

Continuity of Operations



Financial Sustainability For Healthcare Facilities In Disasters

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EXECUTIVE SUMMARY

Can you answer the following questions?

- How long can our hospital stay open if our collections fall by 10% ? 25% ? 50% ?
- In a national disaster, will our key suppliers require “COD”?
- Who will pay for the additional medical care services that our facility or health system is asked to provide during a disaster?
- Are we prepared for a sudden and dramatic shift in our payer mix to more uninsured?

The answers to these questions are at the heart of continuity of operations planning (COOP) for health care facilities. The answers may determine if your facility can survive the next large scale disaster.

The events of September 11 and Hurricanes Katrina and Rita pushed disaster preparedness and planning into the spotlight. The response to the 2008 Midwest floods and, most recently, Hurricane Ike showed that both the public and private healthcare sectors have made advances in their preparedness and response capabilities. Health departments, health systems, and hospitals across the country are continuing to develop and refine emergency response policies and procedures for crucial preparedness issues including altered standards of care, equipment and pharmaceutical caches, and health provider staffing. Yet, despite these ongoing activities, healthcare emergency planners must assess if they have prepared for how a hurricane, pandemic, bioterrorist event, or other disaster will affect the financial viability of their hospitals. Continuity of operations and financial sustainability planning are essential elements of disaster preparedness that are too often overlooked.

Introduction to Continuity of Operations

The concepts of continuity of operations and financial sustainability are intertwined. Financial sustainability refers to an entity’s ability to remain economically viable during and after a disaster¹ by maintaining a revenue stream during the disaster. Continuity of operations refers to a broader plan to maintain business operations during a disaster, which includes assuring an organization’s financial stability. Financial sustainability is an integral part of continuity of operations planning.

The Virginia Hospital and Healthcare Association (VHHA) and Virginia Department of Health (VDH), with funding from the U.S. Department of Health and Human Services Hospital

¹ Many Federal and State laws make a distinction between “emergency” and “disaster.” Throughout this White Paper, the authors have elected to use “disaster” to represent any type of emergency or disaster, including any short or long-term, traditional or non-traditional catastrophic event and pandemic.



Preparedness Program, commissioned Troutman Sanders LLP to create this report to (i) provide hospitals and healthcare providers in Virginia with a comprehensive review of the current legal environment affecting continuity of operations and financial sustainability during disasters and (ii) identify issues impacting continuity of operations and financial sustainability that require further clarification and discussion with both public and private sector payers. This report analyzes both well known and less familiar reimbursement mechanisms—traditional claims submission to public and private payers, waivers of regulatory requirements, insurance to cover economic losses, and reimbursements from the Federal Emergency Management Agency—that hospitals and other healthcare providers should understand as they plan their strategies to assure financial sustainability during and in the aftermath of a disaster.

The Stafford Act and FEMA

Many in the healthcare industry may still believe that the main source of funding for care provided during and after a disaster is likely to be federal funds, specifically from the Federal Emergency Management Agency (FEMA). FEMA administers disaster relief funding allowed under the Stafford Act.² Large scale events in the last decade, such as Hurricanes Katrina and Rita in 2005, however, demonstrated problems and uncertainties with FEMA’s policies, which have subsequently undergone revision in the last several years. Under FEMA’s prior medical care policies, the cost of emergency medical care was not covered. In the revised policies, some aspects of emergency medical care are now covered, including treatment and monitoring of disaster victims requiring medical care, and vaccinations for disaster victims, emergency workers and medical staff. Certain costs such as increased operating costs and loss of revenues remain ineligible under the revised policies.

Despite these revisions, a large segment of providers and services remain ineligible under the Stafford Act and FEMA rules. Reimbursement from FEMA is possible for hospitals and other healthcare providers, but the availability of these funds is limited by the Stafford Act to particular types of entities for particular types of costs and activities. Only private nonprofit healthcare facilities may directly apply for FEMA assistance grants. For-profit healthcare facilities are not directly eligible for FEMA funds. However, incorporation of “for-profit” entities into mutual aid agreements, emergency response plans, or memorandum of understanding may make the “for-profit” entity indirectly eligible for reimbursement by FEMA.

FEMA’s role as “payer of last resort” requires individuals, as well as entities like hospitals and other medical facilities, to exhaust other forms of insurance and reimbursement before seeking reimbursement from FEMA. To the extent that other forms of payment are received in addition to FEMA funds, the recipients must off-set the amount paid out by FEMA and refund monies to the Agency. As a result, healthcare providers should not rely on the

² The Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§ 5121-5206).



availability of FEMA grants as a primary source of reimbursement and funding during or after a disaster.

Social Security Act Section 1135 and Section 1115 disaster waivers

In the midst of a disaster, it may not be practical or even possible for healthcare providers to meet all of the requirements for participation in federal health programs or all federal regulatory requirements. Fortunately, the need to waive, ease, or delay certain requirements has been recognized by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). Unfortunately, however, the scope of the available regulatory relief is narrow and these agencies are reluctant to issue many advance determinations of waivers beyond what is explicitly outlined in law.

HHS has used two waiver mechanisms—Social Security Act (SSA) Section 1135 and Section 1115 disaster waivers—to ease some healthcare regulatory requirements during disasters. While these Waivers are certainly helpful, they tend to be fairly limited in scope and duration, and they leave a series of gaps that healthcare providers should be aware of. Hospitals and healthcare providers have a solid understanding of these waiver mechanisms, but should not rely on them to ensure continuity of operations or financial sustainability during a disaster.

Claims Submission

Medicare, Medicaid, and private payers have specific eligibility and claims submission requirements that must be met for claims to be processed and paid. Failure to follow payers' claims submission procedures inevitably results in delayed payment or no payment at all. The operational circumstances resulting from a disaster—the need to maximize diminished staffing pools, and increased claims volume—will make it even more difficult for healthcare providers to meet many of the payers' requirements, including conditions of participation, certification, and proper claims submission procedures.

Federal and state laws, as well as actions by CMS and HHS during past disasters, offer some expectation that waivers of regulatory requirements related to claims and coverage issues will be available during future disasters. CMS's pandemic influenza guidance offers further examples of how that agency may treat claims and coverage requirements during a pandemic, yet these are subject to change in the future. While Virginia's Medicaid law does not have specific provisions that address the waiver or suspension of claims submission laws and regulations during a disaster, through the broad powers granted by Virginia's emergency laws, the Governor may suspend various regulations including those related to claims submission to allow hospitals to continue to submit claims and receive payments during a disaster. Even private payers have provided some flexibility for providers affected by prior large-scale disasters. Healthcare providers should understand what requirements payers have and have not waived during past



events to begin their financial continuity planning, but should realize that such waivers may or may not be available in the future.

Prompt Payment of Claims

Ensuring payment from third party payers during a disaster is key to continued operations and financial sustainability. During a disaster, payers may find it difficult to comply with the “prompt payment” rules and regulations. Federal and state prompt payment laws and regulations govern the manner and timing in which payers must pay providers or beneficiaries for properly submitted claims. If payers fail to comply with prompt payment rules during a disaster, healthcare providers’ revenue streams could be seriously diminished, creating a host of problems for providers, their vendors, employees, and, above all, patients.

Many providers receive electronic payments from payers. During a non-traditional disaster, such as a cyber-attack, or a more traditional disaster that results in a power outage, the electronic payment process may be inoperable or inaccessible for a prolonged period of time. Healthcare providers should discuss and plan for alternative mechanisms to receive and make payments during a disaster.

Accelerated Payment and Advance Payment from Medicare

CMS has the authority to relax or waive certain billing and claims submission requirements to help providers impacted by a disaster. CMS can supplement the relaxation or waiver of requirements through the use of accelerated payments or advance payments. Medicare accelerated payment provisions allow healthcare providers to receive payment for services before the provider submits a claim to CMS. A provider may receive an accelerated payment if the provider has experienced financial difficulties due to a delay by a Medicare contractor in making payments or if the provider has experienced a temporary delay in preparing and submitting bills. By contrast, an advance payment is an advance of the monies owed to the provider by Medicare, the eligibility for which is triggered by the Medicare contractor’s failure to process a claim in a timely manner.

CMS made accelerated payments and advance payments available to help impacted providers obtain prompt payment after such major disasters as September 11th, Hurricanes Katrina and Rita, the Southern California wildfires in November 2007, and the flooding in the Midwest in the summer of 2008. CMS acknowledges that accelerated payments and advance payments may be used as mechanisms to manage provider payments during an influenza pandemic, but that Medicare contractors will not have significant flexibility in easing the many procedures required to process and approve accelerated payments and advance payments. Healthcare providers must understand that accelerated payments and advance payments will not ensure financial sustainability during a disaster. These mechanisms are just two approaches to



consider in what should be a multifaceted financial continuity strategy. As part of their preparedness efforts, healthcare providers should understand the policies and regulations governing, the mechanisms for seeking and the ultimate impact of obtaining these types of payment.

Insuring Against Economic Losses during a Disaster

Healthcare operations, like all other businesses, purchase insurance to protect against a variety of potential losses. Property insurance is perhaps the most important and well-known type of insurance coverage in the context of traditional disaster preparedness. Property insurance generally reimburses for losses to “covered property” caused by a “covered peril.” While each policy has a unique definition of “covered property” and “covered peril,” many of the traditional disasters are “covered perils” either under the terms of the policy or an endorsement. Healthcare providers must determine whether a non-traditional disaster like a pandemic is a “covered peril” under their policies.

Healthcare providers should think beyond conventional property insurance and consider other types of insurance which may cover losses caused by a disaster, thus helping to ensure financial sustainability during and after the disaster. When deciding what type of coverage healthcare providers need for these purposes, a provider should identify the risks against which it is insuring. Foreseeable risks to revenue during a disaster include closure by a governmental order; cancellation of services; lack of reimbursement for services provided; loss of power, water or communication; and, suppliers’ failure to deliver supplies on time. During a pandemic, additional risks, such as viral contamination of the facility, should also be anticipated.

Given this array of foreseeable risks, healthcare providers should explore the following types of insurance coverage as part of their planning for continuity of operations and financial sustainability: (1) business interruption insurance; (2) civil authority coverage; (3) ingress/egress insurance; (4) contingent or dependent business interruption insurance, and (5) accounts receivable insurance. Whether, and to what extent, these types of insurance will cover losses during a disaster, including a pandemic, is the subject of much debate. Ultimately, a healthcare provider’s actual coverage will depend on the insurer, the language in the policy, and the court that is interpreting the policy language should there be a dispute. It is therefore very important that providers read the terms of insurance policies before purchasing them.



Conclusions

Failure to plan for continuity of operations and financial sustainability during a disaster could expose hospitals and other healthcare providers to various liabilities including medical malpractice; failure to respond; failure to plan and prepare; breach of contract (both vendor and employment); violation of certain federal and state laws and regulations related to claims submission; and loss of facility licensure.

There is not one uniform solution or approach to assuring financial stability and continuity of operations in a disaster. Healthcare providers must adopt a multi-faceted strategy to maximize their coverage and reimbursements from both governmental and private sources. Plans need to be flexible as the options and resources available to address an organization's financial sustainability will vary with the nature and scope of a given disaster. To minimize liability risk and maximize reimbursement, it is imperative that healthcare providers begin to plan now for continuity of operations and financial sustainability during and after a disaster.



I. INTRODUCTION TO CONTINUITY OF OPERATIONS

The devastating effects of Hurricane Katrina forced two of the largest public hospitals in New Orleans to close their doors, resulting in extremely limited access to healthcare services as the community worked to rebuild.³ Earthquakes, terrorist attacks, cyber-attacks, and pandemic influenza could have even more devastating effects on healthcare providers that are unprepared to handle the challenges these disasters create, including the ability to continue to operate during the disaster and to maintain financial sustainability both during and after the disaster. But, have you prepared for how a hurricane, pandemic outbreak, bioterrorist event, or other disaster will affect the financial viability of the hospital? Continuity of operations and financial sustainability planning are essential elements of disaster preparedness that are too often overlooked.

During a disaster⁴, the community will rely heavily on hospitals for care and treatment. All healthcare providers must be prepared to continue to operate so that they can provide essential services during disasters. Adequate staffing, medical supplies and equipment, pharmaceuticals, laundry, food, water, and various ancillary services are critical to a medical provider's continued operations during a disaster, and a steady revenue stream is essential to pay the suppliers of these goods and services. Vendors and employees will expect to be timely paid and, in some instances, will expect additional payments for their services during a disaster. These expectations raise significant planning concerns:

- How will employees and vendors be paid?
- How will providers maintain claims and billing processes?
- What happens if electronic billing is not operational?
- How will hospitals be paid for services provided?
- What does insurance cover?
- How, and to what extent, will the federal government be a source of income and financial assistance?

The concepts of continuity of operations and financial sustainability are intertwined. Continuity of operations refers to a broader plan to maintain business operations during a disaster. Financial sustainability refers to an entity's ability to maintain a revenue stream during a disaster and to continue to be economically viable after the disaster is over. Continuity of operations planning should include an assessment of existing statutes, laws, and regulations relevant to financial sustainability, such as those that govern claims submission and payment, any related waivers to such statutes and regulations, other sources of income, and alternative methods to ensure hospitals can continue to operate during and after a disaster.

³ Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C. L. Rev. 224 (2006).

⁴ Many Federal and State laws make a distinction between "emergency" and "disaster." Throughout this White Paper, the authors have elected to use "disaster" to represent any type of emergency or disaster, including any short or long-term, traditional or non-traditional catastrophic event and pandemic.



The risks posed by natural or man-made disasters are well documented so these risks are imminently foreseeable. Failure to plan for continuity of operations and financial sustainability during a disaster could expose healthcare providers to liability if they cannot provide essential services. There are several new theories of liability emerging in the aftermath of recent disasters. These new theories of liability are in addition to claims for medical malpractice, breach of contract (both vendor and employment), violation of certain hospital specific federal and state laws and regulations related to claims submission, and facility licensure and operation.⁵ It is therefore imperative that healthcare providers begin to plan for continuity of operations and financial sustainability during and after a disaster.

This paper focuses on the financial aspects of continuity of operations and financial sustainability and the associated legal issues healthcare providers will face related to payment for services during, and after, a disaster.⁶ This paper is intended to assist healthcare providers in the first phase of their planning by identifying important issues they should consider and address to ensure financial sustainability during and after a disaster.⁷ It is important to recognize that not all disasters are the same. This paper addresses disasters in terms of “traditional” and “non-traditional.” The term “traditional disaster” is intended to address those events with which there is significant experience: hurricanes, tornados, earthquakes, bombings, and other such natural or man-made disasters. The term “non-traditional disaster” refers to events such as pandemic influenza, a cyber attack, or other events with which there is little experience.

Section II of this paper provides a detailed look at federal disaster relief, specifically looking at the Stafford Act and Federal Emergency Management Agency (FEMA) reimbursement issues as they relate to financial sustainability. Section III discusses the various waivers available to hospitals to supplement revenue during disasters. Sections IV and V address claims submission and prompt payment. Section VI addresses ways in which hospitals

⁵ After Hurricane Katrina, plaintiffs brought an action against a hospital for wrongful death and survival damages alleging, in part, that the hospital failed to implement an adequate evacuation plan, to have a plan in place to transfer patients to another facility, and to have a plan for transferring patients in the event of a mandatory evacuation. *Lacoste v. Pendleton Methodist Hospital, L.L.C.*, 966 So. 2d 519 (2007).

⁶ This paper is not intended to address other aspects of continuity of operations such as supply delivery, security, staffing, etc.

⁷ There are two additional resources that may assist hospitals in planning for financial sustainability during an emergency. The California Department of Public Health, *California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies: Volume III: Payers* (hereinafter “California Guidelines”) and the New Jersey Hospital Association, *Finance Planning & Assessment Tool: A Healthcare Guide for Pandemic Flu Planning- Planning Today for A Pandemic Tomorrow*, New Jersey Hospital Association (April 2008) (hereinafter “New Jersey Finance Module”) have addressed continuity of operations during a healthcare surge or pandemic. The California Guidelines focus on steps payers should take to prepare for a healthcare surge while the New Jersey Finance Module focuses on helping hospitals develop tools and strategies to address continuity of operations during a pandemic.



can obtain accelerated payments or advanced payments from payers. Finally, the various types of business insurance that healthcare providers should consider are outlined in Section VII.



II. FEDERAL DISASTER RELIEF

A. Overview

Almost every conceivable disaster will result in injuries requiring medical attention. Hospitals are a key component of the nation's disaster response infrastructure. Many in the healthcare industry believe that a major source of funding for care provided during and after a disaster is likely to be federal funds, specifically from FEMA, which administers disaster relief funding allowed under the Stafford Act. Experiences during Hurricane Katrina, however, have brought into question the assumption about the available mechanisms for federal reimbursement for emergency healthcare services. In the aftermath of Hurricane Katrina, FEMA, the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) have tried to clarify the types of healthcare services and providers eligible for reimbursement under FEMA. Despite these clarifications, a large segment of healthcare providers and services remain ineligible under the Stafford Act and FEMA rules.

This section provides a basic overview of the Stafford Act and the types of healthcare services and healthcare providers eligible for reimbursement under the Act. The mechanisms through which hospitals and other healthcare providers can seek reimbursement including FEMA Public Assistance grants, mutual aid agreements, and emergency protective measures for pandemic influenza are discussed herein. The section concludes by identifying issues that require further discussion and clarification with FEMA and its state and regional representatives, HHS and CMS.

B. The Stafford Act and FEMA

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (the "Stafford Act") was created to provide a continuing mechanism for the federal government to supply assistance to state and local governments responding to disasters.⁸ To accomplish this goal, the Stafford Act establishes a process for requesting and obtaining a Presidential disaster declaration, defines the types and scope of assistance available from the federal government, and describes the conditions for obtaining such assistance.

⁸ The Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§ 5121-5206).



1. Declaration of Presidential Emergency or Disaster

A prerequisite to obtaining assistance under the Stafford Act is a declaration by the President of an emergency or major disaster.⁹ An “emergency” is defined as “any occasion or instance for which, in the determination of the President, federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.”¹⁰ A “major disaster” is defined as “any natural catastrophe...or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.”¹¹

The Stafford Act requires that a Governor of an affected state make a request to the President for a declaration that a major disaster exists.¹² The Governor must make the request through his or her regional FEMA office and take appropriate action to execute the state’s emergency plan.¹³ The Governor’s request must include information on the nature and amount of state and local resources that have been or will be committed to alleviating the disaster, an estimate on the amount and severity of damage caused by the disaster, and an estimate of the amount of federal assistance that will be needed. Based on the Governor’s request, the President may either declare that a major disaster or emergency exists or deny the request.¹⁴

2. Types of Assistance Available under the Stafford Act

Once the President declares that either a major disaster or an emergency exists, there are three types of assistance available under the Stafford Act:

⁹ A Presidential declaration typically follows a state declaration of emergency and a request by the state for aid from the Federal government. *See* 42 U.S.C. § 5170.

¹⁰ 42 U.S.C. § 5122(1). The definition of “emergency” does not specifically mention pandemic influenza, but it does include a “public health emergency,” which would certainly include pandemic influenza. The President would have to declare the influenza pandemic to be an emergency for purposes of the Stafford Act to trigger the availability of reimbursement. FEMA has issued Disaster Assistance Policy 9523.17, *Emergency Assistance for Human Influenza Pandemic* (March 31, 2007), which is discussed in detail in subsection 3.D of this document.

¹¹ 42 U.S.C. § 5122(2). The definition of “natural catastrophe” includes “any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought.” *Id.*

¹² 42 U.S.C. § 5170.

¹³ *See* Federal Emergency Management Agency, *A Guide to the Disaster Declaration Process and Federal Disaster Assistance*, available at http://www.fema.gov/pdf/rebuild/recover/dec_proc.pdf (last accessed April 12, 2009).

¹⁴ 42 U.S.C. § 5170.



- *Individual Assistance* – Provides assistance to individuals and households;¹⁵
- *Public Assistance* – Provides assistance to public and certain nonprofit entities for certain emergency services and repair or replacement of disaster-damaged public facilities;¹⁶ and
- *Hazard Mitigation Assistance* – Provides funding for measures designed to reduce future losses in disasters.¹⁷

Individual Assistance and Hazard Mitigation Assistance grants are briefly discussed below, with emphasis on the availability of assistance for healthcare-related expenses. The bulk of the discussion and analysis focuses on Public Assistance grants as this is likely the primary mechanism through which hospital providers will be reimbursed.

Individual Assistance grants cover housing and other necessary expenses and serious needs caused by the disaster.¹⁸ Individuals may use these grants to cover needs for items other than housing, including disaster-related medical and dental costs, as well as disaster-related funeral and burial costs. To receive grant funds for non-housing needs that are disaster-related, individual applicants must meet all of the following criteria:

- (1) The losses occurred in a geographic area that has been declared a disaster area by the President;
- (2) A request for insurance benefits has been filed, but the damage or costs are not covered by insurance or the insurance payment is insufficient to cover the costs;
- (3) The individual applicant or someone in the applicant’s household is a U.S. citizen, a non-citizen national, or a qualified alien;
- (4) The applicant has necessary expenses or serious needs because of the disaster; and
- (5) The applicant has accepted assistance from all other sources for which he or she is eligible, such as private insurance or Medicare/Medicaid.¹⁹

Thus, Individual Assistance grants may be available for individuals to help pay for their healthcare costs if the above criteria are met. Healthcare providers should be familiar with

¹⁵ 42 U.S.C. § 5174.

¹⁶ 42 U.S.C. § 5170b. *See also* FEMA State and Local Guide (SLG) 101 - Guide for All-Hazard Emergency Operations Planning, 1996, *available at* <http://www.fema.gov/plan/gaheop.shtm> (last accessed April 9, 2009).

¹⁷ 42 U.S.C. § 5170c.

¹⁸ 42 U.S.C. § 5174(b). Covered housing costs include temporary housing, repairs, replacement, and permanent housing construction. *Id.*

¹⁹ 42 U.S.C. § 5174(e). List adapted from FEMA Questions and Answers for Disaster Assistance, *Do I qualify for ‘Other than Housing Needs’ Assistance?* (information updated as of April 27, 2006), *available at* http://www.fema.gov/assistance/process/qualify_other_housing.shtm (last accessed April 9, 2009).



FEMA Individual Assistance benefits and the mechanisms through which patients or employees may file for assistance.

FEMA awards Public Assistance grants to specific types of entities for certain types of work. Public assistance grants provide aid to state and local governments and certain private nonprofit entities and facilities in their response and recovery activities for disasters. The agency provides assistance for certain categories of work. FEMA encourages protection from future damage by providing assistance for hazard mitigation measures during the recovery process; however, Public Assistance grants cannot be used to cover the cost of disaster planning.²⁰

Private nonprofit organizations, which own or operate facilities that provide certain services of a governmental nature, are eligible for assistance.²¹ Eligible private nonprofit organizations are those that provide education, medical, custodial care, emergency, utility, irrigation facilities, and other essential governmental services.²² To be eligible for Public Assistance grants, private nonprofit organizations must either have (1) an effective ruling letter from the Internal Revenue Service (IRS) granting them tax exemption at the time of the disaster or (2) approval from the state that the organization is an approved nonprofit entity organized or doing business under state law.²³ The specific facility for which the organization seeks funding must be used primarily for an eligible purpose that is consistent with the covered services and, generally, must be open to the public.²⁴ However, certain types of private nonprofits—educational, utility, emergency, medical, or custodial care services—are not required to be open to the public.²⁵

FEMA identifies three general types of work that may be eligible for Public Assistance grants: (1) debris removal; (2) emergency protective measures; and (3) permanent restoration. Debris removal and emergency protective measures are considered “emergency work,” which must be performed to “reduce or eliminate an immediate threat to life, protect public health and

²⁰ Federal Emergency Management Agency, *Public Assistance Guide*, FEMA 322 (June 2007), available at <http://www.fema.gov/government/grant/pa/policy.shtm> (last accessed April 9, 2009).

²¹ *Public Assistance Guide*, p. 10. The guide notes that PNP organizations, their facilities, and their services must meet additional eligibility criteria beyond those that apply to governmental applicants, as outlined in Federal Emergency Management Agency, *Private Nonprofit Facility (PNP) Eligibility* (FEMA Policy 9521.3) (July 18, 2007), available at <http://www.fema.gov/government/grant/pa/950Otoc.shtm> (last accessed April 9, 2009).

²² *Public Assistance Guide*, pp. 10-11. Essential governmental services are: museums; performing arts facilities; community arts centers; zoos; community centers; libraries; homeless shelters; rehabilitation facilities; senior citizen centers; shelter workshops; and health and safety services of a governmental nature. Health and safety services of a governmental nature include services such as: low-income housing; alcohol and drug treatment centers; residences and other facilities offering programs for battered spouses; facilities offering food programs for the needy; and daycare centers for children or those individuals with special needs (such as those with Alzheimer’s disease, autism, and muscular dystrophy). *Id.*

²³ *Public Assistance Guide*, p. 11. Private nonprofits must be approved by the IRS under Sections 501(c), (d), or (e) of the Internal Revenue Code.

²⁴ *Public Assistance Guide*, p. 11.

²⁵ *Public Assistance Guide*, p. 11.



safety, and to protect improved property that is threatened in a significant way as a result of the disaster.”²⁶ FEMA also refers to debris removal as “Category A” emergency work, and emergency protective measures as “Category B” emergency work. Permanent restoration is “permanent work” that includes restoring a facility back to its pre-disaster design, function, and capacity, including meeting any codes and standards applicable to the approved work. The type-of-work designation is important because the eligibility of costs for reimbursement can differ depending on whether the work is considered “emergency” or “permanent.”

All private nonprofit organizations that are eligible for FEMA assistance may apply to FEMA through the state for reimbursement of the costs of emergency work. All eligible applicants for all types of work must meet three general criteria: (1) the work must be required as direct result of the declared major disaster or emergency; (2) the work must be located within a designated disaster area; and (3) the work must be the legal responsibility of the applicant at the time of the disaster.²⁷ Damage caused by negligence on the part of an applicant after the disaster is not eligible for reimbursement.²⁸

Hazard Mitigation Assistance is provided to state and local governments, tribes, and certain nonprofit organizations to implement long-term hazard mitigation measures after a major disaster declaration.²⁹ Only applicants that reside within the geographic area designated as a disaster area are eligible for hazard mitigation grants.³⁰ These funds may be used for projects that will reduce or eliminate losses from future disasters by providing long-term solutions to problems, such as elevating structures or critical equipment, or moving or buying out owners in flood-prone areas.³¹ The funds may be used to protect public or private property.³²

FEMA has a Pre-hazard Mitigation program that provides competitive grants to states and localities for advanced hazard mitigation planning activities and projects that reduce the impact of disasters and the need for disaster relief funds.³³ Private nonprofit organizations are not eligible for these grants, but governmental entities can apply for projects that benefit private nonprofit organizations, including hospitals.³⁴

²⁶ *Public Assistance Guide*, pp. 26, 66.

²⁷ *Public Assistance Guide*, pp. 29-31.

²⁸ *Public Assistance Guide*, pp. 31-32.

²⁹ 42 U.S.C. § 5170c. See also Federal Emergency Management Agency, *Hazard Mitigation Grant Program Fact Sheet: Building Stronger and Safer* (June 2007), available at <http://www.fema.gov/government/grant/hmgp/index.shtm> (last accessed April 8, 2009).

³⁰ 42 U.S.C. § 5170c.

³¹ *Hazard Mitigation Grant Program Fact Sheet*, p. 1.

