Centers for Medicare & Medicaid Services
Office Hours on the Ending of the Public Health Emergency
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Webinar recording:
https://cms.zoomgov.com/rec/share/h8Ybu7_IAcBokyq645nqTfqN33lNAoO2-xvlor1SgJyvWODk7CUkpQ5G52S7K-Oz.rqgbZodxdWcut0on Passcode: F5??1ieU

Will Harris: Hi everybody. Welcome to this webinar on the ending of the COVID-19 public health emergency, the office hours here for the Centers for Medicare and Medicaid Services to answer your questions and present some information about what you need to know about the end of the PHE. My name is Will Harris. I'm a Senior Advisor in the Administrator's Office here at the Centers for Medicare and Medicaid Services. And I want to thank you for joining us today on this call about the end of the PHE.

I'm going to be walking through at a high level how the PHE ending will affect you, what effects that will have. And then we have a wealth of subject matter experts here across CMS who are on the phone and ready to help answer your questions. Before I do that, I do have to walk through a couple of housekeeping items. This webinar is being recorded. In a few days, we will post it on the CMS national stakeholder's calls page. And while members of the press are certainly welcome to attend this call, please note that all press and media questions should be submitted using our media inquiries form, which may be found on the CMS newsroom website.

All participants will be muted during the presentations, and closed caption 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 that our CMS webpages, frequently asked questions, Medicare learning network products, and our factsheets are as accurate and comprehensive as possible. During this webinar, we'll be posting links to those pages in the chat. And we want to hear Q&A from you, because hearing what questions you have will help us to inform those products in the future. And don't forget that for many questions regarding a provider's individual circumstances that may be best answered by your own Medicare Administrative Contractor or MAC.

And with that, I'd like to start stepping through the slide presentation that you're going to see on your screen.

So again, welcome to this webinar. At CMS, we have taken action over the course of the pandemic to put flexibilities and guidelines in place to help facilities navigate the public health emergency while still making sure that people are able to get access to the care that they need.

You can go to the next slide, please. Thank you. This has been going on since a national emergency declaration occurred in March of 2020. And also, CMS has been responsible for implementing several important pieces of legislation that Congress passed during this time that are listed in that second bullet. Some of those being the Families First Coronavirus Response Act, the CARES Act, the American Rescue Plan Act, and of course the omnibus funding bill that happened at the end of last year and before that the Inflation

Reduction Act, all of which had important pieces in it that helped us address the threat and spread of COVID-19.

More recently, the reason why we are all here, on January 30, the administration announced that it intended to end the PHE related to COVID-19 on May 11 of 2023. So that's what we're here to talk about the fact that the deadline is coming up and how to prepare for that.

Next slide, please. So, how can you prepare? As I mentioned at the top of the call, CMS used a combination of emergency authority, waivers, regulations, enforcement discretion pieces and other types of sub-regulatory guidance to make sure that people had access to the care that they need while also making sure that providers had flexibilities in place to respond to COVID-19 and ensure that there were not barriers to access to care.

Many – some of those are going to end when the PHE ends, because those flexibilities were intended to address what was happening during acute and extraordinary circumstances of the public health emergency as we face the spread of that virus.

The link that you see at the bottom of this slide is a terrific resource for you to go look at. I would highly encourage you to check it out. It's at https://www.cms.gov/coronavirus-waivers. And that has a wealth of resources there the top of which I would say that you should go check out is a list of provider specific factsheets that you can click on and go see – click on your provider type and it tells you exactly how you will be affected by the end of the PHE, what's ending, what's not ending and gives you more detail. So, check those out first.

And let's go to the next slide. Again, there were many – as COVID-19 spread across the United States, we responded in a really robust fashion and we're able to get flexibilities pushed out to make sure people got the care that they needed. That included things like telehealth waivers to make sure that people could use telehealth in ways that they weren't able to before the public health emergency. We saw a big uptick in that. Expanding hospital capacity, letting folks get care audio only by phone and also making sure that facilities had flexibility that they needed to be able to forego some of the requirements that they were usually held to so that during the pandemic they were able to keep access to care flowing.

Let's go to the next slide. So, we started preparing – as we went through the public health emergency, we were always evaluating what actions that CMS was taking. So, along the way, we were always looking at what's working, what's not working, what was a good idea, what wasn't a good idea and how do we get ready to wind this down.

