Centers for Medicare & Medicaid Services
COVID-19 National Stakeholder Call
Moderator: Alina Czekai
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12:00 p.m. ET

Operator: This is conference # 7786289.

Alina Czekai: Good afternoon. Thank you for joining our CMS COVID-19 National Stakeholder Call. I'd like to introduce CMS Administrator, Seema Verma. Administrator, turning it over to you.

Seema Verma: Thank you and thank you all for joining the call. First, I want to convey my deepest sympathies to those who have lost loved ones due to the coronavirus as well as those currently fighting for their lives. Our hearts and minds are with you. I also want to send a message of gratitude to the foot soldiers in the struggle against the coronavirus, many of whom are on today's call; the men and women on the frontlines in hospitals and clinics across the nation.

Doctors, nurses, and others providing care and comfort to Americans that have been infected by this virus. You've chosen to be healers. And that calling is being tested by a pandemic of unprecedented proportions. Your country is grateful for your many sacrifices, and each and every one of us stands in your debt.

We've never face anything quite like this. And in a pandemic of this magnitude, significant strain on the healthcare system is inevitable. And some areas of the country are experiencing that strain already. And unfortunately, in all likelihood, there is more to come.

In short, as the President has said, we are engaged in a war against an invisible enemy. And in war time, the assumptions of peacetime must be revisited and adjusted to meet the demands of the moment. We must fundamentally rethink what our healthcare regulations demand of physicians, nurses, and other clinicians facing this challenge, which is altogether new.

And so, under the President's leadership, CMS is waving a wide and unprecedented range of regulatory requirements to equip the American healthcare system with maximum flexibility to deal with an influx of cases. Many health care systems may not need these waivers, and they shouldn't use them if the situation doesn't warrant it. But the flexibility is there if it does. And in a time of crisis, no regulatory barriers should stand in the way of patient care.

There are several components to yesterday's announcement. So, let me start with what we are calling the CMS Hospital Without Wall Strategy, which will see hospital systems function as a kind of collaborative headquarters coordinating a variety of settings of care. This will allow hospital systems to create new treatment sites, to expand capacity, safely separate patients infected with the coronavirus from those who are not, and preserve personal protective equipment.

CMS is, doing incredible, incredible work setting up hospitals in New York and other areas. But, under these waivers, hospital systems won't have to rely on them exclusively. Rather, they complement and augment the work of FEMA and state and local public health authorities by allowing hospital systems to make use of dorms, hotels, gymnasiums, and allow the main hospital facility to focus on those need the most intensive care.

Today, many surgery centers are rightly delaying elective surgeries. And so, they may have excess capacity that can be devoted to hospital-like care centers – hospital-like care such as cancer treatment or essential surgeries. And CMS will temporarily increase payment to the surgery centers to provide services as long as they are working in concert with their state's pandemic plan.

The waivers also allow hospitals sorely needed flexibility to increase their capacity. So, for example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate a surge. Furthermore, we typically pay for ambulances to transport to select locations such as to the emergency room and among hospitals. But, now, Medicare will

pay for them to be used as transportation between various sites such as doctor's offices and urgent care facilities where medically appropriate.

These changes also allow healthcare systems, hospitals, and communities to set up testing sites exclusively for the purpose of identifying coronavirus positive patients in a safe environment. That includes drive-thru and off-campus locations. And we also issued updated guidance that describes how hospitals can use telehealth and off-site locations to triage incoming patients. And this ensures maximum flexibility for testing and screening for COVID-19.

Second, we are making changes to facilitate testing. Some Medicare individuals that need a coronavirus tests are not physically able to leave their location to obtain it. And to address this problem, Medicare will pay for lab companies to collect samples in people's home or nursing homes. And we hope that this will encourage more testing of our nursing home residents, who are among the most vulnerable. We know that over 150 nursing homes have been affected. By increasing testing, we can help isolate those patients that have been infected and keep other residents healthy.

