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WHA, Along with Nearly 30 Associations, Launch "Stop the COVID Spread!" Coalition to Combat COVID Crisis

As the pace of COVID-19 infections continues to increase rapidly in Wisconsin, a robust group of the state's leading advocacy organizations have launched a new coalition aimed at combating the growing COVID-19 crisis.

"Stop the COVID Spread!" is a coalition of nearly 30 of Wisconsin's leading health care, business, and advocacy organizations who have joined together in a campaign to educate the public about the seriousness of the pandemic and the critical need for preventative measures including social distancing, hand washing, and the use of protective masks.

Co-chairs of the coalition include the Wisconsin Hospital Association, Wisconsin Grocers Association, Wisconsin Manufacturers & Commerce, Wisconsin Counties Association, and the Wisconsin Restaurant Association. The coalition co-chairs held a press conference October 9, addressing the looming public health crisis that is threatening to overwhelm health care systems around the state which drew statewide coverage from more than 30 media outlets.

"The impact of Wisconsin's growing COVID situation is most visible in health care, a sector that touches all our lives and all industries," said Eric Borgerding, WHA president and CEO at the October 9 press conference. "But COVID goes beyond health care, and it's why we are joining with colleagues to launch Stop the COVID Spread! – a collaboration of business, local government and higher education organizations banding together and taking steps to help combat COVID," Borgerding continued.

The new coalition builds on previous statewide efforts to educate Wisconsinites about the public health crisis, including a series of public service announcements launched by various partner organizations encouraging the use of crucial safety measures to help reduce the spread of COVID-19.

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Alternative Care Facility for COVID-19 Patients Opens in Milwaukee

The Alternate Care Facility (ACF) at State Fair Park in Milwaukee opened October 14, 2020, for transfers of certain COVID-19-positive hospital patients. The ACF opened with 50 staffed beds, and the ability to increase the number of beds rapidly in increments of 25 if needed. According to the ACF, the vast majority of the ACF's staffing has been secured through a staffing agency contracted by the State of Wisconsin.

The ACF leadership team has released an updated ACF process and protocol reference guide that details the process for intake requests, ACF patient admission inclusion and exclusion criteria, discharge process, and the ACF's admission form. The reference guide includes the ACF's Command Center telephone number and other important information for hospitals planning to request a transfer of one or more patients.

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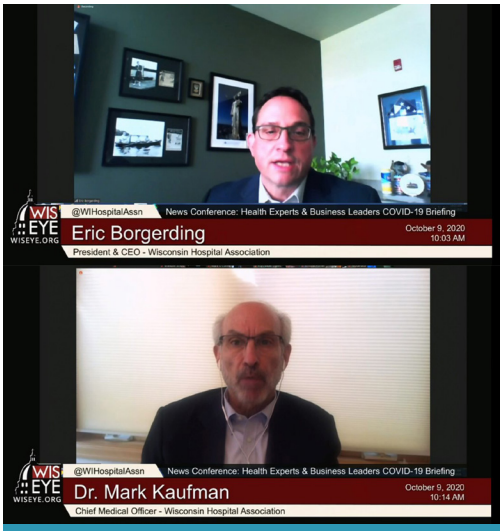
Coalition efforts will include a new public service announcement on broadcast channels statewide, as well as a digital advertising campaign. These campaigns will urge Wisconsin residents to take preventative measures seriously in order to keep the state's health care system stable and accessible, protect the health and safety of workers, and prevent further shutdown of Wisconsin businesses and economic functions.

Each of the coalition member organizations will also be engaging their own staff and members on employing preventative measures to help combat the growing public health crisis.

"This diverse, and I predict growing group, rapidly came together, and even more impressive, it's a coalition representing the gamut of industries across Wisconsin – restaurants, realtors, grocers, gas stations, manufacturers, the State Chamber of Commerce, tech companies, telecommunications, county municipal governments, banks, builders, the UW System, and, of course, health care – these are some of the Wisconsin's most influential organizations now aiming that influence at COVID, and working together to slow this down and turn it around," said Borgerding.



WHA President Eric Borgerding and WHA Medical Director Mark Kaufman, MD speaking at the Oct. 9 press conference.