In August of 2022 is when we first started talking about what you should be doing to prepare for when the PHE would end. And we did that through what we called a roadmap for the end of the COVID-19 PHE. And that's linked here on the screen. We can make sure that that's on the chat for you as well. That blog did a really good job of laying out what our thinking was around what we've been thinking about during the PE, about, like I said, figuring out what works and keeping it on hand for future emergencies, figuring out what we had the authority to extend and what we should keep going even after the PHE and figuring out what maybe we should have ended early and what we did end up ending early, and that'll segue as well into the next slide.

So, we were always focused on keeping patients and facility residents at the center of what we were doing. So, there were instances in some cases where we had a flexibility in place for the very acute most phase of the PHE and then after looking at that, evaluating it and seeing what happened, we decided to end that before the PHE ended. So that was just an example of that. So, there were several instances outlined in that memo where we went back to pre-pandemic guidelines.

Let's go to the next slide. There are several different types of flexibilities that we have put in place. We did this in a number of different ways. In general, they were issued in response specifically to the public health emergency and were appropriate only as emergency measures. So, there were instances when we don't think it would be appropriate for those to occur outside of a PHE, because it is important as always to follow those guidelines to make sure that we are keeping patients safe and following those regulations.

The regulations that were in place prior to the pandemic and remained in place in one way or another are there to ensure patient health and safety and we want to make sure that that continues as a top priority here at CMS. That being said, there are lessons that we learned during the pandemic, and we want to apply those lessons moving forward. And a few of those flexibilities are going to extend beyond the PHE and we were able to keep in place one way or another either through our own authority or through congressional action, and I'll touch on those for a minute.

But first, we'll go to the next slide and talk about some of the waivers that we'll be ending on May 11, 2023. Though, these are just some highlights. Again, if you look at the provider specific factsheets that you – that I mentioned earlier at the top of the call, those will have all the details in it about what's ending, what's not, but there are some things that we just don't have the authority, either don't have the authority to extend past the PHE or were otherwise unable to. Some examples of that are the three-day inpatient hospital stay requirement for SNF care that is written in the statute, so we're not able to waive that outside of a PHE. The Medicare coverage for COVID-19 over the counter tests was – we

did that coverage and payment using a demonstration that was set up to be time limited during the PHE. So, whenever we announced and rolled out that demonstration, we also announced that it would be ending with the PHE. So that one is also time limited. And there're several other requirements that we've been able to waive during the PHE, that just by law, we were unable to extend.

Let's go to the next slide to visualize what I mean by that. So, this is a timeline that you can see here for some of topmost issues in our waivers and flexibilities. May 11 of 2023 is the leftmost point there when the PHE ends. And you can see how that will roll out. I'll let you guys look at the timeline there for a second.

Let's go to the next slide. So, the Consolidated Appropriations Act of 2023, the omnibus funding bill that I mentioned a little while ago, also it provided an extension to the acute hospital at home initiative so that was extended through the end of 2024. This is an expansion of what you saw referred to earlier as the hospitals without walls initiative which was launched in March of 2020. Those flexibilities allowed for safe hospital care for eligible patients in their home and updated some staffing flexibility to allow ambulatory surgical centers to provide more inpatient care whenever that was needed. So, hospitals can continue to apply to participate in the initiative if they meet the requirements that are spelled out in the law. And we have more information available online about the reporting requirements and other requirements that you have to meet in order to participate in that program.

Next slide, please. Obviously, one of the most exciting pieces of flexibility that many folks took advantage of particularly early on in the PHE was the expansion of telehealth. And we also saw that expanded in omnibus funding bill, the consolidation – Consolidated Appropriations Act of 2023. That extended many of the telehealth flexibilities that CMS has put in place until the end of 2024. So those are things like being able to get telehealth in any geographic area, not just rural areas. That's been extended to 2024. Folks – patients can get care in their homes. They don't have to go to a healthcare facility to engage in telehealth. And it also expanded many of the audio only services that we've put in place for people who might not have access to broadband and not be able to do video telehealth.

Next slide, please. Please keep in mind too that Medicare Advantage plans might offer additional telehealth services. So, Medicare Advantage might have a supplemental benefit that covers even more than we might, and accountable care organizations might also offer telehealth services that allow primary care doctors to get care to patients even without an in-person visit. So, keep that in mind as well.

And you can go to the next slide. Really important to keep in mind for Medicaid and CHIP that for the Medicaid program, telehealth flexibility has been part of Medicaid for a very long time and even before the PHE. So that's not something that's going to change whenever the PHE ends. That varies state-by-state, but it's always been available to those programs. The Medicaid program has a very thorough toolkit that you can go check out at this link to go look at tools that are available for state Medicaid programs to offer telehealth to those state's residents.

