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**WHA Board Holds Special Meeting; DHS Sec. Palm Gives COVID-19 Update**

WHA’s Board of Directors held a special meeting Wednesday afternoon by webinar to discuss the latest news on Wisconsin’s COVID-19 virus situation and share observations and current challenges hospitals and health systems are facing. WHA staff updated the board on efforts pertaining to current and ongoing priorities.

The in-depth discussion focused on a number of immediate and continuing priorities, including testing for COVID-19, WHA’s actions to request immediately-needed waivers from both the state and federal governments, the operations of the state’s Health Emergency Readiness Coalitions (HERCs), current availability and projected need for personal protective equipment (PPE), challenges for health care workers to obtain child care and WHA’s strategy for engaging state and federal lawmakers to help assist hospitals with current and anticipated needs.

The board also discussed the immediate need to amplify public communication and education of the public on critical issues such as the need for social distancing, the challenges health care faces with current COVID-19 materials supply and distribution, and why some elective procedures and appointments are being postponed or cancelled. As a part of the effort, WHA today issued a [press release](#) highlighting how the public can help make sure their health care workforce is there when needed most. WHA’s messaging echoed that of Governor Tony Evers, who also today appealed to the public to take important precautions via [radio](#), [press release](#) and [social media](#).

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**WHA Asks Business Associations, DWD to Help Gather PPE for Health Care Workers**

Earlier this week, the Wisconsin Hospital Association began working with statewide business groups and partnering with Wisconsin Department of Workforce Development Secretary Caleb Frostman to request the donation of health care worker personal protective equipment (PPE) to local hospitals.

“As I am sure you know, the COVID-19 outbreak is placing tremendous strain on Wisconsin health care’s supply of Personal Protection Equipment. This includes quickly dwindling supplies of gowns, gloves, eye shields and, especially, face masks (specifically NIOSH 95 masks, or N95s),” WHA President and CEO Eric Borgerding said in an appeal to the state’s largest business, building and construction groups. “This equipment is critical to protecting our frontline health care workforce from infection when testing and treating for COVID-19, keeping our dedicated doctors, nurses, technicians and others there when we all need them most.”

Many construction associations and trade groups responded immediately to the calls from Borgerding and Frostman, alerting their members to health care’s need. The state’s Department of Workforce Development (DWD) and industry association Wisconsin Manufacturers & Commerce (WMC) also took to social media to help promote the ability for Wisconsin companies to join together in assisting health care’s safety.

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**EDUCATIONAL EVENTS**

**March 25, 2020**

*EMTALA Update – 2020*  
 Part 3 of a 3-part series - Webinar

**April 1, 2020**

*LGBTQ 101 for Health care professionals*  
 Webinar

**Visit [www.wha.org](http://www.wha.org)  
 for more educational  
 opportunities**

***(WHA Asks Business Associations, DWD to Help Gather PPE for Health Care Workers. . . Continued from page 1)***

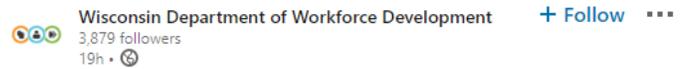
“I want to thank WMC, the Wisconsin Builders Association, Associated Builders and Contractors Wisconsin, Associated General Contractors Wisconsin and many other businesses and trades unions who have responded to this request,” Borgerding said. “It is a great example of how Wisconsin pulls together in a crisis. We are very grateful.”

Wisconsin is expected to receive a portion of the health care protective equipment national stockpile soon, but the Department of Health Services has already warned this allocation of supplies is limited. WHA is encouraging businesses and groups willing to donate PPE and related supplies to their local hospital, as every hospital is in need. Groups with supplies should contact their local hospital directly.

“Tonight, I am echoing a message sent out by the Wisconsin Hospital Association,” said Secretary Frostman to several building trade groups across Wisconsin. “I am hoping your groups and members here in Wisconsin might be able to donate N95s to their local hospitals. Time is not on our side, unfortunately...”



WMC Facebook post



Secretary Caleb Frostman has called on Wisconsin's construction industry, labor organizations, and private industry to donate any available N95 masks to local hospitals. These masks are in short supply and hospitals need them to help protect workers & patients seeking care and stem the spread of COVID-19. Pictured are Wisconsin Laborers John Schmitt and Craig Ziegler donating 100 N95 masks to Wisconsin Hospitals. Thank you Wisconsin Labor, we're in this together!



