Centers for Medicare & Medicaid Services
COVID-19 Call with Hospitals and Health Systems
Moderator: Alina Czekai
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Operator: This is Conference #: 3249355.

(Alina): Good afternoon. Thank you for joining our CMS COVID-19 call with Hospitals and Health Systems. I'd like to introduce our speaker today, Demetrios Kouzoukas. Demetrios is the principal deputy administrator and director of the Center for Medicare. We're also joined by numerous CMS subject matter experts, who will be here on the line to answer questions you may have.

Demetrios, I'll turn it over to you.

Demetrios Kouzoukas: Thank you so much, (Alina). And thank you all for joining the call. It's a real privilege to have an opportunity to spend time with you at this moment, especially when I know that so many of you are focused as are we on dealing with the coronavirus pandemic, and supporting all the doctors, nurses, other workers who are providing so much care and comfort to Americans that have been infected by the virus and those who are concerned about their health care and also those who have everyday needs and need to be able to access the healthcare system at this time.

The pandemic has required us to fundamentally rethink what our healthcare regulations demand of physicians, nurses, and other clinicians facing this challenge. It's an altogether new situation. And so under the leadership of the administrator, the Secretary and the President, we are waiving a wide and unprecedented range of regulatory requirements to equip the American healthcare system with maximum flexibility to deal with an influx of cases.

We're making these changes through our ability to issue waivers and also modifying our regulations. Many healthcare systems may not need all of these flexibilities and changes. And in many cases, they may not need to use all of them, but the situation doesn't warrant it. But the flexibilities are there if

they are needed every day, but especially at this critical time, regulatory barriers should not stand in the way of patient care.

There are several pieces to our announcement. I'd like to spend a little bit of time just giving you a bit of an overview. So, we're starting from the same point. First, there's what we are calling this the hospital without walls strategy, which allows hospital systems to function as a kind of collaborative headquarters, coordinating a wide variety of settings of care. This will allow healthcare providers to work with state and local public health officials to create new treatment sites to expand capacity, safely separate patients infected with coronavirus from those who are not, and to preserve personal protective equipment.

FEMA, of course is doing incredible work setting up hospitals in New York and other areas. But under these waivers and regulatory changes, 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, or gymnasiums, or whatever other facilities are needed in order so that hospitals can focus on those that need the most intensive care.

Today, many healthcare facilities are rightly delaying elective surgeries, and they may have excess capacity that can be devoted to hospital like care, such as cancer treatments and essential surgeries. The changes that we announced yesterday allow hospitals sorely needed flexibility to increase their capacity.

Furthermore, we typically pay for ambulances to transport to select locations such as the emergency room, or among hospitals. But now Medicare will pay for ambulances 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 offsite locations to triage incoming patients.

This ensures maximum flexibility for testing and screening for COVID. Second, we are making changes to facilitate testing. Some people that need a coronavirus test are not able to physically leave their home to obtain it. To address this problem, Medicare will pay for lab companies to collect samples in people's homes or nursing homes.

We hope 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 already. By increasing testing, we can isolate those patients that have been infected and keep other residents healthy.

The third component, in addition to the changes that I've described so far, hospitals without walls and testing provides flexibility to the health care system to boost the 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 are helping hospitals increase staffing.

We're also letting a broad range of health care workers like nurse anesthetist, respiratory therapists, and more, perform all the functions for which they are trained. To take just one example, nurse anesthetist could help with anesthesia during essential surgeries and procedures, which frees up anesthesiologist for ICU care.

And Medicare will not require them to meet extra rules in order to practice at the top of their licensure. 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 child care services while they're on duty. These are all things our regulations normally disallow.

And then there's telehealth. We already announced a dramatic expansion of telehealth services to our nation's 62 million seniors with Medicare. Yesterday, we announced that we are going even further. We will be getting rid of barriers to telehealth that have long existed in the Medicare program, such as virtual E.R. visits allowing doctors to supervise clinical staff remotely and eliminating requirements that many visits be provided face to face.

Crucially, clinicians can also provide remote patient monitoring services to both new and established patients. We're also expanding the use of telehealth for inpatient rehabilitation, hospice, and home health settings.

Finally, our efforts to put patients over paperwork is a long standing CMS initiative. And the President started with his executive order to cut the red tape. As part of today's actions, we are ramped – yesterday's actions, we are ramping up patients over paperwork even further to meet the unique demands of this emergency.

We are providing temporary relief from many audit and reporting requirements by extending an array of deadlines and suspending documentation requests, all of which take time away from patient care. To reiterate, in this short summary, we've barely scratched the surface of the unprecedented flexibilities we are offering health care providers. They will maximize the system's preparedness by freeing providers from regulations ill-suited to the unprecedented need to this emergency in which all too often get in the way of patient care.

