COVID-19 Call- Hospital Industry
Moderator: Alina Czekai
March 16, 2020
12:00 pm

Coordinator: Welcome and thank you all for standing by. Today's call is being recorded. If you have any objections you may disconnect at this time. All participants are in a listen-only mode until the question and answer session of today's conference. At that time you may press Star 1 on your phone to ask a question. I would now like to turn the conference over to (Alina Czekai). You may begin.

(Alina Czekai): Great thank you operator. I will turn it over to CMS Administrator, (Verma). Thank you.

(Administrator Seema Verma): Good afternoon and thank you for joining us today. I want to first start just by apologizing for the lateness of the call. I think we had some trouble with the line in getting all our speakers in. So appreciate your patience.

Let me first start by just saying thank you for what you're doing. You guys are all on the frontlines. And I know there's a lot of, you know, people are concerned, a range of different emotions. And at the same time we're all trying to do our jobs. So thank you for what you're doing. I can't say that often enough.

You know from our perspective what we're trying to do is number one keep the lines of communication open with those of you that are on the frontline. The other thing that we want to do is make sure that we are getting rid of any administrative barrier that gets in your way of providing care and providing or being able to respond to the virus and issues that are at hand day to day.

And then the other piece of this is that it's our job to support you in your work as well. I know that there's been a lot of questions about testing and supplies. We had this call last week and I brought Dr. (Hahn) to talk about the testing issue. I think there's been a lot more – a lot of developments over the last few days here and you'll continue to hear more.

The third area – the second area that I'm hearing a lot about are supplies. And we've asked HHS who runs the national stockpile to be here today. We're still I think the guy that runs it got pulled into another meeting so I'm hoping he can join us at the end.

But let me just give you at least a few general pieces here. On the testing it's very much so ramping up. What we've outlined in terms of the federal response in the testing centers those are going to be done in conjunction with state and local governments. We're sort of the back stop in terms of providing supplies. We're also allowing for public health workers to help man these testing sites. But those are really geared towards people that are over 65 with symptoms and healthcare workers.

So I want to emphasize that it's still, you know, the existing system that we have today for doing routine testing we're still counting on that to be a major part of this. The other testing sites at least initially are going to be focusing on healthcare workers and people over 65. And you're going to be hearing more about those and how they're going to come up over the next few days. But again that's something that the state and local government's going to be running.

And that's another point that I want to emphasize is that the reason why I'm having this call today is I want to talk about some of the Medicare rules and

things, like, that that we have waive. But would encourage you to be working with your state and local health departments. They actually are, you know, the frontline resource for you. And they're speeding up to us. So even issues that you have on supplies and things, like, that I think those are things that you want to be discussing with them.

So let me go into a few things in terms of what CMS has done and give you an opportunity. Also we'll open it up to questions. I also want to emphasize that today if we have the answer we will give you the answer. If we're not sure of the answer we're going to go look it up and make sure that we get back to you. So sometimes we don't have it at the ready. But if we do we'll certainly hand it off if not, you know, we're also going to be putting out FAQs or having more calls and opportunities for you all to get your questions answered.

We're also recording today's call and will make that available so for some of your team that hasn't been able to or can't attend the calls they at least have a resource as well.

So as you know the president declared a state of emergency. And this allows hospitals across the country to trigger their emergency preparedness programs. And also empowers CMS to implement a broad range of flexibilities to hospitals as you ramp up your response to the virus.

So to bolster readiness we are and these are a part of the waivers that we put out that are out there right now under 1135. I wanted just to kind of give an overall statement to say there's a series of what we call blanket waivers. So that is for every healthcare institution across the United States you don't have to apply for anything else.

That being said we've already heard from providers on the frontline saying I think I may need something else. And so over the next, you know, few days here we'll be putting out more information about how you can get a more targeted waiver specific to your hospital.

So today what I want to cover is just the blanket waivers. Many of you that have dealt with disasters before hurricanes, those of you in Florida and in Texas are probably used to these kinds of things. But I know in some areas of the country that may be new to you. So we're going to go through some of these blanket waivers. And again to emphasize it means you don't have to do anything. You can just disregard these rules. And on the backend, you know, we're getting rid of the claims that would prevent payment for this.

First piece of this is that we're allowing hospitals to reserve beds for the most severe cases of COVID-19 by discharging less severe cases to skilled nursing facilities. I will also add that we put out guidance about a couple weeks ago. I think it was a couple weeks ago now. But it really explains recommendations around transferring people, discharges as well. So if you have any questions about that I would urge you to look at that guidance that kind of explains or gives you some detail.

