Centers for Medicare & Medicaid Services
National Medicare Education Program (NMEP) Meeting
Moderator: Susie Butler
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2:00 pm ET

Coordinator: Thank you for standing by. At this time all participants will be on a listen-only mode until the question-and-answer session. At that time, please press star followed by the number 1, unmute your line and record your name purely as prompted to be introduced. Today's conference is being recorded, if you have any objections, you may disconnect. I'd now like to introduce (Susie Butler) Ma'am, you may begin.

(Susie Butler): (Robin), thanks so much. Hi, everyone. This is (Susie Butler), I direct the Partner Relations Group in the Office of Communications here at the Centers for Medicare and Medicaid Services. And I want to welcome you to today's National Medicare Education program meeting. We've done them via webinar before, but I believe this is our first all remote call. So I appreciate you taking the time to join us today.

These are challenging times and so we're excited to bring you some new information and bring you some updates. We know that trusted organizations like yours are on the front lines with our beneficiaries and you are working to connect them to Medicare information. You are also looking for resources, services, and information that is pertinent to those beneficiaries. So we hope today's discussion will assist you with your important work.

I also want to mention that this call is open to everyone. However, if there are some press on the call, please refrain from asking any questions during the Q&A portion of the call and direct your inquiries to the press office. You could reach them at press@cms.hhs.gov.

As always, we welcome the opportunity to open the dialogue and to hear from you. We'll be taking questions after each presentation today but I'll be minding the schedule. And to keep us on time -- so just to give you a lay of the land here. To keep us on time, I will be moderating the questions and I will cut it off at around each half-hour so that each presenter has time to speak and answer a few questions. If you don't get to ask a question that is really important to you, please send it to the partnership mailbox, and that mailbox is partnership@cms.hhs.gov.

So, I'd like to introduce our speakers for today. First of all, we have Jon Booth, he's the director of Web and Emerging Technology in the Office of Communications. He will be providing the updates on the Medicare Plan Finder. After Jon, will be Jean Moody-Williams. She's the Acting Director of the Center for Clinical Standards and Quality. She will provide an update on the latest COVID-19 guidance and requirements for nursing homes. And then finally will be Emily Yoder in the Center for Medicare. She's an analyst in the Hospital and Ambulatory Policy Group, and she will provide an update on telehealth as many hospitals and physicians are currently using this avenue.

So, we'll take your questions after each presentation. It's now my pleasure to turn over the waves -- airwaves, to Jon Booth. Jon?

(Jon Booth): Great. Thanks, (Susie). Good afternoon, everyone. Yes. So I'd like to walk you through some updates through Medicare Plan Finder. A couple of which just went out the door last week and then others that are kind of coming up.

So I want to thank everybody. Since we did launch the redesigned Plan Finder last fall, or last summer, you all have given us lots of feedback. So all of your perspectives and insights have been and continue to be really helpful in the

process of kind of prioritizing the improvements that we need to make.

So, the redesign - the rebuild of Medicare Plan Finder was a huge undertaking. There's a lot of improvements we have - we're going to talk through today. And more to come. We do want to highlight to you all that you know we are committed to continuing to evolve and improve this tool. And, you know, one of the challenges is it doesn't feel like we have that much time between the end of an open enrollment, so the time when we start begin getting training all of you and all of our partners for the next open enrollment. And so it's very important that we kind of focus on, you know, the most high impact, high priority changes.

And also, you know, we're very committed this year, as I go through the updates we're talking about the goal is to have our updates kind of, you know, done over the summer as we head into (OE) like I said the tools vary for the stable and we've gotten you all the training you need to support beneficiaries over the upcoming open enrollment.

So we have, as you'll hear over the rest of this session, as you see the agency has been very focused on response to sort of the COVID-19 work. Having said that, we are going to be making some significant improvements to Plan Finder this year, and we're excited about this. So we'll be taking you through them today and making sure you have the information you need.

So, top priority out of last year really came down to feedback that we received on sort of the default sort order and the information that we were prioritizing on the plan cards. So we heard that. One of the things that we were able to do last year with the new plan finder is to sort of like test, change, and work with users and conduct user testing in a way that we had not been able to before. So what we did find is out of the testing that we did, the feedback that we heard

from a lot of you did point in - to help point us in the right direction.

And so there are a few changes that we made. Those changes are we did change last week the default sort order in the Plan Finder from premium, which was what the default was when we wanted to (see the tool), now to lowest drug plus premium cost as the default sort.

And in conjunction with that, we rolled out some changes to the plan cards that I'll take you through. And then also last week we rolled out a couple of other visual design changes as well. We've got a few slides that I'd like to run through quick just to highlight these. These changes are live now. So you haven't seen them yet, do that through the Plan Finder. And just use the tool and you will see these changes in practice.

If we can go to the next slide, please?

So, again, current reflects actually kind of middle of last week. The new card is on the left, and what you'll see is the old design has premium as a very large number. The other cost - associated cost kind of the smaller number. The major changes we made here are all of the costs are grouped together, so they're on the left, they're sort of stacked vertically against one another. We put other information such as the benefits, whether the plan includes drug coverage or not, on the right. We've used the star ratings with the plan name, and we have lumped the action buttons together. So enroll, plan details, and add to compare (url). Plus served together on screen.

Next slide please? So this will show you the drug plan cards. It's a little simpler because we don't have those MA benefits but very similar layout here.

