Centers for Medicare & Medicaid Services
Hospital Association Office Hours Call on the
Ending of the COVID-19 Public Health Emergency
Friday, May 5, 2023
3:00 pm-4:00 pm ET
Webinar recording:
https://cms.zoomgov.com/rec/share/_KQV0li_hiDKWDiyusLMbXuIxLDthk54NNdne6uc_1m4Wcx9Gww6UovpJoi3CNC3.jnqQq7dvwsfcbVvs
Passcode: na1n$=g9

Will Harris: Hello and welcome everybody. Thanks for coming in. We are going to let people in for another few seconds and then we will get started. Looks like it's slowing down now and we have quite a full room so let's get rolling. Hello and welcome. My name is Will Harris. I'm a senior advisor in the Administrator's office here at the Centers for Medicare and Medicaid Services. Thank you so much for joining us today for the stakeholder call on the ending of the COVID-19 public health emergency. I'm going to be walking through what will be changing for Medicare after May 11th and we have an incredible group of subject matter experts from across CMS to answer questions that you submitted and to make sure we answer lingering questions that you asked coming in here.

Before I do that, I do have a few housekeeping items to go over. The webinar today is being recorded. In a few days we will post it on the CMS national stakeholders call page. While members of the press are welcome to attend this call, please note that all press and media questions should be submitted to us using our media inquiries form which you can find on the CMS Newsroom page. All participants will be muted during the presentation. Closed captioning is available via the link shared in the chat by our zoom moderator. While we won't be able to individually respond to every question, we're working hard to make sure our CMS web pages, Medicare Learning Network, FAQs and work sheets are accurate and comprehensive.

During this webinar we will be posting links to the pages in the chat. Any Q&A that you submit that we won't get to we will be reviewing and making sure to use that in our work to continue to provide clarity on this important issue. Don't forget that for many of the questions regarding any provider's individual circumstances, it might be best answered by your Medicare Administrative Contractor or MAC, that would also be a great resource.

With that I'm going to turn it over to Jean Moody-Williams who is the Deputy Center Director for the Center for Clinical Standards and Quality. And then We'll go from there with remarks from Nancy Foster from the American Hospital Association. Thank you.

Jean Moody Williams: Thank you Will. Hello, I wanted to add my thanks on behalf of all of us at CMS to all of you for everything you've done to ensure access to quality healthcare in extreme circumstances. Throughout the pandemic, we have benefited from your open dialogue, your recommendations for solutions and it has been really something that we worked through together. We would also like to thank Nancy Foster for working to keep the lines of communications open even as we begin to wind down from the emergency phase. We've learned a lot during the pandemic and we're using that knowledge to build a stronger healthcare system.

We also know we're going to continue to learn over the upcoming weeks and months. So, we welcome you to share your research, your knowledge, your thoughts with us as we prepare for the next event, because there likely will be another event. We want to make sure that we have established a resilient system of health and healthcare. So again, thank you and with that I will turn to Nancy to frame our discussions. Nancy.

Nancy Foster: Thanks so much, Jean. I really want to reach out on behalf of the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, and America's Essential Hospitals to thank CMS for hosting this webinar to help all our hospitals and health systems be prepared for next week when the public health emergency comes to an end.

We know that there's still a lot of questions out there in the field and very much appreciate your willingness to get on this webinar with us. But more importantly I really want to thank CMS. During the pandemic, early in the pandemic you rapidly stood up a plethora of waivers that really enabled the healthcare system to rapidly expand capacity to work with our clinicians, to allow them to practice at the top of their license so that we were better serving hundreds of thousands of Americans, millions of Americans coming to us for care during the pandemic. Literally, hundreds of thousands of lives were saved as a result of the work you did that enabled us to do a better job in the work that we do. And it couldn't have been done without the waivers that you all provided us. So, thank you for that.

I know that over the last couple of weeks we've been hearing a wide variety of questions from our members but there are four I would like to call out as being particularly common questions that we hear. And I hope that you'll be able to address them during this webinar. First on telehealth. We know that Congress acted to extend the waivers on telehealth or at least many of them but not all of them. So, some clarity around what can be done particularly in hospital outpatient departments, what can be provided, what can be billed for and what cannot, would be helpful.

