



CMS COVID-19 Update Call

Moderated by: Nicole Cooney
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Announcements & Introduction

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Presentation

Nicole Cooney: Good afternoon, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'll be your moderator today. I'd like to welcome you to this Medicare Learning Network COVID-19 Call.

During today's session, CMS experts provide updates on recent actions taken to address the COVID-19 public health emergency. At the end of the presentation, we'll open the lines for a question-and-answer session.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL – go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the question-and-answer session. If you have inquiries, please contact press@cms.hhs.gov. At this time, it's my great pleasure to introduce Kim Brandt, who is the Principal Deputy Administrator for Operations here at CMS. Kim?

COVID-19 Response

Kimberly Brandt: Thanks so much, Nicole. And good afternoon everyone. I just want to start by saying thank you to all of you who are out there on the front lines helping to help address this crisis by treating patients, working with patients and really just doing everything you can in the health care field to really help us take a wide approach to combating this pandemic. We are very appreciative of your efforts.

And at CMS, we have been very focused on making sure that we are doing all we can within our existing regulatory flexibility to help all of you have the tools you need to be able to contain its spread and to really be able to treat those patients who have already been impacted.

So, with that, let's go ahead and jump right in. My goal today is to give you an overview of our waiver process. This is how it is that we can actually exercise some of those flexibilities. And we really wanted to you all to understand exactly what that process is and how it works.

So, let's start with slide number 2 if you turn to your deck. First of all, let me give just a little bit of a general overview of what we've been doing here. As I mentioned, as part of our role to responding to COVID-19, CMS has really been taking a lot of proactive steps using our waiver authority, which we are given under Section 1135 of the Social Security Act, as well as, where applicable, authority granted to us under Section 1812f of the same Act.



These waivers allow us to really be able to waive certain conditions of participation for our program, reporting requirements, and also enforcement actions where it's deemed appropriate. And that allows us to be able to give you all the flexibility you need to be able to focus on what you need to, which is taking care of patients.

In order for us to do these waivers and to exercise this authority, there are two requirements that must be met. The first is that there has to be a presidential declaration of disaster or an emergency under the Stafford Act or the National Emergencies Act. In this case, that occurred on March 13 of this year when President Trump declared that, as part of the COVID-19 effort, a national emergency exists nationwide because of the widespread nature of the pandemic.

The second part is that the HHS Secretary must declare a Public Health Emergency under Section 319 of the Public Health Services Act. That occurred on January 31 of this year when Secretary Azar of the Department of Health and Human Services declared a nationwide public health emergency which was retroactive back to January 27, 2020. So, on March 13, when the President declared the national emergency under the Stafford Act, that allowed us to go ahead and start moving forward with our flexibility under these waivers.

We have been in constant contact at CMS with our state health official and health care provider and supplier partners throughout this pandemic thus far. Part of that is to get a full understanding about new needs across all settings, and also to keep all of them updated on the process by which they can request additional support. We heard from many of them and we've had continuously stakeholder calls and other outreach efforts to try and keep that dialogue going.

We are also working to make sure that every stakeholder in the system is fully informed on what is required and what is recommended based on the latest information from the CDC, in terms of health guidelines, and from us, in terms of regulatory flexibility. Thus far, we have put out guidance for Nursing Homes, Hospitals, Home Health, Hospice, and more. And we are going to continue to do everything in our power to make the health care system run as smoothly as possible by keeping that dialogue going with all of you.

What is an 1135 Waiver?

So, now, let's turn to slide 3 and talk a little bit more about exactly what is an 1135 waiver. An 1135 waiver allows HHS to waive various administrative requirements to increase access to medical services during a time of National Emergency. What's necessary is that these waivers ensure that sufficient health care items and services are available to meet the needs of Medicare, Medicaid, and Children's Health Insurance Program beneficiaries, and also that health care providers can provide such services in good faith, and those that do can be reimbursed for them and not be subjected to sanctions for noncompliance absent any findings of fraud and abuse.

When can 1135 Waivers be issued?

On page – slide 4, this will talk a little bit about when these waivers can be issued. There are two requirements, as I talked about, for the waivers to be issued. It's the presidential declaration and the HHS Secretary declaring the public health emergency.



Scope of 1135 Waivers

Then, on slide 5, let's talk about the scope of the waivers. These waivers apply to federal requirements only. It does not apply to any of those requirements that are established by states. And they begin as of the effective date of declared emergency.

In this instance, the emergency was declared on March 13. But the decision was made because of the fact that the pandemic started even earlier that they would be retroactively effective as of March 1, 2020. These waivers end no later than the termination of the emergency period or whenever it is that the President declares the emergency period to be over, or 60 days from the date that the waiver is published, unless the HHS Secretary extends the waiver by notice for an additional period of up to 60 days.

So, in practical terms, that means that at whatever point the president declares the national emergency is over is technically the end date for these waivers, unless the HHS Secretary decides to extend that period by an additional 60 days to allow little more time for health care providers to be able to do what they need to, to deal with some of the aftermath of the pandemic.

What don't 1135 Waivers do?

Turning to slide 6, we will talk a little bit about what 1135 waivers do not do. They do not provide grants or financial assistance. They do not allow reimbursement for services that otherwise would not be covered. They do not allow individuals to be eligible for Medicare who otherwise would not be eligible. And they do not last past the duration of the emergency period. All of these flexibilities are very extraordinary, but they will only last for as long as the emergency does.