Rural hospitals will likewise receive increased capacity thanks to the removal of restrictions on critical access hospitals. So that limits length of stays. All of those are alleviated during this time. We're also ensuring or trying to ensure an adequate and flexible workforce by allowing healthcare professionals to provide care across state lines more easily and relaxing clinician enrollment requires for Medicare. And we're making the same option available to states in their Medicaid Program.

So this essentially says if you're treating a Medicare program or Medicaid participant across state lines, Medicare will allow for reimbursement. But states also have to do that on the local level to ensure payment for Medicaid. And we're working with governors on that issue.

We're also working with states to help them make changes in their Medicaid Program. And under the 1135 it actually unlocks a lot more flexibility for the states. And so we're working with states on an individual basis.

In terms of Medicare – so over the last two years the Trump Administration has dramatically expanded the use of Telehealth so seniors can communicate with their doctors from home and limit the spread of the virus. And we're also - just so you know in very short order we are trying to expand the Telehealth benefit across the entire system.

So right now people can call their doctor and those types of services are reimbursed. But now we're going to go a step further and this is due to the 1135 waiver and also some of the flexibility that we got from Congress. You're going to see more in very, very short order to allow widespread use of Telehealth across the healthcare system in a variety of different settings.

So a couple of things. We talked about Telehealth. And again we're trying to get this – you're going to hear more about that. And I think we'll put some guidance out in pretty short order. So expect to see that and probably won't spend too much more time on that.

A couple of other things that I wanted to flag that CMS has already done. You asked us to temporarily waive mask fit test requirements that, you know, waste valuable and 95 masks. And so yesterday we directed surveyors to temporarily stop validating the day of the fit test for our healthcare workers.

It doesn't eliminate OSHAs requirement to perform those tests. But it tells hospitals that we're not going to cite you for fit testing.

And so that kind of brings me into the area of survey insert more generally. Because of the 1135 waiver we have some more flexibility to waive a lot of your normal accreditation or more of the end survey – the surveys that routinely get done. That being said the president has been very clear that he wants agencies to focus or to double down on infection control efforts.

And so we're developing a template that is more streamlined that we will have surveyors go out to healthcare facilities and to evaluate infection control. It's intended to be very streamlined, very targeted just around infection control. I can tell you right now I do not want surveyors getting in your way of doing the work that you need to do and that is our goal.

We've been very explicit with the surveyors. And that's why we're going to a much more targeted way of doing this that's, you know, more focused. I think we've shared that with the hospital association and the nursing home association to get their input as well.

In terms of cost sharing I think that we've made it very clear that Medicare covers cost sharing. You're hearing about legislation that's on the bill that would essentially waive all cost sharing. But even without that bill Medicare pays for it. Medicaid pays for it. And you've heard private insurance companies saying they're waiving all copays related to testing.

The other piece of this is the uninsured. But the uninsured those tests can be processed by state labs and there's no cost for that. We've also provided flexibility for our Medicare Advantage and Part D plans. And so just last week we gave them a lot of flexibility to waive cost sharing, you know,

beyond just testing. And to also waive higher authorization requirements to make sure that patients have the medications that they need.

Also we've put out guidance on EMTALA waivers. And we've clarified that it's possible in our recent guidance that emergency departments can deploy COVID-19 screening locations elsewhere on campus so that emergency departments – emergency departments are not the sole site performing COVID-19 screening.

You've also asked about – we talked about surveys. And we'll be putting out – so I think I've already covered surveys. The other piece of this is that I think you've asked for guidance about preparing the community for outbreaks and helping us understand who can care for themselves at home and who should be hospitalized and what personal protective equipment is needed and who should wear it.

In the past few days we have issued guidance on this nursing homes, home health agencies, dialysis units and hospitals all aimed at clarifying actions that they should take to reduce the risk of COVID-19 spread in their facilities. Hopefully our guidance is clear and provides answers that healthcare workers need. And we've basically coordinated all of our policies with CDC and it provides links to the CDC information in our guidance. But ours I think is a little bit more specific in what you'll see from CDC.

So with that let's open it up to questions. I know that there's a lot of questions on supplies. And we're still waiting for Dr. (Kevlak) to join us. I think right now let's open up the questions to the 1135 waivers. And if you have any questions about that we have our whole technical. And then when Dr. (Kevlak) can join us I'll have him give you an update on supplies.

