Moderator: Alina Czekai
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6:54 pm ET

Coordinator: Good evening and thank you for standing by. I'd like to inform all participants that your lines have been placed on a listen only mode until the question and answer session of today's call.

Today's call is also being recorded. If anyone has any objections, you may disconnect at this time. I would now like to turn the call over to Ms. Alina Czekai. Thank you. You may begin.

Alina Czekai: Great. Thanks, operator. Hello, everyone, good evening. Thank you so much for joining our call this evening. I know it's been a flurry of activity.

Today's call is being hosted by the CMS Office of the Administrator in regards to today's emergency declaration in response to COVID-19. In just a moment I will be turning it over to Kim Brandt, who is the principal Deputy Administrator for operations here at CMS.

She would like to share an important update with you all after which we will open it up for some brief Q&A. As always, we are a channel for communication so please feel free to call us or email if there is any clarification or additional information you need. But for now, I will turn it over to Kim.

Kim Brandt: Great. Thanks, Alina. And good evening, everybody. Thanks for joining us on a very nice Friday night here in Washington. We appreciate you all taking time out from what you're doing to join the call.

As I think you all probably are aware if you've gotten our press release, which just went out just in time for this call or were watching the President's announcement earlier today, the President did go ahead and declare a National Emergency Act and Stafford Act national emergency declaration earlier today, which was very important from our perspective because that coupled with the fact that the Secretary back on January 31 had issued a public health emergency declaration means that we now have the authority we need to go ahead and use our 1135 waiver authority.

For those of you who have not used these or have not been familiar with them, these are waivers that we typically use more on a localized basis for certain types of emergencies. We're typically using them in response to things like hurricanes or earthquakes or wildfires or other types of major disasters.

However, this is one of the rare instances in which we will be using it on a nationwide basis. So this is something where it's an unprecedented step forward. The last time that it was used was for H1N1, I believe, back in 2009. So this is a pretty big proactive step that we're doing.

What it allows us to do in plain English is to basically waive or modify a lot of our requirements across our programs, particularly with Medicare and Medicaid and the children's health insurance program.

It also allows us to issue a lot of blanket waivers, meaning that these are blanket waivers, and I'll go through some examples in a couple of minutes, for certain types of services and certain types of facilities, meaning that you do not have to get specific authority.

What it means is that, you know, the CMS regional offices will review providers specific requests as those come up. But for the most part these

blanket waivers means that you do not have to go and get that provider's specific approval.

And our goal in doing this is it will provide a lot of flexibility to allow for as much continued access to care for beneficiaries as possible.

I'll just put a quick plug in for those of you who want to take a look at the full range of these that we have. Please, and also on waivers we've granted in the past, please go to our Web site at cms.gov and then slash emergency and you can see an entire list and a lot of the history on that.

So some of the specific flexibilities that we are doing relate to both federal flexibilities and state flexibilities. So I wanted to put a quick plug in for some of the flexibilities that we are going to be giving to states and territories, particularly Medicaid agencies, which will give them a much wider range of flexibilities than they had.

They will be able to take a look at these flexibilities and figure out, you know, what it is that they need to be able to do, such as having out-of-state providers render services, temporarily suspend certain types of provider enrollment and revalidation requirements to promote access to care. Allowing providers to provide care in alternative settings, which is really important. Waiving prior authorization requirements and also temporarily suspending certain pre-admission and email exchange for nursing home residents, all of which are really important.

On the Medicaid side a lot of these flexibilities and a lot of the things that they are able to have are outlined in our Medicaid toolkit, which you can also find on our Web site.

So, you know, with the Medicaid, though, these are not blanket waivers. You do have to ask for them. So it's something where you will need to work through our normal channels.

But it's just something that, you know, the 1135 waivers give us that flexibility to be able to work with states to be able to grant those flexibilities. So, again, the toolkit will give you a lot of that information and help you to be able to do this.

Our Medicaid folks will be holding a state call on Tuesday to discuss with all the states. And so you will be able to ask more questions then for those of you that want more information about that. And the invites have already gone out to that.

So now let me go back and talk about some of the blanket waivers that we are giving on the Medicare side. I want to talk about those and obviously you can ask questions at the end.

One of the big ones that, you know, we always field a lot of questions on is the skilled nursing facility requirement. We're waiving the requirement which requires a three day prior hospitalization, you know, before you can go ahead and transfer to a nursing facility.

In this instance, you know, it gives more flexibility to provide a transfer sooner if needed. And then also, you know, if there is some sort of, you know, other reason like the hospital is full or they need to find a place to put people that maybe aren't as acutely sick and don't need to stay in a hospital, it allows them to put them to those facilities.