Let's go to the next slide. Same for private insurance, it varies by plan. Check with your plan to figure out what coverage might be available to you.

Next slide, please. Let's talk quickly about how the end of the PHE will affect payment and coverage of vaccines, testing and treatments. And I'm going to talk about this by program, because it varies by which program we're talking about, any one of our, what we call our three M's, either Medicare, Medicaid, or the marketplace.

So, I'll first talk briefly about vaccines and treatments. When it comes to Medicare, nothing is going to change for your experience getting vaccines or treatments on May 12, as it is on May 11. I know that there can be some confusion about the difference between the end of the PHE and commercialization of the COVID-19 products. But what we're talking about here today is the end of the PHE. And the vaccines will continue to be covered, continue to be paid for. Treatments, same thing, the treatments will be treated on May 12, the same as they are treated on May 11. Again, testing the folks on – who have Medicare will continue to be able to get lab tests for the diagnosis of COVID with no cost sharing when it is ordered by a doctor or other qualified provider.

Let's keep going to the next slide. For Medicaid, the American Rescue Plan Act created something called an American Rescue Plan coverage period. And to make a long story short that continues coverage in Medicaid for vaccines, tests, and treatments all the way through September 30 of 2024. So that will also be unchanged.

Let's go to the next slide to talk about private insurance. And again, you still have coverage and payment for vaccines, testing of the – coverage of testing was a requirement for private insurance plans under the American Rescue Plan Act, and that requirement ends at the end of the PHE. So, it's going to vary by plan depending on what your – what a particular insurance plan decides to do for over-the-counter testing since that requirement, the ARP does end. But there will be no other change as far as coverage. The end of the PHE does not require plans to make any other changes about their coverage. So, whatever their coverage is on May 11, nothing changes about the way they need to cover things on May 12.

Let's go to the next slide. There are several useful resources listed here on this slide. I would certainly encourage you to check those out. The CMS current emergencies pages list all of the different flexibilities and announcements that CMS made throughout the pandemic. Those provider specific factsheets really are probably the best resources for you to look at to figure out how to prepare and I would encourage you to look at that first.

Let's go to the next slide. Separate from the public health emergency ending is the fact that the pause on Medicaid redeterminations ended at the end of March by statute because of action that Congress took. So, in addition to everything we're talking about here today, we're going to be focused on the impacts of our waivers and flexibilities ending at the end of the PHE. There's another very significant portion of work occurring about making sure that people who have Medicaid coverage are able to keep coverage if they are – remain qualified for that or transition to other coverage that they might now be eligible for.

I would encourage you to help us get the word out about this process, make sure that people who have Medicaid have their address updated with their state Medicaid program, make sure they're on the lookout for any mail from their state Medicaid program to make sure to respond to that appropriately. And also, to check out other coverage that might be available to them on healthcare.gov if they find themselves needing coverage that way.

Let's go to the next slide. One of the things that's been very important to us in responding to the ongoing PHE that will end on May 11 is making sure that we're ready for the next public health emergency. And the next time when we'll have to put waivers and flexibilities like this in place. This happens from time to time and during weather emergencies, natural disasters, there are frequently public health emergencies declared after events like that. So, we've been able to learn from the experience that we've had over those last several years to think about what we should have on hand to switch back on if we need it. We've also streamlined our request to the process by which you can request or inquire about waivers through our 1135 waiver and flexibility request an inquiry web portal that's linked there on that slide, and we have created many additional resources over the course of the pandemic to teach folks about these important flexibilities.

And that is the end of our slideshow. So, let's take down the slides if you don't mind. Thank you. And we are going to move into answering some questions. Many of you submitted questions during registration. Thank you very much for doing that. It helped us gather those up and make sure that we were ready to go today. And also, many questions are coming in through the Q&A function. So, I'm going to pull that to a different part of my screen to make sure we have that. And we will get started with these questions. Luckily

many of the questions that I see coming through the Q&A are also ones that we are – that we got through registration so we can start going through those.

Let's start with this one. A number of folks wanted to know after the end of the PHE, how hospital outpatient departments and provider-based facilities can bill for telehealth. They're specifically asking about the HCPCS codes G0463 and Q3014. I know that we've got similar questions about partial hospitalization programs, billing for remote services and whether you can continue to bill for remote services after the end of the PHE. So, I'm going to turn to a couple of folks in CM, I think, if Emily Yoder and Nicholas Brock are on, feel free to come on and answer that one.