Before closing, I want to note that the CARES Act, which Congress recently passed and the President signed, allows for additional flexibility. So we are evaluating and implementing. We wanted to get this intervention out as soon as possible to prepare the health system. CMS will make further updates based on the legislation.

There have been many, many dedicated caregivers in the ongoing war against the coronavirus. But I want to take this opportunity to single out members of our CMS team for special thanks. And they're on our call, you'll hear from them today perhaps.

Normally, the rulemaking and the kinds of actions that we took yesterday, takes many, many months. But these public servants have done it in a few weeks while working remotely to boot. They have thought boldly and creatively to respond to the needs of the healthcare system. And listen to all of you and many others from whom we are hearing constantly. And they have worked night and day, foregone time with their families at this very sensitive

time, all to respond to the many needs of the health care system during this trying time.

The administrator and I could not be prouder to serve alongside them. Our efforts are important because we know that they support your efforts and the efforts that that you all are supporting as well. That people on the frontlines working in the health care system are also working long hours, sacrificing time with their families, and risking their own health to care for coronavirus patients.

We owe all of you every bit of support we can muster and the least of it is to ensure that regulation does not get in your way. And so that's what we intended to convey with our announcements yesterday. And we look forward to working with you in order to make sure that you have every opportunity to take care, to implement these flexibilities in a way that helps patients and communities. Thank you.

(Alina): Thank you Demetrios. With that operator, we will open up our line for questions please.

Operator: And ladies and gentlemen, to ask a question, please press star one on your telephone keypad. To withdraw your question, please press the pound key. Again, in order to ask a question, please press star one.

And we have a question from (Susan Green). Your line is now open.

(Susan Green): Thank you. Good afternoon, everyone. And thank you for this call. It's been very helpful. I have a question on the accelerated payment schedules. Specifically, I have called the hotline and they have informed us that after seven months if we have – if CMS or you have not recouped all of the accelerated payments, you will charge interest at 10.25 percent. First of all, are you aware of that? And second of all, that is a very high rate. So we're looking for some help in reducing that.

Demetrios Kouzoukas: I understand. This question comes up often, whenever interest is mentioned in the federal government. Unfortunately, the way that the interest rate requirements work, our hands are tied to use a particular rate that's tied to

certain treasury mixed figures. And so we don't have much of a choice to use a different interest rate.

(Susan Green): Just to expound on that the Treasury is up the all-time low. So it would be great if we had some transparency into what the calculation is. But moreover, it is not disclosed in any of the fact sheets, so our independent providers and physicians are making decisions to take this and there's no transparency or disclosure in the fact sheet, you have to call the helpline. And even then, it wasn't clear yesterday. So I just request transparency into it in the fact sheet to include that as providers are making these decisions, very important decisions. Thank you.

Demetrios Kouzoukas: Understood. We know that operating and keeping the cash flow working in order to keep your operations going is really important at this time and you need to know all the facts to make your decisions. I don't know if our colleagues on the phone, do you have anything more to say about the underlying tied to treasury or which rate it is?

Marion Couch: Demetrios, this is Marion Couch. (Megan) just got off a phone call at noon with a number of the stakeholders. And we will take this back and make sure that it's more transparent. But we're working on that. We're well aware of that and we understand the impact in, though it's out of our hands, we're very willing to keep working on that piece of it.

So we can take it back right away in terms of making it transparent and then we work on how to figure out ways to work with current guidelines in the Hill on the other piece of setting it right. Thank you.

(Susan Green): Thank you.

(Alina): Thank you. Next question, please.

Operator: Your next question is from (Tim Walters). Your line is now open.

(Tim Walters): Yes. Thank you very much for all the waivers that have been announced so far. We operate a small rural hospital in Southwest Missouri. We just are now starting to get cases and try and look at some bed flexibility. We are

limited to 50 beds, because we are exempt from the Rural Health Clinic cost limit for our provider-based rural health clinics. We are wondering, is it possible to get that 50 bed limit waived so we can get additional beds prepared to put in the service for the expected surge in patients?

(Ing-Jye Cheng): Hi. This is (Ing-Jye Cheng). I work with Demetrios in the Center for Medicare. And I'll jump in here. This is an issue that we've heard of from other providers as well. And we're actively looking into what we can do to make sure that you're able to have that capacity. So we don't have anything in the ISG at this time. We're on the waiver list, but we're actively investigating this issue.

(Tim Walters): OK. Thanks very much. Appreciate any help you can provide there.

Operator: Your next question is from (Justin Hunter). Your line is now open.

(Justin Hunter): Hi, am I in the call?

(Alina): You are. Thank you.

(Justin Hunter): Hey, Demetrios, thanks to you and the team for all that you all are doing and have done. It's unprecedented and it's greatly appreciated.

Demetrios, you mentioned that you all are aware of some provisions in the CARE Act that were enacted into law, I guess, like last Friday night, and just didn't make it into yesterday's interim final rule, but that you all will be addressing those later. Any idea when you all might be clarifying the waiver of the earth, three-hour rule, please?