Second, in several communities we know that hospitals remained very, very full, even overwhelmingly full and that many of the pandemic flexibilities that were allowed, such as the hospital without walls flexibilities, continue to be used to serve our communities. If a hospital is in that situation, is there anything they can do to help work with you and continue some of those flexibilities so that they can continue to care for the massive demand they're experiencing in their community.

Third, during the pandemic we saw critical access hospitals take advantage of one of your waivers, the waiver of the 96-hour rule and be able to care for patients for longer periods of time. Now that the pandemic is coming to an end sort of in the middle of a calendar year, in the middle of many fiscal years, how is CMS going to calculate whether they comply with that 96 hour average over the course of the year? And also, if they have shown to themselves and their communities that they could care for those more complex patients for longer periods of time, is there a way we can have a conversation with CMS about whether there's a better way to create a line of demarcation between the kinds of care that should be delivered in a critical access

hospital and what should be transferred to a more major hospital than just imposing a sort of blunt 96 hour rule?

Finally, with the announcement you all made earlier this week about the end of the vaccine mandate, just a process question. How will we know when that occurs? I know it's a condition of participation, it wasn't included in the memo that -- that very helpful memo that you all sent out earlier this week, but what's the signal? What signal are we looking for to know that the vaccine mandate has ended? So, with that, I really want to turn it back to Will to get to everyone's questions and again thank you so very much.

Will Harris: Thank you very much, Nancy. Appreciate that. We've got a slide deck that we're going to go through. It's a medium-sized slide deck that we're going go through to give an overview of what's changing before we then get to some questions. Thank you, Jill, for running this for us and feel free to go to the next slide.

So as background that I don't think here needs, this is sort of a timeline of how we came to be where we are. You'll remember that this all started with a national emergency declaration in March of 2020 under the National Emergencies Act. There have been several major pieces of legislation enacted that affect what we're doing going forward including the FFCRA, the CARES Act, the American Rescue Plan, the Inflation Reduction Act and even the omnibus bill from the end of last year. All of these have had major impacts on you and the rest of the healthcare sector about how we will be moving forward from the PHE. The end of the PHE, anticipated end of the PHE happening next Thursday was announced on January 30th and we have been putting out information about how to prepare for that since even before then. But since the end of January we've all known that this moment was approaching. Next slide, please.

So, during the PHE we took a number of steps. We used emergency authority waivers, we issued new regulations, we engaged in enforcement discretion and also sub regulatory guidance to make sure that we were doing what we could to ensure access during the Acute phase of the pandemic. Many of those steps are going to terminate with the PHE for a few reasons. In a lot of those situations CMS just doesn't have the statutory authority to take that action outside of a PHE. So, we are just limited by the authority we have and need to comply with the law when a PHE is not in place. Again, a lot of these steps were really what I would call break glass efforts to make sure that we kept access flowing; we kept access to healthcare services available. They were necessary during those acute and extraordinary circumstances of the pandemic. But we do need to return to normal operations for many of those regulation that help us to ensure patient safety and high quality care. Next slide, please.

You'll remember that these are some of the ways that we took action during the pandemic, particularly early on and have continued to in the several years since. You'll remember seeing these images coming through. Next slide, please.

Back in August like I said earlier, we started talking about how the healthcare community should start preparing for the end of a PHE. So, in fact since the third or so week of August 2022 we started saying you should start thinking about how you will prepare for the end of the public health emergency, make sure you're ready for it, here's how. In that roadmap blog, we laid out

