On-Demand Webinar: "COVID-19 Waivers: What Providers Can and Can't Do"

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0:06
Good morning everyone and welcome to today's webinar hosted by PYA, "COVID-19 Waivers What Providers Can And Can't Do?"

0:17
PYA is leading Professional Services firm providing expertise and healthcare tax management consulting and audit and Assurance. We are pleased to offer you our thought leadership on this important topic all attendees have been placed in listen-only mode. You may submit written questions using the questions pane of the control panel. Our presenters will address as many questions as possible during the Q&A session at the end of the webinar.

0:47
Our if we cannot answer all questions due to time limitations, we will supplement the written transcript with our written responses. Please be aware with more people using online platforms outages can occur should the webinar be paused we will work to restore it as quickly as possible and all of our webinars are recorded and released after the event that I would like to introduce our presenters, Marty Ross and Kathy Reep.

1:22
Thank you, Laura and good morning everyone. This is Marty Ross speaking with you today from my home office here in Kansas City. Join with my colleague. Kathy Reep who is coming from her home office in Orlando, Florida. Kathy really glad you're able to join us today. Kathy is formerly the Vice President of Finance with the Florida Hospital Association and in her four decades and Healthcare she has seen a hurricane or two, and has intimate knowledge and experience working with the section 1135 emergency waiver.

2:00
So after doing some introduction regarding the waivers in terms of the legislative authority for the secretary to take action will do an introduction to the initial blanket waivers that CMS has published them were weighted have these of a dive more into the opportunity for individual states to pursue waivers, then finally, we'll discuss how individual providers can avail themselves of this process and then we intend to leave as much time as possible or question and answer. So let's just jump right in to our substance here. Well, actually, let's go back a bit.

2:47
One of the 1135 waivers was a new authority that Congress gave HHS as part of the original COVID-19 response legislation. That was the expansion of the Medicare Telehealth waiver.

Specifically Congress authorized Medicare to lift the geographic and location restrictions for Medicare reimbursement.

3:13
We addressed that subject in our webinar on Monday and it is now available on-demand on our site, you see the link here. Yesterday in a national telephone conference CMS administrator Burma announced that there would be additional guidance coming forward on the Telehealth waiver and its application. It was in the context of hopefully by the end of the week. But as soon as that information becomes available, we'll be sure to get it to you. The one bit of good news that we can report here is that you're all familiar now that there's been agreement reached on the CARES Act and although there's not been a public release of the actual language of the agreement. We do know in the original proposed legislation. It did include the expansion of Telehealth benefit to rural health clinics and federally qualified Health Centers. That's one small update. We can provide since the webinar on Monday. So with that we're going to focus on the balance of the 1135 waivers starting again with that.

4:22
That legislative authority and it's a series of events that have to occur before CMS begins publishing the actual waivers first. We have to have the president declare an emergency under the Stafford act or the national emergencies act. We know that occurred on March 13, and then the Secretary of Health and Human Services has to declare a public health emergency that happened way back on January 31st.

4:51
So once those two events occur, under Section 1135 of the Social Security Act, the HHS administrator then can exercise waiver authority with regard to very specific list of Medicare and Medicaid Program requirements.

5:09
And then in fact Secretary Azar took that action also on March 13th in most part authorizing the center for Medicare and Medicaid services to both publish blanket waivers that apply across Is the board to all impacted Medicare Medicaid providers, but also then to have the authority to issue individual waivers based on requests from States as well as individual providers. Each waiver that is issued remains in effect for 60 days.

5:38
Although they can be renewed, but they terminate automatically at the end of the emergency. There may be provisioned for some very short wrap-up period that is the most part keep in mind as we talk through these requirements and they Opportunities they all terminate at when the emergency is lifted. Also keep in mind. These are federal requirements only there is no authority under Section 1135 or the secretary to waive any state law requirement at all has to be accomplished by individual action on the part of State Governors. So be sure you're following closely your office of the governor website to see the publication of different authorities impacting State programs I've mentioned previously The authority under Section life 1135 to issue formal waivers is limited to certain program requirements. It is not “across the board”, “however, you feel like doing it” authority to CMS.

6:44
There are in fact these ten areas in which CMS or other HHS agencies can take action under Section 1135 and that comes with a small asterisk as you note item number 10 here on the slide

refers to the three day prior hospital stay that is actually not an 1135 waiver. It's a 1812 waiver. But who's going to argue over say a few sections, But as you see these are limited in scope primarily go to administrative tasks that providers have to accomplish and is very specific in where we can go to impact change in addition to this.