³² *Hazard Mitigation Grant Program Fact Sheet*, p. 1.

³³ Federal Emergency Management Agency, *Pre-Disaster Mitigation Grant Program* website, available at <http://www.fema.gov/government/grant/hmgp/index> (last accessed April 8, 2009).

³⁴ See Federal Emergency Management Agency, *Mitigation Best Practices* web-based searchable portfolio that includes a number of hospital and healthcare facility-related projects, available at <http://www.fema.gov/mitigationbp/index.jsp> (last accessed April 8, 2009).



Hospitals may be able to use Hazard Mitigation grants to repair, replace, retrofit, or reposition key facilities and equipment; however, finding an appropriate mechanism for applying for these funds could be problematic. Hospitals should work with their local and state emergency planning agencies to look for opportunities to have their facilities included in governmental applications for FEMA grants.

3. FEMA as Payer of Last Resort

An important concept within the Stafford Act is that FEMA is the payer of last resort when it comes to reimbursing for costs associated with disasters. The Stafford Act requires individual, institutional, and governmental entities to exhaust commercial and other governmental outlets for compensation before FEMA will reimburse.

This concept is further reinforced by the Stafford Act's prohibition against the duplication of benefits which precludes a person or entity from receiving assistance under the Act if it has "received financial assistance under any other program or from insurance or any other source."³⁵ While an entity cannot receive duplicate benefits, this provision does not prevent an entity from receiving benefits from another source if (1) those benefits had not been received when the entity applied for FEMA benefits and (2) the entity agrees to repay FEMA for any duplicative benefits.³⁶ Therefore, FEMA expects to be reimbursed for any duplicative payments it makes to an entity for costs that another source ultimately pays.

An issue arises, however, when FEMA provides more funding than an entity receives from another payer. Although it is permissible for FEMA to reimburse a person's or entity's eligible costs that were not covered or not completely covered by another payer, the language of the Stafford Act requires them to reimburse the federal government "to the extent such assistance duplicates benefits *available* to the person for the same purpose from another source."³⁷

The meaning of the word "available" was at issue in a dispute between FEMA and the state of Hawaii over the amount the state was required to refund FEMA based on the state's insurance settlement from Hurricane Iniki in 1992. In *Hawaii v. FEMA*, the Ninth Circuit Court of Appeals held that § 5155(c) of the Stafford Act sometimes requires reimbursement beyond what the disaster victim actually received from another source in a settlement, but only if the settlement was not a commercially reasonable one.³⁸ The court found that Hawaii's settlement

³⁵ 42 U.S.C. § 5155(a).

³⁶ 42 U.S.C. § 5155(b).

³⁷ 42 U.S.C. § 5155(c) (emphasis added).

³⁸ 294 F.3d 1152, 1158 (9th Cir. 2002). Hawaii entered into a global settlement agreement with its insurer for \$42 million, which covered a number of damaged facilities and the state then allocated portions of the settlement proceeds to different facilities. For a set of specific projects for which FEMA enlisted the Army Corps of Engineers (ACOE) to repair, FEMA paid out more than \$12 million to the ACOE, yet the state allocated just over \$7 million



was commercially reasonable, so FEMA could only seek reimbursement for the portion of the settlement allocated to the properties at issue.

The decision in *Hawaii v. FEMA* is relevant for hospitals because it sets up a scenario that could occur: if FEMA pays a hospital and the hospital is then paid by other means (i.e., insurance) at a lower rate, the hospital then must decide if it has to reimburse FEMA at the rate at which FEMA paid or only to the extent the other sources paid. In determining how much hospitals must repay to FEMA, a court will have to determine whether settlement of claims at a rate lower than the FEMA rate is commercially reasonable.³⁹ If it is reasonable, then a hospital will only have to reimburse FEMA to the extent the other source paid the hospital. If it is unreasonable, hospitals will be liable to FEMA for the entire amount that FEMA reimbursed. This could leave hospitals paying FEMA for care it rendered to disaster victims.

Immediately after Hurricanes Katrina and Rita, hospitals in Louisiana acted both as shelters and medical care providers for the hurricane victims. Because the hurricanes were Presidentially declared major disasters, hospitals believed that they were entitled to Stafford Act funds to reimburse them for both types of assistance provided. Disaster Specific Guidance #2 (“Guidance #2”), issued by FEMA on September 9, 2005, supported this belief by outlining those costs which would be eligible for Stafford Act reimbursement including short term sheltering and medical care.⁴⁰ Specifically, the guidance noted that nursing care rendered to evacuees within a shelter constitutes “eligible costs” as do the “costs associated with the transportation, diagnosis, testing, and stabilization of [an] evacuee” who is transported to a hospital after becoming ill in a shelter.

Additionally, “if an evacuee was undergoing medical treatment at the time of the event and the treatment is required to continue to protect the health and safety of the individual or residents at large, the costs for ensuring availability of the treatment will be eligible.” Examples of these types of costs include transportation to a medical facility or the securing of resources to administer the treatment if they are not locally available. These eligible costs are limited, however, by the requirement that any insurance coverage for the treatment (private or otherwise) be documented and subtracted from eligible costs. In other words, if any other source of payment for treatment exists, FEMA will not be the payer.

from the settlement proceeds to the ACOE projects. FEMA sought reimbursement for the total \$12 million it paid out for the ACOE work, not just the \$7 million the state allocated to it. FEMA’s position was that because the state received \$42 million in the settlement, it had the full \$12 million available to it to pay for the ACOE work, not just the amount it allocated to it.

³⁹ To the extent FEMA reimburses hospitals, it will be at the Medicare rate.

⁴⁰ Memorandum for Federal Coordinating Officers, et al from Nancy Ward, Recovery Area Command regarding *Disaster Specific Guidance #2 Eligible Costs for Emergency Sheltering Declarations Hurricane Katrina*, September 9, 2005



C. Hospital Reimbursement Issues

Public Assistance grants are likely the primary mechanism through which hospitals will receive reimbursement from FEMA. However, only private nonprofit entities may directly apply for FEMA Public Assistance grants.⁴¹

1. Eligible Medical Facilities

FEMA guidance defines a medical facility as “any hospital, outpatient facility, rehabilitation facility, or facility for long-term care” and includes those that offer “diagnosis or treatment of mental or physical injury or disease.”⁴² Administrative and support facilities essential to the operation of the medical facility are eligible, even if these ancillary facilities are not contiguous to the medical facility.⁴³

2. Eligible Costs and Activities

FEMA issued a revised policy on its treatment of medical care costs in July 2008. The updated policy, *Emergency Medical Care and Medical Evacuations* (“*Emergency Medical Care*”), contains significant changes from the prior version, and overall, it better reflects the role of healthcare providers in responding to disasters.⁴⁴ However, as will be discussed in this section, the policy still has some limitations which could hinder a robust medical response and potentially make it difficult for eligible healthcare providers to seek reimbursement from FEMA for eligible costs. The *Emergency Medical Care* policy relates to other FEMA policies discussed in this section, including those addressing mutual aid and evacuation and sheltering operations. Healthcare providers should carefully evaluate their potential eligibility for reimbursement under the various FEMA policies related to or affecting medical care.

FEMA’s prior policy on medical care costs, *Medical Care and Evacuations*⁴⁵ (“*Medical Care*”), which had been in effect since 1999, did not reflect the lessons that the medical and emergency management communities learned in the aftermath of events like Hurricane Katrina. This prior version of FEMA’s *Medical Care* policy covered only extraordinary expenses for medical care in temporary facilities and for evacuees of medical and custodial care facilities. The

⁴¹ There have been numerous attempts to amend the Stafford Act to include for-profit hospitals without success. The most recent attempts at amendment were HR 3714 and S. 1393, the Hospital Emergency Assistance Act of 2005, which were introduced on September 8, 2005, and July 13, 2005, respectively.

⁴² *Public Assistance Guide*, p. 16.

⁴³ *Id.*

⁴⁴ Federal Emergency Management Agency, *Emergency Medical Care and Medical Evacuations* (FEMA Policy 9525.4) (July 16, 2008), available at http://www.fema.gov/government/grant/pa/9525_4.shtm (last accessed April 10, 2009).

⁴⁵ Federal Emergency Management Agency, *Medical Care and Evacuations* (FEMA Policy 9525.4) (August 17, 1999). Although the names of the policies have changed, FEMA retained the same policy number designation from the 1999 version to the 2008 version.



costs of emergency medical treatment of any kind (including medications and vaccines) were ineligible. Additionally, costs of medical staff and medical supplies incurred during evacuations were ineligible. The 1999 *Medical Care* policy drew a distinction that FEMA would generally pay for facilities and equipment needed to provide healthcare services during disasters, but it would not cover the cost of the care itself.

a. Costs under the Emergency Medical Care and Medical Evacuations Policy (FEMA Policy 9525.4)

The *Emergency Medical Care* policy provides that, “[w]hen the emergency medical delivery system within the designated disaster area is destroyed or severely compromised by a disaster event, assistance for emergency medical care and medical evacuations of disaster victims” is available for eligible facilities through Public Assistance Grants and direct federal assistance.⁴⁶ The policy defines “emergency medical care” as “medical treatment or services provided for injuries, illnesses and conditions caused as a direct result of the declared disaster, and which require immediate medical treatment or services to evaluate and stabilize an emergency medical condition.”⁴⁷ The policy further notes that “[e]mergency medical care may include care provided during transport under a medical evacuation and stabilization of persons injured during evacuation.”⁴⁸

State and local governments and private, non-profit entities that operate medical care facilities (e.g. hospitals) or custodial care facilities (e.g., nursing homes) are eligible applicants.⁴⁹ While the *Emergency Medical Care* policy explicitly states that “private for-profit medical service providers are not eligible applicants for Public Assistance [Grants],” it does also note that “some costs associated with for-profit providers may be eligible for Public Assistance [Grants] when contracted for by an eligible applicant.”⁵⁰ The policy likewise allows for the delivery of emergency medical care through mutual aid agreements according to FEMA’s *Mutual Aid Agreements* policy, discussed in Section III.C.3 below.

i. Emergency Medical Care Costs

Eligible entities may receive reimbursement for costs associated with providing emergency medical care, but the costs should be “reasonable and customary for the emergency medical services provided.”⁵¹ The *Emergency Medical Care* policy states that, where applicable,

⁴⁶ *Emergency Medical Care and Medical Evacuations*, p. 1.

⁴⁷ *Emergency Medical Care and Medical Evacuations*, p. 2 (emphasis added).

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*



“FEMA may rely on Medicare’s cost-to-charge ratio to determine the reasonableness of costs.”⁵² However, eligible costs are “limited to a period of up to 30 days from the date of the disaster declaration, or as determined by [FEMA].”⁵³ Eligible costs include, but are not limited to, the following:

- Overtime for regular full-time employees performing eligible work;
- Regular time and overtime for extra hires specifically hired to provide additional support as a result of the declared disaster;
- Transport of disaster victims requiring emergency medical care to medical facilities, including EMS and ambulance services;
- Treatment and monitoring of disaster victims requiring emergency medical care, including costs for:
 - Triage, medically necessary testing, and diagnosis;
 - First aid assessment and provision of first aid, including materials (bandages, etc.);
 - Prescription assistance limited up to a one-time 30-day supply for acute conditions and to replace maintenance prescriptions; and
 - Durable medical equipment;
- Vaccinations for disaster victims and emergency workers, including medical staff;
- Provision of health information;
- Temporary tents or portable buildings for treatment of disaster victims;
- Leased or purchased equipment for use in temporary facilities; and
- Security for temporary facilities.⁵⁴

Despite broadening the costs now eligible under the *Emergency Medical Care* policy, some major costs remain ineligible, including:

- Medical care costs incurred once a disaster victim is admitted to a medical care facility on an inpatient basis;
- Costs associated with follow-up treatment of disaster victims beyond 30 days of the disaster declaration;

⁵² *Emergency Medical Care and Medical Evacuations*, pp. 2-3. FEMA defines “cost-to-charge ratio” as the “ratio established by Medicare to estimate a medical service provider’s actual costs in relation to its charge.” *Emergency Medical Care and Medical Evacuations*, p. 1.

⁵³ *Emergency Medical Care and Medical Evacuations*, p. 3.

⁵⁴ *Id.*



- Increased administrative and operating costs to the hospital due to increased or anticipated increased patient load; and
- Loss of revenue.⁵⁵

FEMA states in the revised *Emergency Medical Care* policy that ineligible costs remain ineligible even if incurred under mutual aid or other assistance agreements.⁵⁶ Finally, the revised policy cross-references the *Evacuations and Sheltering* policy, noting that “[e]ligible costs of emergency medical care provided in congregate or transitional shelters” are covered under that policy.⁵⁷ Therefore, both policies should be read together to determine the range of potentially eligible or ineligible costs for healthcare providers.

ii. Medical Evacuation Costs

FEMA has likewise broadened the scope of eligible costs related to medical evacuations to include costs for medical staff, supplies and equipment, which had been deemed ineligible in the prior version of the *Emergency Medical Care* policy. Eligible entities may seek reimbursement for extraordinary evacuation expenses if a disaster threatens or causes severe damage to eligible medical and custodial facilities such that the patients must be evacuated to a temporary facility or to an existing facility with available capacity. Costs associated with an evacuation may be eligible, including transportation expenses and the use of emergency medical service personnel. The prior version of the policy would only cover labor costs for non-medical staff assisting in the evacuations. The following eligible costs are identified in the revised *Emergency Medical Care* policy:

- Overtime for regular full-time employees to evacuate and assist in the transport of patients from the original facility;
- Regular time and overtime of extra hires employed to evacuate and assist in the transport of patients from the original facility;
- Equipment costs incurred in the transport of patients from the original facility;
- Labor and equipment costs incurred during transport while returning the patient to the original medical or custodial care facility;
- The costs of treatment of patients requiring emergency medical care, including costs for medically necessary tests, medication, and durable medical equipment required to stabilize patients for transportation; and
- Costs incurred from the activation of contracts, mutual aid agreements, or force account resources in advance of a disaster necessary to prepare for medical

⁵⁵ *Id.*

⁵⁶ *Emergency Medical Care and Medical Evacuations*, p. 4.

⁵⁷ *Id.*



evacuations in threatened areas. Eligible equipment costs include mobilization of ambulances and other transport equipment; eligible force account labor costs are limited to overtime for regular full-time employees and regular time and overtime of extra hires.⁵⁸

The one identified ineligible cost related to medical evacuations costs are those for equipment and labor costs incurred during standby times.⁵⁹ In the aftermath of Hurricane Katrina, many health systems were asked by the Secretary of DHHS to form 100 person teams to be deployed to the hurricane affected sites. These systems incurred significant costs to keep these teams on stand-by but these costs were not reimbursed.

iii. Duplication of Benefits

As noted in Section III.B.3 above, the Stafford Act and related FEMA regulations expressly prohibit the duplication of benefits. The revised *Emergency Medical Care* policy reaffirms this prohibition and newly specifies that eligible applicants must verify and document that no duplication of benefits is occurring. The policy requires eligible applicants to “take reasonable steps to prevent [duplication of benefits], and provide documentation on a patient-by-patient basis which verifies that insurance coverage or any other source of funding—including private insurance, Medicaid, or Medicare—has been pursued and does not exist for the costs associated with emergency medical care and emergency medical evacuations.”⁶⁰ Therefore, the revised policy requires that healthcare providers seek alternate sources of payment and document these efforts before they may be eligible for reimbursement from FEMA.

This requirement further reinforces the need for healthcare providers to maintain some capacity during a disaster to document care and process payment requests appropriately to third-party payers. During a pandemic or other wide-scale event, it may not be possible for providers or third-party payers to meet the claims processing and/or documentation requirements implicated in the *Emergency Medical Care* policy. Providers eligible for FEMA reimbursement should work with FEMA regional personnel to discuss alternatives to the verification and documentation requirements should the circumstance of a disaster prevent the provider from complying with these requirements.

iv. Preparation Costs

FEMA added a new section to the revised *Emergency Medical Care* policy, which addresses the eligibility of preparation costs. The policy specifically states that, “[c]osts incurred *in preparation for an increased patient load* from an emergency or disaster, including costs of

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Emergency Medical Care and Medical Evacuations*, pp. 4-5.



personnel, emergency medical equipment, and standby for ambulance services and emergency medical service personnel are not eligible for Public Assistance grant funding” [emphasis added].⁶¹ This is contrasted with preparation costs in anticipation of a medical evacuation from a facility in a threatened area, which costs are eligible.⁶² Therefore, healthcare providers should be aware that they will not be covered by FEMA for costs associated with preparing the healthcare facility for a medical response to a disaster, but can be reimbursed for costs to prepare that facility for evacuation. Although FEMA has now expanded the *Emergency Medical Care* policy to cover the costs of medical treatment, including medical personnel, equipment, and medication, the policy’s omission of facility preparation costs could be seen as a disincentive to healthcare providers to prepare to receive victims from a disaster or as a penalty on healthcare providers who do responsibly prepare for a disaster.

b. Costs under the Eligible Costs Related to Evacuations and Sheltering Policy (FEMA Policy 9523.15)

FEMA’s policy on *Eligible Costs Related to Evacuations and Sheltering* (“*Evacuations and Sheltering* policy”) applies to expenses related to state and local emergency evacuation and sheltering activities eligible for reimbursement as emergency protective measures under FEMA’s Public Assistance grant program.⁶³ This policy covers the reasonable costs for congregate sheltering, at “any private or public facility that provides contingency congregate refuge to evacuees, but that day-to-day serves a non-refuge function” (e.g., schools, stadiums, and churches).⁶⁴ Congregate shelters may be staffed with emergency medical technicians, paramedics, nurses, or physicians for the purposes of screening the health of shelter residents, assessing and treating minor illnesses and injuries, and making referrals (e.g., calling 911).⁶⁵ The policy acknowledges that special needs shelters require higher-skilled medical staff (e.g., registered nurses) than a general population shelter and the costs of this care is covered under this policy. Additionally, the policy states that “vaccinations administered to protect the health and safety of congregate shelterees and supporting emergency workers are, for transmissible or contagious diseases, an eligible expense.”⁶⁶

⁶¹ *Emergency Medical Care and Medical Evacuations*, p. 5.

⁶² See discussion of medical evacuation costs *supra*, Section 3.C.2.b.

⁶³ Federal Emergency Management Agency, *Eligible Costs Related to Evacuations and Sheltering* (FEMA Policy 9523.15) (April 6, 2007), p. 1, available at http://www.fema.gov/government/grant/pa/9523_15.shtm (last accessed April 10, 2009).

⁶⁴ *Eligible Costs Related to Evacuations and Sheltering*, p. 1. Congregate shelters are contrasted with “transitional shelters,” which FEMA defines as “any private or public facility that, by design, provides a short-term lodging function and an increased degree of privacy over a congregate shelter” (e.g., hotels, motels, cruise ships). *Eligible Costs Related to Evacuations and Sheltering*, p. 2. FEMA states that it will contract directly for transitional shelters, so it will not reimburse state and local governments for these expenses. *Eligible Costs Related to Evacuations and Sheltering*, p. 1.

⁶⁵ *Eligible Costs Related to Evacuations and Sheltering*, p. 3.

⁶⁶ *Eligible Costs Related to Evacuations and Sheltering*, p. 4.



Under the *Evacuations and Sheltering* policy, the costs of the following emergency medical services administered in congregate shelters may be eligible for reimbursement:

- Conducting a first aid assessment;
- Providing first aid, including materials (e.g., bandages, etc.);
- Providing health information;
- Caring for individuals with chronic conditions and the special costs associated with that care;
- Supervising paid and volunteer medical staff;
- Issuing prescription medications required for stabilizing the life of an evacuee/shelteree (supply not to exceed 30 days);
- Providing medical staff for emergency and immediate life stabilizing care, including care to mental health and special needs evacuee/shelteree populations; and
- Providing a public information officer and social worker(s).⁶⁷

The costs of triage, medically necessary tests, and medications required to stabilize an evacuee/shelteree patient for transportation to a hospital or other medical facility may be eligible. However, the policy re-enforces that FEMA is a payer of last resort. This means that applicants cannot seek reimbursement from FEMA if the costs can be underwritten by private insurance, Medicare, Medicaid, or another pre-existing private payment agreement.

Costs to transport an evacuee/shelteree patient to a hospital or other medical facility may be eligible if the congregate shelter medical staff determines that an evacuee or shelteree requires immediate medical or surgical attention and the emergency life sustaining treatment is not available at the shelter. The costs associated with the transportation, diagnosis, testing and initial treatment for the moved evacuee or shelteree are eligible. However, eligible outpatient costs are limited to: (1) “local professional ambulance transport services to/from the nearest hospital equipped to adequately treat the medical emergency; and (2) physician services in a hospital outpatient department, urgent care center, or physician’s office, and related outpatient hospital services and supplies, including X-rays, laboratory and pathology services, and machine diagnostic tests for the period of time that the evacuee/shelteree is housed in congregate sheltering.”⁶⁸

⁶⁷ *Eligible Costs Related to Evacuations and Sheltering*, p. 3.

⁶⁸ *Eligible Costs Related to Evacuations and Sheltering*, p. 3-4.



c. Reimbursements for Labor Costs

Regular wages and benefits for an eligible applicant's permanently employed personnel who performed emergency work are not eligible for reimbursement,⁶⁹ but overtime wages for these personnel are.⁷⁰ Permanently employed personnel are "those employees whose positions are already included in the applicant's budget."⁷¹ In determining which employees are eligible for overtime pay, FEMA reviews an applicant's written policies and union contracts regarding overtime in non-disaster settings. Exempt employees are not eligible for overtime unless they are paid overtime in non-disaster settings. FEMA will only reimburse a healthcare provider for overtime wages for those employees actually performing tasks that are eligible for reimbursement under FEMA's rules.⁷²

FEMA will reimburse emergency pay for essential personnel. If a facility is required to close under a disaster declaration by a state or local government, but the facility's existing written policies or union contracts require certain essential personnel to report to work and perform eligible emergency work, payment of emergency wages is reimbursable for non-exempt employees.⁷³ Time spent on standby, on-call or on rest period is not eligible for reimbursement, but overtime pay that compensates an employee for actual eligible work performed is eligible for reimbursement.⁷⁴ Finally, the labor costs for employees assigned to perform tasks that are not within the normal scope of their jobs are eligible for reimbursement as long as they are performing eligible work.⁷⁵

d. Increased Operating Costs

The costs of operating a facility or providing a service may increase during or after a disaster. When medical facilities in a disaster area experience increased patient loads and operating costs, these costs are generally ineligible for reimbursement even though many of these additional patients may be disaster victims who lack insurance or cannot provide evidence of coverage. Examples of ineligible healthcare and other administrative costs include: increased costs for hospital patient care; feeding the residents and staff of critical facilities; administrative operations such as copying, parcel delivery, photography, supplies, fuel, materials, and telecommunications (e.g., additional cell phone instruments and fees); obtaining electrical power

⁶⁹ 44 C.F.R. § 206.228(a)(2).

⁷⁰ Federal Emergency Management Agency, *Labor Costs – Emergency Work* (FEMA Policy 9525.7) (November 16, 2006), available at <http://www.fema.gov/government/grant/pa/9500toc.shtm> (accessed April 10, 2009).

⁷¹ *Labor Costs – Emergency Work*, p. 2.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Labor Costs – Emergency Work*, pp. 2-3.

⁷⁵ *Public Assistance Guide*, p. 43.



and water from alternate sources; and finance charges (e.g., interest on loans and bond costs to finance rebuilding).⁷⁶

FEMA will fund some costs associated with providing additional facilities for emergency treatment in extraordinarily catastrophic disasters, such as when eligible public and private non-profit hospitals and custodial facilities (e.g., nursing homes) are adversely affected by the disaster and cannot provide proper care for their patients. Reasonable short-term, additional costs that are directly related to accomplishing specific emergency health and safety tasks as part of eligible emergency protective measures may be covered. If the costs can be documented and identified with a specific emergency task, examples of potentially eligible costs include: increased utility costs of a permanently mounted generator at a hospital; increased water-testing and water-treatment supplies in the immediate aftermath of a disaster to counter a specific threat; and increased facility costs (e.g., electricity) for emergency operating centers of eligible applicants.⁷⁷

e. Loss of Revenue

An entity's loss of revenue is not an eligible cost authorized by the Stafford Act and is not an eligible cost under the public assistance grant program. Examples of revenue loss events, which FEMA specifically mentions as ineligible for FEMA assistance, include a hospital's release of non-critical patients to make room for disaster victims or damage caused to a hospital's facilities that reduces its pre-disaster capacity.⁷⁸ FEMA notes that applicants may suffer other costs that are ineligible for FEMA assistance, such as payment of salaries for employees sent home during a disaster.⁷⁹ This exact situation occurred on September 11 when trauma centers within 100 miles of Washington, D.C. were instructed to discharge patients and cancel elective surgeries to create "surge" capacity for victims of the attacks. Few, if any, victims ever arrived, meaning that no care was provided and no revenue generated.

3. Reimbursement through Mutual Aid Agreements

Mutual aid agreements are commonly used during disasters. Hospitals and other medical facilities often enter into mutual aid agreements with local or state governments to provide care to disaster victims. The Emergency Management Assistance Compact (EMAC) is an example of a mutual aid agreement between states.⁸⁰

⁷⁶ FEMA Region VI, Disaster-Specific Guidance on Special Needs Shelters (January 26, 2005), available at http://www.ohsep.louisiana.gov/memorandum_to.htm; last accessed April 24, 2009).

⁷⁷ *Id.*

⁷⁸ *Public Assistance Guide*, pp. 54-55.

⁷⁹ *Public Assistance Guide*, p. 54.

⁸⁰ The Emergency Management Assistance Compact (EMAC) establishes procedures whereby an impacted state can request and receive assistance from other states quickly. All states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have joined EMAC. Under EMAC, the state requesting aid agrees to assume liability for



In its August 2007 policy on *Mutual Aid Agreements for Public Assistance and Fire Management Assistance* (“*Mutual Aid*”), FEMA states that mutual aid will be covered if it:

- has been requested by a jurisdiction in which there has been a Presidentially declared disaster;
- the activities and costs directly relate to that disaster;
- the activities and costs are related to eligible work; and
- the costs are reasonable.⁸¹

A key element of the policy is that the agreement for mutual aid must be in writing. Although FEMA “encourages parties to have written mutual aid agreements in place prior” to a declared event, FEMA will recognize post-event mutual aid agreements so long as the understanding of the receiving and providing parties has been reduced to writing and signed by representatives of both parties to the agreement.⁸² The reimbursement provisions of the mutual aid agreement cannot be conditioned upon a federal declaration of disaster. The receiving party must be obligated to reimburse the party providing the services even if the receiving party cannot seek reimbursement from FEMA.

Mutual aid that provides work classified by FEMA as “emergency work” (i.e., work necessary to address immediate threats to life, public health and safety, and improved property) is eligible for reimbursement.⁸³ As stated in the *Mutual Aid* policy, and consistent with other FEMA policies discussed in this section, the provision of emergency medical care is an eligible expense.⁸⁴

FEMA issued a related policy, *Host-State Evacuation and Sheltering Reimbursement*, in July 2007, which clarifies its reimbursement policies for states receiving evacuees (“host-states”) from states subject to a federal disaster declaration (“impact-states”).⁸⁵ This policy allows host-states to be reimbursed for their eligible evacuation and sheltering costs associated with providing services to residents of impact states who are evacuated. The reimbursement can come either through a mutual aid agreement between the states, or through a direct

out-of-state workers deployed under EMAC and reimburse assisting states for deployment-related costs. For more information, see the EMAC website, available at <http://www.emacweb.org> (last accessed April 10, 2009).