what our principles were in thinking of how we would be moving forward past the PHE, how we would use the lessons learned, and how we would be moving forward. As a short kind of high level way to think about this, and as I'm sure you heard before, if you've heard me or any of my friends here on the call talk about it, we sort of put the different waivers and flexibilities that CMS engaged in into a few different buckets. There were things that were appropriate during the acute and extraordinary phase of the emergency, that were good ideas to do, that we are learning from our experience on, and we want to keep those on hand for the future. We're putting those in our play book for, you know, what we do when there's a public health emergency. It's not just a pandemic that can cause a public health emergency, but a natural disaster can occur and make a localized area necessitate a public health emergency. I'm from Louisiana and I always think of hurricanes because that was my life when I lived there. And often times when a hurricane comes through if it has a significant impact on a system in a localized area the process occurs to declare a public health emergency and that happens. We'll keep some of these regulatory flexibilities on hand so we can switch them on. We know they are good ideas, we have them for the future. We don't have to go through the process of developing them and getting requests for them. In the future we will switch them back on. That's one bucket. Another bucket are things that were good ideas that we have the authority to extend and continue or that Congress gave us the authority to extend and continue during the pandemic. And it will last longer and will be around on May 12th in addition to May 11th. So that's very exciting too. And then the third bucket, if you go to the next slide, Jill, the third bucket are things we decided, you know, we have to keep the safety and high quality of care for patients and residents of a healthcare facility at the center. There were some that we ended even before the PHE. This is just a couple of examples of those. Feel free to go to the next slide, Jill, please.

Again, these are just a few of the ways that we initiated some of those flexibilities. We did it in different ways and they all have different ways that they are now pulling down. Next slide, please. Some of the high-profile waivers and flexibilities that are ending just to point out here, and we have more detailed information about them in our fact sheets and frequently asked questions, but many folks asked us about whether we can continue to waive the requirement for a three-day inpatient hospital day at a skilled nursing facility care. That's one where the statute says that CMS cannot waive it. So, the statute requires us to do that. So, on May 12th that waiver will no longer be in place. The COVID-19 demonstration authority that we use, we set up a demo to pay for over the counter tests through Medicare. When we created that demo we created it to end when the PHE ends. So that's how that will work. And I know we've already mentioned hospitals without walls and how that will end and how related services are treated. We'll get to that in just a second. Next slide, please. This is a graphic visual timeline for you that shows when different things end. May 11th being the far left point there of when the PHE ends. Many of the blanket waivers, most of the blanket waivers will end on that day. There's, you know, a couple of flexibilities like one that allows for long term care pharmacies to go in and separately bill Medicare for vaccinating long term care residents in skilled nursing facilities. That ends on June 30th of 2023. That doesn't mean they can't do it after June 30th, it just means they have to seek payment from the facility instead of separately billing Medicare. That was an enforcement discretion activity that we weren’t able to extend beyond June 30th. You can read everything else that's on the timeline there. I don't have to go through it all. As you all know, many of the telehealth flexibilities that we have put in place that we're going to get into further detail about in

a little bit were extended through the end of 2024 by the omnibus funding bill back in December. Next slide, please.

I'll talk about Acute hospital care at home just for a second. This expanded the hospitals without walls initiative. So, I mentioned earlier that hospitals without walls will end with the PHE. Acute Hospital care at Home continues and the omnibus funding bill from December extended that program through the end of 2024. So, you can still apply to participate in that. There's a link there for you where you can learn more. Next slide, please. We're going to talk about telehealth for a little bit here and we'll get into more detail when we get into questions. But as I just mentioned, the CAA id 2023 extended many of those flexibilities through the end of 2024. Those telehealth flexibilities remain in any geographic area, not just rural areas which was the case prior to that legislation. They can be done at home. The patients can seek that care from their home instead of going to a healthcare facility to engage in that service. Audio only services continue to be available for people who might have trouble accessing broadband or not have smartphones. Next slide, please.

As you probably also know, Medicare advantage plans can offer broader or additional telehealth services and accountable care organizations or ACOs may offer telehealth services that allow for primary care doctors to care for patients without an in-person visit. Next slide. In Medicaid, what a lot of folks perhaps didn't realize is that telehealth flexibilities have been around for a long time even before the pandemic for the Medicaid programs. Telehealth has been offered, was offered before the pandemic in many states. That coverage varies by state. The states have always had that flexibility and that doesn't change with the end of the PHE. The Medicare team put together an incredible telehealth tool kit that the link is here but if you search CMS Medicaid telehealth tool kit you will get to the same spot. It's really an incredible resource. I encourage you to look that if you're interested. Next slide, please.