They also should not impact any response decisions such as things like evacuations at the local level. Furthermore, the 1135 waivers cannot waive requirements that are in statute or regulation. We can only waive things, as I mentioned before, that are within our control such as conditions of participation, reporting deadlines, or enforcement actions.

So, now, let's talk a little bit more about what are the types of 1135 waivers. There are two types of these waivers. One is blanket waivers and the others are provider and supplier individual waivers.

The blanket waivers are ones that basically are implemented when we determine that a whole set of similarly situated providers in the emergency – which, in this case, is the whole country – need a similar waiver or modification when they – at which time they apply automatically to all applicable providers and suppliers.

So, the minute we issue a blanket waiver, it would apply to everyone that is similarly situated. In this case, it will be everyone in the entire country. So, when we issue blanket waivers for a hospital or a hospice or a home health or any of our other providers types, those are applicable to all of those providers across the entire country.

Second, we have individual waivers which can be issued for states, providers, or suppliers. They're only necessary for those items that are beyond what is provided underneath an existing blanket waiver. So, it could



be something that is unique to a particular geographic region, or it might be applicable to only a particular type of supplier or provider that might not be something that everybody needs across the country in that area.

To be able to see more information on the waivers themselves as well as a full list of the blanket waivers that have been approved to date, all of which, as I mentioned, are retroactive effective to March 1, 2020 through the end of the national emergency period. We've got various Web links on the sites that you can go to. And you can also go to our CMS Emergencies webpage, which is www.cms.gov/emergency.

Already Issued Blanket Waivers

Turning now to slide 8, let's talk a little bit about some of the different waivers and regulatory flexibilities that we have announced that are very specific to the COVID-19 crisis. On March 13 when the president declared the national emergency, CMS announced that we automatically were taking certain waiver actions and regulatory flexibilities to help health care providers and states respond to and contain the spread of COVID-19.

We have certain automatic statutory blanket waiver authority and other key administrative actions that we can take, and we were able to exercise those immediately. Some of those include waivers and flexibilities for hospitals and other health care facilities such as Skilled Nursing Facilities, Critical Access Hospitals, Acute Care Hospitals, Inpatient Psychiatric Services, Inpatient Rehabilitation Services, Long-Term Care Acute Hospitals, Home Health Agencies and Hospice.

We also have a lot of flexibility under the waivers to be able to waive certain things related to provider enrollment and practice flexibility, such as allowing people to practice across state lines if they are an enrolled Medicare provider with good state licensure. We also can suspend a lot of our enforcement activities such as going after people for failure to report, or other cases of things that are related to reporting or bureaucratic requirements that do not rise to a fraud and abuse level.

We also exercised this to greatly expand our telehealth capabilities, waived a number of our signature requirements, particularly for Part B and Part D drugs and other types of durable medical equipment. And we also issued financial relief for Medicare providers with accelerated and advanced payment.

Again, all of the details for the blanket waivers can be found on the cms.gov/emergency page I mentioned earlier. And you can also find information about all of these other actions including the advanced payments on those pages as well.

Flexibility and Relief for State Medicaid Agencies

Turning now to slide 9, let's talk a little bit about what the flexibility and relief have been for state Medicaid agencies. So, states and territories can seek Section 1135 waiver relief and flexibilities for a variety of Medicaid program requirements. Specifically, we can allow them to have providers located out of the state or territory to provide care to another state's Medicaid enrollees impacted by the emergency, as much as I mentioned we could do in Medicare.

We also can temporarily suspend certain provider enrollment and revalidation requirements to increase access to care, which is really critical when you need to have additional providers come in and help in a particularly



hard-hit area. As of April 7, CMS has approved 46 state waivers under Section 1135 and 21 state requests to invoke emergency flexibilities in their programs that care for the elderly and people with disabilities in their homes and communities.

CMS has also posted guidance to states on how to apply for Section 1135 waivers through the Medicaid Disaster Response Toolkit. One of the things that we have done is develop a new set of comprehensive checklists and tools for state Medicaid and CHIP programs to make it easier for them to receive federal waivers and implement flexibilities in their programs. Additionally, we have launched a dedicated [medicaid.gov](https://www.medicicaid.gov) COVID-19 resource page that will be continually updated with relevant information, similar to the [cms.gov](https://www.cms.gov) emergency page which has a lot of the Medicare information.

Special Waivers

So, turning to slide 10, let's talk a little bit about some of the special types of waivers. There are two that are really unique that I wanted to highlight. The first is the EMTALA or Emergency Medical Treatment and Labor Act waiver. There are only two aspects of the EMTALA requirements that can be waived under 1135 waiver authority.

The first is the transfer of an individual who has not been stabilized if the transfer arises out of an emergency. The second is redirection to another location such as an offsite alternate screening location to receive a medical screening exam under a state emergency preparedness or pandemic plan.

For the duration of the COVID-19 emergency, CMS is waiving the enforcement of Section 1867a of the Social Security Act for EMTALA to allow for screening at a location offsite from the hospital campus. It is not waiving the transfer portion. That will still require an individual request if people want to do that.