Coordinator: We will now begin our question and answer session. If you would like to ask a question please press Star 1 from your phone and unmute your line. Please speak your name and organization clearly when prompted to be placed into the queue. Again if you would like to ask a question please press Star 1 from your phone. One moment as we wait for any questions.

Susie Emmert: Hello.

(Alina Czekai): Hi there. We're happy to address our first question.

Susie Emmert: Hi this is Susie Emmert with Hennepin Healthcare System in Minnesota. I just want to make a – I have a question about the (Intollo) Waiver. You said emergency departments can deploy COVID-19 clinics elsewhere on their campus. I just want to confirm that that is available and they can do that now. We don't need any additional approval for that.

David Wright: Yes this is David Wright with CMS. In setting up and altering a screen location on campus of the hospital does not require any sort of CMS approval. So as long as it's on campus that's fine. If you want to do it off campus then we just need to have some discussions about what the setup's going to be and how it's going to go. But our experience is most hospitals are successful in setting up these locations on campus and routing patients then through their E.D. or wherever they need to go for additional treatment.

Susie Emmert: Thank you.

(Alina Czekai): Thank you next question please.

Woman 1: …to the skilled nursing facilities. So as far as being able to receive those patients and freeing them up at the acute care for the inpatient rehab facilities

that have the staffing and the acuity a little bit higher capabilities, are the waivers for conditions of participation for the ERFs, part of that blanket to be part of the surge process as a licensed acute care hospital.

David Wright: I missed the first part. This is David Wright again and happy for anyone else to jump in too. But I believe it's for the use of otherwise excluded units for acute care patients. And yes that is allowed under the waiver as well.

Woman 1: So that's a blanket waiver. We would not need to have a special waiver on that for the ERF level of care accepting other patients?

David Wright: That's my understanding. If there's anyone else from CMS who has a different view please speak to it. But that is a blanket waiver authority.

Woman 1: Thank you.

(Alina Czekai): Thank you, next question please.

Rich Rasmussen: Is the line open for asking questions?

(Alina Czekai): The line is open. Happy to take our next question.

Rich Rasmussen: This is Rich.

(Alina Czekai): Hi Rich.

Rich Rasmussen: Yes this is (Rich Rasmussen) with the Montana Hospital Association. If you can provide some clarification for us. As we look at the blanket waivers it looks as if they did not become operative unless the state requests them. So can you clarify that for us because much of what we've been reading in

conversation with colleagues is that there needs to be a request to have those blanket waivers applied. Can you fill that in for us?

(Alina Czekai): Thanks Rich for your question. I'll turn that question over either to Kim Brandt or my colleague from CMCS.

Kim Brandt: So Rich this is Kim Brandt. I think, you know, in terms of the blanket the administrator was talking about regarding the hospital flexibilities and stuff, like, that. Those are sort of widespread. There are certain state specific things and we can hook you up with our colleagues in the Centers for Medicaid and Services to kind of walk you through what some of those restrictions are. But in terms of the larger waivers those are blanket waivers that you would not have to put a specific request in for.

Rich Rasmussen: So effective today those blanket waivers are in effect in all 50 states and territories correct?

Kim Brandt: Correct because it's a national emergency under the Stafford Act. And the secretary identified a public health emergency declaration which is what's required to trigger that level.

Rich Rasmussen: Okay, thank you.

(Alina Czekai): Thank you next question please.

Man 1: Question is regarding the teleservices that people that we haven't seen in the last three years. Will the waiver cover that so we'll be able to bill for those persons that we haven't seen in the last three years?

(Alina Czekai): Thank you. Would you mind repeating that question please?

Man 1: Sure. My question is about billing for people for teleservices for people that we haven't seen in the past three years. So can we - using Telehealth with regard to Medicare patient will we be able to bill for those patients even if we haven't seen them within the last three years under these waivers?

Kim Brandt: So we will – we'd have to confirm that unless our CMS colleagues are on to be able to answer but somebody from PM?

Man 1: And then follow up - a second question. With regard to Telehealth reimbursement will we be reimbursed at the same rate as an in person visit?

Kim Brandt: (Liz) I'll defer to you on that.

(Administrator Seema Verma): Hi I'm sorry (Liz) had to step out for another meeting. So we'll probably have to get back to you on that.

Man 1: Okay, thank you.