Demetrios Kouzoukas: As soon as we can. I don't know if we have (Jason) or (Hillary) on the phone.

(Jason): Hi. This is (Jason). Yes, we're actively looking at that and working to get it released as soon as possible.

(Justin Hunter): Great, thanks a lot. And again, thanks for all that you all are doing.

Demetrios Kouzoukas: Thank you.

Operator: And your next question is from (Matt Morgan). Your line is now open.

(Matt Morgan): Thank you for all the work you've been doing. As it relates to the hospital without borders provision, you list a lot of facilities that can be used as alternate sites of care under a hospital billing et cetera. I did not see skilled nursing facilities listed, are they available to be used?

Demetrios Kouzoukas: (Ing-Jye) do you want to take that or (Jason)?

I mean, I can give you the short answer and then some of our folks can correct me or add to it. But the concept behind the hospitals without walls strategy is really that we would allow, essentially, almost – or anything that is sort of suitable and appropriate. It can meet all of the conditions of participation that we haven't waived in order to be part of a hospital.

Now, you know, how that – and that could conceivably include a skilled nursing facility. What I don't know and maybe our team can fill in is how that affects the SNFs sort of eligibility enrollment and status of the SNF, if you will.

(Jason): This is (Jason). I don't have any additional details. Demetrios as you were discussing there, I would just note that we do have the three-day waiver in place for SNFs and that is nationwide. And it applies to patients who may not necessarily or may be COVID positive or may not be COVID positive. It applies to anyone who meets the appropriate need for skilled care in a SNF.

And part of the rationale for that is to try to transition patients as quickly as possible out of hospitals and into SNFs so that we can have those hospital beds available.

Demetrios Kouzoukas: What we're really hoping to get out is the – what we announced yesterday is really to give you all the flexibility to put the pieces together. So essentially at some level, as you assemble the pieces that has to overall be a hospital, to the extent we haven't waived the requirement. But, and that can have an important role for an existing hospital facility, acute care facility,

working with a SNF and then providing assets, resources, and personnel, or other sites, in order to fill in around that.

And really where people – and I hope we see a lot of permutations that are specific to individual communities and their capacity and resources and strategies that they take on the ground.

(Alina): We'll take our next question, please.

Operator: And your next question is from (Todd Kennedy). Your line is now open.

(Todd Kennedy): Yes, thank you. I'd heard earlier that you mentioned that CRNAs can work at the top of their license and currently I believe, you know, a CRNA has to be over one anesthesiologists can oversee for CRNAs. So in a surge capacity does this bill or act allow us to allow a CRNA to practice without having that same ratio hold? Could we surge, you know, one MDA that oversee eight for example?

Demetrios Kouzoukas: (Jean) or (David) are you on the phone?

(David): Yes, Demetrios. This is (David). So we've waived the – we've waived the physician supervision requirement for CRNA as long as it's allowed under state licensure and scope of practice.

(Todd Kennedy): OK, all right. Thank you.

Operator: Your next question is from (Kathy Shaw). Your line is now open.

(Kathy Shaw): Hello. This is (Kathy).

(Alina): Hi, there, we can hear you. Thank you.

(Kathy Shaw): Hi. I'm just wondering if physical therapists are able to provide telehealth? I see there's physical therapy codes to build but I'm still confused as to whether there's physical therapists are able to use the telehealth code.

Demetrios Kouzoukas: So at the time that we put this regulation together and put it out, we didn't have the authority to go as far as having the physical therapists provide

that particular service. But we do have the codes there. So that physiatrists or in situations where there might be a medical doctor, who would be needed or able to do that that we provided even that flexibility in that circumstance.

But we are looking now at what the CARES Act provides and considering how we might be able to implement that in a way that meets your needs.

(Kathy Shaw): OK. Thank you.

Operator: The next question is from the line of (Denise Taylor). Your line is now open.

(Denise Taylor): Hi, hello. My question is …

(Inaudible)

(Denise Taylor): … COVID-19, is there any specific billing requirements for any services related to COVID-19?

Demetrios Kouzoukas: What kind of facility or billing type or setting are you in?

(Denise Taylor): Acute.

Demetrios Kouzoukas: (Ing-Jye), do you want to take that?

(Ing-Jye Cheng): Sure. And I'd be happy to take questions offline if there's specific services that you're interested in. But as far as acute care hospital billing at this time, we don't have any specific requirements other than how you would normally bill your DRG. As you know, the CDC recently released guidance on a new diagnosis code that is effective starting April 1st tomorrow for COVID-19, diagnosis of COVID-19 for services prior to April 1st. There is another ICD-10 code in place.

(Denise Taylor): OK.

(Ing-Jye Cheng): I don't think there is any special billing work. Sorry, go ahead.