DWD LinkedIn post

## **CMS Announces COVID-19 Telehealth Waivers for Medicare Program**

The federal Centers for Medicare & Medicaid Services (CMS) this week issued [information](#) on waivers of Medicare telehealth restrictions for the duration of the COVID-19 pandemic.



The major changes announced March 17 for Medicare telehealth include:

- Geographic restrictions placed on Medicare telehealth are waived. Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- Restrictions on location of the patient are waived. Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any health care facility and in their home.
- Payment for Medicare telehealth visits will be the same as in-person visits. The Medicare coinsurance and deductible will generally apply to these telehealth services. However, the HHS Office of Inspector General (OIG) is providing flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by federal health care programs.
- HHS will not conduct audits to ensure that a prior patient-provider relationship existed for claims submitted during this public health emergency.
- HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies.

In the March 13 declaration by the President of a national emergency, the Secretary issued a 1135 waiver for “requirements that physicians or other health care professionals hold licenses in the state in which they provide services if they have an equivalent

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## *(CMS Announces COVID-19 Telehealth Waivers for Medicare Program . . . continued from page 2)*

license from another state.” However, CMS did not issue further guidance in the March 17 information on how this will be implemented.

CMS also reminds providers that Medicare virtual check-ins and e-visits are already available as other means to communicate with patients without face-to-face contact. These modes of communication are explained further in the [CMS fact sheet](#).

CMS has also prepared a “[Frequently Asked Questions](#)” document for Medicare telehealth that contains useful information.

For questions concerning telehealth reimbursement during the COVID-19 pandemic, contact WHA Vice President of Policy [Laura Rose](#).

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## How Census Bureau Data is Used by Federal Health Care Programs

*Note: This is the third in a series of five The Valued Voice articles about the U.S. Census and why it's important for health care.*

- March 5: [Growing Focus on Complete Census Count is Important for Health Care](#)
- March 12: [Census Basics: Decennial Census Timeline and Census Bureau Tools](#)
- **March 19: How Census Bureau Data is used by federal health care programs**
- March 26: [Hard-to-count areas in Wisconsin and how to encourage census participation](#)
- April 2: [Have you responded to the Census yet?](#)



Starting last week, the U.S. Census Bureau began mailing letters to households. The letters contain unique identifying codes. Entering the code in the U.S. Census Bureau website enables the household to complete the census online. Households who do not complete the census online will receive a paper copy of the census in the mail.

If you have chosen to respond online and reviewed the census form, you will quickly realize that the decennial numbers, on their own, cannot guide the distribution of federal funds. Therefore, Congress has authorized a series of more current and descriptive datasets derived from the Decennial Census. This article focuses on major federal health care programs that use measures which are derived from the Census:

**Medicaid Funding Formula:** The costs of Medicaid benefits are shared between the federal government and each state depending on a state’s federal medical assistance percentage (FMAP). The FMAP, which is recalculated each year, is based on each state’s per capita personal income over the most recent three calendar years compared to the national average for those years. Per capita personal income data used in the FMAP calculation are from two separable data streams, income and population, which are calculated respectively by the Bureau of Economic Analysis (BEA) and the Census Bureau. BEA combines the two streams to produce the per capita income estimates. Between the decennial censuses, population data used for the state per capita estimates are those generated by annual estimates produced each year from the July Current Population Survey (CPS), a Census Bureau tool.

**Medicare Physician Fee Schedule:** Fee-for-service Medicare payments to practitioners are based on the Physician Fee Schedule (PFS). Each of the PFS’ 7,000 distinct codes has an assigned number of relative value units (RVUs) that represents the cost of resources required to provide a particular procedure or service relative to the resources associated with other procedures or services. Geographic adjustments are made to the RVUs using the Geographic Practice Cost Index (GPCI). The GPCI is derived in part from the American Community Survey, which is a Census Bureau tool. The ACS provides one-year estimates of economic characteristics, including wages. ACS data include both employed physicians and self-employed physicians.

**Health Professions Shortage Areas (HPSAs):** HPSAs are designated by the Health Resources Services Administration (HRSA). HRSA designates HPSAs using standard national data sets and if applicable, supplemental data provided by the states. Demographic data used to determine HPSAs comes from the U.S. Census Bureau. Other data sources include National Provider Identifier (NPI) data and the Centers for Disease Control and Prevention (CDC) for national vital statistics.

