course of the last month. In addition, the state of Kansas has opened up vaccines to all individuals over the age of 16, starting last week as well. We have seen the rankings for the state of Kansas increase to 35th in the percentage of COVID-19 vaccines administered across the state. We are pleased to have Phil Griffin from KDHE join us again. As always, we are here to help you, so if there are any questions you may have following this call, reach out to our team and let us know. We are happy to serve you and provide whatever information you may need.

Statistics Relative to COVID and Dashboard Update – Sally Othmer
(Slides attached to the COVID-19 email 4-7-21)
The hospital data from TeleTracking continues to demonstrate that we are going in the right direction as the number of COVID-19 hospitalized patients has dropped since our numbers peaked in November and December. We are now back to where we were in mid-July.

Our region 7 HHS has begun sending weekly notices of non-compliance to KHA, and KHA monitors this as well. It gives us a list of those who are out of compliance and not getting their data in daily and timely. As you know, submission to TeleTracking is a condition of participation in the Medicare program. I reach out to those that are missing data. KHA has scheduled a call with HHS to discuss the continued reporting mandates and burden on hospitals.

All six regions demonstrated a drop in the number of new cases from the week prior. The bottom graph displays weekly new statewide cases and deaths. All of the data from these graphs are pulled from information posted on the KDHE website. Weekly deaths are based on the cumulative number published by KDHE every Monday, Wednesday and Friday. Weekly new cases are down to where we were in May.

As cases drop and vaccinations rise, we are hoping to move the dashboard to a focus on vaccine administration. The state data for these graphs come from KDHE, and the national stats come from the CDC website. They display the number of first dose, second dose and the percentage of the state and national population.

Updates to TeleTracking and some vaccine resources are available here and at the KHA website. The KHA COVID Dashboard has changed over time and will continue to be updated to report information in the best way possible. Please reach out to Sally Othmer at sothmer@kha-net.org with questions or recommendations.

COVID-19 Preparedness, Response and Vaccine Update – Ron Marshall
On the last few calls we have provided brief updates on the COVID-19 virus on a national and more global basis related to trends and variants. We think it is important to follow what is happening in Europe, because we have historically seen similar waves to follow here in the US.

Worldwide we are seeing a fourth wave in multiple European countries. Among them Italy, Sweden France, Germany and UK reinstituting lock downs and school closures. In Canada, they are experiencing a third wave. What is particularly concerning is this wave is affecting younger individuals more severely than the wild virus

(the original strain). In the last few weeks, Canada is experiencing a 64 percent increase in new cases of which 90 percent are the B117 (UK) variant. This wave is spreading much more quickly than the previous waves in Canada. Like Europe, this wave is resulting in new lockdowns and school closures. In one province, nearly half the ICU patients are under 60 years old. In one large city, the majority of ICU patients are 30, 40 and 50 years old. Therefore, the younger individuals seem to be impacted versus what we have seen in earlier waves, which were 65 and older. Part of the issue in Canada is that they have been very slow in vaccinating the population. All vaccines have to be imported from other countries into Canada. As of April 1 only 1.75 percent of the Canadian population has been fully vaccinated and 12.0 percent have received a first does.

The US has now seen variants in 51 states and territories. Minnesota, New Jersey and New York are being hit especially hard. On a CDC map this morning, South Dakota is also at a high rate. The US has experienced four consecutive weeks of increasing new cases. Yesterday, California reported identifying the first confirmed case in the US on the double mutation on the spike protein virus. This particular variant appears to be the same one identified in India last month. The double mutation appears to allow the virus to attach to cells more easily, making it more transmissible and possibly, although not known at this time, evading neutralizing antibodies.

Kansas has reported cases of the B117 variant in several counties now. Dr. Norman described last week Kansas variant are "smoldering" with identified cases in the 100s but not the 1000s. Kansas also identified the first case of the South African variant just last week.

We share this information to show how important the race to vaccinate is to slow the spread for a possible new wave and also to make certain we do not relax our mitigation efforts. We continue to wear masks, social distance and avoid mass gatherings until more people are fully vaccinated before we have more control over the virus.

Latest Vaccine Reporting – Phil Griffin
(Slides attached to the COVID-19 email 4-7-21)
Phil Griffin, Director of the Bureau of Disease Prevention, KDHE, thanked everyone for having him on the call. He reiterated what Ron was saying with the variants and cases happening around Kansas with other states. One of the keys in prevention of allowing that to impact Kansas as much is making sure that people are vaccinated as soon as possible. Chad alluded to the fact that we have had great progress I recent weeks, so significantly more vaccines. But as you can see with the slide that is up, that can taper off a little bit in the next couple of weeks. This is all subject to change. It seems like every Tuesday when our actual real allocations come up, the projections have been altered by one or more vaccines at that time.