Next slide? So, yes. I'll go through a couple of the visual design tweaks we

made. These were relatively small - you might notice some if you're using the tool a lot, but otherwise people might not even notice them but we'll go through a couple of them so if we could go to the next slide. And really these were designed to sort of improve the readability of the pages and visual hierarchy of information. So, what we've got here is the plan and comparison screen. This is where user's comparing three plans side by side. Next slide?

This is the plan details page we've got up. So, again, if the user clicks into a specific plan - and one of the changes we made here is we just sort of improved the display of that left hand navigation so that it's clear that that's what that is on the page.

Next slide? This is the drug entry screen.

Next slide, please? And then we also rolled out visual designs to three kind of supporting schools that are linked from Plan Finder that people might use looking for specialized test - coverage types. So we've done that for the (pace) tool, that for (the moment) includes the elderly, the prescription assistance program tool, and the state pharmaceutical assistance program tool. So these are all now visually realigned to look like the rest of Medicare App but also mobile optimized.

Next slide? So this will just show you a detail if you click into the (Maryland SPAP) details kind of looks on screen.

Great, and I think that takes us to the end of the slides. So what I'd like to focus on now is just to run through a set of changes that we are - that we're planning to roll out. So we'll go into a set of things that relate to data in the tools. So we did hear a lot of feedback and sort of questions from people around the data. And so we've made a variety of improvements to address

those. So I'll just run through these.

We wanted to start with kind of the authenticated experience to log in and account creation process. We did make changes behind that - behind the scenes to ensure that that process is smooth. And now in the Plan Finder for users who have authenticated who have logged in, the online enrollment form is pre-populated with data that we already have about them so that the user does not have to enter that information again. So those specific fields include the beneficiaries name, their address, their Medicare number, and their coverage date. So they no longer need to enter those pieces of data.

We've also worked on the timeliness of data on a couple of fronts. One of those is low income subsidy information. And so we've made an improvement from your updating that data on a daily basis now so that it's fresh and accurate for users, it's not out of date. And then we'll be working on one of the future enhancements over the course of the summer is - and before (OE) is we will have a user future (LIS) status in the tool as well, with that changing from year to year. So that they will see coverage for the next year. We will accurately reflect the (LIS) status that they will have.

We're also updating plan data in the Medicare Plan Finder on a daily basis, including the weekends, so that includes all of the information about a planned benefit package. Their cost. Their contact information, all that sort of data. So updated much more frequently than it was in the Plan Finder previously.

An area that's coming up - so last year we have redesigned the (Medi Gap tool). The (MediGap Finder). But we didn't have a chance to change the data and that's a tool where we've had challenges with data a lot over the years because we don't - CMS doesn't really have any regulatory legislative

authority to correct the data. So we are going to be switching that tool this year to a commercial data source which is going to give us more timely and sort of (curate) data than we've had in the past. So we're excited about that.

So in addition to improved data the new data - the changes we're making will allow us to display more specific premium information for (Medi Gap) plans and that will be updated on a weekly basis. We'll also have some additional information on the plan parts in that tool, and it will be aligned to look more closely aligned with the Plan Finder tool.

As before, though, you know, the (Medi Gap) tool ultimately is a directory of offerings. The beneficiary, once they find a plan, will need to continue to reach out to the issuer to do the enrollment process.

Another behind the scenes change that we're excited about relates to the plan previous process. So issuers, you know, over the course of the year leading up to (OE), issuers submit their plan information to CMS. And one of the things that they do as part of that (OE) readiness process is review their data to ensure that it will look accurate and that it aligns with what they expected to see.

So last year that was done in a way that kind of required some guessing or interpretation about how the data would display in Plan Finder. This year the - when plans are previewing their data, they will see it in the Medicare Plan Finder. So they will look at it exactly the way it will look when we get to October 1st and we open the 2021 plan. So that will help a lot with just, you know, ensuring that the preview period works well and we address any issues before we open the door for (OE).

Two more updates on - from the data front. One is we've continued with the

new tool - we've talked about this before. We rewrote the drug pricing engine so that that's a tool that CMS kind of owns end to end now. We've been able to sort of document that drug-pricing methodology so that questions come in if a plan or an organization that's sort of wondering about why pricing is displaying in certain ways - we've got that all very thoroughly documented and want to be sort of sharing that and socializing that so that people understand how that all works.

And then finally one - this is a common piece of feedback. We will be updating the refill frequencies in the Medicare Plan Finder to add two additional refill frequency options. One for 6 months, and one for every 12 months. So if somebody who takes a certain type of drug once a year will be able to take that in the tool. Again, that will be something we'll release over the summer and that will improve the accuracy of people drug costs for drugs that they do have on that, sort of, refill cycle. So we're excited to get that rolled out.

Next, I'd like to run through a couple things that are really sort of multi-year efforts and so we are beginning to make roll-outs and enhancements to these this year and we've got plans for subsequent enhancements in future years to really get where we want it to be. But, again, there's some good features we can roll out this year.

So, one of the first is, again, another area we've heard lots of feedback around. And that is how the, sort of the pharmacy search functionality works in the Medicare Plan Finder. So over the summer, we're going to be adding a couple of features on the pharmacy selection screen in Plan Finder. We will allow users to find a pharmacy by name as well as by distance, and we're going to be improving the usability and functionality of the map that displays on that pharmacy selection page at the same time.