Finally, with private insurance it can vary by plan, and patients of course contact their plan to learn more about their individual coverage. Next slide, please. Let's talk briefly about access to COVID-19 vaccines, testing and treatments. I see this get reported on incorrectly a lot so I'll take a moment to talk about what we're not conflating here. For just about everything when it comes to access and payment for vaccines and treatments for COVID, nothing is different on May 12th as it is for May 11th. There's a separate process that some of these products are going through that you might have heard called commercialization about how these products are going to come to the commercial market, when they are no longer purchased by the United States government. So right now, any of the vaccines or treatments that folks can get, with the exception for one treatment that's already reached the commercial market, those are procured by the United States government and then distributed across the country so that they can then be provided to patients. So long as that United States government procurement is occurring nothing is changing. Right. So, the United States government procurement of those products is not changing because of the end of the PHE. That's a separate track and a later track later this year that is based on the commercialization timeline and to the private market for those products. So, when a Medicare beneficiary has a test, a COVID-19 test, lab test that's ordered by a doctor or other qualified provider, that is going to continue to be covered without cost sharing. Access to the vaccine will continue to be covered without cost sharing and the treatment and access to oral antivirals will be the same after the PHE as it is now. Next slide, please.

Another wrinkle to talk about: the American Rescue Plan Act is what kicks in for the Medicaid program. State Medicaid and CHIP programs have to provide coverage without cost sharing for COVID-19 testing, vaccines and treatments through September 30th of 2024. It's until the end of the calendar quarter that ends one year after the end of the calendar quarter in which the PHE ends. So, if the PHE ends as anticipated on May 11th of 2023, the ARP coverage period ends on September 30th, 2024. Next slide.

Finally, with private insurance, vaccines will continue to be covered. The American Rescue Plan provision that required private insurance to cover over the counter tests ends with the PHE. So that requirement of the plan will end, of the private insurance plans will end. Some plans may continue to do that and may choose to do that. It's going to vary by plan and folks should reach out to their plan to make sure they know what their own coverage is. And treatments should generally continue to be covered. Again, there's no requirement that private insurance plans cover the treatments without cost sharing. There hasn't been during the PHE and there won't be after the PHE. They may make changes to that but if they do it won't be because of the end of the PHE. Next slide, please.

Finally, Nancy mentioned the vaccination requirements earlier as I'm sure you saw announced earlier this week after the given current events and after the legislation that was signed that ended the national emergency and the end of the PHE coming up next week. In light of those developments and comments that we received when we issued the interim final rule, we are soon going to end the requirement that covered provided and suppliers have policies and procedures in place for staff vaccination. We're going to share more details regarding ending this requirement at the anticipated end of the public health emergency. In all cases we're going to continue to remind everyone that the strongest protection against COVID-19 is the vaccine. We are continuing to encourage everyone to stay up to date with their COVID-19 vaccine. This also of course does not change anything about you as a hospital, your ability to require that of your own employees. So, nothing would change there. This is just the CMS requirement that will be ending. I know that Nancy mentioned wanting to know how you'll know when this occurs. CMS will announce this and will ensure that that gets to you. We will not be hiding that announcement. I will ensure that it gets to you personally. But I also think it will be very hard to miss. Next slide, please.

Finally, there's some other useful resources that we linked to here on this last slide. I'll say very quickly that I think the best and most comprehensive resource that we have are the provider specific facts sheets that we have available on our coronavirus waivers website. If you go to CMS.gov/coronavirus-waivers and then look in the section about the provider specific fact sheets, each one of those is really your best source of truth for what is going to be different on May 12th than on May 11th. In addition, we've had a few different fact sheets and sets of frequently asked questions rolling out over the last week. I know I've heard that those have been helpful despite obviously more questions coming in along the margins, but I hope you have found those helpful and that those have provided some clarity that you needed. Next slide, please.

