

2020 Health Care Financial Management

Resource Guide



**A steady hand at
the helm when the
sailing gets rough.**



The global health crisis has made for rough sailing in the healthcare industry. From navigating funding opportunities, to optimizing revenue streams and aligning physician compensation, JTaylor provides a steady hand at the helm to maximize the opportunities – today and long after the storm.

Isn't it time you sought a Taylored approach?

JTaylor  TM

Healthcare Consulting | Valuation

4800 Overton Plaza | Suite 360 | Fort Worth, Texas 76109 | 817. 924. 5900 | jtaylor.com

Navigating Through Uncertain Times: Health Care Financial Management During a Time of Crisis

Courtney L. McKay, CPA, *Partner, Consulting Services* | JTaylor
cmckay@jtaylor.com

Herd A. Midkiff, CVA, *Partner – Dir. of Consulting Services* | JTaylor
hmidkiff@jtaylor.com

Since the beginning of the coronavirus pandemic, we have been flooded with news and information that changes on a daily basis. In addition to worrying about their personal health and the health of their staff and communities, leadership of health care entities also must consider both the immediate and long-term operational and financial implications of this crisis to their organizations. From preparing for and responding to the immediate COVID-19 crisis, to addressing cash flow concerns, staffing needs, and procurement of necessary supplies and equipment, to anticipating and adapting to long-term changes in the health care industry, health care providers and administrators are certainly navigating tumultuous waters during this challenging time.

The Pandemic

The coronavirus, later identified as “COVID-19,” first emerged in China in December 2019 and began to spread to other countries by January 2020.¹ Cases began to emerge in the U.S. in February, and President Donald Trump declared a national state of emergency on March 13, 2020.² Subsequently, many state and local governments issued stay-at-home orders and other measures in an effort to contain the spread of the highly contagious virus. Hospitals were immediately faced with challenges, starting with procuring adequate personal protective equipment (PPE) to enable their staff and physicians to safely care for COVID-19 patients. Meanwhile, elective procedures were banned by many state and local officials in order to preserve PPE and keep hospital space available to treat the expected surge of COVID-19 patients. This created the combined effect of increasing operating costs while revenue plummeted. Furthermore, many of the delayed or canceled elective procedures are often the highest-margin activities in a hospital due to the way payer contracts have historically been negotiated. To compensate, many health systems furloughed non-essential staff (both clinical and administrative), while others chose to take other cost-cutting actions and delay capital projects.³

As administrators, providers, and health care investors cope with the challenges of managing their organizations through this crisis, they must focus on remaining financially strong so they can successfully emerge from the current turbulence and ensure continued access to care in the communities in which they operate. This article focuses on four primary areas impacting the financial management of health care organizations as they navigate the current uncertainty:

1. Funding and cash flow sources, primarily resulting from the CARES Act and subsequent legislation;
2. Provider revenue streams;
3. Physician compensation; and
4. After the crisis.

Funding and Cash Flow Opportunities

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was enacted on March 27, 2020, in response to the sudden and severe economic impacts across the country from the pandemic and subsequent shutdowns and stay-at-home orders. Many of the CARES Act provisions relate directly to funding for the health care industry. Other provisions relate more broadly to small businesses, which include a number of physician practices and other health care entities. The CARES Act also included provisions giving health care providers increased flexibility to serve patients more effectively during the crisis—most notably, in the area of telehealth. Subsequent legislation was passed to increase funding for certain CARES Act programs, including the Paycheck Protection Program and Health Care Enhancement Act (PPP) enacted on April 24.

Provider Relief Fund

A total of \$175 billion was earmarked to reimburse eligible health care providers for health care related expenses or lost revenues attributable to coronavirus.

Approximately \$50 billion of the fund was tagged for “General Allocation,” and in order to get money to providers quickly due to the dire nature of the need, an initial \$30 billion distribution was made based on providers’ relative share of 2019 Medicare fee-for-service reimbursements. Subsequent communication from the Department of Health and Human Services (HHS), the agency responsible for overseeing the program, noted that the initial distribution was, in effect, an advance on the actual allocation that would be based on each eligible provider’s relative share of 2018 net patient revenue. For entities required to file CMS cost reports, this data was already available to HHS. However, many other health care providers do not file cost reports and instead were required to submit revenue information to HHS in order to be considered in the allocation of funds. On July 10, 2020, HHS announced that dental providers, who had previously been excluded from the program, were also eligible to apply for relief.

