Centers for Medicare & Medicaid Services
COVID-19 Lessons from the Front Lines
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 9545128.

Alina Czekai: Thank you for joining our CMS Lessons from the Front Lines on COVID-19 call today, May 1. We'd like to begin by thanking all of you for the work you are doing day in and day out to care for the patients around the nation amidst COVID-19.

This is Alina Czekai leading stakeholder engagement in the office of CMS Administrator Seema Verma and today's call is part of our ongoing series Lessons from the Front Lines. And while members of the press are always welcome to attend these calls, we do ask that they please refrain from asking questions.

All press and media questions can be submitted using our media inquiries form which can be found online at cms.gov/newsroom. And any non-media COVID-19 related questions for CMS can be directed to covid-19@cms.hhs.gov. We recognize that government's role during COVID-19 is to offer maximum flexibility and regulatory release to allow you all to do what you do best, care for patients in your local communities.

And around the nation providers in local communities are innovating in response COVID-19. At CMS we hope to bring together local innovators to share their best practices that can be scaled at the national level. And today's call will focus on these expanded flexibilities.

We will hear from providers who are seizing the opportunity to innovate and transform to support our local communities. We will hear from providers who are in the midst of reopening their healthcare systems for example, including

procedural and non-procedural care. And we'll also hear from providers on their best practices for treating vulnerable patients via telehealth.

We encourage you to direct your questions to our guest speakers on the line and should you have more technical questions on CMS waivers and guidance we do encourage you to continue to join our CMS office hours which are held every Tuesday and Thursday at 5:00 pm Eastern.

So first I'd like to begin with a brief update from the agency. Just yesterday CMS unveiled a second final rule and additional waivers that institute a further set of regulatory flexibilities under the authority of President Trump's emergency declaration as well as the CARES Act.

And there are several components to these new policies which largely run along the same lines as our previous rule. That includes hospitals without walls, maximizing the healthcare workforce, expanding telehealth, putting patients over paperwork and testing. I'll provide some important detail on all five of these elements but I do want to focus especially on the testing piece especially as we're joined by FDA today.

Testing has been a priority for a longtime and over the last several months CMS has worked to quickly implement recently enacted legislation that removed barriers to testing and Medicare, Medicaid and private insurance. In addition, this legislation provides $1 billion to cover testing for the uninsured which we are quickly working to make available to providers.

From day 1 CMS has worked to ensure costs was not a barrier to being tested for coronavirus committing Medicare to covering tests with no cost sharing. Before the CARES Act required it, CMS also worked with private insurance companies and state Medicaid agencies to cover testing with no cost sharing. In Medicaid we implemented the family's first Medicaid optional illegibility group and this allows states to cover uninsured citizens testing costs with no cost sharing.

In addition, we increased Medicare reimbursement for high through-put tests that allow for more tests to be administered and paid labs to conduct tests in

people's homes including nursing homes. And these actions have led to a surge in testing for our Medicare beneficiaries. Now, under the new rule CMS is giving states and localities the flexibilities they need to ramp up the diagnostic testing and access to medical care when confronting COVID-19 in their community.

These steps are a critical precursor to ensure a phased, safe and gradual reopening of America. Specifically, we are making it easier for seniors to access testing established by their local pharmacies or by their doctors. This will allow more beneficiaries to come to testing sites to get a test without doctor's orders.

CMS will also separately pay hospital outpatient departments and physician practices to collect lab samples. Medicare will also pay pharmacies that are enrolled as labs to perform tests for beneficiaries. This will encourage these entities to make tests available at parking lot sites and promote widespread access for Medicare beneficiaries. And we're doing something similar in the Medicaid program as well where we're giving states flexibility to cover parking lot COVID-19 tests and tests in other community settings such as the home.

Finally, CMS is covering serology or antibody tests which are helpful for patients, practitioners and communities in making decisions on medical treatment and responsible social distancing policies. And when it comes to supporting our healthcare workforce, CMS is expanding the number of practitioners that can provide important health services that patients may need to remain home during these times.

For example, home health patients can get care planning services from nurse practitioners and more, in addition to physician. We are further reducing burden using a variety of measures, and one important action is to waive the requirement that ambulatory surgery centers periodically reappraise medical staff privileges for the duration of the emergency declaration.

You may remember that we did something similar with hospitals in the previous rule and this simply aligns ambulatory surgery centers many of

which are now providing hospital services with what we did for hospitals. We're also further increasing hospital capacity as part of our CMS hospitals without walls initiative.

We're helping providers increase their supply of beds to manage a surge due to COVID-19 while still maintaining stable, predictable Medicare payment. This will allow institutions such as teaching hospitals and free-standing inpatient rehabilitation facilities to alleviate the strain on traditional hospitals while not forfeiting Medicare reimbursement.

We're also be paying for outpatient hospital services like wound care and drug administration and behavioral health services that are delivered in temporary expansion sites like parking lots, tents, converted hotels, patient's homes and so on.

And finally, I'd like to close our update from the agency by highlighting even more – even more expansions on (Medicare) telehealth. Telehealth, as you all know, has been one of the Administration's top priorities during the pandemic because it really is a win-win, it gets Americans (inaudible) they need and it reduces unnecessary exposure to the virus.

This rule waives all restrictions on which kinds of clinical practitioners can furnish telehealth. Previously only doctors, nurse practitioners, physician's assistants and others could deliver care through telehealth. Now many others are eligible including physical therapists, occupational therapists and others.

We're allowing hospitals to bill for services furnished through telehealth technologies provided by clinical staff of the hospital when Medicare patients are registered as hospital outpatients, including when the patient is at home. In addition, this rule increases our payment for services conducted by phone to match payments for similar office and outpatient visits.

Finally, we are implementing provisions of the CARES Act that increases telehealth for federally qualified health centers and rural health clinics often in rural areas. In summary, CMS continues to assess what government regulations are doing more harm than good in the context of a pandemic of

unprecedented scope and fury. And given the severity of the challenge we are facing we've really endeavored to be resourceful and unsparing throughout this effort.

So now that you've all heard our exciting and importing updates from CMS, I'd like to turn it over to the FDA for an update. I'd like to introduce Deputy Commissioner for Medical and Scientific Affairs Dr. Anand Shah. Anand, over to you.

Anand Shah: Thank you, Alina, and thank you Administrator Verma for inviting FDA to the discussion. I want to thank all of you for joining us on the call today and especially for your hard work, your creativity and your commitment during this challenging time. Your expertise and leadership and sacrifice are a truly critical part of our efforts to address and find solutions related to the pandemic.