The growing coalition is currently made up of the following organizations:

- Wisconsin Hospital Association, CO-CHAIR
- Wisconsin Counties Association, CO-CHAIR
- Wisconsin Grocers Association, CO-CHAIR
- Wisconsin Manufacturers and Commerce (WMC), CO-CHAIR
- Wisconsin Restaurant Association, CO-CHAIR
- LeadingAge Wisconsin
- League of Municipalities
- Metropolitan Milwaukee Association of Commerce (MMAC)
- Pharmacy Society of Wisconsin
- Rural Wisconsin Health Cooperative
- UW System
- Wisconsin Association of Health Plans
- Wisconsin Bankers Association
- Wisconsin Builders Association
- Wisconsin Dental Association
- Wisconsin Health Care Association/Wisconsin Center for Assisted Living
- Wisconsin Healthcare Business Forum
- Wisconsin Medical Society
- Wisconsin Petroleum Marketers & Convenience Store Association
- Wisconsin Realtors Association
- Wisconsin Safety Council
- Wisconsin State Telecommunication Association
- Wisconsin Technology Council
- Wisconsin Director of Nursing Council
- Wisconsin Credit Union League
- Arts Wisconsin

Initial funding for the "Stop the COVID Spread!" Coalition's public messaging efforts is provided by the WHA-affiliated 501(c)(4) nonprofit organization, the Healthy Wisconsin Alliance.

The coalition is currently running a statewide digital ad drawing awareness to the situation and the coalition itself. A series of PSAs are in production to be released in the coming weeks. All of the coalition's initiatives will be shared on the coalition web page at www.wha.org/StopTheCOVIDSpread.

HHS Announces New $20 Billion CARES Act Distribution

On October 1, the U.S. Department of Health & Human Services (HHS) announced the newest round of funding from the federal CARES Act Provider Relief Fund (PRF).

In all, HHS announced $20 billion would be distributed to a variety of health care providers, including hospitals. All interested entities will need to apply for this funding, which HHS will distribute via the following methodology:

1. Any providers that have not yet received relief fund payments equal to at least 2 percent of patient care revenue will receive a payment that, when combined with prior payments (if any), equals 2 percent of patient care revenue;
2. Using any remaining balance of funds, if any, HHS will make "equitable" add-on payments with the following considerations: changes in operating revenues for patient care; providers' changes in operating expenses from patient care, including incurred expenses related to COVID-19; and payments already received through provider relief fund distributions.

While the application window is open through Nov. 6, HHS is encouraging applicants to apply early. To apply, go to this link and scroll down to "How to Apply for Phase 3 General Distribution."

Contact WHA Vice President of Federal and State Relations Jon Hoelter with questions.

WHA & RWHC Object to Changes in CARES Act Provider Relief Fund Guidance

In an October 6 letter to U.S. Department of Health and Human Services (HHS) Secretary Alex Azar, WHA partnered with the Rural Wisconsin Health Cooperative (RWHC) to express concerns over recent changes to the federal guidance governing how hospitals can use funding received from the Provider Relief Fund (PRF) authorized by the CARES Act. WHA also held a member webinar with corporate member Husch Blackwell covering this guidance. WHA members can view the webinar on WHA's on demand learning center.

At issue is guidance released on September 19 that significantly changed the definition of lost revenue. Prior to this change, the CARES Act and HHS guidance allowed a much broader definition of lost revenue, which essentially allowed hospitals to use the funding for any health care revenue lost due to coronavirus. WHA previously estimated Wisconsin hospitals and health systems lost around $2.5 billion statewide from the pause in elective procedures early in the pandemic and has estimated they have received about $1.1 billion in PRF funds. The change in guidance, however, redefined lost revenue to mean something closer to a change in a hospital's operating margin.

The change in guidance has created significant confusion and uncertainty over how hospitals will be able to spend COVID relief dollars. In the letter, WHA and RWHC noted that hospitals were led to understand both by a plain reading of the statute and initial guidance from HHS that lost revenue would be just that. However, as both noted in the letter, "All too often, our members make the best financial decisions they can with the information at hand only to have the rug swept out from under them as rules change midstream. This is unfortunately another example of that." The letter requests that HHS revert back to the former definition of lost revenue, which is more in line with the federal statute and Congress' original intent for these funds.

WHA has raised this issue with Wisconsin's Congressional Delegation and is continuing to ask for their support in ensuring HHS allows hospitals to use these funds in a way that is consistent with Congressional intent.

For more information, contact WHA Vice President of Federal and State Relations Jon Hoelter.

WHA Urges CMS to Revise Proposed CY 2021 Physician Fee Schedule Rule

WHA submitted comments on the CY 2021 Medicare Physician Fee Schedule (PFS) proposed rule to the Centers for Medicare and Medicaid Services (CMS) on October 5. WHA expects a final rule in early December. A summary of WHA's comments follows:

Conversion Factor. In the rule, CMS proposed a decrease in Medicare physician payment rates of 10.61% in CY 2021. This proposed reduction would result in an estimated conversion factor of $32.26, a reduction of $3.83 from the CY 2020 conversion factor of $36.09. WHA strongly opposed this decrease. This significant reduction of the conversion factor could result in drastic cuts to many physician specialties. CMS proposed this conversion factor cut without any clear, transparent explanation into how it was calculated. Moreover, while these proposed changes may be budget neutral for Medicare as a whole, they would not be budget neutral for individual providers, including hospitals and health systems.