They also, if people have exhausted their SNF benefits, it authorizes renewed SNF coverage without having to start a new benefit period, which is really significant.

We're also waiving our requirements to provide relief to SNF from the time frame requirements or reporting minimum dataset assessment and transmissions. So we're waiving our reporting requirements on that to give people relief as well.

With respect to critical access hospitals, this is something we lifted for them in emergencies. We're once again waiving the requirements to limit the number of beds to 25 and that the length of stay be limited to 96.

So the limitations will be lifted, again, to give as much flexibility as possible so that hospitals, when new people arrive, be able to have them where they need to be at the time they need to be.

The same holds true for some of the requirements that we have about housing acute care patients and excluding the distinct part unit. Basically this is something where typically we would - you know, we're going to waive the requirements that will allow acute care hospitals to be able to house those patients in other distinct part units, where the distinct part unit's beds are appropriate for those acute care patients.

It's also allowing under IPTS the hospital to be able to bill for that, which is something that is a flexibility a lot of people have asked about.

Another flexibility that we have, which is something I don't think has gotten covered during other remarks today, is that if you have a patient who has their durable medical equipment that might be lost or rendered unusable or they

need to get a replacement for it because they have to leave their home to go somewhere else because of the fact that they might be at risk of contagion or something like that, we have a flexibility to be able to get them to replace that by waiving the replacement requirements such as the face-to-face requirement, getting a new physician's order and looking at new medical necessity documentation. So we would waive those as well.

We have some other very specific flexibilities regarding things like care for excluded inpatient psychiatric unit patient and some rules on that as well as care for excluded inpatient rehabilitation unit patients in acute care units, encouraging you to look at our list of flexibilities. I won't spend a lot of time going into all of those. But, you know, things that we do there are things like waiving requirements to allow inpatient rehabilitation facilities to exclude patients from the hospital unit's inpatient populations for purposes of calculating whether or not they meet for threshold associated with requirements to receive payment, in other words, the 60% rule.

So things like that and the flexibilities. Again, the goal here is to allow - the hospital should be able to, as long as they can provide the care needed for patients, try and move the patients around as needed, give as much flexibility as possible.

Another flexibility that we're doing are allowing long-term care hospitals to exclude patient stays where the LTCH admits or discharges patients in order to meet the demands of the emergency. That's from the 25-day average length of stay requirement. So that's something else that's a needed flexibility.

And then we've also with home health agencies provided relief on the time frames related to OASIS transmission. It will allow them to extend the auto

cancellation day of the request for anticipated payments during emergencies as well.

We've also temporarily waived the requirements that out of state providers be licensed in the state where they are providing services where they are licensed in another state.

So here in Ohio when you go to provide services in Washington, that way it will allow that to occur. This only applies though to Medicare and Medicaid. So just be aware of that. You know, it's only for federal billings. At the state level, if there's something that doesn't get covered under Medicaid, you would need to deal directly with the state on that.

Under provider enrollment, we're, you know, basically waiving a lot of our screening requirements, such as fingerprinting and background checks. We're postponing all of our revalidation actions and we're expediting all pending or new applications for providers.

And then we're also, you know, doing some things to allow more flexibilities in appeals. And our fee for service, Medicare Advantage and Part D programs, such as extending the time frame to file an appeal, waiving time lines for requests for additional information to adjudicate the appeal and basically utilizing all the flexibilities that we have in the appeal process if the good cause requirements are satisfied.

So the goal here at the end of the day is we are basically bringing out every tool in our toolbox to be able to give the provider community as much flexibility as possible and to allow you all to have the full range of tools available.

We will be continuing to, you know, issue new tools and work with the provider community on new tools. The administrator mentioned earlier today we will be coming out with additional guidance very soon on the new telehealth requirements and a couple of other things. So we'll be issuing more on that early next week.

But for right now I'll stop and turn it back over and we'll see what kind of questions people have and encourage you all again to go to our Web site to be able to find not only the full list of waivers at our emergency tab, but we also have a COVID link on main CMS Web page, which you can use.

And then also to really answer questions, particularly on the Medicaid side, they have pulled together an excellent toolkit that I mentioned earlier. I really encourage you to go there as well.

So with that, I'll turn it back over to Alina.

Alina Czekai: Great. And thanks so much. Operator, we're happy to open up the line now for Q&A. Thank you.

Coordinator: Thank you. To ask a question, please press star followed by a 1. Please ensure that your phone is unmuted and record your name clearly when prompted. Again, star followed by 1 to ask a question. And to withdraw your request, please press star 2.

