DOCTORS' RESOURCE SPECIALISTS

"Nothing in life is to be feared, it is only to be understood. Now is the time to understand more, so that we may fear less."
~~ Marie Curie

Client Memo
May 2020

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New Round of Regulatory Waivers and Rule Changes Issued – *CMS Press Release*

On April 30, 2020, CMS issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens.

CMS's goals during the pandemic are to:

1. expand the healthcare workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community or other states;
2. ensure that local hospitals and health systems have the capacity to handle COVID-19 patients through temporary expansion sites (also known as the CMS Hospital Without Walls initiative);
3. increase access to telehealth for Medicare patients so they can get care from their physicians and other clinicians while staying safely at home;
4. expand at-home and community-based testing to minimize transmission of COVID-19 among Medicare and Medicaid beneficiaries; and
5. put patients over paperwork by giving providers, healthcare facilities, Medicare Advantage and Part D plans, and states temporary relief from many reporting and audit requirements so they can focus on patient care.

Many of CMS's temporary changes will apply immediately for the duration of the Public Health Emergency declaration.

CMS also is requiring nursing homes to inform residents, their families, and representatives of COVID-19 outbreaks in their facilities.

Key areas covered in the CMS Press Release are outlined below. For the full press release, please go to:

https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

COVID-19 Diagnostic Testing Expanded

Under the new waivers and rule changes, **Medicare will no longer require an order from the treating physician or other practitioner for beneficiaries to get COVID-19 tests and certain laboratory tests** required as part of a COVID-19 diagnosis. To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written practitioner's order is no longer required for the COVID-19 test for Medicare payment purposes.

Pharmacists also can perform certain COVID-19 tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist's scope of practice and state law.

Expanded Telehealth Services

For the duration of the COVID-19 emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Prior to this change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. **Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.**

CMS previously announced that Medicare would pay for certain services conducted by audio-only telephone between beneficiaries and their doctors and other clinicians. Now, **CMS is broadening that list to include many behavioral health and patient education services**. **CMS is also increasing payments for these telephone visits** to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020.

Since some Medicare beneficiaries don't have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, **CMS is waiving the video requirement for certain telephone evaluation and management services,** and adding them to the list of Medicare telehealth services.

As a result, Medicare beneficiaries will be able to use audio-only telephone communication to get these services.

Some of the applicable services that can be billed as telehealth with audio-only telephone communication are:

Code	Description
96127	Brief emotional/behavior assessment
96160	Patient focused health risk assessment
99356	Prolonged service inpatient 1 hour
99357	Prolonged service inpatient additional 30 minutes
99497	Advanced care planning 30 minutes
99498	Advanced care planning additional 30 minutes
G0108	Diabetes management training per individual
G0406	Inpatient telephone follow-up 15 minutes
G0407	Inpatient telephone follow-up 25 minutes
G0408	Inpatient telephone follow-up 35 minutes
G0436	Tobacco-use counseling 3-10 minutes
G0438	Annual wellness exam
G0439	Subsequent annual wellness exam
G0442	Annual alcohol screen 15 minutes
G0444	Annual depression screen
G0506	Chronic Care Management Care Planning

A complete list of telehealth services, including those that can now be audio only, is located at:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Increased Healthcare Workforce

Since beneficiaries may need in-home services during the COVID-19 pandemic, nurse practitioners, clinical nurse specialists, and physician assistants can now provide home health services, as mandated by the CARES Act.

These practitioners can now:

a. order home health services;
b. establish and periodically review a plan of care for home health patients; and
c. certify and re-certify that the patient is eligible for home health services.

Previously, Medicare and Medicaid home health beneficiaries could only receive home health services with the certification of a physician. These changes are effective for both Medicare and Medicaid.

These actions, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov.

Provider Relief Fund Program Update

A FAQ sheet on the Provider Relief Fun program was released on April 27, 2020 by the US Department of Health and Human Services (HHS), announced the HBMA. It can be viewed at:
https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf

HHS is authorized to distribute $175 Billion from the CARES Provider Relief Fund to Providers and Suppliers enrolled in the Medicare or Medicaid programs.

Thus far, HHS has authorized the release of $50 Billion as a "General" Distribution:

$26 Billion on 4/10;
$4 Billion on 4/17; and,
$20 Billion on 4/24.

HBMA's understanding is that $40 Billion of the $50 Billion authorized for distribution was distributed as of 5:00 p.m. on Friday April 24th.

$10 Billion remains for distribution based on information Provider Relief Fund recipients are being asked to submit on the Provider Relief Fund Application. (Note: letters went out to recipients the last week of April.)

Future Provider Relief Fund distributions will likely be what the Department refers to as "Targeted" Distributions.