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This change was made in conjunction with a revaluation of some Evaluation and Management (E/M) and related codes, which WHA urges CMS to finalize. Because of budget neutrality requirements, WHA urged CMS to work with Congress to secure a waiver of budget neutrality for the PFS for at least calendar years 2021 and 2022. Doing so would allow CMS to protect patient access to care by increasing payments for E/M visit codes without an overall cut to payments in excess of 10 percent.

If CMS cannot secure a waiver of budget neutrality from Congress, WHA asks CMS to delay the implementation of the revaluation of the E/M and related visit codes and the corresponding budget neutrality adjustment so as not to hinder the ongoing work hospitals and health systems must do in response to COVID-19.

Telehealth flexibilities

Highlights of the rule's telehealth provisions include:

New category for adding telehealth services. In the rule, CMS proposes to create a new category for adding telehealth services to the Medicare telehealth list. In this new Category 3, services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic, and for which there is likely to be clinical benefit but there is not yet sufficient evidence available to consider the services as permanent additions, will remain on the list through the calendar year in which the PHE ends.

WHA asked CMS to provide additional direction regarding the type of evidence CMS is looking for in order for these codes to qualify for more permanent inclusion. WHA also asked CMS to consider keeping Category 3 services on the list for a longer period of time than a calendar year. This would allow more time to gather evidence which would support or refute the permanent addition of these services.

Audio-only services. WHA members have emphasized the importance of retaining reimbursement for audio-only telehealth services that was authorized during the PHE. These services have literally been a lifeline for patients without internet access, whether or not they live in rural areas. Senior citizens especially benefit from audio-only services as they may not have computers or if they do, may not feel comfortable using them for telehealth visits. Our members also report that behavioral health patients have embraced the opportunity to receive services over the telephone.

Because CMS does not believe it has authority, without Congressional action, to permanently add audio-only services to the Medicare telehealth list it is not proposing to continue to recognize audio-only payment codes under the PFS in the absence of the PHE for the COVID-19 pandemic. However, it acknowledges that the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection.

In its comment letter, WHA strongly urged CMS to move forward with coding and payment for a service similar to the virtual check-in, but for a longer unit of time and a higher value that would allow for use of telephone. Even when the PHE ends, it is likely that many patients will not feel comfortable leaving their homes until a vaccine is widely available, and in those cases, telephone may be the only way some patients have to access providers, and not all of them will have a pre-existing relationship.

Remote Patient Monitoring (RPM). CMS proposes to continue reimbursement policies for RPM that it established during the PHE, but only for established patients. WHA disagrees with this limitation and urged CMS to retain RPM for new patients, as has been permitted under the PHE.

Virtual supervision definition. For the duration of the PHE for the COVID-19 pandemic, for purposes of limiting exposure to COVID-19, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/ video real-time communications technology. WHA supports continuing this policy beyond 2021, relying on the clinical expertise and discretion of as supervising physician or practitioner regarding the use of virtual supervision.

Quality Payment Program

Merit-Based Incentive Payment System (MIPS). Under current MIPS policy, MIPS-eligible clinicians and groups participating in certain Alternative Payment Models (APMs) – including the Medicare Shared Savings Program (MSSP) – receive special scoring under the MIPS APM scoring standard. For CY 2021, CMS proposes to sunset the MIPS APM scoring standard, and replace it with a new APM performance pathway (APP) While the APP is similar to the APM scoring standard in several ways, it would significantly diverge from it by requiring clinicians and groups to report and be scored on a common set of six quality measures. These measures reflect diabetes control, depression screening/follow up, blood pressure control, patient experience, hospital-wide readmissions and admissions for multiple chronic conditions. This requirement would apply to APP participants regardless of the APM model in which they participate.

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In its comment letter, WHA stated that requiring all MIPS APMs to report on the same six quality measures would be a misguided, "one size fits all" policy that fails to improve upon current policy, and urged CMS not to adopt it. WHA wrote that it is hard to understand how the six proposed measures could be equally relevant to all 12 of the APMs that currently meet MIPS APM requirements. For example, for clinicians participating in the Bundled Payment for Care Improvement Advanced (BPCI A) model, it is not clear how depression screening and follow up are relevant to those models that are focused on procedural inpatient care. Instead of adopting the APP model, we are asking CMS to instead to retain the existing requirement that MIPS APMs report the measures already required under their models.