We at FDA are collaborating across government, including with CMS and with the private sector including doctors, nurses and other healthcare professionals, as well as scientists, researchers, and members of the pharmaceutical industry.

Today I want to take a few minutes and focus on diagnostic and serology testing. Regarding diagnostics, we've been extraordinarily fast in issuing emergency use authorizations in umbrella EUAs for certain devices as well as a number of guidances that provide maximal regulatory flexibility to help ensure that patient needs are met.

Since the COVID-19 pandemic began we've worked with more than 380 test developers, including serological test developers who have said they will be submitting emergency use authorization requests to the FDA for tests that detect the virus. We've issued 44 individual molecular diagnostic EUAs or emergency use authorizations for test kit manufacturers and laboratories. In addition, 24 authorized tests have been added to the emergency's authorization for high complexity molecular based laboratory developed tests or LDTs.

More than 230 laboratories have began testing under the policies set forth in our most recent guidance and just a few words on serology tests. This is certainly another important and promising area which can play a critical role in the fight against COVID-19 by helping healthcare professionals on the front line identify individuals who may have been exposed to the virus and who may have developed an immune response. We're helping to support the development of these tests that detect the presence of antibodies to SARS-coV-2 in the blood.

Last month on March 16th we issued a policy providing regulatory flexibility to develop certain serological tests who have validated their tests to begin to distribute or use their test without prior FDA review as set forth in the parameters in the policy and we developed and issued this policy to really help increase early patient access to these tests. We're encouraging interested developers to request FDA authorization through the EUA process which is one of several tools the FDA is using to help make important medical products available quickly during the pandemic.

As of today, we've already issued ten emergency use authorizations for serological tests and we expect that number to continue to grow in the coming weeks. We're not aware of an antibody test that has been validated for the diagnosis of SARS-coV-2 infection and while we encourage professionals to continue to use serological tests as appropriate, they should also be aware of the limitations. Namely, serological tests should not be used as a sole basis to diagnose COVID-19 but really is information about whether a person may have been previously exposed.

And again, not all marketed serological tests have been evaluated by the FDA. The FDA has authorized tests or listed on our website publicly on our FAQs, and really to enhance our ability to identify high quality tests and inform our decision making we're collaborating with the NIH multiple Centers there including the NCI and NIAID, as well as the CDC to develop a capability at the NIH to evaluate serological tests for developers.

As Alina mentioned earlier, the FDA is working very closely with CMS to close the gaps that often exist between medical product development that

comes through the FDA and ultimately access to these tests, specifically issues related to payment and delivery. We're very grateful to CMS for the partnership over the past many weeks on these issues and we look forward to answering your questions later today.

With that I'll turn it back over to CMS.

Alina Czekai: Thank you, Dr. Shah, I really appreciate the FDA update. And now we'd like to introduce Dr. Betsy Thompson. Dr. Thompson is the director of the Division for Heart Disease and Stroke Prevention at the CDC. Dr. Thompson, over to you.

Betsy Thompson: Thank you, and thank you to CMS for the invitation and to all of you for being with us today, I really appreciate what you do every single day. I am not going to give a general update from CDC, rather I'm going to focus in on some issues particularly of concern to us in the National Center for Chronic Disease Prevention and Health Promotion which is where my usual job resides as Alina said as the director of the Division for Heart Disease and Stroke Prevention. Currently though I am deployed with the National Response Coordinating Center to work on non-COVID and out of hospital care in particular.

And so, I wanted to give you a little bit of information about what we are doing there. I think that – I presume that all of you have been keeping as up-to-date as you can with the CDC website as a means of source for most of the coronavirus information that is relevant in terms of clinical practice but what I wanted to talk about is some of the issues that you don't see yet on the website perhaps but I think many of us have been thinking about or concerned about, there's really five, I'll go over them fairly briefly.

The first one is just the general concern about care that is being deferred during or delayed during the pandemic. Some of which it's very appropriate to defer it, it continues to be so in this locality, but there is some care, whether it's new acute onset stroke symptoms, acute abdomen, myocardial infarction that care should never be deferred. And we recognize that that has occurred. There's increasingly reports in the media and in the (inaudible) literature

about that. So, we're working hard to get out some guidance to help both for healthcare providers as well as the public to understand that there was never an intent to defer all care other than COVID care.

The second area is that unfortunately the potential for increasing disparity there's more data that that potential is being realized during the pandemic and we are working to try and mitigate that to reduce the – that potential as much as possible and I know that some of you have been concerned about that as well.

The third area is the – both the potential and the pitfalls for telehealth during this time and that again going back to the disparity's issues sometimes the very types of patients most in need of services that could be provided remotely may not have access either because of limitations on their side, whether it's broadband or actually limitations to providers that can provide telehealth services.

The fourth area is really part of that first one about deferring care. We need to get out guidance about resuming and expanding care, not just don't defer care that is really needed now, but also how do you safely resume and expand care if you didn't – if you've been either closed or just limited in what's been provided?

And then finally we're trying to look forward to the opportunities that always exist no matter how dire the situation and I think that there are opportunities presented by this pandemic, and one's already been mentioned by CMS and we certainly, in the chronic disease center at CDC, the idea of expanding some care that can be provided safely, effectively, and more equitably by remote means is something that we have pushed for a long time and my area of self-measured blood pressure is one of them. There's many other cases too where there's evidence for actually not just as effective as care but that care can be improved at least controlled by prevention in that particular case.

I am going to stay within my time limit and stop there. I realized I have raised more questions than given answers but I really look forward to being part of

this today and listening to the discussion, the questions and the comments that all of you have. Thank you.

Alina Czekai: Thank you, Dr. Thompson. Operator, we'd like to open up the lines to take a couple of questions, thank you.

Operator: You're welcome, ma'am. To ask a question via the telephone please press "start" "1". If you would like to withdraw your question, press the "pound" key. We have our first question from the line of Camille Bonta. Your line is now open.

Camille Bonta: Hi, good morning or good afternoon. I'm calling on behalf of the American Society for Gastrointestinal Endoscopy, and I'm wondering if someone could provide some clarification on the audio only coverage for telehealth, specifically whether or not the expansion of parity for telehealth for certain E&M services are for just established patients or for new and established patients and if it's just the established rate that is being reimbursed for new patients. I'm wondering if someone could provide some clarification in that regard?

Emily Yoder: Hi, this is Emily Yoder, I'm an analyst who works on telehealth, and in the first interim final rule where we begin to make separate payments for those codes, we said that we were exercising enforcement discretion so that they could be furnished to both new and established patients.

