Minnesota Hospital Association

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March 17, 2020

Via email: jan.malcolm@state.mn.us

Commissioner Jan Malcolm
625 N. Robert St.
Saint Paul, Minnesota 55164-0975
United States

Dear Commissioner Malcolm:

Thank you for the opportunity to share collected ideas from Minnesota's hospitals and health systems about the types of regulatory relief that would be beneficial as we respond to COVID-19. Below is a list of top priorities gathered from health care providers across Minnesota.

The Minnesota Hospital Association appreciates your partnership on this and other emerging health care issues in this rapidly changing pandemic situation. We continue to stand ready to provide support and collaboration in any way.

Sincerely,

Rahul Koranne, M.D., MBA, FACP
President & CEO

Cc: Assistant Commissioner Marie Dotseth (marie.dotseth@state.mn.us)

COVID-19 Regulatory Relief Proposals
March 16, 2020

- **Requirement/Survey relief**
  - Delay or postponement of CMS, Joint Commission and all MDH surveys during this time
  - Healthcare systems are working on when elective surgeries will be stopped. This is happening this week. We will need MDH help in also applying to this to ambulatory surgery centers to conserve PPE.
  - Ability to create bed capacity in non-traditional spaces still applicable for payment
  - COVID 19 to be classified as an Extreme and Uncontrollable Circumstance and a natural disaster
    - Health care organizations would be automatically eligible for *Extreme and Uncontrollable Circumstance.* This would provide respite from Merit-Based Incentive Payment System and Promoting Interoperability reporting.
    - Lift timelines and requirements for renewing Medicaid and other benefits.

- **Technology**
  - Use of FaceTime/Skype/Zoom/other media for at home medical interventions.
  - Remove barriers to payer reimbursement for telehealth and allow telephone conversations to be reimbursed as a telehealth visit. Remove any barriers as to where

the licensed health care provider or patient is located to ensure that both the provider and patient could be located at home so that quarantined providers could provide telehealth care and quarantined patients can receive it.
    - Waive the requirement for e-visits, video, telephone encounters and telemedicine visits that they can be billed only if they do not result in a face to face visit within seven days.
    - Clarify and allow that "Store and Forward" will be paid:
        - MN Medical Assistance has indicated to Great Plains Telehealth and Resource Center (GPTRAC), the telemedicine resource center, that store and forward codes would not meet the definition of a covered service under the MN DHS Telemedicine policy.
        - "Store and Forward" is defined as: the asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. Medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

- **Licensure**
    - Cross state licensure for providers (already in state and federal waiver)
    - Waiving requirement for day care licensure
    - Postponing license continuing education requirements or expiration for next 3 months
    - Removing duplicative background checks. Either have DHS or the licensing board do them. Not both. Expedite background checks.

- **Structure**
    - Prioritize testing: prioritize inpatients and healthcare workers first. When there is a suspected case in an inpatient setting the protocols use up precious supplies while waiting for confirmation. We also don't want healthcare workers unnecessarily quarantined at home.
    - National guard surveillance around hospital perimeter to offer symptom check for staff and visitors or offer help with testing
    - Housing/quarantine sites for homeless population

- **Additional Measures to Protect Hospitals**
    - Delay scheduled Medicaid DSH cuts beyond the May 22 expiration (when cuts are currently scheduled to be imposed) through the end of 2020.
    - Teaching hospitals:
        - One very important step that must be considered is the role of a resident or fellow providing direct care in a teaching hospital or setting. Currently Medicare (CMS) pays for services furnished in teaching settings through the Medicare Physician Fee Schedule (PFS) if the services meet one of these criteria:
        - They are personally furnished by a physician who is not a resident;
        - They are furnished by a resident when a teaching physician is physically present during the critical or key portions of the service or;
        - They are furnished by a resident under a primary care exception within an approved Graduate Medical Education (GME) Program.
    - Request: Removal of the language limiting Primary Care Exception (PCE) rules to a staff physician supervision of four or fewer residents at one time.
    - Allow an expanded application of the PCE billing model to all areas of care delivery. This would allow well trained residents and fellows to expand access and care delivery with faculty supervision that is available, but not necessarily physically present during the key

portions of the service including, but not limited to surgical procedures, inpatient care, and outpatient visits that are in specialties beyond family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.