7:27
There is guidance that CMS has issued back in March of 2019 which define how the agency will exercise its authority. So we have to keep that in mind as well as we walk through what's happening now with the 1135 waivers.

7:47
I'm going to turn this over here now to Kathy since she has greater familiarity with the requirements with regard to claim submission when you're acting under an 1135 waiver, Kathy.

8:02
Thanks, Marty. Good morning to everybody. Glad you're able to participate on the webinar this morning. Just a little bit from a billing perspective because of some of the waivers that have been issued in order to get your claim to bypass current edits and we'll talk about some of these a little bit later, but some of the edits that are in the medicare payment systems once a waiver has been approved or issued. Then there are certain codes that you have. To put on your claims in order to bypass edits for institutional claims you're going to use the DRCondition code just basically saying that it is disaster-related. You do not use a DRCode currently on claims submitted for Part B. You would submit the CR modifier for professional claims.

9:02
However, there was on Monday a meeting of the national uniform billing committee. The national uniform billing committee has approved that the condition code DRCould be used on Part B claims.

9:22
Once that has been adopted by the national uniform claims committee and I believe they are meeting very quickly to move forward with adoption of that code, so that they would also be at you would also be able to put DROn A Part B non-institutional claim. I think the thing to remember on these codes is that the use of the DRor the CR really goes back to the designation of the public health emergency by the Health and Human Services and unless there is a waiver in place for particular items with in your state or a blanket waiver nationally, then you cannot use the DRor CR codes you must have the authorizations in place first. Marty?

And just one note is as we discussed in the Telehealth webinar on Monday one does not utilize these codes or condition codes or modifiers on new telehealth claims CMS is very explicit on that point and its publication of the guidance with regard to the Telehealth waiver.

10:46
Oops. Sorry went page too far there. Of course while the 1135 is the formal process for waving regulatory requirements during an emergency. There are other options available to the federal agencies to provide regulatory relief or providers during a National Emergency. There is a process by which they can informally waive procedural Norms that are part of their own guidance or policy.

11:15

As you know, there are Miles and Miles of manuals under which CMS operates and how it directs the activities of its medicine Medicare administrative contractors. There is authority there so long as that procedure isn't in fact a reflection of a regulatory or statutory mandate CMS has flexibility there. And in fact, it has begun to issue guidance to the max specifically related to different guidance based requirements. Additionally the agencies can exercise enforcement discretion, and where we saw this this week was CMS ‘s action with regard to survey inspection. They announced they would be following a new streamlined process for hospital and skilled nursing surveys.

12:12

And in fact, those surveys would be limited to immediate Jeopardy inspections based on complaints as well as very targeted infection control inspection inspections. They would not engage in regular stands surveys or re-inspections. The action that CMS took in this regard is consistent with what we're seeing from the accreditation agencies such as joint commission and their decision also during the National Emergency not to pursue surveys.

12:41

But again, that's an exercise of agency discretion and I believe we’ll see more and more coming out from different agencies under this discretionary action as more specific obstacles are being identified within the emergency circumstances.

13:00

And finally, of course the agency retains the ability to publish interim final rules with comment period. On the administrative procedure act generally requires an agency to publish a proposed rule, allows us to specified period of time for comment, review of that comment and then publication of final rule. But an exigent circumstances an agency can issue an interim final rule, but poor going the comment period up front but allowing for the comment period subsequent to the Publications rule. Again, on the webinar yesterday Administrator Burma indicated that it is likely that we will see these interim rules coming out of CMS.

13:43

So where they don't have the authority under Under 1135. They potentially can then change the regulatory structure through this interim final rule process. Again, our job here is to keep on top of that make sure that we're push that information out to you as quickly and as relevantly as possible.

14:04

But with that background, let's talk about the blanket waivers that CMS has issued thus far. If you want to get to the core documents here. There are three that pertain to the blanket waivers.

14:21

The first was the March 13th emergency Declaration of the healthcare waivers provider fact sheet, which came out at the same time that secretary Azar signed the actual waiver authority to The CMS explaining how it's going to the first round of its implementation of the waivers. Then there's a March 18th MLN matters special edition article. It is probably the authoritative piece right now.

14:51

If you want to turn that document certainly what we use to build this presentation for you today complimenting that the office of civil rights issued its HIPAA bulletin which talks about the particular waivers of HIPAA requirements during the emergency again.