But, to be able to allow hospitals, psychiatric hospitals, and critical access hospitals to be able to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, we are waiving the part about redirection to another location. This will allow hospitals and other facilities to be able to do things like screen patients in parking lots or other offsite locations and, thus, keep them away from the emergency room where they might infect others or pick up an infection.

The second area of special waiver where we have given some unprecedented authority actually has been with respect to the Physician Self-Referral Law or otherwise known as the Stark Law. Typically, we have issued individual types of waivers under this in past types of emergencies.

However, for the first time ever, because of the nationwide nature of this particular pandemic, CMS has issued blanket waivers of sanctions under the Physician Self-Referral Law. The blanket waivers may now be used without notifying CMS. In the past, it did require individual notification.

Unlike the other waiver requests that I've talked about, any request for individual waivers of sanctions under the Physician Self-Referral Law that are related to COVID-19 and are not covered by the blanket waivers that we have issued will be handled by our technical staff in the CMS Baltimore office.



There is information on the slide about how you can go ahead and submit those requests and some information about what you should include. But I encourage you to really take a look at that if you think you have something that's not covered by the blanket waiver.

Is your need covered by a Blanket Waiver?

So, with that, let's turn to slide 11, and we will sort of talk about is your need covered by a blanket waiver. So, if you have needs for a relief that already falls under an existing blanket waiver, again, which – you can find the whole list of them, of which there are 66-plus and counting, on our website – if you see that it is not covered by one of those, you do not have to – if you – you do not have to notify CMS if you are taking action in accordance with the waiver during the time period for the waiver is valid.

So, in other words, if you've got a need and it's covered by one of those 66 waivers, you do not need to notify us. You can just go ahead and start using it. You do not need to make a request for a blanket waiver that has already been issued. So, that means that you have a wide degree of flexibility using the new range of flexibilities that we issued last week with the 66-plus blanket waivers.

Who needs 1135 Waivers?

So, turning to slide 12, let's talk about who actually needs the 1135 waivers. The waivers can be issued to any entity or individual provider, health system or facility, for whom Medicare requirements are posing issues or challenges for health care delivery. Any of those people can apply for a specific waiver for an accommodation. Any state can apply for a Medicaid or CHIP waiver.

And, in short, if CMS regulations are impeding your ability to respond to or recover from something related to this emergency, you may need a waiver. But, first, check and see whether or not there is a blanket waiver which already may impact your needs and already cover what it is that you are trying to do. And we are continuing to issue new ones of those and updating that list on a regular basis.

Waiver Authority and Review Process

So, now, let's talk a little bit about the authority and the process for these waivers on slide 13. So, as we consider issuing waivers, the considerations that we use are, one, number – it's the scope and severity of the event with a specific focus on health care delivery. This is an unprecedented event. And, so, as a result, we are issuing more waivers and flexibilities than we ever have before.

We also want to look at whether there are unmet needs for a health care provider. That's part of the reason that we are doing so many blanket waivers right now, but also why we need you to tell us if there are things that you are seeing that are unmet needs where we should think about issuing waivers. And, lastly, if these unmet needs need to be resolved, or something that we can't do within our current regulatory authority, let us know, because that's something that would trigger whether or not we would then issue a waiver.

During the waiver review process, the questions our team works through include things like is this something that is appropriate for this particular type of emergency. Because this is nationwide in scope, it's a little broader than it normally would be. Is there an actual need?



Is this something that's unique to just one type of provider or just one area that maybe wouldn't be as widespread, or is it much broader? Can this be resolved within our current regulations? In a lot of instances, the answer is yes. But, in the cases where it's no, that's when we would consider it.

We also are looking at is this something that would be necessary to have for the whole duration of this emergency, or is it a short-term sort of need? Will the regulatory relief requested actually address the stated needed? And, then, should we consider it as an individual or a blanket waiver?

How to Request an 1135 Waiver

So, if you do find that you have a need for a waiver, the way to request it is on slide 14. In that case, you can submit your request to the following email address – 1135waiver@cms.hhs.gov. It then asks you to include all of the appropriate information such as your full name, phone number, email address, where you are applying from – in other words, your state or territory – the 1135 flexibility that you are requesting and, where applicable, the type of provider that they would apply to.

Waiver Review Inputs

And, then, on slide 15, the waiver review stakeholders are sort of the primary parties or the relevant people that will look at this. We look at it as far as – as an individual facility, a provider community, a state emergency staff and licensure law, and HHS Regional Emergency Coordinator. These are the parties who help us to kind of make the decision as to whether or not these waivers would indeed be appropriate.

Also, you can combine waiver requests across multiple groups. We have had multiple associations, multiple states grouping together, multiple types of providers grouping together to request waivers. So, please feel free to join together if you see something that cuts across multiple types of needs.

Waiver Request Status

Then, on slide 16, we will take waiver requests from all of these groups, and we monitor the intake to determine whether or not we need a blanket waiver. As I said, we issued a huge group of them last week in addition to the standard ones that we have under statute. But we will continue to update them as we see additional needs, maybe related to workforce issues or particular flexibilities with relation to telehealth and some of our new things. And, so, we'll take all of those into account.

