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Medicare Compliance & Reimbursement

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Quality Payment Program

CMS Offers COVID-19 Relief for QPP Participants

Know the extreme and uncontrollable circumstances policy update.

The feds realize that clinicians are battling the 2019 novel coronavirus (COVID-19) in hospitals across the nation. Plus, they understand that the last things providers want to worry about are administrative burdens and impending deadlines during a pandemic.

Now: On March 22, the **Centers for Medicare & Medicaid Services** (CMS) offered Quality Payment Program (QPP) participants an administrative olive branch. The agency extended the deadline for 2019 Merit-Based Incentive Payment System (MIPS) measures' submissions to April 30, 2020. Plus, CMS gave hospitals and post-acute care programs (PACs) a break, making Q4 quality data submissions — Oct. 1, 2019 to Dec. 31, 2019 — optional.

Here's Why the Feds Eased Up on QPP Requirements

While many MIPS-eligible clinicians (ECs), hospitals, and PACs are entrenched in the fight against COVID-19 and caring for sick patients, there's no way for them to collate data and submit accurate QPP information. "CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period," acknowledges the agency in a release.

"In granting these exceptions and extensions, CMS is supporting clinicians fighting Coronavirus on the front lines," stresses CMS Administrator **Seema Verma** in a release. "The **Trump** Administration is cutting bureaucratic red tape so the healthcare delivery system can direct its time and resources toward caring for patients."

Know These MIPS Updates

In addition to MIPS ECs, Medicare Shared Savings Program Accountable Care Organizations (ACOs) will also have until April 30 to submit 2019 MIPS measures. If your organization is struggling, and you know the new deadline will be impossible to meet — that's OK. If you choose not to submit as a MIPS EC, you'll automatically qualify for the "extreme and uncontrollable circumstances policy and will receive a neutral payment adjustment for the 2021 MIPS payment year," CMS says.

But: However, if you do end up submitting measures as an individual in two or more MIPS categories — Quality, Improvement Activities, and/or Promoting Interoperability — or you're "part of a group that submits data on behalf of its clinicians," your performance categories will be reweighted and you could receive a positive or negative 2021 payment adjustment.

The Cost performance category is weighted at 0 percent under an automatic extreme and uncontrollable circumstances policy and doesn't factor into adjustments, reminds the QPP COVID-19 response fact sheet.

Find the measures/payment breakdown in Appendix A of the QPP COVID-19 fact sheet at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/966/QPP%20COVID-19%20Response%20Fact%20Sheet.pdf.

Important: CMS plans to review options and offer guidance on 2020 QPP measures submissions and incentives in the months ahead.

See New 2019 QPP Submission Changes for Hospitals and PACs

According to new guidance, Q4 submissions are optional for hospital and PACs under the new Medicare updates; however, you can still send your quality data. "If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate)," explains the agency.

Hospital and PAC data from Jan. 1, 2020 to June 30, 2020 (Q1-Q2) won't be used as a qualifying requirement for the QPP participants. Consequently, hospitals and PACs don't need to submit quality data for this time period at all, indicates the release.

"In addition, no data reflecting services provided January 1, 2020 through June 30, 2020 will be used in CMS' calculations for the Medicare quality reporting and value-based purchasing programs," CMS says.

AMA Weighs In

Industry organizations agree that CMS did the right thing by pushing back deadlines for providers, who are already strapped and struggling due to the pandemic. "CMS' decision to offer relief from the submission demands in the Quality Payment Program will be felt immediately. Doctors don't have much time to breathe a sigh of relief, but if they did, they would take a moment to thank CMS for this wise decision," says **Patrice A. Harris, MD, MA,** president of the **American Medical Association** (AMA) in a release.

Resources: Review the QPP release and charts at www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting and see the CMS memorandum on the changes at www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf. ❑

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COVID-19

Feds Ease Up on HIPAA Under Telehealth Expansion

Tip: Non-public facing apps are now OK.

As the 2019 novel coronavirus (COVID-19) continues to push healthcare organizations' limits, the feds offer new guidance on how to navigate HIPAA under Medicare's telehealth expansion.