The third component of today's announcement provides flexibility to the system to boost the healthcare workforce. During a surge, hospitals may need to hire more doctors and nurses. By removing barriers to the hiring of physicians, nurses, and other clinicians, we're helping hospitals increase staffing. And we're also letting a broad range of healthcare workers like nurse anesthetists, respiratory therapists, and more to perform at the top of their license in coordination with their state laws.

To take just one example, nurse anesthetists could help with anesthesia during essential surgeries and procedures, which frees up anesthesiologists for ICU care. Current regulations allow hospitals to provide only minimal extra benefits to physicians while they treat patients at the hospital. But, now, hospitals will be able to support their hard working physicians by providing benefits such as daily meals, laundry services, or childcare services while they're on duty. And so, this marks waivers of the stark law.

And then there is telehealth. We already announced a dramatic expansion of telehealth services to our nation's 62 million seniors with Medicare. And we appreciate all the hard work of the healthcare system to implement telehealth so rapidly. And we're also announcing that we are going to go even further.

We will be paying doctors for clinical phone calls with their patients. And we're getting rid of barriers to telehealth – to telehealth that have long existed in the Medicare program such as virtual emergency room visits. And we're allowing doctors to supervise clinical staff remotely. And we're also eliminating requirements that visits and Medicare be provided face to face.

Crucially, clinicians can provide remote patient monitoring services to both new and established patients. We're also expanding the use of telehealth for inpatient rehab, hospice, and home health. And finally, our effort to put patients over paperwork, a long standing CMS initiatives that the President started with his executive order to cut the red tape, and, as part of our actions, yesterday, we're ramping up patients over paperwork even further to meet the unique demands of this emergency. We're providing temporary relief for many audits and reporting requirements and extending an array of deadlines, suspending documentation requests, which all take time away from patient care.

I also want to mention that, on Saturday, the President directed CMS to offer advance payments for health care providers experiencing cash flow problems due to the pandemic. Again, many providers are complying with our recommendations around social distancing and delaying nonessential elective surgeries. And they shouldn't be penalized for doing the right thing. To reiterate, I've barely scratched the surface of the unprecedented flexibilities that we're offering healthcare providers.

CMS has put together provider-specific tear sheets that provide more details by the type of provider, whether it's home health or hospital or hospitals or teaching facilities. And this – all of these regulations or these flexibilities in our regulations will maximize our healthcare system's preparedness by freeing providers from regulations ill-suited to the unprecedented needs of this emergency.

And before closing, I want to also note that, while the Cares Act allows for additional flexibilities, we're currently evaluating those. We wanted to get these flexibilities out as soon as possible to allow our healthcare systems to take advantage of these new changes. And CMS will be making further updates based on the legislation in the coming days.

There have been many heroes and the ongoing war against the coronavirus, but I want to take this opportunity to single out members of my – of the CMS team for special things. You know, as you all know, rulemaking normally takes about a year. But these public servants have done an amazing job. In just a couple weeks, they've put this – these waivers and this rule together. And they've thought boldly and creatively to respond to the needs of the healthcare systems, working day and night. And I couldn't be prouder of them. So, I hope you all will thank them.

Their efforts are the utmost importance, because every day heroic nurses, and doctors, and other health care professionals, and people on the call today are working long hours, sacrificing time with their families, and risking their very lives to care for coronavirus patients. And we owe all of you, those that are on the frontlines, every ounce of support that we can muster. And that's exactly what our announcement yesterday does.

So, with that, I will open it up to questions.

Alina Czekai: Operator, would you please open the lines for questions? Thank you.

Operator: If you'd like to ask a question, please press star one on your telephone keypad. Please press star one now to ask a question. Your first question comes from a caller. Caller, please go ahead.

Shannon Kennedy: Can you hear me?

Alina Czekai: Yes, we can hear you.

