GOVCHAT LIVE:

UNWINDING THE PUBLIC HEALTH EMERGENCY (PHE)

Inspiring healthcare excellence.℠

MGMA®

TODAY'S PRESENTERS

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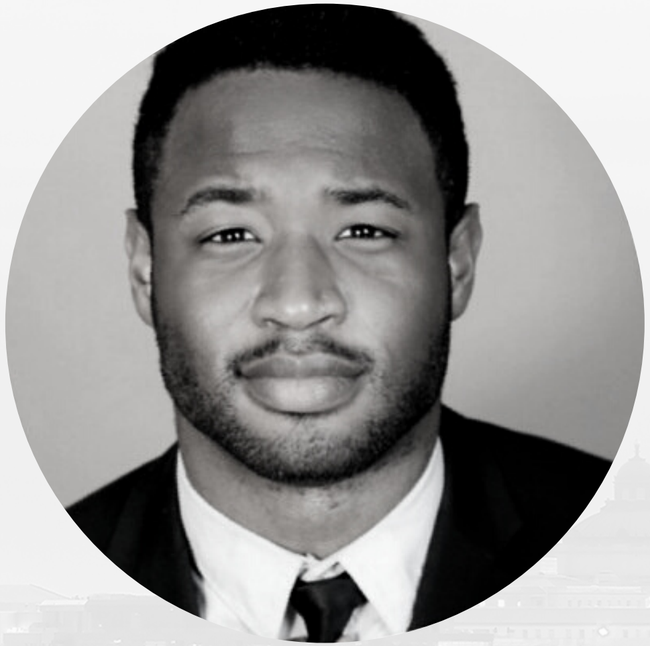

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IMPACT OF RECENT CONGRESSIONAL ACTION (NATIONAL EMERGENCY)

POTENTIAL IMPACT OF HOUSE JOINT RESOLUTION 7 (H.J.RES.7)

"In response to questions related to how the ending of the National Emergency by H.J.Res.7 impacts the Public Health Emergency for COVID-19, we wanted to share the following question and answer broadly:

WHAT HAPPENS IF A NATIONAL EMERGENCY ENDS BEFORE THE PHE ENDS?

To be clear, the federal Public Health Emergency (PHE) for COVID-19 declared under section 319 of the Public Health Service Act, is not the same as the COVID-19 National Emergency declared by the Trump Administration in 2020 and implicated by H.J.Res.7. Therefore, an end to the COVID-19 National Emergency does not impact current operations at HHS, and does not impact the planned May 11 expiration of the federal PHE for COVID-19 or any associated unwinding plans. Even if the COVID-19 National Emergency were to end, any existing waivers currently in effect and authorized under the 1135 waiver authorization for the pandemic, would remain in place until the end of the federal PHE for COVID-19."

SOURCE: HTTPS://WWW.CMS.GOV/ABOUT-CMS/AGENCY-INFORMATION/EMERGENCY/EPRO/CURRENT-EMERGENCIES/CURRENT-EMERGENCIES-PAGE

COVID-19 VACCINES AND TESTING

PHE POLICY

- Medicare will cover all COVID-19 vaccines and tests without cost-sharing
- Group health plans and individual health plans are also required to cover COVID-19 , vaccines, testing, and related services without cost-sharing during the PHE

POST-PHE POLICY

- Tests ordered by a healthcare provider and performed by a laboratory will still be available without cost sharing under Medicare (Part B)
- Most plans will continue to cover vaccines from in-network providers without cost-sharing
- Mandatory coverage for COVID-19 testing will end and vary by plan. CMS encourages plans to continue to cover
- Current access to OTC COVID-19 tests will end
- State Medicaid programs must provide coverage without cost sharing for COVID-19 testing through Sept. 30, 2024

MEDICARE TELEHEALTH WAIVER TIMELINE

TELEHEALTH POLICY	PRE-PHE POLICY	PHE POLICY	DATE POLICY ENDS & REVERTS TO PRE-PHE
Originating site/geographic location	Beneficiaries must receive services at originating site in a rural area (not the home)	Location is waived – patients can be seen anywhere	Dec. 31, 2024 ***exception: mental health services*
Qualifying providers	Certain providers are allowed to deliver telehealth services	Provider types extended to PTs, OTs, and SLPs	Dec. 31, 2024
Audio-only services	CMS did not cover audio visits without a visual component	CMS will reimburse for services via phone (E&M visits)	Dec. 31, 2024
FQHCs and RHCs	FQHCs and RHCs could not qualify as distant site providers	Can qualify as distant site providers	Dec. 31, 2024
Payment parity	Telehealth services were reimbursed at typically lower, facility rates	Telehealth can be reimbursed at in-person rate if modifier 95 is used	Dec. 31, 2023
Cross-state licensure	Providers must be licensed in state where patient is located	If providers meet four conditions, can treat patients in other states (still must comply with state licensure requirements)	May 11, 2023
HIPAA compliant platforms	Providers must use HIPAA compliant platforms	Providers could use non-HIPAA compliant platforms so long as not public-facing	Aug. 9, 2023 (90-day transition period)