HHS has established two portals:

Attestation Portal for funds already received on 4/10, 4/17 and 4/24: https://covid19.linkhealth.com/#/step/1

This portal is for all providers who received Provider Relief Funds as of 5:00 p.m. April 24th. You will be asked to accept the terms and conditions for receipt of these funds. If the provider fails to complete the attestation, it will be assumed that the provider has agreed to the terms and conditions.

Application Portal for additional "General" disbursements: https://covid19.linkhealth.com/docusign/#/step/1

The Application Portal is to collect information from providers who received General Distribution payments prior to April 24th and who wish to be considered for an additional disbursement from the General Distribution.

If a provider did not receive any funds from the previous releases, the provider is likely ineligible for any of the remaining $10 Billion General Distribution. However, these providers MAY be eligible for future Targeted Distributions.

For providers who are able to enter the Application Portal, HHS will be requesting the following information:

1. A provider's "Gross Receipts or Sales" or "Program Service Revenue" as submitted on their federal income tax return;
2. The provider's estimated revenue losses in March 2020 and April 2020 due to COVID-19;
3. A copy of the provider's most recently filed federal income tax return;
4. A listing of the TINs any of the provider's subsidiary organizations that have received relief funds but that DO NOT file separate tax returns

Provider Relief Hotline

HHS has established a Provider Relief hotline for inquiries related to the CARES Act grants. Please call (866) 569-3522 to find out if your practice was on the list to receive funds.

Accelerated Payment Program and Advance Payment Program Changes

On April 26, 2020, CMS announced that it would be re-evaluating the amounts that will be paid to hospitals under its Accelerated Payment Program and immediately suspending its Advance Payment Program to Part B suppliers such as doctors, non-physician practitioners and durable medical equipment suppliers.

The agency made this announcement following the successful payment of over $100 billion to healthcare providers and suppliers through these programs and in light of the $175 billion recently appropriated for health-care provider relief payments.

Since expanding the Accelerated and Advance Payment programs on March 28, 2020, CMS approved over 21,000 applications totaling $59.6 billion in payments to Part A providers, which includes hospitals. For Part B suppliers, including doctors, non-physician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing $40.4 billion in payments.

Beginning April 26th, CMS stopped accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments in light of historical direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund.

Significant additional funding will continue to be available to hospitals and other healthcare providers through other programs. Congress appropriated $100 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (PL 116-136) and $75 billion through the Paycheck Protection Program and Health Care Enhancement Act (PL 116-139) for healthcare providers.

The CARES Act Provider Relief Fund has already released $30 billion to providers and is in the process of releasing an additional $20 billion, with more funding anticipated to be released soon. This funding will be used to support healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic.

Medical Groups Slam CMS For Suspending Advance Payment Program – Jacqueline LaPointe, *Revcycle Intelligence*, April 29, 2020

The American Medical Group Association (AMGA) is calling on CMS to reverse its decision to end the Advance Payment Program for the remainder of the COVID-19 crisis.

In an April 28th letter to CMS Administrator Seema Verma, the association representing more than 175,000 physician practices criticized CMS's recent decision to suspend the program providing upfront Medicare reimbursements to providers to offset cash flow issues stemming from the COVID-19 crisis.

"The program helps ensure healthcare providers have the financial resources they need to continue operations during this public health emergency," wrote Jerry Penso, MD, MBA, president and CEO of AMGA. "CMS has not indicated the reasoning that led to this decision. We ask that CMS reverse this decision and instruct the Medicare Administrative Contractors to continue processing loan requests for both Part A and Part B providers."

CMS announced on April 26th, 2020, the suspension of the Advance Payment Program, which has given approximately $100 billion in upfront Medicare reimbursements to hospitals and physicians alongside the Accelerated Payment Program, a similar loan program operated by the agency.

Medical groups disapproved of the agency's decision, arguing that the Advance Payment Program should stay open as long as the public health emergency is in place.

The groups also called for extended repayment periods of at least 12 months and lower interest rates of no more than two percent.

COVID-19: New Programs Can Provide Money to Keep Your Practice Running

Ninety-seven percent of medical practices have experienced a negative financial impact directly or indirectly related to the COVID-19 pandemic, according to new data from the Medical Group Management Association (MGMA).

On average, practices report a 60% decrease in patient volume and a 55% decrease in revenue since the beginning of the public health emergency writes Lisa Eramo in her April 20, 2020, article for *Medscape Medical News.*

However, there are ways to offset revenue loss and remain financially viable during the economic uncertainty of the COVID-19 pandemic. Options include:

- US Small Business Administration's (SBA) Paycheck Protection Program;
- SBA's Emergency Economic Injury Disaster Loan
- Medicare's Advanced Payment Program; and
- SBA Coronavirus Economic Stabilization Act (CESA) loan.