Emily Yoder: Sure. Thanks. I can kick us off beforehand to get off to Will. So – or excuse me, Nick. After the end of the COVID-19 PHE, when a practitioner located in a hospital furnishes a Medicare telehealth service, the hospital will no longer be able to bill for the hospital clinic visit, which is described by HCPCS code G0463 or the originating site facility fee for Medicare telehealth, which is HCPCS code Q3014. However, provided that that practitioner is an eligible distance site practitioner and can bill separately for their professional services, they may bill as a Medicare distance site practitioner provided all of the other Medicare telehealth requirements are met.

The Consolidated Appropriations Act extension of telehealth services applies to services provided by physicians and practitioners. So, to be clear, this does not extend those remote flexibilities for most facility services billed under the OPPS. However, in the CY 2023 OPPS rule, we did establish coding and payment for behavioral health services under existing OPPS authority to that are provided via communication technology to beneficiaries in their home by hospital staff. And I'll hand it off to Nick here to talk about PHP.

Nicholas Brock: Thanks Emily. Yes, so just building on what Emily said, again, the Consolidative Appropriations Act's extension of telehealth services applies to services provided physicians and practitioners. That is, specifically for partial hospitalization, the CAA telehealth extension does not extend the remote flexibilities for partial hospitalization services. The statutory definition of partial hospitalization does not allow it to be provided in a home or residential setting. We don't have a statutory authority to recognize remote services as PHP codes after a public health emergency.

Will Harris: Thank you both very much. I'm going to move – Emily since we started with you, I'll stick with you for a second and get to another question about the Consolidated Appropriations Act of 2023. It extended the ability of physical therapists, occupational therapists, and speech language pathologists to continue to bill as distant site practitioners

from Medicare telehealth until the end of 2024. We've got a question about whether there's a similar extension for hospital employed therapists billing for services furnished to beneficiaries through the communication technology following the end of the PHE, they also wondered about the DSMT services. Emily, did you want to take that one as well?

Emily Yoder: Sure. Thank you. And I want to recognize that this is a question that we have been receiving quite frequently, and I noticed it popped up in the chat as well. So, the answer to this is for hospital employed therapists, the answer is no. The extensions in the CAA 2023 apply only to therapists who bill separately for their professional services. So, following the end of the PHE, hospitals may only bill for therapy service furnished to beneficiaries who are physically on-site at the hospital. That also applies to DSMT, which is Diabetes Self-Management Training. After the end of the PHE, hospitals will only be able to bill for DSMT provided the beneficiaries who are physically within the hospital.

Will Harris: Thank you very much, Emily. I want to make sure we get to some of our questions for CCSQ as well, so I'm going to pull up a few of those. There are – I looked in the Q&A chat function and did see that there were a number of questions about masking requirements and different source control requirements at different facilities. So just to say a little bit about how CMS handles that, CMS requires that facilities follow nationally recognized guidelines for infection prevention and control. Those are set by our infectious disease and other federal partners over at the – places like the CDC and OSHA. So, we really look to them for setting those kinds of guidelines. And though any changes that they make or any announcements that they make will be what we look at when we're thinking about the future after the PHE. So, look at that as well.

Let's move some of these others. I'm going to turn to Evan Shulman from CCSQ for a couple of these. Some folks asked what – can you talk a little bit more about how the PHE ending will impact COVID-19 reporting through NHSN and other reporting at skilled nursing facilities?

Evan Shulman: Sure. Thanks, Will, and good afternoon, everyone. Well, COVID-19 reporting through NHSN has been extremely valuable throughout the pandemic. Thank you all for your attention to sticking with that.

The – in a rule in 2021, CMS actually finalized that requirement to extend through December 31, 2024. So, COVID-19 reporting through NHSN does not end on May 11, it continues. But we will continue to work with the CDC on making sure that we only collect those data elements that we absolutely need to observe the current trajectory of COVID-19, but it does continue through December 31, 2024.

Will Harris: Thanks, Evan. I also wanted to – Evan since you're on, I'll move to another one that I think you might be able to get to which is on whether nursing homes are required to test for COVID-19 after the PHE.