DOWNLOAD MGMA'S TELEHEALTH MEMBER RESOURCE HERE

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ORIGINATING SITE/GEOGRAPHIC LOCATION

EXPIRING: DEC. 31, 2024 *Exception: mental health services

PRE-PHE POLICY

- Beneficiaries must receive services at an originating site (not the home)
- Must be in a rural area

PHE POLICY

- Location requirements are waived – patients can be seen anywhere
- Patients can permanently use telehealth to receive behavioral/mental health services in their homes

QUALIFYING PROVIDERS

EXPIRING: DEC. 31, 2024

PRE-PHE POLICY

- Physicians and certain other providers (clinical social workers, clinical psychologists) were able to deliver telehealth services

PHE POLICY

- List of non-physician provider types allowed to deliver telehealth services extended: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Audiologists

AUDIO-ONLY SERVICES

EXPIRING: DEC. 31, 2024

PRE-PHE POLICY

- CMS did not cover audio visits without a video component

PHE POLICY

- CMS will reimburse for services such as E&M visits via phone. *The full list of services allowed to be delivered via telehealth can be found here.*
- Behavioral and mental telehealth services **can permanently be delivered** with audio-only platforms (note in-person requirements)

FQHCS AND RHCS

EXPIRING: DEC. 31, 2024

PRE-PHE POLICY

- FQHCs and RHCs could not qualify as distant site providers

PHE POLICY

- Can qualify as distant site providers for behavioral/mental health and non-behavioral/mental health
- FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental health through 2024 and can permanently serve as a distant site provider for behavioral/mental health

PAYMENT PARITY

EXPIRING: DEC. 31, 2023

PRE-PHE POLICY

- Telehealth services were reimbursed at typically lower, facility rates.
  Pre- PHE, telehealth services were distinguished with the use of POS 02

PHE POLICY

- Telehealth can be reimbursed at the in-person rate if modifier 95 is used

CROSS-STATE LICENSURE

EXPIRING: MAY 11, 2023

PRE-PHE POLICY

- Providers must be licensed in state where patient is located

PHE POLICY

- If providers meet four conditions, can treat patients in other states (still must comply with state licensure requirements)
- CMS will defer to state law after the PHE

THE FEDERATION OF STATE MEDICAL BOARDS HAS A RESOURCE REVIEWING THE TELEHEALTH REQUIREMENTS IN RESPONSE TO THE PHE FOR ALL THE STATES AND TERRITORIES

HIPAA COMPLIANT PLATFORMS

EXPIRING: AUG. 9, 2023 (90-DAY TRANSITION PERIOD)

PRE-PHE POLICY

- Providers must use HIPAA compliant platforms
- **Privacy Rule:** covered providers must implement reasonable safeguards for protected health information (PHI) and sets limits on the uses and disclosures of such information
- **Security Rule:** requires administrative, physical, and technical safeguards to protect electronic PHI
- **Breach Notification Rule:** covered entities must provide notification of a breach to affected individuals, the Secretary, and sometimes, the media

PHE POLICY

- OCR issued a notice of enforcement discretion and has not imposed penalties for noncompliance with HIPAA regulatory requirements for the good faith provision of telehealth while using a non-public facing application during the COVID-19 PHE

OCR'S FAQ CAN BE FOUND HERE

E-PRESCRIBING OF CONTROLLED SUBSTANCES

EXPIRING: MAY 11, 2023

PRE-PHE POLICY

- Under the Ryan Haight Act, practitioners must conduct an in-person medical evaluation of the patient before prescribing controlled substances by means of the internet (includes telehealth)

PHE POLICY

- The DEA waived the in-person requirement for prescribing controlled substances

THE DEA RECENTLY RELEASED A PROPOSED RULE TO ALLOW CERTAIN PERMANENT EXCEPTIONS TO THE IN-PERSON REQUIREMENT:

- 30-day supply of schedule III-V nonnarcotic substances and buprenorphine w/o an in-person visit
- A second practitioner can prescribe via telemedicine if referred by a practitioner after an in-person exam

MEDICAID UNWINDING

EXPIRING: DATES WILL VARY

- The continuous enrollment condition is no longer linked to the PHE and **ended March 31, 2023**
- On Feb. 1, 2023, states could resume Medicaid CHIP eligibility reviews (i.e. patients could lose coverage)
    - Beneficiaries should reconfirm that the information that their state plan has on file is up to date.

