Special Open Door Forum: Hospital without Walls
Moderator: Susie Butler
April 9, 2020
1:30 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants will be on a listen-only mode for the duration of today's conference. The call is also being recorded. If you have any objections you may disconnect and I'd like to introduce Susie Butler. Ma'am you may begin.

Susie Butler: Thanks so much (Robin). Hello everyone, thank you for joining us today for this special open-door forum on Hospital Without Walls. We'll be answering questions that have been previously submitted. If you did not submit a question or if you have a question that is not addressed today please send it to partnership@cms.hhs.gov and we will try to address it in a future call.

This special open-door forum is open to everyone. If you are a member of the press you may certainly listen in but please refrain from asking questions during the Q&A portion of the call.

With that I would like to introduce our two speakers, first for an overview and some background Dr. Shari Ling who is our Acting Chief Medical Officer and then to walk us through some of the work going on in the innovation center is Dr. Michael Lipp. And then we have a whole panel of subject matter experts who will be responding to some questions that have been submitted. So let's start with Dr. Ling.

Dr. Shari Ling: Hello, good afternoon and thank you all for committing some of your precious time to spend it with us today and let me first say that we are eternally grateful for all that you are doing to care for our beneficiaries who are your patients.

So by way of overarching welcome we just want you to know that we at CMS are making every effort for you and your roles as part of the healthcare system expanding capacity to respond to the COVID-19 Coronavirus pandemic. And it can be overstated that this really is an unprecedented situation and from what we see and hear of you all are really rising to the occasion.

So over the past recent time, over the past few weeks we've actually finalized new risks waiver and regulatory flexibilities for both healthcare providers, healthcare personnel and facilities and together these actions are really intended to provide ways for our health systems expand to meet the surge – the demand to temporary expansion site as well as enhance and expand the healthcare workforce.

And finally the enhancing the ability to provide care for patients wherever they are through alternative care sites including the home and using technology through some of the telehealth flexibility that you've heard of recently so collectively the flexibility from the facilities and temporary expansion sites have functioned as part of a Hospital Without Walls concept that we believe will bring value to solving to the current healthcare needs.

We have been tracking some of the healthcare providers and systems and in collaboration other federal agencies really bearing witness to some of the innovative and approaches that are being taken really again to be able to meet not only the demand of – and needs of our beneficiaries and patients who have COVID-19 but also those who do not and who remain in need of healthcare.

So really appreciate all that you are doing and at this time I'd like to turn it over to Dr. Michael Lipp who is our Chief Medical Officer for the Center for Medicare/Medicaid Innovation and he will be walking you through at a high

level some of these flexibilities and also helping to pull this together for a broader understanding. So with that Michael are you on the line?

Dr. Michael Lipp: Yes I'm here. Thank you, Shari, great. Given that there's a diverse group on this call that may be working in different parts of the healthcare system I'm going to spend a few minutes talking about the new flexibilities at a high level which really aim to increase hospital capacity and then I'll touch a little bit on the flexibilities for providers who will be essential to staff if possible.

So CMS has two critical roles. So number one, to ensure that beneficiaries receive safe and effective care during the COVID-19 public health emergency and number 2, to ensure that Medicare payment and coverage policies during the COVID-19 public health emergency do not impede providers from working to expand capacity to patients.

In light of the public health emergency CMS is enabling significant health system flexibility through waivers and regulatory flexibility. For waivers CMS issued National Blanket 1135 waivers for hospital conditions of participation of provider-based rules, the physician self-referral law or STARK law and this will enable expansion of hospital services and on and off campus in existing clinical and non-clinical spaces to allow hospitals to work under arrangements with providers.

Under the regulatory flexibility CMS published an interim final rule with common period that will clarify rules for hospitals to furnish inpatient services under arrangements with providers, expands physician supervision requirements for inpatient and outpatient hospital services, expands services that can be furnished through telehealth, expands coverage of ambulance transport to additional sites.

What does this mean for hospitals? So under the waivers and new rules CMS is allowing hospitals to provide services in locations beyond their existing halls to help address the urgent need to expand care capacity and develop sites dedicated to COVID-19 treatment. Under the current requirements, hospitals must provide services within their own buildings which raises concerns about capacity for treating COVID-19 patients during a surge, especially those patients which may require a ventilator or intensive care.