And then in a subsequent release we're going to be making some changes to the way pharmacies work on the plan details page. So we do allow users to change a pharmacy from plan details page, but they basically have to go back through a multi-phase step. And then navigate back to the plan. So we will basically be allowing users to change a pharmacy in context on that plan details page and not having to go back through that flow anymore.

So if the user - for example - got to a plan details page and found that they had picked a couple of pharmacies that were all out of network from that page they could find the pharmacies that were in-network and switch over to those to compare the impact that that would have on the pricing for that - for their enrollment in that plan.

Additionally, in the tool we will be making some enhancements to the sort and filter capabilities in the tool. So one is we will have a filter to support filtering by plan type. So a couple examples might be somebody who's looking for cross-plans or Medicare savings plan. There's numerous other types that will be shown there.

We will also offer a filter in the Plan Finder for the insulin demonstration plans that will be available for next year. And those are the plans that will reduce the cost of insulin for beneficiaries that take those. So if somebody wanted to look at just those particular set of plans we would give them the ability to do that.

And printing is something is something we've heard a lot of requests for. We're not making major changes this year to the printing capabilities in the plan finder but we are looking to streamline those forms and reduce the amount of paper that they take. And as I mentioned, these are - all these topics

that I mentioned now are things where - as we get into next year and the subsequent (OE needs) is that (we have additional) things planned to improve those and respond to the feedback that we've heard.

And then I want to talk about a couple of things that are on our multi-year road map that won't be in place for this year. So the first of those is the request to bring back the anonymous drug list that we had in the old Plan Finder. So we're not planning to bring those back. What we're actually looking at is - right now - so there's - you know, we think that the drug list created in the logged in experience are better drug lists for beneficiaries. Those are based off of their claims data and so you save a lot of drug entries.

Right now though, to create a Medicare account you have to have a Medicare ID and so how - the way we'd like to tackle this is we actually want to evolve our Medicare log-in system to allow people who aren't in Medicare -- and those could be people that are aging in the Medicare that don't have their Medicare ID yet. Those could be some sort of (an assister), those could be a family member or a caregiver. To basically allow them to create a Medicare account and that would allow them to use the authenticated drug list function that we have in the tool now.

So we will be having discussions with a number of, you know, assister organization over the summer to really understand the need there and to make sure that we kind of think up a specific requirements that their (body would need) if that was the route we went. That we went down. And again we do - we definitely recognize the need, you know, to have secure support for the beneficiary community from our assisters.

We want to make sure that we do that right. It is a very complex undertaking. So, again, it's important that we get that right.

And then the last feature that I wanted to mention as a multi-year out year feature that we've gotten a lot of feedback on is around provider directory. So the request for people to be able to use Plan Finder and search for their doctor and find which plan might have their doctors in-network.

So CMS did issue an (interoperability) rule at the beginning of this year. That rule does require plans to publish (APIs) -- Application Programming Interfaces, to their provider directories online, beginning in calendar year 2021. So as plans begin to put those online we will definitely be working with the industry and we're excited that these things - as they come online that we'll actually be able to tackle that and these will reduce some future work in that area.

So that's a lot of information that I ran through. Again, we're excited at the work that we've got lined up for this year. But I'll stop there. I'd be happy to take any questions that you all might have.

And I will mention -- you know, we do these releases over the summer we'll be certainly coming back and (briefing) you with additional details on things that I may have just touched on briefly today. Thanks.

(Susie Butler): Thanks, (Jon). (Robin)? Can you open up the lines for questions please?

Coordinator: Yes, thank you. At this time if you have a question from the phone line, to please press star followed by one on your line and record your name clearly as prompted.

All right, one moment here for the first question. (Sharon DeLisle), your line is open you may ask your question.

(Sharon DeLisle): Good afternoon. I just wanted to know we will receive the slides from today?

(Jon Booth): Yes. This is (Jon). We'd be fine with sharing these slides. That's not a problem. So we can work with the team to get those out.

(Sharon DeLisle): Okay, thank you so much.

(Susie Butler): Any other questions, (Robin)?

Coordinator: Yes. Our next one comes from (Joan Adler), your line's open.

(Joan Adler): Hi, my name is (Joan Adler). I'm unable to see the webinar, I registered in advance, I'm at the website, I put my name in and it's not letting me in so I'm not seeing the slide. So I'm very happy to hear that we will be getting a copy of the slides. I don't know how many other people may not be able to see the slides.

(Susie Butler): We appreciate that and we'll make sure that you get a copy of the slides.

(Joan Adler): Thank you. Is there any technical help to get in to see the rest of the slides for today's conference?

(Susie Butler): There are no other slides.

(Joan Adler): Oh. Great. Thank you.

Coordinator: And then you. One moment for the next question. (Rob Ernest), your line is open. You may ask a question.

(Rob Ernest): Thank you. I'm with the (Yeshiva Program) in the State of Oregon. Could you run by the general search vs. the personalized search again, the proposal that you're going to make on that. I find the general search to be very, very valuable and I really don't want to see that changed.

(Jon Booth): So by general you would mean an anonymous search without being logged in?

(Rob Ernest): That is correct.

(Jon Booth): Yes. So I think actually - so I'm just looking through kind of my notes here. I think everything we talked about. Those enhancements would really be coming to both experiences. The only ones that wouldn't - the online enrollment forms, would not be pre-populated if you're not logged in, but yes. I believe all the other features would apply to both of those.

(Rob Ernest): Thank you very much. Glad to hear that.

Coordinator: Thank you. Our next question is (Jerry Siconopy). Your line's open?