⁸¹ Federal Emergency Management Agency, *Mutual Aid Agreements for Public Assistance and Fire Management Assistance* (FEMA Policy 9523.6) (August 13, 2007), available at <http://www.fema.gov/government/grant/pa/9500toc.shtm> (last accessed April 8, 2009).

⁸² *Mutual Aid Agreements for Public Assistance*, pp. 3-4.

⁸³ *Mutual Aid Agreements for Public Assistance*, p. 5.

⁸⁴ *Mutual Aid Agreements for Public Assistance*, p. 6.

⁸⁵ Federal Emergency Management Agency, *Host-State Evacuation and Sheltering Reimbursement* (FEMA Policy 9523.18) (July 18, 2007), available at <http://www.fema.gov/government/grant/pa/9500toc.shtm> (last accessed April 10, 2009).



reimbursement from FEMA based on a request from an impact-state to evacuate its residents.⁸⁶ Eligible costs for the host-state's activities are the same as those contained in FEMA's *Eligible Costs Related to Evacuations and Sheltering*, discussed in depth in subsection 2.b above. Therefore, healthcare providers staffing shelters or healthcare facilities (including hospitals) who provide eligible care under the *Evacuations and Sheltering* policy can seek FEMA reimbursement through the state or local government.

b. National Disaster Medical System Reimbursement

When the emergency medical delivery system within the designated disaster area is destroyed or severely compromised such that it constitutes a public health emergency, the federal government may provide direct aid in the form of emergency medical assistance to the area through the National Disaster Medical System (NDMS). In these cases, the costs of the emergency medical operation are paid by FEMA or another federal agency like the Department of Homeland Security (DHS). The NDMS is one example of direct federal mutual aid to a state or locality.

The NDMS operates by sending specialized teams of healthcare professionals, administrative support, and equipment into disaster areas to supplement or replace healthcare resources in the affected area.⁸⁷ NDMS teams can place patients in hospitals and other facilities for acute inpatient care. CMS has developed a payment system through which hospitals and other healthcare providers (nonprofit or for-profit) can directly bill CMS for their services and expenses in treating NDMS patients. Like FEMA, the NDMS reimbursement system also requires providers to seek reimbursement from NDMS as a last resort after seeking payment from all other payers (e.g., private insurers) except another federal payer of last resort, such as Medicaid.⁸⁸

⁸⁶ *Host-State Evacuation and Sheltering Reimbursement*, p. 2.

⁸⁷ The teams that NDMS fields include: Disaster Medical Assistance Teams; Disaster Mortuary Operational Response Teams; National Nurse Response Teams; and National Pharmacy Response Teams.

⁸⁸ NDMS template *Memorandum of Agreement for Definitive Medical Care*. See also HHS, NDMS website available at <http://www.hhs.gov/aspr/oepo/ndms/index.html> (last accessed April 13, 2009).



c. Use of For-Profit Entities through Mutual Aid Agreements

For-profit entities may be incorporated into mutual aid agreements or included in emergency response plans, memorandum of understanding or other agreements referenced in a mutual aid agreement. By being incorporated into a mutual aid agreement or emergency response plan, a for-profit hospital or other medical facility may become indirectly eligible for reimbursement by FEMA. FEMA reimbursement would go to the eligible applicant (e.g., state or local government) which would then reimburse the for-profit hospital. For-profit entities are limited to receiving reimbursement for the same types of eligible costs outlined in this section that other eligible applicants (i.e., governments and private nonprofits) are permitted to claim.

4. Recordkeeping Requirements

Given the patchwork of eligible and ineligible facilities, activities, costs, and personnel under the Stafford Act and FEMA regulations and policies, it is imperative that hospitals keep detailed records of their costs incurred in responding to a disaster and all reimbursements received from non-FEMA sources. During a disaster, detailed recordkeeping will be extremely difficult, but such recordkeeping is critical to maximize the hospital's likelihood of receiving FEMA reimbursement.

General FEMA guidance on recordkeeping is available in the Agency's *Public Assistance Guide* and *Public Assistance Applicant Handbook*.⁸⁹ Hospitals and other healthcare entities are reminded that FEMA recordkeeping requirements are in addition to those of other federal programs like Medicare, state Medicaid programs, and private medical insurers, as well as any business insurance carriers.

Guidance regarding special needs shelters issued by FEMA's Region VI outlines important recordkeeping requirements that applicants for reimbursement must comply with to have their claims paid. This guidance may serve as a useful example of the types of considerations an applicant seeking FEMA reimbursement should consider. Reimbursement requests must account for costs used to prepare, evacuate, and return persons with special needs and staff separately from the housing costs of sheltering special needs evacuees and staff.⁹⁰ A request for reimbursement for staff compensation must "describe the duties performed by each staff member or by type of staff (custodial, security, etc.) being claimed."⁹¹ Hospitals and other

⁸⁹ *Public Assistance Guide*, pp. 137-138. Federal Emergency Management Agency, *Public Assistance Applicant Handbook* (FEMA 232) (September 1999), available at <http://www.fema.gov/government/grant/pa/policy.shtm> (last accessed April 13, 2009).

⁹⁰ Specifically, the applicant's reimbursement request must include "the number of special needs people evacuated and housed at the sheltering facility, the name and location of the sheltering facility, and the beginning and ending dates of the evacuation." FEMA Region VI, Disaster-Specific Guidance on Special Needs Shelters. Additionally, "[c]laims for staff housing costs must be accompanied by third party invoices." *Id.*

⁹¹ *Id.*



healthcare entities should act now to incorporate the documentation required by FEMA into its disaster documentation protocols.

D. Pandemic Influenza and FEMA Reimbursement

In March 2007, FEMA issued a new disaster assistance policy, *Emergency Assistance for Human Influenza Pandemic, DAP 9523.17* (“*Pandemic DAP*”).⁹² The policy establishes the types of “emergency protective measures that are eligible under the Public Assistance Program during a Federal response to an outbreak of human influenza pandemic in the U.S. and its territories.”⁹³ The policy acknowledges the differences between an influenza pandemic and most “traditional” disasters, including the expected longer duration of a pandemic, the arrival of the pandemic in waves, the reduced number of healthcare workers and first responders able to work during this type of event, and the scarcity of resources in many locations at the same time.⁹⁴ The policy is based on a number of assumptions derived from the CDC, the HHS *Pandemic Influenza Plan*,⁹⁵ and the U.S. Homeland Security Council *National Strategy for Pandemic Influenza Implementation Plan*.⁹⁶ The assumptions look to, in part, the conditions required for a pandemic to begin, the resulting surge in demand for healthcare services, and the rates of illness and absenteeism in key essential services.

FEMA’s pandemic influenza policy is reviewed in detail below because it presents a disaster scenario atypical of the events FEMA customarily addresses. The pandemic policy covers the same types of eligible healthcare related costs as FEMA’s other healthcare related policies described earlier in this section. The FEMA pandemic policy treats several costs, activities and providers as ineligible, which distinction may ultimately prove to be ambiguous or incorrect during an influenza pandemic.

1. Emergency Protective Measures Eligible During a Pandemic

The Pandemic DAP identifies a number of emergency protective measures that may be eligible for reimbursement to state and local governments and certain private non-profit organizations for pandemic influenza activities. “Emergency protective measures” are those activities undertaken by a community before, during, and following a disaster that are necessary

⁹² Federal Emergency Management Agency, *Emergency Assistance for Human Influenza Pandemic, DAP 9523.17* (March 31, 2007) (hereafter “*FEMA Pandemic DAP*”), available at <http://www.fema.gov/government/grant/pa/9500toc.shtm> (last accessed April 13, 2009).

⁹³ *FEMA Pandemic DAP*, p. 1.

⁹⁴ *FEMA Pandemic DAP*, pp. 1-3.

⁹⁵ U.S. Department of Health and Human Services, *HHS Pandemic Influenza Plan* (November 2005), available at <http://www.hhs.gov/pandemicflu/plan> (accessed April 13, 2009).

⁹⁶ U.S. Homeland Security Council, *National Strategy for Pandemic Influenza Implantation Plan* (May 2006), available at <http://www.pandemicflu.gov/plan/federal/index.html> (accessed April 13, 2009). See also U.S. Homeland Security Council, *National Strategy for Pandemic Influenza* (November 2005).



to: (1) eliminate or reduce an immediate threat to life, public health, or safety; or (2) eliminate or reduce an immediate threat of significant damage to improved public or private property.⁹⁷

The following measures listed in the *Pandemic DAP* may be eligible for reimbursement by FEMA:⁹⁸

1. Activation of state or local emergency operations center to coordinate and direct the response to the event;
2. Purchase and distribution of food, water, ice, medicine, and other consumable supplies;
3. Management, control, and reduction of immediate threats to public health and safety;
4. Movement of supplies and persons;
5. Security forces, barricades and fencing, and warning devices;
6. Emergency medical care (non-deferrable medical treatment of disaster victims in a shelter or temporary medical facility and related medical facility services and supplies, including emergency medical transport, X-rays, laboratory and pathology services, and machine diagnostic tests);
7. Temporary medical facilities (for treatment of disaster victims when existing facilities are overloaded and cannot accommodate the patient load);
8. Congregate sheltering (for disaster victims when existing facilities are overloaded and cannot accommodate the patient load);
9. Communicating health and safety information to the public;
10. Technical assistance to state and local governments on disaster management and control;
11. Search and rescue to locate and recover members of the population requiring assistance and to locate and recover human remains;
12. Storage and internment of unidentified human remains;
13. Mass mortuary services; and
14. Recovery and disposal of animal carcasses.⁹⁹

⁹⁷ FEMA 322 Public Assistance Guide - June 2007, p. 71. Emergency protective measures are listed as “Category B” in FEMA’s categories of work eligible for reimbursement. FEMA further defines emergency protective measures as those “cost-effective” and “prudent actions taken by a community to warn residents, reduce the disaster damage, ensure the continuation of essential public services, and protect lives and public health or safety are eligible for assistance.” *Id.*

⁹⁸ *FEMA Pandemic DAP*, pp. 3-4.

⁹⁹ Removal of animal carcasses is covered except if another federal authority funds the activity (e.g., U.S. Department of Agriculture, Animal, Plant and Health Inspection Service provides for removal and disposal of livestock). *FEMA Pandemic DAP*, p. 4.



This list encompasses a broad range of activities. However, this does not necessarily mean that a healthcare facility will be paid for the costs of providing these services.

2. Costs under FEMA's Pandemic Policy

a. Eligible Costs

Overtime pay for an applicant's employees may be eligible for reimbursement; however, the regular salaries of an applicant's employees who perform eligible work are not eligible for reimbursement.¹⁰⁰ Regular and overtime pay for extra-hires may be eligible for reimbursement, as is eligible work accomplished through contracts, including mutual aid agreements. Costs for equipment, materials, and supplies used to accomplish the emergency protective measures may be eligible. These parameters are consistent with the costs allowed under the FEMA reimbursement rules.

b. Ineligible Costs

FEMA has defined the following activities as ineligible for reimbursement under its *Pandemic DAP*:¹⁰¹

1. Definitive care, which FEMA defines as "care that will improve rather than simply stabilize a casualty's condition through the use of medical treatment or services beyond emergency medical care and is generally initiated upon inpatient admissions to a hospital;"
2. Cost of follow-up treatment of victims per FEMA's Recovery Policy 9525.4 on *Medical Care and Evacuation*;¹⁰²
3. Loss of revenue;
4. Increased administrative and operational costs to the hospital because of increased patient load;
5. Rest time for medical staff, including the time a staff member is unavailable to provide assistance with emergency medical care; and
6. Damages covered by insurance.¹⁰³ Applicants should not seek reimbursement for these costs if they are underwritten by private insurance, Medicare, Medicaid, or a pre-existing private payment agreement.

¹⁰⁰ *Id.*

¹⁰¹ *FEMA Pandemic DAP*, pp. 4-5.

¹⁰² Note that, as discussed in Section 3.C.2 of this paper, FEMA's Disaster Assistance Policy 9525.4 was revised in July 2008. The *FEMA Pandemic DAP*, which was released in March 2007, refers to the prior version of 9525.4 *Medical Care and Evacuation*. The new policy, *Emergency Medical Care and Medical Evacuations*, covers treatment up to 30 days from the emergency event of the date of emergency declaration. After 30 days or once the victim is admitted as an inpatient to a medical facility, costs are no longer eligible.



As it does in its other policies, FEMA specifically notes that ineligible costs remain ineligible even if they are covered under contract, mutual aid, or other assistance agreements.¹⁰⁴ Thus, if a hospital facility or hospital staff (including for-profit hospitals) are incorporated into a mutual aid agreement or some other pandemic planning document, they will not be eligible to receive reimbursement from FEMA for costs it deems ineligible. Hospitals and other healthcare facilities should therefore ensure that there are alternative mechanisms through which their costs for participating in pandemic preparedness and response activities will be covered, including seeking guarantees from state or local governments.

3. Comparing Pandemic and Traditional Disaster Reimbursement

An influenza pandemic is qualitatively different from other traditional disasters with which FEMA has historically dealt, both in terms of nature of the event and its anticipated magnitude. The *Pandemic DAP*, while acknowledging key assumptions and features about a pandemic that make it different from other public health emergencies, still maintains distinctions about the type of care and the mechanisms through which care is delivered which are either outdated or inapplicable to a pandemic scenario. The Stafford Act was not drafted with a pandemic disease event in mind.

a. FEMA Pandemic Policy Issues

There are several aspects of FEMA’s *Pandemic DAP* that demonstrate its failure to adequately capture the nature of pandemic influenza and state and local plans for responding to a pandemic.

- *The distinctions between eligible and ineligible types of medical care will not be clearly delineated in a pandemic.*

The *Pandemic DAP* allows for the provision of emergency medical care, which it defines, in pertinent part, as non-deferrable medical treatment of disaster victims in a shelter or temporary medical facility. This is contrasted in the policy with ineligible medical costs for definitive care, defined as medical treatment beyond emergency medical care. A person presenting with influenza-like symptoms at a shelter or a temporary medical facility may or may not ultimately be diagnosed as having the pandemic influenza strain. The eligible “emergency medical care” that a person receives for pandemic influenza will not be qualitatively different than “ineligible” medical treatment or follow-up care. Unlike the injuries sustained in other disasters, it may be impossible to distinguish pandemic and non-pandemic patients. During the 2009 H1N1 outbreak, without first conducting time-

¹⁰³ The Stafford Act does not allow disaster assistance to duplicate insurance benefits.

¹⁰⁴ *FEMA Pandemic DAP*, p. 5.



consuming laboratory testing, it was impossible to distinguish patients suffering from H1N1 from those suffering from the seasonal flu strain.

- *The important role that hospitals and other non-governmental medical facilities will play is not fully recognized.*

Care that is provided in shelters or temporary medical facilities is eligible under the *Pandemic DAP*. State and local pandemic response plans may look to hospitals and other permanent healthcare facilities (e.g., skilled nursing facilities) as foundational elements in their pandemic response activities. If care provided in a permanent facility is part of a community’s response to pandemic influenza, arguably, this care would NOT be covered. Even if the hospital is included in the state or local pre-event response plan or by contract, if the expense is deemed ineligible (in this case because it is in a permanent facility), then it will not be reimbursed by FEMA. Hospitals, other healthcare providers and state and local emergency response/public health planners should discuss this and other specifics with their regional FEMA representatives about how the state/locality intends to use permanent medical facilities during a pandemic and their likely eligibility for reimbursement under the Public Assistance Grant Program. It will also be important to understand the interplay between the *Pandemic DAP* and FEMA’s other policies related to the provision of healthcare during disaster, which are discussed in this section.

- *The important role that private sector hospitals will play in a pandemic response is missing.*

The *Pandemic DAP* is not, on its face, limited to either state/local response or nonprofit entities, so it is applicable to both governmental and private nonprofit entities. However, for-profit hospitals and other medical facilities are excluded as eligible applicants under the Public Assistance Grant Program because they are excluded by the Stafford Act. This exclusion fails to recognize the large numbers of private for-profit medical facilities and their vital role in a pandemic response. Should a hospital want to be eligible for reimbursement under the FEMA Public Assistance Grant Program, it is important then that they become incorporated into their state and/or local pandemic response plans and have some type of agreement or memorandum defining their responsibilities during a pandemic.

b. Stafford Act Issues

The poor fit between the *Pandemic DAP* and the reality of pandemic response planning, rests, in part with the Stafford Act, which limits FEMA’s ability to craft regulations and policies. Although the Stafford Act definition of “emergency” includes threats to public health and therefore is sufficiently broad to include pandemic influenza, the traditional conceptions of



“emergency” and “disaster” upon which the act rests did not include a disaster such as a modern influenza pandemic.¹⁰⁵

The *Pandemic DAP* states that it applies to both major disasters and emergencies, although the definitions of “disaster” and “emergency” in the Stafford Act suggest that a pandemic falls under the emergency category. This distinction becomes significant when the amount of financial assistance available under the Stafford Act for emergencies versus disasters is considered. Responses to an emergency event are capped under the Stafford Act at \$5 million; Congress must be informed if the \$5 million cap will be exceeded. While Congress is almost certain to approve the expenditures in excess of the \$5 million cap, the cap demonstrates the Stafford Act’s limited scope to address a public health emergency.

E. Unresolved Issues and Action Recommendations

Reimbursement from FEMA is possible for hospitals and other healthcare providers, but the availability of these funds is limited by the Stafford Act to particular types of entities for particular types of costs and activities. FEMA’s role as “payer of last resort” requires individuals, as well as entities like hospitals and other medical facilities, to exhaust other forms of insurance and reimbursement before seeking reimbursement from FEMA. To the extent that other forms of payment are received in addition to FEMA funds, the recipients must off-set the amount paid out by FEMA and refund monies to the Agency. Large scale events in the last decade, such as Hurricanes Katrina and Rita in 2005, demonstrated problems with FEMA’s policies, which led to revision of these policies. Despite these revisions, however, there remain fundamental unresolved and unaddressed issues around how healthcare providers and facilities are reimbursed for their critical contributions during disasters. We will briefly discuss these issues.

- *The Stafford Act and FEMA do not fully recognize or address the role of private healthcare providers in emergency response.*

The Stafford Act’s limitations on the types of healthcare providers, particularly its exclusion of “for-profit” hospitals and other medical facilities, significantly limits the number of facilities eligible to be reimbursed for their contributions to a community’s emergency response. Exclusion under the Stafford Act is a further hurdle that for-profit health providers must overcome when trying to provide care under extreme circumstances. Congress continues to be

¹⁰⁵ As noted earlier in this section, the Stafford Act defines a “major disaster” as “any natural catastrophe (including any hurricane, tornado, storm, high water, winddriven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion.... 42 U.S.C. § 5122(2). Arguably, an influenza pandemic could be construed as a natural catastrophe; however, the specific types of catastrophic events listed in that definition and the general understanding of the term suggests that a pandemic does not easily fit the definition of disaster.



reluctant to amend the Stafford Act to include these important segments of the healthcare industry.

- *For-profit hospitals and healthcare providers should make sure that they are included in their community's emergency response plans and/or mutual aid agreements to receive reimbursement through a FEMA-eligible entity.*

Because for-profit hospitals and other medical facilities are not by themselves eligible for FEMA reimbursement, they should consider entering into mutual aid agreements with eligible private nonprofit entities (or governments) for which the for-profit entity will perform FEMA-eligible services. The eligible private nonprofit can apply for FEMA reimbursement and pass on the reimbursement owed to the for-profit entity. Forming this mutual aid relationship deserves greater attention and discussion between affected parties.

- *FEMA's distinctions between the types of health care eligible for reimbursement are not always clear cut in practice.*

The distinction that FEMA makes between “emergency medical care” and “definitive care” in determining the eligibility of these costs for reimbursement is not always clear cut. This is especially evident in the agency's *Pandemic DAP*. FEMA should re-examine the types of healthcare services it will reimburse in a disaster.

- *The federal government's system to pay for and/or reimburse individuals, hospitals and other healthcare providers for their healthcare costs in a disaster must be better coordinated.*

FEMA's role as the payer of last resort requires that individuals and entities seek reimbursement from all other sources to offset the amount that FEMA ultimately pays for a disaster. To the extent that an individual or facility will seek payment or reimbursement from Medicare, Medicaid or other federal health programs for expenses because of a disaster, it makes sense to coordinate potential benefits under FEMA at the same time. As discussed in other sections of this paper, CMS, HHS and the states should be engaged in a broader discussion with FEMA about better coordinating a system of payments for health-related expenses in a disaster.

III. WAIVER OF FEDERAL LAWS & PROGRAM REQUIREMENTS



A. Overview

In the midst of a disaster, it may not be practical or even possible for healthcare providers to meet all of the requirements for participation in federal health programs or all federal regulatory requirements. Fortunately, the need to waive, ease, or delay certain requirements has been recognized by the HHS and CMS. Unfortunately, however, the scope of the available regulatory relief is narrow, and these agencies are reluctant to issue many advance determinations of waivers beyond what is explicitly outlined in law.

This section describes two waiver mechanisms—Social Security Act (SSA) Section 1135 and Section 1115 disaster waivers—used by HHS to ease some healthcare regulatory requirements during disasters. Examining the scope and duration of the waivers issued in previous disasters is instructive, but not definitive, regarding the future use and scope of waivers by HHS and CMS, including those related to pandemic influenza. Hospitals and healthcare providers must be familiar with Section 1135 and Section 1115 disaster waivers, know where to look for waivers issued during a disaster, and understand what these waivers ultimately mean for their compliance and reimbursement.¹⁰⁶

B. Section 1135 Waivers

1. Overview

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 added Section 1135 to the SSA. Section 1135 authorized the Secretary of HHS to waive or modify select requirements of the SSA under specified disasters.¹⁰⁷ Upon a Presidential declaration of emergency or disaster pursuant to the Stafford Act¹⁰⁸ or a Secretarial declaration of public health emergency pursuant to the Public Health Service Act,¹⁰⁹ Section 1135 authorizes the Secretary of HHS to “temporarily waive or modify the application of” certain Medicare,

¹⁰⁶ Historically, HHS and CMS have announced the issuance of Section 1135 and Section Section 1115 disaster waivers on their websites’ media or press release areas. Additionally, affected states will announce the availability of waivers and other regulatory relief information on the websites for state officers and entities such as the Governor, state health agency, and/or state Medicaid agency. State medical societies and other health professional or provider associations may also have waiver and regulatory relief information available.

¹⁰⁷ P.L. 107-188 (2002).

¹⁰⁸ The Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5206 (the “Stafford Act”), was created to “provide an orderly and continuing means of assistance by the Federal Government to State and local government in carrying out their responsibilities to alleviate the suffering and damage which result from disasters.” 42 U.S.C. § 5121(b).

¹⁰⁹ Section 319(a) of the Public Health Service Act, authorizes the Secretary of HHS to declare a public health emergency and “take such action as may be appropriate to respond” to that emergency consistent with existing authorities. 42 U.S.C. § 247d. The Secretary may declare a public health emergency when, after consultation with public health officials, he finds that “a disease or disorder presents a public health emergency or a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists.” 42 U.S.C. § 247d(a).



Medicaid and State Child Health Insurance Program (SCHIP) requirements to the extent necessary to exempt healthcare providers from sanctions when the disaster’s circumstances have left them unable to comply with such requirements.¹¹⁰ Sanctions can be waived for the following requirements:

- *Conditions of Participation* – Conditions of participation or other certification requirements for healthcare providers; program participation and similar requirements for individual health care providers; and pre-approval requirements;
- *Licensure Requirements* – Licensure requirements for physicians and other health care professionals that require licensure in the state in which they provide services;
- *EMTALA*¹¹¹ – Sanctions under the Emergency Medical Treatment and Active Labor Act (EMTALA) relating to transfer and redirection;¹¹²
- *Physician Self-referrals* – Sanctions regarding limitations on physician referrals;¹¹³
- *HIPAA*¹¹⁴ – Sanctions and penalties for noncompliance with several provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹¹⁵ Specifically waived requirements/conditions are failures to: (1) obtain a patient’s agreement to speak with family members or friends; (2) honor a request to opt out of the facility directory; (3) distribute a notice of privacy practices; and (4) provide patients with a right to request privacy restrictions or confidential communications;¹¹⁶ and
- *Out-of-Network Payments* – Payments to out-of-network health care providers for items and services furnished to Medicare Advantage patients.¹¹⁷

¹¹⁰ 42 U.S.C. § 1320b-5(a)(2).

¹¹¹ For an in-depth review of EMTALA during emergencies, see *EMTALA Compliance in Disaster Circumstances*, prepared by Troutman Sanders LLP for the Virginia Hospital and Healthcare Association (March 2, 2007).

¹¹² A waiver or modification of selected EMTALA requirements is only in effect if “such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay.” 42 U.S.C. § 1320b-5(b).

¹¹³ 42 U.S.C. § 1395nn(g).

¹¹⁴ 42 U.S.C. § 1320d-2. For an in-depth review of HIPAA during emergencies, see *Sharing Information During Disasters: HIPAA Implications*, prepared by Troutman Sanders LLP for the Virginia Hospital and Healthcare Association (April 23, 2007).

¹¹⁵ 42 U.S.C. § 1320b-5(b)(5).

¹¹⁶ A waiver or modification of selected HIPAA requirements is only in effect if “such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay.” (42 U.S.C. § 1320b-5(b)).

¹¹⁷ Section 1135 requires that the Secretary reconcile payments made on behalf of enrollees in the Medicare Advantage program to the “extent possible given the circumstances” to ensure that enrollees do not pay more than if they received services from healthcare providers within the network. (42 U.S.C. § 1320b-5(b)). The Secretary may reconcile payments to the Medicare Advantage plan offerer to ensure that the offerer “pays for services for which payment is included in the capitation payment it receives under the [Medicare Advantage] plan.” *Id.*



It is important to note that Section 1135 states that deadlines and timetables for performance of required activities may only be modified, not waived completely.¹¹⁸ In other words, the requirements are not set aside; it is the sanctions for non-compliance that are waived.

2. Scope and Duration of Section 1135 Waivers

The Secretary of HHS can only issue Section 1135 waivers for healthcare services rendered during an “emergency period” in an “emergency area.”¹¹⁹ The statute defines “emergency area” and “emergency period” as the geographical area and time period (respectively) in which there is a Presidential declaration of disaster or emergency under the Stafford Act or a public health emergency as declared by the Secretary under the Public Health Service Act.¹²⁰ The Secretary has the discretion to make waivers or modify requirements retroactively to the beginning of the emergency period or any subsequent date.¹²¹ Section 1135 waivers are not available for local and state declared disasters for which there is no Presidential declaration.¹²²

Section 1135 waivers expire with the termination of the declared disaster, the termination of the declared public health emergency, or 60 days from the date the waiver or modification is first published.¹²³ If the waiver terminates because the 60-day period has expired, the Secretary may extend it for subsequent 60-day periods.¹²⁴ Extension of the waiver period by the Secretary does not affect the termination of the Section 1135 waiver period if the underlying emergency declaration ceases.¹²⁵ EMTALA requirements waived by Section 1135 are generally limited to the 72-hour period commencing with the implementation of a hospital disaster protocol unless the waiver arises out of a public health emergency involving a pandemic,¹²⁶ in which case, the waiver terminates as specified generally for Section 1135. HIPAA requirements waived by Section 1135 are limited to a 72-hour period commencing with the implementation of

¹¹⁸ 42 U.S.C. § 1320b-5(b)(5).