Under the new temporary waivers and rules hospitals will be able to treat patients in temporary expansion sites including sites that were previously used for clinical care such as ambulatory surgical centers, freestanding emergency departments or inpatient rehabilitation hospitals or for those not used for clinical care but had been repurposed such as tents, hotels or dormitories.

In these locations, there's still the inability to receive hospital level payment. For example a healthcare system may convert a nearby hotel to provide inpatient care for acute medical surgical beds while using the hospital to care for COVID-19 patients that may be of higher acuity.

In addition CMS has created a specific path with more streamlined enrollment and cost reporting requirements to allow ASCs to become hospitals subject to meeting the more flexible conditions of participation which are in place during the public health emergency. Some other flexibilities include these such as CMS waivers that will permit doctor owned hospitals to increase the number of beds and as I mentioned earlier allowing ambulances to transport patients to a wider range of locations when other transportation is not medically appropriate.

So what does this mean for providers? CMS wants to add depth of the healthcare workforce since doctors, nurses and other staff on the front lines

are being challenged like never before. CMS is issuing a blanket waiver to allow hospitals to provide benefits and supports to their medical staff such as – things such as meals, laundry service, with childcare service as well for physicians and other front line staff caring for patients from the hospital.

CMS is making it easier to provide us to enroll in Medicare. We know that local private practice clinicians and their trained staff may have greater availability given that non-essential care in elective surgeries may be postponed during the pandemic.

Entering the health teaching hospitals quickly expand the workforce and medical residents will have more flexibility to provide services under the direction of the teaching physician. In addition to being able to directly supervise a resident with their physical presence teaching physicians can now provide support virtually using audio/video communication technology. CMS will also permit wider use of verbal orders rather than written orders by hospital doctors so they can focus more of their time on taking care of business.

So as Shari mentioned clinicians will be able to care for both COVID positive and COVID negative patients in a variety of different locations and bill for their services. This can include caring for patients within the walls of the hospital where clinicians can care for hospital inpatients with face-to-face visits or via telehealth. They can do so as part of the hospital staff or as the independent medical practice of those group professional services.

Of course these clinicians should meet their hospital credentialing requirements and ideally be versed in the hospital EMR system. In the temporary hospital expansion sites this may include tents and other non-clinical locations that have been repurposed for inpatient care. Clinicians may

care for patients and bill for professional services as they would if these services were furnished within the walls of the hospital. So again these locations clinicians can care for patients with face to face visits or using telehealth.

So after a hospital discharge clinicians may decide to care for patients in the patient's home and that could be either with a face to face house call or via telehealth. And this may be supplemented with things like home health and remote monitoring. For a group of patients, a provider may decide to have the patient follow up in the office for necessary face to face visit and ideally when doing this, this would be using measures to avoid potential COVID transmission between patients and that can include things such as spacing appointments between patients and avoiding use of the wait areas.

So in all of these different settings providers really play a critical role not only in managing patients during the hospitalization but also after discharge to ensure good care transitions and ensure close follow up, ideally with the patient's primary care provider. So with that I'm going to stop there and hand it back to Shari.

Dr. Shari Ling: Thank you Dr. Lipp. So with that we thought it would be appropriate to answer some of the questions that we have been receiving and know that you will have additional questions, some of which are at a very detailed level. But all in all we encourage you to continue to submit your questions to the COVID-19 mailbox. But for the question-and-answer period I'd like to turn this over now to Susie Butler.

Susie Butler: Thank you so much Dr. Ling. So I'm going to ask a few questions here and I have some folks I'll be calling on for responses. So we'll just work through the list as time allows.

First question, on your hospitals without walls there's an already enrolled hospital provider need to revise this enrollment to reflect an increase in temporary beds in alternative care sites such as a convention center, a hotel, temporarily constructed beds, et cetera. (Ing-Jye)?

(Ing-Jye): Thank you Susie. CMS usually requires hospitals to file an amended form CMS 855-A when there's a new location that's been added. And we also generally require an onsite survey for compliance for all of the hospital conditions for participation for new inpatient locations.

However CMS will be exercising our enforcement discretion and will now be conducting the onsite survey for these hospital search locations during the public health emergency. In addition hospitals may begin billing for their care in these search locations prior to completing the amended CMS 855-A for care furnished during the PHE, Public Health Emergency.