(Jerry Siconopy): Yes. This is (Jerry Siconopy). My question is in regards to the new default sort. So when you list lowest drug plus premium cost, are you referring to the co-payments for Part D drugs?

(Jon Booth): Yes. So essentially it would be all of your drug costs based on the list that you entered into the system. So as you were building your drug list in the tool based on the plans that you report and we would also take into account your - again, if you had some sort of LIS status we would apply that as well to the sort so that it reflected your cost.

The only thing that it doesn't - that does not get counted into that default sort

now is our out of pocket cost estimate. That does display on the plan details page. That's not a part of the sort algorithm.

(Jerry Siconopy): Perfect. Thank you.

Coordinator: And thank you. One moment. (Kristin), your line's open. You may ask your question.

(Kristin Helfertesler): Hi, my name is (Kristin Helfertesler), I'm with a (Virginia SHIP office). And you had mentioned that some of the data will be updated every day during the week, and I think you also mentioned cost, meaning drug cost. I just wanted to confirm that drug cost in summation will be updated on a regular basis.

(Jon Booth): That's correct. So there is a slightly different cadence for the drug pricing. That information is updated on a weekly basis. And that's just based on the cadence of when plans are submitting updates to CMS. Which is the one reason that piece isn't updated every day. But yes. It is regularly updated in the tool.

(Kristin Helfertesler): So on a weekly basis throughout the year?

(Jon Booth): That's correct.

(Kristin Helfertesler): Okay. Thank you.

(Susie Butler): We have time for one more question, (Robin).

Coordinator: Thank you. Our question comes from (Sharon Glass). Your line is open. (Sharon Glass)? Your line is open?

(Sharon Glass): Thank you. I apologize. My question is, if I am a (part B) - if I'm a Medicare beneficiary who takes (Part B) as in boy drugs, how would I do a profile on Plan Finder to identify if my Part D drugs would be covered by a particular plan?

(John Booth): I'm going to take that one back to the team and we can follow up with you to get that answer just to make sure that it's exactly right. I do know that we request (part B) coverage in the Plan Finder tool but I'll follow up with the team and we can reach out to you afterwards and get you the specifics on that.

(Sharon Glass): Okay. Thank you so much.

(Susie Butler): And just for everybody's information - we share those answers with everybody. So we'll post that as part of the process after the call.

(Jon), thank you so much for your time today and for the presentation. I'd now like to interest to you Jean Moody-Williams. (Jean), you have the airwaves.

(Jean Moody-Williams): Thank you so much. And - for asking me to speak and thanks to you all for joining this call. I'm going to speak a little bit about what we're doing in the area of nursing homes. It is, I know, a topic that is getting a lot of questions and visibility. And as right as it should.

This work is extremely important as we realize that nursing home residents are particularly vulnerable for complications from the coronavirus given the age, the usual presence of underlying conditions, such as heart disease and diabetes. The close living quarters, congregational activities, and staff that may need to work in more than one facility, and then there are many other factors that come into play.

We of course seeing that during COVID-19, issues that existed before are exacerbated by this virus, such as (hospital) disparities, and coordination and care. So I think what you can probably - we can all remember, and will for years to come, when we began to realize that we had a real issue and that we would be in it for the long haul.

We were fresh moved to action in early February when we heard that there was an incident of the novel coronavirus in the United States. As we were faced with the potential spread of COVID-19, we took early action in February 6 and really - what we did is reiterate the importance of the requirements of infectious disease control and planning and how important it is to really institute and enhance well known and section control practices. That was in February and I could make the same statement even now.

But it was only a couple of weeks later, on a Saturday, actually I recall it very well, I got a call from the administrator alerting me that there had been a death reported in Washington state and the Washington State Survey Agency had just been notified of a sequence of respiratory infections (and staff) immediately began to work with the state, with the nursing home, and the governor's office, and it's that kind of partnership that really has been in effect since that time as well as all of the various stakeholders in Washington state, and many states since that time.

As a bit of background. As the primary role for health and safety of residents, of course that belongs to the front line providers, the nursing homes. But because CMS is responsible for administering the Medicare and Medicaid programs, we issued a regulations and guidance that set forth the Federal Standards and then we also go out and inspect nursing homes to ensure that they are compliant with those standards. But we do that in partnership with

state government, their state surveyors that also go out to these nursing homes to ensure that we're implementing the regulations from the guidance and then the state also has a responsibility for doing checks to maintain licensure.

So we frequently get the question of well, you know, who's doing what? And we do work together on that - those items to ensure the health and safety of all.

So, I'd say that we're taking (aggressive) and kind of unprecedented actions to address the spread of COVID-19 within nursing homes, to keep residents safe and provide better quality. I mentioned that starting with February 6 we've issued nine guidance documents based on existing infection control requirements. And - and this is the important part - we learned something new almost every day about how this virus is evolving and how it impacts our population. And so we update as we get new information and the information primarily we work in coordination with the Centers for Disease Control and Prevention, the CDC, and they primarily are the ones that develop the evidence base and the science of infection control processes and then we take that and we ensure that we incorporate it in our requirements and we sent that out to the state surveyors who then go out and help out with the nursing homes. The nursing homes also get that information.

So, our guidance focused primarily on screening entrants into facilities using personal protective equipment, restricting non-essential medical staff and visitors, and (safety inspecting cohorting), or placing patients with COVID-19 together and keeping those that aren't impacted separate.