15:09
We have links to these documents available to you on the PYA COVID-19 Hub. So what we know of the blanket waivers, they break down into five categories.

15:20
We're going to talk about these waivers within this categorization. About Hospital capacity, workforce expansion, eliminating red tape and administrative requirements and then specifically what has been done under HIPAA and EMTALA requirements, very important to understand the limitations on the waiver authority, especially in the context of HIPAA and EMTALA and is Kathy will talk about that presents opportunity to pursue a request for individual waivers that go beyond those relatively limited waivers that are within the plant under the blanket.

15:56
So starting with hospital capacity in three particular areas, under skilled nursing facilities and probably the most significant of all the blanket waivers, is CMS permitting the transfer patient to a Skilled Nursing Facility without a prior three prior three-day qualifying Hospital stay.

16:18
So this allows hospitals to effectively clear out less acute patients and get them to a Skilled Nursing Facility where they can receive an appropriate level of care. You don't have to go through the three days before you can transfer to a SNF and have that then SNF State qualify for reimbursement. So because this is creating its own set of capacity issues. Now of the skilled nursing facilities is there are seeing increased volume. So certainly encourage hospitals to be working with those post-acute Partners open very clear lines of communications.

16:55
We're going to see much more rapid transfer patients in this facility.

16:59
Second area for expanding Hospital capacity was the utilization of Hospital distinct part units the rules as they stood before the waiver. We're very specific on where patients could be bedded with in a hospital that had the state part units. So first of all you are able to place a cute patients and a steak part unit such a psychiatric units or Inpatient Rehab units provided that you can provide appropriate care to those acute care patients in those units.So as you are increasing the need for bed capacity, you've run out of acute beds, it allows you to effectively invade those units to provide acute care services. The flip side, it’s also true if you have patients that are in distinct part units, it becomes necessary to transfer them to acute beds, you may do so. Again only so long as you can continue to provide the appropriate level of care, rehabilitive care, psychiatric care, in those acute care beds. CMS also clarifies here that you would continue to bill for those Services Under either the psychiatric or rehab IPPS, even though the patient is then actually in an acute care unit.

Yes, but for the patient who are cute that you put indistinct part your first bullet, you do continue to build those patients under the inpatient prospective payment system not the payment system for the unit where they've been placed.

18:39
Excellent. Third opportunity for increasing Hospital capacity is looking to our critical access hospitals. Do you know the conditions of participation for those hospitals require that they limit

their inpatient beds 225 that they are restricted to have admissions that do not exceed 96 hours. Both of those limitations have been lifted and we're already hearing reports of are several critical access hospitals that are finding themselves bumping up against those units against those limitations.

19:09
Keep in mind again. You can only take this action and move these patients, manage capacity, in response to COVID-19. So you'll have to be big sure you're within that appropriate context. Now that's medicare's world, what they're doing. What do we know about the commercial payers in this context? The American health insurance plan board of directors, a couple of days ago, released a statement.

19:39
with regard to hospital capacity issues. You'll see here the quoted language from those statements first making clear that yes, it's permissible to move patients into skilled nursing facilities. The expectations and Commercial plans is that both the hospital and the Skilled Nursing Facility will provide notice to the plan the next business day after that transfer occurs. More broadly on other Hospital capacity issues,

20:07
you'll see more the board of directors encouraging and reinforcing action by other commercial plans that are expanding out to mirror what Medicare has done. Again, don't worry about taking a snapshot of your computer right now. The slides will be available on our website as well as the recorded transcript from this presentation. But this is positive news, certainly if AHIP is taking this lead. They AHIP board of directors is very representative of the large commercial payers.

20:39
So we're seeing some good movement here. But otherwise the fact Medicare is issued the waiver as we said before doesn't change anything except that a care rules and just hope that commercial payers follow suit. So we have consistency, continuity as we adjust our business plans, adjust our procedures to reflect the blanket waivers.

21:03
But that second category of waivers relate to Workforce. Importantly CMS has a broad requirement across all of its programs that the individual Furnishing services, to be reimbursed under Medicare, must be appropriately licensed in the state in which they are Furnishing those Services. The blanket waiver now allows the provision of services by an individual in the state in which they are not licensed.

21:31
But only again for the purpose of providing services that relate to the emergency. Keep in mind. However, and this is the critical exception, is nearly every State Board of Medicine requires that an individual Furnishing services to a resident of that state be licensed in that state.