(Denise Taylor): I was going to say, are they on the website?

(Angie Chang): It is on the CDC website as well as other information about specifically the types of cases. The coding is different depending on if you have the pneumonia, somebody's presenting with pneumonia and a variety of different scenarios, but then walk through that specifically on the CDC website.

(Denise Taylor): OK. I will check it out. I had another question, if I may. For telehealth, is the beneficiary copay being waived?

Demetrios Kouzoukas: So, the Office of Inspector General did provide some guidance that allowed waivers in many circumstances that wouldn't normally be allowed under their normal rules. And so there will be opportunities for providers to waive copays, so consistent with that guidance.

(Denise Taylor): So the providers can waive copays because I know on the website it stated that the telehealth would be used or, you know, as person to person, it would be the same as person to person, although it's telehealth. So, you're just saying the provider had the obligation or it would be on the provider to waive the copay for these services?

Demetrios Kouzoukas: That's the flexibility that the officer Inspector General has afforded through their reports and discretion on the anti-kickback statute.

(Denise Taylor): OK. All right. Thank you.

Operator: And your next question is from (Jenny Towatz). Your line is now open.

(Jenny Towatz): Hello. My question is also around telehealth services in an effort to protect our patients and to preserve PPE, we have numerous outpatient hospital departments who are beginning to provide telemedicine services, services such as P.T., O.T., wound care, lactation, basically, HOD visit type services. Can hospital employed therapists or providers provide these services and bill a facility charge on the U.B.?

(Ing-Jye Cheng): Hi. This is (Ing-Jye Cheng). And just to answer that, it's a question we've gotten, I think, from a number of different providers is whether or not outpatient services can be provided at telehealth and billed accordingly. And we're actively working on that issue at the moment.

(Jenny Towatz): OK, thank you. Once that guidance comes out, if it could be very specific to include the revenue codes and CPT codes and if the modifiers are required on the claims that would be very helpful for us.

(Ing-Jye Cheng): OK, got it. Thank you.

(Jenny Towatz): Thank you very much.

Operator: And your next question is from the line of (Diane Davidson). Your line is now open.

(Diane Davidson): Good afternoon. I had a question regarding the telehealth for the rural health clinics. We understand that we were delayed in providing the telehealth to our Medicare patients until the phase three regulatory issues were passed. But our last information as of last night from the National Association of Rural Health Clinics, was that we are still awaiting guidance on how to build these and whether or not they were telling us that we're not going to be all inclusive rights that would be a fee schedule payment and how they would impact the cost report. Is there any update to that as to whether it's going to be an all-inclusive rate or a fee schedule and whether our providers time must be carved out of the cost report?

Demetrios Kouzoukas: The legislation that was enacted on Friday does speak to RFCs providing telehealth. And so we're working through implementing that right now. It does – the legislation also has a provisions that are specific to payment. And so, I expect that there will be some variation in the payment that is a detail that is more than a detail an important question or an issue that we're working through as we look to the legislation. But I'd point you to the legislation if you're looking for sort of what the latest is on it.

(Diane Davidson): Well, I know it's concerning for the community that's having these discussions and, you know, collaborating with local other clinics. Some our being told by consultants that they are free to go ahead and bill the telehealth and bill it like face to face and that they will get the all-inclusive right and that's just not what we're being told by, you know, leadership that's interpreting this for us like the National Association of Rural Health Clinics.

They're saying to hold off, well, they don't know yet. So it sounds to me like you're saying, it's still not hasn't quite been determined the coding, the billing, or how it's going to be held accountable to either cost of the clinic visit or whether or not it's going to be carved out because just to share the fact that if it's less than a cost, and we still have to carve out our in provider's time, it's really not going to be helping the rural health clinic or they have to exceed in any way.

Demetrios Kouzoukas: We're definitely are looking as we interpret and try to apply the statute to provide as much flexibility as we can. And I think the kinds of issues you raised are very much foremost in our mind. Just this morning, we were on an internal call, trying to work through some of these issues. So we're aware of the situation and the urgency that you all are feeling. I don't know if Ing-Jye), do you have anything (form or drop her) up?

(Ing-Jye Cheng): No. As Demetrios said, we're working very quickly to put together an implementation plan for the legislation that passed on Friday. And this is one of the first and foremost issues that my area is working on.

(Diane Davidson): Thank you, we'll wait. We'll await your guidance as soon as possible. I appreciate it.

Demetrios Kouzoukas: Thank you.

(Alina): Thank you. Next question, please.

Operator: Your next question is from Bunny Reid. Your line is now open.

(Bunny Reid): Hi. I have a question regarding the temporary testing sites that is being set up off campus. The guidance we received from the National Uniform Billing Committee indicated that we will bill using the main hospital address. However, the MACs have been telling us that we need to put these on the 855 with the actual address. So my question is, do we actually have to put them on 855? And if so, why would we do that if we're using the hospital's main address to bill and they're only temporary?