These are in addition to several other strategies aimed at reducing costs and improving revenue.

Paycheck Protection Program -- The Paycheck Protection Program is a short-term loan that helps small businesses keep staff employed during the COVID-19 crisis. The loan covers a variety of costs, including payroll, rent, utilities, mortgage interest, and interest on any other debt obligations incurred before February 15 of this year.

SBA's Emergency Economic Injury Disaster Loan -- EIDL is a low-interest, long-term loan (capped at 3.75% for small businesses) that practices with 500 or fewer employees can use to pay fixed debts, payrolls, accounts payable, and other bills that could have been paid had the disaster not occurred. Borrowers can ask for up to $2 million, and the maximum term of this loan is 30 years, though the overall process for obtaining these loans will depend on the lender.

Medicare's Advanced Payment Program -- Under this program, eligible physicians are those who:

- billed Medicare for claims within 180 days prior to the date of the request;
- are financially solvent (ie, aren't in bankruptcy);
- are free from any active medical review or program integrity investigations;
- are in good standing with Medicare (ie, don't have an outstanding delinquent Medicare overpayment)

If physicians meet these criteria, they can ask their Medicare Administrative Contractor (MAC) to provide an advanced payment of up to 100% of the Medicare payment amount based on a 3-month lookback period. Repayment will occur in the form of automatic recoupments beginning 120 days after the advanced payment is received. Medicare has already approved more than 21,000 requests totaling more than $51 billion.

CESA Loan -- Specifically for mid-size practices, the details of which have yet to be announced, CESA loans will enable practices to access funds with an annualized rate no greater than 2% and with no principal or interest due for at least 6 months.

Loan Forgiveness Calculator

The Paycheck Protection Program provided loans to small businesses to keep their workers on the payroll. SBA will forgive loans if all employees are kept on the payroll for eight weeks and the money is used for payroll, rent, mortgage interest, or utilities.

Applications for forgiveness must be submitted within 90 days after the eight-week loan period and must include the following documentation:

- Record of the number of full-time employees and pay rates maintained during the eight-week load period;
- Proof of payment for mortgage, lease, and utility payments;
- Certification that the loan was used as intended;
- Any additional information required by the lender.

A Loan Forgiveness Calculator distributed free to the public by Blum Shapiro, a CPA firm, is available to assist loan recipients in determining their status.

The Loan Forgiveness Calculator Template can be downloaded for free from the Blum Shapiro website at: https://info2.blumshapiro.com/loan-forgiveness-toolkit

Medicare Sequestration Temporarily Suspended

In accordance with the CARES Act signed into law on March 27, 2020, CMS has implemented a temporary suspension of Medicare sequestration, beginning May 1, 2020, and ending on December 31, 2020.

This action will increase the Medicare fee-for-service payments by approximately 2% as compared to what they would have otherwise received during this period. Because of this temporary suspension, the CARES Act also extended the mandatory sequestration policy by an additional year, through 2030.

Public, Private Payers Offer Upfront Reimbursement Amid COVID-19

Many providers are struggling to keep their organizations operating with the loss of procedures that normally drive revenue. To mitigate financial losses incurred during the COVID-19 crisis, CMS recently expanded its Accelerated and Advance Payment Program to almost all Medicare Part A and B providers. The program provides three to six months' worth of Medicare reimbursement upfront to approved providers.

On the heels of Medicare, some private payers are also offering their provider partners upfront claims reimbursement to help them shoulder the burden of operating in a COVID-19 world.

Blue Shield of California announced on April 6 that it will make up to $200 million in direct support available to its healthcare providers and hospitals through advance payments and other options, such as financing guarantees and contract revisions.

On April 7, UnitedHealth Group also unveiled its plans to accelerate nearly $2 billion in claim reimbursement and support to healthcare providers to address the short-term financial challenges created by COVID-19.

UnitedHealth Group coupled its advance payment program with prior authorization flexibilities., similar to Blue Shield of California. UnitedHealth Group will also extend timely filing deadline for claims during the public health emergency and implement provisional credentialing to allow out-of-network care providers who are licensed independent practitioners to participate in one or more networks.