Background: On March 17, the **Centers for Medicare & Medicaid Services** (CMS) announced an expansion of telehealth benefits for specific providers and their patients. The changes allow clinicians to provide telehealth visits to patients anywhere, not just in rural areas, and in their homes rather than at a healthcare facility (see *Medicare Compliance & Reimbursement*, Vol. 46, No. 6).

Reminder: Back on Jan. 31, HHS Secretary **Alex Azar** declared a public health emergency (PHE), which was followed by President **Trump** signing the Coronavirus Preparedness and Response Supplemental Appropriations Act on March 6 and issuing a national emergency declaration on March 13. The combination of the new law and the declarations made an 1135 waiver possible; the telehealth expansion is an example of a regulatory flexibility under the waiver.

"These changes allow seniors to communicate with their doctors without having to travel to a healthcare facility so that they can limit risk of exposure and spread of this virus," CMS Administrator **Seema Verma** said in a release. "Clinicians on the frontlines will now have greater flexibility to safely treat our beneficiaries."

FaceTime, Skype Are OK for F2F Encounters Now

"Patients will now be able to access their doctors using a wider range of communication tools including telephones that have audio and video capabilities, making it easier for beneficiaries and doctors to connect," CMS says in its telehealth expansion release.

The feds have further clarified that non-public-facing technologies like FaceTime and Skype can be used for telehealth visits, but public-facing technologies like TikTok and Facebook Live can't.

"We are empowering medical providers to serve patients wherever they are during this national public health emergency," said **Roger Severino**, **HHS Office for Civil Rights** director. "We are especially concerned about reaching those most at risk, including older persons and persons with disabilities," Severino added.

Hand-in-hand with the telehealth expansion came an OCR announcement of HIPAA enforcement discretion. "OCR will ...not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency," OCR said.

And HHS also issued a waiver of certain sanctions for noncompliance with certain HIPAA requirements that day.

Further, the **HHS Office of Inspector General** (OIG) announced it would not apply "administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services," according to a March 17 announcement.

Remember: The telehealth visit doesn't have to be for COVID-19 reasons to qualify for the expansion and exemptions. "OCR emphasized the need to ensure remote access to care for patients, especially those most at risk, regardless of whether or not the service is related to COVID-19," note attorneys **Rebecca Schaeffer** and **Cheryl Choice** with law firm **K&L Gates** in online analysis. "Increasing access to telehealth will reduce the need for healthy or nonsymptomatic individuals to travel to facilities for health care, which in turn will help interpersonal interactions and further reduce transmission."

Don't Forget That State Laws Still Apply

Providers must also look to another authority which may have stricter requirements, Schaeffer and Choice

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remind. "Telehealth is heavily regulated by state law, and providers should ensure that they are meeting all state requirements prior to initiating telehealth services."

"Many states impose licensure, technology, consent, or other procedural requirements. Unless waived by state agencies, these state laws must also be considered before launching telehealth services," warns attorney **Kim Stanger** with **Holland & Hart LLP** in the firm's Health Law blog.

Also, don't take the OCR statement as carte blanche to ignore HIPAA requirements. "While these OCR pronouncements give covered entities some additional flexibility, it is limited, and overall HIPAA requirements continue to apply," Schaeffer and Choice caution.

Heads up: Not only should you be checking in with your Medicare Administrative Contractor (MAC) and state boards, but you may want to revisit private payer telehealth policies, too, urges Stanger. "Absent state laws to the contrary, whether private payers will pay for the telehealth services generally depends on the payer contracts. Accordingly, just because a provider may render services via telehealth does not necessarily mean that the provider will be paid for such services," he says.

Do this: Point your referring docs who are considering telemedicine to the **American Academy of Family Physicians'** website on the topic, which includes software recommendations and billing tips: www.aafp.org/patient-care/emergency/2019-coronavirus/COVID-19-daily/telehealth.html.

Resources: Here are the telehealth expansion and HIPAA releases referenced above:

1. CMS telehealth release: Review CMS' telehealth expansion announcement at www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak.