Other funds were allocated to specific uses, including:⁴

- » **High-Impact Allocation** (\$22 billion) – These funds were designated for areas most significantly impacted by the outbreak of COVID-19 cases. The initial round of \$12 billion was distributed to 395 hospitals, with over half going to providers in New York and New Jersey.⁵ On July 17, HHS announced a second round of \$10 billion to be distributed to hospitals with more than 161 COVID-19 admissions between January 1 and June 10, 2020, with payment of \$50,000 per admission.⁶ Any payments received in the first round of funding will be considered in the determination of eligibility for second round distributions.
- » **Rural Providers** (\$11 billion) – These funds were provided to rural acute care general hospitals, critical access hospitals, rural health clinics, and community health clinics located in rural areas. Texas received the highest distribution from this fund (\$634 million for a total of 393 providers).
- » **Skilled Nursing Facilities** (\$4.9 billion) – These funds were intended to enable nursing homes to provide quality care to seniors and keep them safe during the pandemic.
- » **Safety Net Hospitals and Acute Care Hospitals** (\$13 billion) – \$10 billion was distributed to safety net hospitals and \$3 billion was distributed to hospitals serving vulnerable populations.
- » **Testing and Treatment of Uninsured** – No specific funding amount was specified, but this portion of the fund will be used to reimburse providers for care provided to uninsured COVID-19 patients. Providers must submit claims through the program to receive reimbursement at Medicare rates, subject to availability of funds. To date, over \$82 million has been paid on claims for testing and over \$265 million has been paid on claims for treatment.

Hospital Inpatient Prospective Payment System Add-On Payment

During the emergency period, the weighting factor that would otherwise apply to the diagnosis-related group (DRG) to which a patient’s discharge is assigned is increased by 20% for Medicare patients

diagnosed with COVID-19. This provision was implemented in an effort to ensure that hospitals caring for COVID-19 Medicare patients are adequately reimbursed for such care, given the uncertainty surrounding length of stay and total cost of care for the diagnosis. State Medicaid agencies are authorized to make the same adjustment, even if they have received a 1115A waiver.

On July 25, 2020, HHS renewed its determination that a public health emergency exists.⁷ This renewal effectively extends the add-on payment for another 90 days, or until the public health emergency is either rescinded or extended.

Delay of Medicare Sequestration

Medicare sequestration was suspended from May 1, 2020 through December 31, 2020, resulting in a 2% increase in Medicare reimbursement on all claims for services provided during this period. However, sequestration will be extended through fiscal year 2030 (rather than expiring as scheduled in 2029) to recover those funds.

Paycheck Protection Program (PPP)

A total of \$659 billion has been appropriated for forgivable loans to small businesses, primarily for the purpose of paying their employees during the COVID-19 crisis. While the PPP was not an option for large hospitals and health systems, this program was available to qualifying physician practices, dental practices, and other smaller health care providers who also experienced significant disruptions to their normal patient volumes. Eligible entities were generally required to have fewer than 500 employees, and could borrow up to 2.5 times average monthly payroll costs, not to exceed \$10 million, and use the funds to pay payroll costs (including benefits), mortgage interest, rent, and utilities during a covered period following receipt of the loan. The covered period was initially established as eight weeks but was expanded to 24 weeks in the Payroll Protection Program Flexibility Act of 2020, enacted June 5. The expansion was considered by many small businesses to be necessary given the duration of stay-at-home orders and the inability of many businesses to resume normal operations within the timeline initially contemplated.

Loan amounts under this program are forgivable to the extent the number of employees during the covered period is maintained at historical levels, and salaries and wages for individual employees are not reduced by more than 25%. No more than 40% of the forgiven amounts may be for approved non-payroll related expenses.

As of this writing, PPP funds are still available. The original application deadline of June 30 was extended until August 8 to give small businesses more opportunity to avail themselves of this funding as they begin to re-open. Additionally, new legislation was proposed in the Senate on July 27 that seeks to allow eligible small businesses to access a “Second Draw” PPP loan, and adds several categories of eligible expenses. This legislation is likely to be heavily debated, and it is unclear at this point what the final outcome will be.