THE ANTICIPATED STATE-BY-STATE TIMELINES FOR RENEWAL INITIATIONS CAN BE FOUND HERE.

STARK LAW WAIVERS

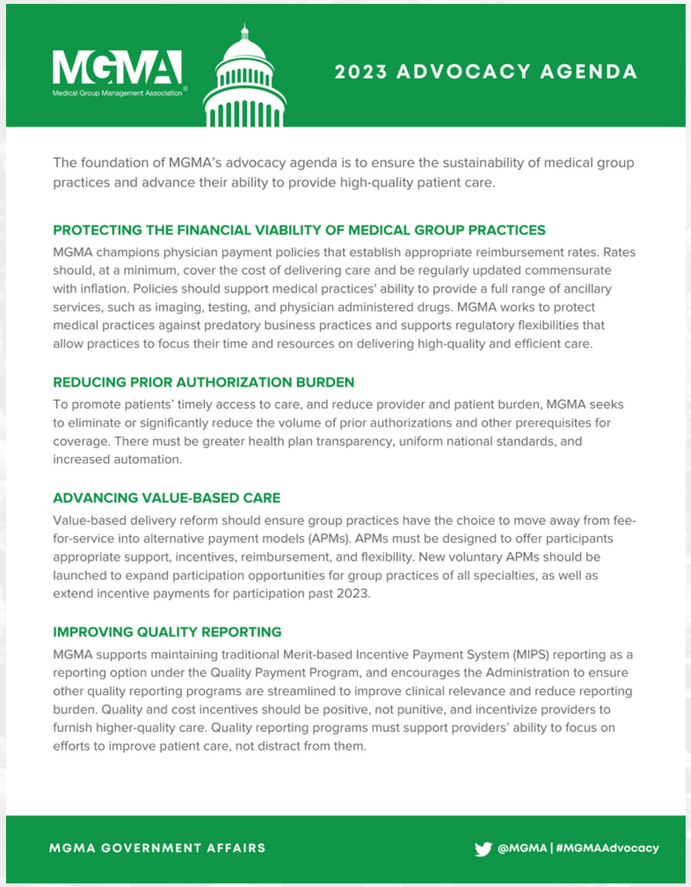
EXPIRING: MAY 11, 2023

- CMS issued blanket waivers of sanctions under the physician self-referral law (Stark Law) to give physicians flexibility during the COVID-19 PHE
- The blanket waivers of Section 1877(g) will expire on May 11, 2023, in conjunction with the end of the PHE
- CMS may still grant individual 1877(g) waivers
- The *Consolidated Appropriations Act of 2023* established a new exception for physician wellness programs

THE STARK LAW:

1. Defined the term “group practice” for the first time in Medicare policy
2. Prohibits group practices from providing certain ancillary services to their patients and regulates the “in-office” provision of many others
3. Regulates how group practices may compensate their physician owners and employees
4. Prohibits or heavily regulates the financial relationships that physicians in group practices have with outside entities physicians may refer patients to

2023 ADVOCACY AGENDA



MGMA Medical Group Management Association®

2023 ADVOCACY AGENDA

The foundation of MGMA's advocacy agenda is to ensure the sustainability of medical group practices and advance their ability to provide high-quality patient care.

PROTECTING THE FINANCIAL VIABILITY OF MEDICAL GROUP PRACTICES

MGMA champions physician payment policies that establish appropriate reimbursement rates. Rates should, at a minimum, cover the cost of delivering care and be regularly updated commensurate with inflation. Policies should support medical practices' ability to provide a full range of ancillary services, such as imaging, testing, and physician administered drugs. MGMA works to protect medical practices against predatory business practices and supports regulatory flexibilities that allow practices to focus their time and resources on delivering high-quality and efficient care.

REDUCING PRIOR AUTHORIZATION BURDEN

To promote patients' timely access to care, and reduce provider and patient burden, MGMA seeks to eliminate or significantly reduce the volume of prior authorizations and other prerequisites for coverage. There must be greater health plan transparency, uniform national standards, and increased automation.