Expectations of Waived Providers

And, then, on slide 17, our expectations of the waived providers as are follows. We expect that anyone requesting a waiver of flexibility will provide sufficient information to justify their actual need. Thus far, we have seen very good justifications. People want to do particular types of setups or certain types of care coordination, and they need waivers to be able to do that to really best fit the need of this particular epidemic.

Also, once the requirement has been waived, providers and suppliers will be required to keep careful record of the beneficiaries to whom they provide services in order to ensure that proper payment have been made. And, lastly, providers must return to normal operations and resume compliance with normal rules and regulations as



soon as they are able to do so, once the national emergency is declared ended and once the waiver authorities recede.

So, with that, giving an email address at the end as well as a phone number. And, then, we also have a special COVID email which I wanted to point out which is not on here. It's covid-19@cms.hhs.gov. And you should feel free to send questions of general nature to that email address. And, again, if you have a specific waiver issue, send them to the waiver email box, which is 1135waiver@cms.hhs.gov. And, with that, I will hand it back over to Nicole.

Question & Answer Session

Nicole Cooney: Thank you so much, Kim. Before we get started on the Q&A, I just wanted to set a few ground rules – ground rules for today's session. We are happy to have a large number of participants on today's call, and we'd like to take as many questions as we can.

When we open your line to ask a question, please be respectful of everyone on the line with us today and limit your question to just one. Additionally, I'll be monitoring the time that we spend on each question and answer so we can hear from as many people as possible today. As a reminder, today's session is being recorded and transcribed.

Okay, Dorothy, we are ready for our first caller.

Operator: To ask a question, press "star" followed by the number 1 on your touch-tone phone. To remove yourself from the queue, press the "pound" key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization.

Please note, your line will remain open during the time you are asking your question, so anything you say, or any background noise, will be heard in the conference. If you have more than one question, press "star," 1 to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster. Your first question comes from the line of Ronald Hersch.

Ronald Hersch: Hi. In the Families First Notice that came out this morning, it says that there is no cost sharing not only for the COVID test itself, but also on visits or facility fees where the test is either done or considered, and that we should use the CS modifier. I just want to make it clear. Does that mean CMS will be paying 100 percent of the allowed amount, or is this like what you are doing with all telehealth visits where you pay 80 percent and the provider is allowed to waive the 20 percent?

Kimberly Brandt: Do we have a person from CM on the line who maybe can address that? If not, we might need to get back to you on that, Ronald. So, if you can ...

Ronald Hersch: Okay.



Kimberly Brandt: The email address that I gave – you can send an email on that. Sorry we are still working through implementation of a lot of these. So, just shoot us an email and we will inaudible your questions as we can.

Ronald Hersch: Do I get to ask a question – can I ask a question you could answer?

Kimberly Brandt: Sure.

Ronald Hersch: If a hospital inaudible hallway talking to a patient and there's patients in the room on FaceTime, is that considered a telehealth visit, or is that an in-person visit?

Kimberly Brandt: Ryan, do you know the answer to that?

Ryan Howe: Yes, I do. So, for that one – so, telehealth wouldn't apply if the patient and the practitioner are in the same location. So, the short answer is that that shouldn't be billed as a telehealth service. But, that can certainly be billed as long as the – as long as the service can be done that way from the clinical perspective, then that would – that could be billed without the use of the telehealth modifier.

Ronald Hersch: Thank you.

Kimberly Brandt: Thanks, Ryan.

Operator: Your next question comes from Mark Hartstein.

Mark Hartstein: Thank you. Hey, Kim. Nice to hear your voice. A question about temporary expansion states. In the Hospitals Without Walls Provision, it allows for temporary expansion for a hospital to add that. Does a hospital need to – an existing hospital that's already enrolled and is furnishing services that adds temporary beds in one of these temporary expansion sites to have to modify its enrollment to apply for those additional beds that are intended to be temporary?

Kimberly Brandt: So, I don't know that we have anyone from CPI on the line on the enrollment side or if anybody from CCSQ wants to weigh in. But, I know in general what we've been trying to do is to have it so that when there is an expansion that people can go under their existing enrollment and not have to do any new enrollment except for where we really feel that it's a whole new type of facility. But, again, I will – I will let anybody else on the line weigh in on that if they have other thoughts.

Jean Moody-Williams: Yes. I think ...

David Wright: Yes.

Jean Moody-Williams: Go ahead.

David Wright: Go ahead.

Jean Moody-Williams: You go ahead.



David Wright: I'm just going to say – sorry. I was just going to say, Kim, that – and hey, Mark – that we are allowing for hospitals to extend their bed capacity. They just need to contact – they – that can be done automatically. So, they can increase the number of certified beds. They have to account for any that might be in a temporary expansion area. And as Kim pointed out, they don't have to do a new certification or enrollment for those.

Mark Hartstein: Thank you, David.

Kimberly Brandt: Thanks, Mark.

Operator: Your next question comes from the line of Patrician Ren.

Patrician Ren: Hi. Good afternoon. I was wondering – is there a website or a location on the CMS website that would allow me to find all of the waivers that have been issued?

Kimberly Brandt: Yes. If you go to the [cms.gov/emergency](https://www.cms.gov/emergency) page, there is a link to waivers on there. And, then, we also have – you will also see a link to a Waivers and Flexibility page. And they will give you a link to all the waivers that have been issued as of last Monday.