2. CMS telemedicine fact sheet: Check out the details at www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

3. HIPAA Enforcement: See OCR's notice of enforcement discretion at www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

4. HIPAA Waivers: Read HHS' HIPAA waiver announcement at www.hhs.gov/sites/default/files/hipaa-and-covid-19-limited-hipaa-waiver-bulletin-508.pdf.

5. OIG: Analyze OIG's copay waiver notice at https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/factsheet-telehealth-2020.pdf.

6. COVID-19 FAQ: Find CMS' COVID-19 FAQ with coverage information on a range of issues and across the Medicare spectrum at www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf. ❑

Medicare Advantage

Register These 2021 Medicare Advantage and Part D Proposals

Hint: CMS continues to push telehealth services.

With pandemic worries dominating the news, you may have missed the feds' Medicare Advantage and Part D proposed rule last month. But several of the policies on the table are surprising, and you may want to submit your opinion on the rule while you still can.

Context: On Feb. 18, the **Centers for Medicare & Medicaid Service** (CMS) published a Medicare Advantage (MA) and Part D proposed rule for the 2021 and 2022 contract years in the *Federal Register*. The proposals codify provisions, infuse 21st Century Cures Act mandates, and update end-stage renal disease (ESRD) policies — all the while pushing more risk onto providers. Interestingly, CMS nixed its annual MA call letter, suggesting instead that its proposals offered the necessary provider guidance — a move that is surprising and could have repercussions during the bid submission process.

"Much of the proposed rule serves to codify subregulatory guidance that is already in place today," says attorney **Melissa Wong,** a partner with **Holland**

& Knight LLP in Boston. "I do think it is interesting though that CMS announced that, for the first time, they are not issuing a call letter at all this year."

Wong continues, "Even in past years with the issuance of major proposed rules, CMS has always issued a call letter as scheduled. Plans will need to prepare a bid submission this year and potentially future years without this guidance from CMS."

Consider These 6 Takeaways from the Proposed Rule

Over the last year, many of CMS' releases follow patterns similar to ones in the MA and Part D proposals. The feds offer rules that aim to save consumers money with a combination of regulatory rollbacks and technology advancements — however, the policies often prove challenging for Medicare providers to implement.

Read on for six things to know in the proposed rule:

1. Growth Rate: MA providers can expect a minimal pay raise in 2021, which translates to less than this year's growth rate. "CMS proposes a growth rate that is 2 percent lower than the growth rate estimated in the CMS preview released two months earlier," notes attorney **James Roosevelt, Jr.** with **Verrill Dana LLP** in Boston. "In December, CMS released an early preview that estimated a 4.46 percent growth rate. The advanced notice calls for only a 2.5 percent growth rate in the county benchmark rates."

This growth rate reduction could translate to MA plans requiring higher premiums or reduced benefits, Roosevelt suggests. "Reduced benefits could include higher copays and deductibles. Higher premiums could mean the beneficiaries will choose plans that lower premiums by increasing copays and deductibles. Hospitals should be prepared for reduced utilization or increased bad debt if this occurs," he acknowledges.

2. ESRD: CMS proposes to allow ESRD patients to enroll in MA on Jan. 1, 2021 to align with a Cures Act requirement. This "is a major shift that will require plans, providers, and patients to sort out many issues related to provider network coverage, contracting, and reimbursement as well as how plans will factor in the additional needs and cost of insuring this population," Wong warns.

"This proposed rule also implements related MA and Medicare [fee-for-service] FFS payment changes made by the Cures Act — FFS coverage of kidney acquisition costs for MA beneficiaries and exclusion of such costs from MA benchmarks," the advance notice fact sheet relates.

3. Telehealth: With a nod to Bipartisan Budget Act of 2018 (BBA 2018) mandates, CMS aims to bolster network adequacy by authorizing more telehealth benefits for MA providers.

"CMS proposes to give MA plans a 10 percent credit towards meeting network adequacy for certain specialties through the use of telehealth providers," explains Washington D.C.-based attorney **Christine M. Clements,** a partner at **Sheppard, Mullin, Richter & Hampton LLP**.

Plus, the agency "also proposes to give MA plans another 10 percent credit if the plan's ability to meet CMS network adequacy requirements is impacted by a state certificate of need law or other 'anti-competitive' state restriction that limits the number of providers permitted to provide a particular type of service in the state," Clements continues.