**Medically Underserved Areas/Populations (MUAs/MUPs):** MUAs and MUPs are designated by HRSA. MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. HRSA assigns a weighted value to an area or population’s performance on four demographic and health indicators: provider per 1,000 population ratios; percent of population at 100% of the Federal Poverty Level (FPL); percent of population age 65 and over; and infant mortality rate. The percent of population age 65 and over comes directly from the Census. The other indicators are from census-derived data sets.

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**Rural Health Clinics:** Governors may designate areas of their state as shortage areas specifically for the purpose of Rural Health Clinic (RHC) certification. These areas must meet specific criteria. The service area must meet several high-need health indicators, one of which is what percent of population age 65 and older is higher than the state average, derived directly from the Census. Other indicators are from census-derived data sets.

Next week, *The Valued Voice* will provide information on hard-to-count census areas in Wisconsin, and how health care providers can encourage census participation. For questions regarding the U.S. Census and health care, contact WHA Vice President of Policy [Laura Rose](#).

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## New CPT and HCPCS Codes for COVID-19 Testing



The American Medical Association (AMA) announced, effective March 13, that hospitals, health systems and laboratories may use new CPT code 87635 (infectious agent detection by nucleic acid [DNA or RNA]; severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [COVID-19], amplified probe technique) to report testing for COVID-19. Health care professionals may contact third-party payers to determine their guidelines regarding applicability for retroactive billing and reimbursement.

Last month, the Centers for Medicare & Medicaid Services (CMS) developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) has been added which allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). (On February 29, 2020, the Food and Drug Administration issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers.) CMS expects that having specific codes for these tests will encourage testing and improve tracking. The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after Feb. 4, 2020.

The Coordination and Maintenance Committee Meeting announced that the COVID-19 code that was originally scheduled to become effective October 1, 2020 will now be effective April 1, 2020. The code that will be effective is U07.1. The effective date was changed due to the national health emergency of COVID-19. The code is not retroactive and more guidance on its usage will be out soon.

The WHA Information Center (WHAIC) recently updated its database to accept either code from the AMA or CMS in the discharge data files. For more information contact WHAIC Vice President and Privacy Officer [Jennifer Mueller](#).

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## Remembering David Fish

Longtime HSHS St. Joseph's Hospital in Chippewa Falls CEO David Fish has passed away. He was deeply involved in the Chippewa Falls community for more than a quarter-century and was a much-respected figure among his peers during his long involvement with WHA.

Originally from Cedar Rapids, IA, Fish joined the Hospital Sisters Health System in Chippewa Falls in the mid-1970s. After a brief three-year stint at HSHS headquarters in Springfield, IL, Fish returned to Wisconsin as St. Joseph's executive vice president. Over the next 25 years Fish led impressive development at the hospital, including overseeing the startup of home health and hospice services, expansion of chemical dependency treatment programs, creation of an occupational therapy program and the opening of a treatment center in Green Bay. He stepped down from his leadership position in 2010.



Fish was also heavily involved in WHA over four decades. He served on the Board of Directors from 1988-1993, then again from 1995-1998 including as chair in 1997. He was a longtime participant in the Council on Public Policy, the Nominating and Awards Committee, the PAC Committee and multiple task forces.

"Dave was a genuinely exceptional person," Eric Borgerding, WHA President and CEO said. "As soon as you met Dave, you immediately loved the guy. He was a strong believer in WHA and helped shape what the organization is today.

"He was just a great man and human being."

## Respirators and Ventilators

As the coronavirus that causes COVID-19 spreads across the United States, availability of certain personal protection devices and medical equipment to help protect health care workers and treat patients may be in high demand.



One key piece of equipment to provide necessary care to patients severely affected by COVID-19 is the [ventilator](#), which can help the most seriously ill patients breathe. These machines are often crucial in sustaining life in certain emergency situations, so the potential respiratory effects of COVID-19 make the nation's ventilator supply a core area of interest.