Shannon Kennedy: Hi, my name is Shannon Kennedy. Excuse me. I'm with Oregon Health and Science University in Portland, Oregon. And I have a question about the

expansion for the accelerated payments. Typically, this program is used to help get the providers in advance on services already rendered. And many of the attestations that we will have to sign to participate in that program require us to attest that these services have already been rendered.

And I'm just curious, does this expansion include services not already rendered in order to provide relief for those of us that are no longer performing elective procedures?

Seema Verma: So, what the accelerated payments do is that it looks back at your historical spend. And then it makes an advance payment. And so, then if you have claims coming in, you can put those against what you've already pulled down in the advanced payment. And then there's a reconciliation period. So, it's more of a – and it's an advance payment. But it's not – it's not a subsidy.

Now, that being said, there is $100 billion that Congress passed in the Cares Act. And we're working on how those will be distributed. So, that's an additional – that's more of a subsidy, whereas I think the accelerated payments are really just an advance payment. But it does look back at your historical spend. And ultimately, those dollars need to be recouped.

Shannon Kennedy: OK. Thank you. So, when we make our attestation, essentially, we're testing to the fact of the services that have been previously rendered that calculation is based on. It's not that we're attesting that we're getting in advance for services that are rendered already. Just it's a historical calculation.

Seema Verma: Yes. And essentially, think of it as something to help your cash flow. But there will be additional support with the Cares Act and the $100 billion that Congress has authorized to support health care facilities. So, I think I would be thinking about that. And there'll be more information on that, hopefully, pretty soon.

Shannon Kennedy: OK. So, MACs definitely have some forms out there and some attestations out there that don't necessarily reflect what you're describing. And so, if, if we could have the MACs look at their forums, I think more hospitals will be comfortable participating in the accelerated payment

program, when we're not attesting to some language that feels a little bit different than what you're describing.

Seema Verma: OK. Well, we can take that as a suggestion. I appreciate it. Thank you.

Shannon Kennedy: Thank you so much.

Alina Czekai: Next question, please.

Operator: The next question comes from a caller. Caller, please go ahead, please. Your line is unmuted.

Cynthia Morton: Thank you for the phone call this morning. This is Cynthia Morton with the National Association for the Support of Long Term Care. There's a little bit of confusion out there with the three-day stay waiver that was accomplished by CMS. It is a blanket waiver, which we understand that mean the facilities – nursing homes do not have to apply individually for the waiver.

But the language in the waiver says that the three-day stay is waived for emergency areas only or the areas impacted by the emergency. So, do I have that accurate? Because people are confusing the nature of the blanket waiver with the language in the waiver that with respect to it only applies to patients affected by the emergency. Thank you very much.

Seema Verma: So, we have a national emergency declaration. So, that applies to the entire country. And the blanket – when it says blanket waivers, that means it's for everybody in the country. It is not geographically specific.

Cynthia Morton: OK. Thank you for that clarity. And so, the three-day stay waiver then would reply – apply entire – to the entire country. All the nursing homes, irrespective, if that community is dealing with the emergency or not.

Seema Verma: Correct.

Cynthia Morton: Thank you very much.

Seema Verma: I think it's safe to say that, you know, from our perspective, every community is being impacted by this. Obviously, there are some areas of the country that

are harder hit. And we don't want to wait until healthcare communities are in a crisis. We want to make sure that they have those flexibilities on the front end.

That being said, you know, if – if you don't need the waiver, you shouldn't be using it. And so, we're just calling on local communities to decide, you know, what the situation is in their area and make decisions accordingly.

Cynthia Morton: Thank you. Appreciate that clarity. Thank you.

Alina Czekai: Thank you. Next question, please.

Operator: Next question. Caller, go ahead. Your line is open. Go ahead, caller.

Female: Hello. Can you hear me?

Alina Czekai: Yes, we can.

Seema Verma: Yeah.

Female: My question to you was regarding that three-day waiver. It was to confirm that the waiver would go into effect, even if it was not a COVID positive patient. For example, if you had availability for a stroke patient, but they wanted to forego the three-day stay, could we accept that patient even though it would not be a COVID necessary related stay, but it would be to free up the bed for the hospital to utilize for a COVID patient possibly?