¹¹⁹ 42 U.S.C. § 1320b-5(g).

¹²⁰ *Id.*

¹²¹ 42 U.S.C. § 1320b-5(c).

¹²² The Technical Advisory Group to HHS on EMTALA issues (“EMTALA TAG”) recommended that Section 1135 waivers be expanded to provide protections to include declared state, county and city emergencies as well as hospital-specific emergencies as determined by Centers for Medicare and Medicaid Services, Office of Inspector General (CMS/OIG) on a case-by-case basis. *See Report Number Five to the Secretary of the U.S. Department of Health and Human Services From the Emergency Medical Treatment and Labor Act Technical Advisory Group*, November 2-3, 2006 (issued February 6, 2007), available at http://www.cms.hhs.gov/EMTALA103_emtalatag.asp (last accessed April 14, 2009) (hereinafter “EMTALA TAG Report”).

¹²³ 42 U.S.C. § 1320b-5(e)(1).

¹²⁴ 42 U.S.C. § 1320b-5(e)(2).

¹²⁵ *Id.*

¹²⁶ 42 U.S.C. § 1320b-5(b). The EMTALA TAG Report recommended that the 72-hour limitation be extended to allow the waiver to remain in effect until the hospital is no longer in an emergency situation or the government-declared emergency has been terminated. *See EMTALA TAG Report*, p. 74.



a hospital disaster protocol; thereafter, the provider must comply with the HIPAA requirements for any patient still under the provider's care.¹²⁷

3. Use of Section 1135 Waivers

After the Presidential declaration of disaster in Louisiana and surrounding states for Hurricane Katrina in August 2005,¹²⁸ the Secretary of HHS issued a Section 1135 waiver for the impacted states, which included waivers for: (1) conditions of participation; (2) physician licensure requirements; (3) EMTALA; (4) Medicare Advantage out-of-network providers; and (5) HIPAA.¹²⁹ The waiver specifically noted the 72-hour waiver period for the listed EMTALA and HIPAA requirements, and that the waiver was not effective for any action taken that discriminates among persons based on their source of payment or ability to pay.¹³⁰ The text of the August 2005 waiver announcement did not include a waiver of the physician self-referral limitations ("Stark waiver"), as permitted by the statutory language in Section 1135. A supplemental 1135 waiver addressing Stark was subsequently issued on September 29, 2005, and made retroactive to the dates of the federal disaster declarations for each of the impacted states.¹³¹

The use of Section 1135 waivers has continued in recent years. The Secretary of HHS issued Section 1135 waivers in Minnesota¹³² and North Dakota¹³³ in 2009 and in Indiana¹³⁴ and

¹²⁷ 42 U.S.C. § 1320b-5(b).

¹²⁸ See *Statement on Federal Emergency Assistance for Louisiana issued by The White House*, August 27, 2005, available at <http://georgewbush-whitehouse.archives.gov/news/releases/2005/08/20050827-1.html> (last accessed April 14, 2009).

¹²⁹ See HHS, *Waiver Under Section 1135 of the Social Security Act* (September 4, 2005), available at <http://www.hhs.gov/katrina/ssawaiver.html> (last accessed April 14, 2009).

¹³⁰ Regarding EMTALA, during the time the waiver was in effect, hospitals were permitted to make otherwise prohibited transfers after conducting a medical screening exam so long as the transfer was necessitated by the disaster circumstances. Furthermore, hospitals were permitted to transfer patients prior to conducting a medical screening exam so long as such transfer was performed pursuant to a "state emergency preparedness plan." If the state did not have an emergency preparedness plan which provided guidelines for such redirection, hospitals remained responsible for providing medical screening exams to all who came to their emergency departments.

¹³¹ Secretary of Health and Human Services, *Supplemental Waiver Under Section 1135 of the Social Security Act* (September 29, 2005).

¹³² HHS, *Waiver or Modification of Requirements under Section 1135 of the Social Security Act* (March 27, 2009) available at http://www.cms.hhs.gov/Emergency/Downloads/1135Waiver_Minnesota.pdf (last accessed April 25, 2009).

¹³³ HHS, *Waiver or Modification of Requirements under Section 1135 of the Social Security Act* (March 25, 2009) available at http://www.cms.hhs.gov/Emergency/Downloads/1135Waiver_NorthDakota.pdf (last accessed April 25, 2009).

¹³⁴ HHS, *Waiver or Modification of Requirements under Section 1135 of the Social Security Act* (June 14, 2008) available at <http://www.cms.hhs.gov/Emergency/Downloads/Indiana1135Waiver.htm> (last accessed April 25, 2009).



Iowa¹³⁵ in 2008 in response to a declaration of disaster and a declaration of public health emergency related to wide-spread flooding in those states. The content of the Section 1135 waiver issued for Midwest floods is essentially the same as that of the waivers issued during Hurricane Katrina, but included the Stark waiver in the initial waiver.

a. Examples of Requirements Waived/Modified Under Section 1135 Waivers

The statutory language in Section 1135 provides the Secretary with broad authority to waive and modify SSA requirements. In reality, the authority has been used very specifically. Since the creation of this waiver authority in 2002, the specific requirements that HHS will and will not waive or modify have evolved with each new federally declared disaster. These refinements are based on the experience and feedback of healthcare providers and agency personnel at all levels of government. HHS has announced the changes through a variety of guidance documents, letters, press releases, and question-and-answer documents. Examples of the types of waivers and modifications permitted by HHS include:¹³⁶

- *Hospitals* – recordkeeping requirements, certification for organ transplants;
- *Inpatient Beds* – modifications to expand the number of available beds;
- *Critical Access Hospitals* – waiver of classification requirements for critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, psychiatric units;
- *Medicare Billing and Accelerated Payments* – relaxing of Medicare requirements including the fee-for-service policy and billing, offering accelerated payment options for hospitals and other healthcare providers who supply care during a disaster;
- *EMTALA Sanctions* – waiving EMTALA sanctions for transferring patients to other facilities for assessment, if the original facility is in the area where a public health emergency has been declared (other provisions of EMTALA remain in full effect);
- *HIPAA* – waiving certain HIPAA privacy requirements so that healthcare providers can talk to family members (other provisions of HIPAA remain in full effect);
- *End Stage Renal Disease* – providing reimbursement to non-traditional dialysis facilities;

¹³⁵ HHS, *Waiver or Modification of Requirements under Section 1135 of the Social Security Act* (June 14, 2008) available at <http://www.cms.hhs.gov/emergency/downloads/iowa1135waiver.htm> (last accessed April 25, 2009).

¹³⁶ List adapted from CMS Open Door Forum, *Attachment A: Regulatory, Policy and Other Flexibilities Made Available for Special Consideration by CMS during Hurricane Katrina*, available at <http://www.cms.hhs.gov/OpenDoorForums/Downloads/031408CMSRequirementsRelaxedwaived.pdf> (last accessed April 14, 2009) and Texas Medical Association, *Hurricane Katrina Government Payor Information Web Page, October 12, 2005 Update: State Issues Rules for Filing Katrina Patient Treatment Claims*, available at <http://www.texmed.org/Template.aspx?id=4314> (last accessed April 14, 2009). There are many other examples available on the CMS web site at www.cms.hhs.gov.



- *Medicare Advantage and Medicare Prescription Drug Plans* – modifications allowing the use of out-of-network providers, issuing guidance for providing prescription drugs to Medicare participants during disasters;
- *Nursing Homes and Skilled Nursing Facilities* – modifications addressing the three-day prior stay requirement and minimum data set requirements;
- *Physician Self-Referral* – waiver of certain sanctions for arrangements that did not meet the criteria for exceptions, provided that the arrangements did not lead to patient abuse; and
- *Survey and Certification* – coordinating with state survey agencies and accrediting organizations regarding flexibility to balance patient protections with a disaster’s circumstances.

Healthcare providers should be aware that these waiver examples, and those listed elsewhere in this document, are collected from prior HHS decisions. These specific waivers may be modified or may not be granted in the future. In late 2008, CMS released its series of *Influenza Pandemic Emergency Policies* as guidance to Financial Intermediaries and Medicare Administrative Contractors regarding the Agency’s anticipated payment and operations policies during an influenza pandemic.¹³⁷ These policies are generally consistent with CMS’s policies during prior disasters. However, CMS notes that these currently released policies are subject to further revision in the future and may or may not be enacted in whole or in part when a pandemic disaster is declared.

It is imperative that hospitals and healthcare providers consult with appropriate federal, state and local government agencies now to determine the exact waivers and modifications to be granted during an actual disaster. They should also review with legal counsel who is knowledgeable in this area of law, how future waivers can be used by the healthcare provider.

C. Section 1115 Medicaid Waivers

1. Overview and Use of Section 1115 Medicaid Waivers in Disasters

Generally, Section 1115 authorizes the Secretary to conduct demonstration projects that further the goals of Medicaid, Medicare and SCHIP. States must submit proposals outlining their intended waivers to CMS for approval before the state implements the waivers.¹³⁸ The Secretary of HHS has allowed states to use Section 1115 of the SSA to ease some statutory requirements

¹³⁷ For a complete listing of the CMS *Influenza Pandemic Emergency Policies*, see Section 5.C.1, *infra*.

¹³⁸ Evelyn Baumrucker, et al, *Hurricane Katrina: Medicaid Issues*, Congressional Research Service Report for Congress RL33083 (Sept. 15, 2005), p. 13. Section 1115 demonstration projects have been authorized for a variety of issues, including independent living for the elderly and disabled, those living with HIV and AIDS, and consumer driven healthcare. Their use in emergencies is a more recent evolution of the program.



during disaster for persons eligible for Medicaid, Medicare and SCHIP. A Section 1115 disaster waiver was used in New York to address the immediate aftermath of September 11.

Section 1115 waivers were again used to assist states directly impacted by Hurricanes Katrina and Rita or those hosting evacuees from the impacted states. CMS's approval of Section 1115 demonstration waivers during a disaster indicates the Agency's past willingness to use this as another mechanism for disaster response. An analysis of these waivers is instructive for hospitals and healthcare providers that must seek reimbursement under the Section 1115 disaster programs or from uncompensated care pools, if available.

2. Section 1115 Disaster Relief Medicaid Program: New York City, 9/11/01.

In the immediate aftermath of the September 11, 2001, terrorist attacks in New York City, the State of New York requested and received approval for a four-month temporary "Disaster Relief Medicaid" (DRM) program because the city's Medicaid computer system was damaged during the attacks.¹³⁹ The DRM program used an abbreviated one-page application form and only required applicants to produce one form of identification.¹⁴⁰ Enrollment in the DRM program ran from late September 2001 through January 30, 2002, and it was the only Medicaid program available to New York City residents during that time.¹⁴¹ In total, more than 342,300 New Yorkers applied for the program.¹⁴² Persons qualifying for the DRM program received temporary authorization to access Medicaid services, which included all fee-for-service benefits except residential long-term care facilities.¹⁴³

In December 2005, Cornell University released an evaluation of the DRM commissioned by New York State.¹⁴⁴ Expenditures for the DRM totaled approximately \$670 million.¹⁴⁵ The top four categories of expenses were: (1) inpatient services; (2) outpatient services; (3) dental services; and (4) pharmacy expenses.¹⁴⁶ A summary of the findings reveals that greater than

¹³⁹ Eugene LeCouteur, *New York's Disaster Relief Medicaid: What Happened When it Ended?* Commonwealth Fund Publication Number 737 (July 2004), p. 1. CMS approved New York's Section 1115 disaster waiver for the DRM program on December 31, 2002. CMS did not apply the usual Medicaid cost neutrality requirements for the DRM program because of the unusual circumstances of the 9/11 attacks, but SCHIP allotment neutrality requirements remained in effect. Baumrucker, *et al.*, *supra* note 146, p. 16.

¹⁴⁰ LeCouteur, *supra* note 147, p. 1.

¹⁴¹ Applicants did not have to be directly impacted by the terrorist attacks. Additionally, although the DRM program waiver was supposed to provide only four-months of coverage, ultimately the waiver ran through January 2003 to allow the state to schedule eligibility re-determination for persons enrolled in the DRM program. Baumrucker, *et al.*, *supra* note 146, p. 16.

¹⁴² LeCouteur, *supra* note 147, p. 1.

¹⁴³ Baumrucker, *et al.*, *supra* note 146, p. 16.

¹⁴⁴ *Disaster Relief Medicaid Evaluation Project* (Cornell University, School of Industrial and Labor Relations) (Marcia Calicchia, Principal Investigator) (December 2005) (hereinafter "DRM Evaluation Project").

¹⁴⁵ *DRM Evaluation Project*, p. 7.

¹⁴⁶ *Id.*



anticipated enrollment in the program occurred because of higher income eligibility levels, a streamlined enrollment process, significant community-based advertising about the program, and a recent federal court ruling that allowed many previously ineligible immigrants to access Medicaid services.¹⁴⁷ The report further determined that the DRM placed significant burdens on agency staff to process and verify eligibility and exposed the state’s program to potentially more fraudulent activities by enrollees and healthcare providers because of the DRM’s presumptive eligibility standards and high enrollment numbers.¹⁴⁸ Putting the DRM in the larger context of disaster response, the authors of the Cornell report concluded that “Medicaid recipients are not unique in a disaster, and that [e]mergency healthcare for those who need it should be coordinated and funded by the federal government under its emergency management protocols.”¹⁴⁹ Federal funding would also shield programs from criticisms that “times of disaster result in significant violations of [Medicaid] program integrity.”¹⁵⁰

New York ultimately requested that FEMA cover the non-federal share of its Medicaid expenditures for the DRM program (approximately 50% of the state’s Medicaid expenditures) through FEMA’s public assistance funds.¹⁵¹ FEMA denied the request and the state appealed the decision with FEMA.¹⁵²

3. Section 1115 Disaster Relief Emergency Medicaid Waiver Program: Hurricane Katrina

On September 15, 2005, CMS announced the availability of a new Disaster Relief Emergency Medicare waiver (the “Section 1115 disaster waiver”) demonstration program, to “ensure that the Medicaid and (SCHIP) will respond to the health care needs of beneficiaries and medical providers affected by Hurricane Katrina.”¹⁵³ To assist the states directly impacted by the hurricane, as well as residents of the impacted states who were evacuated to other jurisdictions, CMS created a Section 1115 model waiver template for states to use in applying for the

¹⁴⁷ *DRM Evaluation Project*, p. 6. See also *Aliessa v. Novello*, 96 N.Y.2d 418 (2001) (exclusion of legal immigrants from full Medicaid coverage violated Article XVII of the New York Constitution and the equal protection clause of both the New York and U.S. Constitutions).

¹⁴⁸ *DRM Evaluation Project*, pp. 7-9.

¹⁴⁹ *DRM Evaluation Project*, p. 9.

¹⁵⁰ *Id.*

¹⁵¹ Baumrucker, *et al.*, *supra* note 146, p. 16.

¹⁵² *Id.*

¹⁵³ CMS, *Medicaid Fact Sheet, Disaster Relief Emergency Medicaid Waiver Program: Speeding Access to Care, Helping Those in Need* (hereinafter “CMS Disaster Relief, Medicaid Fact Sheet”) (September 15, 2005). At the time the CMS program was announced, there were Congressional proposals circulating that would have created a temporary disaster Medicaid program legislatively. Although the CMS program was initiated for Hurricane Katrina victims, it was later expanded to include Hurricane Rita victims.



waiver.¹⁵⁴ States with approved program waivers were permitted to submit their full costs (including the state share) of providing care under the waiver directly to the federal government. This allowed the states to be “made whole” for the costs they incurred in caring for hurricane victims..¹⁵⁵ Initially, the Section 1115 disaster waiver applied to persons impacted by Hurricane Katrina, but Hurricane Rita survivors were subsequently included.

Under the Section 1115 disaster waiver program, states can provide evacuees temporary eligibility of federal benefits for five months, including those under Medicaid and SCHIP, without having to verify the income or employment status of evacuees. Host states were allowed to determine evacuee eligibility either through simplified federal eligibility rules or by applying the eligibility rules of the evacuee’s home state. All states in the program elected to use the simplified eligibility rules. Host states were also given the option of using its own resource test or waiving that requirement, as well as waiving cost-sharing requirements.¹⁵⁶ Evacuees were given benefits in the host state. Providers in host states caring for evacuees were reimbursed at the host states’ rates. Host states could grant exceptions to the five-month program period and cover the extended coverage periods.¹⁵⁷ Displaced persons could apply for evacuee status through January 31, 2006; the waiver program ran through June 30, 2006.¹⁵⁸ After the waiver period expired, evacuees could apply for continued coverage under the host state’s regular Medicaid program. In total, CMS approved Section 1115 disaster waivers for 32 states, which enrolled over 118,600 evacuees under Medicaid.¹⁵⁹

¹⁵⁴ The template Section 1115 disaster waiver application was transmitted by CMS to state Medicaid and state SCHIP directors in a letter dated September 16, 2005 (CMS SHO # 05-001). The letter included the “Multi-State Section 1115 Demonstration Application Template, Medicaid and SCHIP Coverage for Evacuees of Hurricane Katrina” (hereinafter “CMS Section Section 1115 disaster waiver Template”) letter and template *available at* <http://www.cms.hhs.gov/smdl/downloads/sho091605.pdf> (last accessed April 25, 2009). CMS reported that, on average, it approved the 1115 waiver requests within 38 days of the state’s application. CMS, *A Summary of State Reports for Medicaid and the State Children’s Health Insurance Program Hurricane Katrina Section 1115 Demonstrations* (March 2007), p. 2 (hereinafter “CMS, *Summary of State Reports*”), *available at* <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Hurricane%20Katrina%20Final%20Summary%20Report.pdf> (last accessed April 14, 2009).

¹⁵⁵ CMS Disaster Relief, Medicaid Fact Sheet, pp. 1, 2.

¹⁵⁶ As per the CMS template Section 1115 disaster waiver application, if a host state decided to use the evacuee’s home state eligibility requirements, then it would have to apply the home state’s resource test. All tests of budget and allotment neutrality were waived for the Disaster Relief Emergency Medicaid waiver program. Evelyn P. Baumrucker, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers* (CRS Report to Congress RS21056) (March 17, 2006), p. 3.

¹⁵⁷ For example, Texas covered pregnant evacuees until they gave birth and for two months of post-partum care. Texas Medical Association, Hurricane Katrina Government Payor Information Web Page, *October 12, 2005 Update: State Issues Rules for Filing Katrina Patient Treatment Claims*, *available at* <http://www.texmed.org/Template.aspx?id=4314> (last accessed April 14, 2009).

¹⁵⁸ CMS Disaster Relief, Medicaid Fact Sheet, p. 2.

¹⁵⁹ The jurisdictions with approved Disaster Relief Emergency Medicaid waivers were: AL, AZ, AR, CA, DE, DC, FL, GA, ID, IN, IA, LA, MD, MA, MN, MS, MT, NV, NC, ND, OH, OR, PA, PR, RI, SC, TN, TX, UT, VA, WI, and WY. CMS, *Summary of State Reports*, Appendix B. Virginia reported enrolling 641 evacuees. *Id.*



a. Healthcare Providers

The CMS template for the Section 1115 disaster waiver program noted the following “Standard Features” regarding healthcare provider reimbursement issues:

- A. Health care providers that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricane Katrina, will be paid for services provided and will be exempt from sanctions for noncompliance, unless it is discovered that fraud and abuse occurred.
- B. Crisis services provided to Medicaid and SCHIP patients who have been transferred to facilities not certified to participate in the programs will be paid.
- C. Programs will reimburse facilities for providing services to patients in alternative settings, e.g., providing dialysis to patients with kidney failure in alternative settings.
- D. Normal prior authorization and out-of-network requirements may also be waived for enrollees of Medicaid or SCHIP managed care plans.
- E. Normal provider requirements for doctors, nurses, and other health care professionals who cross State lines to provide emergency care in stricken areas will be waived as long as the provider is licensed in their Home State.¹⁶⁰

b. Uncompensated Care Pools

For the 32 jurisdictions participating in the Section 1115 disaster waiver program, CMS approved eight uncompensated care pools from eight jurisdictions.¹⁶¹ These pools reimbursed healthcare providers in those jurisdictions for their uncompensated costs for “medically necessary services and supplies for evacuees” that were not covered through insurance or another relief option. The pools could also be used to provide reimbursement for benefits not covered under Medicaid and SCHIP in each state.¹⁶² The uncompensated care pools were not included in the template Section 1115 disaster waiver program, but were considered on a state-by-state basis.¹⁶³ For a healthcare provider to receive approval for an uncompensated care pool, CMS required that the state have a high number of evacuees and border or closely border one of the directly affected states.¹⁶⁴ Healthcare providers submitting claims for reimbursement from the uncompensated care pool were generally required to attest that: (1) evacuees had no other healthcare coverage on the date services were provided; (2) the healthcare provider either did not

¹⁶⁰ CMS Section 1115 disaster waiver Template, p. 5.

¹⁶¹ CMS, *Summary of State Reports*, p. 2. The states with approved uncompensated care pools were: AL, AR, GA, LA, MS, SC, TN, and TX. CMS, *Summary of State Reports*, p. 4.

¹⁶² CMS, *Summary of State Reports*, p. 2.

¹⁶³ CMS, *Summary of State Reports*, p. 3.

¹⁶⁴ *Id.*



or did not expect to receive reimbursement for the care from any other source; (3) the care recipient was a Hurricane Katrina evacuee from one of the designated eligible counties or parishes; and (4) the services or supplies were medically necessary and within the scope of the hurricane response effort.¹⁶⁵

c. Federal Payments for the Section 1115 Disaster Waiver Medicaid Program

The Deficit Reduction Act of 2005 (DRA) provided \$2 billion in federal funds for Hurricane Katrina Relief efforts, which included the Section 1115 disaster waiver program.¹⁶⁶ Section 6201 of the DRA provided funding for, among other things: (1) the non-federal share for care delivered under a Section 1115 disaster waiver; (2) uncompensated care pool costs; (3) reasonable administrative costs related to the prior two items; (4) the non-federal share for medical care provided to persons under existing Medicare and SCHIP state plans; and (5) funding to improve access to health care in impacted communities, as approved by the Secretary. According to a summary report of states' activities in the Section 1115 disaster waiver program, the most costly service categories reported by the states were: (1) inpatient hospital services; (2) physicians; and (3) prescription drugs.¹⁶⁷ States also reported significant numbers of claims for nursing facilities, dental services, and outpatient hospital services.¹⁶⁸

The HHS Office of Inspector General (HHS-OIG) is conducting audits of the states that participated in the Section 1115 disaster Medicaid demonstration projects. In the four audits published as of June 2008, the HHS-OIG requested refunds for some portion of the reimbursements made to states under the waiver program.¹⁶⁹ Common reasons that HHS-OIG cited for denying claims included: (1) administrative costs not related to the disaster 1115 waiver program were made; (2) evacuees did not meet the eligibility requirements; (3) services were provided after the five-month program eligibility period; (4) claimed expensed lacked supporting documentation; and (5) reporting errors.¹⁷⁰

¹⁶⁵ CMS, *Summary of State Reports*, p. 6.

¹⁶⁶ P.L. 109-171. The DRA was signed into law by President Bush on February 8, 2006.

¹⁶⁷ CMS, *Summary of State Reports*, pp. 7-8.

¹⁶⁸ CMS, *Summary of State Reports*, p. 8.

¹⁶⁹ The four audits completed as of June 2008 are for DE, DC, MD, and VA.

¹⁷⁰ In March 2008, the OIG issued a draft report to the Virginia Department of Medical Assistance Services auditing the state's claims for reimbursement under the Section 1115 disaster waiver program. Virginia was asked to refund nearly \$73,000 of the approximately \$523,000 in reimbursements it had received from CMS. Of the \$73,000 to be refunded, over \$63,000 was for administrative costs. Virginia agreed to the refund amount, but reiterated its desire to see that future disaster 1115 waiver initiatives make demonstration waiver requirements immediately available so that states are notified of necessary eligibility rules and data to fully benefit from the waiver demonstration project. June 12, 2008, Memorandum from Daniel R. Levinson, HHS Inspector General to Kerry Weems, Acting Administrator, CMS Regarding Final Report on Medical Assistance Provided by Virginia to Hurricane Katrina Evacuees (A-03-07-00211).



d. Reactions to the Section 1115 Disaster Waiver Program

All states approved to participate in the Section 1115 disaster waiver program were required to submit final reports as a condition of participation in the waiver program. CMS summarized the states' experiences and reactions in its report, "A Summary of State Reports for Medicaid and the State Children's Health Insurance Program Hurricane Katrina Section 1115 Demonstrations." Several key themes emerged from the states' feedback and from other sources evaluating the program.

- *It was problematic fitting a "disaster" program within the confines of a "regular" program.*

Regular eligibility categories are too narrow in a disaster. A disaster may make a victim who was previously ineligible for Medicaid assistance newly eligible. Differences in states implementation strategies, as was permitted by CMS, resulted in differences in access to care for evacuees. Even though all states used simplified eligibility criteria under the model 1115 demonstration project, there were differences between the benefits offered by the home and host states.¹⁷¹

- *There needs to be broader program parameters for a "disaster" program.*

Because of potential differences in access to care and delays in implementing the Section 1115 disaster waiver program, some states noted that a national Medicaid disaster plan is needed. Such a plan would have broader parameters than the 1115 model used in Katrina.¹⁷² The plan should have a longer eligibility period for victims and a longer time frame in which providers could submit claims.¹⁷³ The program should not require individual approval for each state, even if it is based on a template application. The delay of over a month in the Katrina disaster waiver approval process was too long; evacuees needed services and healthcare providers required reimbursement before that time.¹⁷⁴

- *Uncompensated care pools should be more widely available in a disaster.*

Virginia noted, and other states agreed, that there should be greater availability of uncompensated care pools because many evacuees did not meet Medicaid or SCHIP eligibility requirements.¹⁷⁵ The Governor's Commission on Recovery, Rebuilding & Renewal in Mississippi recommended that an uncompensated care pool should cover

¹⁷¹ CMS, *Summary of State Reports*, p. 10.

¹⁷² CMS, *Summary of State Reports*, p. 9.

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ Virginia final report cited in CMS, *Summary of State Reports*, p. 11.



healthcare services for at least two years.¹⁷⁶ Reimbursements from the federal uncompensated care pool should be defined as uncompensated care provided to any individual from a designated disaster area.¹⁷⁷ Further, the Commission recommended that services provided by all healthcare providers which are not covered in a Medicaid beneficiary’s home state should qualify for uncompensated care reimbursement.¹⁷⁸ Finally, the Mississippi report noted that many hurricane victims and evacuees are likely to fall into the uncompensated care pool after their eligibility period ends, especially if they do not meet the criteria for eligibility under a regular Medicaid program.¹⁷⁹

- *The availability of federal funds is imperative.*

The funding provided through the DRA was critical to the Section Section 1115 disaster waiver program after Katrina. The availability of federal funds in future events will be imperative to cover costs if a home state cannot pay its state share for evacuees seen in other states or if a host state ultimately has to pay because of uncompensated care. Without adequate uncompensated care pools, there is the potential that healthcare providers may have to cover the uncompensated portion, that costs are shifted to other payers, and ultimately, that healthcare provider reimbursement rates will decrease in the states most adversely affected by the disaster.

D. Unresolved Issues and Action Recommendations

With the addition of Section 1135 to the SSA and new use of Section 1115 demonstration programs as an emergency response mechanism, it is clear that Congress and HHS have recognized the need for some regulatory relief and special reimbursement during disasters. However, the actual implementation of these efforts have left many gaps. Healthcare providers who are impacted by a disaster, including those treating evacuees, must know the scope of the waivers and when those waivers have been issued. Healthcare providers must also understand that waivers and modifications will arise from a variety of federal and state sources that impact areas beyond sections 1115 and 1135 (e.g., pharmaceutical prescription and dispensing rules).