However, when we were setting the – the payment rates in the second ISD we thought that the resources associated with the mid-level established patients offers up patient (inaudible) were sort of more accurate for terms – for in terms of the type of services that we thought would be described by the phone visits, so that was why we just chose to apply those payment rates, but they can be furnished (inaudible) established patients.

Camille Bonta: Great, thank you. Appreciate the clarification.

Alina Czekai: Thank you, we'll take our next question.

Operator: Sorry ma'am. Next in line is (Angela Badey). Your line is now open.

(Angela Badey): Hi, my question is about the recent expansion for hospitals to bill for hospital-based services. Do we have an effective date around that? Will that be going retroactively?

Emily Yoder: Yes. This is Emily, again. All of the changes in the second and final rule are retroactively applicable to March 1st.

(Angela Badey): Great, and one other question is, when can we expect to have reimbursements for the antibody serology testing?

Emily Yoder: I'm not a subject matter expert on this, so we'll have to take that back and get an answer for you.

(Angela Badey): Great, thank you very much.

Alina Czekai: In the interests of time, we are going to move to hearing from our guest speakers. We have a number of physician leaders from around the country who have offered to share what they're facing in their local communities, and the strategies that they're working on, as we address the pandemic.

Also joining me from CMS are several of our physician leaders who will offer their expert perspective throughout the conversation, as well, and from CMS, joining me is Dr. Marion Couch, Senior Medical Advisor to Administrator Seema Verma; Dr. Shari Ling, Acting Chief Medical Officer at CMS; Dr. Michelle Schreiber, Director of the Quality, Measurement and Value Based Incentives Group at the Center for Clinical Standards and Quality at CMS; Dr. Barry Marx, Director of the Office of Clinical Engagement, and Dr. Michael Lipp, Chief Medical Officer at the Center for Medicare and Medicaid Innovation.

And we'd like to first hear from physicians around the country on their perspective, as we work to reopen the healthcare system. Our first speaker is Dr. Valerie Rusch, a member of the American College of Surgeons, and she is a Thoracic Surgeon at Memorial Sloan-Kettering in New York City. Dr. Rusch, over to you.

Valerie Rusch: Thank you so much. I wanted to thank CMS for the invitation to participate in this. I serve as the current president of the American College of Surgeons, and I work as a thoracic surgeon at Memorial Sloan-Kettering Cancer Center in New York, for over three years, and can bring to this discussion the perspective of how to navigate through this difficult time in the management of cancer patients.

The College, starting at the beginning of March, has worked strenuously to provide evidence-based recommendations to surgeons around the country, in all specialties, in all geographic locations, regarding how best to navigate through this pandemic, and continue to provide optimal care for our surgical patients, and to that direction, we have issued twice a week an electronic newsletter which provides guidance in clinical care, information about ongoing research, information about regulatory issues, and so forth, and that actually is accessible through our website.

As the pandemic started to ramp up, we developed guidelines for how to ramp down surgical volume, while maintaining necessary care for patients such as those mentioned by Dr. Thompson. Cancer, heart disease, strokes, et cetera, do not take a vacation during this time, and so, we have to consider how best to maintain care for patients who need our support for acute problems.

As we recognized that the pandemic was beginning to recede a couple of weeks ago, we issued a framework for ramping surgery back up, and of course, this varied by geographic region and by the degree to which the pandemic has affected various locales across the country.

The framework was summarized in a joint statement led by the American College of Surgeons, but in collaboration with the American Society of Anesthesiologists, the Association of Perioperative Registered Nurses, and the American Hospital Association, and then the College, also along with that issued a more detailed version of criteria and methods for ramping up elective surgery, and as a subset of that, we developed additional guidelines for the management and ramping up of care for cancer patients.

Those two sets of guidelines were issued in a press release. They are also available on the American College of Surgeons website, and so I won't go through them in detail, but I will just sort of mention some of the key points.

The first was to consider the timing of reopening for elective surgery and making sure that you are confident that your area and your hospital are actually seeing a decline in COVID positive patients over the past two weeks, and that, of course, resumption of elective surgery was authorized by the relevant states.

The second was to consider a COVID-19 testing within your facility, and of course, this varies a great deal around the country in terms of access and speed, although it's noted by the previous speakers, access is becoming less and less of an issue, and that is COVID testing in the perioperative setting for patients, as well as COVID testing for healthcare workers, and that we provide the safest, most COVID-free environment for the surgical patients.

The third was to have a clear idea of the available equipment in your hospital, and that ranges from the number of ICU beds, as well as OR equipment and personal protective equipment, and then a strong recommendation to continue doing what we have recommended throughout the pandemic crisis, which is to have a committee within each hospital that would look at case prioritization, really getting back into the operating on the patients who have been waiting and whose disease process requires the most immediate access to the operating room.

And finally, to ensure that you really have the perioperative resources, not only to care for the patients in the pre-operative and inter-operative setting, but also to discharge them to a safe environment. I will note that the American College of Surgeons also is acquiring data through our large national databases, to try to provide longer-term information about the care of patients during the time of the pandemic, and the long-term impact that it may have on the outcomes in surgical patients.

So I'll stop there, and I want to thank you again for the opportunity to participate.

Alina Czekai: Thank you, Dr. Rusch. Really appreciate your perspective. I'd now like to turn it over to leadership from the American Academy of Orthopedic Surgeons. Today we are joined by Dr. Joseph Bosco, President, and Dr. Daniel Guy, First Vice President. Over to you.

Joseph Bosco: Thank you. I'm going to start off and then I'll have Dan Guy talk as well, and again, not to reiterate, but thank you very much for the opportunity, and thank you to CMS for really working closely with clinicians to provide care for the people of the United States.

Basically, not to repeat what Dr. Rusch has said, but we agree that opening for elective surgery should be locally determined, based on resource availability, including staff, PPE, hospital beds, ICUs, and also based on the COVID burden and where you are on the disease process, whether you have an upswing or downswing. I think all healthcare professionals agree on this.

One thing that we've determined is that elective surgery is obviously defined as – or non-elective surgery is defined – a delay would cause harm to the patient, but what we are grappling with, and what we are starting to define a little better is, what do you mean by delay. There are certain procedures that, if you delay an hour, 30 minutes even, there's harm to the patient, certain procedures that we do, like compartment syndrome, or like that.

Other procedures, they can wait a week or two before harm comes to the patient. Other things like joint replacements, nerve decompressions, sure, they can wait a month, maybe six weeks, but afterwards, patients start being harmed and the disease starts getting worse, so at some point, delay does cause harm to patients, so it's a continuum. There's no line between what is elective and what is not, and what guides it, as Dr. Rusch said, is local availability of resources, so if you have no beds and no ventilators, then you're not going to do elective surgery of any type, obviously.