Seema Verma: Correct. These waivers …

Female: Also …

Seema Verma: … apply across the board. And they are not COVID positive patient specific. They just apply across the board. The idea here is we do want to make sure that hospitals have the capacity to deal with the incoming and the influx. So, we're trying to create as much flexibility in the system. All of these waivers are designed with the idea that hospitals could be facing or already are facing surges. And we need to be able to give them the flexibility to be able to meet that demand.

Female: Great. And that's good to know. I also have one second question. And that would be for more of a life safety fire hazard. Would it be possible that you could answer that with CMS', you know, recommendation to go ahead and remove non-necessary medical. We have some facilities that do have potentially inspections that would be routine, i.e. it be annual or whatever. And we got clarity from our state that said that, for fire purposes, we would still need to continue that.

Seema Verma: I'm going to let our safety and quality folks answer that question. But we did already issue guidance that we are suspending surveys – more of the routine surveys. And the types of surveys that we're focusing on are those with immediate jeopardy. So, any cases of abuse or neglect.

And then the second area is around infection control. So, all of the surveyors across the country are supposed to be focused on a more targeted survey that's just around infection control. And we're suspending the other ones in the short term. I don't know if anybody from CCSQ, (Jean) or (David), if you want to speak to that.

(David): Yes. Thanks, administrator. The routine surveys have been suspended, which include life safety code surveys. If you're speaking to other maintenance visits that you receive, were not currently serving for compliance with those scheduled maintenance visits. And really are asking fully …

Female: Yes.

(David): … to focus only on those that are essential in terms of the operation of that facility.

Female: OK. So, essential was exactly what I was trying to get at. So, like, in one of our campuses, our fire panel, we're going to continue, but not necessarily in another facility, where we have (annual) inspection.

(David): Those timeframes for the annual or regularly scheduled inspections that you received from your – from your vendors with regard to fire safety, we're not

monitoring for compliance at that time. Because, again, we want to restrict to only those visits in facilities that are really essential for health and safety.

Seema Verma: (Inaudible).

Female: Does this also include – does this also include hospice if we decided to – because hospice people – we have asked them not to come into our long term care community due to the fact that they traveled to multiple health – home health – I mean multiple homes and multiple nursing homes. And they're telling me that they have a 14-day required cert. Is that also going to be waived?

(David): That 14-day onsite recertification has been waived in terms of in-person. Those can be done through telehealth or other means.

Female: And if they're not set up for telehealth? Because that's the criteria that we asked issued is to ask them to do telehealth only. And they said that they have not been approved. So, is there a fast track for those hospice to be approved?

(David): There's not a formal approval. It's if they have the means to be able to conduct those visits with whatever technology they have available.

Female: OK. So, just for clarity, we can issue out that we are refusing hospice insurance due to the risk of the COVID-19 in our community that is pretty prevalent. And that they can refer to telehealth for the waiver for the 14-day, and if they don't telehealth (inaudible) …

(David): Yes. Sorry.

Female: I'm not sure where we stand with.

(David): Yes. I would just say the one thing we do want to stress is that any healthcare workers who are going in to provide direct care should still be able to do so as long as they have appropriate PPE or – and meet whatever screening you have in place at your facility. So, we still want healthcare workers to be able to provide direct care to their patients. If, for example, they're being provided hospice care, they should still be able received direct care from the hospice

provider, but, the re-certifications, we've waived and providing other options for that to occur.

Female: Got it.

Alina Czekai: Thank you. Let's get our next question, please.

Operator: The next question comes from a caller. Caller, please go ahead. Please unmute your line. Go ahead, caller.

(Corrine Oakley): Hello. Hello.

Alina Czekai: Hi. We can hear you.