This week delivery, we have 41,800 doses of Johnson and Johnson coming into the state. That is being spread across the state with a variety of locations and types of practices and so forth. However, that is going to drop back to 15,800 next week and the following week. Part of that is due to the information that was in the news the last couple of weeks about an ingredient problem that occurred several months ago in the production of Johnson and Johnson vaccine. That is now down the pike and impacting the availability of vaccine now. So while we have had an increase, we had a big jump in Pfizer a couple of weeks ago. Then that dropped back. We have had a slight increase of about 1,200 doses of Moderna that is holding steady for right now. For the next couple of weeks, we're going to be back to where we were two or three weeks ago with vaccines. It is a fluctuating point, which makes planning a little more difficult for all of us.

We are doing our best to do direct shipping as possible to practices. As we have opened up to all phases, it's important that we have vaccines spread as widely as possible in as many different types of providers as possible. Obviously, our best opportunity to get people vaccinated is when the vaccine is available right then and there. The most important recommendation comes from the provider, and when that provider is also able

to provide that vaccine, it makes things much easier. We tried to capitalize on that as much as we can. We are also dealing with areas of the state that have some decreased demand. We are having to shuffle vaccine around when we look at county equity, vaccine would be going to different counties, but those counties are not seeing demand. They are pausing and returning their vaccine to the state allocations, which we then re-allocate to areas of greater demand and to other providers. We always have continued to deal with several constraints in the allocation process. The minimum order considerations for Moderna and Johnson and Johnson are 100-dose minimum order. Pfizer is the 1,170 minimum dose orders. We tried to do as little centralized redistribution as possible because of complications involved with that. But we want to encourage partnering at local re-distribution which can happen through hospitals to other clinic associated with the hospitals or with a conglomerate of individual practices that may be in an area together. May be a medical office building with 3-4 different types of providers and specialties that may be in one building and can partner together where one receives 100 doses and distributes them equally between the four or five. Looking to be out of the box in as many ways as possible to get direct shipment to the hospitals and providers and to all types of different providers wherever feasible.

We will be converting to an ordering plan in the next couple of weeks. There will be some webinars that will be announced for next week. We are doing six webinars April 14-16 at different times during the day. The announcement will go out on the 8th with registration information. We will make sure those go to the hospital association as well as to all those on our various lists. We will be talking about it on the all-provider call on Thursday, basically just saying that training will be available. There will be a brief 30-minute demonstration on how to do the ordering process in Kansas WebIZ. It is pretty straightforward. You go in and you select the vaccine that you want and the quantity that you would like to have them in. Again, considering those minimum dose delivery packs. Prior to that, there will be a survey that will go out to all enrolled providers where you indicate the type of vaccine that you would prefer and vaccines that you would be willing to receive. My biggest concern is that everybody is going to want Johnson and Johnson. Obviously, if I have 15,800 doses coming to the state, not everybody can get Johnson and Johnson. So we will have to use that as a priority mechanism and an equitable mechanism. So if you want to ensure that you can get vaccine, please don't limit yourself to a single type of vaccine, because it is not going to be possible to do that. We will at that point want to turn on the ordering process. We will have a system where whatever orders are placed by Monday will be considered in the allocation rollout. On Wednesday, we will sent notices to everyone on what we anticipate being able to allocate based on the information from the order that was placed and what is available. We will do our best to meet orders, but if demand is greater than supply, obviously those will have to be adjusted and we will do the best that we can do. We will send that information out for confirmation for everyone to be able to determine "yes, I do want to receive the vaccine," or "no, I don't." Or "I'm just not able to take that number of that particular vaccine this particular week." Those allocation requests will be responded to by Thursday. We will place orders at the federal level on Friday of each week. They will be delivered the following week. Basically, you are going to be planning at least a week ahead in what you would like to order and should know by the middle of the week what is likely to be able to come to you the following week.