Evan Shulman: Yeah. Thanks, Will. This one is a little bit nuanced. We've been receiving this question quite often. Technically speaking, the interim final rule that required nursing homes to test for COVID-19 does end with the PHE. However, and Will just as you described, we expect nursing home, long term care facilities to follow nationally accepted standards to have an effective infection prevention and control program. In doing so, we believe that there will still be the expectation for nursing homes to continue to test individuals in accordance with national standards like the CDC such as individuals with symptoms, or those who are close contacts of those who test positive for COVID-19, so those expectations for testing will likely still exist.

In other words, while the PHE is ending, the need to continue to protect ourselves and our loved ones from COVID-19 is not. It's just not an emergency. So, we can't forget what we've learned throughout the pandemic on what we can do to mitigate transmission and reduce severity of disease by COVID-19. And this also applies to masking and hand hygiene as well. So, continue to follow the nationally recommended practices for testing and other infection control practices. But technically speaking, yes, it does end, but the expectation of tests will continue most likely past the end of – past May 11 of this year.

Will Harris: Thanks very much, Evan. And we got that question several times. If Lauren is around from CCSQ as well, I also noticed in the Q&A we got this question many times about what the end of the PHE means for the healthcare worker vaccination role and also what changes to the rule folks need to be aware of after the CDC and FDA's announcements last week.

Lauren Oviatt: Good afternoon. I would note that the CMS's COVID-19 vaccination requirements for healthcare workers have not changed. Our rule requires that workers be fully vaccinated using the definition included in the rule which is having had all doses of a multi-dose vaccine or one dose of a single dose vaccine. Having completed the primary series sometime within the past couple of years still continues to meet this requirement. We note that if someone is currently unvaccinated, they can meet this rule of requirements by receiving one dose of the new bivalent vaccines.

Will Harris: Thank you, Lauren. I know a lot of folks were asking about that, so thank you for that. Let's go back to some of the payment questions that look like they are coming in. If John Kane is around and can come off, it looks like a lot of your questions were

coming in. Can you talk a little bit about whether the three-day rule for post-acute placement waiver will be extended past the end of the PHE?

John Kane: Sure. So, the three-day waiver policy that's – is currently in effect is going to end as of May 11 of this year. And what that means is that for any Medicare Part A-covered SNF stay that begins on or prior to May 11 of 2023 without a qualifying hospital stay, that stay can continue for as long as the beneficiary has Part A SNF benefit days available and for as long as the beneficiary continues to meet the SNF level of care criteria, for example, requiring daily skilled care.

However, for any new Medicare Part A-covered SNF stay which begins after May 11 of 2023 without that where – sorry, for any new SNF stay that begins after May 11 of 2023, which includes stays that experience a break in party coverage that exceeds three consecutive calendar days before resuming SNF coverage, those days will require qualifying hospital stay. So, I know a number of you have been asking about instances or examples where a person was admitted without a qualifying hospital stay prior to May 11, and they continue on. Some people have asked, does the stay have to end on May 11, and the answer is no. That stay can continue past May 11 as long as that person still requires skilled care and does not have a break in coverage.

However, if a person does experience a break in coverage for more than three days, that is another way of thinking about this is if they're starting on day one of their variable per diem schedule, so it's a new SNF stay. If that SNF stay did not have a qualifying hospital stay, then the patient will not receive coverage. This means, I know that this is another question that people had, that the 30-day transfer policy that typically applies to SNF coverage does not apply to those stays where the initial stay had no qualifying hospital stay, there was a breaking coverage, and now you want to pick the person back up under Part A. That 30-day transfer policy does not apply within that context, because the initial stay – the new stay does not have a qualifying hospitalization. So, you would need a qualifying hospital stay to pick a person up under Medicare Part A after May 11.

Will Harris: Thank you very much, John. I know that got to a lot of the questions that we saw coming in. If Michele Hudson and Don Thompson are around from CM, I want to make sure to get to a question that you might be able to hit here. A couple of folks asked when the 20% IPPS add-on payment for hospitals, for individuals diagnosed with COVID-19, can you talk about when that ends and when exactly that ends and how that transition will work?

Michele Hudson: Sure. Section 3710 of the CARES Act directed the Secretary to increase the weighting factor assigned to the diagnosis related group by 20% for individuals

diagnosed with COVID-19 that were discharged during COVID-19 public health emergency. That section of the law does not authorize this 20% increase after the end of the COVID PHE period. So, at the end of the PHE, at the end of the day on May 11, any IPPS discharges discharged after May 11, 2023, are not eligible for that 20% increase.