Finally, a word about the unwinding of the Medicaid continuous enrollment requirement. As I'm sure you know, other legislation that Congress passed ended the requirement that states not engage in Medicaid redeterminations during the pandemic. So that ended at the end of March. So, states can engage in those redeterminations now. You are talking to folks who might be covered by Medicaid and may see them in your practice and your communities. I would encourage you to help us tell them to make sure that their mailing address is correct with their state Medicaid program and make sure they are on the lookout for any letters or correspondence from their state Medicaid programs to make sure they answer that mail and ensure that they continue to have the coverage that they need. There's a resource page here if you go to Medicare.gov/unwinding they have got an incredible set of resources that you can use to help people know what they need to do to make sure they maintain coverage. So, check that out. Next slide, please.

I think this is our last slide. Finally, during to say how we've learned from this experience and how we're moving forward into the future, my friend Jean Moody-Williams who spoke earlier is leading the effort at CMS to, you know, look at and evaluate, analyze what we did, what went wrong, what went wrong during the course of the pandemic and make sure that we're incorporating the lessons learned during the public health emergency into our efforts to ensure that the healthcare sector is resilient moving forward. We're just so proud of that work at CMS and think that we have come a long way and we'll continue to be prepared in the future. We've streamlined the process by which you can request and ask for 1135 waivers. There's a link there to learn more about it. There are new additional resources to help folks learn about how to submit new 1135 waivers. Next slide. Is that it? I think that might be the last slide. In which case you can just pull down the slides Jill. Thank you very much.

That is that. I hope that was helpful. I'm going to turn to the list here of questions that we got during registration and I'm going to call on folks to help me answer those as well as try to answer some of them myself. But I'll try not to be too dangerous doing that. The first one I think I just talked a little bit about but I want to make sure to acknowledge that we got it. The question here, I'll read a little bit of it says that many of the changes during the PHE seemed to be well received by patients and clinicians. Are we open to hospitals making the case that some of those changes should be permanent? Essentially is CMS opening to listening? I know Nancy mentioned this question earlier. The answer is of course. Like one of our strategic pillars that our Administrator, Chiquita Brooks-LaSure has laid out for us is listening to stakeholder input and making sure we incorporate that into our policymaking. We're of course open to doing that at any time. The healthcare resiliency work group that Jean leads is of course looking at that. We want to hear about that. So, we want to hear about what worked well, what didn't, what you want to know about. We're your right resources to come to. I know Nancy knows how to reach us. I'm happy to also funnel those requests and suggestions to the right place. So, I'm very happy to do that. We want to hear about it and want to know more moving forward. Like I said earlier, the best things we did and the things that worked well, we will have in our playbook for the future. I want to make sure that my friend Jean doesn't want to add anymore on that based on our healthcare resiliency work group work. Jean?

Jean Moody Williams: Thanks. We are continuing to look at it. We have a process by which we involve the entire agency including our senior clinicians, we have many clinicians that are here.

But as I mentioned, we know that because of the nature of the blanket waivers, we don't always know who used them and how effective they were. So, we welcome any information that you have as well. So please feel free to engage us in your ideas. Thank you.

Will Harris: Thank you very much, Jean. Thank you for that question. Another question that we got that came in that I believe Nancy mentioned at the top was on the 96 hours length of stay requirement. That is a requirement that won't be waived after the PHE. It does end there. I know we have a couple of really technical questions about when exactly that end does, when does it begin. We're looking at how to make sure we're clear about that in our documents and the information that we're putting out. But I will say that probably the best resource for you on that one is to talk to your MAC and ask that Medicare Administrative Contractor for the details about how they are going to be treating those billing technicalities. So that's the information that we have there. I wanted to address that since I know that came in a couple of times.
I want to turn to Emily Yoder who is going to help me out with some of the next questions. We've gotten a few questions about telehealth and some detailed technical questions about what telehealth will look like after the PHE ends. So, Emily, why don't you take that away? Thank you.