(Alina Czekai): Thank you. We will take that question as one of our follow up questions. And really quickly has Dr. (Kevlak) joined our call? Other questions please.

(Steve Kline): I have a question if the line is open. This is (Steve Kline) from Bozeman Health in Bozeman, Montana. Can you hear me?

(Alina Czekai): I can, thanks (Steve). So my question generally and I think the prior individual asked about it a little bit. But as I understand it if the hospitals want to do something that fits within the blanket waiver, then from a CMS standpoint we can go ahead and do it and we don't need to request any additional approval. If it's outside the blanket waiver we would.

(Steve Kline): And so my follow up question assuming I have that right is I assume the CMS waivers do not you know, apply to any state healthcare regulatory agencies. So we would also need to follow up with them separately as it relates to activities we want to do that are covered by the blanket waiver to make sure there are no issues from a state standpoint. Is that accurate?

David Wright: Yes this is David Wright. The waiver authority is only for the federal certification and regulations. And so any state law or state licensure provisions that would be in conflict with that would have to be approved by the appropriate state entity as well. That's a great question.

(Steve Kline): Okay got it. Thank you very much.

(Alina Czekai): Thank you next question please.

(Liz Richter): Hi this is (Liz Richter). We're waiting for the next question. I understood there was a – I had to step out for a moment. But I understood there was a question about the payment rate for Telehealth.

(Alina Czekai): Correct (Liz). They were asking if it was the same for Telehealth versus a regular office visit.

(Liz Richter): So Telehealth visits are paid facility rate but they're paid the same rate as an in-person facility visit would be or whatever the service is.

(Alina Czekai): Thank you (Liz).

Kim Brandt: The other think I want to add on Telehealth in terms of the previous relationship with patients we are definitely working on that to even see if there's something that we can do on CMS' end around enforcement

discretion. So we're hoping to resolve that issue one way or the other in short order.

(Liz Richter): Next question from folks on the phone.

Coordinator: Our next question comes from (Lesley Pierce). Your line is now open.

(Lesley Pierce): Could you please clarify how we're going to handle Medicare Advantage Plans in regards to authorizations for post-acute providers and also around patient choice?

(Liz Richter): On Medicare Advantage we've given them a whole list of broad flexibilities. But you'll have to touch base with them to understand that. We will be encouraging them to put that information out to you so that you can have some more clarity and we'll pass your questions onto the plans. That being said, like, I said we've given them, you know, broad flexibility to make the process easier for everyone.

Kim Brandt: And just so people know we do have an email address that is open that you can send emails to as well for these types of questions. It's 1135waivers@cms.gov. So again it's 1135waiver no S on the end sorry @cms.hhs.gov. And our Web site cms.gov/emergency also has a lot of good information on there. So please use both those sources in addition to asking questions here.

(Alina Czekai): Thank you Kim. And I understand that Dr. (Kevlak) has joined us. Dr. (Kevlak) if you maybe want to give some opening remarks about supplies. I know we've gotten a lot of questions about that. And then if folks have questions specifically around supplies they can bring those up now. And as Kim said and we'll be getting out the information on the Web site and the

email address. We'll repeat that at the end of the call. So with that I'll turn it over to Dr. (Kevlak) and thank you for joining us.

Dr. (Kevlak) do we have you on the line? Operator we have our next speaker who just joined us. Can you please turn it over to him? Thank you.

Coordinator: Could you please press Star and 0 from your phone if you're Dr. (Kevlak). Please press Star 0 from your phone. Your line is now open.

(Alina Czekai): Dr. (Kevlak) this is (Alina Czekai) at CMS. We'd love for you to offer your remarks.

Dr. (Kevlak): Yes can you hear me now?

(Alina Czekai): We can thank you so much for joining. We understand it's been a busy, busy day.

Dr. (Kevlak): It has and Administrator Verma please accept my apologies and to all on the phone as well for my tardiness. I was with the secretary for the last 35 minutes working with the private sector on the issues of the supply chain which are vital to all of you and to all of us in the country.

So let me distill my comments down to a few basic points here. One is that the strategic national stockpile which has a significant but quite frankly very small percentage of what is needed in today's crisis. And certainly very small in comparison to what you use not only every day but on a yearly basis. It's made available to states to basically to meet specific needs that are provided by state health officers with the emergency management colleagues to submit a request.