Though the telehealth proposals offer incentives and allow MA plans to reach more patients, traditional Medicare FFS providers may feel forced into going the MA route. "In one sense, this proposal could be successful in drawing in more specialty providers with telehealth capabilities," Wong says. "On the other hand, providers may feel more pressure to contract with MA

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plans, even on less favorable terms than desired, in light of potential increased competition from providers practicing farther away."

4. Star ratings: In the spirit of heightened transparency, CMS plans to change the measure weights for MA plans under its Star Ratings system. According to the proposed rule, the agency will bump up weights for patient complaints, experience, and access measures.

In an effort to clarify and consolidate, the agency plans to "remove the Rheumatoid Arthritis Management (Part C) measure from the Star Ratings," update the "specifications of the Health Outcomes Survey (HOS)" measures, and add two new MA measures to the Star Ratings program, the rule notes.

CMS also proposes "to codify additional existing rules for calculating MA Quality Bonus Payment (QBP) ratings," stresses the rule.

5. Opioid prescribing: The proposed rule offers more guidance on opioid abuse treatment. As part of its drug management programs under Part D, "providers may need to more closely manage patients identified as 'at risk' for drug abuse, namely opioid drug abuse," Wong advises.

For example: "If a patient shows a history of a past opioid-related overdose … the sponsor may limit that patient's access to opioids to a specific prescriber or network pharmacy, which in turn may require a prescribing provider's involvement in rounds of prior authorizations and appeals to obtain access even for legitimately prescribed and dispensed medications," says Wong.

6. Real-Time Benefit Tool: Back in May 2019, CMS required Part D plans to have a real-time benefit tool (RTBT) available to prescribers on Jan. 1, 2021, "with complete, accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information," reminds the rule.

Now: CMS proposes that Part D plans have a RTBT available for beneficiaries by Jan. 1, 2022, the rule says.

"This tool fits into the current administration's emphasis on transparency and information, although I think that the success of this tool in achieving those goals will depend on whether the seniors enrolled in Part D plans will be tech-savvy and motivated enough to access the full range of information in real time," Wong says.

"The proposed January 1, 2022 timeframe for launching this tool is aggressive, and the information that may be shared in a real-time benefit tool could be confusing to patients unless carefully and accurately presented," she cautions.

What Impact Will the MA Changes Have on FFS Providers?

Over the last few years, CMS has subtly promoted Medicare Advantage — and this has not necessarily been a positive for mainstream Medicare FFS providers, who may have trepidation about moving into the managed care realm. However, as more and more beneficiaries move toward MA, these practitioners may feel compelled to enter into contracts with MA plans to reach more patients.

"This administration has worked to make MA plans more appealing to consumers, and whether or not in direct response to these changes, enrollment in Medicare Advantage has reached all-time highs and continues to grow," Wong points out.

MA plans are continually touted as cost-saving alternatives to traditional Medicare as well. "Value-based payments are very popular with the **Trump** Administration, so regular Medicare providers should expect more value-based proposals from CMS even with CMS' increased focus on MA," says Clement. For the time being, however, "regular Medicare is still very popular with beneficiaries," she adds.

Risk factor: In the past, Medicare providers may have played it safe with FFS Medicare. But as MA enrollment continues to spike, clinicians may be willing to take on the added fiscal perils. "Many MA plans share risk with providers. Some providers have been reluctant to join the MA networks because of reluctance to take on risk," explains Roosevelt. "However, the increase in the MA enrollment may force them to reconsider. Providers will need to become more efficient and coordinated care better to have a favorable experience with risk sharing."

Deadline: CMS will accept comments on the proposals until April 6 at 5 p.m. EST.

Resource: Review the proposed rule at www.govinfo.gov/content/pkg/FR-2020-02-18/pdf/2020-02085.pdf.

Reader Question

Verify MBI Status If Problems Arise

Question:
A few of our Medicare patients' claims have been rejected, despite using their Medicare Beneficiary Identifiers (MBIs). Am I doing something wrong?
SuperCoder Subscriber

Answer:
If you're getting rejections due to incorrect MBIs, do some research into the error code.