Many payers have already implemented strategies to broaden access to affordable COVID-19 treatment during the public health emergency, but now many are finding ways to support their provider partners who are on the frontline of the pandemic, writes Jacqueline LaPointe, *Health Payer Intelligence,* April 9, 2020

Financial Assistance for Non-Medicare Providers

A handful of specialties, including family medicine, obstetrics/gynecology, pediatrics, and other primary care specialties, are calling for targeted and urgent relief payments from the federal government, saying that they have been left out of distributions aimed at alleviating the financial fallout associated with the novel coronavirus, reports Alicia Ault in her April 30,. 2020, article "Ob/Gyns, Peds, Other PCPs Seeking COVID-19 Financial Relief From Feds" for *Medscape Medical News.*

The federal government has already distributed something like $150 billion to clinicians, but, to date, the money has only been given to providers who bill Medicare, and not even all of those individuals have received payments.

"It is critical that frontline physicians who may not participate in Medicare fee-for-service, in whole or in part, including obstetrician-gynecologists, pediatricians, and family physicians, have the resources they need to continue providing essential health care to patients amid the pandemic and in the months to come," said the AAFP, the AAP, and the ACOG in a letter to HHS Secretary Alex Azar.

In particular, the organizations are concerned that no money has been distributed or earmarked for clinicians who serve Medicaid recipients.

"The organizations that signed that letter are the primary providers of care to the Medicaid population," Shawn Martin, senior VP for the AAFP, told *Medscape Medical News.*

On April 23, Azar said HHS was working on a distribution plan for providers who only take Medicaid, as well as for dentists and skilled nursing facilities. An HHS spokesperson confirmed to *Medscape Medical News* that the agency still intends to provide money to those groups of providers and that the agency is committed to distributing funds quickly and with transparency.

An additional $75 billion will now be available through the Public Health and Social Services Emergency Fund (PHSSEF) as part of the third congressional COVID relief package, signed into law on April 24, 2020.

AAFP and other physician organizations have been talking with HHS about how to distribute money from that new pool of funds. The American College of Physicians (ACP) also has urged HHS to give special consideration to its members. The group wrote to Azar on April 28, recommending that payments from the new $75 billion PHSSEF be prioritized for primary care, as well as for smaller practices, those that provide care in underserved areas, and internal medicine subspecialty practices.

ACP said the government could pay physicians on the basis of the amount of additional expenses incurred that were

related to COVID-19, such as extra staffing or temporary relocation of their place of residence to prevent exposing family members to the virus. Pay should also be based on the percentage of revenue losses from all payers, including Medicare, Medicaid, and commercial insurers.

AAFP, AAP, and ACOG also had a suggestion for distributing payments to non-Medicare providers. "Given that most women's health, pediatric, and family practices have received less financial relief to date, we recommend that HHS provide these practices with a larger proportion of funds relative to their reported revenue than is provided on average across specialties," they wrote

AMA COVID-19 Resource Center
For helpful tips and updates, please visit the AMA Resource Center
https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians

Quality Reporting Measures Suspended by CMS

CMS announced it is suspending data collection and reporting for several key quality survey programs, writes Emily Sokol for *Health Payer Intelligence*, April 22, 2020

The announcement came on April 18, 2020, halting all data collection and reporting for the Qualified Health Plan Enrollee Survey, Quality Improvement Strategy, and Quality Rating System for plan year 2021.

Each year, health plans qualifying for the federal exchange must collect clinical data on key performance metrics including HEDIS and Pharmacy Quality Alliance (PQA) measures. HEDIS and PQA help plans and providers understand if they are meeting certain benchmarks for patient wellness, like offering colonoscopies and wellness visits as well as driving medication adherence and safety.

The move also aims to protect individuals in charge of collecting provider data. Patient medical records and information from physicians' offices must be exchanged with payers to report on these measures. Data collectors are, therefore, at risk if they must go to a provider's office to gather information or review patient medical records.

CMS's decision to suspend quality reporting allows providers to focus on patient care and keeps payers safe.

This will be a challenge in many value-based contracts for payers because many HEDIS, PQA, and Qualified Health Plan Enrollee Survey metrics are used as quality measures for value-based care contracting. While CMS is no longer mandating reporting, payers still need to monitor these measures if they are to report and pay out value-based care contracts to providers.

MIPS News

CMS providing relief to clinicians responding to the COVID-19 pandemic (*HFMA,* April 29, 2020)

MIPS-eligible clinicians who did not submit any MIPS data by April 30, 2020, will not need to take any additional action to qualify for the automatic extreme and uncontrollable circumstances policy. Providers will be automatically identified and will receive a neutral payment adjustment for 2021 MIPS-payment year.

MIPS 2019 Data Submission Period Now Closed

Preliminary performance feedback data is now available for viewing if MIPS data was submitted through the Quality Payment Program website. Final scores and feedback will be available in July 2020.

You will be able to access preliminary and final feedback with the same HCQIS Authorization Roles and Profile (HARP) credentials that allowed you to submit and view your data on the QPP site during the submission period

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