As seen with the Section Section 1115 disaster waiver program, federal and state benefits may differ. State programs may make refinements or add on benefits as permitted by federal law or guidance. Healthcare providers must be aware of the allowable services and costs when operating under a disaster Medicaid waiver program. And, as noted by the state of Mississippi in a report regarding the aftermath of Katrina, federal authorities should recognize that “the impact

¹⁷⁶ Governor’s Commission on Recovery, Rebuilding & Renewal, *After Katrina: Building Back Better than Ever*. (December 31, 2005) (hereinafter “*Mississippi Governor’s Commission Report*”), p. 134, available at <http://www.Governorbarbour.com/recovery/links/documents/FinalReport.pdf> (last accessed April 14, 2009).

¹⁷⁷ *Mississippi Governor’s Commission Report*, p. 134.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*



of a disaster on healthcare providers will last for many months and should provide [sic] coverage for affected individuals for a period of at least 24 months.”¹⁸⁰ Most importantly, healthcare providers must understand that these federal efforts are not simply going to remove regulatory compliance obligations or provide significant amounts of cash.

Further discussion is needed with CMS and the Virginia Department of Health and DMAS officials about providing advance direction for the compliance and payment requirements that will be waived, modified, and/or delayed during a declared disaster.

IV. CLAIMS SUBMISSION

A. Overview

Medicare, Medicaid, and private payers have specific eligibility and claims healthcare submission requirements that must be met for claims to be processed and paid. Generally, for healthcare providers to receive payment for services rendered, the beneficiary must be eligible to receive the services rendered, providers must be eligible for payment for those services, the services must be covered by the payer from whom payment is sought, and healthcare providers must submit certain information regarding the services rendered. (See Appendix B for a detailed discussion of the basics of Medicare and Medicaid claims submission.)

Healthcare providers must be familiar with the various claims submission methods to ensure continued payment during a disaster. Failure to follow payers’ claims submission procedures inevitably results in delayed payment, or no payment at all. The consequences of not receiving payment for services rendered could be far-reaching and dire for hospitals, their employees, patients, and vendors. This section discusses the importance of continued claims submission during a disaster.

B. Claims Submission during a Disaster

The operational circumstances resulting from disaster—the likelihood of diminished staff, possible disruption of utilities, possible damage to key facilities, and increased claims volume—will make it difficult for healthcare providers to meet many of the Medicare requirements, including conditions of participation, certification, and proper claims submission procedures. For example, during a pandemic, absenteeism in healthcare facilities is expected to exceed 40%; therefore, healthcare providers will need to use their available staff in the most effective and efficient manner. This may result in other health professionals or staff providing certain services that CMS specifically requires physicians to provide. Since Medicare will not pay for services unless those services are administered by “qualified” providers, healthcare

¹⁸⁰ *Id.*



providers should consider working with CMS to create exceptions to these rules during a disaster.

Healthcare providers are already familiar with the Medicare conditions of participation, and they should keep these conditions in mind when preparing for continuity of operations during a disaster. During a disaster, the conditions of participation may be difficult for healthcare providers to meet depending on the volume and acuity of the patients.¹⁸¹ Volunteers, out-of-state personnel, altered standards of care, including personnel-to-patient ratios and the number of patients per room, may impact a hospital's ability to comply with conditions of participation, and thus impact the hospital's eligibility for payment from Medicare. Hospitals should consider working at the federal and state level to create minimum data sets that can be used during a disaster.¹⁸²

Additionally, private-pay individuals may not have a payment method available upon presentation for care during a disaster. Depending on the nature of the disaster and the nature of the patient's injury or condition, healthcare providers may not be able to collect co-payments. To the extent possible, healthcare providers should use their best efforts to collect co-payments in a timely manner, ideally at the time care is provided, and they should also should collect sufficient information to bill for these services.

Private payers have their own sets of claims submission rules and deadlines. Private payers may require healthcare providers to submit "clean claims,"¹⁸³ submit claims electronically, or submit claims on a specific form.¹⁸⁴ Strict adherence to third-party payers' claims processes will be complicated during a disaster when a healthcare provider's billing staff is limited and claims volume is higher than normal. A variety of other circumstances that hospitals may or may not be able to control can be expected as well.

During a natural disaster, such as a hurricane, electronic claims submission may be unavailable because of power outages or interruptions in internet service. Similarly, a cyber attack could impair a healthcare provider's ability to maintain records, submit electronic claims, and process checks to pay employees and vendors. Healthcare providers should evaluate a paper-based system to use during such events to ensure continued operations.

¹⁸¹ 42 C.F.R. § 482.11.

¹⁸² See The California Department of Public Health, *California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies: Volume III: Payers* (hereinafter "California Guidelines") (2008) available at http://bepreparedcalifornia.ca.gov/NR/rdonlyres/57E4038B-EDC7-4C46-81AE-646F987FC312/0/volume3_Payers_FINAL.pdf (last accessed April 25, 2009).

¹⁸³ A "clean claim" is defined in the U.S. Code of Federal Regulations as a claim "that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity." 42 C.F.R. § 447.45(b).

¹⁸⁴ Code of Virginia § 38.2-3407.15.



C. Waivers Applicable to Claims Submission Rules and Regulations

Federal and state laws, as well as actions by CMS and HHS during past disasters, offer some expectation that waivers of regulatory requirements related to claims and coverage issues will be available during future disasters. This subsection reviews some of the federal and state mechanisms that healthcare providers can use to waive claim submission requirements. A review of waivers granted in past disasters provides examples of possible future waivers, although it is difficult to predict entirely whether, and to what extent, such relief will be available. Healthcare providers should not rely on past experience, but instead should check with HHS, CMS, state agencies, and private insurers regarding their policies for each disaster event as it occurs. (For an in-depth discussion of the various federal healthcare waivers during a declared disaster, see Section IV of this document.)

1. Federal Authority

a. CMS Payment and Operations Policies during a Pandemic

In November 2008, CMS issued a series of guidance documents addressing the agency's anticipated payment policies during an influenza pandemic (collectively, "*Influenza Pandemic Emergency Policies*.").¹⁸⁵ While the guidance documents are specifically labeled for pandemic influenza, language within the documents notes that their scope applies to "a pandemic or other emergenc[ies]."¹⁸⁶ The guidance documents are intended for Financial Intermediaries and Medicare Administrative Contractors (collectively "contractors") to prepare them to implement CMS's pandemic policies.

Contractors must be prepared to implement the CMS pandemic policies within a short time of the policies' release, although they will not be operationally implemented until

¹⁸⁵ The CMS pandemic influenza guidance documents are: (1) *Influenza Pandemic Emergency – The Medicare Program Prepares*, MLN Matters Number SE0836 Revised (December 8, 2008), available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0836.pdf> (last accessed April 14, 2009); (2) CMS Manual System Change Request 6164 (Transmittal 402), *Influenza Pandemic Emergency – Policies Concerning the Medicare Prescription Drug Program (Part D) and Medicare Advantage (Part C)* (November 19, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R402OTN.pdf> (last accessed April 14, 2009); (3) CMS Manual System Change Request 6174 (Transmittal 403), *Influenza Pandemic Emergency – Instructions Concerning Financial Management Policies* (November 19, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R403OTN.pdf> (last accessed April 14, 2009); (4) CMS Manual System Change Request 6146 (Transmittal 404), *Influenza Pandemic Emergency – Medicare Fee-For-Service Payment Policies and Billing Instructions* (November 19, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R404OTN.pdf> (last accessed April 14, 2009); and (5) CMS Manual System Change Request 6209 (Transmittal 411), *Influenza Pandemic Emergency – Additional Instructions Concerning Financial Management Policies* (December 5, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R411OTN.pdf> (last accessed April 14, 2009).

¹⁸⁶ CMS *Influenza Pandemic Emergency – The Medicare Program Prepares*, MLN Matters Number SE0836 Revised (December 8, 2008).



contractors receive notice of disaster from CMS and instructions to implement the disaster policies.¹⁸⁷ Upon receiving such notice, contractors must implement the policies within two (2) business days of receiving the notice.¹⁸⁸ CMS' will make a decision to implement its pandemic influenza policies if all of the following three conditions are met:

1. The President declares a disaster under the National Emergencies Act¹⁸⁹ or the Stafford Act; and
2. The Secretary of the HHS declares that a public health emergency exists under section 319 of the Public Health Service Act; and
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act pursuant to Section 1135 of that Act.

Contractors must be prepared to cease implementation of the pandemic policies within two business days of receiving from CMS notice to terminate.¹⁹⁰

CMS will notify contractors when to begin communicating with healthcare providers about the emergency pandemic influenza policies. The currently released guidance documents are not clear as to whether communications with healthcare providers would commence in advance of a notice from CMS to contractors to implement the emergency policies. However, CMS' guidance documents Outline, in question and answer format, the emergency pandemic influenza policies in the following areas:¹⁹¹

- Medicare prescription drug program (Part D)
- Medicare Advantage (Part C)
- Financial management
- Program integrity
- General payment policies
- General billing procedures
- Drugs and vaccines under Part B
- Laboratory and other diagnostic services

¹⁸⁷ The same preparedness and operational implementation requirements are listed in CMS Manual System Change Request Numbers 6164, 6174, 6146, and 6209.

¹⁸⁸ The same two-day operational implementation requirement is contained in CMS Manual System Change Request Numbers 6164, 6174, 6146, and 6209.

¹⁸⁹ 50 U.S.C. §§ 1601-1651.

¹⁹⁰ The same two-day termination requirement is contained in CMS Manual System Change Request Numbers 6164, 6174, 6146, and 6209.

¹⁹¹ Policies in these topics areas are specified in CMS Manual System Change Request Numbers 6164, 6174, 6146, and 6209.



- Ambulance services
- Durable medical equipment, prosthetics, orthotics, and supplies
- Mental health counseling
- Hospital services – general
- Hospital services – acute care
- Hospital services – EMTALA
- Hospital services – critical access hospitals (CAH)
- Skilled nursing facility (SNF) services
- Home health services
- Medicare FFS administration

The guidance documents cover a number of issues important to healthcare providers, but the list of question-and-answers is by no means comprehensive. Further, all of the guidance documents note that CMS may change these policies over time, and the agency ultimately may decide not to implement some or all of the policies during a pandemic.¹⁹² Providers should check with their Medicare contractor and review the CMS pandemic influenza web page for updates to the policies.¹⁹³

b. Claims Certification

During a disaster, it may be difficult to comply with the paperwork and time limits set for physician certification and recertification of medical necessity. The Act (SSA) has an exception to the requirement for written request and certification when the Secretary of HHS finds it impracticable to request and certify payment.¹⁹⁴ Delayed certification and recertification materials must contain a written explanation for the delay.¹⁹⁵ Hospitals and other healthcare providers should supplement their Continuity of Operations Plan to provide for this documentation

c. Electronic Claims Submission

Payer requirements for electronic claims submission may be difficult for healthcare providers to meet during a pandemic where knowledgeable billing staff are unable to work because they are sick or caring for sick family members. The Secretary of HHS can waive Medicare requirements for electronic claims submission as he finds appropriate.¹⁹⁶

¹⁹² This qualification is contained in each CMS Manual System Change Request Numbers 6164, 6174, 6146, and 6209.

¹⁹³ The CMS pandemic influenza web page is at http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp (last accessed April 14, 2009).

¹⁹⁴ 42 U.S.C. § 1395n.

¹⁹⁵ *Id.*

¹⁹⁶ 42 U.S.C. § 1395y(h)(1)(B).



The Secretary of HHS has delegated to CMS the authority granted in the *Administrative Simplification Compliance Act* to issue waivers of electronic billing requirements, thereby allowing healthcare providers to substitute paper claims under certain circumstances.¹⁹⁷ The waiver applies in the following situations:

1. Situations where a provider can demonstrate that the applicable adopted HIPAA claim standard does not permit submission of a particular type of claim electronically;
2. Disability of all members of a healthcare provider's staff prevents use of a computer for electronic submission of claims; or
3. Other rare situations that cannot be anticipated by CMS where a healthcare provider can establish that because of conditions outside of its control, it would be against equity and good conscience for CMS to enforce the requirement.

Healthcare providers must send a written request to their Medicare contractor to obtain this waiver.¹⁹⁸ Providers should supplement their continuity of operations plan to provide a mechanism for getting this documentation in place when needed.

d. Claims Coding

After Hurricane Katrina, CMS created new conditions and modifier codes for healthcare providers to use during a disaster for disaster-related claims. The condition code "DR" identifies claims "that are or may be impacted by specific payer policies related to a national or regional disaster."¹⁹⁹ The modifier code "CR" indicates "a specific Part B service that may be impacted by policy related to the disaster."²⁰⁰ For physicians billing their local carriers, the CR modifier should be used.²⁰¹ For hospital billing, either code may be used.²⁰² Healthcare providers should become familiar with these codes and their applicability now, and staff should be educated about how to use the codes during a disaster to ensure the healthcare provider's reimbursement for services rendered.²⁰³

¹⁹⁷ CMS, *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 24 "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," Section 90.3) available at <http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf> (last accessed April 25, 2009).

¹⁹⁸ This waiver application is available through the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp (last accessed April 14, 2009).

¹⁹⁹ CMS Pub 100-20 Transmittal 181 (September 23, 2005), available at <http://www.nubc.org/R1810TN.pdf>, (last accessed April 14, 2009). See California Guidelines, p. 42.

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.* See also CMS. ICD-9-CM Official Guidelines for Coding and Reporting (April 1, 2005).



CMS also created a set of “External Codes” (“E codes”) that coding professionals can use to code healthcare services and identify the cause of injury to the patient during disaster. “E codes” are appropriate for use in the following situations:²⁰⁴

- Accidents due to natural and environmental factors;
- Poisoning and adverse effects of drugs, medicinal substances, and biologicals;
- Transport accidents;
- Accidental falls;
- Accidents caused by fire and flames;
- Late effects of accidents, assaults, or self injury;
- Assaults or purposely inflicted injury; or
- Suicide or self inflicted injury.²⁰⁵

The codes should not be used for “encounters to treat the medical conditions of the individuals affected by an emergency when no injury, adverse effect or poisoning is involved.”²⁰⁶ Multiple E codes may be used to explain the cause of the injury. It is not clear whether the new modifier, the condition code, or the E codes would apply to a pandemic; further clarification from CMS is needed on this point. Healthcare providers and coding professionals should understand when and how to use these disaster-related codes to ensure timely and proper reimbursement.

²⁰⁴ CMS, *ICD-9-CM Official Guidelines for Coding and Reporting* (April 1, 2005) available at <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf> (last accessed April 25, 2009). See also American Hospital Association et al., *ICD-9-CM Coding Advice for Healthcare Encounters in the Hurricane Aftermath* (undated) available at www.ahacentraloffice.com/ahacentraloffice/images/Katrina_coding%20advice.pdf (last accessed April 14, 2009).

²⁰⁵ ICD-9-CM Official Guidelines, p. 58.

²⁰⁶ See California Guidelines, p. 42.



2. Virginia Authority

Virginia Medicaid does not have specific provisions that address the waiver or suspension of claims submission laws and regulations during a disaster. In Virginia's *Emergency Services and Disaster Law*, however, there are provisions that allow the Governor to act to protect the safety of the citizens of the commonwealth during a disaster.²⁰⁷ The Governor is designated as the Director of Emergency Management for the Commonwealth. In that role, the Governor is charged with taking such actions as necessary to promote and coordinate state and local emergency services activities that relate to the safety and welfare of the state during natural or man-made disasters.²⁰⁸ The Governor's disaster powers and duties include:

- To proclaim and publish such rules and regulations, and to issue such orders as may, in his judgment, be necessary to accomplish the purposes of this chapter including, but not limited to, such measures as are in his judgment required to control, restrict, allocate or regulate the use, sale, production and distribution of food, fuel, clothing and other commodities, materials, goods, services, and resources under any state or federal emergency services programs;
- To adopt and implement the Commonwealth of Virginia Emergency Operations Plan, which provides for state-level emergency operations in response to any type of disaster affecting Virginia and that provides the needed framework within which more detailed emergency plans and procedures can be developed and maintained by state agencies, local governments and other organization; and²⁰⁹
- To issue executive orders declaring a state of emergency addressing exceptional circumstances that exist relating to an order of quarantine or an order of isolation issued by the state health commissioner for a communicable disease of public health threat.²¹⁰

Through the broad powers granted by Virginia's emergency laws, the Governor may suspend various state regulations, including those related to claims submission, to allow hospitals and other healthcare providers to continue to submit claims and receive payments during a disaster.

²⁰⁷ Code of Virginia § 44-146.17.

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ *Id.* The State Health Commissioner is authorized to issue quarantine orders for affected areas of the state pursuant to Code of Virginia § 32.1-48.05, *et seq.*



3. Claims Submission during Recent Disasters

During Hurricane Katrina, CMS relaxed certain standards and regulations to ensure that evacuees had continued access to healthcare.²¹¹ For example, documentation requirements were waived and CMS established a “presumption of eligibility” for Katrina evacuees.²¹² Pre-authorization requirements were relaxed or waived, and HHS permitted Medicare Advantage enrollees to obtain out of network health services in a disaster. CMS deemed it acceptable for plans to implement a liberal service authorization policy.²¹³

Additionally, CMS paid healthcare providers who furnished services in good faith, but were unable to comply with the “normal program requirements because of Hurricane Katrina.”²¹⁴ These healthcare providers were exempt from sanctions for noncompliance barring abuse or fraud.²¹⁵ EMTALA sanctions were waived for transferring patients to other facilities, and the licensing requirements for physicians, nurses, and other healthcare professionals from other states who provided services in the affected states were waived as long as the healthcare provider was licensed in his or her home state.²¹⁶

Private payers also relaxed certain policies and standards during Katrina to ensure continued coverage for their beneficiaries. Private plans suspended their authorization and pre-certification and referral requirements for hospital admissions and some even “deemed all physicians caring for affected members as in-network providers regardless of their actual status.”²¹⁷

D. Unresolved Issues and Action Recommendations

Healthcare providers should plan now for ways to streamline the Medicare, Medicaid and private payer claims submission processes and to ensure they are prepared to respond to a “claims surge” resulting from a healthcare surge during and after a disaster. While healthcare providers cannot control many of the consequences a disaster may have on continuity of operations and the claims process, they should focus on those things over which they have some

²¹¹ See John O. Agwunobi, MD, MBA, MPH, Assistant Secretary for Health, Dept. of Health and Human Services, *Testimony on Hospital Disaster Preparedness: Past, Present, and Future before the Subcommittee on Oversight and Investigations Committee on Energy and Commerce, United States House of Representatives* (January 26, 2006), available at <http://www.hhs.gov/asl/testify/t060126.html> (last accessed April 14, 2009). See also Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, *N.C. Law Review*, Vol. 85, p. 262 (2006).

²¹² Texas Medical Association, “Hurricane Katrina Government Payer Information,” September 9, 2005 Update available at <http://www.texmed.org/Template.aspx?id=4314> (last accessed April 25, 2009).

²¹³ California Guidelines, p. 26.

²¹⁴ Texas Medical Association, “Hurricane Katrina Government Payer Information,” October 12, 2005 Update available at <http://www.texmed.org/Template.aspx?id=4314> (last accessed April 25, 2009).

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ Weeks, *supra* note 2, p. 263.



control. Additionally, healthcare providers should consider approaching federal and state agencies to develop abbreviated claims submission processes for disaster situations.

- *Review options and create a plan for handling claims in disasters*

The California Department of Health created instructive guidelines for use in planning for healthcare surge during disasters. These guidelines identify the following areas healthcare providers should consider in planning for continued and effective claims submission and payment during a disaster:

- Data elements for charge capture and billing;
- Claims policies – timely filing and periodic billing;
- Determination of medical necessity;
- Health plan’s utilization management and discharge planning protocols;
- Authorization procedures;
- Health plan’s medical policies;
- Eligibility verifications;
- Benefits determinations;
- Collection of co-payments;
- For cause termination provisions; and
- Amendments to contract language that relieve parties from certain obligations not critical to patient care during a healthcare surge, including claims submission and billing requirements.²¹⁸

The California guidelines have specific recommendations for streamlining the billing process by using minimum required data elements for billing that are derived from the Uniform Billing Form 04 and CMS 1500 forms.²¹⁹ These recommendations provide a good starting point for a healthcare provider’s plan for maintaining economic viability during a disaster.

²¹⁸ California Guidelines, pp. 12-16. The California Guidelines also recommend creating a minimum data list for charge capture that enable facilities to bill for services, receive payment, and maintain cash flow and continuity during a surge. *Id.* at 39. Specifically, the Guidelines suggest the following minimum data list for charge capture from the Guidelines: patient name; medical record number; date of service; capture units/dose/quantity; department services provided in; service description; disaster incident number; and work related injury. *Id.* at 39-40. The issue of whether an injury is “work-related” is complex and will be especially difficult to determine during a pandemic if an employee contracts pandemic influenza at work. This issue is beyond the scope of this paper but must not be ignored in planning to respond to emergencies.

²¹⁹ *Id.* at 40-41. See also Appendix A.



- *Review staffing and training needs for administrative and billing staff during disasters.*

Continuity of operation planners should determine the number of administrative and billing staff needed during a surge to ensure there are adequate numbers of staff qualified to process claims. Staff training on the use of national code modifiers should be done in advance, and periodically reinforced, to ensure that staff can proficiently use the codes during a disaster for a healthcare provider to achieve complete economic return for services.²²⁰

- *Review payment agreements addressing continuation of payments and claims submission processes.*

Healthcare providers should designate individuals to assess the various payment agreements with payers and determine whether there are provisions that address continuation of payments or modified claims submission processes to use during declared disasters. Where the agreements are silent on these issues, healthcare providers should work with payers, both private and public, to amend agreements and develop provisions that will help maintain continuity of operations during a disaster. Implementing these provisions now will help healthcare providers to maintain a steady revenue stream and continue operations during a disaster.

- *Create minimum data sets of essential claims elements for use in a disaster.*

Timely claims submission may become problematic for healthcare providers during a prolonged disaster, especially if staff absenteeism is high. Healthcare providers should review and evaluate the provisions of their contracts with private payers to determine whether the contracts contain provisions that allow for streamlined claims submission during disasters or a pandemic. If these contracts do not contain such provisions, healthcare providers should work with private payers to create a minimum data set of essential elements for claims submission and to streamline the claims process during a pandemic or other disaster. These provisions should be included in the payer contracts and should have clear terms regarding when the provisions are triggered and when they end.

Appendix D contains a glossary of Essential Healthcare Financing Terms that may be useful.²²¹

²²⁰ See CMS, ICD-9-CM Official Guidelines for Coding and Reporting, effective April 1, 2005, for detailed information regarding using national modifier codes during disasters. See also AAHIM, ICD-9-CM Coding Advice for Healthcare Encounters in the Hurricane Aftermath, available at <http://www.aahim.org/education.html> (last accessed April 14, 2009).

²²¹ Healthcare Financial Management Association, *Glossary of Essential Healthcare Financing Terms and Calculations*, available at http://www.hfma.org/NR/rdonlyres/CBE63921-66B9-4D7F-9D13-D6DD5D4301FF/0/Report_5_glossary.pdf (last accessed May 8, 2009).



V. PROMPT PAYMENT OF CLAIMS

A. Overview

Ensuring payment from third party payers during a disaster is key to continued operations and financial sustainability for a healthcare provider. Both federal and state laws and regulations govern the manner and timing in which payers must pay healthcare providers or beneficiaries for properly submitted claims. These laws and regulations are often referred to as the “prompt payment” rules. (See Appendix C for a detailed discussion of the basics of federal and state prompt payment laws.)

If payers fail to comply with prompt payment rules during a pandemic or disaster, the revenue streams of healthcare providers could be seriously diminished, creating a host of problems for healthcare providers, their vendors, employees, and, above all, patients. A healthcare provider’s ability to continue to provide services depends on whether or not it is being paid for the services that the healthcare provider has rendered. During a disaster, payers may find it difficult to comply with the prompt payment rules and regulations. Therefore, it is incumbent upon healthcare providers to plan now and to work with payers to ensure continued payment during disasters.

B. Prompt Payment Issues during Disaster

Failure to receive timely payments for services during a disaster may result in a healthcare provider’s inability to continue operations. This would significantly degrade the overall ability of the community to effectively respond to the disaster. If payers do not make timely payments, healthcare providers may not be able to pay employees, purchase supplies or maintain even basic operations.

Many healthcare providers receive electronic payments from payers. During a non-traditional disaster, such as a cyber-attack, or a more traditional disaster that results in a power outage, the electronic payment process may be inoperable or inaccessible for a prolonged period of time. Healthcare providers should discuss and pre-plan for alternative mechanisms to receive and make payments during a disaster.

Payers may experience a high rate of absenteeism related to staff illness or inability to travel to work for a variety of other reasons, such as a disaster. This may result in delayed processing of payments. CMS states in its guidance *“Influenza Pandemic Emergency Preparedness – Medicare Fee-For-Service Payment Policies and Billing Instructions”* that the Agency requires every enrolled Medicare healthcare provider to have a continuity of operations plan to “ensure that operations are not materially disrupted so that providers and beneficiaries continue to be served,” and CMS reviews and approves each of these continuity of operations



plans.²²² CMS also states that it has an Agency-wide continuity of operations plan that includes contingency plans should one of its contractors be unable to maintain operations, although the Agency does not elaborate on the plans, citing security concerns.²²³ However, it is very unclear the extent to which any of these plans have been operationalized. Healthcare providers should initiate discussions with payers to address these issues. Healthcare providers should also consider working with state and national associations to develop and propose legislation that will address prompt payment of claims during a disaster.

C. Unresolved Issues and Action Recommendations

- *Discuss prompt payment issues with CMS and other payers.*

There are no specific provisions in federal law that permit the Secretary of HHS to suspend the prompt payment requirements during a declared disaster. The Governor of Virginia has broad powers under Title 44 to suspend the state's prompt payment regulations. Delays in payment during a disaster could have a devastating effect on a healthcare provider's financial sustainability; therefore, healthcare providers should work with CMS and other payers to ensure that payments will continue to be promptly made during disasters.

- *Review payment agreements addressing prompt and continued payment in disasters.*

Healthcare providers should plan for delays in payments during a disaster and should assess whether payer agreements contain provisions addressing prompt payment and continuation of payment during a disaster. Depending on the language of those agreements, healthcare providers may want to negotiate, with their payers, continued and prompt payment provisions for disaster situations.

- *Review options and create a plan if payments cease or are delayed.*

The following options should be considered by healthcare providers in planning for financial sustainability during a disaster in the event payments from payers cease, or are delayed:

- Determine the amount of "cash-on-hand" the healthcare provider has and how long operations can be sustained on these existing resources;
- Identify additional sources of income and how they can be used to sustain operations during a disaster;

²²² CMS Manual System Change Request 6146 (Transmittal 404), *Influenza Pandemic Emergency – Medicare Fee-For-Service Payment Policies and Billing Instructions*, Attachment B, Item 51 (November 19, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R404OTN.pdf> (last accessed December 29, 2008).

²²³ *Id.*



- Calculate operating costs for 12 months to determine how much revenue is required to continue to operate and pay vendors and employees.²²⁴ This information is especially important for prolonged disasters like a pandemic.