Susie Butler: Let me follow on with another question there (Ing-Jye). If a hospital and an ASC arrange for the ASC to be a temporary expansion hospital site but the site cannot comply state licensure laws for hospitals would Medicare still pay the hospital for its hospital services provided at that ASC site?

(Ing-Jye): For the hospitals expected to be operating under the state's locality emergency preparedness or pandemic plan for the hospital to meet the PLTs and obtain the necessary state approvals including licensure subject to that plan. We believe many states have put in place emergency actions to streamline their approval and licensing processes for temporary expansion sites but this is still required.

Susie Butler: Great, thank you. (Chris) I have one for you. Can a hospital temporarily relocate an on-campus provider based department to an off campus site in response to the COVID-19 emergency and continue to bill under OPPS for services furnished by the provider based department.

(Chris): Hello. This is a great question and it really has to do with the subpoena levels that we recognize for on campus and off campus providers under some recent rules. I think right now what we've been able to say is that we've allowed hospitals to expand that capacity through our 1135 waivers. These are related to conditions to participation and we've also waived on that blanket waiver list the requirements for (unintelligible) based departments that's for 1365.

However the question of payment remains one that we are still actively considering so we want folks to know that we are working on that issue but we don't have an answer at this time.

Susie Butler: Thanks (Chris). (Ing-Jye) and (Ryan), this next one's for you. Are there requirements as to the quality of video and/or related to interruption of video transmission during the provision of a telehealth visit?

(Ing-Jye): That's also a good question. This is (Ing-Jye). There are none to furnish telehealth services under Medicare and the practitionary furnishing that telehealth needs to use a device that has real time audio and video capability but we do not have specific rules for the quality of the connection. But we would note for folks providing these telehealth services is that the code recorded should always accurately describe the service that is provided.

So for example, you can't do a visual evaluation because of a bad connection. You should not be reporting and billing the service that requires that – this rule evaluation.

Susie Butler: Great, thank you. (Chris) here's one for you. I'm interested in whether the Hospital Without Walls initiative contemplates hospital level of care being delivered in a home setting and if so how would payment be structured?

(Chris): So this is a question that is coming up a lot Susie and one that we are spending a lot of time thinking about. Obviously we have waived the requirements for provider based rules but the questions that are coming up is what happens when care is furnished in the home and can the hospital bill.

I think right now our statement to date has been that is the hospital is furnishing services outside locations that a field can comply with the requirements that we have waived to date, then as long as it remains responsible for the quality control of care that falls within the scope. But we do understand that folks would like a little bit more understanding of what in the home means and we're actually working on that question.

Susie Butler: Thanks much. Well I've got one more for you here. Can freestanding EDs that are not connected with a hospital system provide care on behalf of hospital system through hospitals without walls?

(Chris): Yes. During the COVID-19 emergency we are allowing hospitals to provide inpatient hospital services at temporary expansion sites. These can include ambulatory surgical centers, repurposed gyms, tents, freestanding emergency departments and other sites that are deemed to meet the – that the hospital believe they can guarantee the refined levels or condition of participation veterans set that intersect during the public health emergency.

We also will pay for an inpatient care being furnished at sites under arrangement. So if the hospital again can guarantee the quality and that they

have sufficient control responsibility over the patient then that also is an option for folks.

Susie Butler: Well (Chris) you're on a roll so I've got another question for you. With CMS waiving the provider based department requirements at 42 CFR 41365 does this mean that hospitals can use all hospital owned facilities listed under 413.65 A12 at hospital locations for providing those inpatient and outpatient services that facilities include ASCs, corps, HHAs, SNFs, hospices, IRFs, ITDs, ESRD facilities, ambulances and RHCs? The locations would also need to be remaining hospital conditions of participation.

(Chris): Correct. That's correct. I'm not 100% on ambulances but in general there are several facilities that are not allowed to be pro rata based apartments. However, we have those waived those requirements in order to allow for tremendous flexibility and operating temporary expansion sites during the public health emergency.

So Medicare will pay for inpatient services provided at those sites as if they were provided at a permanent inpatient location of the hospital again assuming the hospital has official control and responsibility over those locations.

Susie Butler: Okay great, one more for you (Chris). For critical access hospitals using an offsite location what other directives for qualifying level of care when using the offsite location. Will a new level of care be identified specifically for COVID and offsite care sites? Has a level of care been determined for direct placement to offsite locations through ED triage? Are there specific requirements for discharge planning from offsite location?