Looking at inventory reporting, we'll continue to have the daily report to Vaccine Finder. That is the federal requirement of all vaccine providers. You can also opt in to the Vaccine Finder option of being public view, so that when people are going and looking for vaccines, they know where the providers are that have the vaccine and will show your availability of vaccine on any given day. The weekly snapshot was the daily and is now converted over to just a weekly that needs to be reported sometime between Friday midday and Monday morning. That is a once-a-week look in time to where things are. It's a point for validation so that we can manage the administration rates and administration gaps and be able to have early identification of any problems. One of the things we got into is there were a lot of challenges with the data of accuracy, and it made us look like we were not getting vaccines administered properly in the state. It really had to do with transfers not being tracked properly. Or organizations thought their information was going through HL7

messaging, and there were glitches in that so it wasn't showing up for one reason or another. So that is the purpose of the weekly snapshot is to stay on top of that and to be able to capture and manage any problems early before they become a major problem again. We are looking for people, now that we are reaching a point where demand is less in many cases than what supply is available. There is a greater anticipation that there will be inventory around two weeks instead of one week, and that will be generally acceptable. There will be times that we may go a little longer than two weeks, but we really need people to try to manage that as supplies and demand are trying to balance themselves out.

Action plans that we have been talking about are not going to be required in general situations. If we do run into a situation where a particular provider seems to be sitting on a great deal of vaccine or vaccine that has risk of expiring, then we may request an action plan from that provider in order to continue to provide them with additional vaccine.

Administration reporting groups will continue to be required in WebIZ. That is to be downloaded in 24 hours. That is part of the agreement that everyone signed on to at the federal level in the provider enrollment process. It is to be reported to the state IIS within 24 hours. There are some challenges with that data with the federal programs. There actually could be a 3 or 4 day delay as the federal program is reported to the federal level. Then it is dumped into a data lake. Then it eventually finds its way back to the Kansas WebIZ. If the providers that are participating to the federal programs are not reporting back to the WebIZ but only reporting to the federal mechanisms, then there could be a delay in that. There have also been some questions regarding mass vaccination clinics and people coming into the office to get their second dose, but they can't find their record of when they got their first dose. Those are individual matters that we have to look into, so without detail, I can't really speak to exactly what that issue may be. The expectation is that everyone continue to get those doses in within 24 hours and get reported as administered, so they should be showing up in WebIZ in that 1-3 day range. That's why we continue to do the weekly snapshots so we can track those types of challenges that come up. I think what you find that they are less and less today than they were a few weeks ago.

COVID-19 Vaccine Update – Karen Braman
KHA will continue to monitor vaccine-related information, including clinical trials in adolescents and children; and the Astra Zeneca and Novovax COVID-19 vaccines which are anticipated to be submitted to the FDA in the coming weeks and months for emergency use authorization.

Finance and Reimbursement Update – Jason Barb, BKD
RHC COVID vaccine administration – There was some new information released by CMS on April 1, 2021. This is specific to those of you who may be providing the vaccine in a rural health clinic setting. Last week, the information that came out was that the COVID-19 vaccines and administration would be paid at 100% cost in the rural health clinic setting. That will work very similar to how flu and pneumonia shots have been working for many years in that particular setting. As of right now, the cost report software is not set up for that, but CMS does indicate that you will be able to request a lump sum payment in advance of cost report settlement. However, as of today, no guidance received yet from WPS on exactly how you will request the lump sums or how that will play into your cost report filing. We hope to have some information on that soon and will get that to KHA to provide to the membership as we get that information.

PRF reporting portal – No updates listed on the portal website. Still no ability to enter data in the portal. Current understanding is providers will have a minimum of 30 days to report from date portal opens.

PRF FAQs – There were multiple updates on March 31, 2021. However, when you look at those and really compare what was updated to what was previously on the website. There is really no significant changes. It was mostly minor tweaks to language or moving things to where it was in a different order within the FAQs.

Sequestration – The Senate passed bill to extend the moratorium on sequestration through December 31, 2021. The House is expected to pass the bill when they return April 13. That is expected to be passed into law. Hopefully, as of early next week, we will have a final answer on that and the 2% moratorium will be extended through the end of year. CMS has instructed all of the MACs to hold claims payments for anything with date of service on or after April 1, 2021. This is with the intent of minimizing the number of claims that would need to be reprocessed under the assumption that the moratorium will pass. You may start to see towards the end of this week or early next week a little bit of reduction in payments depending on how quickly your claims normally process. Anything with a DOS on or after April 1 will be held pending the outcome of the moratorium.

Medicare Accelerated Payments – Recoupment has begun on that. Recoupment is facility specific on the date and will begin one year from date accelerated payment was issued if you opted into that program. For the first 11 months, recoupment will be at 25% of Medicare payments. Those will be coming out. I have had conversations with a variety of providers. There are some who are opting to return that amount in full. That is an option out there if you do not want to deal with the administration of recording the recoupments at the 25% rate, you have the ability to return those funds in full if you so choose.