In New York, where I'm at, recently they did a study where they did legitimate antibody testing, and found in New York City, 25 percent of people were antibody positive, who they tested. This is a random sample. Upstate,

Northern New York, where I was born and raised, one percent, so again, there's huge regional differences. We're learning as we go along.

We started to ask our patients, survey our patients about whether they'd be willing to undergo – their surgery cancelled, 500 elective joint replacements at our institution, and in New York, about a third of them weren't sure they were going to have their surgery any time soon. A third said three to six months. A third said anytime.

But this is different, depending on the burden, and I'm going to hand it off to Dr. Daniel Guy, who practices in Lagrange, Georgia, which is about as different from New York City as it can possibly be. So go ahead, Danny.

Daniel Guy: Thank you, Joe, and thank you to CMS, the FDA and CDC for their support and their flexibility during this crisis. As Joe mentioned, I'm in a town of about 35,000 so I'm 180 degrees from Langone in New York City, and just to give you a sampling of where we are today, I work out of a 280 bed hospital, and currently in our county, we have 150 confirmed cases, four deaths, and ten confirmed cases hospitalized, five on ventilators and five more under investigation.

We currently have adequate resources locally, considering the COVID load, but we have not yet initiated elective surgery, as we are still determining guidelines for safety. So again, we represent the opposite end of the spectrum.

With regard to surgical care, we continue to provide urgent and emergency care. We think outpatient surgery may begin in about two weeks. While we screen 100 percent of our patients, the lack of ability to provide pre-operative testing for COVID-19 remains a big challenge for us.

Additionally, what constitutes the right testing is important, as it has been reported, 20 percent of COVID positive patients are asymptomatic, and that's a well-documented fact. Besides risk of transmission of the virus to the care team, there has also been a reported increased risk to the subgroup of patients that are COVID positive, asymptomatic, to develop symptomatic COVID with a tended increased morbidity, mortality, with elective surgery.

So with that in mind, we will be moving forward, but in a measured fashion, again, somewhere around mid-May, and for those patients who meet the following criteria for non-urgent inpatient surgery, would be under age 65, anesthesia class 1 and 2, and anticipated length of stay less than 48 hours, with no anticipated transfer to rehab facilities.

We are also initiating a COVID antigen test, 96 hours pre-op, and quarantine patients until day of surgery, and for those whose tests have not resulted on the day of surgery, they will get the rapid Abbott test.

I just want to touch briefly on telehealth. It's been a valuable addition, and before the crisis, almost no-one in the United States was using it, but now I would suspect most clinicians have embraced it. There is a recent report in the Journal of the American Academy of Orthopaedic Surgeons from Johns Hopkins, regarding telehealth, and it indicates that clinicians are able to achieve about 50 percent of their usual clinic volume within two weeks, and for myself, and I am doing telehealth, the visit can go pretty smoothly, but there are a few barriers, and I just want to touch on just a couple, and I know another speaker is going to comment on this a bit later.

Many patients just don't have the electronic capability to participate, or if they do, they're just not technically savvy enough to manage a smart device, so you are limited to a telephone call with them, but that group that don't have that capability is unfortunately older patients, as well as those with few economic means, and therefore we are still unable to use video help for a substantial number of patients.

The visit is not difficult for the physician, but it requires a lot of back office time to set it up, by staff, and finally, we are not yet confident that this is an appropriate tool for evaluation of new patients, or established patients with new problems in an orthopedic practice. The inability to perform a satisfactory exam or obtain and review pertinent X-rays and other imaging, remains a barrier to offer an accurate diagnosis and developing an appropriate treatment plan.

Again, thank you for the opportunity to be on the call today.

Alina Czekai: Thank you, Dr. Guy and Dr. Bosco. I'd now like to turn it over to Dr. Neil Stollman. Dr. Stollman is a gastroenterologist in the San Francisco area, representing the American College of Gastroenterology. Dr. Stollman, over to you.

Neil Stollman: Thank you so very much. Again, thank you for having us on the call today. Indeed, I am both a private practice GI in Oakland, California, and I will speak to the sort of micro of what my individual life is like, but I'm also currently the Chair of the Board of Governors for the American College of Gastroenterology, and I'm going to speak to what we as a society are doing about that on a macro level first.

So let's start with that. From a society level, this is obviously hugely important to us, and 10 or so days ago, when we could start thinking about reopening and ramping up again, I was asked to co-chair a task force on safely resuming endoscopy, particularly our (inaudible), and we decided we were going to come up with a roadmap to do so.

We put together a dozen amazing practitioners and representatives from disparate practice patterns, different parts of the country. They all think we chose 12 because they fit in a beautiful Zoom box, and we've been living on Zoom with this task force a lot in the last week, but these twelve people are super smart, and we have been doing what we do.

First of all, we also collected a ton of data from our members. We did a giant member survey. We have almost 400 respondents, I think, well over 350 already, and not surprisingly, there is a tremendous impact on our members and GI doctors in this country, including, the majority of whom who have closed their ambulatory surgery centers. More than half of them have shuttered their facilities, and a substantial proportion of whom – not a half, but about a quarter – have also reported inadequate PPE availability for them, so those are real problems.

So we all got together and we did – as much evidence as we can find. We're still doing that. We're collecting evidence. We're trying to be as evidence-based as we can, but as everybody knows, there's not a lot of evidence for

some of these questions, and when there isn't, expert consensus is what we go with.

Earlier this week, we put on a very large webinar for our community, which was over 25,000 registrants, which was actually one of the largest webinars I think we've had in our little GI world. It was very well received. In fact, that will be live on our website, on the ACG website today, if anyone wants to go listen in on that. We're now busy turning that webinar, which was sort of an outline plan for us, into a more concrete white paper that we will hopefully have out next week, and the intent, again, is to give sort of best practices and practical guidelines to our members, peer to peer.

Interestingly, when I looked at our agenda today, the title of this section was "Best Practices and Peer to Peer Learning", and I looked at that and said, in fact that's exactly what I think we're trying to do. We're trying to communicate those best practices to our peers. I can speak in the Q&A to very specific recommendations we've made. They are very similar to Dr. Rusch's and Dr. Boscos's and Dr. Guy's. I won't list them all for you, but I'm happy to answer any of them, as the Q&A goes on.

So that's kind of the macro-societal viewpoint. Personally, I'm in Oakland, as I mentioned. It's neither New York City nor Georgia. It's probably somewhere in the middle of that, but our office and our ASC were both completely shuttered over a month ago because of the shelter in place in California. We went to solely video visits for a period of time, and we're doing only emergency endoscopies in the hospital, and the outpatient unit wasn't even open.