(Chris): So that's a lot of great questions there. Some of them are going to be specific because each facility I should say is going to have to figure out some of those answers for themselves. I think what we're saying, I think it's important to emphasize that we're not making them different in the conditions of participation that are operating at COVID or non-COVID sites.

These are levels of conditions of participation that are available for folks to operate their temporary expansion sites, whichever population they're dedicated to and whether they are on or off site. The big requirement is that the hospital has to be sure that those refined COPs and they are certainly much more flexible during this public health emergency than normal as the ones that are in effect. As long as those are in effect then the hospital has quite a bit of flexibility to be furnishing services on and off site.

Susie Butler: Great, thank you. (Ing-Jye) this next one is for you. We have also received several questions regarding the rules for observation status and the use of condition code 44 in light of the PHE. Is there anything we can say at this point on these issues?

(Ing-Jye): I think what we can say at this point is we haven't changed the definition or the payment rates for services like observation services. One of the questions that many of you on the phone probably already know, that the use of condition code 44, condition code 44 is a code that could be used on a claim if a physician ordered an inpatient admission but subsequently determined that in fact the stay would not be inpatient.

And it's a little unclear to me what the questioners are specifically asking about as far as why we would be pursuing changes related to these policies. So it'd be very helpful for those who wrote in on this if people could provide some specific examples or shed some light on the context in which these

questions are being asked. And I'll share an email that they can send those to that would help us better refine our response to this. And the email address is hapg_covid-19@cms.hhs.gov.

Susie Butler: You might want to give that one more time.

(Ing-Jye): Sure. It's H-A-P-G, underscore, C-O-V-I-D, dash, 19 at C-M-S dot H-H-S dot gov.

Susie Butler: Terrific, thanks. (Chris) we're back to you. If an enrolled hospital expands capacity with a temporary site like a building on its campus and that site is approved by the state agency for purposes of safety, must the enrolled hospital request case by case waivers for each condition of participation that they believe they cannot meet in that space where such conditions of participation are not already addressed by the existing waiver package?

(Chris): So it's a great question and lots of institutions feel like they're in this space. I think what we're asking is where folks feel like there is a blanket waiver that hasn't been issued that needs to be addressed and we'll do two pieces. Blanket waivers are ones that apply to everybody. If you feel like there's something in the blanket waiver that hasn't yet been addressed and you would like the agency to consider it broadly you should let us know and I'll give the email box at the end.

Second, to the extent that there are specific places where you feel like you need additional flexibility on a case by case basis, you can always write into the box and let us know as an institution what those concerns are. Those would be sometimes we issue specific waivers but we do need to get the requests into the box. I do think that there – it might be worth checking with your local map on what it is they plan to look at locally and discuss through

some concerns that you may have about a specific condition of participation and that email inbox is 1135waiver@cms.hhs.gov.

Susie Butler: Great, thanks (Chris), looks like the next question is for you as well. We received a few questions regarding certain PPS exempt hospitals such as cancer hospitals or pediatric hospitals acting as surge sites during the PHE and furnishing medical care to beneficiaries that are not their typical patient, for example a pediatric hospital treating an adult. Are these things – are there things that we can tell these types of providers about these circumstances?

(Chris): So again I want to make the distinction between any payment specific concerns if you have a particular kind of hospital, a PPS exempt hospital and you have a specific concern about the conditions around your exemption status that you would like to be considered then that is a question that we would take separately.

I think beyond that as long as your hospital is consistent with the state's pandemic plan and licensure and the alternative care site or your facility is meeting the conditions of participation as we have outlined, then that facility can operate either as a temporary expansion site facility or if they are an enrolled facility, they can operate and bill the program. If you have a specific question about the payment status of a particular hospital, those questions should come into the box that (Ing-Jye) mentioned earlier. They are HAPG_COVID, C-O-V-I-D dash 1-9 at CMS dot HHS dot gov.

Susie Butler: Perfect, thanks (Chris) and again another (Chris) question for you. We have also received questions about the state government, U.S. Army Corps of Engineers or other governmental entity establishing a new care location in our area by repurposing and retrofitting a convention center, gymnasium, tent or other site for patient care.

Hospitals are then asking what happens if they are brought in after these sites are built to operate the staff. Can they bill Medicare for the facility and professional services that are furnished there?