So we're kind of a stop gap state response entity that would provide limited quantities of materials. But what we're trying to do now is really create a national fusion center whereby which we can basically align all of the federal governments; capacities and capabilities and requirements with that of the private sector. So we're in the midst of basically creating this national fusion center that will have representatives from the major GPOs, distributors and manufacturers as well as systems to basically pull this altogether.

The second thing is probably very specifically about where we are in some of the PPE issues which are vital to protect our healthcare workers as well as areas where we have not traditionally considered PPE as vital. But we certainly see in the near term in the skilled nursing facilities and elder care facilities where some of our most vulnerable people in our nation are congregated by age and preexisting illness. And so we're working very hard to basically address what are the needs of both the healthcare community at large and those specialized subcommittees where we have vulnerable populations.

The third issue is how do we do this. We're doing it by buying spot purchases. The intent is to basically make large – pardon me requests for proposals or requests for sales of materials, half a billion in 95 mass for example working with CDC and NIOSH to basically ensure that we could use both medical and non-medical. We're also known as industrial N95s available under emergency use authorization and prep act liability protection. And then working with CDC to extend the reuse and use of these products so we could use them longer and hopefully get more benefit out of what have traditionally been single-use products.

So that is kind of like a thumbnail sketch of what we're doing broadly. Specifically, I think Administrator Verma mentioned to me about the

ventilator situation. I will be on a call with our Deputy Secretary this afternoon subject to the major manufacturers of ventilators today to address with them what's their existing supply and supply chain and surge capacity to meet the needs. But also to look at other alternatives that will allow us to regionally reuse or remove ventilators to the point of need and care.

A critical area that Administrator Verma are working on with her team is how do we modify the rules and regulations that give you more flexibility to the requirements for use of ventilators as it relates to staffing and the like so that we can basically make sure that not only do we make more ventilators available, but then we could also basically give you more latitude on how to manage ventilator patients should you have to do that.

With that I'll stop and be happy to take any questions.

(Alina Czekai): Great thanks Dr. (Kevlak). We'd love to open it up to questions from folks on the phone, operator.

Coordinator: Our next question comes from (Lesley Pierce). Your line is n ow open.

(Lesley Pierce): Can you speak to how we should address patient choice in regards to discharge planning to post-acute services or other services to bank bed capacity?

Dr. Marian Couch: Hi this is Dr. Marian Couch in the Office of the Administrator at CMS. We put out guidance on that. And given more flexibility in terms of where the patients can go. But I'll refer you to the guidance for more details on that.

(Lesley Pierce): Which guidance is that?

Dr. Marian Couch: If you look at the waiver information that was put out late last week it talks about the circumstances under which patients can be put in part units or distinct part patients could be put in acute care beds. And I think that's the information you're looking for.

(Lesley Pierce): We're also waiving the three-day SNF rule?

Dr. Marian Couch: Yes that's also in there.

(Lesley Pierce): So the question is on the choice. Does the patient have the choice of where they can go still? If we're trying to move patients rapidly, sometimes families tend to take days to make a choice. Do we have the option to move patients rapidly?

Dr. Marian Couch: That is a complicated question. We'll have to get back to you on that. We acknowledge your question and we'll get back to you shortly on that.

(Lesley Pierce): Thanks so much.

Dr. Marian Couch: Thank you.

(Alina Czekai): The next question from the folks on the phone.

Coordinator: Our next question comes from (Brent Robinson) from (Quinasen) Hospital. Your line is now open.

(Brent Robinson): Thank you ma'am. This may have been addressed on the waiver you just spoke about. But for a long-term acute care hospital does the 25-day rule length of stay get waived for the time being?

(Liz Richter): So when you admit a patient because of the emergency, you put a condition code on the claim that says that's why you admitted them. And then that admission doesn't have to count towards the 25-day stay calculation.

(Alina Czekai): Thank you (Liz). Questions from other folks on the phone?

Coordinator: Our next question comes from Rich Jacob from Yale University. Your line is now open.

Rich Jacob: Thank you. My question was already answered.

(Alina Czekai): Thank you Rich. Next question.

Coordinator: Our next question comes from Ben Carter from Trinity Health. Your line is now open.

Ben Carter: Thank you. The question I had is in similar vein to the Telehealth question regarding billing. But in terms of waiving cost sharing as I understand it it's for the testing itself but does not include either a physician visit or an emergency room visit. Is there any consideration being given to waiving cost sharing for those elements of a visit as well?