(Corrine Oakley): Oh, good. Thank you. My name is (Corinne Oakley). I'm from Mayo Clinic Hospice in Rochester, Minnesota. And I just wanted to clarification. You might have just answered it. I hear you say providers, when you talk about hospice and telehealth – and we just need a clarification on the nurse's visits. And I think your gentlemen just actually verified that nurse's 14-day visits would count in the telehealth visits. Is that correct?

(David): That's correct.

(Corrine Oakley): OK. And that's exactly what I just needed, that clarification. So, thank you very much.

Alina Czekai: Thank you. Next question, please.

Operator: Next question comes from a caller. Caller, please go ahead. Your line is open. Go ahead, caller. Caller, your line is open. I'm afraid …

Alina Czekai: Operator, perhaps, we can take the next question. Thank you.

Operator: Caller, your line is open. I'm just going to move to the next one. Caller, your line is open.

Male: Can you hear me?

Alina Czekai: We can. Thank you.

Male: My question is related to hospice billable visits for physicians. In the pre-emergency world, the physicians that were either employed or contracted through a hospice to treat patients for medically-necessary visits related to the terminal illness. We're allowed to bill those on the UB-04.

There is no – there is no place to put a place of service to to represent telehealth. And I'm wondering if there is any specific requirement that needs to go on the UB04 when a hospice physician or a nurse practitioner that's been elected the attending provides a medically-necessary billable service in the form of an E/M code.

So, should they just be using their normal revenue codes and documenting somewhere on their documentation that the visit was done via telehealth?

(David): I, I can answer that one. They should use the modifier 95, which is the CPT modifier for telehealth services.

Male: So, that's – so, that instruction is only that – well, for the hospice side of the house, not on the part B fee for service side. Because I've seen transmittals that say no modifiers are necessary on the B side.

(David): So, in the – in the interim rule that was just released yesterday, the modifier is to be used for all of the telehealth services now on both the professional and the institutional side.

Male: OK. Wonderful. Thank you. And then another question – sorry – that piggybacks on this. You released additional telehealth approved codes like home visits and domiciliary visits. However, the provider rendering the service at the distance site would probably be in an office location. Should they be using Office or other outpatient codes or the home visit codes where the patient resides?

(David): So, they should use the code that best reflects the kind of care that they're furnishing, which, in some cases, of course, will be the location of the patient, and, in other cases, could be the location of the practitioner. Obviously, this is

a unique set of circumstances. And so, we understand that. I think it'll take some time to adjust. Yep.

Male: OK. So, it sounds like, if it's a part B normal fee for service clinic based practice, they would use their normal office visit codes regardless of where the patient is. But, if it's a type of home based service where they were normally billing home based codes, whether it's a hospice or Part B home or palliative practice, they would use the traditional codes they've been using with the 95 modifier.

(David): Right. That's what it is.

Male: OK. Wonderful. Thank you so much. Thank you.

Alina Czekai: Thank you for your question. Next question, please.

Operator: Caller, please go ahead with your question. Your line is open.

Female: Hello.

Alina Czekai: Hi. We can hear you.

Female: I have a question about the certification and training for nurse's aides. Can you talk about the waiver for that?

David Wright: Yes. This is David Wright. So, what we've done is allowed – basically lifted the previous four-month limit that applied for aides to be able to receive their certification and keep working in the facility. Nurse aides still have to receive competency checks and training, but we're eliminating that four-month requirement that otherwise would trigger them having to be a certified nurse aide or else have to no longer work in the nursing home.

Female: OK. And there's no – nothing planned for like a shorter class version to have LNAs be certified directly after the class?

David Wright: Not it this time. And so, what we've got right now we believe is going to help address a lot of the shortage issues, but we'll continue to explore that.

Female: OK.

Alina Czekai: Thank you for your question. Next question, please.

Operator: Your next question comes from a caller. Caller, go ahead, please.

Male: Hello.

Alina Czekai: Hi, we can hear you.

Male: Can you speak to whether the qualified interpreter standards will be relaxed due to the surge of patients?