(Sabin): Hi. This is (Sabin) from provider enrollment. That's right. You don't need to report that on the 855 if you're going under enrolled hospital TCM.

(Bunny Reid): OK. Thank you.

(Alina): Thank you. Next question please.

Operator: Your next question is from (Jonathan Gold). Your line is now open.

(Jonathan Gold): Hi. Yes, just echoing what everybody said and appreciate all the efforts you put in to provide additional flexibilities. My question is regarding the hospital without walls and the under arrangement provisions. Specifically, if a freestanding rehabilitation hospital is being used for surge capacity in an under arrangements type setup, to what extent is the freestanding rehabilitation hospital have discretion to use their nurses and other clinicians to provide the care to the patients that are in the acute care patients, as opposed to how much does the acute care hospital have to continue to oversee that care that's being provided in the freestanding rehabilitation hospital?

Demetrios Kouzoukas: I can just get started and others may weigh in. The concept here really is that within under arrangements, kind of situation is that the hospital that's doing the contracting is the accountable party, the one that we're looking to really to fulfill all the requirements in the program.

And that, obviously, while there might be other laws around how contractual arrangements can work, that we're seeking to provide flexibility for hospitals to enter into arrangements that are going to allow them to provide the hospital with a level of care in a variety of different settings.

And so, in good part without obviously getting into the specifics of any particular service or situation, and we'd be happy to work with questions if you have, work if you have questions about those. But in general, the idea here is that there would be flexibility to work that out between the various entities and in a way that makes most sense for patients. I don't know if others on the team have anything to add to it.

(Jonathan Gold): Great. Well, yes, I really appreciate that. And do you envision a situation where a freestanding rehabilitation hospital could directly care for an acute care patient if there's a need for additional beds and the patient could be safely cared for in the rehabilitation hospital?

Demetrios Kouzoukas: Under arrangements freestanding?

(Jonathan Gold): No. If it (inaudible) and they took the patient directly because they needed a bed and some care that the rehabilitation hospital could provide.

Demetrios Kouzoukas: (Jason) I think you've got an answer to that.

(Jason): I think the additional waiver authority that is in the CARES Act may provide some flexibility in a circumstance like that, depending on the particular patient. But otherwise, the under arrangements model would working with an acute care hospital that might be in the vicinity may be one of the most effective ways in the circumstance you're describing.

(Jonathan Gold): Great, thank you again.

Operator: And your next question is from (Joe Kanish). Your line is now open.

(Joe Kanish): Yes, good evening and thank you for having this call. My question has to do with the exemption in the quality reporting, specifically under the hospital acquired condition, reduction program, and value-based program. And speaking to the infection control measures, the four measures for MRSA, C. Diff, CLABSI, and CAUTI , it's exempt from the CMS reporting program but does that also exempt required reporting under CDCNHSNrequirements.

(Jean): Hi. This is (Jean) and I'll take that question. So, yes, you're correct, it does. It is exempt for the CMS program which of course has payment ramifications. We – it is not exempt per se from the CDC program, they would have to look at what flexibilities they can give. I will say that, of course during this time of inspections, they're interested in getting as much data as they can better understand the circumstances that you all are working on just for payment purposes to visit there.

(Joe Kanish): Thank you.

Operator: And your next question is from (Louise Bryant). Your line is now open.

(Louise Bryant): (Louise Bryant). I wanted to echo the question that was asked regarding the physical therapy telehealth. I'm representing a rehab company. And I just wanted to confirm that I understood it correctly that CMS is working on a plan to include physical occupational and speech therapy in the ability to provide telehealth for Medicare beneficiaries.

Demetrios Kouzoukas: We are looking at our ability to do that under the CARES Act. I regret that we don't have all the details here to share with you. But know that we're looking to see what we can provide under the flexibilities in the legislation in order to allow more of these kinds of services to be provided by telehealth.

(Louise Bryant): Thank you.

Demetrios Kouzoukas: … therapist as well.

(Louise Bryant): Thank you.

Operator: Your next question is from (Jessica Jensen). Your line is now open.

(Jessica Jensen): Hi, good afternoon. I do have a question on the supervision requirements for teaching hospitals. It noted in the new releases that that supervision can happen via the audio or technology methods. But is that – how does that work in relation to the attending or somebody being there for the key and critical portions? In addition, how it kind of limits the availability of some of these residents to be able to perform services to free up the attendings or the physicians to focus on the COVID-19 patients?

Demetrios Kouzoukas: I'll pass that one out to (Ing-Jye Cheng).

(Ing-Jye Cheng): I'm happy to answer that. But I wonder if you can actually repeat the first part. I heard it after attending being there for the key and critical portions but I didn't quite catch the first part of your questions.