Emily Yoder: Sure. Thanks, Will. Before I get started I actually want to point out that I believe that a link was posted in the chat but we have updated the provider facts sheet that provides basically some FAQs about the issues that I'm going to cover. So, I'm going to provide an update on a few of the specific telehealth questions that you all submitted. So first I'd like to clarify the circumstances under which a hospital would bill for the originating site facility fee, which is HCPC code Q3014. When the hospital would bill for the clinic visit G0463G code, which is G 0463 visit after the end of the PHE. So, after the end of the PHE, hospitals may only bill for the originating site facility fee if the beneficiary is located within the hospital and the beneficiary received the Medicare telehealth service from an eligible distant site practitioner. In that circumstance, the hospital is serving as the originating site. Regarding G0463, that should only be reported if the beneficiary is within a hospital and receives a hospital outpatient clinic visit. This can include mental and behavioral health visits from a practitioner who in the same physical location. However, if the beneficiary is not in the hospital or is in their home and receives a mental or behavioral health service from hospital staff using telecommunications technology and there are no separate professional services, in this circumstance would bill for the applicable C codes describing remote mental health services furnished for beneficiaries in their homes. Those are HCPC codes C7900 through C7902.

We have also received a number of questions regarding to the extent to which hospitals can continue to bill for certain services such as therapy services when initialed furnished to beneficiaries in their homes through communication technology on the UB4O claim form following the end of the PHE. The waivers that currently allow for this flexibility were under the hospitals without walls initiative and as you know and as Will covered that, that will expire at the end of the PHE. In context of the anticipated end of the PHE, we have received a number of inquiries from you all regarding the expiration of this policy and including questions about whether policies other than the expiring waivers are relevant to this issue. We want to say that we recognize the urgency of these questions and they are currently under review. Any updates to these policies would appear on our emergency pages. So, folks should keep an eye on those.

Finally, we've also been asked about whether eligible distant site practitioners may furnish Medicare telehealth services from provider- based departments of hospitals without violating specific provider based rules. Answer is yes. Consistent with our pre PHE policies, eligible distant site practitioners and provider based departments may bill for their professional telehealth services without violating the provide-based rules. With that I will turn it back to Will.

Will Harris: Thank you very much, Emily. That's very helpful. I know that answered a lot of the common questions that we got that came in during registration. I want to answer a couple of the questions that came in in the Q&A function. This is common, we've gotten this question in other settings as well about what's happening with mask requirements and other type of source control requirements in healthcare settings. How is the end of the PHE being affected by that? As I'm sure a lot of you know what CMS does is defer to experts and essentially incorporate by reference nationally recognized infection control and prevention efforts or guidelines in our conditions of participation. So, CMS requires that facilities follow nationally recognized guidelines. What we mean by that are the guidelines put out by folks like our sister agency at CDC or places like OSHA. So, we really defer to the expertise of the epidemiologists and the infectious disease control experts at agencies like those. So be on the lookout for any updates from them. We will make sure to follow and will be paying attention in our requirements based on what they are recommending as far as source control and other infection prevention and control efforts. I know that's come in a couple of times.

Let me see if there were others I can get to. There were a couple of questions about data reporting and burden. You know, we hear that and want to make sure to say we hear the concern on that obviously. The CDC and their data collection efforts are important for surveillance reasons. You know, we have announced that those reporting requirements can continue unless we take other action until the end of April 2024. We'll be keeping a close eye on what is working there and how to move forward there. But we are in close touch with our colleagues at the Center for Disease Control and Prevention and are frequently discussing moving forward with our friends at that sister agency. So, thank you for raising that. I will go to one of the next areas of questions that we got during registration. If Nicolas Brock can help me out, one of the questions that came in was about whether partial hospitalization programs or intensive outpatient programs will be able to provide virtual services. Nicholas?

Nicolas Brock: Thanks, Will. So, the consolidated appropriations act in 2023 telehealth extension does not extend remote flexibilities for partial hospitalization services. The statutory definition does not allow it to be provided in a home or residential setting. At the end of the PHE all partial hospitalization services must be provided in a hospital or CMHC. Regarding intensive outpatient, this is not currently defined as a benefit under Medicare. However, as Emily mentioned earlier, in some circumstances, hospitals will continue to be able to bill for mental behavioral health services furnished to beneficiaries in their homes by hospital staff using telecommunications technology on a permanent basis. This policy only applies when no separate professional service is billable. This was a policy finalized in the calendar year 2023 outpatient prospective payment system and ambulatory surgical payment system final rule. These services are considered to be remote mental health services. With that I'll pass it back to Will. Thanks.