Will Harris: Thank you very much. If Sarah Shirey-Losso can come on, I want to make sure we get to some of the questions about lab testing that we received during registration and also, I see many of those technical questions coming in now that I want to make sure we hit. Sarah, can you talk about what will be the Medicare payment rate for the HCPCS code U0005 after the PHE ends? Or how – what will happen to that code with the PHE? And will that code no longer be payable for dates of service on or after May 12? And how should labs report – facilities and labs report on that after the end of the PHE? Sarah?

Sarah Shirey-Losso: Sure. Yeah. So, as you might be aware, we do have this all addressed in our factsheet as well. But just as a quick summary, Medicare did pay a higher rate for COVID-19 lab tests making use of high throughput technologies. And some of the codes created for that were U003 through U005 HCPCS codes. Now, that policy doesn't extend beyond the PHE. However, AMA, CPT created many new CPT codes very quickly to address laboratory testing throughout the PHE and these codes are still available. They're reflected on Medicare's clinical lab fee schedule. Generally, providers and suppliers should select the most appropriate CPT code that describes their test, and there are a range of payment amounts available on Medicare's clinical lab fee schedule. As an example, PCR tests or the reimbursement amount for those is about $51.

Will Harris: Thank you, Sarah. And there is a – that factsheet – there it is. Thank you, Jane, or I think it was probably Jane who posted that in the chat. I was just about to try to do that myself, so thank you for doing that. That is a terrific resource for you to read about what changes and what doesn't change at the end of the PHE. Sarah, you might also want to talk here a little bit about – I hit on it in the slides a little, but it's worth clarifying. After the PHE ends, can providers bill patients for insurance cost sharing related to COVID-19 testing?

Sarah Shirey-Losso: So, for Medicare, I could speak to Medicare fee for service. The clinical lab fee schedule actually does not have cost sharing. This was before the COVID-19 public health emergency. So that continues after as well. So, there's no cost sharing for Medicare, for diagnostic clinical lab tests that are ordered by a provider, performed by a lab that's CLIA certified and medically necessary. Thanks.

Will Harris: Thank you, really important for folks to know for sure. And David Rice, if you are around, also there was a question that came in that you might be able to answer.

Will hospitals be able to continue to bill HCPCS code C9803 for COVID-19 testing, specimen collection and hospital outpatient departments after the PHE ends, if you could talk about that code specifically?

David Rice: Sure. Thanks, Will. So, for HCPCS code C9803, which is the hospital outpatient clinic visit specimen collection code for COVID testing, that'll remain active and can be billed through the end of calendar year 2023. The status for that code for calendar year 2024 will be addressed in the CY 2024 outpatient annual rule making process.

Will Harris: Thank you very much, David. Looking through the Q&A and making sure I've matched things up here. A couple of questions that Brian Slater and Kelly Vontran might be able to get to. Brian and Kelly, could you talk about – we've got a question here about whether nurse practitioners and physician assistants can continue to be allowed to certify home health services, meaning to sign – the plan of care and certification there.

Kelly Vontran: Sure, this is Kelly Vontran. Allowed practitioners in addition to physicians can certify and recertify beneficiaries for eligibility, order home health services and establish and review the plan of care. We do define allowed practitioners in the regs at forty-four point two as a physician assistant, a nurse practitioner, or a clinical nurse specialist. All of these practitioners are required to practice in accordance with state law in which the individual performs their services. Now these regulation changes became permanent. We actually did that in the second interim final rule and are not limited to the period of the PHE for COVID-19.

Will Harris: Thank you. And one other question that you might be able to get to is whether hospice practices can still use visual technology to supplement their care.

Kelly Vontran: Sure. So, the regulatory flexibility that we put in place at fourteen, two and four is explicitly for the provision of routine home care services during the public health emergency. So, after the public – the end of the PHE, the expectation is that routine home care hospice services will be provided in-person. However, there is nothing precluding hospices from using technology that have thought about communication with the patient and their family as long as the use of such technology does not replace an in-person visit.

Additionally, such follow-up contact should be documented in the hospice medical record similar to the way telephone calls would be documented now. Also, such documentation must be in accordance with the standards of practice and also the hospice's own policies and procedures. Now, we can't enumerate all the different scenarios in which there could

be such contact via technology for follow-up, because each patient, each family and each situation is different. So, decisions about when such follow-up contact using technology may need to be based on the needs of the patient and family as well as the hospice's own policies and procedures.

