Million Hearts® Model

Cardiovascular Disease Risk Reduction Model

COVID-19 Public Health Emergency Model Related Impact Medicare Telehealth Regulations Frequently Asked Questions (FAQ)

Intervention Group

Last Updated: May 2020

OVERVIEW

The purpose of this document is to provide Participant Organizations (POs) with information related to recent Medicare telehealth policy changes.

Promoting Telehealth in Medicare

The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.[1] Under the complimentary 1135 waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020.[2] Additionally, The Interim Final Rule with comment period (IFC), CMS-1744-IFC: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, is available through the Federal Register at the following link: https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public Please note that this regulation is not final, and comments must be submitted by June 1, 2020 for consideration[3].

Million Hearts® Model Intervention Group participants may both enroll eligible beneficiaries into the model and risk-reassess high-risk beneficiaries via telehealth visits. Telehealth visits will be accepted if dated after March 6 while the 1135 waiver is still in effect.

MILLION HEARTS® MODEL TELEHEALTH FAQ

Beneficiaries Visits

Q1. Can Participant Organizations use Medicare covered telehealth visits in place of the required in-person visits for the Model?

A. Yes, under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.[1]

Q2. What if we cannot collect blood pressure or cholesterol data for an enrollment visit?

A. If you cannot collect blood pressure or cholesterol for an enrollment visit, please do not enroll the beneficiary. The MHM Data Registry rules will not allow you to create a visit without a blood pressure reading. Only blood pressure readings collected using a device validated for clinical accuracy will be accepted.[3]

   For enrollment visits, cholesterol data can be up to 5 years old and must be entered into the MHM Data Registry within 60 days of submitting a visit.

Q3. What if we cannot collect blood pressure or cholesterol data for a high-risk beneficiary's risk re-assessment visit?

A. If you cannot collect blood pressure or cholesterol for a risk-reassessment visit, please do not add the risk-reassessment visit to the beneficiary's record.

   The MHM Data Registry rules will not allow you to create a visit without a blood pressure reading. Only blood pressure readings collected using a device validated for clinical accuracy will be accepted.[3]

   For risk-reassessment visits, you can use cholesterol data collected up to one year before the visit date, or submitted up to 60 days after the risk-reassessment visit date.

Q5. What if I cannot conduct a risk-reassessment within the Anniversary Window (10-14 months) for a high-risk beneficiary?

A. Your organization can still add follow-up visits after the 10-14 month window. These beneficiaries may become 'Lost to Follow-Up' (LFTU) in the MHM Data Registry, but adding visit data is still permitted, even after they have a status of 'Lost to Follow-Up'. Organizations will not be penalized for missing risk-reassessment

Q6. How long will records be available after becoming Lost to Follow-Up (LTFU)?

A. If beneficiaries become LTFU, they will remain LTFU in the MHM Data Registry (i.e., will NOT be soft deleted) until they have a follow-up visit added to the MHM Data Registry and that visit is validated through the next Evaluation, Validation, Alignment, and Adjudication (EVAA).

Q7. How will my organization's payments be impacted by LTFU beneficiaries?

A. Currently, if one of your beneficiaries becomes LTFU, and a follow-up visit is made after the 14th month, Risk Reduction (RK) payments for this beneficiary are reduced. Since RK payments are per beneficiary per month that the beneficiary is eligible and aligned, the number of months your organization will be paid for this beneficiary will be deducted by the number of months past the 14th month, from a maximum of 12 months.

CMS is revising this policy for all beneficiaries that become LTFU during Performance Period 1, Performance Year 4. This change will not occur until the fall 2020 validation and payment cycle. Additional details will be available before the impacted validation cycle(s).

Q8. What is the current soft-deletion policy in the MHM Data Registry?

A. The current soft-deletion policy refers to records in the following statuses: Released for Validation, Incomplete Record, Verify Visit, Verify Beneficiary, Verify HICN, Verify MBI, and Pending Acceptance. If these records are not addressed and validated through the EVAA cycle, they will be deleted from your Patient Grid in the MHM Data Registry after two consecutive performance periods (6 months each). If these records are older than two performance periods, you will be unable to update them with follow-up information.

Evaluation, Validation, Alignment, and Adjudication (EVAA) & Payments

Q1. Will the 2020 EVAA timelines change given the public health emergency?

A. At this time, the spring and fall 2020 EVAA timelines will not change. CMS will validate all applicable data during each cycle to ensure that model payments will not be delayed. Due to the public health emergency, participant organizations will not be penalized for not meeting enrollment requirements during Performance Year 4. Given the current circumstances and uncertainty of the Public Health Emergency the Model team is working to determine if changes to the fall 2020 EVAA timeline will need to be made. Your organization will be updated as needed as decisions are made.

Providers

Q1. Can our participants see different providers within our practice if they were not previously included in our organization's NPIs in the MHM Data Registry?

A. Yes, beneficiaries are allowed to see different providers. Please note that if the providers are not included in your organization's NPIs in the MHM Data Registry, the beneficiaries seeing them will not be eligible for validation or payment for that visit unless your organization adds the provider to the MHM Data Registry. More detailed information is provided in the NPI Quick Reference Guide.

REFERENCES

1. CMS "Medicare Telehealth Frequently Asked Questions (FAQs)" (17 Mar 2020). Retrieved from https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

2. CMS “COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing” (1 May 2020). Retrieved from https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
3. CMS “Medicare and Medicaid Programs, Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” (6 April 2020). Retrieved from https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public