Will Harris: Thank you. Thank you very much for that. Another set of questions that came in through the Q&A function here as well as in registration is about virtual supervision. I'm going to get Gift Tee can come on as well as Patrick Sartini who is going to help with a couple of these questions. Can you please answer this question that came through during registration? Is virtual supervision for auxiliary staff allowable regardless of location through the end of the year supervision for residents limited to non-metropolitan service areas starting on May 11th and is there a reason for that distinction? Gift and Patrick?

Patrick Sartini: This is Patrick Sartini. I can speak to that. So virtual direct supervision is in effect through the end of this calendar year currently. Teaching physicians are also allowed to virtually supervise residents in any location until the end of the PHE. Beginning on May 12th teaching physicians will be required to be physically present during the key portion of the service unless the training site is located out of an MSA. So, we finalized this distinction in the 2021 PFS rule. We believe that allowing teaching physicians to meet the requirements to bill under the PFS for their services through virtual presence in rural training settings would increase access to Medicare coverage services and would expand training opportunities for residents. So, we anticipate considering claims data or other studies to determine if this virtual presence policy could potentially be expanded to other teaching settings which may inform potential future rule making. Thank you.

Will Harris: Thank you, Patrick. Don't go too far because I'm going to call on you for a couple of others here. The next about verbal consent for telehealth services. Will providers be able to obtain consent for telehealth services after the end of the PHE?

Patrick Sartini: Practitioners should adhere to any code specific requirements for beneficiary consent. There are no additional consent requirements for Medicare telehealth services. For other types of virtual services such as virtual check ins, beneficiary consent is required and may be obtained on an annual basis.

Will Harris: Thank you. I know we also got a couple of questions about remote patient monitoring for new versus existing patients. I'm wondering if you can talk about that for a little bit. One of the questions, if a patient is discharged from the hospital with a referral for remote monitoring can they be enrolled for remote monitoring provider virtually for the first time after they are discharged? I think we also got asked about a patient who has been seen by a provider who determines they need follow on services that can be provided virtually and then refers that patient to a provider that has the capacity to do so remotely, do they still need an in-person visit with that provider first? Maybe you can address those and talk a little bit about those questions?

Patrick Sartini: Sure. Thanks. So, CMS does not require in-person enrollment for our PM services. However, before a practitioner furnishes our PM services to a Medicare patient we do require that the billing practitioner conduct an initiating visit for new patients or patients who have not been seen within a year. This initiating visit can occur during separately available services including annual wellness visit, initial preventive physical exam or comprehensive face-to-face or virtual E and M visit. If the E and M visit is allowed to be furnished during telehealth. We also asked for practitioners to obtain informed consent before furnishing a beneficiary with RPM services. This obtaining consent helps ensure that beneficiaries who may receive the RPM

service as appropriate are engaged and aware of their cost sharing responsibilities and also helps prevent duplicate practitioner bills. So, during the PHE, CMS clarified its existing policy about how practitioner could obtain beneficiary consent. We explained that patients could obtain this consent at the specific Care Management service initiated by auxiliary staff who work to furnish the service visit. When the beneficiaries' consent is separately obtained it may be obtained during the general supervision of the billing practitioner and may be verbal if it's documented in the medical record and includes notification of the required information. Okay. So, we expect that after the PHE, practitioners will continue to appropriately obtain informed consent before they start furnishing RPM services to a beneficiary. With that I can turn it back over. Thank you.