Patrician Ren: Perfect. Thank you.

Operator: Your next question comes from the line of Elizabeth Buckley.

Elizabeth Buckley: Hello. My question is – hopefully, a short – two short questions. The first question is are we allowed as a health system to apply for a waiver that applies to each agency in our system, which would include agencies in 11 different states, or do we have to apply state by state?

Kimberly Brandt: So, in general – and I'll let others jump in on this as well. But, in general, if you are with a system, and particularly because of the way that this has been working, we have tried to allow for a system – for the system as a whole so you wouldn't necessarily go state by state.

But, again, it depends on what you are asking for and the type of waiver you are requesting. So, we'd need to consider that when looking at your request. But we have been trying where are systems in, particularly because this is a national emergency, to make them as broadly applicable as possible. But, again, it depends to a certain extent on what you are asking to have waived.

Elizabeth Buckley: Okay. And just approximately, what's the turnaround time from the time it's received in your department from the time we know it's applicable.

Kimberly Brandt: We've been trying to get to them as quickly as possible. I don't have an exact turnaround for you. But we've really been trying to get back to them within a short a time period as possible.

Jean Moody-Williams: Yes, Kim. And this is Jean. And I'll just add to that. As Kim said, we try to look at if you send it in to see if it would be one that we could even issue as a blanket thing. But, the important thing in what



you just said is that you would still have to look to see what's different at each one of those states, of course, because we don't waive the state. We only waive the federal.

Elizabeth Buckley: Okay. Thank you.

Kimberly Brandt: Great point, Jean. Thank you.

Operator: Your next question comes from the line of Heather Hoke.

Heather Hoke: Hi. I'm just wondering – we bill for a teaching facility in which we have residents seeing patients. They are discussing the case with their teaching provider. But, the teaching provider, due to limited PPE, is not examining the patient. With this situation, do these qualify to be billed since the discussion is happening? We just cannot get an exam. The resident is examining them, but the teaching doctor is not.

Kimberly Brandt: Do we have anyone on the line that can answer that one?

Ryan Howe: Yes. Hi, Kim. Ryan again. So, under the interim final rule that we issued last week, the teaching physician supervision of the – of the services personally provided by the resident can happen via virtual communication technology. So, as long as there is the capacity for audio, video supervision.

Heather Hoke: Okay. Yes. And this is situation where the physician may be overseeing numerous residents and that resident will come out and discuss cases with that teaching physician and advise of where things are, but they are not physically in the room and/or doing visual. We do have some that are doing visual. But these physicians are perhaps on a floor also in their situation, but they don't have the PPE to go in the room.

Ryan Howe: Right. So, they would need to be capable of providing the supervision through a virtual presence ..

Heather Hoke: Okay.

Ryan Howe: ... if such supervision were necessary. Yes.

Heather Hoke: Okay. Thank you.

Operator: Your next question comes from the line of Shelly Fulzelberger.

Shelly Fulzelberger: Yes. I do hear any information regarding what CPT codes, what an FQHC bill for telehealth services. Would they be the ones listed on CMS' website like the office and outpatient visits?

Ryan Howe: So, under current rules, FQHCs can't report services via telehealth. There are provisions in the CARES Act that we are actively working on providing guidance on – that will address under the new – there are new provisions that will allow both RHCs and FQHCs to bill for the services that their practitioners furnish via telehealth. But those mechanisms have not been made effective yet. We understand the urgency of the issue and are working as hard as we can to make that happen.

Shelly Fulzelberger: Do you have an approximately timeframe if you were just to guess?



Ryan Howe: We are hopeful that as soon as possible – again, we understand the urgency. There is – there is obviously a lot going on and, obviously, that’s not an excuse just to – just to say as a practical matter. I think we are moving as quickly as we possibly can. Certainly not a long-term issue but rather short term. But we are optimistic – so, as soon as we can.

Kimberly Brandt: Thanks, Ryan.

Shelly Fulzelberger: No worries. I understand. Thank you so much.

Operator: Your next question comes from the line of Tom Bornheimer.

Tom Bornheimer: Yes. Hi. I had a question about when and whether telehealth services will be allowed for Medicare Advantage payment purpose on both RAPS and EDPS submissions.

Kimberly Brandt: Ryan, do you have an answer on that one?

Ryan Howe: I don’t. I don’t know if there’s anybody on – from the inaudible.

Kimberly Brandt: Yes. I think we’ll need to get back to you on that one, sir. I don’t think we have the right subject matter expert. Great question. But we will have to get back to you. Again, if you want to send an email to the email address that I mentioned that are on the slides – covid-19@cms.hhs.gov – and put your contact info, we will get back to you ASAP. Sorry about that.

Tom Bornheimer: Okay. Thank you.

Operator: Your next question comes from the line of BJ Stepsps.

BJ Stepsps: Well, I thank you for taking the time. My boss mentioned something today about sending in any old claims that were possibly in review – that they were expediting these old claims. And I’ve not heard anything about that, and I was wondering if anyone else has.

Kimberly Brandt: I’m not sure that we have anybody on that can speak to that per se. I know that we have been trying to work with people who need additional time to submit claims. But I haven’t heard specifically on that. But, again, if you want to email us, we can certainly circle back and clarify that for you.

BJ Stepsps: Okay. Thanks so much for taking the time.

