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More Hospitals To Hit Capacity In Early April As TCF Center Becomes Field Hospital

*(This story presented in cooperation with **MIRS**, a Lansing-based news and information service)*

Multiple southeast Michigan hospitals are at capacity with COVID-19 patients and several more expect to hit capacity the first week of April as the number of patients continues to climb, according to the president and CEO of the Michigan Health and Hospital Association.

Michigan's COVID-19 cases jumped to 6,498 by 3 p.m. March 30 with 81 percent still in the three-county region of Macomb, Oakland, and Wayne counties. Detroit continues to be the epicenter with 1,801 cases and 52 deaths.

With 134 hospitals statewide and roughly half in Southeast Michigan, Gov. Gretchen Whitmer is accepting the U.S. Army Corps of Engineers' recommendation to move 900 bed spaces into TCF Center, formerly Cobo Hall, to address imminent capacity issues.

Even with the extra capacity, MHA President Brian Peters continues to have concerns. The first is what happens if the coronavirus spreads outstate and there is not a large facility like the TCF Center available to convert into a field hospital.

"Southeast Michigan, Detroit is experiencing the brunt of that now," Peters said. "Our greatest concern is that we're going to see that occurring in communities throughout the state of Michigan in the days and weeks ahead."

One projection model from the University of Washington estimated that Michigan hospitals will hit their peak coronavirus demand on April 8 and that the state will be 10,563 beds short on that day, according to the Detroit News. Peters called this projection and other models "sobering" and said, "We have to do all we can right now to gear up for this crisis becoming worse." He insisted people adhere to the governor's social distancing orders.

If COVID-19 spreads into the rural areas "some of our rural communities are not in a great position to deal with an onslaught of COVID-19 patients," Peters said.

Peters said lack of access to staff is another emergent problem.

"At the end of the day, quite frankly, we could have all the physical space and hospital beds in the world, if you don't have enough qualified staff who can provide the care, we're going to have a real problem," he said.

The Corps is looking into other venues that, if needed, with some Southeast Michigan hospitals already at capacity with COVID-19 patients, the governor said on State of the Union with Jake Tapper March 29.

The Henry Ford System reported March 30 that it had 507 COVID-19 patients hospitalized among its five campuses. It has a combined 360 intensive care unit beds and about 150 negative pressure isolation rooms. Staff has tested a combined 1,086 positive for the virus.

UNMEER

'Red Dawn Breaking Bad': Officials Warned About Safety Gear Shortfall Early On, Emails Show

By RACHANA PRADHAN & CHRISTINA JEWETT

A high-ranking federal official in late February warned that the United States needed to plan for not having enough personal protective equipment for medical workers as they began to battle the novel coronavirus, according to internal emails obtained by Kaiser Health News.

The messages provide a sharp contrast to President Donald Trump's statements at the time that the threat the coronavirus posed to the American public remained "very low." In fact, concerns were already mounting, the emails show, that medical workers and first responders would not have enough masks, gloves, face shields and other supplies, known as PPE, to protect themselves against infection when treating COVID-19 patients.

The emails, part of a lengthy chain titled "Red Dawn Breaking Bad," includes senior officials across the Department of Veterans Affairs, the State Department, the Department of Homeland Security and the Department of Health and Human Services, as well as outside academics and some state health officials. KHN obtained the correspondence through a public records request in King County, Washington, where officials struggled as the virus set upon a nursing home in the Seattle area, eventually killing 37 people. It was the scene of the first major outbreak in the nation.

"We should plan assuming we won't have enough PPE — so need to change the battlefield and how we envision or even define the front lines," Dr. Carter Mecher, a physician and senior medical adviser at the Department of Veterans Affairs, wrote on Feb. 25. It would be weeks before front-line health workers would take to social media with the hashtag #GetMePPE and before health systems would appeal to the public to donate protective gear.

In the email, Mecher said confirmed-positive patients should be categorized under two groups with different care models for each: those with mild symptoms should be encouraged to stay home under self-isolation, while more serious patients should go to hospital emergency rooms.

"The demand is rising and there is no guarantee that we can continue with the supply since the supply-chain has been disrupted," Eva Lee, director of the Center for Operations Research in Medicine and HealthCare at Georgia Tech and a former health scientist at the Atlanta VA Medical Center, wrote that same day citing shortages of personal protective equipment and medical supplies. "I do not know if we have enough resources to protect all frontline providers."