In addition to the items listed above, healthcare providers should become familiar with the processes for receiving advanced and accelerated payments from CMS (discussed in Section VII), should evaluate their insurance policies to determine whether and to what extent they can rely on these policies for income and financial support (discussed in Section VIII), and should become familiar with other additional federal or state funding opportunities (discussed in Sections II and IV). The staff responsible for seeking these waivers should be well-versed on how to obtain them.

VI. ACCELERATED PAYMENT AND ADVANCE PAYMENT FROM MEDICARE

A. Overview

As discussed in Section IV, CMS has the ability to relax or waive certain billing and claims submission requirements to help healthcare providers impacted by a disaster. CMS can supplement the relaxation or waiver of requirements through the use of advanced or accelerated payments. CMS made such payments available to help impacted healthcare providers obtain prompt payment after such major disasters as September 11th, Hurricanes Katrina and Rita, the Southern California wildfires in November 2007, and the flooding in the Midwest in the summer of 2008. In the CMS *Influenza Pandemic Emergency Policies*, the Agency acknowledges that accelerated payments and advanced payments may be used as mechanisms to manage provider payments, so long as a healthcare provider is “still rendering some services or who are taking steps to be able to render services again.”²²⁵ CMS’s pandemic policies further seem to suggest that contractors will not have significant flexibility in easing the many procedures required to process and approve accelerated payments and advanced payments.²²⁶ CMS notes that while it is the Agency’s “intent to provide expeditious customer service on accelerated payments or advanced payments,” its primary concern is to determine whether a healthcare provider will

²²⁴ See *Finance Planning & Assessment Tool: A Healthcare Guide for Pandemic Flu Planning – Planning Today for a Pandemic Tomorrow*, New Jersey Hospital Association Preliminary Release (April 2008).

²²⁵ CMS Manual System Change Request 6174 (Transmittal 403), *Influenza Pandemic Emergency – Instructions Concerning Financial Management Policies*, Attachment B, Item 2 (November 19, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R403OTN.pdf> (last accessed April 14, 2009).

²²⁶ CMS Manual System Change Request 6209 (Transmittal 411), *Influenza Pandemic Emergency – Additional Instructions Concerning Financial Management Policies*, Attachment B, Items 1 and 4 (December 5, 2008), available at <http://www.cms.hhs.gov/transmittals/downloads/R411OTN.pdf> (last accessed April 14, 2009).



remain or will quickly regain viability to generate billings which will repay the accelerated payment or advanced payment.²²⁷

As part of their preparedness efforts, healthcare providers should understand the policies and regulations governing, the mechanisms for seeking and the ultimate impact of obtaining these types of payment. While related, accelerated payments and advanced payments differ. Therefore, they are discussed separately below.

B. Accelerated Payments

The Medicare accelerated payment provisions allow Part A healthcare providers to receive payment for services after the services have been provided but before the healthcare provider submits a claim to CMS.²²⁸ Generally, a healthcare provider who requests accelerated payment may receive such payment if “the provider has experienced financial difficulties due to a delay by the intermediary in making payments or in exceptional situations, in which the provider has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle.”²²⁹ Both CMS and the fiscal intermediary (FI) must approve the accelerated payment.²³⁰ The amount of the payment is a percentage of the net reimbursement for unbilled or unpaid covered services.²³¹ To the extent that the accelerated payment is an overpayment, the FI may recoup the excess as the healthcare provider’s bills are processed or by direct payment from the provider.²³²

There are three situations that may justify accelerated payment:

1. A delay in payment by the FI for covered services rendered to beneficiaries whereby the delay has caused financial difficulties for the healthcare provider;
2. Highly exceptional situations where a healthcare provider has incurred a temporary delay in its bill processing beyond the healthcare provider’s normal billing cycle; or

²²⁷ CMS Manual System Change Request 6209 (Transmittal 411), Attachment B, Item 1.

²²⁸ Healthcare providers who participate in Medicare Part A are eligible for accelerated payment under certain circumstances. To the extent that these Part A providers also render services covered by Part B, the provider may receive accelerated payment for the Part B services. See 42 C.F.R. § 413.64(g).

²²⁹ 42 C.F.R. § 413.64(g). See also Medicare Financial Management Manual, CMS Pub. 100-06, Ch. 3, § 150 Accelerated Payments (the “FI Manual”); the Provider Reimbursement Manual, CMS Pub. 15, Part 1, Ch. 24, § 2412 Accelerated Payments (the “Provider Manual”); the Financial Management Manual requirements pertain to the FI only. As its name implies, the Provider Reimbursement Manual contains requirements for providers.

²³⁰ *Id.* The FI Manual requires the FI and the “appropriate regional office” to approve payment while the Provider Manual states the FI and CMS must approve the payment. CMS should clarify this apparent inconsistency and the process for approving applications for accelerated payment.

²³¹ *Id.*

²³² *Id.*



3. Highly exceptional situations where CMS deems an accelerated payment is appropriate.²³³

Once one of the three “justifying” situations occurs, providers must meet all of the following five conditions to be eligible for accelerated payment:

1. A shortage of cash exists whereby the healthcare provider cannot meet the current financial obligations;
2. The impaired cash position described above is due to abnormal delays in claims processing and/or payment by the FI. However, requests for accelerated payments based on isolated temporary healthcare provider billing delays may also be approved where the delay is for a period of time beyond the healthcare provider’s normal billing cycle. In this instance, the healthcare provider must assure and demonstrate that the causes of its billing delays are being corrected and are not chronic;
3. The healthcare provider’s impaired cash position would not be alleviated by receipts anticipated within 30 days which would enable the healthcare provider to meet current financial obligations;
4. The basis for financial difficulty is due to a lag in Medicare billing and/or payments and not to other third-party payers or private patients; and
5. The FI is assured that recovery of the payment can be accomplished according to the instructions set forth in the manual.²³⁴

Using a CMS approved form,²³⁵ healthcare providers must submit the required information that will allow the FI to calculate the accelerated payment if the request is approved.²³⁶ To compile this required information, the healthcare provider will have to undertake some financial diligence and calculation. Healthcare providers are well advised to create policies and procedures now to govern the collection and evaluation of this information during a disaster. Doing so will make sure that they are not left trying to locate needed information in the midst of a disaster when time is of the essence and resources may be scarce.

²³³ Financial Manual § 150; Provider Manual § 2412.

²³⁴ Financial Manual § 150.1; Provider Manual § 2412.1.

²³⁵ Financial Manual § 150, Exhibit 1; Provider Manual §§ 2412 and 2412.2.

²³⁶ Provider Manual § 2412.2. The FI calculates accelerated payment according to the following formula: amount of interim reimbursement for unbilled and unpaid claims minus the deductibles and coinsurance amounts times 70%. Financial Manual § 150.2.



One condition noticeably absent from the accelerated payment regulation and manuals is how often a healthcare provider may request accelerated payment. These materials suggest that accelerated payments are reserved for unique circumstances and cannot be used routinely.²³⁷ Even so, there is no stated limit on the number of times a healthcare provider may request or receive accelerated payment or how consecutive payment requests are handled. If the request is based on delays at the healthcare provider, it is unclear if the healthcare provider must first submit clean claims information supporting the first accelerated payment made before it submits an application for the next accelerated payment. If it is the case that supporting clean claims must be submitted before CMS/FI will make subsequent advance payments to a healthcare provider, this would have significant impacts on that healthcare provider's ability to use the accelerated payment mechanism to maintain financial sustainability during a prolonged event such as a pandemic. Healthcare providers should seek clarification from CMS on how frequently they can use the accelerated payment process during a disaster and how consecutive accelerated payments will impact the recoupment requirements.

Once the FI approves the application and pays the healthcare provider, the FI must attempt to recover the accelerated payment within 90 days after payment is issued.²³⁸ The FI recoups 100% of accelerated payments based on a delay in the billing process by withholding the amount "against the provider's bills ... and other monies due after the date of issuance of the accelerated payment."²³⁹ Any additional amounts are recovered by direct payment within 90 days of the accelerated payment.²⁴⁰ Payments necessitated by "abnormal delays in claims processing" or payment by the FI are recouped based on a schedule "to coincide with the improvement in the FI's billing process."²⁴¹ Recoupment must be completed within 90 days of the FI processing the healthcare provider's claim. Recoupment under these circumstances should not impair the healthcare provider's cash position.²⁴²

Accelerated payments that are not completely recovered either 90 days after the payment is issued or 90 days after the FI begins processing claims are delinquent.²⁴³ The FI sends a demand letter for delinquent payments stating that "100 percent recoupment by withhold" is in effect until the debt is paid in full or other arrangements are made."²⁴⁴ The demand letter must also include the "intent to refer" language necessary to refer the debt to the Treasury Department.²⁴⁵ Interest accrues starting on the 31st day after the demand letter.²⁴⁶

²³⁷ 42 C.F.R. § 413.64(g); Provider Manual § 2412; Financial Manual § 150.

²³⁸ Financial Manual § 150.4; Provider Manual § 2412.4.

²³⁹ Financial Manual § 150.4.

²⁴⁰ *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.*

²⁴⁵ *Id.*



Because accelerated payments allow the FI to pay healthcare providers for claims not yet submitted, the recoupment process for accelerated payments, as evidenced by the discussion above, is much more stringent than the recoupment process for advance payment. Healthcare providers must understand the recoupment process *before* applying for accelerated payment. If for any reason, the healthcare provider does not think that recoupment is possible or if the recoupment will further impair the healthcare provider’s financial sustainability, it should not seek accelerated payment.

1. Application to Traditional and Non-Traditional Disasters

Part A healthcare providers may find accelerated payments attractive in extraordinary circumstances because they allow FIs to pay healthcare providers for services before the healthcare provider submits a claim. CMS and FIs are relatively experienced in handling accelerated payments during and after traditional disasters; however, they have little experience with handling the volume of expected accelerated payment requests during a large-scale, non-traditional disaster such as a pandemic. It is, therefore, important for healthcare providers to identify the potential trouble areas in the accelerated payment system and work with CMS to address these issues now.

Any one of the three justifying events for accelerated payment may be present during a non-traditional disaster, such as a pandemic. For example, a delay in payment by the FI for covered services is expected to occur during a pandemic because of foreseeable staffing shortages. During a pandemic, all businesses, including the FI, should expect an absenteeism rate of 30-40%. With such high levels of absenteeism, the FI’s ability to timely process claims will be impaired. Likewise, a temporary delay in the provider’s bill processing is expected to occur during a pandemic for multiple reasons, including high absenteeism, documentation issues or Internet connectivity problems. Finally, CMS may deem accelerated payments appropriate during a pandemic in light of the significant problems that a pandemic will present for FIs and healthcare providers alike.

While at least one of these three situations justifying accelerated payment will likely exist during a large-scale prolonged disaster, healthcare providers may have difficulty meeting all of the five eligibility criteria.²⁴⁷ In particular, two of the eligibility criteria potentially present the largest obstacles in a pandemic.

²⁴⁶ *Id.* For additional details on recoupment, see the Medicare Financial Manual § 150.4 and the Provider Manual § 2412.4.

²⁴⁷ The eligibility criteria include: (i) a cash shortage caused by abnormal delays in claims processing and/or payment by the FI or isolated temporary provider billing delays, if the provider demonstrates that the causes of its billing delays are being corrected and are not chronic; (ii) the cash shortage will not be alleviated by receipts expected within 30 days; (iii) the basis for financial difficulty is due to a lag in Medicare billing and/or payments



The first eligibility criterion requires a cash shortage caused by “abnormal delays” in claims processing or payment by the FI or “isolated temporary provider billing delays,” if the healthcare provider demonstrates that the cause of its billing delays are being corrected and are not chronic. During a disaster, delays in FI claims processing and in provider billing are likely to occur, and over a prolonged disaster, such as a pandemic, delays may become normal or “chronic” situations. Staffing shortages in the billing and claims department at the FI and at the healthcare provider may be prolonged. FI billing and payment delays during such disasters may become “normal”, and provider billing delays may, despite best efforts, become “chronic,” thus making this criterion difficult to meet. Healthcare providers should work with CMS to determine how this eligibility criterion will be interpreted during a pandemic or other prolonged disaster.

The third eligibility criterion requires that the basis for financial difficulty is because of a lag in Medicare billing or payments and not to other third party payers or private patients. During a pandemic, to the extent that the healthcare provider is experiencing billing or payment delays, it will probably experience these delays with all payers—not just Medicare. Healthcare providers should discuss with CMS its willingness to relax this condition during a pandemic.

2. Unresolved Issues and Action Recommendations

Healthcare providers must recognize that accelerated payment will not ensure financial sustainability during a disaster, especially if the event is a pandemic. Accelerated payments are just one approach in a multifaceted continuity of operations strategy. Healthcare providers should seek clarification from CMS on the following issues related to accelerated payments during an disaster:

- *Determine if CMS will adjust what it considered to be “abnormal” delays at the FI to reflect the impact of the disaster on the timing of payments or if the norm will continue to be the same as prior to the disaster.*
- *Determine if CMS will consider a staffing shortage during a pandemic that causes prolonged delays in provider billing to be “chronic.” Identify the instructions CMS will give the FI in evaluating the healthcare provider’s ability to “correct” the cause of the delay.*
- *Determine if CMS will relax the requirement that the financial difficulty giving rise to the request for accelerated payment must be based on a lag in Medicare billing and/or payments and not to other third-party payers.*

and not to other third-party payers or private patients; and (iv) the provider assures the FI it can recover the payment according to the instructions set for in the manual. Financial Manual § 150.1; Provider Manual § 2412.1.



- *Determine how often healthcare providers may use the accelerated payment process during a prolonged disaster. Identify how consecutive accelerated payments impact the recoupment requirements.*

C. Advance Payment

1. Overview

An advance payment is an advance of the monies owed to the Part B healthcare provider by Medicare. Advance payment is defined as “a conditional payment made by the carrier in response to a claim that it is unable to process within established time limits.”²⁴⁸ The failure of the carrier—an insurer contracted to process Part B claims on behalf of CMS—to process a claim triggers a healthcare provider’s ability to seek advance payment.²⁴⁹

Healthcare providers who receive payment under Medicare Part B are entitled to “advance payment” under certain conditions.²⁵⁰ The carrier must notify a healthcare provider if payment will be late and offer the option of advance payment.²⁵¹ The healthcare provider must then request advance payment in writing to the carrier.²⁵² CMS may waive this requirement if it determines the “circumstances warrant the issuance of advance payments to all affected [healthcare providers].”²⁵³

Carriers cannot make advance payments more frequently than every 2 weeks,²⁵⁴ and they cannot make advance payments on more claims than were submitted on a daily basis for the 90-day period prior to the event giving rise to the need for advance payment.²⁵⁵

A carrier may make advance payment only when the following three conditions are all met:

1. The carrier is unable to process the claim timely;
2. CMS determines that the prompt payment interest provision is insufficient to make a claimant whole; and

²⁴⁸ 42 C.F.R. § 421.214.

²⁴⁹ See Section VI for a discussion of the Prompt Payment Act.

²⁵⁰ Advance payment is akin to accelerated payment for Part A providers. Importantly, healthcare providers who participate in Part A and Part B are only eligible for accelerated payment. They are not eligible for advance payment. See Section VII B for information on accelerated payment.

²⁵¹ 42 C.F.R. § 421.214(f)(1). The regulation uses the term “supplier” to refer to a Part B provider. In this paper, we will refer to the “supplier” as a healthcare provider.

²⁵² 42 C.F.R. § 421.214(e)(1).

²⁵³ 42 C.F.R. § 421.214(g)(1).

²⁵⁴ 42 C.F.R. § 421.214(f)(1)(v).

²⁵⁵ 42 C.F.R. § 421.214(f)(2).



3. CMS approves the advance payment in writing.²⁵⁶

Healthcare providers who are delinquent in repaying a Medicare over-payment, under active medical review or program integrity investigation, have not submitted any claims, or have not accepted assignments within the most recent 180-day period preceding the request for advance payment are ineligible for advance payment.²⁵⁷ Because a review or investigation could lead to administrative, civil or criminal penalties, CMS states that “[t]o authorize an advance payment without final resolution of the medical review or program integrity investigation is not in the best interest of the Medicare trust fund.”²⁵⁸ Additionally, if a healthcare provider does not accept assignment, it does not receive monies from Medicare, and there is no basis for an advance payment.²⁵⁹ The same is true for a healthcare provider who has not submitted claims.²⁶⁰

The carrier “must calculate an advance payment for a particular claim at no more than 80 percent of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid the [healthcare provider].”²⁶¹ Recognizing that this calculation may be difficult if historical data are not available or the carrier cannot identify backlogged claims, the carrier can use another CMS approved methodology to calculate advance payment.²⁶²

Like accelerated payments, CMS recoups any overpayment through all available mechanisms, including applying the balance against future Medicare payments due to the healthcare provider.²⁶³ To the extent that the advance payment is an underpayment, the healthcare provider is entitled to interest on the difference between the full amount owed on the claim and the amount advanced.²⁶⁴

2. Application to Traditional and Non-Traditional Disasters

CMS and carriers are relatively experienced in handling advance payments caused by traditional events like natural disasters. By contrast, they are relatively inexperienced in handling such payments caused by non-traditional, wide scale disasters, like a pandemic, for the simple reason that they have not yet faced this situation. In preparing for a disaster, especially a pandemic, it is important for a healthcare provider to identify the potential trouble areas in the advance payment mechanism and work with CMS to address these issues now.

²⁵⁶ 42 C.F.R. § 421.214(c).

²⁵⁷ 42 C.F.R. § 421.214(d).

²⁵⁸ 61 F.R. 49271, 49274 (Sept. 19, 1996).

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ 42 C.F.R. § 421.214(f)(1)(i).

²⁶² 42 C.F.R. § 421.214(f)(3)(iv).

²⁶³ 42 C.F.R. §§ 421.214(f)(v)(3), 421.214(g)(2).

²⁶⁴ 42 C.F.R. § 421.214(h).



Healthcare providers must remember it is the *carrier's* inability to process claims in a timely manner that triggers eligibility for advance payment. This is important for two reasons. First, CMS measures “timely” claims processing against the prompt payment laws, discussed in Section V. During a disaster, including a pandemic, the Secretary of HHS may suspend prompt payment requirements. It is therefore difficult for a healthcare provider to predict how CMS will interpret “timely” processing requirements. Second, the healthcare provider’s inability to submit claims due to a disaster or the healthcare provider’s need for payment are not determining factors in the CMS’s determination to make advance payment. Accordingly, the advance payment regulation does not relieve the healthcare provider of the requirement to file clean claims. In fact, a clean claim and the carrier’s inability to process that claim is the basis for any advance payment. If a healthcare provider does not submit a clean claim, it does not meet one of the eligibility criteria for advance payment.

Once the threshold criteria have been met—that the carrier cannot process clean claims within the applicable time limit—the healthcare provider must request advance payment in writing, unless CMS waives this requirement. As part of the planning for continuity of operations, healthcare providers should create a template written request for advance payment to efficiently process the requests.

Healthcare providers, however, should also work to obtain a waiver of the writing requirement during disasters. CMS may be unwilling to issue such waivers because of the sheer volume of advance payment requests that could arise out of a disaster, especially during a pandemic when many healthcare providers throughout the country will be affected. Because some disasters, such as pandemics, will impact carriers throughout the country, it may not be fiscally or operationally possible to make advance payment to all healthcare providers who apply. These are very important issues that require further discussion with CMS.

If CMS waives the written request requirement to avoid being inundated by the volume of such requests during a wide-spread disaster, arguably the Agency should simplify or waive the requirement that advance payment requests must be approved in writing by CMS. Should CMS not waive this requirement and continue to require that the carrier obtain written approval from CMS for each advance payment request, CMS and the carrier could be quickly overwhelmed during a disaster. The potential backlog for approval could defeat the intent of the advance payment system. Healthcare providers should work with CMS and carriers to identify approval criteria that have been pre-cleared by CMS, which criteria carriers can use to process claims efficiently for advance payment.

Given the sheer volume of advance payment requests expected during a pandemic or other such disaster, it is unreasonable to think that the carrier will be able to calculate advance payments for each healthcare provider based on that healthcare provider’s historic claims data. Instead, healthcare providers should explore options with CMS to simplify the advance payment



process by developing a methodology that all carriers can use to calculate all approved advance payments during a disaster.

3. Unresolved Issues and Action Recommendations

Healthcare providers must understand that advance payment will not ensure financial sustainability during a disaster. At most, the healthcare provider will receive 80% for claims filed. As a result, advance payment is just one approach in a multifaceted continuity of operations strategy. Healthcare providers should seek clarification from CMS on the following issues related to advance payments during a disaster:

- *Determine how CMS will interpret and measure “timely” claims processing during a disaster, including a pandemic.*
- *Determine if CMS will issue a waiver for the written request for advance payment during a disaster.*
- *Determine if CMS will waive the requirement for written approval for advance payment during a disaster.*
- *If CMS does not plan to issue a waiver for either the request or the approval, determine how quickly the agency and the carriers can process and approve each request for advance payment during a disaster.*
- *Determine what methodology carriers will use to calculate approved advance payments during a disaster.*

VII. INSURING AGAINST ECONOMIC LOSSES DURING A DISASTER

A. Overview

Like all other businesses, healthcare providers purchase insurance to protect against a variety of losses. Property insurance is perhaps the most important and well-known type of insurance coverage in the context of traditional disaster preparedness. Property insurance generally reimburses for losses to “covered property” caused by a “covered peril.” While each policy has a unique definition of “covered property” and “covered peril,” many of the traditional disasters are “covered perils” either under the terms of the policy or an endorsement. Therefore,



healthcare providers must determine whether a non-traditional disaster like a pandemic is a “covered peril” under their policies.²⁶⁵

This paper encourages healthcare providers to think beyond conventional property insurance and to consider other types of insurance which may cover losses caused by a disaster and ensure financial sustainability during and after the disaster. When deciding what type of coverage healthcare providers need for these purposes, a healthcare provider should identify the risks against which it is insuring. Foreseeable risks to revenue during a disaster include

- closure by a governmental order;
- cancellation of services due to lack of staff or a government request to “free up” capacity;
- lack of reimbursement for services provided;
- loss of power, water or communication;
- disruption in the “e-commerce” system; and
- suppliers’ failure to deliver supplies on time.

During a pandemic, healthcare providers should also anticipate additional risks, such as viral contamination of the healthcare facility and government ordered isolation and quarantine.

Given this array of foreseeable risks, healthcare providers should explore the following types of coverage as part of their planning for continuity of operations and financial sustainability:

- Business interruption insurance;
- Civil authority coverage;
- Ingress/egress insurance;
- Contingent or dependent business interruption insurance; and
- Accounts receivable insurance.

Whether, and to what extent, these types of insurance policies will cover losses during a disaster, including a pandemic, is the subject of much debate. While actual coverage will depend on the

²⁶⁵ Because of the great variability among insurance policies and state laws governing them, an analysis of if, and to what extent, events during a pandemic will be covered is beyond the scope of this paper.



insurer, the language in the policy, and the court that is interpreting the language,²⁶⁶ there are certain trends that may be informative for healthcare providers. This section includes a general description of these insurance policies, their application in traditional and non-traditional disasters, and their limitations. Understanding these insurance options will inform counsel's review of existing policy language and negotiations with insurers to obtain a healthcare provider's desired level of coverage.

B. Business Interruption Insurance

1. Overview

Business interruption insurance “is designed to do for the business what the business would have done for itself had no loss occurred.”²⁶⁷ The Insurance Information Institute describes business interruption insurance as that which:

...compensates [a business owner] for lost income if [the] company has to vacate the premises due to disaster-related damage that is covered under [the] property insurance policy, such as fire. Business interruption insurance covers the profits [the business] would have earned, based on financial records, had the disaster not occurred. The policy also covers operating expenses, like electricity, that continue even though business activities have come to a temporary halt.²⁶⁸

The extent of coverage provided depends on the actual language in an insured's policy. Further, business interruption policies tend to vary more than general liability policies.²⁶⁹ It is, therefore, essential for counsel to scrutinize the business interruption insurance policy to determine if the policy covers the healthcare provider or facility for foreseeable losses.

²⁶⁶ “[T]here is a dearth of case law interpreting the key coverage provisions in these complex [business interruption] policies. This lack of controlling legal authority is partly due to the fact that business interruption claims fall under first-party policies, nearly all of which contain appraisal provisions. Therefore, unless the insurer responds with an outright denial of coverage, non-lawyers, such as independent adjusters and forensic accountants, will typically adjust a business interruption claim. If negotiations fail, an appraisal proceeding, rather than litigation, results.” Alexander Anglim, *Business Interruption Insurance Law After 9/11*, *ABA Coverage*, 13 Coverage 3 (Sept./Oct. 2003).

²⁶⁷ *A & S Corp. v. Centennial Ins. Co.*, 242 F. Supp. 584, 589 (N.D. Ill. 1965).

²⁶⁸ Insurance Information Institute, *Do I need business interruption insurance?*, available at <https://www.iii.org/individuals/business/basics/interruption> (last accessed April 15, 2009).

²⁶⁹ Alexander Anglim, *Business Interruption Insurance Law After 9/11*, *ABA Coverage*, 13 Coverage 3 (Sept./Oct. 2003).



Based on the template insurance forms, the factors that trigger business interruption coverage are:

1. A loss in business income;
2. during the period of restoration;
3. caused by a necessary suspension (including a slowdown) of the policyholder’s ‘operations’;
4. which in turn is caused by direct physical loss or damage to property (either at, or very near, the insured property);
5. which was the result of a covered peril.²⁷⁰

Each element is equally important in making a successful claim for coverage, and each element is equally controversial. Numerous articles addressing interpretation and application of each element are available; however, a thorough discussion of each element will not be reproduced here. This section will focus on the third and fourth elements as they may be most difficult to satisfy in a non-traditional disaster.

2. Application to Traditional and Non-Traditional Disasters

Much of the case law interpreting business interruption policies stems from claims made by insureds after the September 11th terrorist attacks. Insurers aggressively defended claims under business interruption policies “[d]espite expectations of good will in the aftermath of the disaster.” Because “[m]ost business interruption policies are narrowly worded and...there is little case law interpreting such policies ... insurers have not been afraid to deny claims in close cases by relying on narrow, literal interpretations of policy language.”²⁷¹ Healthcare providers should expect a similar response following future disasters —especially a pandemic—that will have global impact and huge financial implications. It is imperative for healthcare providers to examine their policies now, identify any wording that insurers could construe against the provider, and negotiate more favorable terms now to forestall insurers’ future attempts to deny claims after the next disaster.

a. Complete Cessation vs. Partial Cessation

As described above, under the template form, the loss of income must be “caused by a necessary suspension (including a slowdown) to the policyholder’s ‘operations.’” Coverage under a policy which uses the form language would cover both a complete cessation of business

²⁷⁰ Lon A. Berk & William A. Schreiner, Jr., *Business Income Coverage: Old Lessons Apply in New Context*, *ABA Coverage*, 15 Coverage 1 (Nov./Dec. 2005).