State and Federal COVID-19 Advocacy Update – Audrey Dunkel/Tara Mays
Sequestration – As Jason mentioned, the sequestration relief bill passed the Senate. We do expect it to pass the House next week. The big difference there is that the House did not have a pay for and the Senate version does have a pay for, and that is to extend the sequester through 2030. So we have added another year to the sequester, but that seems a long way away. I think we will be addressing that in the future.

Infrastructure Bill – We also know the Biden infrastructure plan is under discussion. There is $400 billion over for the homeland community-based services program. If you are familiar with that, we spend a lot of time debating here in the state if we are going to add more money to that program. I think it is a recognition of needing to take care of, not only our disabled, but also our elderly in our country. We expect that infrastructure to have some other health care related provisions and expect an announcement sometime later this month. Maybe as early as tomorrow, but that seems unlikely right now.

It's been quite busy with the legislature returning from a long weekend today to begin to work through conference committees ahead of their first adjournment deadline coming up on April 9. That deadline will signal the last legislative discussions until they return for veto session on May 3.

SB 283 – Providing continued liability protections and priority regulatory relief for COVID-19 response until March 2022. Passed the House 96-28, passed the Senate 30-10 and was signed by the Governor.

SB 175 – REH and Rural Innovation Hospital Grant Program is in conference committee. The bill with just the designation passed the Senate on a vote of 39-0 and in the House they added the innovation grant program and passed out on a vote of 119-3. The legislation is now in conference for discussion between house and senate health committee members.

SB 212 – Vaccination Legislation: limits the ability of KDHE to add vaccinations to the schedule for the purposes of attending daycare or schools, it also includes language from SB 213; which restricts employers from taking any actions against any employee based on the employees vaccination status. The legislation SB 212 had hearing and was worked in committee to add language from SB 213. The legislation passed as amended, KHA has led efforts with the business community in drafting and distributing a letter that emphasizes our concerns with the legislation. The bill is below the line in the Senate. While it is unknown if it

will debated at this time, the House has not indicated a desire to take the legislation up with the short turnaround time.

HB 2126 – Which provides adult care homes liability protections has passed both chambers and has been presented to the Governor.

Sen Sub for HB 2062 – Which Prohibiting boards of county commissioners, boards of trustees or employees from restricting visitors of residents of a county home for the aged or patients in a county hospital and permitting such residents and patients to waive state, city or federal restrictions on the right to receive visitors. The bill passed out of committee and is below the line in the Senate.

Member Questions – Cindy Samuelson
Q1: *Are hospitals that registered as vaccine providers now able to order, or are we still only working through the local health department?*
A1: Phil – Hospitals are not able to order yet. The order process will start in a couple weeks. Training will happen over the next week - training dates will be shared on April 8. Hospitals are eligible to receive vaccines through direct allocation, depending on the hospital and where it's at and what the need is within the county. KDHE is using the data we have from the most recent KHA survey that we asked hospitals to do. KDHE is aware of which hospitals are willing to vaccinate, are interested in vaccinating and what those parameters are. Hospitals will have an opportunity in the next week to go through those trainings, after they have done that, they will be able to do the direct order.

Q2: *On your slides, you mentioned the word "provider." We want to clarify that includes hospitals, clinics and local health departments.*
A2: Phil – Yes. That includes anybody that can put a vaccine in somebody's arm and properly store it.

Q3: *Will direct reporting take the place of the current system at some point? Is there a possibility that the minimum orders will decrease, especially for Pfizer?*
A3: Phil – As mentioned in the attached slides, the weekly snapshot is ongoing for now. We do not anticipate any time in the near future any changes in the minimum order. That is largely because it is all about a production system right now. It is much faster and gets vaccine to market faster when you are doing larger, multi-dose packs than when you are doing smaller, single dose. It is a major challenge to all of us, and we are running into a lot of problems now with demand issues and even getting in some small areas having ten people in a six-hour window to get a Moderna vaccine is posing some challenges. As of right now, there is no indication that they are changing any of that. We would anticipate as we move farther into later in the year, we will see some changes in those distribution channels as we are looking at ongoing vaccination processes. As we move from a EUA ultimately an approved vaccine process, I think some of those will change. Even to change the dose counts or the vials or the number in a shipment right now requires a change in the EUA through FDA. That's not where the focus is at the manufacturer's federal level. It's more about getting the most vaccine out as possible, so that's where they are sticking right now.