Medicare Accelerated / Advance Payment Program

Though not part of the CARES Act, CMS early in the crisis allowed Medicare Part A and Part B providers to request accelerated payments on a periodic or lump sum basis to provide needed liquidity.

Providers could request up to 100% (or up to 125% for critical access hospitals) for up to a 6-month period after the emergency declaration associated with COVID-19 (i.e., March 13, 2020). Eligible providers included inpatient acute care hospitals, children's hospitals, specialized cancer hospitals, critical access hospitals, and Part B providers such as ambulatory surgery centers, physicians, and durable medical equipment (DME) suppliers. After enactment of the CARES Act, CMS expanded the accelerated payment program to include all Medicare Part A and Part B providers and suppliers throughout the country who had billed Medicare for claims within 180 days prior to making the request for an advance, among other criteria.⁸ CMS stopped accepting new applications for the Advanced Payment Program on April 26, citing that providers have access to other funds through the Provider Relief Fund and other federal funding programs.

Hospitals that received advance payments have up to 120 days before claims start being offset against the advance to recoup the accelerated payments. The outstanding balance must be paid in full within twelve months of the date of the initial advance. Provider entities that accessed these funds are concerned that the repayment provisions as currently constructed will have an extremely detrimental impact on cash flow once current claims start being offset against the advances, in effect merely delaying the revenue decline from April/May to six months later.

Legislation has been introduced in Congress to address these concerns. Key changes to the program would include delay of any

recoupment for a full year, and capping recoupment at 25% of claims. It would also give providers two years to repay the advances and caps the interest rate at 1%.⁹ Concerned that legislation might not be enacted before current repayment provisions are scheduled to begin, key industry groups are urging CMS to delay repayments until after legislation is adopted.¹⁰

COVID-19 Telehealth Program

The CARES Act appropriated \$200 million to the Federal Communications Commission (FCC) to support health care providers' efforts to address the coronavirus pandemic by ramping up their use of telehealth. This program provides funding for costs related to telecommunications services, information services, and devices necessary to enable the provision of telehealth services during the emergency period. As a result of this authorization, the FCC established the COVID-19 Telehealth Program.

The Telehealth Program was open to eligible health care providers in both rural and non-rural areas, providing support for fund recipients to purchase telecommunications, information services, and connected devices to provide telehealth services on a temporary basis in response to the pandemic, whether directly for treatment of COVID-19 or for treatment of other conditions during the emergency period. Rewards under this program provide full funding for eligible services and devices, though awards to any single applicant were capped at \$1 million. Funding received from the Telehealth Program could be used for any necessary eligible services and connected devices.

COVID-19 CRISIS TIMELINE	
Dec 2019	Coronavirus emerges in China
21-Jan-20	1st coronavirus case confirmed in U.S.
3-Feb-20	U.S. Declares Public Health Emergency
1-Mar-20	CMS issues blanket Stark waivers
13-Mar-20	National State of Emergency declared by President Trump
17-Mar-20	CMS Expands Telehealth, relaxes restrictions
27-Mar-20	CARES Act becomes law
28-Mar-20	CMS expands Accelerated & Advanced Payment programs
24-Apr-20	PPP and Health Care Enhancement Act becomes law
26-Apr-20	CMS stopped taking new applications for AAP programs
1-Feb-20	Medicare Sequestration suspended through 12/31/2020
5-Jun-20	PPP Flexibility Act of 2020 becomes law
23-Jun-20	Hospital Price Transparency Rule upheld
25-Jul-20	HHS renews Public Health Emergency declaration

The Telehealth Program was limited to nonprofit and public health providers in the following categories:

- » Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- » Community health centers or health centers providing health care to migrants;
- » Local health departments or agencies;
- » Community mental health centers;
- » Not-for-profit hospitals;
- » Rural health clinics;
- » Skilled nursing facilities; or
- » A group of health care providers consisting of one or more entities falling into the previous categories.