Now that the state, as you know, has started to open up, again they're calling it more elective, and I share the panel's concerns about the terminology of just what is really elective, but we are now just this week resuming procedures in one room out of three, so in a far, far, far less aggressive way. We're moving rooms with longer cases. We're of course screening everyone. We're distancing. We're obviously using high-level PPE for everything, and these are only for urgent cases. These are not in any way elective. These are sick people, generally.

And not surprisingly to anybody, we're finding stuff. I did some cases this week. We had two colon cancers we just found, two new ulcerative colitis patients. We are dilating strictures. These are people who need care. There's absolutely no question about it, that care has to happen for these people, and they've been waiting quite a bit already.

So we are opening. We're doing it very slowly. We're doing it according to local guidelines. Our hospitals are not in a surge or in an overwhelmed state where we are right now. It's certainly better, I think, and from all our perspectives, to keep these patients out of the hospital, if we can take care of these needy patients in this way.

I'll add that we're still PPE vulnerable in a lot of places. That is not a solved problem for sure, and testing – I know we like to think that everybody has testing. I will tell you that community doctors do not have easy access to pre-procedural testing. Medical centers do better at that certainly, but in the community, that's still a tremendous challenge for us. And with that, I'll stop and stay on, of course, for questions after.

Alina Czekai: Thank you, Dr. Stollman. Really appreciate hearing your perspective from California. I'd now like to turn it over to Dr. Sam Jones, a cardiologist at the Chattanooga Heart Institute in Chattanooga, Tennessee, representing the American College of Cardiology. Dr. Jones, over to you.

Sam Jones: Great, thank you so much, yes. I'm coming from our beautiful Chattanooga city. I'm a Cardiac Electro Physiologist here, Chair of our Health Affairs Committee for the American College of Cardiology and I also serve as our – one of our leads for our service line in our national hospital CommonSpirit for electrophysiology. And I really just want to, once again, thank you guys for allowing us to come and speak to you and echo many of the comments already made by my colleagues.

I think that, in the cardiology world, like as already been said, we view this as more of a re-emergence plan, not so much a reopening because we have been open the entire time. You've probably seen some of the headlines that have come out about where have all the heart attacks gone. Well, we've continued

to see many acute care issues going on. We have seen quite a bit of drop going on because, frankly, patients are just scared and not wanting to come into the ER and that has led to some patients not getting the care they need.

We also, of course, have had just a significant drop off that's been mentioned. Many of our practices are about 60 percent down from what they normally are. So I think that that has been important for us to share that information. Right away the American College of Cardiology started a website, a COVID hub, which has been tremendous for us to share that information. We've had multiple webinars and I think it's really through that sharing of information that we've been able to appropriately get through this pandemic.

Constantly we're trying to balance the public health concern with the individual care, knowing that these patients have ongoing cardiovascular morbidity, mortality. And how do we – how do we do that? Certainly, right now, many of our practices, as we talked about on our recent webinar that – we are going into our re-emergence plan. So how do we do that? As mentioned in that from Dr. (Roush) in the American College of Surgery, which is an excellent paper, we looked at what is our prevalence, what is our preparation. And then we develop our planning strategy.

The prevalence, of course, is what we discuss with our local health administrators, our local department of health and our state department of health and we try to determine, to our best guess, what is that prevalence and incidence. Although that can be difficult, as been stated, because we don't always have the testing capability in all areas of the country. But then we'll also use our surrogate hospital numbers to look at our COVID numbers, our ICUs and our ventilators and that gives us at least an idea.

And, as CMS has said, once we see a downtick in that, then our regions will try to determine when to start. So, for example, in Chattanooga we're starting our electives and semi-electives in the next one to two weeks. And then we look at our preparation. The preparation is, as mentioned by others, really dependent upon each hospital looking at what is your PPE capability, what is your workforce, what's the supply chain and what is your testing. But this is

not a one size fits all, we think that has to be regionally directed. And then we get into our planning strategy.

With the planning strategy, we say what is – which patients need to be seen and how do we protect our healthcare workers? I think that point is something that just cannot be stressed enough. And so when we think about how to protect our healthcare workers, every single area in cardiology we are really focused on that. So when we break it into clinic, imaging and procedural areas, we look at that very carefully.

So in clinic, as we transition from telemedicine to face-to-face, we're still looking at, as patients come back into the clinic, how do we adjust our waiting rooms, how do we limit the time in clinic, whether it's keeping patients in their cars longer, and then making sure that we're limiting our providers and masking all of our staff. But we know that the telemedicine, of course, is here to stay and, as Administrator Verma recently said, the genie's out of the bottle.

And I'd take this moment just to thank you guys for the relaxations of the requirements for telemedicine that you've already done. The mention yesterday that came out was met with a lot of fanfare with the audio telephone parity with the face-to-face encounter, so we really do appreciate everything that CMS has been responsive to our request for that.

I will say on that front, though, especially for telephone parity and the other telemedicine, that we'll – this will have to be phased out over time, that our hope is that once the emergency declaration is over that that doesn't suddenly end and that at some point, it'll have to go through some sort of formal process to make sure that that telemedicine is to stay because we know that many areas of the country will still have some need for telemedicine for a while.

When we get into that imaging, for us that's echocardiograms, CT scans and nuclear. We're doing everything we can to shorten those procedural times. When patients come in to get exercise and they're breathing heavily, that's not good for our technicians who are there. So we're actually trying to switch

from a normal exercise over to more CT scans or to just doing other means of stress testing, again to try to protect our healthcare workers.

But that also requires some relief in terms of payment reform. And then just our procedures, as our surgical colleagues said, that – we have to prioritize that, reduce our visitors. I think the final thing I would say is that we have to be very careful watching for a resurgence of cases. This is something that – the COVID-19 has been a very unpredictable virus and, if anything, we don't know how this is going to go.

So watching our local hospitals to make sure that we look for positive cases, looking for if there's a spike in our ICUs, watching our department of health to make sure that those cases don't go up and we have to have some sort of guardrails in case. To that end, doing a slow ramp up, we feel, is important in cardiology. So we've asked many of our places to go from not zero to 100 but certainly go for a 25 percent, maybe keep that for a week or two and then go to 50 percent.

And that's important not only to look at the PPE supply but also the supply chain, but then also allows to watch those numbers more carefully so that if we did have a resurgence, we'll be more resilient and we can certainly go back to another phase of the pandemic.