(Jessica Jensen): Yes, sorry. So the – it notes, you guys have released these supervisions for a meeting to be face to face with the attending provider to allowing that supervision to happen via these telecommunication methods. Are there certain portions of the visit that the attending needs to be immediately available on that telecommunication method and then furthermore, that's one on one, one resident, and that attending still being available for every one of those visits?

(Ing-Jye Cheng): So, what we did in the rule is tried to change the requirement so that we would, to the extent the attending would need to be involved that could be done by a virtual presence. So interactive audio visual communication, not necessarily physical presence. So it's really changing the nature of that requirement.

We really didn't opine on whether or not the specific nature of their involvement would change. So I think we would still defer very much to the individual setting in which the attending is working with the resident when they would need to be involved. I don't think our role was intended to change that interaction. Other than to provide additional flexibility to say if there's any reason whether it's PPE related or otherwise for the attending to be remote that could happen.

(Jessica Jensen): And do you have any thoughts or anticipation of maybe loosening up even the availability of residence to see patients and maybe practicing more like a primary care exception maybe across the board during this timeframe or that's not been discussed yet?

(Ing-Jye Cheng): That wasn't something that we had addressed in the rule that we released last night. But certainly, it's something I'm happy to take back and think about further in the context of the authority that we have under the new legislation.

(Jessica Jensen): Great, thank you.

Operator: Your next question is from (Robin Freed). Your line is now open.

(Robin Freed): Hello. In regards to a patient who presents to an emergency department, can you please clarify if telehealth can be used for the medical screening exam?

Demetrios Kouzoukas: I think the answer is, yes. (Ing-Jye Cheng) anything from that?

(Ing-Jye Cheng): One of the things that we did in the ISC and the rule that we released last night was we made a number of different services payable as Medicare telehealth including E.D. visits. I think your question is not just as the visit itself payable, but your question is more on the EMTALA end of it the medical screening exam.

And I think to the extent that the screening exam is part of that visit, certainly, it could be payable as telehealth. I don't know if my colleagues who are more tuned to the EMTALA side of the universe want to offer any additional insight.

(David Wright): Yes. Hi, (Ing-Jye), this is (David Wright). And yes, we issued guidance last night to simply addressing that telehealth can be used to remotely perform the screening exam either remotely with regard to conditions not having to (done) PPE in order to perform it or even offsite, a physician offsite using telehealth to perform the screen examination of a patient at the emergency department.

(Robin Freed): Thank you.

Operator: And your next question is from (Linda West). Your line is now open.

(Linda West): Hello. My question is regarding behavior health and wanting to know, are there specific provisions made for those of us who are providing mental health services via telehealth?

Demetrios Kouzoukas: So, tell us a little bit more about what counseling sessions?

(Linda West): Absolutely. We are private mental health center. And we have seen a huge spike in the number of people requesting mental health services both new and established patients. And so I'm just wondering, are there provisions being made to bill for those patients? And what is done?

Male: So under Medicare payment policies, the psychotherapy services as well as the psychiatric diagnostic exam, and other related services that are available under Medicare, by psychologist, psychiatrist, and licensed clinical social

workers are all on the list of telehealth services and can be furnished via telehealth.

(Linda West): Yes. What about we have – we've seen a number of patients who don't have the ability to FaceTime or any of the ways that we normally do on telehealth, some don't have computers. Are there any provision in around mental health on how to address those patients?

Male: So there are some services that are available for billing under Medicare, both new services under the rule that was released yesterday as well as preexisting services for relatively brief interventions, when just a telephone sort of audio telephone is used. But that's something that we continue to consider under the new authorities in terms of the new legislation and so we continue to look at that.

(Linda West): Yes. Is that on the website?

Male: The codes that are available are on the website with all of the information related to the telehealth services.

(Linda West): Great. Thank you.

Operator: Your next question is from (Ken Yasvesh). Your line is now open.

(Ken Yasvesh): In regards to the telephone services that you just mentioned, the code, the (D) 2020, 21 to 2012 code specifically alludes to an established patient, is that now going to be open to a new patient as well?

Male: Yes, in the in the rule that we released yesterday, we announced that those codes can be used for new patients as well as establish patients during the length of the public health emergency.

(Ken Yasvesh): And are there any modifiers required to that G code to represent that it's a new patient versus established or will the code, the code descriptor must be changed?

Male: The code descriptor won't be changed. But for Medicare purposes, we're not enforcing adherence to that particular part of the descriptor.

(Ken Yasvesh): OK, thank you.

Male: So there won't there won't be any modifier. Yes.

(Ken Yasvesh): OK.

(Jean): And Demetrios, this is (Jean). I did get clarification on the question about the CDC reporting and for those infections that were listed, it is exempt. However, I do want to emphasize the letter that we're not to hospitals to encouraging participation in the new module for COVID-19. Thank you.