Reached on Saturday, Lee said she isn't sure who saw the message trail but "what I want is that we take action

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Everything Old Is New Again: Telehealth Takes Center Stage In Pandemic

By EWA MATUSZEWSKI

Despite its high-tech sounding name and implications, telehealth is not new. Our own organization was using it years ago for a very challenged subset of society—teems who had urgent and ongoing mental health needs living in rural areas underserved by behavior health specialists. The grant-funded program was offered with the assistance of Michigan Medicine and I strongly believe it was a lifesaver for some teens. Despite relatively early adoption in this and other select cases, though, I certainly can't brag that all of our practices were using—or even remotely interested (pun intended) in—telehealth. It was a continuum from zero awareness to occasional use. What a difference a pandemic makes!

Interestingly, one of the earliest adopters of telehealth in mid-March 2020 was a "senior" internal medicine physician in our organization who still uses paper charts. He saw 30 patients in one day using telehealth. Moreover, many of these patients were elderly. The practice team, frequently the receptionist (thank goodness for high performing teams), walked patients who were amenable to it through the relatively easy telehealth set-up process.

Wait! Doesn't a practice need an EHR to use telehealth? Surprisingly no. Any device can be used for "video chat" in a pinch, although it's not advisable long-term, for reasons I'll explain later. In the absence of telehealth, I actually know physicians in Southeast Michigan primary care practices who were laid off due not only to a decrease in patient visits, but also a lack of personal protective equipment that prohibited them from safely seeing patients. I think it's safe to say these practices (assuming they survive) will be eager to get HIPAA-compliant telehealth services added to their practice once the immediate pandemic needs have eased.

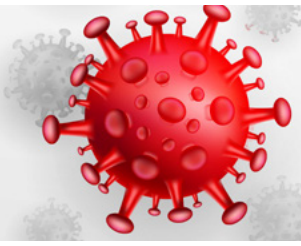
When an established EHR/telehealth vendor relationship exists, assistance is available at the time of need, eliminating days of frantic searching for interim solutions. Further, while Facebook Live, FaceTime, Google Duo and other public services worked in the throes of a pandemic—and HIPAA-compliance was eased to accommodate access to the unusually high demand for care—they are merely temporary and risky telehealth bandages. With thousands of patients sharing patient information over unsecured networks, and no clear understanding of how the various platforms will use these phone numbers of confidential patient information, they are not viable options as we move past, or at least adjust to, the current crisis. Moreover, they do not present a mechanism to easily track the patient visit for electronic medical record documentation purposes and reimbursement. An actual telehealth program, connected with an EHR system, does both. I must add here, though, that an EHR, telehealth or not, doesn't automatically equate to a well-run practice.

While I am a strong advocate for EHRs, I have seen physician offices without them who have better organized workflows and, hence, are more efficiently run, resulting in better quality metrics and more profitable practices. Technology is not a substitute for effective practice management. It's a tool that must be appropriately applied to already sound practice operations.

Back to telehealth, I need to give a shoutout here to CMS, BlueCross Blue Shield of Michigan, HAP, Priority Health and other health insurers, including Medicaid payers, who stepped up early in the healthcare crisis to put patients first and waive co-pays on telehealth services, while guaranteeing reimbursement for providers. They join our healthcare community, first responders, physician leaders, public health experts and key government officials as heroes in the collective and valiant effort to conquer COVID-19.

Ewa Matuszewski

Ewa Matuszewski is the CEO of MedNetOne Health Solutions and a champion of innovative primary care and chronic care initiatives. Areas of expertise include health policy analysis, physician workforce strategies, physician practice environment, primary care team leadership, primary care practice management/governance interface and quality improvement and validation within physician practices. (formerly Medical Network One).



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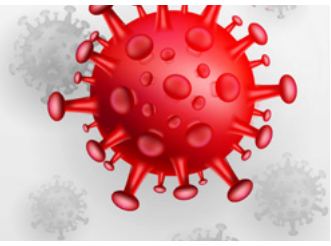

Most Henry Ford COVID Patients Getting Anti-Malarial Drug

*(This story presented in cooperation with **MIRS**, a Lansing-based news and information service)*

The "vast majority" of COVID-19 patients being treated at Henry Ford Health System hospitals are receiving hydroxychloroquine, the anti-malarial drug at the center of a national controversy over "off-label" use in late March, a hospital official said March 31.

"We have had a number of success stories, patients that have been very severely ill. We've gotten them off the ventilator, gotten them out of the hospital. Unfortunately, when patients are presenting to the hospital, we are seeing patients that are very seriously ill when they come into the hospital," said Dr. Marcus Zervos, division head of Infectious Disease.