Will Harris: Thank you. Thank you for going through that. I think for my next one I'm going to turn to Alisha Sanders for our Center for Program Integrity to answer a question. I believe one of the ones we got during registration here is about providers being concerned about reporting their home address as the site of service for telehealth work. Can you confirm that through the end of this year, calendar year, providers can continue to use the billing address of the site that they have delivered care and what are we considering for this requirement? Is Alisha Sanders on? Did we lose her? We might have lost Alisha and CPI. I'm sorry about that. I will quickly answer for y'all that during the PHE I know we allowed practitioners to render telehealth services from their home without reporting that home address while continuing to bill from the currently enrolled location. That waiver is going to continue through December 31st of 2023. So that's not a change that will occur on May 12th. Alisha is on. Did I skip over you? I was looking for you.

Alisha Sanders: I was not connected correctly but I am now. But I did hear your response and that was accurate.

Will Harris: Sorry about that. Thank you very much. Let's go here. Several of these telehealth questions came in several times so we already hit them. We also hit on that. I'm just making sure we get to more of these questions that came in during registration. Patrick, I might have to call you back. We did get one that was specifically about teaching physicians. Can residents who are in metropolitan statistical areas continue to provide telehealth services after the PHE ends? And would the teaching physician need to be in the room with the resident for the resident to provide telehealth services?

Patrick Sartini: Sure. So, under our primary care exception policy we do allow residents to furnish telehealth services that represent low to mid-level E and M services but only in training sites outside of an MSA. Also, I'll note that teaching physicians or residents should be physically present in the same room for the key or critical parts of the service. If the training site is outside of an MSA, then the teaching physician can be present for key or critical parts via audio/video technology. That is not in the same room as the resident.

Will Harris: Thank you very much. Another question that came in just to make sure that we're clear about this one if Michelle Hudson or Don Thompson are around to answer payment questions. I think this is clear, but when does the 20% IPPS add on payment for individuals diagnosed with COVID-19 end?

Michele Hudson: Sure. This is Michelle Hudson. The CARES Act provided that 20% increase to the DRG weighting factor for patients diagnosed with COVID-19 for discharges occurring during the public health emergency. So that means that 20% increase is available for those IPPS discharges that occur on or before May 11th. Discharges that occur on May 12th or after that even if they were admitted prior to that date, they will not be eligible for that 20% increase. And we've also had a couple of questions about how this 20% add on sort of interacts with the new technology add on payment for COVID treatments, the NCTAC payment. We just wanted to note that while the 20% add on will no longer be available for discharges on or after May 12th, the NCTAT payment will continue to be available through the end of the federal fiscal year for eligible discharge. That NCTAT payment is available for discharges on or before September 30th, 2023.

Will Harris: Thank you very much for that, Michelle. In just a moment we'll turn it over to my friend Jean for concluding remarks here. But wanted to make sure to tell you all that even if we didn't -- again, if we didn't get to your question today, we do keep the transcript of the Q&A and look at that and use it to inform our work going forward. And if there's something that you're feeling like you don't have clarity about right now that hasn't been addressed in the FAQs that we put out about two hours ago or any of the facts sheets and information that we put out over the last couple of weeks or the information that we put out earlier this quarter on this provider specific fact sheet, we want to know about it. Like frequently asked questions don't happen until the questions are frequently asked. So please do send those to us and we'll make sure that our information is clear about that and gets you what you need. So please do continue reaching out to us with that. With that I'll turn it back over to Jean Moody-Williams to do some concluding remarks for us. Thank you very much.

Jean Moody-Williams: Thank you so much, Will. You got that “thank you very much” down. Sounds a little bit like Elvis there. We really do appreciate all of the questions that we have received during this session as well as prior to the session and after the session. So, we received an open opportunity to continue to send in your questions and we will address them and continue to put out the frequently asked questions as they come in. We do really thank you for, again, all that you have done. As we go through this next week and the weeks after, we will keep these lines of communications open with you and with your associations as we have done. So, with that, unless there are others that would like to speak, I think we will conclude the call. Are there any others for comments?

Lee Fleisher: Jean, this is Lee Fleisher. I just really want to thank everybody. As someone who continues to practice in a hospital setting, we know that while the PHE has ended we continue to have challenges so we really look forward to working with the entire healthcare ecosystem to serve those that we care for in the best possible way and we really do look forward to that collaboration going forward. Thank you.

Jean Moody-Williams: Thank you. And this will conclude the call.