Client Memo
November 2022

"I am grateful for what I am and have. My Thanksgiving is perpetual." -- Henry David Thoreau

NEWS Update

Public Health Emergency Update

October 13, 2022

The U.S. Department of Health and Human Services (HHS) must renew the PHE related to COVID-19 every 90 days to maintain certain health care flexibilities and waivers. The PHE has been in place since January 27, 2020, and renewed throughout the pandemic. The latest HHS extension for the PHE is effective **through January 11, 2023.**

COVID-19 PHE EXTENDED ANOTHER 90 DAYS

Telemedicine Was Made Easy During COVID-19 -- Not Any More

Telemedicine exploded in popularity after COVID-19 hit, but limits are returning for care delivered across state lines, writes Tom Murphy, AP Health Writer, for the October 10, 2022 issue of *Medscape Medial News*.

Over the past year, nearly 40 states and Washington, D.C., have ended emergency declarations that made it easier for doctors to use video visits to see patients in another state, according to the Alliance for Connected Care, which advocates for telemedicine use.

Some, like Virginia, have created exceptions for people who have an existing relationship with a physician. A few, like Arizona and Florida, have made it easier for out-of-state doctors to practice telemedicine

Doctors say the resulting patchwork of regulations creates confusion and has led some practices to shut down out-of-state telemedicine entirely. That leaves follow-up visits, consultations or other care only to patients who have the means to travel for in-person meetings.

To state medical boards, the patient's location during a telemedicine visit is where the appointment takes place.

The Federation of State Medical Boards recommends that states loosen some telemedicine restrictions. That includes permitting virtual follow-ups for someone who has traveled out of state to seek care or for people who temporarily move but want to stay with a doctor. States could also form regional compacts with their neighbors to ease cross-border care, noted Dr. Ateev Mehrotra, a Harvard health policy professor who studies telemedicine.

TRICARE COVID-19 Response Updated

In 2020, in response to the COVID-19 pandemic, the Department of Defense (DOD) implemented many temporary changes to the TRICARE benefit, ranging from increased reimbursement for COVID-19 inpatient stays to covered audio-only office visits to copayment/cost-share waivers for covered telehealth services.

The DOD has since published updates to the TRICARE manuals that terminate, modify, or keep in place some of the temporary changes. Regional contractors implemented these changes on Sept. 6, 2022.

Telemedicine copays reinstated. TRICARE has reinstated copayments, cost-shares and deductibles for covered telehealth (telemedicine) services rendered on or after July 1, 2022. We will be working with our telehealth partners to share this update. Referral requirements for telehealth remain the same as in-person visits.

Audio-only office visits now a permanent benefit. Effective July 1, 2022, TRICARE has made permanent the previously temporary benefit that allowed for medically necessary telephonic office visits. TRICARE will cover medically necessary audio-only telehealth between providers and beneficiaries and telephonic provider-to-provider consults. Telephone calls of an administrative nature remain excluded (for example: appointment scheduling, prescription refills, obtaining test results).

Temporary hospitals and FASCs remain TRICARE-authorized. Hospitals and FASCs, or other entities, enrolled with Medicare as a hospital on a temporary basis will continue to be considered TRICARE-authorized facilities through the expiration of Medicare's Hospital Without Walls initiative.

Qualifying hospital stay for SNFs admissions still waived. For SNF admission dates on or after March 1, 2020, TRICARE will continue to waive the requirement for a qualifying hospital stay of three consecutive days or more prior to a SN F admission through the end of the public health emergency period.

Temporary payment adjustments remain on inpatient claims for those diagnosed with coronavirus or COVID-19. Inpatient claims reimbursement for coronavirus/COVID-19 admissions on or after January 27, 2020, will continue to reflect a 20% increase to the diagnosis-related group (DRG) weighted rate through the end of the public health emergency period.

Long-term care hospitals (LTCHs) to continue to be reimbursed at higher rate. Per the CARES Act, LTCH admissions on or after Jan. 27, 2020, will continue to be reimbursed at the LTCH prospective payment system (PPS) standard federal rate instead of the lower site-neutral payment rate through the end of the public health emergency period.

Changes to the No Surprises Act Independent Dispute Resolution Process

– Brennan Cantrell, *FPM Journal*, September 1, 2022

The No Surprises Act (NSA) protects patients covered under group and individual health plans from receiving surprise medical bills and also establishes an independent dispute resolution (IDR) process by which entities decide certain payment disputes between physicians and payers that qualify as surprise billing situations under the NSA.

On August 19, 2022, three federal agencies released a final rule, effective October 25, 2022, finalizing NSA requirements relating to the IDR process.