"Once somebody is very severely ill, it is much more difficult to treat them. We are treating patients with severe infections with hydroxychloroquine along with other therapies. But I think its benefit is greater if we are able to start the therapy earlier and we know for sure that if a patient presents earlier, if they are less ill, they are likelier to do better."

The Henry Ford Health System is seeking U.S. Food and Drug Administration approval to conduct clinical trials on the use of the drug, but because formal studies can take months, sometimes years to complete, patients are already being treated in off-label fashion with the drug, normally prescribed for lupus and rheumatoid arthritis.

That's the drug President Donald Trump touted in press conferences and tweets as a possible "game-changer" in the fight against the COVID-19 global pandemic.

It also is the drug the Michigan Department of Licensing and Regulatory Affairs issued a letter about to health care providers, warning that stockpiling of the drug could lead to "administrative review."

"I don't want to give the impression that this is the only therapy. What is most important in the management of these patients is still supportive care. We know that oxygen is important, managing any heart or kidney complications that the person can have," Zervos said. "There is a variety of other agents that are also being studied. I don't want to give the impression that this is the absolutely essential therapy. And when we do go through clinical trials, it may show that there isn't a benefit to it. However, we are doing what we think is best under the circumstances. There may be another drug that may come out to be a better alternative later on. We are learning a lot as we care for more patients."

Already underway are clinical trials of the effect of Remdesivir on COVID-19 patients with severe symptoms. Remdesivir is an anti-viral that has been shown to have some effect on two other coronaviruses structurally similar to COVID-19, the viruses that cause MERS and SARS. More than 2,000 patients are expected to be enrolled in those clinical trials internationally.

A second study will evaluate Remdesivir in patients with COVID-19 who have been hospitalized but display more moderate symptoms.

A small number of Henry Ford patients received Remdesivir under the compassionate use program that allows sick patients to have access to unproven treatments. Most of the patients got the drug too late. Two other patients are in the ICU and being monitored. It is still too early to tell if the medication has made a difference in their recovery.

Other anti-virals are in the process of being studied as well, Zervos said. The use of zinc supplements also is being studied. Another study plan that has not yet begun is using the convalescent serum of people who have already recovered from the infection.

Still, the focus is on hydroxychloroquine.

"We feel that this is the important therapy. We should be doing it on our patients, but I wouldn't tell somebody else that it is wrong if they don't do it either," Zervos said.

He does not approve of its use on an outpatient basis because of the potential for complications involving heart problems.

"We have seen it, but it has been nothing that is permanent and nothing that is serious. By stopping the medication, we have been able to eliminate it. There are actually heart complications related to coronavirus itself," Zervos said. "By monitoring the patient we are able to deal with that upfront before there is any kind of serious complication, but where that happens is very rare."

Zervos said the use of hydroxychloroquine was justified by early studies and the experience of doctors using it in China.

"What it does, what has been shown in earlier literature or earlier experience, is that it reduces viral shedding of the amount of virus that a person has as a result of their infection. There is data from China that shows there is a clinical benefit, that patients do better when they receive it, even in randomized studies. So, the thought is that if we did use it earlier that there potentially would be a better outcome."

The drug also has an influence on the immune system, preventing some of the immune-related complications of the virus.

Zervos said using it earlier may have an additional benefit of keeping people out of the hospital, but he does not recommend that now outside of a study situation.

LARA's initial concern about the use of the drug to treat COVID-19 patients and potential stockpiling was that it could lead to shortages for lupus and arthritis patients, for whom the drug is effective. Then the drug company Teva announced it would donate 6 million doses of hydroxychloroquine tablets to hospitals across the United States, to "meet the urgent demand for the medicine as an investigational target to treat COVID-19."

The FDA on March 29 issued an Emergency Use Authorization to allow hydroxychloroquine and chloroquine phosphate products, donated to the Strategic National Stockpile, to be distributed and prescribed by doctors to hospitalized patients for COVID-19, even when a clinical trial is not available.

"Currently, we do not have shortages," Zervos said. "We are able to administer it to our patients who need it. However, there are worldwide shortages, because the drug is being increasingly utilized and the drug is going to be made available now through Health and Human Services to hospitals that are doing studies in one way or another. So, we feel that the drug will still be available to us, but there are concerns about shortages because coronavirus is so widespread and there is so much interest in using the drug."

Much of the public discussion about hydroxychloroquine proposes using it in combination with azithromycin, an antibiotic.