And so I want to say a little bit about that because particularly - I'll start with visitation as I know this is a common area of concern for most residence, families, and beneficiaries. There was in early March where we issued

guidance restricting the entry of anyone with symptoms of respiratory infections. So, if you had a respiratory infection, if you traveled to certain locations, then your entrance was restricted but it was quickly thereafter that we learned more and found that the trajectory of the virus so we took aggressive action to something we'd never done before and we implemented nation-wide restrictions on non-essential medical staff and all visitors.

It really was a very hard decision to restrict the interaction between residents and their loved ones but it was necessary to protect the lives of the residents. This guidance remains in effect from the CDC, and from CMS. We have not changed that to date.

So for all facilities nationwide, facilities should restrict visitations to visitors and non-essential personnel, except for certain cases of compassionate care, end of life situations.

And when visitors or essential personnel do enter into the nursing home then of course they should use all precautions, use PPE appropriately and there are areas to preserve PPE so as dictated by the situation and visitation decisions have to be made on a case by case basis including clergy, bereavement counselors, etc. Considering the conditions that are in existence of the nursing home, and the nursing home facilities are the ones that then have to make those decisions.

And so I do want to note though if you noticed that there are exceptions to this patient rule and this is an area we frequently will hear from families about, well, you know, the hospice nurse wasn't allowed in or the clergy wasn't allowed in and again while the nursing home because they are - they're on the front lines have to make those decisions it should be clear that they are an exception to the visitation rules. Our guidelines do allow healthcare workers,

ombudsmen, EMS personnel, dialysis technicians, and others that provide care to residents to enter into the nursing home.

When we are speaking of - when we say non-essential, we are not saying that their work is not important. We're just prioritizing at this point so the barbers, some of the activity coordinators, those kinds of persons, (still) have restrictions.

So, again, if families are having difficulties and they feel like this person is an essential medical worker that needs to be in they should have a discussion with the nursing home about the practice that they're following.

So, we've also prioritized a number of our survey activities. So we do actually have surveyors that are entering into nursing homes to evaluate what they're doing, if they're following the regulations, and if they're following the infection control processes. What we did was to say we're not going to do any more routine surveys. So if you're hearing from families or others, you know, they're not even inspecting, they don't know what's going on. We are not doing routine surveys that we would normally do during this course of time but we are going in for - to investigate complaints. So if there's any allegation of physical or sexual abuse, neglect, or other conditions that would create an immediate harm or we call that immediate jeopardy, those cases will be evaluated.

We also are going in to do what we call targeted infection control survey. And so in this case both federal and state surveyors are going in for a streamlined process in which we're using assessment tools to look to see if certain basic principles are being followed. And as well each of the nursing homes have this self-assessment tool, so that they can go ahead and assess themselves and again we are encouraging families to have discussions, you know, do you

have this assessment tool. How'd you do with it? Any kind of dialogue to - that may help if they have questions.

So there are - I'll acknowledge, there are varying opinions as to whether we should be doing surveys. Some say, you know, we're in the midst of a crisis and here comes someone looking over my shoulder and then there are others that say, in particular family members and others, 'We can't be there with our loved ones. So we expect that you will be. So that you can ensure what's going on in there.' And so we don't take that lightly and we continue to do our work in the most non-intrusive manner possible.

So, what do we see when we go out? So the first thing I'll say is we absolutely see hard workers. They are - many are overwhelmed; they are dealing as we all are with situations that they've never really had to deal with before. They're having to be the worker, the family member, the advocate, and all of the above. And so we acknowledge that and we applaud that especially this week which is still nursing facility week.

We also did identify issues. And we are making sure that we communicate that to the nursing homes. We've had calls with the governors. This is - well, we've had calls with governors all along but during this week in particular we've talked to governors and state leaders. This afternoon when I leave this call I'll be talking to several thousand nursing home workers to share our findings. We do find that on occasion, there needs to be more attention to increasing the rate of recognizing that someone is going into some respiratory problems and noting that there are perhaps infections among the residents, making sure there are back-up plans, when workers -- a number of the workers are getting ill themselves. And so looking to see, okay, this physician or clinician, nurse practitioners not available, who will back that person up?

Making sure that certain basic infection control practices are followed, such as handwashing and putting on and removing the protective equipment correctly. And it's not a matter - at this point, when I'm talking about is not a matter of whether it's available but how it's being used when it is available and those are some of the things that we've picked up by observation and actually being into the nursing homes.

And for the most part the nursing homes are very appreciative when we say, you know, this is the way that this needs to be done. We also have a number about how you improve your organizations, providing technical assistance and support, and making sure that they have the latest information themselves.

We're also seeing a number of very good practices as well as innovative techniques on how to connect family members with their loved ones. We have authorized the use of certain funding that's available, several monetary (penalties) funding that the states have so the states can purchase equipment for virtual visits such as an (iPad) or a laptop or whatever might be necessary to be able to connect the resident with their loved ones and so that's what's going for (nursing homes) are being creative regarding their social distancing policy. Wherein we discourage certain activities like - I was just talking to a nursing home last week, they've implemented what they call a six-foot bingo. And other kinds of things where they're keeping the residents (apart) but also allowing them to be able to do the things that they find most enjoyable.

And our - since we've started this we've done over 6800 surveys since March 1. And those then have not been surveyed as (I said) we have provided this self-assessment tool so that they can go ahead and make sure that they have what they need.