While today we consider a “respirator” to be an important piece of PPE (such as the N95 mask), decades ago hospitals were learning about “respirators” that were the precursor to today’s modern ventilator equipment. The following are excerpts taken from a 1948 Wisconsin Hospital Association newsletter, reporting on conferences held in Madison at the University of Wisconsin:



N95 mask

### THE RESPIRATOR AND ITS CARE

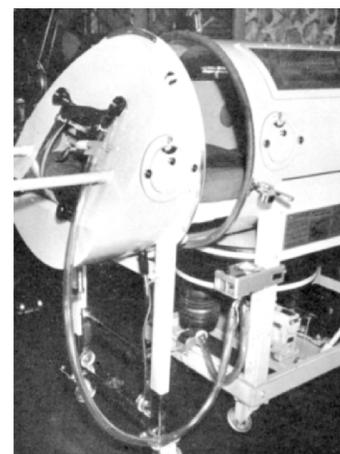
Oscar E. Olson, Engineer, State of Wisconsin, General Hospital

*The normal mechanism of respiration dependent upon changes in the pressure in relationship to atmospheric pressure. A respirator attempts to simulate the normal mechanism of respiration by producing pressure changes around the body of the individual. The body type of respirator with the patient's head and neck protruding has proved satisfactory. It functions by alternately producing negative and positive pressure or negative pressure alone.*

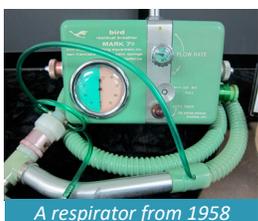
### CARE OF THE PATIENT IN THE RESPIRATOR

Marion J. Dunn, R. N., B. S., Instructor in Nursing

*Poliomyelitis is not the only disease in which a respirator may be used. Other reasons for respiratory aid may be asthma, brain injury, severe respiratory infections and others. A patient is placed in a respirator for the first time only on a specific order from the doctor; later it may be a R.R.N. procedure as determined by the nurse.*



Front view of the (Bennett) positive pressure respirator attachment mounted to a Drinker-Collins respirator, 1948.



A respirator from 1958

*The function of the respirator may be as an aid to voluntary respiration or as a complete substitute for voluntary respiration. The doctor and nurse use every effort to adjust the machine to the patient's rate of breathing rather than vice versa; however when a patient is completely dependent on the machine, the doctor will decide the respiratory rate necessary. Again the doctor is the one to determine the amount of positive and negative pressure needed by the patient and usually to make the initial adjustment, but the nurse must understand the regulation of pressures in order to maintain the machine on those pressures in the doctor's absence. Usual positive pressure is 0 to 5 cm. of water, negative pressure (vacuum) is from 15 to 20 cm. of water for adults, 10 to 15 cm. of water for children.*

[See full article here.](#)

The 1918 influenza pandemic was the most severe pandemic in recent history, with many deaths due to the lack of medical equipment used decades later. That pandemic was caused by an H1N1 virus with genes of avian origin. Although there is not universal consensus regarding where the virus originated, it spread worldwide during 1918-1919. In the United States, it was first identified in military personnel in spring 1918. It is estimated that about 500 million people – or one-third of the world's population at the time – became infected with this virus. The number of deaths was estimated to be at least 50 million worldwide with about 675,000 of those deaths occurring in the United States.



## AHA Annual Meeting Cancelled

The American Hospital Association's annual membership meeting scheduled for Apr. 19-21 has been cancelled. Read more on [AHA's website](#).

*(WHA Board Holds Special Meeting; DHS Sec. Palm Gives COVID-19 Update . . . continued from page 1)*

### **DHS Sec. Andrea Palm, other state officials give update and take input**

Later in the meeting a host of high-level state government officials joined the call by phone, including Department of Health Services Secretary-Designee Andrea Palm, DHS Dept. Secretary Julie Willems Van Dijk, Gov. Evers Chief of Staff Maggie Gau, Lt. Colonel G. David Brown from the Wisconsin National Guard, Department of Administration Dept. Secretary Chris Patton and Dept. of Children and Families Assistant Secretary Danielle Melfi.

Sec. Palm led off the conversation with an update on the latest news about COVID-19's spread in Wisconsin, including the first jump in the number of positive cases into triple digits. She described the efforts the state is making to obtain additional virus testing kits and current statistics regarding the testing capacities of the two state labs and private labs in the state. Many board members shared their experiences in collecting and delivering samples to the labs, and the challenges health care faces due to the serious constriction of testing elements and distribution of new supplies.

DCF's Melfi shared the latest efforts her department is spearheading in dealing with the child care issue, acknowledging the priority of ensuring health care workers can find proper child care options for their children. Board members emphasized how important a priority this is, and how more widespread child care options can help avoid exacerbating an already difficult workforce shortage.

Lt. Col. Brown provided his perspective on how the Wisconsin National Guard is ramping up planning for infrastructure and staffing should a surge occur, and how the Guard is already facilitating the delivery of COVID-19 testing supplies and PPEs arriving from the Strategic National Stockpile.

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