And then also we just know patients are scared. That's why they're not coming in and that's why we're not seeing those acute cases. So we have to keep having ongoing clear and transparent communication and reassure them that, when they come back into the hospital or to our clinics that we've got a plan in place and I think that's going to be our best way to proceed.

I'll end there and be available for any questions later on. Again, thank you so much for the opportunity.

Alina Czekai: Thank you, Dr. Jones. And I'm pleased to introduce our final speaker in this segment, Dr. Charles Powell. Dr. Powell is the Assistant Chief of the Division of Pulmonary Critical Care and Sleep Medicine, as well as the CEO of the

Mount Sinai National Jewish Health Respiratory Institute, representing the American Thoracic Society. Dr. Powell, over to you.

Charles Powell: Well, thank you very much and thank you for the opportunity to participate in this important discussion on behalf of the American Thoracic Society. I'm coming to you from the Mount Sinai health system where currently we have 975 COVID inpatients in our health system.

This is the first day in over a month that we've had fewer than 1000 COVID-positive inpatients in our health system. We have 275 patients in our ICU. But I'm here really to speak about respiratory disease and I'm going to focus on the unique aspects of respiratory disease and I'm going to focus on evaluation and management activities.

So the respiratory disease perspective is unique in that many of our patients have chronic and acute symptoms that overlap with those of patients infected with COVID. And this complexity is mitigated – it can be mitigated – by the use of COVID diagnostic testing so we can better identify patients who have had this disease, while we understand the limitations of these (assays) and it also is mitigated, in part, by the widespread use of telehealth and remote monitoring, which we and others have deployed.

So as we prepare guidance for our members to consider, as we reopen onsite evaluation and management activities, we focus on approaches that protect our staff and patients from exposure to the virus, that account for local restrictions on access to staff, equipment and spaces that may be essential for the care of COVID patients in regions with high prevalence, such as the case in New York at present, and also provide access to care that is needed by our patients for acute and chronic healthcare needs.

So, to develop a framework that can be applied for this reopening process, we've adopted the CMS framework that classifies patients into Tier 1, Tier 2 and Tier 3. And these differ in the need for onsite evaluation. So Tier 1 patients typically require routine services or a check-in. Tier 2 patients typically are those with chronic symptoms or they can be new patients with

chronic symptoms. And Tier 3 patients are those who are typically new patients with new symptoms or any patient with severe symptoms.

So we apply this framework. Tier 1 patients can typically be well accommodated using remote access telehealth, telephone, whereas Tier 3 patients are preferentially accommodated on site. Tier 2 patients can go either way. Either modality can be fine and that determination typically will be guided by patient preference or provider preference or local availability. In essence, it's a form of shared decision making.

In all situations, the preference is for patients to be tested before each visit in communities with endemic disease, preferably within 48 hours of the visit, again taking into account the overlap of symptoms in patients with lung disease with patients who have COVID. We also, of course, recommend onsite screening of patients, visitors and staff for new symptoms, recent contact and fever. And the mitigation approaches that are recommended for application in each of these settings is guided by disease prevalence and by the presence of acute symptoms that may be detected on screening.

We've heard about some of these approaches. And, just in general, they include using spacing, provide separation between patients and between staff, mask use by patients and staff with utilization of additional PPE for more intensive mitigation needs, and also to optimally create different spaces for management of patients who are at low risk that would be distinct from spaces that would be used for patients with unknown or moderate risk. And those spaces can be done geographically or temporally, both will serve the same purpose.

So these are the general approaches that we suggest, being guided by the need for onsite versus potential utilization of remote approaches to care for patients who have acute and chronic lung disease. Thank you.

Alina Czekai: Thank you, Dr. Powell, really appreciated. It really is fascinating to hear what providers of all different specialties are doing throughout the country as we move towards this next phase in caring for patients. And before we open up to questions from the audience, I'd like to give our physician leaders here at

CMS the opportunity to ask any questions of our speakers or share any comments with the group.

Marion Couch: Thanks, Alina. This is Marion Couch and I would like to thank them. At every step of the way we've been able to reach out to you and professional medical societies and the degree to which people want to get this right, the degree to which people will put their patients over their pocketbook has been awe-inspiring. And I can't thank you enough but I know all of us at CMS are inspired by you, so thank you.

The second thing is I do want to encourage you to consider using registries and tracking patient outcomes as you go forward. And many of you have already – not only have you embraced that idea, you've developed registries and I want you to know that we're very supportive of that. We're going to learn things as we go forward and the concept of a registry will make us be able to make better decisions. So I really want to thank you on multiple fronts, but I – you are – it's just been marvelous to see how all of you have responded, thank you.

Alina Czekai: Thank you, Dr. Couch. And now we'll open up to audience questions and I will encourage everyone to keep their questions for our guest speakers today. If you do have technical questions or questions about CMS's recent guidance or billing questions, we do encourage you to join our CMS office hours, which are held every Tuesday and Thursday at 5:00 pm Eastern. And, operator, we'll now open up the lines for audience questions.

Operator: To ask a question via the telephone, please press "star", "1". No questions over the phone, please continue.

Alina Czekai: Great, thank you. We'll now transition to our next part of the agenda, which is a discussion on telehealth. Telehealth has been a topic on almost all of our lessons from the frontline calls and this week we'll be focusing on using telehealth to care for patients with disabilities as well as caring for patients with behavioral health needs.

So I'd first like to introduce Dr. Curtis Lowery. Dr. Lowery is the medical director of the Institute for Digital Health and Innovation at the University of Arkansas for Medical Sciences. Over to you.

Curtis Lowery: Thank you very much. I appreciate the opportunity to speak to the group today and I thank CMS for having the insight to set this up. In Arkansas, we've been doing telehealth for more than 15 years. It started because Arkansas was a very rural state and there are large areas which are underserved with physicians or any kind of practitioner, for that matter. So our idea has been to build a connected healthcare system that goes across space in almost all hospitals.

Over the years we've built a system that's in every hospital, every health department, every – almost all telequalified healthcare centers and other systems around the state, so it's very connected. But if you're going to provide healthcare to patients, there's the practitioners but then there's the support service that everybody needs to interact with patients. And, of course, one of the big problems is that some of our patients are – communication skills are impaired, whether it's because of non-English-speaking patients or patients with visual or auditory impairments.

A long time back we started thinking about this within the confines of the University of Arkansas and we decided that a solution to interpreting patients would be to centralize this resource so that our interpreters, our medical interpreters could reside in one place and then they could be scheduled using video conferencing to the clinics which were spread out. This was very successful and really kind of made the service immensely more efficient because now the contributors would video into the clinic and could see the patient and the patient could see them.