We - beginning in April we issued a call to action for states and nursing home

leaders to really work together to ensure that PPE and testing is prioritized for nursing homes. I know we - you know, we have to take care of the hospitals and front-line workers and the first responders but we also have to make sure that there is equipment as the state is making their decisions for the nursing homes and so that the call to action was issued.

And then testing has been a focal point especially with the nursing homes. Testing should be done proactively so that we can continue to find information about what is occurring and we announced that we nearly doubled the payment for certain lab tests, for Medicare, when with the use of certain (how we put technology) so they can rapidly diagnose the virus. And in addition to expanding assets and diagnostic testing we have expedited some of the paperwork and the clearances that are needed so that testing can be done and we also implemented a change to the payment rules that will actually allow a lab to go into the nursing home to select the sample and be paid for that. That is all in our prioritization of testing.

Recently we issued regulations that required nursing homes to report COVID-19 infections and deaths to CDC on a weekly basis. This was very important for transparency. And now it's required to report to their state and local health departments that there was no national employee (death life) required.

So what wanted to do was to increase transparency in the nursing home by requiring facilities to also inform residents, family, and their representatives of potential or confirmed COVID-19 cases.

So if you are working with (sensitive persons) and your families and what we heard and I'm sure you did as well it's we don't even know, we're not sure what's going on, we don't know if they have COVID cases or not. This requirement was intended to address that. Now I will say that the reporting

just started this past week. Each state generally does or does have is now generally each patient has this information so it should be available to families to find this out. However, with this national reporting system all the states started to report - or nursing homes this week so it will be probably another couple of weeks to get the data in and then our plan is to publicly report that so you will have that information available and we will try and get the word out as best we can to families and beneficiaries that this is available as well and know that you will - and hope that you will help (assisted) with that.

So we've - so we've done a lot - I've gone through a lot of what we've already done but every day we continue to ask ourselves what else can be done to keep residents in nursing homes healthy and safe and its - the question that we have - what we said is we want to not only ask ourselves but we want to ask our stakeholders as well. And so, I'm happy to have this opportunity to talk with you today and I'm going to stop in a minute so I can get any questions or also solutions or anything that you might have, but I did want to mention that we established a new independent coronavirus commission for safety and quality in nursing homes. It was announced by the president at the end of April and this commission will conduct a comprehensive assessment of nursing homes responses to COVID-19. It will also look at our response and, you know, help us come up with a plan for data analysis going forward in future responses and so I think that being - the application process or nomination process I believe is being released this afternoon or tomorrow for those who have an interest in that.

And also as a part of skilled nursing care week we are pleased - we unveiled today, a brand new resource, it's a tool kit on what states are actually doing to mitigate COVID-19. Kind of some of the best practices. We surveyed every - looked at what every state is doing. We've developed this toolkit in the nursing home and we're sharing it with the state, because they're looking for

answers and so now they have the tools if they can look to see, okay, over here this state, you know, Massachusetts is doing this and Indiana's doing this, and California's doing this and they can look to see and learn from each other. And that already is very popular. We mentioned that it was going to be available and we've already gotten several requests. It will be on our website.

So, that I think - we've noted. I spent a lot of time talking about nursing homes. I just want to spend one more minute saying that we also hear from home health agencies, hospice, and other settings. We conduct provider calls every week and that people just call in and ask questions and share what they're doing and one of the things that we've heard consistently on hospice and home health calls is that we understand that families are often fearful to allow home health workers to enter and that's certainly understandable, and it certainly is their right. It is important, however, that families have conversations with their healthcare workers to ease their minds when it is important for them to have a face to face visit. Many - most disease workers have been trained and screened prior to entering the home and they can also go use telehealth services from - on the basis of the many waivers that we've offered.

We also hear that the beneficiaries are fearful to seek necessary care (in regards to the emergency) department. There was one home health agency that reported that a beneficiary experienced a heart attack and expired because they were afraid to go to the emergency department because they were afraid that they were going to get COVID. But the alternative was they lost their life.

So we encourage beneficiaries to seek help. Call. You know, do whatever they need to help them make the best decision they can for themselves and their family members. So we understand that lots of work remains and we're committed to continue to work with you, the state, and local leaders, as well

as nursing homes to provide the best quality care that we can for our I think our most vulnerable and precious persons in the nursing homes.

So let me stop and take any questions.

(Susie Butler): Jean, thank you so much. Very important work. (Robin), can you open up the line for questions please?

Coordinator: Yes, thank you. At this time, to ask a question, please press star followed by number 1. And again, that's star followed by number 1, unmute your line and record your name clearly as prompted.

One moment for the first question.

(Caroline Rick) your line's open. You may ask your question.

(Caroline Rick): Hi, this (unintelligible) and I'm with (Colorado SHIP), my question is I've been reading recently, I know a vaccine is a long ways off yet, I've been reading about the ethical and moral dilemmas about who should receive a vaccine first, and my thing is I would just really like to encourage CMC - CMS to strongly advocate for healthcare workers in nursing homes to be able to receive vaccines right away. That's it.

(Jean Moody-Williams): Okay. Thank you for that comment. And it is important as many of you - you know, we've stopped visitations but in many cases the virus still continues to get transmitted and so we want to protect our workers as well as our residents so thank you for that comment.

(Susie Butler): Any other questions?

Coordinator: At this time just a reminder to touch star followed by one, unmute your line, and record your name clearly as prompted.

I'm sorry no further questions.