(Liz Richter): So our waiver authority doesn't extend to changing payment amounts. The Office of the Inspector General can sometimes be thinking about whether providers of their own volition could waive copays or deductible amounts. But that's not something that we can do. So for example we couldn't change the payment to 100%. We'd have to pay the 80% that the statue specifies.

Ben Carter: Thank you.

(Alina Czekai): Thank you, next question please.

Coordinator: Our next question comes from Bill Hayes from Ohio State University. Your line is now open.

Bill Hayes: Thank you. On the Telehealth flexibility you're looking at doing we're hoping you're thinking of even providers, like, physical therapists, occupational therapists, clinical pharmacists. And I just don't know if that's where you're at and if it is great and if not please think of that.

(Liz Richter): Thank you for the input. I don't think we can anything more specific about it right now. But we'll certainly be taking that into account as we continue to plan that.

(Alina Czekai): Terrific. Thank you for your feedback. Next question please.

Coordinator: Our next question comes from (Bill Locklear) from McCloud Health. Your line is now open.

(Bill Locklear): Thank you. Are there plans to release any of the emergency stockpiles of PPE and if so can you give us some idea of when that might happen and how we would go to apply for it? Thank you.

Dr. (Kevlak): Well thank you and it is already happening, number one. We've gotten a number of requests by several states that are experiencing not only singular cases but community transmission. So we've been fulfilling that to probably about over – about I think 16 states right now. The best way to basically and if you will request material from your state or from us is through your state health officer, state emergency management. There is a mechanism by which they electronically submit that. And it is representative of their requirements.

So if you identify your requirements as part of theirs that will be incorporated and then we can respond to you.

Sir as a matter of just, you know, detail here where are you calling from so I can follow up with your state representative, over.

(Bill Locklear): South Carolina.

Dr. (Kevlak): Thank you.

(Bill Locklear): Eastern South Carolina.

Dr. (Kevlak): Thank you sir.

(Bill Locklear): Thank you.

(Alina Czekai): Thank you for your question. Next question please.

Coordinator: Our next question comes from (Cheryl Wilson). Your line is now open.

(Alina Czekai): Hi (Cheryl) what is your question.

Coordinator: (Cheryl Wilson) your line is now open.
(Alina Czekai): (Cheryl) is your line unmuted? We'd love to hear your question.

(Cheryl Wilson): This is (Cheryl Wilson).

(Alina Czekai): Hi (Cheryl).

(Cheryl Wilson): Does the three-day waiver for skilled nursing facilities – does that also apply to the critical access hospitals for the swing (unintelligible)?

(Liz Richter): I think we're going to have to get back to you on that one. Thank you for the question. Unless there's someone else on who has an answer.

Dr. (Kevlak): No (Liz) that was going to be my answer as well.

Kim Brandt: Yes I think we're going to have to get back to you. Sorry about that. It's a great question and make sure to reach out and we'll get back to you.

(Cheryl Wilson): Thank you.

(Alina Czekai): Thank you (Cheryl). The next question from folks on the phone please.

Coordinator: Our next question comes from (Ron Marshall). Your line is now open.

(Ron Marshall): Thank you. I don't know how this could be addressed. But what we're experiencing is long-term care, skilled nursing facilities refusing to accept patients from acute care hospitals for fear of admitting an elderly person that came from a hospital. Is there any mechanism to help hospitals address that because we can't surge if there's no place to send patients.

David Wright: Yes this is David Wright. We've issued guidance to nursing homes specifically indicating that they shouldn't refuse to accept patients being discharged from hospitals. We do not have the ability or authority to compel them however to accept patients so we lack that authority.

(Liz Richter): We will reach out to them. We're also just as we're having meetings with hospitals we are having meetings with nursing homes as well. And we will certainly highlight that with them.

(Ron Marshall): Thank you.

Coordinator: Our next question comes from (Lisa Rivas). Your line is now open.

(Lisa Rivas): Good afternoon. My question is related to the guidance that was issued Friday night from CMS specifically for skilled nursing facilities and related to communal dining are not having communal dining or activities. Do you feel, like, that this means that we cannot have any meals in the dining room and are we being instructed to keep our residents in their rooms at this time and not let them come out of their rooms?

David Wright: This is David Wright. We're not saying that residents need to stay in their rooms. We are of course trying to reflect the CDC guidance in terms of infection control and distancing that needs to occur. And so we're not being overly prescriptive just trying to provide some parameters for nursing homes to follow in terms of being able to meet the needs of both the residents as well as the infection control risk that gathering in groups can pose.