And, of course, we all know that there's auditory communication but then also we communicate by facial expressions and hand gestures and even postures. So, building on the success of this as we began to then go an increasing number of consults from our subspecialists around the state, we decided that using this resource around the state in these communications was also a very good idea, particularly when you look at rural areas in which they have almost

no medical interpreters or even problems with hearing and sign language interpretation.

So this is – now we've built on this and now we're successfully doing this. Because we were doing so much telemedicine prior to the crisis, we could rapidly adapt to direct consumer videoconferencing as well as in the other clinics around the state and we could readily bring in these interpreters.

In recent times, there are more applications available, such as, you know, text, language-to-text interpretation, speech-text and even Google now has an artificial intelligence program that allows sign language to be converted to text. So the visual aspect of the videoconferencing that we're able to do dramatically expands the capabilities of us to communicate and provide resources in underserved areas.

So I would encourage the group to think outside the box, to think about other resources that could be put into the digital healthcare world and use these resources to make the experience between the patient and the practitioners more robust.

And I don't think that we're ever going back to the post-COVID world, that we're going to expand and figure out how best to use these resources along with traditional healthcare and a new hybrid kind of both digital and real practitioner kind of world. But we'll be focusing on the patient and making the experience better for the patient than it has been in the past. So with that, I'll conclude and then we'll go on to the next speaker.

Alina Czekai: Thank you, Dr. Lowery. I really appreciate hearing your perspective and especially appreciate you encouraging our physicians on the phone to think outside the box. I think this is a time where providers around the country are doing just that. I'd now like to introduce our next speaker on this topic, Dr. Chris Cargile. Dr. Cargile is the Director of the Behavioral Health Service Line at the University of Arkansas for Medical Sciences. Dr. Cargile, over to you.

Chris Cargile: Thank you so much, and I'll echo everyone's thanks both for the invitation, and also for CMS not only putting this together, but really the work in the past few weeks, and especially related to the telehealth platform and sort of unfettering us from – and really able to make use of it in a more meaningful way for some of our at-risk patients.

I'm a general psychiatrist in Little Rock, Arkansas at the only academic medical center in the state, and I've been participating, either dealing directly or administrating programs, that have provided mental health care on telehealth platforms for almost 20 years, but in many ways, I would say there's sort of the before and after of a lot of the changes that we've seen over the last three to four weeks.

Really, if you'd talked with me even six months ago, I would have described all of our care as really an office-to-office care platform where we really relied on the office, at the receiving end of our telehealth services, where we had support staff, we could bring patients and families into a typical brick-and-mortar area.

These are often underserved community mental health centers, primary care centers such as FQHCs and underserved areas, and we've certainly provided what I believe to be a meaningful service, and one that was impactful, but there was always this very visceral understanding that there was a real limit to what we could do in some of these most underserved areas, and these most at-risk populations, because they relied on still a traditional brick-and-mortar platform for them to access, and as Dr. Lowery just described, even a bare minimum of such services is sometimes difficult to access in our state.

So, as we have more options, including greater options for patients to use other platforms, including telephone only services, it really kind of opened the doors, not just for patients that were having difficulty because of the pandemic, in coming in, either because of (inaudible) transportation, et cetera, but also patients that we just struggled to reach in the past with more specialized care.

So we have really ramped up stuff that we have been wanting to do, or had worked some with Dr. Lowery on doing (inaudible) with HIPAA compliant softwares. We really have been able to take some leaps and bounds forward in doing that. I'll just talk briefly about the things that we've found that have been very helpful, and the fairly predictable obstacles and struggles that we still run into.

On the latter, we, I think, anticipated some technical difficulties, whether it be uptake on the patient's side, as many of the speakers have alluded to, some of these populations most in need are the ones that have least accessibility to technology, and have perhaps the least comfort level utilizing that technology to activate their receiving end function. We certainly found that.

It's been much less with telephone services than tele-video, but we had it really with both. We've been able to overcome that some by really utilizing a lot of family and other peer support, but also being able to deploy peer professionals, other staff out into the home, again, which really wouldn't have been possible previously, armed with a phone, armed with a laptop, armed with an iPad with cellular connection. So there are challenges, but some opportunities also to overcome that.

The other thing that I think we have been working on, but not probably as robustly without the urgency, is really coming up with the policies and procedures to do this kind of work safely without the formal support structure of a clinic. We've worked through those. Again, this is sort of an opportunity to get a lot of work done with some urgency, but I think the payoff, despite some of these challenges, has really been remarkable.

We've been able to provide, even with these obstacles, a level of care and a frequency of contact with a lot of our rural patients and our patients that have problems with access, that we've really not been able to do before. We've seen patient satisfaction really go through the roof.

We've seen patient engagement in some of these areas also really go through the roof, so I just applaud CMS in opening up some of these opportunities, and I think, as Dr. Lowery alluded to, really thinking outside the box, and for

us at times it's about – having someone bring that technology into the home has really, really paid off, and I agree with all of the speakers, but I think the toothpaste is out of the tube, so to speak, probably not going to go back in, and it would behoove us to figure out how to best make use of it.

I'll stop there, and will certainly entertain questions later. Thank you.

Alina Czekai: Thank you, Dr. Cargile, and our final speaker in this segment is Dr. Wayne Sparks. Dr. Sparks is the Senior Medical Director of the Behavioral Health Service Line at Atrium Health, and he's based in Charlotte, North Carolina. Dr. Sparks, over to you.

Wayne Sparks: Alright. Thank you, and thank you to CMS for this presentation opportunity, and we'll probably echo some of the – or second some of the things that Dr. Cargile has mentioned about being able to ramp up some of our work in virtual health more quickly than we may have been able to do in the past, so this is a very exciting time to be able to do this.

So, Atrium Health is nationally recognized for expertise on delivery of healthcare services on a virtual care platform. We've been doing this for about 22 years, especially through our emergency department, with virtual care. With the onset of COVID-19, the focus turned pretty quickly to a rapid expansion in existing areas, as well as moving into new areas that we really haven't done virtual care before, but I'm going to focus primarily on some of our behavioral health service line areas, and the first is our ambulatory care practices.

Since about March 15th, 16th, somewhere in there, we were really starting to hit with planning for alternate delivery models, and since then we've provided about almost 8,000 virtual outpatient visits, utilizing telephonic and virtual visit platforms. This represents about 85 percent of our patient visits, so we were able to transform pretty quickly on the virtual space in those areas.