21:50
So now in follow to the blanket waiver, we're saying a number of Governors now issuing orders that permit Unlicensed individuals to come to the state and furnish services. For example here in Kansas on Sunday Governor Kelly issued an order of course waving the licensure requirement, but requiring Physicians to provide written notice to the State Board of Healing Arts. They will be providing services in the state of Kansas. So all of these orders from the states are going to

have some variation them in as well. Be sure you're aware of these. The general consensus is that this includes Telehealth that it would allow.

22:31
Allow an individual to provide that my health services to patients and other states within the concept of the Telehealth waiver, Though CMS has not specifically addressed that issue. There is some inconsistent prior guidance on this point, but it appears now that the consensus is around that this applies also to Telehealth, but remember got to worry about the state licensure requirements in this context. Second Workforce expansion.

23:02
Action taken by CMS and of the blanket waivers concerns provider enrollment. Provider enrollment CMS is simplifying the provider enrollment process. They have in fact now published on their website toll-free hotlines where you're able to enroll quickly and receive your temporary.

23:31
Re-enrollment and they're also waving fingerprint requirements and site visits and they're postponing revalidation actions. Again, their goal is to get as many people into the system providing Services possible CMS with respect to other those apply, excuse me to Providers a non-physician practitioners for other providers CMS.

23:51
Also Expediting the process, promising to act within seven days of a clean online submission 14 days for a clean paper submission of application and are also waving some of those background requirements as well with regard to provider enrollment.

24:08
Third category are administrative requirements. And sort of are all across the board. But most importantly on the area of Medicare appeals. We're extending time periods in which to file those appeals they’re waving timeliness and request for information. They're processing appeals. So, allowing appeal to go forward, even if you do not have the appointment of representation forms completed yet, and they're also following they're going to permit requests for appeal even today.

24:37
Not meet all the required elements.

24:39
So a great deal of Grace being exercised by CMS here with regard to the appeals process. For home health agencies import they are relieving the time frames in which Oasis Transmissions must be completed and they are also giving the Medicare administrative contractors the authority to extend Auto-cancellation dates from the date of requests for anticipated payment. Skilled nursing facilities, they are providing extended benefits for individuals who have exhausted coverage in certain circumstances, without having to start a new benefit period which becomes critical in terms of your total SNF day allowance and they also relieving the timeframes for MDS assessments and transmission for are durable medical equipment providers. They have issued the blanket waiver that permits the replacement of lost DME.

25:38
If the beneficiary is unable to access or if they've lost their equipment due to the emergency that can be replaced without the requirements of physician visit physician authorization in the like and finally with respect to Part B. Drugs. They've expanded coverage for replacement

prescriptions in those instances where medications that are either unusable or unavailable due to the emergency.

26:06
So very specific in the area of requirements. These are very similar to what one has seen through the hurricane emergencies as CMS has issued those blanket waivers. Fourth category on HIPAA, and most important thing to keep in mind here is this is really narrow. As you see there are only five specific HIPAA requirements where CMS, excuse me, office of civil rights, the agency that enforces the HIPAA Privacy Rule, they have waived penalties associated with non-compliance in five specific areas. So it includes the having to First receive the patient's permission to speak with friends or family members, honoring a request to opt out of the facility directory, the requirement of Distributing the notices of privacy practices as patients arrive at the facility,patient's right to request privacy restrictions ,and patient's right to request confidentiality Communications.

27:06
OCR will not pursue penalties against hospitals for non-compliance with those Provisions, but only, but only, underline that a couple of times, only when the hospital has instituted its faster protocol and only for a period of 72 hours following the implementation of that protocol. So, keep in mind it's only for hospitals.

27:31
It's only very specific provisions of HIPAA, and it's only going to remain in effect for 72 hours following the implementation of disaster protocol. Again Kathy's going to talk about the opportunity to seek expanded waivers under HIPAA. Finally. Let's talk about EMTALA. Prior to the National Emergency declaration. So pre waiver, on March 9 CMS published guidance on EMTALA as it applies to COVID-19.

28:07
Noted that it is appropriate for a hospital to identify an alternative screening site on the hospital's campus, but required that a qualified clinician be present to redirect anyone who actually arrived at the emergency department, they would have to escort them to determine appropriate and escort them to that alternative facility with regard to off-campus Alternative screening sites.

28:37
CMS noted that it is appropriate to encourage the public to go to these sites, but made clear that you could not redirect a patient from the emergency department once they arrive to go to an off campus facility. Now with the waiver, CMS expands that authority.So there are now more options available to a hospital under with regard to managing this patient flow into the ED without risking EMTALA liability.