Operator: Your next question comes from the line of Sharon Ballard.

Sharon Ballard: Yes. I have a couple of questions. And she just asked kind of the same thing. Should we see delay if we submit data service before 3/1/2020 for payment? Will that be processed as a normal claim? And for services after 3/1 of 2020, what types of delay should be expected if we submitted with place of service 02 versus place of service 11, or with a modifier that we were previously directed to follow, and then CMS changed those guidelines and we released some of those claims?



Kimberly Brandt: So, again, I apologize. I'm not sure that we've got the right folks on the line that can answer that specific level of question. As I mentioned, we are working with our Medicare Administrative Contractors to just try and ensure that claims are getting paid as timely as possible and to work with folks who need extensions on submission and to make sure people know the right modifiers to put on the claims. But, if you shoot an email, we will try and get back to you with a little more specificity on that one. Thank you.

Ryan Howe: Kim, I can add something on the ...

Kimberly Brandt: Yes. Thank you.

Ryan Howe: Just to add something on that in terms of the – for the telehealth service claims. We are changing the guidance to use the 95 modifier instead of the place of service 02. But we don't have the expectation that the place of service 02 claims will not be paid, understanding that that was obviously the previous guidance. So, if there are problems, we certainly want to hear about that. And – but, the expectation would not be that they would automatically be rejected or returned or anything like that.

Kimberly Brandt: Thanks, Ryan.

Sharon Ballard: What about the 02 modifier, the 95 modifier? Are we clear on which modifier you all want at this time?

Ryan Howe: Yes. So, that is a pretty significant change. For all telehealth services, that 95 modifier should be used for the duration of the public health emergency, for all telehealth services. But, again, because the 02 would have been the pre-existing policy, I don't think – the expectation is that claims would necessarily not process or be paid appropriately if one were to use the 02.

That hasn't been prohibited. But, the 95 will allow the payment to be maintained regardless of whether or not telehealth is used. And, so, it may be to your advantage to use the 95 rather than the 02. But, the 02 would continue to pay.

Sharon Ballard: And not to CS in any market that you know of. Right?

Ryan Howe: I think we'll have to get back to you on the other modifiers.

Kimberly Brandt: Yes.

Ryan Howe: But, for telehealth continue to use the 95. Yes.

Kimberly Brandt: But, definitely on the other modifiers and the others' questions, we will get back to you. Just please send an email. And apologies that we just don't have the full range of people on the call to be able to answer everything.

Operator: Your next question comes from the line of Angela Howell.



Angela Howell: Hi. I'm calling from Colorado. Actually, CMS certified Pediatric Home Health Agency. We have an initial assessment waiver. We are licensed under CMS as well as the state. But we have the initial waiver – assessment waiver that we can do via remote or record review, but nothing on recertification visits. Is that coming? Or is there a waiver I'm missing for that?

Kimberly Brandt: Do we have someone who can answer that for her? Maybe one of the CTSQ folks.

Jean Moody-Williams: Could you repeat that again? I'm sorry.

Angela Howell: Sure. We are a Pediatric Home Health Agency. We service only disabled children, so they are in the high-risk category. CMS has a blanket waiver for initial assessment. We had not seen anything, to my knowledge, for recertification. Every 60 days, we have to go out for a visit. I'm just wondering, is there a blanket waiver coming? Is there one in place I don't know about, where we can do these recertification visits via telehealth or some kind of video conference?

Jean Moody-Williams: Yes. I thought – as we continue to talk about guidance was for both that we had something on recertification. So, I'll try and find while the call goes on.

Angela Howell: Okay. Thank you very much.

Kimberly Brandt: And please email us as a follow up on that just in case we can't get back to you by the end of the way. That way, we can follow up. Thank you.

Angela Howell: Thank you.

Operator: Your next question comes from the line of Sophie Wilson.

Sophie Wilson: Hello.

Kimberly Brandt: Hello. Yes. We can hear you.

Sophie Wilson: Okay. Sorry. My question is actually when we are hiring new staff for officiate with this emergency, do we have a waiver to eliminate their physical exam or new physical for the new employees? And, also, for patients who are put in a COVID room, do they have to be in private room or can we cohort them to get the Medicare reimbursement properly?

David Wright: This is David Wright. What kind of facility is it?

Sophie Wilson: I'm sorry. It's a Skilled Nursing Facility.

David Wright: Okay. I don't think we have – and I know skilled nursing homes as well. I don't think we have a requirement first that staff receive physicals. But, Evan you can speak to that. And, also, could you address the cohorting guidance that we have issued?



Evan Shulman: Sure. Hi, everyone. This is Evan Shulman. And, yes, we don't have specific requirements around physicals. But we have waived requirements that allow facilities to hire individuals to serve as nurse aides. We have made the requirements easier for facilities to get people that helps supplement their staff.

On the cohorting thing, I can't speak to the reimbursement. But maybe someone from the Center for Medicare who can comment on that piece. But, generally speaking, we are advising facilities to cohort residents following also CDC guidelines – to cohort residents, to separate residents who have COVID-19 from those that don't have COVID-19 and also from residents that are unknown to have COVID-19 and still may be asymptomatic such as new admission from hospitals.