Requirements for Dispute Resolution

Following recent court decisions, the final rule changes how various data points must be considered in the IDR process. The payer and the physician or provider must each submit their offer for the out-of-network payment amount for a claim. When determining which offer to select, the certified IDR entity must consider the qualified payment amount (QPA), which is generally the plan or issuer's median contracted rate for the same or a similar service in the specific geographic area.

The certified IDR entity must consider all additional information submitted to determine which offer best reflects the appropriate out-of-network rate.

The changes are more closely aligned with advocacy from the American Academy of Family Physicians and other medical societies, who raised concerns that previous regulations disadvantaged physician practices by placing too much emphasis on the QPA.

The certified IDR entity must explain its determination in a written decision submitted to the parties and the Departments of Labor, Health and Human Services, and the Treasury. The written decision must explain why the offer selected as the out-of-network rate best represents the value of the qualified IDR item or service.

Requirements for down-coded claims

The final rule also requires payers and issuers to provide additional information to physicians and facilities when they have "down-coded" a claim, defined as altering the service code or a modifier to lower the QPA to an amount less than that billed by the physician or facility.

The plan or issuer must provide a statement that the service code or modifier billed was down-coded, why it was down-coded (including a description of which service codes or modifiers were altered, added, or removed), and what the QPA would have been if the service code or modifier had not been down-coded.

Changes to Medical Collection Debt Reporting

The three nationwide credit bureaus — Equifax, Experian, and TransUnion — announced significant changes to how medical debt sent to collections will appear on consumers' credit reports, writes Justin Hakes in his March 18, 2022, *Consumer Data Industry Association* article: "National Credit Bureaus Support Consumers with Changes to the Medical Collection Debt Reporting."

The joint action will remove nearly 70% of medical collection debt reporting tradelines from credit reports. The move follows months of industry research and supports consumers facing unexpected medical bills.

The staff at *Equifax.com* reported that Equifax, Experian and TransUnion jointly announced that effective July 1, 2022, all medical collection debt that has been **paid by the consumer in full** will no longer be included on U.S. consumer credit reports. In addition, the time period before **unpaid** medical collection debt will appear on a consumer's credit report is being increased **from six months to one year**, giving consumers more time to address their debt before it is reported on their credit file.

These changes precede an additional measure set to occur in the first half of 2023, namely the removal of medical collection debt with an initial reported balance of less than $500 from credit reports.

Most healthcare providers do not directly report to Equifax, Experian and TransUnion. The changes being made by the Nationwide Consumer Reporting Agencies (NCRAs) are designed to assist consumers who have medical debt that has been sent to a collection agency for recovery. Before this joint measure, if a healthcare provider turned a consumer's overdue account over to a collection agency for non-payment, the collection agency could report that information to the NCRAs after a 180-day (six month) period.

Copays for Preventive Services

In his September 15, 2022, *Medscape Medical News* article "Court Ruling May Spur Competitive Health Plans to Bring Back Copays for Preventive Services," Harris Meyer writes that health plans and self-insured employers, those that pay workers' and dependents' medical costs themselves, may consider imposing cost sharing for preventive services on their members and workers.

That's because of U.S. District Judge Reed O'Connor's September 7th ruling in a Texas lawsuit filed by conservative groups claiming that the ACA's mandate that health plans pay the full cost of preventive services, often called first-dollar coverage, is unconstitutional. Judge O'Connor agreed with them.

If the preventive services coverage mandate is partly struck down, patients who have serious medical conditions or are at high risk for such conditions may have a hard time finding a plan that fully covers preventive and screening services.

Judge O'Connor also held that requiring the plaintiffs to pay for HIV prevention drugs violates the Religious Freedom Restoration Act of 1993. He's also considering throwing out the mandate for first-dollar coverage for contraceptives, which the plaintiffs also challenged under that statute.

No matter what the judge does, the case is likely to be appealed by the federal government and could reach the Supreme Court.

States Await CMS Approval For Skilled Nursing TNA Waivers As Deadline Looms – Jordyn Reiland, *Skilled Nursing News*, October 3, 2022

Nursing homes across the country are anxiously waiting for the federal government to approve temporary nurse aide (TNA) waivers just days before the program is set to expire.

Massachusetts, Washington, Indiana and Louisiana have had their statewide waiver requests approved so far, but more than 10 states were still waiting for further information to be able to apply for the waiver, according to the American Health Care Association/National Center for Assisted Living (AHCA/NCAL).

Issued at the beginning of the pandemic, the 1135 waiver temporarily allowed, among other things, non-certified nurse aides to work for longer than four months as they prepare for their exams.