The first question comes from (Ronald Hirsch). Your line is now open.

(Ronald Hirsch): Hi. Thank you. Can you tell me for the SNF waiver, does it begin with the date of service today and does the patient have to have a visit in a hospital or

could they potentially go right from home or a physician's office into a skilled nursing facility?

Kim Brandt: So I will say that these waivers, the way the national declaration was, is that it's going to go back to dates of service to March 1 in terms of the date. And then I'm going to let one of my colleagues answer your specific question about the transfer.

So can (Blake) or (Sandra), one of our SMEs jump in on that?

(Sandra): Yes. The transfers from the hospital waive the three day requirement so that they can go straight from the hospital to the nursing home without having that three day stay.

(Ronald Hirsch): So that includes an observation stay or an ED visit only.

(Sandra): No. If they had to be in the hospital, maybe they were admitted for one day or two days and then the hospital needed to decompress. They were stable enough to send them back to the nursing home. It doesn't have to be three, four days.

(Ronald Hirsch): Right. So, again, for clarity they must have an inpatient admission to qualify.

(Sandra): I will have to follow-up on that. But I do know that it does waive the three day that's normally required, that you have a three day inpatient stay.

(Ronald Hirsch): All right. It's an important clarification. Thank you.

Kim Brandt: Thank you for the question.

Coordinator: Our next question comes from Cynthia Morton. Your line is now open.

Cynthia Morton: Thank you. A similar question. You answered the date of service goes back to March 1. The question is can a potential SNF patient be admitted from the community or from a doctor's office to the skilled nursing facility and begin a Part A stay?

David Wright: This is David Wright. And sorry. I couldn't get on earlier. But, yes, by waiving the three-day hospital stay that means a SNF patient is eligible whether they are discharged from the hospital or admitted from the community.

Cynthia Morton: Thank you.

Coordinator: Our next question comes from Joseph Rodrigues. Your line is now open.

Joseph Rodrigues: Thank you. Yes, this is Joe Rodrigues. I'm the California state long-term care ombudsman. Will there be guidance coming out this weekend around banning visits to nursing homes?

Kim Brandt: So this is Kim. I'll answer that and then let any of our colleagues insert. As indicated earlier today by the administrator, we are working on finalizing that guidance. And we do anticipate getting that guidance to be coming out very shortly that gives additional clarity around the limitations we're going to put on visitors to nursing homes.

And I'll welcome any of my colleagues to jump in with anything else on that. But I think the goal is you should be seeing that, hopefully, very shortly.

Joseph Rodrigues: Can you answer whether or not ombudsman representatives will be included in that ban?

(Sandra): Could you repeat that?

Kim Brandt: The question was would ombudsman representatives be included in the ban of people? I'll let one of our technical experts clarify that. But, (Sandra), do you want to maybe address that one or (David)?

David Wright: I'm sorry. I don't recall directly if ombudsman are included or not. But, again, the guidelines will be coming out very shortly. But I'm not directly aware right now. I apologize for that.

Joseph Rodrigues: That's okay. Thank you very much.

(Jean): Yes. This is (Jean) and we will have to get back to you. The guidance does not speak specifically to ombudsman.

Joseph Rodrigues: Thank you.

Kim Brandt: It sounds like you raised a good question for us. So certainly as we get ready to issue that guidance, it's something that we'll try to help add some additional clarification on or do a follow-up FAQ. So thank you.

Joseph Rodrigues: Thank you.

Coordinator: Our next question comes from (Jeffrey Davis). Your line is now open.

(Jeffrey Davis): (Unintelligible).

Kim Brandt: Do you have our next question?

Coordinator: Yes, ma'am. Our next question comes from Jeannee Parker Martin. Your line is now open.

Jeannee Parker Martin: Yes. Thank you. I'm Jeannee Parker Martin from LeadingAge California. And I wondered if you could repeat and clarify the staffing requirement waiver and waiver on any background checks, et cetera.

Kim Brandt: Sure. So I can go through - so are you talking specifically in terms of provider enrollment? Was that what you were referring to?

So for the provider enrollment, what we are doing is we are waiving the screening requirements for the application fee, the criminal background checks and site visits, all which are in accordance with our various CFR provisions. So that's what we're doing on that. And I'm sorry, what was the other part of your question?

Jeannee Parker Martin: That was my question. Thank you.

Coordinator: Our next question comes from (Molly Gilbert). Your line is now open.

(Molly Gilbert): Hi. This is (Molly Gilbert) from the Medical Group Management Association. And thank you to Kim and company for hosting this call. I just wanted to confirm and clarify something about the telehealth waivers.