(Susie Butler): Right.

(Jean Moody-Williams): Great. So if you're - you know, have any ideas or anything that you would like for us to consider such as the last commenter, (Susie) will again share how you can do that and I thank you all so much for all that you do as well on a daily basis. Thank you.

(Susie Butler): Thank you, Jean. And thanks for all you're doing and she's off to another call. So thank you so much.

Now it's my pleasure to introduce (Emily Yoder). (Emily)?

(Emily Yoder): Thank you, (Susie). Good afternoon everyone. I'm an analyst in the Center for Medicare and I work on Medicare Telehealth. I'm going to provide a summary of many of the changes to CMS policies around Medicare Telehealth and other virtual services both through the 11-35 waivers and through other regulatory actions.

So starting with Medicare Telehealth since that's where the majority of the really big changes have been - just a quick bit of background. I'm sure you're all familiar with the - sort of restrictions around Medicare Telehealth that sort of were existing prior to (PHC).

So current - so I'm going to run through them just in case. So current

telehealth law only allows Medicare to pay for telehealth services in specific circumstances. Most significantly only beneficiaries in rural areas are eligible for telehealth services and the beneficiary must be in a medical facility, so not in their home. The statutes also limit the types of practitioners who can furnish telehealth services and stipulate that the technology used to furnish these services must be two-way audio and video.

So using the 11-35 waiver authorities that were granted through the (Family First Coronavirus Preparedness Act) and the (CARES Act) we were able to first temporarily eliminate the requirements that the originating site must be a healthcare facility and we able to allow Medicare to pay for telehealth services when the beneficiaries are in their home.

We were also able to allow telehealth services to be furnished to beneficiaries in non-rural areas. We've also waived the restrictions on practitioner types, and are now allowing audio only technology for a subset of telehealth services. And these include counseling and educational services.

We have also undertook two sets of (interim final rule making) so that's as many of the remaining regulatory hurdles as possible. So in the first (interim final rule), we added a number of services to the telehealth list, including initial in-patient and nursing facility visits, emergency department visits, initial and subsequent observation services, in patient nursing facility and discharge management services, home visits, and a number of therapy services such physical therapy, occupational therapy, and (speech language pathology) services.

With the second - and that was - both changes are all retroactive to March 1. And that (interim final rule) was published on March 31, I believe. With the second interim final rule that was published on April 30, we removed the

requirement that were undertake notice and comment rulemaking to add services to the Medicare Telehealth use list.

So what this means is we now have the ability to update the list on a rolling basis as we receive additional requests from the public. We also modified our requirements for billing Medicare Telehealth services. Rather than putting patient service 02 on the claim to identify the services as Medicare Telehealth, we're now instructing practitioners to put whatever place of service they would have used had this service occurred in person and to (access the 95 modifier to the claim) to identify it as Medicare Telehealth.

So for example if a physician furnishes a telehealth visit that, outside of the (PHC), would have occurred in an office, than she would put (place of service code 11) and than the (95 modifier) on the claim.

We also eliminated frequency limitations. So for certain telehealth services we had limitations on how frequently the visits can be furnished via Medicare telehealth and the idea there was that we wanted to be sure that beneficiaries were getting in-person care - the in-person care that they needed and that they weren't having all of their visits being conducted remotely. So for nursing facility visits there was a limitation that a beneficiary could only receive a nursing facility visit by telehealth once every 30 days or in patient services it was only one telehealth visit per three days, and for critical care consults the limitation was one critical care consult per beneficiary per day.

Out of the circumstances of the (PHC) we felt that the need to reduce sort of exposure to COVID-19 outweighed the concerns about sort of access to in-person care and so we waived all of those frequency limitations.

Moving on to the telephone evaluation management or (assessment

management services) this is a set of six codes. Three for practitioners who can separately report (E&M) and three for practitioners who cannot. And we had long considered these services non-covered under the (PSS). So in the (first interim final rule) for purposes of the (PHC), we changed these codes from non-covered to covered and began making separate payments.

We are also electing not to enforce the requirement that is in the code descriptor that these services only be furnished to established patients so that new patients can get the assistance as well.

After that rule went out we began hearing from the stakeholder community that these codes were being used particularly the ones for practitioners who can bill independently for (E&M) and as a reminder those are sort of physicians and certain other non-physician practitioners, but they were really being used as stand-ins for evaluation and management visits when beneficiaries did not have access to or did not want to use the two-way audio video telecommunications technology that stipulated in the statute. And as such the payment rates were not really accounting for the actual resource costs associated with furnishing those types of visits. Therefore, in the second interim final rule we increased since the payment rates these codes, and do you have to do - in order to this we had to do a bit of a legal workaround so we added these services to the Medicare telehealth list, and then waived the audio-only requirement for these audio-only telephone evaluation and management visits.

And the reason why we did that is it's a little confusing and folks have been saying that in particular when we first began making separate payment for this codes we did not - for these codes they were not considered telehealth and so did not require the 95 modifier.

And now we're saying, "No way. They are telehealth and so they do require the 95 modifier on the claim." The reason there is that our sort of legal counsel very rightly pointed out that we can't both say that these services are not telehealth services while saying that we're going to pay them the same as the office outpatient payments that were - that are already on the telehealth list and so that's why we had to add them to the telehealth list.

So moving on to our communications technology-based services - so these are services that utilize communication technologies but don't have all the restrictions or the higher payment rates as Medicare telehealth.