Operator: And your next question is from (John Greywalski). Your line is now open.

(John Greywalski): Thank you so much. I really appreciate the time that you're giving me on this call and all the hard work that you're doing. I actually have a few questions if you hopefully they'll be short and brief. The first is we filed for the advance payment and I was wondering about how long that process is going to take?

Demetrios Kouzoukas: I think we got some general guidance out about timelines. I don't have it at hand, I'm sorry to say so. We need to get back to you on that. But if you – there'll be an e-mail address that I was going to give at the end of the call if you can pass that along.

(John Greywalski): OK. Second question, the Medicare managed care payers are not included in this. Is there any thought of somehow bringing them into the process?

Demetrios Kouzoukas: So there are a number of flexibilities that we provided to the Managed Care Organizations and Medicare Advantage Organizations as well as Part D plan. If you go on our website for the release we issued last night there's a link, they'll take you to sort of individual fact sheets by type and there's one for M.A. and Part D plans. And then it's something we put out about two weeks ago as well, and then we're obviously working on more.

The one of the more notable things there is that we are exercising enforcement discretion with regards to the requirement that plans stay to their bid in terms of the benefits that they offer. And we, with respect to telehealth are allowing

them to initiate new telehealth services even though those were part of their bid. And then the Office of Inspector General has also helped the situation by also saying that they would allow waiver of copays and the like say, there are existing copays.

And so that's a couple highlights there. And we're obviously continuing to work across the entire system to provide maximum flexibility.

(John Greywalski): OK. Any guidance on where to and when to file for either through FEMA or anybody else for the cost associated with the response to COVID-19. We have equipment that we're purchasing drugs, all kinds of employee overtime cost and we've been – it's been suggested to us that we accumulate all of that or some sort of an application or filing. And I'm not quite sure where that is, when that is, and any guidance there?

Demetrios Kouzoukas: Sure. So the Congress appropriated about 100 billion dollars for unreimbursed expenses as well as lost revenue. And it's a very broad list types of providers, entities, suppliers, organizations that are eligible for the for the money. And I know that there's a lot of effort going on right now in order to figure out a fair and appropriate way to ensure that that those funds go to help.

I'll provide confidence to people as they anticipate losses and they work to serve their communities first. So I don't have any particular guidance on that. But I do know that there are people working very hard to figure out how they can quickly launch a program like that. And as you can imagine, it's a large sum, and trying to determine how we're prioritizing and what kinds of rules that would be put around it.

(John Greywalski): OK. I anticipate some cash flow problems in the not too distant future. And, you know, really I would look for some expedited guidance in that regard. And my last question, and I know this really has nothing at all would do with CMS and the Medicare program, but, you know, Medicare represents a portion of our overall receipts. Are there any thoughts of triggering something similar to the National Defense Act to, you know, to create a situation where all the other payers are going to have to come up with some

sort of a periodic interim advanced type program similar to Medicare, that will on an interim basis for three to six months, smooth out cash flow?

You know, again, Medicare, what Medicare is doing is very helpful with the advance program. But that only represents a portion of our receipts and I'm looking at, you know, the month of April and the month of May is critical and probably, you know, the – with people being furloughed and people working from home and, you know, delays and billing and collections and process. I anticipate some cash flow problems from all of the commercial carriers also. And I'm just wondering if there are any thoughts in that regard?

Demetrios Kouzoukas: No, we don't have a program like that today. I know that there have been some suggestions along those lines really would be a congressional program, at least the way you described it. And, you know, obviously, there's – it's always a relationship between two parties here.

And our hope and expectation is really that both payers and providers recognize that they need each other. And that the contracts that they have are ones that are intended to serve patients. And if either party is not there to fulfill their end of the bargain, that's going to put everyone in a difficult spot.

And so obviously, that's not a program, not a check, or requirement, but just a perspective, and we'll definitely, you know, be monitoring the situation as well as in part of any dialogue around solutions.

(John Greywalski): OK, thank you so much. Appreciate your comments.

Operator: Your next question is from (Scott Patterson). Your line is now open.

(Scott Patterson): Hi, thank you. And you may have just answered this. But on some of the waivers that were put in place, particularly like the DME waivers for the surge planning, the expansion of coverage for respiratory related devices is not only applicable for fee for service, Medicare, Medicaid, or would you expect the M.A. plans and the management accounts or Medicaid to expand as well/

Demetrios Kouzoukas: So the blanket waivers that we issued yesterday are largely – are really Medicare fee for service. The Medicaid program has been issuing a

number of state by state waivers. And I think they're up to 34 now and seven days or something like that, eight days. And so they're providing flexibility there to states who are the party that we're in direct relationship with regards to how they can manage and work with their Medicaid managed care plans.