You mentioned that this guidance will be coming out next week. And I was wondering if you could share any additional insight that you might be able to provide to us today about what those waivers are and when exactly they will be coming out. Thank you very much.

Kim Brandt: So all I can tell you is this is a gray area right now. We do anticipate giving guidance hopefully very early next week on the new telehealth provisions that were given to us by Congress and then the recent legislation and bill that was enacted.

We, as you know, at CMS already have a number of telehealth provisions in place that we utilize normally but this gives us additional flexibilities, which allows us to expand and, you know, do things like site of service and really be able to address some of those issues.

But I'm afraid I can't give you any more details until the guidance comes out. But it will be coming out very soon.

(Molly Gilbert): Okay. Thank you very much.

((Crosstalk))

Coordinator: Our next question comes from Cynthia Morton. Your line is now open.

Cynthia Morton: Hi. Thank you. Cynthia Morton again here from National Association for the Support of Long-Term Care.

I'm kind of following up on the ombudsman question. We're a little concerned that the new revised guidance coming out on visitors to nursing facilities could exclude our rehab therapists or our lab techs or our x-ray techs. Can you shed any light, again, on what that guidance may show us later?

Kim Brandt: I'm going to defer to our colleagues in CDFQ to see if there's anything specific that they can speak to you on that before we issue the guidance.

Cynthia Morton: Thank you.

David Wright: There is discussion about health care workers who are tasked with ensuring the - you know, providing service to specific patients within facilities and depending on what's going on in that facility, the level of protective equipment that they'll need to be able to wear in order to be able to see those patients.

Cynthia Morton: Thank you.

(Matt): And this is (Matt). I think to answer the ombudsman question, it is my understanding that residents would still have the right to access an ombudsman if in-person access is allowable.

Alina Czekai: And we'll take one more question, operator.

Coordinator: Our next question comes from (Jeffrey Davis). Your line is now open.

(Jeffrey Davis): Oh, hi. I'm sorry I got disconnected before when I tried to ask my question. But my question relates to EMTALA. Are you considering issuing any EMTALA waivers given the declaration announced today or open to discussing potential waivers?

Kim Brandt: Great question. That is something that we are currently finalizing. And are granted the authority to do EMTALA waivers under 1135. We just did not have a chance to finalize all of our guidance and associated, you know, sort of supporting documentation on that to be able to announce them today.

But that is something we are open to discussing and we are looking to have a follow-up now that we have the overall 1135 authority.

((Crosstalk))

David Wright: On March 9, the agency issued some guidance to state surveyors on EMTALA. You can find that on our Web site.

(Jeffrey Davis): Yes, yes. We try to promote that to our members but it didn't address in that guidance that there are EMTALA waivers if you had this declaration, which you now have. So that's why I asked that question. So thank you for that guidance.

Kim Brandt: Yes, you know, it does give additional authorities, to your point, that the guidance was an important step forward but now this give us even more tools to provide to all of you.

That is one which as you know is more of a facility-by-facility call. So we just wanted to make sure that when we go ahead and actually use that authority that we're set up to be able to answer the questions and be able to triage those incoming requests.

(Jeffrey Davis): And a final point, as you consider potential EMTALA waivers, I think going to your telehealth guidance that you're putting out next week, please consider the ability to provide a screening exam to get telehealth as you are looking at potential EMTALA waivers because that's very important. To be able to provide those medical screening exams via telehealth is really critical during this crisis. So thanks for considering that.

Kim Brandt: That's a great point. Thanks for raising that. And we'll certainly take that back. As you can well imagine, given the situation, it's a very fluid thing and we're trying to give as much flexibility and try to get as much information out as we can. It helps to have folks like you kind of point out some of these issues so that we can piece it all together.

Well, with that, I think we've come to the end of our time. Before I hand it back to Alina, I just want to thank you all for getting on the phone this evening.

I really encourage you to look at our CMS Web site, you know, on either the emergency stage or click on the COVID link that has a lot of stuff the White House also has, a whole section that we get into guidance on this where you can find a lot of this as well.

But please know there are several email addresses and other things in our press release and in the accompanying fact sheet that went out today that you can, you know, email or reach out to us if you have questions. So with that, I'll hand it back to Alina and thank you again.

Alina Czekai: Great. Thanks, Kim. Just echoing Kim's expression of thanks for helping on our call tonight and just overall appreciate everyone's collaboration and good work to address COVID-19. With that I'll end the call. Be well and have a good weekend. Thank you.

Coordinator: This does conclude today's conference. You may now disconnect. Speakers, please stand by.

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