Removal of the Web Interface Reporting Option. CMS proposes to abruptly end the use of the Web Interface reporting mechanism, a tool that has been used since the MSSP's inception. Removing this option for all ACOs with no notice is ill timed and unfair. WHA urged CMS to restore this reporting mechanism in the final rule.

If you have questions about the proposed rule and WHA's comments, please contact WHA's Laura Rose or Laura Leitch.

DSPS Updates WHA-Requested Temporary Interstate Health Care Licensure Process

The Wisconsin Department of Safety and Professional Services (DSPS) has updated and clarified the temporary health care professional licensure forms and criteria that enable health care providers currently licensed in other states to immediately begin providing care in Wisconsin. Those application and notification forms can be found at https://dsps.wi.gov/pages/Home.aspx.

The updated temporary licensure process is a result of a request by WHA of Governor Tony Evers to reinstate the health care workforce related waivers and orders issued this spring which expired in June. On October 1, Gov. Evers issued Emergency Order 2, which largely replicates the previous health care professional licensure orders. Since the October 1 order, WHA has worked with the DSPS to clarify the temporary licensure process and, as a result, DSPS posted updated forms on its website October 10.

WHA has created a summary of Emergency Order 2 and the DSPS temporary licensure process and forms. That summary can be accessed through the WHA Member Log In. For more information, contact WHA General Counsel Matthew Stanford.

New DHS Guidance Issued for SNF Admissions during COVID

On October 15, DHS issued a supplementary document that may allow skilled nursing facilities (SNFs) to admit residents prior to the expiration of a 14-day admissions restriction period previously recommended by DHS in its September 23 guidance. As WHA previously reported in *The Valued Voice*, the September 23 guidance has severely curtailed hospital discharges to SNFs, leaving discharge-ready patients in hospitals, resulting in shortages of available acute care beds.

This supplementary document sets out criteria for a SNF to use to determine if it can safely admit residents to the facility without waiting 14 days. These criteria are:

1. After subsequent facility-wide testing and contact tracing, either no units in the facility are impacted, or the outbreak is limited to a single unit/floor/wing. The facility may admit to a non-affected unit, may establish an alternate temporary quarantine area, or may consider admissions within a wing or floor where an outbreak was identified if the outbreak is contained, and interventions are in place for continued containment.
2. The facility has determined it has adequate caregiver staffing levels to safely allow admissions while in its current outbreak status.
3. The facility has determined it has an adequate supply of PPE, based on CDC guidance, to safely allow admissions while in its current outbreak status.
4. The facility has addressed or mitigated other extenuating circumstances that would preclude it from admitting new residents in less than 14 days.
5. The facility will inform new admissions of the outbreak and steps it has taken to ensure patient safety.

A facility admitting a resident following review and analysis of the above considerations must document and keep record of the findings of the assessment that are being used to support a decision to allow admissions during the outbreak status, including notification to their local public health department.

For further information on this most recent guidance, please contact Laura Rose or Laura Leitch at WHA.

CMS Sends Enforcement Letters to Hospitals Failing to Report COVID Data, DHS Webinar Available

On September 2, 2020, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule (IFC), CMS-3401-IFC, that included new requirements for hospitals and Critical Access Hospitals (CAHs) to report data in accordance with a frequency and in a standardized format as specified by the Secretary during the Public Health Emergency for COVID-19. The regulatory requirements for hospitals and CAHs can be found at 42 CFR §§ 482.42(e) and 485.640(d) respectively (see 85 FR 54873). This data allows CMS to monitor whether individual hospitals and CAHs are appropriately tracking, responding to, and mitigating the spread and impact of COVID-19 on patients, the staff who care for them, and the general public.

CMS has established a multi-step approach to enforcement for non-compliance with the hospital and CAH reporting requirements implemented in the IFC. CMS wrote that hospitals or CAHs that fail to report the specified data elements on a daily basis, with certain exceptions, will receive a notification from CMS of their noncompliance with the reporting requirements and any further noncompliance with reporting requirements may result in future enforcement actions. CMS also wrote that compliance with these reporting requirements will be determined independently from health and safety surveys for all other CoPs performed by state survey agencies or accreditation organizations processes under 42 CFR Part 488.

WHA was made aware that last Wednesday, October 7, 2020, CMS emailed several documents, including the first enforcement letter, to the last known hospital "Administrator" contact. WHA sent a communication to all hospital CEOs, compliance officers and quality mangers to ensure that the information was received and, if not, to provide background on the latest interim rule regarding data reporting and forthcoming penalties for non-compliance. In addition, the email announced a DHS webinar that was intended to provide information on the reporting requirements. You can view the webinar recording here. (No password needed).

Contact Vice President, WHA Information Center Jennifer Mueller for more information.

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