Will Harris: Thank you very much Kelly, super helpful. If Scott Lawrence is here, I want to get to some of the questions that we're getting about supervision. We had a bunch of those in during registration. I'm seeing a couple come in now too. Scott, can you talk about whether CMS is considering extending flexibilities to the Medicare incident to physician billing policy regarding indirect or general supervision? Scott, if you're on your on mute. We might have lost Scott. We'll come back to Scott if he hops back on. If somebody can ping me in the chat whenever Scott's back that would be phenomenal.

Michelle Cruse, if you are around, let's talk about a couple of the vaccine questions that we got. Michelle, can you talk about the allowable fee schedules for the COVID-19 vaccine and its administration?

Michelle Cruse: Yes. Good afternoon. We do have the fee schedule available for each COVID vaccine that's furnished. And that's located on the – our Part B drug page and the payment amount for the COVID vaccines once they are commercially available there. The administration of COVID is available on our CMS page, and I'll put those links into the chat once I'm done. And that information is all available online. Thanks.

Will Harris: Thank you. And 1 other follow-up question for you, Michelle. The FDA and CDC announced some changes last week about COVID-19 vaccines. Would you like to confirm for everyone that Medicare will, of course, cover and pay for that second booster if needed?

Michelle Cruse: Absolutely. Yes. Fee for service, Medicare Part B will pay for the vaccine and the administration with no cost share.

Will Harris: Thank you very much. I want to hit some of the final CCSQ questions that I got during registration. If Kati and Charles and Heidi are around, we had a question in registration about whether providers are still able to file an EUC or ECE for the CMS QRP VVPs because of COVID-19 in either fiscal or calendar year 2023?

Kati Moore: Sure. Thanks, Will. This is Kati Moore from CCSQ for a quality payment program. So, I can speak to MIPS Extreme and Uncontrollable Circumstance Policy and then I'll turn it over to Heidi and Charles to cover the other quality reporting programs. So, for MIPS, which is the Merit-Based Incentive Payment System, we have – we report –

so our data is reported on a full year, so we don't break it up into quarters like some of the other quality reporting programs. So, we have in place an extreme and uncontrollable circumstances application process. So that is currently in place right now for 2023. The application will be available very soon for clinicians. But since the PHE isn't ending until about almost halfway through our 2023 performance year, we'll have the application available for the full performance year.

Will Harris: Thank you very much.

Charles Padgett: And this is Charles.

Will Harris: Go ahead, Charles. Sorry.

Charles Padgett: This is Charles. I just wanted to speak to post-acute care providers and ECE waiver submission. So, for the fiscal year and calendar year 2020 period, CMS will review ECE waiver submissions related to COVID-19. The ECE waiver submissions will be evaluated on a case-by-case basis, but no blanket waivers are currently in effect. After the close of the PHE period on May 11, 2023, CMS will no longer accept any ECE submissions related to COVID-19. So, we'll no longer consider those that are submitted related to COVID-19.

Will Harris: Thank you for that. I've also been alerted that Scott is back on. Scott. I'm going to turn to you for some of the supervision questions that we got. The one that I had just asked was whether CMS is considering extending the flexibility that took to the Medicare incident to physician billing policy regarding the incident or general supervision, can you address that one that we got during registration?

Scott Lawrence: Absolutely. And apologies for the technical problem before. So just to give a little bit of background on the indirect and general supervision, to allow more people to receive care during the public health emergency, CMS temporarily changed the definition of direct supervision to allow the supervising healthcare professional to be immediately available through virtual presence using real time audio and video technology instead of requiring their physical presence. CMS also clarified that the temporary exception to allow immediate availability for direct supervision through virtual presence also facilitates the provision of telehealth services by clinical staff, incident to the professional services of the physician and the other practitioners. And this flexibility is currently set to expire on December 31 of 2023. We are considering the best path for this flexibility in future rule making. Thank you.

Will Harris: Thank you. You're not off the hook yet, Scott. I'm going to stick with you for a second so that we can talk about some other supervision questions that we have got. After the PHE, residents in the primary care exception will no longer be able to bill level 4 and level 5 with the GE modifier.

Scott Lawrence: This is a good question. No, after the public health emergency residents will no longer be able to bill for these level 4 or level 5 services in any setting.

Will Harris: And there's also been a couple of questions about whether residents in the primary care exception clinic would still be able to report CPT code 99441 through 99443 after the PHE?

Scott Lawrence: So, for these particular codes, 99441, 99442 and 99443, they are currently set to expire at the end of 2023. We are considering further actions for these in future rulemaking.