So for these services we removed the requirement that they be furnished to establish patients. We expanded the practitioners eligible to bill for these services from practitioners who could independently bill for E&M to practitioners both who can and cannot bill independently for E&M so that, for example, licensed clinical social workers, clinical psychologists and therapists could bill for these services when applicable.

We also revised our definition of direct supervision to allow for the duration of the (PHC) that direct supervision can be provided using real-time interactive audio and video technology, and this is based on the clinical judgment of the practitioner.

For our remote patient monitoring services, we removed the requirement that there be an established patient-practitioner relationship. We modified the requirement that consent be obtained prior to furnishing the RPM service and we clarified that the RPM service can be furnished to patients with chronic and/or acute illnesses, and we confirmed that RPM treatment or managed services can be furnished under general supervision.

We are also allowing RPM monitoring services to be reported to Medicare for periods of time that are fewer than 16 days of the 30 days specified by the code descriptive but no less than 2 days as long as the other requirements for billing the code are met.

For the office outpatient evaluation and management visits, when these are furnished via Medicare telehealth we are adopting the framework that we finalized sort of independently through the normal PFF rule - Physician Fee Federal rulemaking process for 2021 that medical decision-making or times may be used for purposes of code level selection and that the history and exam could be conducted as clinically necessary.

And so finally, for hospitals under the hospital (unintelligible) initiative, if the beneficiary's home is classified as a provider-based department then the hospital can bill for certain virtual services including some telehealth services when provided by clinical staff of the hospitals. So with that I am happy to take questions. Thank you.

(Susie Butler): (Emily) thank you so much. I believe (Robin) we're ready to open it up again.

Coordinator: And thank you. At this time to ask a question you may press star followed by 1, unmute your line and record your name clearly as prompted. We'll be standing by for questions. And one moment for the first question. Chris Herman your line's open. You may ask your questions.

Chris Herman: Thank you. This is Chris Herman with the National Association of Social Workers. Thank you for your presentation and for the flexibilities that have been granted to clinical social workers and healthcare providers of all types in various settings.

The question is about whether the recent flexibilities extended to PTs, OTs and speech-language pathologists - enabling them to use telehealth would apply to services they provide in home health settings, because the information is pretty broad in the press release and the additional backgrounds.

But when I look at information more specifically and the physicians and other practitioners, information (unintelligible) that you have with more detail and reference as part of the Social Security Act and the Code of Federal Regulations that are specific to Part B independent providers.

(Emily Yoder): Thank you. That's a really good question and one that we've actually been getting a lot particularly through the COVID-19 office hours that are every Tuesday and Thursdays from 5:00 to 6:00 Eastern Time.

So with the huge caveat that I am not a home health expert I believe that while currently they cannot bill for those types of services when furnished by therapists in their employ - but I believe there's some forthcoming guidance that will provide more clarification and perhaps a little bit more flexibility there. So I guess what I would say is just sort of stay tuned and hopefully we'll have some more information soon.

Chris Herman: Thank you very much.

Coordinator: And thank you. As - again as a reminder to press star followed by 1 to (unintelligible) questions. That is star followed by 1. One moment. Rhoda Slagle your line's open. You may ask your questions.

Rhoda Slagle: Thank you. This is Rhoda Slagle with Northern California HICAP. I just wonder if you're aware of the willingness of providers to use these telehealth -

these expanded telehealth benefits and/or the awareness of beneficiaries to request and access these expanded services.

(Emily Yoder): Yes. So I think that we certainly have been trying to make these flexibilities known to practitioners as much as we can, and we've also said that practitioners are welcome to in short educate the beneficiaries on the availability of these services as applicable. I'm not really a communications person. I don't know (Susie) if you have anything you would like to add.

(Susie Butler): It's an interesting question. I don't know that we have the staff on this but I appreciate the question and we'll see what we can find out.

Rhoda Slagle: Thank you.

(Susie Butler): I will add that we have been encouraging telehealth and encouraging organizations to share about telehealth and telemedicine so that beneficiaries feel comfortable in talking to their care provider over the phone. (Robin) I'll turn it back to you.

Coordinator: Thank you. We have a question from Chris Herman. Ma'am go ahead.

Chris Herman: Thank you. I have a follow-up question. Recognizing that home health isn't your specialty area do you have any sense of whether social workers and social work assistants in home health might be included in the forthcoming clarification on flexibility? If not would you be able to pass on the request for them to be included?

(Emily Yoder): I am happy to pass along that request. I don't want to speak without sort of - given my lack of familiarity with the area (unintelligible) very, very high level I wouldn't want to misspeak so I'm happy to pass that along if you would like.

Chris Herman: Thank you again.

Coordinator: Once again with further questions that's star followed by number 1. Showing no further questions.

(Susie Butler): Thanks (Robin). I want to thank everyone for presenting. (Emily) thanks for your presentation. This is really interesting information and very current and I know that others will be interested in this as we move forward.

This concludes today's meeting. We appreciate you joining us today and we hope that the information that we've presented has been helpful to you. We're interested in learning more about the topics you would like to hear on future NMEP meetings so please free - feel free to email your suggestions or any additional questions that you didn't get a chance to ask today but maybe you thought of them later.

Mail those questions to our partnership mailbox that's found at the bottom of the agenda or we'll give it to you now. It's partnership@cms.hhs.gov G-O-V. We look forward to hearing from you and meeting you again probably over the airwaves in about three months. Take care and be safe.

End