CMS announced back in April that it had planned to phase out the waiver, among others tied to the public health emergency (PHE). Anyone hired prior to June 7th would have until October 7th to meet testing requirements, CMS had said.

But in August CMS issued updated guidance that provided opportunities for individual facility and statewide or county waivers to get additional time to certify TNAs when testing and training barriers were apparent.

The waivers will only last as long as the PHE remains in place, according to CMS. The goal is to grant the waivers for "as short as possible" a time period.

About half of states are currently experiencing CNA training and/or testing backlogs, according to AHCA.

The Building America's Health Care Workforce Act was introduced in May by U.S. Reps. Brett Guthrie of Kentucky, Madeleine Dean of Pennsylvania and David B. McKinley, P.E. of West Virginia.

The bill would give them an additional 24 months following the end of the COVID-19 public health emergency. TNAs would also be able to apply their on-

the-job experience and training toward the 75-hour federal training requirement to become a CNA, which is currently allowed in some states, if the bill passed.

End of PHE Medicaid Alerts

Redetermination Update -- *UHC Bulletin*, October 20, 2022

Members will soon need to take steps to find out if they can continue their coverage through Medicaid or the Children's Health Insurance Program (CHIP). This is because states will resume Medicaid and CHIP eligibility reviews upon announcement of the end of the COVID-19 national public health emergency.

This means some people with Medicaid or CHIP could be disenrolled from those programs, but they may be eligible to buy a health plan through the Health Insurance Marketplace and get help paying for it.

Health care professionals can help prepare their patients by reminding those who have Medicaid to:

- **Update** their contact information with the state, ensuring their mailing address, phone number, email or other contact information is correct
- **Check** their mail and email for information from the state about coverage and reinstated renewal requirements
- **Complete** their renewal application promptly and return it to their state to help avoid a gap in coverage

Things to note:

- Each state is handling redeterminations differently. Specific questions can be directed to your state Medicaid agency.
- UHC is also offering support and information directly to affected members to help prepare them for Medicaid redetermination.
- If a patient or their family member no longer qualifies for Medicaid or CHIP, they may be able to buy a health plan through the Health Insurance Marketplace.

Coverage in the Optional COVID-19 Group to End with PHE – *CMS website,* October 2022

Background: COVID-19 PHE and Optional COVID-19 Group

- As a result of changes in federal law related to the COVID-19 public health emergency (PHE), states will have an unprecedented volume of work to complete when the PHE eventually ends.
- Some states expanded access to Medicaid coverage through a new optional COVID-19 eligibility group to ensure that individuals who would otherwise be uninsured could access critical COVID-related services through the last day of the PHE.
- States that adopted the optional COVID-19 group will need to prepare to end coverage for this eligibility group when statutory authority for the group ends (i.e., on the last day of the PHE) as part of their efforts to restore normal operations when the PHE eventually ends.

Payment of COVID-19 Group Claims When the PHE Ends

- Because authority for the optional COVID-19 group expires with the end of the PHE, federal financial participation (FFP) is not available for services provided for the optional COVID-19 group after the last day of the PHE.
- States may continue to file claims for FFP after the PHE for covered services that were provided to beneficiaries only through the last day of the PHE, consistent with all applicable claim requirements.
- States may, but are not required to, use state-only funds to continue to provide coverage for individuals who were enrolled in the optional COVID-19 group but are no longer eligible for Medicaid when the authority for the optional COVID-19 group ends.

No Surprises Act Directory Validation Reminder -- *Blue Cross Blue Shield of North Dakota Healthcare News October 2022*

Blue Cross Blue Shield of North Dakota (BCBSND) is reminding providers of their directory validation process. Instead of mailing providers' directory information this fall, as done in the past, we ask providers to verify or submit changes in Availity Essentials using the directory validation process.

The directory validation process remains important as it ensures the BCBSND directory reflects accurate information. By ensuring information is accurate and updated, you help patients in their search for healthcare.

What you need to do: Each provider group or organization should continue updating BCBSND of their changes as they occur and respond to our semi-annual survey. To review your provider directory information, confirm its accuracy or request changes, please use our Availity Essentials provider portal.

Where to begin: Follow these instructions to complete the directory validation process at: https://www.bcbsnd.com/providers/news-resources/no-surprises-act?cid=email-bcbsnd-hcnews-nsa_2022-102022-providers-directory_validation_process-engagement-na

What if a provider does not complete the directory validation process? If a provider fails to make an effort to update BCBSND as changes occur, they may be removed from our provider directory, starting January 2023. Even if you didn't have changes throughout the year, you still need to validate through Availity Essentials.

We're here to help: For assistance with Availity Essentials registration or login, please call their Client Services at 1-800-282-4548.