On July 8, the FCC announced that it had approved the final round of grants. In total, 539 applicants received funding through this program, with awards ranging from \$1,500 to \$1 million. The median award was about \$263,000. New York received the most funding through this program, with a total of over \$32.5 million among 74 recipients.¹¹

Provider Revenue Streams

Hospitals and physicians experienced significant disruptions to patient volumes due to the suspension of most elective surgical procedures as mandated during the early months of the emergency declaration. Such mandates are now being reinstated in certain areas of the country experiencing more recent surges in COVID-19 cases. Furthermore, many patients chose to delay doctor visits as they followed shelter-in-place orders, and some continue to avoid visiting medical facilities where they face potential exposure to COVID-19. This abrupt decline in volume and change in service mix put a strain on hospitals, since much of their profit is derived from surgical procedures and outpatient activity. Physician groups experienced similar revenue declines, as patients avoided office visits and specialists were unable to perform surgeries that usually comprise a significant part of their practices. Some specialties, such as dentists and optometrists, were required to close their practices (with the exception of emergencies) for a period of time based on government mandates, largely in an effort to preserve PPE for front-line health care workers facing exposure to COVID-19 patients on a regular basis.

While the CARES Act and other legislation implemented changes to Medicare payment levels and reimbursement policies to help address some of the volume disruptions and service mix changes, such measures were not enough to fully address the substantial revenue losses providers experienced as a result of the pandemic. To further protect revenue streams, providers should aggressively work with commercial managed care payers to ensure their contracted rates account for these same changes. Payer negotiations should include both short-term and long-term considerations to enable providers to be fairly compensated for the services they provide.

Hospitals and Health Systems

Hospitals and health systems should reach out to their largest commercial payers and work towards rebalancing their contracted rates to enhance payments for medicine services over surgical services.

This can be accomplished in several ways, including the following:

- » For DRG-based contracts, providers should ensure that updates CMS makes to DRG weightings to effectuate the 20% increase for COVID-19 related DRGs are also adopted in the DRG weight tables used by commercial payers. Some payer contracts automatically follow CMS DRG weights, but many contracts use custom weight tables or DRG weights fixed to a specific year. It is important for providers to ensure their contracts reflect any weight enhancements implemented by CMS.
- » Hospitals could also examine year-over-year volume changes to determine how COVID-19 has impacted their service mix, then negotiate with payers for a one-time payment to make up for the difference in revenue that is attributable to the service mix change. Contracted rates and associated insurance premiums are established based on historical utilization patterns. The COVID-19 disruption represents a material volume shift from historical patterns that could not have been predicted. Accordingly, providers should work with payers to account for such a dramatic shift in volume and service mix.
- » Hospitals should benchmark their charge masters and negotiated contracted rates and examine how their charge levels and rates sit relative to the markets they serve. Charges should be adjusted to maximize contract performance while keeping overall rates within market levels. Contracts with reimbursement rates below market medians should be examined and renegotiated to ensure they are optimized.

Physician Groups

Multi-specialty physician groups containing a mix of primary care physicians and specialists should examine their commercial contracts and pursue a similar rebalancing by shifting dollars from surgical procedures to evaluation and management (E&M) services. Enhanced E&M rates could be implemented on a temporary basis (i.e., through the duration of the emergency designation), and the enhancements removed after the COVID-19 crisis passes.

Additionally, as CMS has expanded the use of telemedicine services by approving reimbursement for previously unreimbursed services, commercial payers should follow suit. Providers should work with commercial payers to ensure reimbursement rates for telemedicine services are equal to the rate for an equivalent service performed in a non-telehealth setting, potentially adjusted to reflect any increase or decrease in the costs associated with such services (i.e., increased technology costs and/or decreased supply costs).

Finally, there is much discussion within the health care industry that the fallout from the COVID-19 crisis has highlighted the need for a change in the reimbursement philosophy, particularly as it relates to primary care. Both the disruptions to the volume of patient visits and

the disparity in overall health of various segments of the population are likely to reinvigorate momentum for a shift away from fee-for-service reimbursement to value-based approaches. Value-based payment systems could lead to a more consistent revenue stream for providers. At the same time, those providers would be incentivized to increase their attention to population health, including preventive care and management of chronic conditions in order to lower the overall cost of care for the patients they serve.