Q4: *We have heard some CAHs are providing financial incentive payments if staff are vaccinated to increase their immunity and protections. They are using HHS funding. Is that an acceptable usage of HHS funding?*
A4: Jason – The short answer is there's not really any black and white answers that. Based upon how I have read the FAQs, essentially anything that is used for the preparation, prevention or treatment of the corona virus are allowable. In prior FAQs, retention bonuses and things of that nature were allowable. I would tend to lean toward "yes," but we have not seen any specific responses to that particular question from HHS, but I would think that there would be a strong argument to make to include that.

Q5: *If a provider chooses to return accelerated payment but recoupment begins before the transaction actually takes place will CMS be able to stop recoupment. The hospital doesn't want to end up returning the accelerated payment plus recoupment.*
A5: NEW from WPS GHA - Thank you for your inquiry regarding returning the payment(s) you received from the COVID -19 Accelerated and Advance Payment (CAAP) Program. You may return these funds in one lump sum by check or wire transfer before recoupment begins. Before doing so, please provide the NPI/ PTAN combination for which you would like to return funds. If you would like to return funds for more than one NPI/PTAN combination, please provide a list. Please also provide the amounts received for each NPI/PTAN combination. We will respond to confirm that the amounts you provide match our records and we will provide you with instructions on how to make payment. Please note that any accelerated and/or advance payments that are not specifically associated with the NPI/PTANs you provide will be subject to the repayment process discussed in the Fact Sheet found here: https://www.cms.gov/files/document/covid-advance-accelerated-payment-faqs.pdf. If you submit a payment and the recoupment process has already started, any excess funds recouped would be refunded back to the provider.

Q6: *There is a vaccine provider manual that our hospitals have been using. Is it anticipated that the manual will be updated with the new processes?*
A6: Phil – The last update was March 31, so we are updating it regularly. Actually, there was some updates done to it even yesterday where we are watching some language. This is something that everybody could be aware of. ICAN, which is Informed Consent Action Network, which has been very active in kind of an anti-vaccine and vaccine hesitancy push is really going after some minute language and creating some havoc in various places. One of the things they have attacked in some sites and state websites is the use of "approved vaccine" as opposed to "authorized vaccine." The FDA has authorized this under the emergency use authorization. These are not technically approved vaccines. They are authorized vaccines. They are taking language like that and making an attack and threatening lawsuits. Basically, what it does is create concern in the public's mind about whether we are lying to them about the vaccine. It is part of the conspiracy and these kinds of things. So we just went through yesterday and combed all of the provider manuals and updated that language. If we ever used the word "approved," it has been changed to "authorized." There weren't many of those situations, but I think there were a couple of places where it said "approved." So the manual is getting updated and will be updated as soon as the rollout is set for ordering.

Q7: *With the guidance from KDHE regarding handling testing for vaccine breakthrough cases, is KDHE considering creating a crosswalk between test results and WebIZ? That would really assist with reducing the provider reporting requirements.*
A7: Phil – Yes, it has been considered. It is far more complicated than you would think. We also have to look into some legal issues of whether or not we can actually do that under the authorization of the registry and what its intended use is based on statute as to whether we can crosswalk and share that data into a treatment side of modalities or into testing, because it reports conditions. Conditions are not a linkable piece within the statutes governing the use of WebIZ. It is something that we would love to do and are looking at the possibility of being able to do, but it is not something that is going to happen in the immediate future because of some technical issues. Being able to have the two systems talk to each other in a way that would be most useful and also if we would be legally do it or not at this point.

Q8: *Did we hear correctly if that state is planning to legislate whether the hospital will allow visitors or not?*
A8: Audrey – There is a bill out there, and it came out of the Senate Public Health and Wellness Committee. It has not been voted on by the full Senate, and our understanding from the House is they are not likely to take up that legislation. But we are watching it very carefully. You are correct, there is legislation out there that would limit your ability if you are a county facility to restrict visitors.

Q9: *Are there any statistics that you can share on vaccine breakthrough cases (reinfection of a fully vaccinated individual)? Can you share how often that is occurring*?
A9: Phil – I do not have the specifics of that. What I can do is pass that over to epidemiology and have them get back with you.

Q10: *Are the hospitals on the line still quarantining admits to post-acute units or facilities?*
A10: Karen – I have not heard any recent commentary on that. Ron – I don't think I have heard of anybody doing that, but it really hasn't come up as part of the discussion lately. Cindy - There were no members posting that they are quarantining in the chat.

Next KHA COVID-19 Hospital Huddle

Hospital Huddles will occur on the first and third Tuesdays of each month. Our next Hospital Huddle will be **at 10:00 a.m.** on **Tuesday, April 20.** Email Cindy Samuelson if you have guest speakers you would like to have present on an upcoming Hospital Huddle.