"One of the reasons that the virus can be so deadly is that it activates the immune system. There is an overreaction of the immune system and the azithromycin may help to reduce some of that overactivity of the immune system," Zervos explained.

There are other antibiotics that can be used for that purpose, he said. Henry Ford also is using a combination of hydroxychloroquine in combination with Dioxycyclin because there appear to be fewer side effects with that combination.

Zervos said the vast majority of COVID-19 patients have a mild illness that can be managed at home with supportive therapy for fever and fluids. Antibiotics are not being given on an outpatient basis.

About 15 percent of patients with COVID-19 have serious issues including difficulty breathing and pneumonia. Some patients require time in the intensive care unit, he said.

The Henry Ford Health System operates five hospitals. As of March 31, those hospitals have had 1,855 patients who tested positive for COVID-19; 3,399 who tested negative.

Some 259 have been hospitalized at Henry Ford Hospital; 96 at Henry Ford West Bloomfield; 102 at Henry Ford Macomb; 65 at Henry Ford Wyandotte; and 17 at Henry Ford Allegiance.

Red Dawn
Continued from page 1

because at the end of the day we need to save patients and health care workers."

Mecher, also reached Saturday, said the emails were an "an informal group of us who have known each other for years exchanging information." He said concerns aired at the time on medical protective gear were top of mind for most people in health care. More than 35 people were on the email chain, many of them high-ranking government officials.

The same day Mecher and others raised the concern in the messages, Trump made remarks to a business roundtable group in New Delhi, India.

"We think we're in very good shape in the United States," he said, noting that the U.S. closed the borders to some areas. "Let's just say we're fortunate so far. And we think it's going to remain that way."

The White House declined to comment. In a statement, VA press secretary Christina Mandreucci said, "All VA facilities are equipped with essential items and supplies to handle additional coronavirus cases, and the department is continually monitoring the status of those items to ensure a robust supply chain."

Doctors and other front-line medical workers in the weeks since have escalated concerns about shortages of medical gear, voicing alarm about the need to protect themselves, their families and patients against COVID-19, which as of Saturday evening had sickened more than 121,000 in the United States and killed at least 2,000.

As Mecher and others sent emails about growing PPE concerns, HHS Secretary Alex Azar testified to lawmakers that the U.S. had 30 million N95 respirator masks stockpiled but needed 300 million to combat the outbreak. Some senior U.S. government officials were also warning the public to not buy masks for themselves to conserve the supply for health care providers.

U.S. Surgeon General Jerome Adams tweeted on Feb. 29: "Seriously people – STOP BUYING MASKS! They are NOT effective in preventing general public from catching #Coronavirus, but if healthcare providers can't get them to care for sick patients, it puts them and our communities at risk!"

Still, on Feb. 27, the FDA in a statement said that officials were not aware of widespread shortages of equipment.

"We are aware of reports from CDC and other U.S. partners of increased ordering of a range of human medical products through distributors as some healthcare facilities in the U.S. are preparing for potential needs if the outbreak becomes severe," the agency said.

Simultaneously, Trump downplayed the risk of the novel coronavirus to the American public even though the Centers for Disease Control and Prevention was warning it was only a matter of time before it would spread across the country. On Feb. 29, the CDC also updated its strategies for health workers to optimize supplies of N95 masks.

An HHS spokesperson said Saturday the department has been in "an all-out effort to mobilize America's capacity" for personal protective equipment and other supplies, including allowing the use of industrial N95 respirators in health care settings and awarding contracts to several private manufacturers to buy roughly 600 million masks over the next 18 months.

"Health care supply chains are private-sector-driven," the spokesperson said. "The federal role is to support that work, coordinate information across the industry and with state or local agencies if needed during emergencies, and drive manufacturing demand as best we can."

The emails from King County officials and others in Washington state also show growing concern about the exposure of health care workers to the virus, as well as a view into local officials' attempts to get help from the CDC.

In one instance, local medical leaders were alarmed that paramedics and other emergency personnel were possibly exposed after encountering confirmed-positive patients at the Life Care Center of Kirkland, the Seattle-area nursing home where roughly three dozen people have died because of the virus.

"We are having a very serious challenge related to hospital exposures and impact on the health care system," Dr. Jeff Duchin, the public health officer for Seattle and King County, wrote in a different email to CDC officials March 1. Duchin pleaded for a field team to test exposed health care workers and additional support.

Duchin's email came hours after a physician at UW Medicine wrote about being "very concerned" about exposed workers at multiple hospitals and their attempts to isolate infected workers.