Alina Czekai: Can any of our CMS staff speak?

(Jane): This is (Jane).

Alina Czekai: Oh, go ahead. Thanks, Jane.

(Jane): I'll just say that we have not relaxed that at this time. We have your question, and we'll continue to look into that.

Alina Czekai: Thank you for your question. Next question, please.

Operator: Caller, go ahead, please with your question.

Female: Hello.

Alina Czekai: Hi. We can hear you.

Female: Hi. Thank you. I'd like to go back real quick to the hospice question about the 14-day visit. I think maybe there's some confusion. I understand that the face-to-face encounter by the physician, an NP for recertification purposes can be done via telehealth. But I think the waiver says that the comprehensive visit, which is currently a 15-day – every 15-day requirement has been extended to 21 days. But it doesn't say that it can be done via telehealth. Can it be done via telehealth?

(David): We'll follow up on that and issue any clarification if we need to just to make sure we've got everything all clear on that.

Female: That would be very helpful.

Female: But, as a matter of fact, there is a call for home health and hospice a little later on today. So, if we can get any clarity by the then, we can also address it.

Female: That will be enormously helpful. Thank you so much.

Alina Czekai: Thank you for your question. Next question, please.

Operator: Caller, go ahead, please, with your question. Your line is open. Caller. I'll move on to the next one. Caller, your line is open.

Male: Hello. I have a question with regards to the advance payments.

Alina Czekai: Sure. What is your question?

Male: Yes. Is that advance payments – is that – is that basically an advanced toward the $100 billion subsidy? Hello.

(Jane): I don't know if someone from – yeah. I'm not sure if someone from CM is on that can answer that. As the administrator noted, it is not – it is not a substitute for the $100 million pot. That is a different pot. And so, those are two separate funding pots.

Male: So, is there a – on the advanced payments, is there anything specific as far as how we – how to – who we contact? Is there a website? Or, who do we contact for these advanced payments?

(Jane): Yes. And actually, it might be a good time to give our website information. There is additional information about it – advance payments there. And as far as the process to follow, there are formulas and things that are normally done. This is not necessarily a new process. So, I would direct you there. And then there's also a place where you can direct questions. And we can get back to you on your specific instance.

Male: So, is there a website you can give to us now?

(Jane): Yes. Our – I'm going to turn to Alina to give all that information to the callers so that they know how to reach us.

Male: OK.

Alina Czekai: Absolutely. Thank you, (Jane). We have a COVID specific email address boxes, and that is covid-19@cms.hhs.gov. And also I would encourage you to check out our website cms.gov, where we have links to all of the guidances and memos that we have issued around coronavirus. Appreciate your question. It looks like we have time for about one more question, operator.

Operator: Caller, go ahead please with your question. Your line is open. Caller, go ahead.

Female: Hello.

Alina Czekai: Hi. We can hear you.

Female: Hello.

Alina Czekai: Hi, what is your question, please?

Female: Yes. Could you speak more about the waiver for SNF associated with using unlicensed beds and common areas, please?

Male: Yes. So, that's for skilled nursing services in a – I assume in a skilled nursing facility. Is that what you're trying to?

Female: Right.

Male: Right. So, what we want to do is allow more use of other patient care settings in the – in the event that a nursing home needs to create more care space for their residents.

Female: And this will be determined by your local state?

Male: It needs to be done in accordance with your state or local pandemic plan and any guidance that they may provide with regard to that as well.

Female: OK. Thank you.

Alina Czekai: Great. Thank you for your questions. This concludes today's call. I'd like to thank everyone for joining us and for sharing your questions. As a reminder, this call has been recorded. So, we will be posting it very shortly to our CMS website. And as always, please don't hesitate to reach out if you have any questions or concerns. We really appreciate the work that you all are doing, many of you on the frontlines and caring for patients and their families as we address COVID-19 as a nation. Thanks again.

Operator: Thank you for joining today's conference call. You may now disconnect.

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