Shari Ling: Hi and this is Shari Ling, Acting Chief Medical Officer. Just to build on David's reply, you know, we recognize how challenging this is because it's always a risk/benefit. We want to maximally protect and reduce the risk of transmission to, you know, our nursing home residents. But we also understand that there are benefits of social engagement. So our thinking is that this is a perfect opportunity to start to explore other means of social engagement. We've actually also provided guidance to enhance virtual means of interaction. It's imperfect. But we are very, very sensitive to that

specifically about dining, you know, it's hard to be prescriptive in that how close is too close.

And so it will also depend on the rates of transmission, community-based transmission. In your specific neighborhood we ask that facilities be aware of that. And we also have provided the guidance to really, you know, curtail some of the visitation that occurs that's not essential and not for compassionate indications. But I think dining also fits into that category. Hopefully that provides you a little bit more guidance and clarity.

Liz Brandt: Just to kind of double down on that I mean nursing homes are ground zero for this. I mean we've seen this situation in Washington State. And sometimes these measures may appear extreme but they're really about protecting the patients. I can tell you that college universities many of them are shut down and gone online.

But before they did that they were not allowing students to eat in dining halls. And they were having carry out food. So I mean those are the precautions for, you know, young people that are, you know, likely very resilient to this and, you know, would have mild symptoms. And that's the precautions that they were taking at universities. So I think the heightened precautions for individuals nursing homes are very, very important to avoid the situation that we've seen in Washington State.

(Lisa Rivas): Yes ma'am. Let me just mention though would this be as we all in skilled nursing facilities are diligently ramping up or infection control and education. It is very hard with some of our residents to help them understand where to be and where to go and not to come out of their room if needed.

But would we more implement this strict no communal dining if it was in our specific community or if it on the one hand got into our facility because we're pretty used to doing that if we have a flu case where we put people on isolation. But for them not having their families in there's no visitation at all. It's a little bit confusing right now about well can they actually just sit out in the dayroom beside each other or near each other and can we serve meals still in our dining room.

Shari Ling: Yes so this is Shari Ling again. I think in this time of national crisis I think we really do have to be very strict and really discourage that close social contact that would risk transmission. And remember it is people who are at risk of this disease which in this population in the older adult population particularly with comorbidities the risk of complication is significantly higher.

So I think the stakes are really high. And so we have been – this was not a decision that we took lightly at all. But I think the risks are really, really high. So hopefully that helps you feel better about being more restrictive and more protective. But as soon as we can we will be revisiting, you know, the guidance. We will keep up on it because we understand that this is difficult.

(Lisa Rivas): Thank you.

Coordinator: Our next question comes from (Bob Downey) from Carding Group. Your line is now open.

(Bob Downey): Thank you. We have a little over 6,000 people in affordable assisted living on Medicaid. And I'm wondering if there will be a time soon when communities, like, ours can have residents tested because they're in an environment that is the high-risk environment.

Kim Brandt: I've definitely heard that concern. So I think you'll be seeing some more information on that. You know the conversation that you're probably seeing on national TV about those testing sites obviously that doesn't work well for people living in nursing homes or assisted living facilities. So that is something that is being addressed. And you should get more information in short order.

That being said and in the interim we would advise that you just take precautions. If somebody is ill or sick, you know, they need to be isolated as soon as possible. But we understand that we need to ramp up testing for those that are in an institutional type setting.

(Bob Downey): Very important. Thank you.

(Alina Czekai): And thank you everyone for joining our call. We are at one o'clock. I know that there are a lot of questions. If you didn't get your question answered today and have a question to share with our team, I would encourage you to send your questions or comments to our inbox. It's 1135waiver – no S @ cms.hhs.gov. I would also encourage you to visit our Web site cms.gov/emergency.

(Administrator Seema Verma): Well and again I just want to thank you all for participating on the call. We appreciate – there's a lot of questions and again we're keeping these lines of communication open. And we're going to try to put out answers to your questions and also make sure that this call goes out nationally and is available for people that didn't have a chance to participate. And we'll be having these calls on a regular basis at least next week. And if we need to do it more frequently we will do that. Thank you again.

(Alina Czekai): Thank you.

Coordinator: Thank you for your participation in today's conference. You may disconnect at this time.

Man 1: Hey (Terry).

End