"I suspect that we will not be able to follow current CDC [recommendations] for exposed HCWs [health care workers] either," wrote Dr. John Lynch, medical director of employee health for Harborview Medical Center and associate professor of Medicine and Allergy and Infectious Diseases at the University of Washington. "As you migh [sic] imagine, I am very concerned about the hospitals at this point."

Those concerns have been underscored with an unusual weekend statement from Dr. Patrice Harris, president of the American Medical Association, which represents doctors, calling on Saturday for more coordination of needed medical supplies.

"At this critical moment, a unified effort is urgently needed to identify gaps in the supply of and lack of access to PPE necessary to fight COVID-19," the statement says. "Physicians stand ready to provide urgent medical care on the front lines in a pandemic crisis. But their need for protective gear is equally urgent and necessary."

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Telephone: (248) 547-9749

Paul Natinsky *Publisher*
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E-mail: pauln@natinskypublishing.com
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Tax Court Case Serves as Reminder for Health Care Providers to Properly Report Income and to Substantiate Deductions

By RALPH LEVY

A recent Tax Court Memorandum decision, S. Ghadiri-Asli v. Comm'r, T.C. Memo 2019-149, serves as a reminder for healthcare providers to report properly all gross receipts and to substantiate business expenses claimed as deductions.

One of the two taxpayers, a physician, practiced medicine as a sole practitioner who specialized in infectious diseases. During the years in question, the physician's billing and collection functions were performed by a third party outside billing service. All payments were remitted directly to the physician. Using the information provided by the physician to the billing service that included explanation of benefit (EOB) forms, patient face sheets and other correspondence received by the physician, the billing service would bill both third-party payors and patients for medical services provided by the physician. Each month the billing service would send the physician a summary of billings and collections received using the EOB's and the other information provided by the physician. Each summary included an invoice for the services provided by the billing service based on a percentage of the total monthly payments received by the physician during the prior month. Although occasionally the physician questioned discrepancies between the monthly summaries and the physician's bank statements, the physician always paid the amount invoiced by the billing service and generally the discrepancies were due to timing differences in billing and collection.

The taxpayer couple used a registered tax preparer to prepare their individual income tax returns with the information contained in the Forms 1099 that the physician's husband, who acted as his wife's de facto office manager, had provided the preparer. The husband never provided the return preparer with the monthly summaries that the collection and billing company had provided the physician.

Upon audit, the taxpayer husband did not cooperate with the agent. As a result, the agent reconstructed the taxpayers' income from Forms 1099 and bank statements that the agent had subpoenaed. The agent also issued a summons to the billing and collection service for the monthly summaries of the taxpayer physician's billings. After an unsuccessful meeting with the taxpayer husband, the agent determined that the taxpayers had unreported gross receipts from the physician's medical practice that totaled over $400,000 during the three tax years under audit. In addition, the agent denied certain business deductions and concluded that the net amount of a monetary settlement paid to the taxpayer husband to settle a suit against his former employer for emotional distress should have been included in income. The agent also assessed a fraud penalty based on the significant amounts of income that the taxpayers had not properly reported.

After a trial, the Tax Court upheld the assessed taxes and the fraud penalty for all three years. In support of its finding, the Tax Court pointed both to the failure of the taxpayers to report a significant amount of their income over the three-year period and their failure to provide their tax return preparer with all available records as to the receipts from the physician's medical practice.

Similarly, the Tax Court upheld the agent's denial of several business-related deductions claimed by the taxpayers based on the failure of the taxpayers to maintain sufficient books and records to substantiate their claimed deductions. In fact, the taxpayers failed to submit into evidence at trial a "shoe box of receipts" for expenses. To make things worse, during trial, the taxpayer physician conceded that her office rental expense as deducted on the taxpayers' tax returns was far in excess of the amounts actually paid.

Because the taxpayers did not provide evidence that their underpayment of tax was not attributable to fraud, the Tax Court upheld the civil fraud penalty that had been assessed by the Internal Revenue Service, an addition to tax of 75 percent of the underpaid taxes. The Court found that by "consistently and substantially" understating their gross receipts and expenses, the facts in their case were sufficient to indicate fraud. By giving false information to their preparer, this was further evidence of fraud. Because "[b]oth [taxpayers] participated in this fraud," the Tax Court found that both were liable for the taxes and the civil fraud penalty.

RALPH LEVY

Ralph Levy is a member partner in the health care practice at Dickinson Wright with over 40 years of experience in counseling clients in the health care arena.

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