ADVANCING VALUE-BASED CARE

Value-based delivery reform should ensure group practices have the choice to move away from fee-for-service into alternative payment models (APMs). APMs must be designed to offer participants appropriate support, incentives, reimbursement, and flexibility. New voluntary APMs should be launched to expand participation opportunities for group practices of all specialties, as well as extend incentive payments for participation past 2023.

IMPROVING QUALITY REPORTING

MGMA supports maintaining traditional Merit-based Incentive Payment System (MIPS) reporting as a reporting option under the Quality Payment Program, and encourages the Administration to ensure other quality reporting programs are streamlined to improve clinical relevance and reduce reporting burden. Quality and cost incentives should be positive, not punitive, and incentivize providers to furnish higher-quality care. Quality reporting programs must support providers' ability to focus on efforts to improve patient care, not distract from them.

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PROMOTING STANDARDIZATION AND EFFICIENCY

MGMA supports policies to standardize healthcare transactions, documentation requirements, claims review processes, and audits to decrease the administrative burden and costs associated with inefficient and inconsistent standards.

MAINTAINING ACCESS TO CARE THROUGH TELEHEALTH

Throughout the COVID-19 pandemic, telehealth usage dramatically increased due to the flexibilities afforded by Congress and the Administration. Recent congressional action extended many telehealth flexibilities until the end of 2024. MGMA supports long-term telehealth solutions that promote cost-effective, high-quality care while appropriately reimbursing practices. Telehealth policies must support continuity of care between a practice and its patients, rather than disrupt it.

EXPANDING THE PHYSICIAN WORKFORCE

The country is facing a significant shortage of physicians and other non-physician healthcare professionals. To ensure a robust provider workforce and enhancements to the nation's graduate medical education system, MGMA supports federal legislative efforts to strengthen and expand physician training programs.

IMPROVING IMPLEMENTATION OF NO SURPRISES ACT REQUIREMENTS

MGMA supports implementation of the No Surprises Act (NSA) in a manner that does not interfere with medical groups' ability to engage in reasonable and balanced contractual negotiations with health plans. Independent dispute resolution (IDR) fees should be minimal to protect the ability of medical groups to initiate the IDR process. MGMA supports clear implementation guidance from the Administration to ensure practices have the information necessary to protect patients. The Administration should provide sufficient time for practices to understand and implement new processes and workflows to comply with the NSA's surprise billing and transparency requirements. ■

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems and cover the full spectrum of physician specialties and organizational forms.

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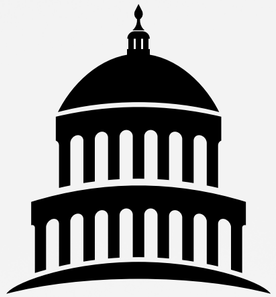
CLICK HERE TO DOWNLOAD THE FULL ADVOCACY AGENDA

CLICK HERE TO VIEW ISSUE SPECIFIC POSITION PAPERS

CLICK HERE TO VISIT MGMA'S GRASSROOTS PORTAL

RESOURCES FROM MGMA GOVERNMENT AFFAIRS



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SPEAK DIRECTLY TO MGMA GA EXPERTS

We would like to hear from you!
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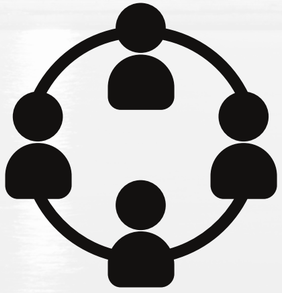

DEDICATED MEMBER E-GROUPS

National members can discuss a wide variety of legislative and regulatory issues with 3,400 MGMA peers and MGMA Government Affairs staff on the GovChat e-group.

FEDERAL RESOURCES AVAILABLE

- Tips to help those who lost Medicaid/CHIP coverage
- FAQs to address COVID-19 diagnostic testing/vaccine coverage
- CMS' current emergencies landing page
- Fact sheet: COVID-19 PHE transition roadmap
- FDA FAQ – EUAs when PHE ends

SAVE THE DATE!

JUNE 6-8, 2023

2023 MGMA SUMMIT: MOVING HEALTHCARE FORWARD

Join us June 6-8, 2023, for a robust and convenient learning experience featuring education from industry leaders covering a wide variety of challenges facing medical practices today. By attending this event, you will develop your skills and set yourself apart as the professional that your organization depends on to move healthcare forward.

This signature online event provides more than our industry-leading content; the MGMA Summit also allows you to take control of your journey by attending live or by accessing the sessions at your own pace until July 8. Additionally, new networking opportunities will make it easy for you to meet industry peers and discuss solutions to your biggest challenges.

ADDITIONAL INFORMATION HERE.

QUESTIONS?

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