²⁷¹ Anglim, *supra* note 277 (unnumbered introduction).



and a slowdown. Coverage of a “slowdown” is not as clear under many other forms. In fact, historically, “business interruption coverage generally *requires a complete suspension of operations.*” (emphasis added).²⁷²

The requirement of a complete cessation of operations is at odds with the concepts of continuity of operations and mitigation of damages. If the policy has a mitigation clause, courts may be more likely to find that complete cessation is not required to trigger business interruption coverage.²⁷³ In *Maier v. Continental Casualty Company*:

...the policyholder suffered a fire at its furniture store but did not completely shut down. The policy at issue provided that the insurer would pay for a loss of business resulting from the ‘necessary suspension of your ‘operations’ during the ‘period of restoration.’ The policy also provided that the insurer would ‘reduce the amount of your Business Income Loss...to the extent you can resume your ‘operations,’ in whole or in part, by using damaged or undamaged property...at the described premises or elsewhere.’ The court rejected the insurer’s contention that a complete ‘cessation’ or shutdown of the entire business was required in order to trigger coverage. The court noted that the foregoing language suggested that the policy ‘clearly contemplates that a policyholder may be compensated for lost income, regardless of whether the business continued to operate at reduced level immediately following the covered loss.’²⁷⁴

Healthcare providers must determine whether their business interruption policy will cover only a complete cessation of business, or will also cover business slowdowns. Counsel should review business interruption insurance policies, and if necessary, obtain clarification from the insurer on this point. Healthcare providers should consider amending policies that require a complete cessation of operations, or that are unclear, to provide for coverage during both complete and partial shutdowns of the facility.

²⁷² Seth A. Ribner & Deborah L. Stein, *Curfews, Blockades and Physical Devastation: A Look at Business Interruption Coverage Post-Katrina*, ABA Coverage, 17 Coverage 39 (Sept./Oct. 2006).

²⁷³ H.B. Monesmith, ‘Business Interruption’ Insurance or ‘Complete Cessation’ Insurance: Are Some Insurers Attempting to Rewrite Their Policies When Claims Are Asserted?, ABA Coverage, 13 Coverage 22 (Sept./Oct. 2003).

²⁷⁴ 76 F.3d 535 (4th Cir. 1996) (internal citations omitted).



b. Physical Damage

One template for business interruption insurance discussed above requires that the interruption be “caused by direct physical loss or damage to property (either at, or very near, the insured property).”²⁷⁵ Historically, this was not a difficult standard to meet because traditional disasters like hurricanes, earthquakes, tornados, floods, and fires (assuming that these disasters are “covered perils” under the applicable policy) all cause physical damage. In the context of a non-traditional disaster like a public health emergency or cyber attack, however, this requirement may be difficult to meet, and the insurer may use this element to challenge claims.

Both a public health disaster and a cyber attack may not cause “direct physical damage” as that term is typically understood. These events, while damaging, will arguably not destroy the physical infrastructure of the healthcare provider's business. They may, however, damage the operational infrastructure of the healthcare provider's business in such a way that slows or stops business. A public health disaster may introduce a contagious virus into a facility and cause a need for partial closure to decontaminate the building. A cyber attack may damage a healthcare facility's electronic infrastructure and make continuity of certain operations impossible.

Because these non-traditional disasters are just that—non-traditional—most policies do not contemplate coverage in these situations, and there is very little case law on this issue.²⁷⁶ Therefore, healthcare providers are well advised to talk with their insurers about whether such “non-traditional” physical damage will trigger existing business interruption policies.

3. Unresolved Issues and Action Recommendations

Healthcare providers should have counsel review their existing business interruption insurance policies to determine whether the policies provide sufficient coverage for the healthcare facility in light of all possible scenarios in which a complete cessation or slowdown of business could occur. Two areas of particular interest are whether:

1. The policy covers a partial cessation (“slowdown”) of business in addition to a complete cessation; and
2. Damage from non-traditional events will constitute sufficient physical damage to trigger the policy.

²⁷⁵ Lon A. Berk & William A. Schreiner, Jr., *Business Income Coverage: Old Lessons Apply in New Context*, *ABA Coverage*, 15 Coverage 1 (Nov./Dec. 2005).

²⁷⁶ “Claims such as those caused by contaminants may, for example, be challenged as not arising out of direct physical loss or damage...The courts have taken different positions on the question of whether there is physical damage where all that must be done to the property is a remediation of contamination.” *Id.*



After reviewing the policies, counsel should discuss these issues with the healthcare provider's or facility's insurance partner and negotiate amendments to the policies where appropriate.

C. Civil Authority Insurance

1. Overview

Civil Authority Insurance (CAI) coverage, an extension of business interruption coverage, compensates a business for lost income and additional expenses arising out of “the suspension of the insured’s operations necessitated by an order of a civil authority (“closure order”) which prevents access to the insured’s premises.”²⁷⁷ For instance, if the state government closes all roads that lead to a business because of damage from a hurricane, CAI coverage would likely compensate the business owner for income lost during the time that the business was inaccessible. Businesses have also tried to recover under CAI policies when they have to close early because of curfews or other state imposed restrictions.²⁷⁸ It is foreseeable that healthcare facilities may seek compensation under CAI coverage for closures necessitated by quarantine orders during a pandemic. This section examines the use of CAI and identifies the uncertainties associated with its use, especially after non-traditional disasters such as a pandemic.

Typically, to trigger CAI coverage, the insured must demonstrate that:

1. An insured peril
2. cause[ed] direct physical loss or damage
3. to property other than the insured property, and
4. that property damage cause[ed] civil authorities to issue an order,
5. prohibiting access to the insured property,
6. which cause[ed] an interruption of the insured’s business,
7. which, in turn, cause[ed] a loss of business income or causes extra expense as defined by the policy at issue.²⁷⁹

2. Application to Traditional and Non-Traditional Disasters

a. Complete Closure v. Partial Closure

²⁷⁷ Anglim, *supra* note 277, § II.

²⁷⁸ See Ribner, *et al.*, *supra* note 280.

²⁷⁹ Andrew B. Downs & Linda M. Bolduan, *The Connection Between Physical Damage and Business Interruption Coverage*, *FDCC Quarterly* (Summer 2004), p. 327.



Generally, “complete cessation of the policyholder’s business is necessary before business interruption coverage [including civil authority insurance] will be triggered. A mere fall-off of business—or even a drastic reduction—is not sufficient.”²⁸⁰ While this is the majority position, it is inconsistent with the goal of minimizing and mitigating losses arising from civil authority orders.

During Hurricane Floyd, a North Carolina court found an insurance company’s denial of a hospital’s claim under its CAI policy was proper because access to the hospital was not completely attributable to “an act of civil authority.”²⁸¹ In that case, the hospital was only partially closed; however, the court’s decision was based on other grounds. The court instead focused on the fact that some roads to the hospital were blocked by flood waters while others were ordered closed by the local authorities.²⁸² Because the civil authority order was not the cause for all of the road closures, the hospital could not recover under the CAI.²⁸³

Counsel for healthcare facilities should review the existing CAI policies to determine whether complete closure of the healthcare facility is required to trigger the CAI coverage. If the CAI policy requires complete closure, or if this point is ambiguous, the healthcare facility should enter into discussions with the insurer to clarify this point, and possibly amend the policy. This can ensure that facility will have the proper incentives to mitigate its damages by keeping as much of the healthcare facility open in the face of civil authority closures as possible.

b. Physical Damage

As with business interruption insurance, the most interesting and potentially difficult elements of CAI to meet in terms of non-traditional disasters are those related to physical damage. The fundamental issue that courts have struggled with is “whether there has been direct physical loss or damage to property from a covered cause of loss.”²⁸⁴ There are at least three elements that counsel must consider when assessing coverage under CAI:

1. The existence of physical loss or damage;
2. The required location of the physical loss or damage;
3. Whether the physical loss or damage was caused by a covered peril.²⁸⁵

²⁸⁰ Laura A. Foggan & Daniel J. Wadley, *Coverage Under Civil Authority Provisions*, *ABA Coverage*, 12 Coverage 19 (May/June 2002). See also Ribner, *et al.*, *supra* note 280.

²⁸¹ See Berk, *et al.*, *supra* note 278, § II.A.2 (citing *St. Paul Ins. Co. v. Pitt County Mem’l. Hosp., Inc.*, No. 4:01-CV-35-H(4) (E.D. N. Car. June 18, 2002).

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ See Foggan, *et al.*, *supra* note 288, § I.

²⁸⁵ *Id.*



The analysis regarding the physical damage requirement is complicated by the fact that “[t]he scope of civil authority coverage... can vary based upon the language of the policy. For example, some civil authority provisions require the [closure] order to have been issued as a direct result of damage to insured property, while others require the damage to be to adjacent property, and still others do not expressly contain that requirement but instead state that the order must be a direct result of a peril insured against.”²⁸⁶ Therefore, knowing the language in a healthcare facility’s policy is crucial to evaluating whether the facility has sufficient coverage for foreseeable events.

A few courts have examined whether direct physical loss is necessary to trigger CAI coverage or whether a closure order issued in advance of physical damage is sufficient. Courts generally have held that “civil authority actions intended to ‘prevent’ future harm do not trigger coverage, as it cannot be said that they are ‘due to’ direct physical loss that has occurred.”²⁸⁷ In *Assurance Co. of America v. BBB Service Co.*, a claim under a CAI policy arose from the evacuation of Brevard County, Florida prior to Hurricane Floyd.²⁸⁸ A fast-food chain closed its restaurants in the county because of the evacuation order. When the chain shuttered its restaurants, there had been no physical damage to the area. In finding for the insurer, the “court held that the mere threat of physical damage was not sufficient to warrant applicability of the civil authority clause[;] [r]ather, physical damage was required.”²⁸⁹ Several other courts have followed this reasoning denying coverage for closures by a civil authority, when such closure orders are preventative safety measures.²⁹⁰

Other courts, however, have allowed preventative civil orders to trigger policies. For instance, based on the specific policy language in question, the Michigan Court of Appeals held that “as long as the source of the civil authority provision was a peril that *would have been* insured against had it caused damage to the insured’s property, the resulting loss was covered under the policy.”²⁹¹ The Eastern District of North Carolina issued a similar finding in *Fountain Powerboat Ind., Inc. v. Reliance Ins. Co.*²⁹² There the court “stated in dicta that a civil authority provision, containing the same language as those [in *Fountain Powerboat*], did not require direct physical loss to the insured’s premises.”²⁹³

A similar question arose out of the events following the September 11, 2001 attacks. In the attacks’ immediate aftermath, the Federal Aviation Administration (FAA) ordered a ground-stop of all air traffic, thereby prohibiting any aircraft from departing from specified airports. The

²⁸⁶ See Ribner, *et al.*, *supra* note 280.

²⁸⁷ See Foggan, *et al.*, *supra* note 288.

²⁸⁸ 576 S.E.2d 38 (Ga. Ct. App. 2002).

²⁸⁹ Alan R. Miller, *Business Interruption Insurance for Damage to Other Property*, *FDCC Quarterly* (Spring 2003).

²⁹⁰ See Ribner, *et al.*, *supra* note 280.

²⁹¹ See Foggan, *et al.*, *supra* note 288, § I.B.

²⁹² 119 F. Supp. 2d 552, 557 (E.D. N.C. 2000).

²⁹³ *Id.*



Metropolitan Washington Airport Authority (MWAA) ordered Reagan National Airport (“Reagan”) closed to the public and airport employees until October 4, 2001. US Airways, headquartered at Reagan, had to cancel all flights departing from and arriving at Reagan during these three weeks. As a result of the cancellations, US Airways claimed sustained income losses, and argued that such losses were compensable under US Airways’ business interruption policy. US Airways’ insurer claimed that the business interruption coverage was not triggered because the FAA and MWAA orders were not “a direct result of a peril insured against.” In other words, the closure was not required because of physical damage at Reagan, but rather fear of a subsequent attack caused the issuance of the closure order. US Airways filed suit in Virginia state court challenging the insurer’s denial of the claim. The court found that US Airways’ business interruption insurance covered its losses because “an order by civil or military authority issued as a direct result of risk of damage or loss to US Airways property” caused the losses.²⁹⁴ This suggests that in at least one circuit court in Virginia, physical damage is not necessary to trigger the CAI provisions of a business interruption insurance policy.

For obvious reasons, whether physical damage is necessary to trigger CAI coverage is important in the context of traditional and non-traditional disasters. Especially in the context of a public health disaster like an influenza pandemic, the government (either the Governor or the state health officer) may quarantine hospitals or parts of hospitals to help slow the spread of infection. These quarantine orders will most likely cause the facility to lose significant revenue, and therefore impact profits. Hospitals may comply with these orders more willingly if they know that their CAI coverage will compensate them for lost profits.

3. Unresolved Issues and Action Recommendations

Healthcare facilities should have counsel review their existing CAI policies to determine whether they provide sufficient coverage for the healthcare facility in light of all possible scenarios in which a civil authority may order a complete or partial closure of the business. Two areas of particular interest are whether:

1. The CAI policy covers a preventative civil authority closure;
2. The CAI policy covers a partial civil authority closure.

After reviewing the policies, counsel should discuss these issues with the healthcare provider’s or facility’s insurance partner.

²⁹⁴ *US Airways, Inc. v. Commonwealth Insurance Company*, 65 Va. Cir. 238 (Cir. Ct of Arlington County 2004) (overturned on other grounds in *PMA Capital Insurance Company v. US Airways*, 271 Va. 352 (2006)).



D. Other Insurance Options

1. Ingress/Egress Insurance

Ingress/egress coverage is similar to CAI coverage except that a closure order from a civil authority is not necessary. To trigger coverage, many ingress/egress policies require, because of damage to the property, that the property be completely inaccessible.²⁹⁵ For instance, if there is only one door to the facility and a fallen tree blocks that door such that the insured is unable to enter the building, the physical damage (e.g. fallen tree) will most likely trigger the ingress/egress coverage. If, however, there is a back door that is accessible even though it is rarely used, the physical damage will not be sufficient to trigger coverage.

Because of the potential for fraudulent claims, actual and direct property damage is usually required for claims to be paid. This type of property damage will likely not occur during a non-traditional disaster; therefore, this type of policy is probably inapplicable. It is foreseeable, however, that a traditional disaster could trigger this type of coverage. Therefore, counsel should be familiar with the provisions of the healthcare facility's specific policy.

2. Contingent or Dependent Business Interruption Insurance

Contingent or dependent business interruption insurance may also be applicable during either a traditional or non-traditional disaster. This type of insurance “protects the earnings of the insured following physical loss or damage to the property of the insured’s suppliers or customers, as opposed to its own property.”²⁹⁶ Some policies refer to the insured’s suppliers or customers as “dependent property.”²⁹⁷ Dependent property is frequently defined as “property operated by others upon whom you depend to: (1) deliver materials or services to you, or to others for your account (not including water, communication or power supply services); (2) accept your products or services; (3) manufacture products for delivery to your customers under contract of sale; or (4) attract customers to your business.”²⁹⁸ Like many of the other types of coverage that have been discussed thus far, “[p]roperty damage is usually a prerequisite to contingent business interruption coverage—an interruption of the supplier or receiver’s business alone is generally not sufficient.”²⁹⁹

Contingent or dependent business interruption coverage may be important for healthcare providers in all types of disasters because of the “just-in-time” delivery systems used by the

²⁹⁵ See Miller, *supra* note 297, § III.

²⁹⁶ *Id.*

²⁹⁷ See Berk, *et al.*, *supra* note 278, § B.I.

²⁹⁸ *Id.*

²⁹⁹ See Ribner, *et al.*, *supra* note 280.



majority of healthcare providers. Healthcare facilities outsource and rely on vendors for many activities that are crucial to the proper functioning of the healthcare facility. Any type of event could impact a supplier's ability to get the healthcare facility its needed suppliers or services, and thus impact its ability to provide care. To the extent a healthcare facility can insure against such losses, it should explore doing so. As with the other types of insurance discussed in this section, physical damage is usually a prerequisite to payment of claims under contingent policies. Therefore, this coverage may not be available during non-traditional disasters like an influenza pandemic. Counsel should review any existing policy language and clarify this with the insurer.

3. Accounts Receivable Insurance

Accounts receivable insurance “protects businesses against their inability to collect their accounts receivable because of the loss of supporting records that have been destroyed by a covered cause of loss.”³⁰⁰ This type of insurance also covers “the extra collection expenses that are incurred because of such loss or damage and other reasonable expenses incurred to re-establish records of accounts receivable after loss or damage.”³⁰¹

Accounts receivable insurance contrasts with normal business interruption insurance in several respects. With business interruption insurance, “only a shortfall in the future earnings of the business, after a loss occurs, will be paid.”³⁰² It will not cover payments on debts.³⁰³ However, “[t]his creates a gap in the coverage, which the accounts receivable policy is designed to fill.”³⁰⁴

If they have not done so already, healthcare providers should talk with their insurance partners to determine whether accounts receivable insurance will cover accounts receivable based on healthcare services rendered if a traditional disaster destroys all documentation. As healthcare providers move to all-electronic systems, they should talk with their insurers about the applicability of accounts receivable coverage to records destroyed by a computer virus.

³⁰⁰ Armfield, Harrison & Thomas, Inc., *Definition of “Accounts Receivable Insurance,”* at <http://www.ahtins.com/glossary/aaa/a037.htm> (last accessed April 15, 2009).

³⁰¹ *Id.*

³⁰² Harpers Risk, Inc., *Commercial Property Insurance, Accounts Receivable,* at <http://www.harperrisk.com/Library/CommProp.htm> (last accessed April 15, 2009).

³⁰³ *Id.*

³⁰⁴ *Id.*



VIII. CONCLUSION

Failure to plan for continuity of operations and financial sustainability during a disaster could result in a healthcare provider's inability to provide much needed services during and after a disaster. For a healthcare provider, there is both direct and indirect liability for its failure to plan for events that are foreseeable. Those responsible for hospital emergency planning should be sure to include their CFO, or their designee, in planning. It is therefore imperative that healthcare providers begin to plan for continuity of operations and financial sustainability during and after a disaster.

For a healthcare provider, there is not one uniform solution or approach to assuring financial stability and continuity of operations in a disaster. Healthcare providers must adopt a multi-faceted strategy to maximize their coverage and reimbursements from both governmental and private sources. Plans need to be flexible as the options and resources available to address an organization's financial sustainability will vary with the nature and scope of a given disaster.



APPENDIX A

Suggested Minimum Data Elements for Institutional Providers Using the Uniform Billing 04 Form

- Subscriber identification policy number
- Time in/time out
- Is the injury work-related?
 - 1: Provider name, address, phone number
 - 4: Type of bill
 - 8b: Patient name
 - 42: Revenue codes
 - 43: Revenue description
 - 44: Healthcare Common Procedure Coding System rates/codes
 - 46: Units of services
 - 47: Total Charges
 - 50: Payer
 - 56: National Provider Identifier
 - 58: Insured's name
 - 67: Principal Diagnosis code
 - 69: Admitting diagnosis
 - 74: Principal procedure code
 - 76: Attending
 - 77: Operating³⁰⁵

Suggested Minimum Data Elements for Non-Institutional Providers Using the Centers for Medicare and Medicaid Services 1500 Forms

- Subscriber identification/policy number
- Time in/time out
- Is the injury work-related?
 - 1: Select which payer
 - 1a: Insured's Identification number
 - 2: Patient name
 - 3: Patient's birth date

³⁰⁵ California Guidelines, pp. 40-41.



- 5: Patient's address
- 21: Diagnosis or nature of illness or injury
- 24 A-G: Date of service, place of service, type of service, procedures/services/supplies, diagnosis code, charges, days or units
- 24K: Use space to include condition code
- 25: Federal tax identification number
- 27: Accept assignment? (Y/N)
- 28: Total charge
- 33: Physician's/suppliers billing name, address, zip code & phone number³⁰⁶

³⁰⁶ *Id.* at 41.



APPENDIX B

Medicaid and Medicare Claims

I. Medicare

A. Basic Conditions for Payment

To receive payment for covered services under Medicare, a healthcare provider must be enrolled in the Medicare program. Upon enrollment, the healthcare provider receives billing privileges and a billing number.³⁰⁷ Once enrolled, healthcare providers must periodically submit certification of enrollment information and report certain information.³⁰⁸

Medicare will not pay for services unless they are reasonably necessary and furnished by a healthcare provider who is qualified to furnish such services.³⁰⁹ The services must be furnished to an individual who is eligible to have payment made for them under the Medicare Program.³¹⁰ The beneficiary must be eligible to receive the services rendered at the time they are rendered for healthcare providers to receive payment.³¹¹ There are provisions for retroactive eligibility and for payment for inpatient hospital services rendered before a hospital is notified that the beneficiary has exhausted the Medicare benefits for the benefit period.³¹² Medicare requires a written request for payment and certification that the services delivered were necessary before payment is made.³¹³

Hospitals participating in the Medicare program must meet certain conditions of participation to be eligible to receive payments and submit claims. These conditions of participation include compliance with federal, state, and local laws related to the health and safety of patients.³¹⁴ The conditions of participation require hospitals to be licensed or otherwise approved by a state agency as meeting licensing standards and to assure that personnel are licensed or otherwise meet state or local standards.³¹⁵ During a disaster, these conditions may be

³⁰⁷ 42 C.F.R. § 424.505.

³⁰⁸ 42 C.F.R. § 424.500, *et seq.*

³⁰⁹ 42 C.F.R. § 424.5.

³¹⁰ 42 C.F.R. § 424.5.

³¹¹ 42 C.F.R. § 424.5(a)(3).

³¹² 42 C.F.R. § 424.5(a)(3). 42 C.F.R. § 424.16.

³¹³ 42 U.S.C. § 1395n.

³¹⁴ 42 C.F.R. § 482.11.

³¹⁵ *Id.*



difficult to meet depending on the volume and acuity of the patients.³¹⁶ Volunteers, out-of-state personnel, altered standards of care including personnel-to-patient ratios and the number of patients per room may impact a hospital’s ability to comply with conditions of participation, and thus impact the hospital’s eligibility for payment from Medicare. Hospitals are already familiar with the Medicare conditions of participation and should keep these conditions in mind when preparing for continuity of operations during a disaster.

B. Certification

It is the healthcare provider’s responsibility to obtain certification and recertification statements and to keep these statements on file for the fiscal intermediary to verify.³¹⁷ Healthcare providers must certify, using the appropriate billing form and have these statements on file.³¹⁸ The actual statements need not be submitted with the claims for payment.

Medicare does not require a special form for certification or recertification statements; however, “there must be a separate signed statement for each certification and recertification.”³¹⁹ For inpatient services of hospitals, the certification must contain the reason for continued hospitalization for treatment or medically required diagnostic studies, the unavailability of a skilled nursing facility bed, or, in the case of outlier cases (those cases that have an unusually long length of stay) the estimated time of the patient’s hospitalization and post-discharge plans.³²⁰

Physicians, and in some cases qualified nurse practitioners or qualified clinical nurse specialists,³²¹ must certify and recertify the continued need for services.³²² The physician responsible for the care, or a physician with “knowledge of the case and who is authorized to do so by the responsible physician or by the hospital’s medical staff” must sign the certification.³²³

Certification is not required for hospital services and supplies that are “incident to physicians’ services furnished to outpatients” or for outpatient hospital diagnostic services.³²⁴

³¹⁶ *Id.*

³¹⁷ 42 C.F.R. § 424.11(a).

³¹⁸ *Id.*

³¹⁹ 42 C.F.R. § 424.11(b).

³²⁰ 42 C.F.R. § 424.13(a)-(b).

³²¹ 42 C.F.R. § 424.13. Nurse practitioners and clinical nurse specialists may certify and recertify the need for post-hospital extended care services. 42 C.F.R. §§ 424.10, 424.11.

³²² 42 C.F.R. § 424.13.

³²³ 42 C.F.R. § 424.13(c).

³²⁴ 42 C.F.R. § 424.24(a).



1. Timing of Certification and Recertification

The initial certification for cases not subject to the prospective payment system (PPS) must be completed no later than the 12th day of hospitalization and must be recertified no later than the 18th day of hospitalization.³²⁵ Thereafter, recertification must be performed “at intervals established by the [Utilization Review] committee (on a case by case basis if it so chooses) but no later than every 30 days.”³²⁶

For hospitals that are subject to the PPS, certification must be completed for “day-outlier cases . . . no later than one day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with §412.80 (a) (1) (i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier.”³²⁷ Recertification intervals may be established by the Utilization Review committee and must be at least every 30 days.³²⁸

Cost outlier cases must be certified no later than “the date on which the hospital requests cost outlier payment, or 20 days into the hospital stay, whichever is earlier” with recertification to be established by the Utilization Review committee.³²⁹ Medicare permits the Utilization Review committee to perform the recertification for cases that are not subject to PPS and for PPS day-outlier cases.³³⁰ When the Utilization Review committee performs the recertification, it must be completed “no later than the seventh day after the day the physician recertification would have been required.”³³¹

Once the Utilization Review committee or a Quality Improvement Organization (QIO), where applicable, determines that medical services are no longer necessary, hospitals under PPS will not receive payment for services after the second day after the day on which the hospital receives notice of such determination.³³² For hospitals not subject to PPS, “payment may not be made for inpatient hospital services . . . furnished the day after” the hospital received such notice unless the Utilization Review committee or QIO approves an additional 1 to 2 days for planning for post-discharge care.³³³

³²⁵ 42 C.F.R. § 424.13(d).

³²⁶ *Id.*

³²⁷ 42 C.F.R. § 424.13(e)(1).

³²⁸ *Id.*

³²⁹ 42 C.F.R. § 424.13(e)(2).

³³⁰ 42 C.F.R. § 424.13(f)(1).

³³¹ 42 C.F.R. § 424.13(f)(2).

³³² 42 C.F.R. § 424.7(a)(1).

³³³ 42 C.F.R. § 424.7(a)(2).



2. Delay in Certification and Recertification

Medicare will accept delayed certification and recertification when there is a legitimate reason for delay.³³⁴ Healthcare providers must include an explanation for the delay in the claims submission.³³⁵ Different services require different levels of information for certification.³³⁶ An authorized healthcare provider must sign all certifications and recertifications.³³⁷ Presumably, the increased patient volume and acuity, diminished staff volumes, and other circumstances related to a disaster would be “legitimate” reasons for delayed certification. Hospitals should plan for how certifications will be accomplished in the timeliest manner possible during a disaster to ensure continued operations.

C. Claims for Payment

Healthcare providers must make a written request for payment “no later than the close of the period of 3 calendar years following the year in which such services are furnished” unless the Secretary deems that efficient administration requires the request be made no later than one calendar year following the year in which services were furnished.³³⁸ Under the Medicare program, healthcare providers must file claims for payment in all cases, unless the services furnished to the beneficiary are done so on a “prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a healthcare prepayment plan (HCPP).”³³⁹

1. General Requirements for Filing Claims

For a healthcare provider to be paid for the services furnished, each claim must meet the following requirements established by Medicare:

- A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions;
- A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD-9-CM;

³³⁴ 42 C.F.R. § 424.11(d)(3).

³³⁵ *Id.*

³³⁶ 42 C.F.R. § 424.11(c). The federal regulations set forth specific information that is required for different types of services. If that information is contained in other healthcare provider records, including physicians’ progress notes, the information does not need to be repeated.

³³⁷ 42 U.S.C. § 1395n; 42 C.F.R. § 424.11.

³³⁸ 42 U.S.C. § 1395n.

³³⁹ 42 C.F.R. § 424.30.