"If you get an eligibility transaction error code (AAA 72) of 'invalid member ID,' or 'The the beneficiary you requested cannot be found. Please verify your information,' your patient's MBI may have changed" since it was originally issued, the **Centers for Medicare & Medicaid Services** (CMS) explains in a new article. "Remember, requests to change MBIs can occur if a Medicare beneficiary, their authorized representative, or CMS suspects a number is compromised."

Patients may give you the old card or seek care before receiving a new one.

When you get such an error code, "do a historic eligibility search to get the termination date of the old MBI," CMS advises. Then, "get the new MBI from your Medicare Administrative Contractor's secure lookup tool."

Remember: You'll need the beneficiary's first and last name, birthdate, and Social Security number (SSN) to use the MBI look-up tool, notes *MLN Matters* SE18006, which was revised on March 19 to address this problem.

See the revision at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18006.pdf. ❑

Industry Notes

See How 1135 Waivers Impact Medicare Enrollment in New FAQ

With the healthcare industry besieged by the 2019 novel coronavirus (COVID-19), the feds have added Medicare provider enrollment to the list of things covered by 1135 waivers.

Context: With a national public health emergency (PHE) called on Jan. 31 by **HHS** Secretary **Alex Azar** and a national emergency declared by the president on March 13, the **Centers for Medicare & Medicaid Services** (CMS) can offer flexibilities under Section 1135 of the Social Security Act (SSA).

According to a new FAQ, CMS is using its 1135 waiver authority to waive certain Medicare provider enrollment requirements. Some of the flexibilities include provider screenings, application fees, site visits, and revalidations.

In addition, the Medicare Administrative Contractors (MACs) in each jurisdiction will offer toll-free hotlines "for physicians and non-physician practitioners (NPPs) to initiate temporary Medicare billing privileges," the FAQ notes.

Clinicians can also call the hotlines with other 1135 waiver flexibility questions and report practice location changes, CMS advises.

Find more Medicare provider enrollment information in the time of COVID-19 at www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf.

Feds Approve 34 States' Waivers — and Counting

If you care for Medicaid beneficiaries in your state, the feds have some good news in these troubled times.

On March 27, the **Centers for Medicare & Medicaid Services** (CMS) approved the 34th state Medicaid waiver request as part of its 1135 waiver authority as outlined in the Social Security Act (SSA) provisions after public health and national emergencies were announced. The agency recognizes that state Medicaid providers are working round the clock to care for the nation's most vulnerable patients as they battle the 2019 novel coronavirus (COVID-19) in their individual states.

"These approvals provide states new flexibilities to focus their resources to provide the best possible care for their Medicaid beneficiaries in response to the coronavirus outbreak," explains CMS in a release.

In addition to the 1135 waivers, the agency accepted "eight state requests to invoke emergency flexibilities in their programs that care for the elderly and people

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with disabilities in their homes and communities," CMS says. "These approvals give states a range of flexibilities including the ability to enroll out-of-state or new providers more quickly, temporarily delay Medicaid hearings to focus resources, and temporarily suspend prior authorization requirements."

See if your state's Medicaid program is approved for an 1135 waiver at www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/index.html.

Beware of COVID-19 Scammers, Warns OIG

Even during a crisis of epic proportions like the 2019 novel coronavirus (COVID-19), you must be on the lookout for Medicare fraud.

On March 23, the **HHS Office of Inspector General** (OIG) updated its site with a COVID-19 fraud alert.

"Scammers are offering COVID-19 tests to Medicare beneficiaries in exchange for personal details, including Medicare information," OIG cautions. "However, the services are unapproved and illegitimate."

"Fraudsters are targeting beneficiaries in a number of ways, including telemarketing calls, social media platforms, and door-to-door visits," says the agency guidance.

Plus: OIG also has a COVID-19 portal with links to alerts on fraud, COVID-19-specific enforcement information and work plan updates, and various other pandemic-related advice.

Check out the alert and other OIG assistance at https://oig.hhs.gov/coronavirus/index.asp?utm_source=web&utm_medium=web&utm_campaign=covid19-landing-page. ❑