Will Harris: Thank you. And just a couple of others that came in. Can you clarify whether virtual supervision of a resident is allowable for virtual visits where all participants are virtual?

Scott Lawrence: So, this is only allowable outside of what we call a metropolitan statistical area once the PHE ends.

Will Harris: And the last one that I've got here about supervision is on whether the ruling to end virtual supervision of residents will be reversed or whether an extension is possible specifically for psychiatry?

Scott Lawrence: We did finalize in our 2021 final rule that this would be – is currently set to end now with the end of the public health emergency. Thank you.

Will Harris: Thank you. Let me get here. Let's hit a couple of more telehealth questions if Patrick is still around for us to get to this. Let's see which ones of these are coming up most frequently. Patrick, could you talk about how practitioners should bill for Medicare telehealth following the end of the PHE? What kind of modifier or place of service code should they be putting on the claim?

Patrick Sartini: Yeah. So up through the end of 2023, practitioners continue using the place of service code they would have used had the service occurred in-person along with the 95 modifier to identify the service as Medicare telehealth. After that period practitioners should use the telehealth specific place of service coding, specifically place

of service codes 2 and 10, 10 for when the beneficiary is located in their home, and 2, when they are located in another eligible originating site.

Will Harris: Thank you. And we also got asked whether communication technology-based services and remote monitoring services will be billable for new patients after the end of the PHE.

Patrick Sartini: The answer to that is no. Following the end of the PHE, these will be limited once again to established patients.

Will Harris: And another question we got that I've seen echoed a few times, Patrick, during the PHE, we've allowed practitioners to provide telehealth services from their homes without reporting their home address on Medicare enrollment while continuing to bill from wherever their currently enrolled location is. If the practitioner is serving as a distant site practitioner for Medicare telehealth, and operating out of their home after the end of the PHE, do they need to update their enrollment information with us to include their home address?

Patrick Sartini: So generally speaking, yes, we expect practitioners to update their enrollment information to reflect where they are performing their services and we would note that some provider enrollment data may be shared publicly through care compare as a tool for Medicare beneficiaries define and compare different Medicare providers. However, we'd note that practitioners who have concerns with their practice location information being displayed publicly can contact Care Compare at qpp@cms.hhs.gov to provide an alternate address or to have their home address suppressed.

Will Harris: Thank you very much, Patrick. And one last telehealth question here that might be for Sarah and Michelle. Will Medicare continue to allow telehealth medical visits for RHC or for rural health clinics and federally qualified health clinics after the PHE?

Sarah Shirey-Losso: Yes, so that is correct. This is Sarah. The CARES Act of 2023 extended the use of – well, for our all intents and purposes for those of you that are billing with the HCPCS code G2025, that is extended. The use of that code is through calendar year 2024, so December 31, 2024. Thanks.

Will Harris: Thank you. We're getting to the end of what we have scheduled here today. I do want to say that we're keeping tabs on the Q&A function. Obviously, not going to be able to get to all of those questions, but – so you may notice that some of them have already been answered if you go over to that answered tab to see if there's an answer to your question there. And even if we didn't get to the answer to the question today, we're going

to download all of these questions that came in through the form to make sure we have that available to us and we're addressing it in future communications and future factsheets.

I did get a few…I saw a few questions about whether this Q&A will be available to anybody. Obviously, yes, we're posting this video afterward and we're going to look at the questions that you're providing here and that will help to inform the information that we're putting out between now and May 11 to make sure you're getting the information you need to prepare for the end of the PHE.

Let's see. I'm just looking through. There's a couple of links that we're going to sure to post in the chat here for you to make sure you get to those resources. And I will again, to wrap up, say that the best resource for you is going to be those providers specific factsheets that are available at cms.gov/coronavirus-waivers, which are really terrific resources about what's going to end and what doesn't. And again, if you do not see the answer that you were looking for in there, I hope you've put it in the Q&A and also feel free to reach out to us in your normal contacts at CMS so we can make sure that we get that addressed.

With that, I know we're almost out of time. I want to again encourage you to look at those links that we've put in the chat. I want to thank you for being here with us today. I hope this has been helpful to you and that you found this to be a useful resource for you preparing for what May 12 will look like. Please keep an eye out on what CMS is announcing between now and May 11 for more information from us as far as frequently asked questions and other guidance that we're putting out about how to help you prepare for the end of the PHE. And keep checking back on our websites for any updates.

Again, thank you for being with us and for your attention today, and thank you for everything you're doing for patients across this country. Thank you.