Physician Compensation

Changes in visit and procedure volumes have also impacted compensation for the many physicians who are compensated based on work RVU production models or collections-based models. These physicians are directly impacted as volume and service mix shifts occur due to directives to halt elective procedures, patients choosing to delay routine visits, shortages of PPE required to safely provide care, and other shifts in resources as providers deal with severe financial constraints brought on by the COVID-19 crisis.

This circumstance is forcing practice and health system administrators to think creatively to ensure physicians are incentivized to provide services where they are most critically needed, while minimizing losses in other areas of the health system. Some creative ways to address physician compensation issues include:

- » Increasing compensation for physicians working directly with COVID-19 patients (i.e., “hazard pay”);
- » Reassigning qualified physicians as “hospitalists” in areas heavily impacted by COVID-19 cases, and adjusting compensation accordingly;

- » Extending compensation guarantees or implementing base salaries for key physicians who are negatively impacted by current volume disruptions but will be required for the health system to maintain adequate care for the community after the crisis subsides; and
- » Temporarily reducing compensation for non-critical physicians whose volumes and associated collections have been negatively impacted by the disruptions.

Any changes to physician compensation levels should be made in a manner to ensure adjusted amounts remain at fair market value for services rendered, or the adjustment qualifies for one of the eighteen blanket Stark waivers issued by CMS on March 1, 2020.¹² While the waivers allow increased flexibility to enable health systems to address the unique impact of the crisis on their organization and the local community, adequate documentation remains important from a regulatory compliance standpoint.

As practices explore shifting more reimbursement to a value-based structure, consideration must also be given to the structure of physician compensation plans. As a greater portion of revenue comes from capitation (i.e., a fixed amount per month per patient on the physician’s panel) or value provisions, physician compensation plans should be realigned to incentivize behavior accordingly. For example, if half of the revenue for a practice comes from capitation but the physician remains on a productivity-based compensation plan, the physician will be incentivized to increase the volume of visits and procedures, and thus compensation, even though such activity may not generate any additional revenue for the practice.

Financial Management During the Crisis

1. Research all available funding opportunities (grants/loans/advances) and determine which one(s) best meet the needs of your organization.
2. Optimize revenue stream:
 - a. Ensure commercial contracts reflect DRG weightings applied by CMS to achieve 20% increase on COVID-19 related DRGs.
 - b. Negotiate with payers to address dramatic shifts in volume and service mix due to COVID-19.
 - c. Adjust chargemaster and renegotiate commercial contracts if needed to align with market levels.
 - d. Ensure commercial contracts include reimbursement for telemedicine services at least commensurate with CMS expansions.
 - e. Prepare for continued shift to value-based payment systems.
3. Adjust physician compensation and/or physician assignments as needed to align with the clinical needs and financial reality of the organization.
4. Plan for the future:
 - a. Budget for multiple scenarios regarding return to pre-pandemic volumes.
 - b. Implement safety protocols for staff and patients.
 - c. Assess technology, staffing, and training needs for increased telemedicine activity.
 - d. Implement plans to achieve compliance with hospital price transparency regulations and determine strategy for utilizing the market data that will be publicly available after January 1, 2021.

After the Crisis

While the focus of providers has understandably been on weathering the storm in the present moment, it is critical for the long-term financial stability of health care organizations for leadership to keep an eye towards the future and what it will look like when we emerge from the COVID-19 crisis.

After honestly evaluating their current financial position, providers should begin planning for their cash needs when the crisis passes and a new normal takes hold. In addition, providers need to assess their ability to serve pent-up demand once directives are lifted (again) and surgical volumes begin to return to pre-pandemic levels. Providers should plan for varying volume and staffing scenarios since it is unclear whether volumes will return immediately, whether there will be a slow build as patients remain tentative about undergoing medical procedures (either from continued fear of exposure to COVID-19 or due to financial constraints resulting from the economic downturn), or whether volumes will ebb and flow along with surges and declines in COVID-19 cases in specific geographic areas over the coming months.

Until there is an effective COVID-19 vaccine, protocols and safety measures must be implemented to ensure the continued safety of patients and staff. All planning should take these enhanced safety measures into account, including developing appropriate processes and procedures as well as procuring required supplies and equipment. Effectively communicating safety measures to patients will also be a critical step in ensuring that they feel it is safe to visit the facility when care is needed.