So, those residents can be placed in single rooms or in double rooms still cohorted. Of course, it all depends on the amount of room that a facility has. But we are strongly suggesting to cohort residents in those groups. I hope that answers your question.

Sophie Wilson: Yes. So, we do cohort everybody who is symptomatic and positive for COVID and separate the others out. But, in one of the Medicare requirements, it says you have to have strict isolation in a private room. That's the only reason that question was asked.

Operator: Your next question comes from ...

Evan Shulman: For – Okay. Yes. I don't think we – we could take a look at that. We'll take that back. I think, again, this really also does depend on the type of space that a facility has. So, we are expecting that when someone does have COVID, I think CDC guidelines does recommend that facilities isolate that person. But, again, only if you have the space to do that.

Sophie Wilson: Thank you.

Operator: Your next question comes from the line of Tee Fairclaw.

Tee Fairclaw: Hi. Thank you very much for your quick work on the MAT program. That was – that was amazing. My question has to do with swing beds. And is there any update on the 72-hour waiver applying – that applies to SNFs and applies to swing beds as well? We still haven't gotten an official notification on that.

And the other question has to do with the 100-day limit on swing bed days in total. With long-term care facilities not accepting patients, is there any sort of waiver for the 100-day total life swing bed days?

Evan Shulman: This is Evan. The first part – could you ask your question again about the 72-hour roll out? What part was that on?

Tee Fairclaw: The 72-waiver – yes. The 72-hour waiver for SNFs. We are waiting an official confirmation that it applies to swing beds and critical access and rural PPS hospitals. We got an email stating that it did. But we haven't gotten an official letter. And, then, the other question has to do with the 100-day lifetime limit.

Jason Bennett: This is – this is Jason Bennett. I can address the first one. Yes, we are working to get the official information out with regard to the swing beds, as you were describing.



Tee Fairclaw: Thank you so much. Because we have a ton of hospitals sitting and waiting on this. So, thank you very much. And on the second, is there anything on the 100-day waiver?

Kimberly Brandt: I think that's one that we are still working on or looking at. So, we don't have anything official on that yet. Is that correct, Jason?

Jason Bennett: Yes. That's correct.

Tee Fairclaw: Thank you so much. You all have a great day.

Kimberly Brandt: So, stay tuned. But we are looking at it. Thank you.

Operator: Your next question comes from the line of Becky Banner.

Becky Banner: Hi. I am calling to see if I can specifically define how we are to be billing telehealth. We are billing place of service 02. We are following the waiver 1135. And now, it comes out saying we are supposed to be billing the traditional place of service with the modifier 95. And can we bill this as provider-based?

Kimberly Brandt: Ryan?

Ryan Howe: Yes. So, you should report the place of service code that you would have reported had telehealth not been used. So, that would include if you are – if you are operating or, I should say, if the – if the practice location is a provider-based department of the hospital, then you would use the place of service code for the provider-based department that you would for in-person.

Becky Banner: With the 95 modifier?

Ryan Howe: With the 95 modifier should you know.

Becky Banner: But, you are going to accept place of service 02 until we get this all changed over?

Ryan Howe: Yes.

Becky Banner: Okay. All right. Thank you.

Ryan Howe: Thank you.

Operator: Your next question comes from the line of Demil Gibson.

Demil Gibson: Yes. How will hospitals get paid for COVID testing and treatment for uninsured patients?

Kimberly Brandt: So, I think on that one, we are still working with the department and overall to sort of figure out exactly how that is going to work. But, we are continuing, particularly in the issue of the uninsured patients, to work very closely with our colleagues across the department, and are hoping to get out guidance on that as soon as there are some resolutions on how to move forward on that.



Demil Gibson: Okay. And, also, can I get the email address again for additional questions?

Kimberly Brandt: Sure. It's covid-19@cms.hhs.gov.

Demil Gibson: Thank you.

Operator: Your next question comes from the line of Theresa Lang.

Theresa Lang: Yes. My question is in regards to the Physician Fee Schedules that were published that would allow for e-health or telehealth visits. And my question is in regard to, there was a fine line somewhere that said that this did not allow for physical, occupational, or speech therapists to do their evaluations via e-visits or telehealth visits. Is that going to be revisited or clarified? Because, depending on where you look, some places have looked like there is no problem and other places identified that it is an issue for therapists.

I'm working in a Skilled Nursing Facility where we have some of our therapists not able to come into our building because they have been exposed to COVID-19 and we do not have it in our building. And there is a physical therapy assistant in the building, but they cannot do the evals. But it would be very helpful to have evals being able to be done via e-visits or telehealth.

Ryan Howe: First of all – first of all, let me say I appreciate the question and we understand the concerns. Also, important to note that I think it's – for what it's worth, it's very - it makes a lot of sense for there to be confusion about it given how quickly things are changing and how much – how much has changed for telehealth over several different changes in law.

So, the current status for therapy services in general is that the therapy services are available on the telehealth list. But, at present, the physical therapists, occupational therapists, and speech language pathologists are not eligible to bill for telehealth services. We are currently examining potential flexibilities based on very recent changes legislatively that would allow us to consider making those changes.

An additional complexity here, of course, is for the institutions that would be billing for those therapist services. And that's another layer of rules that we are actively taking a look at. And, so, that's a lot of words to say I'm sorry that it's not clear. And right now, I don't think that there are codes that can be used in that circumstance. But we are actively taking those questions and hope that we can get additional guidance that will provide more flexibilities in the near future.