The services we provided there were outpatient psychiatry and therapy, as well as treatment specifically designed for our most fragile patients, the serious and persistent mental illness, which is cared for in our clinics and our assertive community treatment teams. To further support our community, we

established virtual psychiatric assistance through our partnership with community facilities, and one facility in particular that manages and cares for the medically fragile, chronically homeless population, and that's been a success there.

We've also been able to use social distancing recommendations to allow patients to continue to see providers in person if they wanted, and particularly some of our groups – there's a DVT group and partial hospitalization services, still keeping those going, and even in our outpatient clinics, if a patient preferred that or didn't have the technology to do virtual.

We've also created a virtual hospitalization for adults, if they wanted to do that process. As in most other areas and facilities, we've done patient and teammate screenings for temperature and COVID-19 symptoms at all entrances, and we have universal masking for patients, so to further protect the patients and our teammates.

In our ambulatory areas, we're also in the process of creating virtual services to our Charlotte Men's Shelter, our homeless shelter, and that houses many of our vulnerable patients. We're also working with congregate care and group homes to create a process to continue to provide care for those residents, as well.

On our inpatient services, early in the crisis, we had some discussions and decisions with our acute care leaders at our other hospitals, to establish processes and protocols for managing our COVID positive patients that are behavioral health. We made the decision that we would move any of our acute care behavioral health patients over to our facilities, and we would keep any of our COVID positive patients either in acute care, or if they became positive in our behavioral health units, we would transfer them.

Just knowing the communal environmental of our behavioral health units, it's just not ideal to have patients with COVID, if we can have other opportunities to move them into acute care.

We developed an inpatient virtual rounding workflow that can be implemented across multiple platforms, and within just a few days, we had

about 70 of our psychiatric providers fitted and ready to go with virtual care, and knowing that workflow, so they learned about the ability to do virtual care with interviewing and assessment, documentation and billing, so a lot of those providers had never done that before, so it was a quick ramp up and it's been working really well across multiple facilities, and at least it gives that option for people to use that platform. It has been quite positive as far as teammates and patients, so that has been quite a success.

In our consultation liaison service, we have multiple hospitals that have virtual consult service already established, but our larger hospitals have onsite in-person consultation teams, and with these COVID-positive patients and more of the influx of these, we've been able to switch up more of those providers to do virtual care, and either provide e-consults, which are consults provider to provider, not necessarily needing to see the patient, but also some virtuals with our patients, as well, in those medical facilities.

One other huge move forward is that we've been able to establish a virtual process to begin the involuntary commitment process. We've struggled with that through the years, getting that process straightened out, and then being able to do that virtually has been quite effective.

One other program, behavioral health integration – we have well-established at Atrium Health a virtual behavioral health integration program, and to our primary care practices. This team has been providing support to our Atrium Health virtual hospital, which was established during this crisis to treat and manage those low to moderate acuity COVID positive patients, without bringing them into the hospital, and caring for them at home.

So our behavioral health integration team has been able to help those providers manage any behavioral health issues of those patients while they're at home. We've also established an outpatient virtual clinic, so we can continue to support those patients once they are discharged from the virtual hospital.

Our ED – we have a 24-hour psychiatric emergency department that's been part of our system for about 23 years, and it's on our largest campus. Also,

that team provides care virtually to 22 of our acute care medical EDs, and we've been modifying some processes there to manage that flow a little bit quicker, creating the triage category for our tele-psychiatry patients so that they are – we are prioritizing the elderly or patients that may be under investigation for COVID, so we can move those patients quickly through that medical ED process.

The last thing I just wanted to mention, we've been certainly trying to focus on patients but we've been recognizing that this has a huge impact on our teammates and providers and staff, so we have been seeing an increase in our EAP visits in our 24-hour call center. Our EAP visits have been up about 15 percent since the beginning of March, and we have been doing some EAP sessions virtually, and continuing to do those even beyond the traditional six session limit.

We've also created a provider APT teammate help support line, where they can contact us, get an appointment for a confidential virtual outpatient therapy or psychiatric services, in our Atrium Health providers and teammates. So that's another program that we're trying to do virtually, to stand up – support for our teams all across Atrium Health.

So that's really what I have. A lot of this is really things that we've moved up quickly, and again, as others have said, we are hopeful we can continue to do a lot of these things, or some mix of these, to reach our patients and keep them well. So I wanted to thank CMS, as well as the National Council for Behavioral Health, for getting me on this call, and I really appreciate the discussion. Thank you.

Alina Czekai: Thank you, Dr. Sparks. Really appreciate it. And before we turn to audience Q&A, I'd like to give our CMS physicians the opportunity to ask any questions or share any comments with the group.

Barry Marx: Hi, this is Barry Marx. First I'd like to thank our speakers for these presentations, and more importantly, for the incredible work that they're doing. This really demonstrates extraordinary resilience and creativity in

responding to the rapidly evolving role of virtual care in the context of the current public health emergency.

One of the things that I'm very interested in is, as practices address the needs of vulnerable populations through virtual care, how and to what extent they're involving patients and their support systems directly, and sort of the design of these systems, and thank you.

Curtis Lowery: This is Dr. Lowery. We engage patients pretty much all of the time continuously. We have a group of patients that participate in working with us as we design these programs, and we can have these sessions virtually by using either the healthcare sites around the state, or directly with some of the software that goes directly to consumers, but we always get feedback after the visits of most of the patients, to determine their satisfaction with their interaction. Does that answer your question?

Barry Marx: Yes, sir. Thank you very much.

Alina Czekai: Operator, let’s open the line to take a few questions. Thank you.

Operator: Once again, if you wish to ask a question, please press “star,” “1” on your telephone. No questions over the phone. I’ll turn the call back over to your presenters.

Alina Czekai: Thank you, operator. I’d like to thank all of our terrific speakers today. At CMS, we really do appreciate having this weekly forum to allow providers on the frontlines to share best practices, strategies, and perspectives with others around the country. Each week, we have thousands of providers on these calls, and I hope they continue to be a helpful forum for you all during these unprecedented times.

And as a reminder, these calls are recorded, and we do post our transcripts online. Should you be interested in looking back or sharing these resources with your colleagues online, you can find the recordings at cms.gov and then go to Outreach and Education, and Partner Resources, Open Door Forum, and posted on the Podcast and Transcript page.

And we hope that you will join us on Tuesday May 5th for our CMS COVID-19 office hours, and on that call we'll be joined by all of our CMS subject matter experts to answer technical questions on our latest guidance, and in the meantime, you can continue to direct your questions or comments to our COVID-19 email box, which is covid-19@cms.hhs.gov.

As always, we really look forward to continuing our collaboration with you all, and appreciate everything that you are doing for patients and their families, as we address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

End