The increase in telemedicine activity accelerated an already existing trend, and this change will impact facility and staffing needs for providers. Telemedicine and technology should definitely factor into a provider's plan for future operations. As a result of certain restrictions associated with telehealth activities being relaxed during the emergency, many practices scrambled to implement these services. A recent survey of American Academy of Family Physicians (AAFP) members indicated that 81% provided telemedicine visits for the first time during the crisis, and 69% expressed a desire to continue such services going forward.¹³ Already, federal legislation has been introduced to make permanent some of the relaxed rules that were enacted during the emergency and expand the use of telehealth for Medicare patients. The bipartisan bill proposed removing geographic restrictions on where a patient must be located to use telehealth and allows telehealth services to be provided to patients in their homes. Further, it extends access to federally qualified health centers and rural health clinics.¹⁴ Time will tell what provisions are included in legislation that ultimately gets passed by Congress and enacted into law, but there are clear signals that the industry is unlikely to revert to the restrictions that were in place prior to the COVID-19 crisis. Telehealth has been proven as a way to offer patients convenient and effective care, and both patients and providers will demand continuation of this avenue of care in some form going forward.

In addition, while hospitals and health systems have been appropriately focused on addressing the COVID-19 crisis, a district court judge issued a ruling in June that upheld CMS's price transparency rule, which is scheduled to become effective on January 1, 2021.¹⁵ This rule will require hospitals to make all negotiated rates for hospital services available to the public, and it could have broad implica-

tions on health care consumerism and how rates are set by hospitals. Health systems must take immediate steps to ensure compliance with the requirements before the deadline, but leadership should also start considering how to use all the newly public data to optimize their strategic position once the deadline passes.

Finally, the crisis has forced everyone in the health care industry to think differently about how care is delivered and what types of contingencies need to be planned for. The government has made available billions of dollars in an attempt to bridge the funding gap during the crisis. The U.S. (and much of the world) has experienced a forced shutdown of its economy at a scale that is unprecedented in our lifetime, while at the same time our medical professionals have been tasked with determining effective ways to treat a previously unknown illness. In the chaos of the present, the seeds of new opportunities are being planted that will drive new alliances, new ventures, and new ways of working. It is important that entities do all they can to remain stable and strong through the current uncertainty so they will be well positioned to engage in new opportunities when they arise.