Theresa Lang: Okay. Thank you for taking my call.

Operator: Your next question comes from the line of Sherie Mitchell.

Sherie Mitchell: Hi. I am trying to find out regarding the blanket 1135 waivers for the 3-day qualifying hospital stays. We are a facility – a SNF – are trying to find out – we have a myriad of questions. I am trying to find out when some type of clarification is going to be provided by CMS hoping – I understood as of one of last week's calls that CMS was working as quickly as possible to get some information guidance out to that effect. And I'm trying to find out will that be disseminated this week, because providers are really kind of in the dark as to specifications.



Kimberly Brandt: I think that's an area where we absolutely understand and appreciate the need for guidance. And we have been working to really try and get that finalized so we can get something out to folks as soon as possible. I can't promise exactly when. But we are trying to get that out as quickly as possible.

Sherie Mitchell: Okay. Thank you.

Operator: Your next question comes from the line of Jillian Harris.

Jillian Harris: Hi. I have a question about billing E&Ms. I keep hearing that smartphones are not required any longer. However, it's supposed to be audio and video. So, could you confirm if audio only can still be billed as an E&M for telehealth.

Ryan Howe: So, there are specific CPT codes that describe telephone evaluation and management. And those codes should be used when just audio technology is used. So, again, for the traditional E&M visits, audio and video are both still required for telehealth. But there are specific codes for telephone evaluation management. And those codes can be reported when audio-only technology is used.

Jillian Harris: Okay. So, the telephone E&Ms are the ones that just became eligible last week that ...

Ryan Howe: Right.

Jillian Harris: ... previously were not? Okay. Thank you.

Ryan Howe: That's right. Yes. Thank you.

Operator: Your next question comes from the line of Jessie Ozuna.

Jessie Ozuna: Hi. Good afternoon. I just had a brief question to follow up and a second question that was asked regarding physicians providing services via telehealth in the same location. I understand it's not allowed in the same location. However, we do have multiple buildings in our health system, particularly one building that's a severe infection disease unit that's down the street and physicians are normally in the hospital. Can they be using telehealth and billing under telehealth for that?

Ryan Howe: Thank you for asking the question. And a special thanks because it allows me to clarify – to make clear. When telehealth technology is used and the patient, and the patients and the physician are in the same location, that is certainly reportable as a service. It's just that that – it doesn't need to be reported as a telehealth service.

So, the telehealth rules only apply when the patient and the physician are not in the same location. But, when they are in the same location and the technology is used, it's not that those services aren't allowed to be reported. It's just they don't need to be reported with the telehealth modifier or following the telehealth rules.



And, so, in cases where the location is two different buildings on the same hospital campus, the same thing would apply. The telehealth rules generally wouldn't apply when it's in the same physical location, including the hospital campus. The intent there is not to prohibit or prevent those services from happening. It's just that they don't need to be reported as telehealth services on the claim.

Jessie Ozuna: Okay. Thank you.

Operator: Your next question ...

Nicole Cooney: Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Jamie Fletcher.

Jamie Fletcher: Hi. Actually, you can go ahead and take one more question because both of mine got answered. Thank you.

Nicole Cooney: Thanks.

Operator: Your final question comes from the line of Britney Paton.

Britney Paton: Hi. Good afternoon. I just wanted to confirm if telehealth – is the requirements for that – if they are going to be accepted for risk adjustment.

Kimberly Brandt: We are still working out sort of how telehealth is going to fit in with Medicare Advantage and how that will be provided for. But, if you want to send us an email to the email address I mentioned before, covid-19@cms.hhs.gov, we'll get back to you as soon as we have some additional guidance on that.

Britney Paton: Okay. Will do. Thank you.

Nicole Cooney: Dorothy, I can take one more question.

Operator: Your next question comes from the line of Marie Olm.

Marie Olm: Yes. My question is regarding Skilled Nursing Facilities and the three-day prior hospitalization waiver. Does that – can we apply that to anybody in our facility, or does their particular situation need to be affected by the COVID-19 emergency?

Jason Bennett: Yes. This is Jason Bennett. This waiver for the 3-day – it is nationwide, and it applies for a patient being discharged, whether or not they are suspected or COVID-positive or have another condition. Our objective here is to help hospitals have the maximum possible bed capacity during this emergency.

Marie Olm: How about the renewed SNF coverage without having to have a new benefit period? Can that just be applied to anybody?

Jason Bennett: There are some more nuances on that. And we are working to get some information out to you about that.

Marie Olm: Okay. Thank you.

Additional Information

Nicole Cooney: Thank you. Unfortunately, that's all the time that we have for questions today. If we didn't answer your question, as Kim had mentioned, we have resource boxes where you could direct your outstanding questions for waivers on slide 17 and slide 20. If your question is of a more general nature, you could send it to covid-19@cms.hhs.gov.

An audio recording and transcript of today's session will be available in about two weeks at the same location where you obtained the slides for today's call. You can also find that at go.cms.gov/npc.

Again, my name is Nicole Cooney, and I'd like to thank our presenters and also thank you for participating in today's Medicare Learning Network COVID-19 Update Call.

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