- A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with §424.36);
- A claim must be filed within the time limits specified in §424.44; and,
- All Part B claims for services furnished to SNF residents (whether filed by the SNF of another entity) must include the SNF’s Medicare provider number and appropriate HCPCS coding.³⁴⁰

Healthcare providers must use the proper claims form to submit claims. CMS-1450 – Uniform Institutional Provider Bill is for institutional providers billing for Medicare inpatient, outpatient and home health services.³⁴¹ CMS 1490S – Patient’s Request for Medical Payment is used by beneficiaries to request payment for medical expenses.³⁴² CMS 1500 – Health Insurance Claim Form is used by physicians and other suppliers to request payment for medical services.³⁴³ The CMS 1660 – Request for Information – Medicare Payment for Services to Patient Now Deceased form is used to request payment for services to a patient who is now deceased.³⁴⁴ The CMS-1450 and 1500 forms are only available by commercial purchase so healthcare providers should be sure they have an ample supply available.³⁴⁵

2. Electronic Claims Submission

Medicare also requires electronic claims submission.³⁴⁶ A claim is “a request to obtain payment, and the necessary accompanying information from a healthcare provider to a health plan.”³⁴⁷ Under the CMS regulations, “an initial Medicare claim may be paid only if submitted as an electronic claim for processing by the Medicare fiscal intermediary or carrier that serves the physician, practitioner, facility, supplier, or provider of services.”³⁴⁸

Claims do not have to be submitted electronically if there is no method available to submit an electronic claim, such as when the standards for healthcare claims under 45 C.F.R. § 1102 do not support all information necessary for payment, or in unusual cases.³⁴⁹ In unusual cases the Secretary may waive electronic claims requirements as he finds appropriate.³⁵⁰ An “unusual case is deemed to exist when there is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim, for the period of

³⁴⁰ 42 C.F.R. § 424.32.

³⁴¹ 42 C.F.R. § 424.32(b).

³⁴² *Id.*

³⁴³ *Id.*

³⁴⁴ *Id.*

³⁴⁵ 42 C.F.R. § 424.32(c).

³⁴⁶ 42 C.F.R. § 424.32(d).

³⁴⁷ 45 C.F.R. § 162.1101(a).

³⁴⁸ 42 C.F.R. § 424.32(d)(2).

³⁴⁹ 42 C.F.R. § 424.32(d)(3)(i).

³⁵⁰ 42 C.F.R. § 424.32(d)(4).



the interruption.”³⁵¹ Other instances that are deemed “unusual” include entities that submit, on average, fewer than 10 claims to Medicare per month and those that only furnish medical services outside of United States territory.³⁵²

Finally, unusual cases are deemed to exist upon “demonstration, satisfactory to the Secretary, of other extraordinary circumstances precluding submission of electronic claims.”³⁵³ Based on the language of this regulation, it is reasonable to conclude that a disaster would be considered an unusual case in which the Secretary would waive the electronic requirement, especially if the number of patients so exceeds the number of staff available and trained to submit electronic Medicare claims.

3. Timing of Claims Submission

Generally, healthcare providers must mail or deliver claims to the intermediary or carrier “on or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year and on or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.”³⁵⁴

Extensions for filing claims are available for error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.³⁵⁵ The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.³⁵⁶ If the last day of the period allowed for timely filing falls on a Federal nonwork day (a Saturday, Sunday, legal holiday, or a day which by statute or Executive Order is declared to be a nonwork day for Federal employees), the time is extended to the next succeeding workday.³⁵⁷

Timely claims submission may become problematic for a hospital during a prolonged disaster, especially if the absenteeism rates are high. Hospitals should consider working with CMS to develop criteria for filing claims during disasters.

4. Signature Requirements

All claims must be signed and filed by the healthcare provider, supplier or hospital.³⁵⁸ Generally, the beneficiary’s signature is required on the claim unless he or she died, or certain

³⁵¹ 42 C.F.R. § 424.32(d)(4)(ii).

³⁵² 42 C.F.R. § 424.32(d)(4)(iii)-(iv).

³⁵³ 42 C.F.R. § 424.32(d)(4)(v).

³⁵⁴ 42 C.F.R. § 424.44.

³⁵⁵ *Id.*

³⁵⁶ *Id.*

³⁵⁷ *Id.*

³⁵⁸ 42 C.F.R. § 424.33. This provision includes all claims by nonparticipating hospitals.



other provisions apply.³⁵⁹ A beneficiary’s legal guardian, a relative or other individual who receives the beneficiary’s social security or government benefits on his or her behalf or who arranges for the beneficiary’s treatment or has responsibility for his or her affairs may sign on behalf of the beneficiary.³⁶⁰ Additionally, a representative of “an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary,”³⁶¹ or a representative of the healthcare provider or the non-participating hospital claiming payment where a guardian, relative, personal representative, or representative of another agency or institution is not available.³⁶² Under certain circumstances ambulance providers may sign the claim.³⁶³ The individual signing the claim must submit a brief statement explaining his or her relationship to the beneficiary and why the beneficiary was unable to sign the claim.³⁶⁴

When a beneficiary is not present for the services, such as a laboratory test sent to a healthcare provider from a physician for testing, then a representative of the healthcare provider, hospital, or supplier may sign the claim on behalf of the beneficiary.³⁶⁵ The representative must explain in a statement submitted with the claim why the beneficiary’s signature could not be obtained.³⁶⁶ Likewise, for claims by “an entity that provides coverage complementary to Medicare Part B” the entity may sign on behalf of the beneficiary.³⁶⁷ CMS may honor claims signed by other parties upon a showing of good cause.³⁶⁸

Medicare permits a separate request for payment statement prescribed by CMS and signed by the beneficiary to be included in the initial claim for Part A services furnished by a participating hospital, SNF, or non-participating hospital that has elected to claim payment, during a beneficiary’s hospitalization to be effective for all claims for such services during the hospitalization.³⁶⁹ Similarly, a signed request for payment statement in the files of a participating hospital or SNF is effective for all claims for services furnished during that hospitalization by the hospital or SNF, a physician whose services are billed by the hospital or SNF in its name, or by a physician who bills separately if the services were furnished in the hospital or SNF.³⁷⁰ For hospitals, these provisions can help streamline the billing process. If hospitals are not already taking advantage of these provisions, they should consider doing so, or having a plan in place to do so during a disaster to save time and effort.

³⁵⁹ 42 C.F.R. § 424.36(a).

³⁶⁰ 42 C.F.R. § 424.36(b)(1)-(3).

³⁶¹ 42 C.F.R. § 424.36(4).

³⁶² 42 C.F.R. § 424.36(b)(5).

³⁶³ 42 C.F.R. § 424.36(b)(6).

³⁶⁴ 42 C.F.R. § 424.37(a).

³⁶⁵ 42 C.F.R. § 424.36(c).

³⁶⁶ 42 C.F.R. § 424.37(b).

³⁶⁷ 42 C.F.R. § 424.36(d).

³⁶⁸ 42 C.F.R. § 424.36(e).

³⁶⁹ 42 C.F.R. § 424.40(a)-(b).

³⁷⁰ 42 C.F.R. § 424.40.



D. Miscellaneous Claims Provisions

1. Payment

Generally, Medicare pays the healthcare provider for services furnished by a healthcare provider; however, Medicare pays the beneficiary for outpatient hospital services where the hospital collects an amount in excess of the unmet deductible and coinsurance.³⁷¹ Medicare pays the beneficiary for emergency inpatient and outpatient services and for certain Medicare Part B services, furnished by non-participating hospitals that have not elected to claim payment under the Medicare regulations.³⁷² A beneficiary also receives payment for emergency services, physician, and ambulance services furnished by a foreign hospital, and for services furnished by a supplier if the claim has not been assigned to the supplier.³⁷³

2. Deceased Beneficiaries

The federal regulations regarding claims submission also address a number of special circumstances under which hospitals may still be paid.³⁷⁴ For example, when a beneficiary has died and payment has not been paid by another party, a provider may obtain payment by submitting the claim on the proper CMS-prescribed form, providing documentation that the services were furnished, and agreeing, in writing, to accept the reasonable charges as the full charge.³⁷⁵ During a disaster, this provision will be particularly important as there will likely be a high number of fatalities.

3. Non-participating Hospitals

Non-participating hospitals, those hospitals that do not participate in the Medicare program, can obtain reimbursement for emergency services³⁷⁶ rendered to a Medicare beneficiary where the hospital is the “most accessible” hospital.³⁷⁷ The emergency services rendered at a non-participating hospital must meet the following conditions for reimbursement:

- The services must be the type Medicare would pay for if they were furnished by a participating hospital;

³⁷¹ 42 C.F.R. § 424.51.

³⁷² 42 C.F.R. § 424.53(a)-(b).

³⁷³ 42 C.F.R. § 424.53(c)-(e).

³⁷⁴ 42 C.F.R. § 424.64. *See* 42 C.F.R. § 424.62 for Payment after beneficiary’s death where the bill has been paid.

³⁷⁵ *Id.*

³⁷⁶ 42 C.F.R. § 424.101 defines “Emergency Services” as those “inpatient or outpatient services that are necessary to prevent death or serious impairment of health, and because of the danger to life or health require the use of the most accessible hospital available and equipped to furnish those services.”

³⁷⁷ 42 C.F.R. § 424.100. For criteria for “most accessible,” see 42 C.F.R. § 424.106.



- The beneficiary’s need for emergency care did not arise while the beneficiary was an inpatient in the non-participating hospital; and,
- The services were furnished during a period in which the beneficiary could not be safely transferred to a participating hospital.³⁷⁸

The healthcare provider must submit information regarding the nature of the emergency, conditions of emergency, and when the care ended.³⁷⁹ Non-participating hospitals must comply with the electronic claims submission criteria and must have a “statement of election to claim payment” in effect.³⁸⁰ For non-participating hospitals, knowledge of and compliance with this provision will be important as the volume of Medicare patients presenting to their facilities for emergency services increases.

4. Assignment of Claims

Generally, healthcare providers are prohibited from assigning the right to Medicare payments.³⁸¹ Exceptions to this rule include payment to a government agency or entity to which the healthcare provider’s Medicare claims have been assigned, payment pursuant to a court order, or payment to an agency that furnishes billing and collection services to the provider where certain conditions are met.³⁸²

II. Virginia Medicaid

Medicaid is a federal and state program that provides medical assistance services to certain eligible individuals. Medicaid is jointly funded by the federal and state governments and is governed by a broad set of federal statutes, regulations, and policies the states must follow in creating and administering the Medicaid program.³⁸³ Based on the federal guidelines, the states establish payment rates, eligibility criteria, scope of services, and must administer their own programs through a state Medicaid agency.³⁸⁴ In Virginia, the Department of Medical Assistance Services (DMAS) is the state agency designated to administer and supervise the administration of the Virginia Medicaid program under Title XIX of the Social Security Act.³⁸⁵

³⁷⁸ 42 C.F.R. § 424.100. For criteria for “most accessible,” see 42 C.F.R. § 424.106.

³⁷⁹ 42 C.F.R. § 424.103.

³⁸⁰ 42 C.F.R. § 424.108.

³⁸¹ 42 C.F.R. § 424.70.

³⁸² 42 C.F.R. § 424.73.

³⁸³ See CMS Medicaid Technical Summary, *available at* www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp (last accessed April 15, 2009).

³⁸⁴ *Id.*

³⁸⁵ 12 Va. Admin. Code § 30-10-10.



A. Basic Conditions for Payment

DMAS must limit participation in the Medicaid program to healthcare providers who “accept as payment in full the amounts paid by the agency plus any deductible, coinsurance, or co-payment required by the plan to be paid by the individual.”³⁸⁶

Virginia requires preauthorization before a patient may be admitted to an inpatient hospital for a planned admission.³⁸⁷ Unplanned or emergency admissions are permitted without preauthorization; however, “review shall be performed within one working day to determine that inpatient hospitalization is medically justified.”³⁸⁸ Pre-authorization is processed through Keystone Peer Review Organization (KePRO), Virginia Medicaid’s preauthorization contractor. Healthcare providers are encouraged to use the DMAS 362 Inpatient Prior Authorization Request form to submit authorization requests.³⁸⁹ Adhering to the pre-authorization process may become too cumbersome during a disaster with the increased volume of patients presenting for care.

DMAS limits coverage for inpatient hospitalization to “a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan.”³⁹⁰ DMAS suspends and manually processes claims for stays exceeding 21 days in a 60-day period.³⁹¹ DMAS will pay for services on behalf of individuals who are under 21 years of age and are eligible for Medicaid whose inpatient hospitalization exceeds 21 days and is medically necessary.³⁹² There is an exception for “individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays” in inpatient hospitals that exceed 21 days per admission “when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination.”³⁹³ DMAS requires that these admissions and the length of stay be pre-authorized and medically justified.³⁹⁴

During a disaster such as pandemic influenza, patients may have prolonged inpatient stays that far exceed 21 days. Hospitals should begin to plan now for ways to address the length of stay limitations during a pandemic or other disaster to ensure they can receive payment for the services provided.

³⁸⁶ 42 C.F.R. § 447.20.

³⁸⁷ 12 Va. Admin. Code § 30-50-100(A)(1)(a).

³⁸⁸ 12 Va. Admin. Code § 30-50-100 (A)(1)(b). There is a reconsiderations process and an appeals process once the claim is denied. 12 Va. Admin. Code § 30-50-100(A)(4).

³⁸⁹ Special Medicaid Memo, February 14, 2007, Updates and Clarification of the Inpatient Prior Authorization Process for Inpatient Acute Care Services.

³⁹⁰ 12 Va. Admin. Code § 30-50-100(E).

³⁹¹ *Id.*

³⁹² *Id.*

³⁹³ *Id.*

³⁹⁴ *Id.*



B. Claims Submission

The Virginia Medicaid program closely follows the federal Medicare regulations for claims submission.³⁹⁵ Pursuant to federal regulations, DMAS requires the initial submission of all claims (including accident cases) within 12 months from the date of service;³⁹⁶ however, DMAS encourages providers to submit claims within 30 days from the last date of service or discharge.³⁹⁷ DMAS permits payment of late claims when a beneficiary obtains retroactive eligibility or delayed eligibility or when a denied claim that was submitted within the 12-month period is resubmitted after the 12-month period passes.³⁹⁸

Like Medicare, DMAS requires invoices to be submitted on the proper forms and signed by the appropriate individual.³⁹⁹ DMAS uses a DRG-based payment methodology that requires proper ICD-9-CM diagnosis and procedure codes and accurate documentation and recording of a complete set of specified data elements. Hospital-based physicians must submit separate billings to DMAS for their professional fee components using the CMS 1500 form (08-05).⁴⁰⁰ There are also separate billing forms for mother and newborn billing and transplant services.⁴⁰¹

DMAS has detailed instructions for claims coding and submission. For example, the instructions for completing the UB-40 (CMS-1450) are approximately 12 pages long.⁴⁰² These instructions require providers to use “red OCR dropout” ink to complete the form.⁴⁰³ Red or blue ink is not permitted.⁴⁰⁴ The font cannot be “smaller than 10-pitch Pica, 6 lines per inch vertical and 10 characters per inch horizontal” and must be printed in accordance with NUBC requirements to be processed by DMAS.⁴⁰⁵ Additionally, certain locator codes, provider numbers, patient identifiers, period of care down to the hours of admission and discharge, referral source, condition codes, and numerous additional pieces of information must be included in the UB-40 form for the claim to be paid.⁴⁰⁶

³⁹⁵ Social Security Act Title XIX.

³⁹⁶ Social Security Act Title XIX; 42 C.F.R. § 447.45(d).

³⁹⁷ DMAS Hospital Manual Chapter V: Timely Filing.

³⁹⁸ *Id.*

³⁹⁹ DMAS Hospital Manual Chapter V – Billing Instructions.

⁴⁰⁰ DMAS Hospital Manual Chapter V – Billing Instructions, p. 10.

⁴⁰¹ DMAS Hospital Manual Chapter V – Billing Instructions, pp. 10-11.

⁴⁰² DMAS, Special Medicaid Memo to All Providers Billing on the CMS-1450 (UB-04) Form from Patrick W. Finnerty, Director, DMAS (February 21, 2007) available at http://www.dmas.virginia.gov/downloads/pdfs/mm-NPI_CMS_1450.pdf (last accessed April 26, 2009).

⁴⁰³ *Id.*

⁴⁰⁴ *Id.*

⁴⁰⁵ *Id.*

⁴⁰⁶ *Id.* DMAS publishes Provider Manuals for Hospitals and Physicians. These Manuals contain detailed information what forms should be used for what services and how to complete these forms. These manuals are available at <http://www.dmas.virginia.gov> (last accessed April 15, 2009).



These detailed billing procedures may be difficult for a healthcare provider to meet during a disaster because of the level of detail required and the likelihood the number of administrative and billing staff will be diminished. Hospitals should consider working on the federal and state level to create minimum data sets that can be used during a disaster.⁴⁰⁷

The State Medicaid Plan requires DMAS to “utilize to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of healthcare services under Medicaid and the Family Access to Medical Insurance Security Plan established under §32.1-351.”⁴⁰⁸ Virginia does not provide electronic claims submission software; providers must purchase software at their expense to transmit claims electronically.⁴⁰⁹ The electronic claims must be submitted in the format specified by HIPAA.⁴¹⁰ Electronic claims submission is encouraged to streamline payment of claims.⁴¹¹

During certain disasters, electronic funds transfer and claims may not be available. Hospitals that submit claims electronically and that receive electronic funds transfers should ensure they have a back up plan for paper-based claims and payments during a disaster. Another consideration related to payment during a disaster is whether the hospital is in the process of returning overpayments to DMAS when a disaster occurs.

III. Private Payers

Generally, private payers have their own set of claims submission rules and deadlines. Private payers may require healthcare providers to submit “clean claims,” which, under the Virginia prompt payment law, must be paid within 40 days of receipt.⁴¹² A “clean claim” is a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.⁴¹³ Healthcare providers should consider amending contracts with carriers to include provisions for continued payment during a disaster.

In Virginia, health plans must reimburse for services covered under the plan that may be legally performed by and are performed by a person (other than a physician) who is licensed to

⁴⁰⁷ See California Guidelines, p. 39.

⁴⁰⁸ Code of Virginia § 32.1-325(H)(3).

⁴⁰⁹ First Health Services Corporation: Virginia Medicaid: Service Center User Manual for Electronic Transaction Submission (March 30, 2004).

⁴¹⁰ DMAS Hospital Manual Chapter V – Billing Instructions, p. 8.

⁴¹¹ *Id.*

⁴¹² Code of Virginia § 38.2-3407.15.

⁴¹³ *Id.*



do so.⁴¹⁴ If “an accident and sickness insurance policy provides reimbursement for a service that may be legally performed by a licensed pharmacist, reimbursement cannot be denied because it was rendered by a licensed pharmacist as long as certain conditions are met.”⁴¹⁵

Most health plans require co-payments in order for services to be furnished. In the event of a disaster, individuals may not have a payment method available upon presentation to a hospital for care. Depending on the nature of the disaster and the nature of the patient’s injury or condition, hospitals may not be able to collect co-payments. To the extent possible, hospitals should make best efforts to obtain co-payments before providing care.

⁴¹⁴ Code of Virginia § 38.2-3408.

⁴¹⁵ *Id.*



APPENDIX C

Prompt Payment

I. Federal Prompt Payment Laws

Under 42 U.S.C. §1395g(a), the Secretary of HHS is to determine how much a health agency providing services under Medicare is to be paid, and once that determination is made, payment is to be made not less than monthly.⁴¹⁶ When payment is made to a healthcare provider under a Medicare contract pursuant to 42 U.S.C. § 1395kk-1, payment must be made within 30 calendar days.⁴¹⁷ Interest is due on late payments beginning on the day they were due at the rate prescribed in 31 U.S.C. §3902 (a).⁴¹⁸

Under the Federal Medicaid regulations, a state agency, such as DMAS, that administers the Medicaid program must require healthcare providers to submit all claims no later than 12 months from the date of service.⁴¹⁹ The agency must then pay 90 percent of all clean claims (defined at 42 C.F.R. §447.45(b)) within 30 days, and 99 percent of all clean claims within 99 days.⁴²⁰ The agency must pay all claims within 12 months of receipt unless specific circumstances apply.⁴²¹

II. Virginia Prompt Payment Laws and Regulations

In general, Virginia requires carriers to “pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information”⁴²² A healthcare provider who does not receive payment within the applicable time period can sue to recover actual damages, and if the trier of fact finds that the violation was a result of gross negligence and willful conduct, treble damages are available, as are costs and fees.⁴²³ There are several exceptions to the general rule.⁴²⁴

⁴¹⁶ 42 U.S.C. § 1395g(a).

⁴¹⁷ 42 U.S.C. § 1395h(c)(1)(B)(ii)(V).

⁴¹⁸ 42 U.S.C. § 1395h(c)(1)(C).

⁴¹⁹ 42 C.F.R. § 447.45(d).

⁴²⁰ 42 C.F.R. § 447.45(d)(3-4).

⁴²¹ DMAS Hospital Manual: Chapter VII: Hospital Reimbursement and Appeals of Reimbursement Rates, p. 2.

⁴²² Code of Virginia § 38.2-3407.15(A)(1); *see* 12 Va. Admin. Code § 30-10-180.

⁴²³ Code of Virginia § 38.2-3407.15(E).

⁴²⁴ Code of Virginia § 38.2-3407.15(A)-(B).



The definition of “Health plan” explicitly excludes Medicare, Medicaid, and CHAMPUS as well as “accident only, credit or disability insurance, long-term care insurance, CHAMPUS settlement, Medicare supplement, or workers’ compensation coverages.”⁴²⁵ Carriers are not in violation of the prompt payment provision if the violation “is caused in material part by the person submitting the claim *or if the carrier’s compliance is rendered impossible due to matters beyond the carrier’s reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.*”⁴²⁶ The Code provisions apply to contracts entered into after July 1, 1999.⁴²⁷ HMOs have 30 days to pay claims, after which, interest may be applied to the claim until the date of payment.⁴²⁸

In Virginia, DMAS is required to “utilize to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of healthcare services under Medicaid and the Family Access to Medical Insurance Security Plan established under §32.1-351.”⁴²⁹

⁴²⁵ Code of Virginia § 38.2-3407.15(A).

⁴²⁶ Code of Virginia § 38.2-3407.15(D) (emphasis added).

⁴²⁷ Code of Virginia § 38.2-3407.15(H).

⁴²⁸ Code of Virginia § 38.2-4306.1(B). “[I]nterest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the health maintenance organization’s receipt of proof of loss to the date of claim payment.”

⁴²⁹ Code of Virginia § 32.1-325(H)(3).



APPENDIX D

Glossary of Essential Healthcare Financing Terms and Calculations

Glossary reproduced from the Healthcare Financial Management Association, *Glossary of Essential Healthcare Financing Terms and Calculations*, available at http://www.hfma.org/NR/rdonlyres/CBE63921-66B9-4D7F-9D13-D6DD5D4301FF/0/Report_5_glossary.pdf (last accessed May 8, 2009).



Term	What is it? Why is it important?	How do you figure it?
Annual Debt Service	Used to determine how heavily leveraged a hospital or hospital system is.	Sum of current portion of long-term debt and interest expense. (Notes and loans payable [short-term] plus interest expense.)
Average Age of Plant	A measure of the average age in years of the hospital's fixed assets. Lower values indicate a newer fixed base and, thus, less need for near-term replacement. Often is a proxy for future capital spending—higher ages indicate the need for more capital spending.	Accumulated depreciation divided by depreciation expense.
Capital Costs Ratio	Used as a measure of the capacity or size of a hospital.	Total capital-related operating costs (e.g., depreciation, interest, and capital leases) expressed as a percentage total of operating expense.
Capital Expenditure	Used to determine other ratios that demonstrate a hospital's financial strength and level of investment.	A cost that is added to the utility of an asset for more than one accounting period.
Capital Expenditure Growth Rate	A gauge of how aggressively a hospital is investing in its plant and equipment. This percentage can vary greatly over time as capital expenditures fluctuate. Higher values for this indicator imply an active capital expenditure program of additions and replacements.	The percentage of the organization's total gross property, plant, and equipment that was added in a given year.
Capital Expense Ratio	Provides an important measure of operating leverage. Because both interest and depreciation are considered fixed costs, a high capital expense ratio would imply greater sensitivity to volume changes. Increases in volume should enhance improvements in profit, while decreases in volume should worsen declines in profit for hospitals whose capital expense ratio is high.	Interest expense plus depreciation expense over total expenses times 100.
Cash	Used to determine liquidity ratios.	Unrestricted cash and investments plus unrestricted board-designated funds.
Current Ratio	The number of dollars held in current assets per dollar of current liabilities. A widely used measure of liquidity. An increase in this ratio is a positive trend.	Current assets divided by current liabilities.



Term	What is it? Why is it important?	How do you figure it?
Cushion Ratio	Measures the relationship between total debt service, both interest and principal, and total cash reserves, both current and noncurrent. A high value would indicate that a hospital is less likely to default on debt service payments because it has the cash reserves to meet its expected obligations. For example, a value of seven would mean the hospital had cash reserves seven times its annual debt service obligation.	Cash divided by maximum annual debt services.
Days Cash on Hand	Measures the number of days of average cash expenses that the hospital maintains in cash or marketable securities. It is a measure of total liquidity, both short-term and long-term. An increasing trend is positive.	Cash plus short-term investments plus unrestricted long-term investments over total expenses less depreciation divided by 365.
Debt Service Coverage	Measures total debt service coverage (interest plus principal) against annual funds available to pay debt service. Does not take into account positive or negative cash flow associated with balance sheet changes (e.g., workdown of accounts receivable). Higher values indicate better debt repayment ability.	Excess of revenues over expenses plus depreciation plus interest expense over principal payments plus interest expense.
Depreciation Rate	Provides a measure of the rate at which the organization is depreciating its physical assets. A rate of 5 percent would imply that the average life of the organization's depreciable assets is 20 years. Increases in this rate often imply that newer assets are being added to the organization's depreciable asset base.	Varies depending on useful life assigned to various assets.
EBITDA or EBIDA	EBITDA (used by for-profits) and EBIDA (used by not-for-profits) as a measure of cash flow.	Earnings before interest, taxes, depreciation, and amortization (EBITDA) or earnings before interest, depreciation, and amortization (EBIDA).
Fixed Asset Turnover	Used as an indicator of operating efficiency.	The number of operating revenue dollars generated per dollar of fixed asset investment.



Term	What is it? Why is it important?	How do you figure it?
Funds from Operations (FFO)	Many securities analysts judge a real estate investment trust's performance according to its FFO growth. When deciding among REITs for monetizing assets, it might be important to look at the FFO as a measure of the REIT's financial strength.	Net income excluding gains or losses from sales of property or debt restructuring, and adding back depreciation of real estate, and after adjustments for unconsolidated partnerships and joint ventures.
Interest Coverage	Used to determine leverage.	Net available for debt service divided by interest expenses.
Investment Grade Bond Rating	BBB- and above. Below that is generally considered below investment grade. Below investment grade is frequently referred to as speculative grade or even "junk."	Provided by rating agencies for a fee.
Long-term Debt to Capitalization	Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt. A declining trend is positive.	Long-term debt divided by long-term debt plus unrestricted net assets.
Return on Assets	Useful as another measure of profitability. It measures the size of the surplus generated in relation to the amount of assets needed to achieve the surplus.	Net income divided by total assets.
Return on Equity	A financial indicator that measures a hospital's ability to add new investment in plant and equipment without adding excessive levels of new debt. An increase is a positive trend.	The amount of net income earned per dollar of net assets or equity. It is the function of three other ratios: total margin, total asset turnover, and equity financing ratio.
Swaption	An option to enter into a swap agreement on preset terms at a future date. The organization receives an upfront payment in exchange for its agreement to swap fixed-rate debt into floating-rate debt or vice versa.	Varies.
Working Capital	Can be positive or negative. Increasing amounts of positive working capital enable a hospital to fund expansions, renovations, and other expenditures.	The excess of total current assets over total current liabilities at a fixed point in time.

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