MIPS UPDATES

The 2022 performance year/2024 payment year is the FINAL YEAR for the additional adjustment for exceptional performance.

Scoring Methodology for the 2022

Final Score 2022	Payment Adjustments 2024
>= 89 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance
75.01-88.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment (0%)
18.76 – 74.99 points	• Negative payment adjustment between -9% and 0%
0 – 18.75 points	• Negative payment adjustment of -9%

Note; Some clinicians may be unable to meet the requirements for each PI measure. Rather than filing for an exemption for the entire performance category, we encourage practices to claim an exclusion for individual measures.

2022 Promoting Interoperability Objectives

Objective	Measure
Electronic Prescribing	e-Prescribing *Bonus:* Query of PDMP
Health Information Exchange -OR-	Support Electronic Referral Loops by Sending Health Information Support Electronic Referral Loops by Receiving and Reconciling Health Information
Health Information Exchange (alternative)	Health Information Exchange Bi-Directional Exchange
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	Report the following 2 measures: • Immunization Registry Reporting • Electronic Case Reporting Report on any one of the following measures: • Public Health Registry Reporting OR • Clinical Data Registry Reporting OR • Syndromic Surveillance Reporting

Be prepared for the following changes* in 2023:

- The "Query of a Prescription Drug Monitoring Program" will be a required measure under the e-Prescibing Objective.
- CMS will discontinue reweighting for the following clinician types in the PI category:
  - Nurse practitioners, physicians assistants, CRNA's, clinical nurse specialists
- Public Health and Clinical Data Exchange Objective will be worth 25 points rather than 10.
- Health Information Exchange Objective will be worth 30 points rather than 40.

*These changes are only proposed and are still subject to change by CMS prior to the release of the 2023 PFS Final Rule.

MEDICARE NEWS

Changes to Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests -- *MLM Matters #MM12656,* released September 29, 2022

Waiving Medicare coinsurance for certain colorectal cancer screening tests amends section 1833(a) of the Consolidated Appropriations Act of 2021 to offer a special coinsurance rule for screening colonoscopies and screening flexible sigmoidoscopies.

This special coinsurance applies regardless of the code you bill for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure. The reduced coinsurance is being phased-in beginning January 1, 2022.

Currently, the addition of any procedure beyond a planned colorectal cancer screening test (for which there's no coinsurance) results in the patient having to pay coinsurance. CMS will gradually reduce this coinsurance until it's completely free for dates of service on or after January 1, 2030.

Effective January 1, 2022, when a screening colorectal cancer procedure, G0104, G0105, or G0121, has the PT modifier submitted on the claim line item with HCPCS codes 10000 – 69999, G0500, 00811, or CPT code 99153 for diagnostic colonoscopy, or diagnostic flexible sigmoidoscopy, or other procedure to indicate that a screening colorectal cancer procedure has become a diagnostic or therapeutic service, the coinsurance is reduced or waived for claims as follows:

- For dates of service in calendar years 2023-2026, the reduced coinsurance is 15%.
- For dates of service calendar years 2027-2029, the reduced coinsurance is 10%.
- For dates of service on or after calendar year 2030, Medicare waives the coinsurance.

Medicare Changes Coverage of Home Use of Oxygen -- Kent Moore, *FPM Journal,* October 5, 2022

In July, CMS amended its national coverage determination (NCD) for home use of oxygen by reducing the period of initial coverage for certain qualifying patients from 120 days to 90 days, conforming with the 90-day statutory time period. The change was effective July 8, 2022.

This means that initial coverage for Medicare patients with conditions not covered in other parts of the NCD may be limited to the shorter of 90 days or the number of days included in your prescription at the Medicare Administrative Contractor's (MAC) discretion.

Oxygen coverage may be renewed if deemed medically necessary by the MAC. Please keep this change in mind as you prescribe home oxygen for your Medicare patients.

Last year, CMS revised its NCD to allow coverage of short- as well as long-term home use of oxygen "in both acute and chronic diseases of respiratory and non-respiratory origin, as is medically necessary."

This change, which was aligned with AAFP comments provided to CMS, allowed for greater access to at-home oxygen supplies for patients not in the previously required chronic-stable state.

SNF Provider Preview Reports Now Available

The Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. These reports contain provider performance scores for quality measures, which will be published on Care Compare and Provider Data Catalog (PDC) during the **January 2023** refresh.

Providers have until **November 14, 2022**, to review their performance data. Corrections to the underlying data will not be permitted during this time. However, providers can request CMS to review their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate.

The staff at AQREVA wishes everyone a very Happy Thanksgiving

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