(Chris): So we know there are – the short answer is yes and I'll walk through a little bit of what we know about this. There are certainly many, many different arrangements that are getting under way around the country and we are working very hard to stay abreast and help get the answers to folks. I know we've seen permutations unseen of mixed, public, private hospitals coming together and our goal is to be as supportive as can be to these different situations given the public health emergency.

And so we're trying to get out information as possible. You may find that you have a unique circumstance that you don't feel like has been addressed and we would continue to ask you to send in those specific questions or circumstances as we continue to try and monitor them. But I will tell you that Medicare enrolled hospitals that assume the majority of operations are the temporary expansion site including gymnasiums, tents, convention centers and others that was built or retrofitted by a public entity can bill Medicare for covered inpatient and outpatient hospital services provided to Medicare beneficiaries at those temporary expansion sites.

These temporary expansion sites need to meet the refined hospital conditions of participation. Hospitals would need to follow existing rules to bill under the applicable Medicare payment system depending on whether they provided outpatient or inpatient care and as folks should know hospitals should as the DR condition code inpatient and outpatient claim for patients treated in temporary expansion sites.

Practitioners that furnish – cover professional services to Medicare beneficiaries in the temporary expansion sites can bill Medicare for these hospital services. Practitioners should use the applicable place of service code depending on whether the temporary expansion site is being used to furnish outpatient or inpatient care and practitioners should add the modifier CR to professional claims for patients treated at temporary expansion sites during the public health emergency.

Susie Butler: Great, thank you. We're going to finish up here with three questions on long term care. So the first one is CMS is offering 1135 waivers to modify conditions of participation to hospitals. As LTCHs participating in Medicare listed here to hospital conditions of participation do these waivers also apply to the LTCHs? (Ing-Jye)?

(Ing-Jye): Sure thing.

Susie Butler: (Unintelligible).

(Ing-Jye): I was on mute. I want to echo what (Chris) said earlier, that our goal with all of these policies is to offer as much flexibility as possible with respect to specific questions on conditions on participation and LTCH, Long Term Acute Hospitals, LTCHs are not subject to a specific LTCH condition of participation. They're subject to the hospital conditions of participation so that such the waivers would apply.

Susie Butler: Great. How about Medicare Advantage cases? Do the 1135 waivers apply to Medicare Advantage cases?

(AJ): That's a great question. We are in the process of following up on this and hope to have more information on that question soon.

Susie Butler: Okay. I have one more question for you (Ing-Jye) and then I'm going to turn it over to Shari before I close it out. The CARES Act temporarily waives site neutral criteria and will pay LTCHs and the LTCH PPS amount for all cases. How will CMS implement this provision?

(Ing-Jye): Section 3711 of the CARES Act waives the site neutral criteria and indicates that CMS should payout the LTCHs, the higher LTCS the PPS amount for all cases. And we are in the process of working on updating a lease to our pricing prop player so that our administrator contractors can implement this temporary payment policy which is effective for claims with an admission date occurring on or after January 27, 2020.

I want to stress that last point that it's admission date and not discharge date and that it would be for admission date on or after January 27, 2020.

Susie Butler: Terrific. Thank you so much and I want to thank all of you who took time to answer questions today. I do want to turn it back to Dr. Ling to see if she has anything to share as we close out the call. Dr. Ling?

Dr. Shari Ling: Yes. Just to sum up by again thanking all of you for joining us today. We hope that the information that we provided is helpful to you but you also have the appropriate mailboxes to send additional questions that may be more specific to your situation. And I know that there will be additional outreach and learning opportunities in the near future. So I want to thank also all our subject matter experts, Dr. Lipp and of course Susie Butler so back to you Susie.

Susie Butler: Thank you Dr. Ling. If you got in late on today's call and want to listen to a recording of the entire call we should have it posted very soon on our podcast

webpage to find that. Go to CMS.gov. Click on the homepage photo of the Coronavirus. Go clear to the bottom and there are partner resources there, a toolkit and the podcast. You can listen to many of the recordings that have occurred already if you do desire or download a transcript.

Since you were on today's call rest assured that you will get invitations to future calls and we'll get those out as soon as we know about them. Thank you so much and thank you for all you're doing. Have a good day.

Coordinator: Thank you. This does conclude today's conference call. You may disconnect your lines. Thank you for your participation.

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