And then with regards to the Medicare Advantage, we – I'd refer you back to the document I mentioned earlier about some of the flexibilities we've given to the Medicare advantage plans. And I'll note that the administrator mentioned in her remarks yesterday and in the press release that we issued around this, that the Trade Association for the Insurers, AHIP, that they have issued a statement that they will be looking to follow Medicare policies in many respects.

And so that's something I think you can continue to hear about it. We've been getting letters and other kinds of communications from various insurers about the accommodations and changes that they're making as well. And so hopefully, those are ones that are going to be helpful and to the extent we can get out of the way of allowing those things to happen, you know, we're working to identify that as well.

(Scott Patterson): Thank you.

Operator: Your next question is from (Marcus Lewis). Your line is now open.

(Marcus Lewis): I want to thank you for the brief discussion and the overall changes as a whole is very helpful. I'm the CEO and administrator of a 14 bed critical access hospital and rural health clinic in rural North Dakota. And although those are very helpful, finalizing the details of billing, and these loose terms, especially on cost-based reimbursement are going to be very pivotal.

So I want to echo the comments of earlier callers regarding telehealth. But I also wanted to ask a question regarding telehealth services within the clinic, the rural health clinic has always had the face to face requirement. So when we talk about COVID-19, we talk about safety. And especially those of us that have rural have a limited number of providers and one provider impacted with a contraction of illness could be detrimental.

So, you know, is there any thought of same place service and also to save on PPE or as I.E., providers in one room see the patient in another room, that patient is possibly at risk due to conditions? I guess that's my question.

Demetrios Kouzoukas: I think we've put out something. (David) did we speak of that sort of intra facility telehealth?

(David Wright): Yes. Yes, we definitely did. It's specific under EMTALA, but I don't think there's any reason that it was be prohibited in any other type.

(Marcus Lewis): Is there a reference, I guess, for that? Is that in that fact sheet, the PDF that's included?

(David Wright): Again, it's in for EMTALA, but I don't think we've specifically called it out for other provider types in terms of telehealth, that's certainly something we can update.

(Marcus Lewis): Yes, that would be, that would be absolutely wonderful because I know that's been a concern for us with limited amount of staff and providers and PPE.

(David Wright): OK.

Demetrios Kouzoukas: Understood.

Operator: Your next question is from Dr. (Lena Rogers). Your line is now open.

(Lena Rogers): Hello. Thanks a lot for having this call. I had a question regarding the wound care clinics which many of them are located, physically located in the hospital. And hospitals are looking to move those clinics offsite. But there's confusion about the 250-yard rule for reimbursement at the full APC rate, whether they'd be able to do that if these clinics were moved offsite to a safer location.

Demetrios Kouzoukas: So, (Ing-Jye), I think we had a blanket waiver for provider-based status.

(Ing-Jye Cheng): I think that's correct. But I'm going to have to go back and check and confirm that.

Demetrios Kouzoukas: So, we did have a waiver. I'm certain we had a waiver for provider-based status. If you need help finding the blanket waiver document, that's what you're looking for is the blanket waiver document. It's got about, I think 30 or 40 entries on it at this point, various kinds of blanket waivers we've provided. And there's a paragraph on provider-base status obviously you want to make sure that your circumstance fits within the box of what is described there. But I think we tried to go broad in general, to provide the flexibilities that are needed.

(Lena Rogers): OK. Thank you.

(Alina): And we have time for one final question. Thank you, operator.

Operator: Yes. We have a question from (Mica Battalion). Your line is now open.

(Mica Battalion): Hello. I appreciate what was stated earlier about CRNAs and would like to ask, will CMS announced under its 1135 public health emergency waiver authority that certified anesthesiologist assistants can function to the fullest extent of their licensure and (delegatory) authority in all settings under physician supervision so long as it is not inconsistent with the state's emergency preparedness or pandemic plan?

Demetrios Kouzoukas: (David), do you want to talk about that? I think we've had some conversations about CRNAs.

(David Wright): Yes. I think we did do that in the waiver language. So I don't know, are you looking for – what are you looking for?

(Mica Battalion): I guess we're asking – yes, specifically, if the certified anesthesiologist assistants can function to the fullest extent of their licensure and (delegatory) authority?

(David Wright): OK, the assistants. OK. I don't think we've addressed that. So we'll have to take that back and look at that a little bit more, but appreciate you raising that.

(Mica Battalion): OK. Thank you very much for your work. Appreciate it.

(Alina): Thank you for your question. And it looks like we are just about the time. Thank you, everyone for joining our call. It looks like we had over 3,000 people. So as always, if you have any questions for the team, you are welcome to e-mail us and that e-mail address is COVID-19@cms.hhs.gov. Again, it's COVID-19@cms.hhs.gov.

I really appreciate your time and all of the work that you're doing for patients and their families around the country as we address COVID. Thanks again.

Operator: Now, ladies and gentlemen, this concludes today's conference calls. Thank you for participating. You may now disconnect.

End