Endnotes

- 1 A Revisit of 'Known or Knowable' and Subsequent Events in the COVID-19 World, BUSINESS VALUATION UPDATE (May 2020), www.bvresources.com/docs/default-source/free-downloads/timeline-covid-19---rosenfield-and-co.pdf.
- 2 *Id.*
- 3 Anna Wilde Mathews & Melanie Evans, *Hospitals, Doctors Feel Financial Squeeze as Coronavirus Sweeps U.S.*, WALL ST. J., Apr. 1, 2020, www.wsj.com/articles/hospitals-doctors-feel-financial-squeeze-as-coronavirus-sweeps-u-s-11585768706?shareToken=std1ad4c906d6a44fe930a807107ca04aa.
- 4 CARES Act Provider Relief Fund: Data, U.S. DEP'T OF HEALTH & HUMAN SERVS., [https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/data/index.html#:~:text=HHS%20is%20distributing%20\\$244.9%20billion,facilities%20by%20State%20%2D%20PDF*](https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/data/index.html#:~:text=HHS%20is%20distributing%20$244.9%20billion,facilities%20by%20State%20%2D%20PDF*) (last reviewed Aug. 14, 2020).
- 5 Provider Relief Fund COVID-19 High-Impact Payments, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://data.cdc.gov/Administrative/Provider-Relief-Fund-COVID-19-High-Impact-Payments/b58h-s9zx> (last updated Aug. 11, 2020).
- 6 Press Release, *HHS To Begin Distributing \$10 Billion in Additional Funding to Hospitals in High Impact COVID-19 Areas*, U.S. DEP'T OF HEALTH & HUMAN SERVS., July 17, 2020, www.hhs.gov/about/news/2020/07/17/hhs-begin-distributing-10-billion-additional-funding-hospitals-high-impact-covid-19-areas.html.
- 7 *Renewal of Determination That A Public Health Emergency Exists*, U.S. DEP'T OF HEALTH & HUMAN SERVS., www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx (last reviewed Jul. 23, 2020).
- 8 Press Release, *Trump Administration Provides Financial Relief for Medicare Providers*, CTRS. FOR MEDICARE & MEDICAID SERVS., Mar. 28 2020, <https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers>.
- 9 H.R. 6837, 116th Cong. (2020), www.congress.gov/bill/116th-congress/house-bill/6837?r=10&s=1.
- 10 *CMS urged to delay repayment of accelerated payments*, AMERICAN HOSP. ASS'N, July 29, 2020, www.aha.org/news/headline/2020-07-29-cms-urged-delay-repayment-accelerated-payments.
- 11 Press Release, *FCC Approves Final Set of COVID-19 Telehealth Program Applications*, FED. COMMUNICATIONS COMMISSION, July 8, 2020, www.fcc.gov/document/fcc-approves-final-set-covid-19-telehealth-program-applications.
- 12 Details for waivers may be found on the CMS website at www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf.
- 13 *Lock in Telehealth Flexibility, Protections, Says AAFP*, AMERICAN ACAD. OF FAMILY PHYSICIANS, July 2, 2020, www.aafp.org/news/government-medicine/20200702telehealthletters.html.
- 14 Heather Landi, *House telehealth leaders move to cement regulatory changes for virtual care*, FIERCE HEALTHCARE, July 16, 2020, www.fiercehealthcare.com/tech/house-telehealth-leaders-move-to-cement-regulatory-changes-for-virtual-care.
- 15 Stephanie Armour, *Trump Administration Price – Transparency Rule Covering Hospitals Upheld*, WALL ST. J., June 23, 2020, www.wsj.com/articles/trump-administration-price-transparency-rule-covering-hospitals-upheld-11592945973.

A Home for All Health Law Professionals

ACADEMICIANS | CPAs | COMPLIANCE OFFICERS | CORPORATE ATTORNEYS |
HEALTH CARE LAWYERS | FOOD & DRUG LAWYERS | HEALTH CARE CONSULTANTS |
HOSPITAL & NURSING HOME ADMINISTRATORS | HUMAN SERVICES ATTORNEYS |
IN-HOUSE COUNSEL | PHYSICIANS | PUBLIC HEALTH OFFICIALS |
REGULATORY PROFESSIONALS | SOLO PRACTITIONERS | STUDENTS



AHLA has grown to include nearly 13,000 members and over 25,000 engaged health law professionals. From attorneys to compliance professionals, in-house counsel to finance and privacy officers, health care consultants to regulators, all health law professionals interested in health care legal and regulatory issues turn to AHLA to stay up-to-date on the changing health care legal environment.

We are the premier association for all who are interested in health law and we invite you to join AHLA and gain access to a variety of resources:

Continuing Education

Learn from experts in the field and obtain your CLE, CPE, and CCB credits through our educational programming, distance learning and trainings.

Practice Groups and Communities

Connect with a health law community that provides you with knowledge, enables you to leverage and share your expertise, and grow professionally.

News & Analysis

Publications providing in-depth reporting on the latest developments affecting health law.

Mentoring Program and Career Center

No matter where you are in your career, we are here to help match you with a mentor or help find your next step.

Health Law Archive

Rich with past content from across our Practice Groups, in-person program papers, journal issues, newsletters, toolkits, briefings, alerts, and much more.

Personalized Membership Experience

Three membership levels from which to choose, providing you with the resources, savings, and value that best meets your professional needs.

Turn to AHLA for all your health law needs.
Join today at www.americanhealthlaw.org/join.



Educating and Connecting the Health Law Community



© 2020 American Health Law Association

1099 14th Street, Suite 925, Washington, DC 20005

www.americanhealthlaw.org

info@americanhealthlaw.org

All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means—electronic, mechanical, photocopying, recording, or otherwise—without the express written permission of the publisher.

Printed in the U.S.A.

This publication is designed to provide accurate and authoritative information with respect to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought. —From a declaration of the American Bar Association.