29:07
So it is now appropriate to relocate a patient to an off-campus site. So what you could previously pre waiver, to relocate a patient to an on campus site, can now also do with regard to a off-campus site. But only if you're taking that action consistent with the state emergency preparedness.

29:32
The other EMTALA exception under the waivers regards transfers on and permitting facilities that do not have capacity or capabilities to manage COVID-19 patients to transfer them while

they are still under the EMTALAs definition of unstable as you know under until there's an obligation on the facility transferring the patient to the receiving facility to stabilize.

30:02
That patient prior to transfer always been an interesting area of interpretation on what's stable for transfer. But in this case CMS has waived that particular requirement to ensure that we have smooth and efficient transfer of patients in from facilities that either are overwhelmed or don't have the capacity for appropriate isolation of COVID-19 patients.

30:30
So that is our realm of the blanket waivers. I think you're probably appreciating as we did as we delve into these that they are relatively narrow and these are blanket waivers that are well tested by CMS. Most have previously been issued under either the hurricane, the flood, or the H1N1 emergency declarations. So that means there's a great deal of room here to pursue individual waiver requests from CMS.

30:59
Appreciating at the same time that CMS is already signaled that it's intended to expand those blanket waivers as it becomes more attuned to the needs of hospitals during the emergency period so I'm going to turn this over to Kathy here to discuss individual waiver request.

31:17
Thanks Marty.

31:22
There we go, in order for an individual and order to get additional waiver request. You must submit a request to your regional office. We have a slide coming up that will give you the addresses for the various Regional Offices and what states apply to each but you must submit a formal request. In the past.

31:55
we have done very extensive letters that were really going through explaining why Needed each and every item that we were asking for. However about well, I guess it was on Sunday CMS came forward with a template format that really was almost a checkbox. Gave a cover introduction saying this is why waivers are being requested, ask for fill-in-the-blank information in terms of what organization or state is asking for the waivers.

32:29
Contact information, things like that and then it went proceeded to give a list of about six or seven items that just said here. Do you want this this this and this and it listed numerous items that you could then go in and check off saying I want this. I think any provider probably would check off saying I want all of these, but for instance under Medicaid authorizations, it was to suspend.

33:00
the Medicaid prior authorization requirement. Also requiring fee for service. Providers to extend pre-existing authorizations for those who have already received them to extend them for a longer time. Suspend the requirements under the paths are Level 1 and 2 assessments for skilled nursing facilities.

33:29

It was already mentioned, but the minimum data set authorizations for skilled nursing facilities and nursing homes to suspend the requirements for that. So a number of items that were listed, that CMS gave the opportunity to say do you want this, and the thing that is important on these items is, they are not automatic unless you submit this waiver request. There are some items that were on here.

34:00
Gve you an example under provider enrollment waive the requirements of Physicians and other Healthcare professionals be licensed in the state in which they are providing services so long as they have equivalent in licensing and another state that is very important and you need to make sure that it is clear that this is a waiver that is of been approved for your state in order to operate under this.

34:29
Another one that I just wanted to call your attention to that is under provider enrollment is a statement wave the conditions of participation or conditions for coverage for existing providers for facilities for providing services and alternative settings including using an unlicensed facility. If the providers licensed facility has been evacuated and that's where it ends with what CMS submit.

34:59
Have to check off in other words in order to use alternative settings including an unlicensed facility. Your facility would have to have been evacuated. We are suggesting that if you are submitting cms's standard waiver request that you add to that the statement or if additional space is needed because many providers are hitting a point of capacity.

35:29
They need to use additional space even unlicensed facilities, but you have not evacuated your existing facility. So I think that's a clarification to date there have been 13 states that were had waiver request approved. Florida was the first followed closely on the heels by Washington State and then a 11 additional waivers were approved earlier this week. The one thing that I gained.

36:00
Many of these included similar items but if you are doing waiver request, it's good to make sure you look at others making sure that they are inclusive of everything you could possibly ask for.

36:14
There is also the ability in order to get additional amendments under the State Medicaid Program, but I wanted to focus because of time on some of the things that we are suggesting you make sure You include in your request the first one that I've mentioned under EMTALA we Marty discussed the EMTALA waiver that has been approved. But I also urge you to consider the request to CMS right now. There is a requirement to obtain special designations for qualified medical professionals who can perform medical screening exams requirements.

36:59
Or that involve approval by the medical staff by the governing body.

37:06
If you're bringing in other individuals into your organization to help with the volume of patients, and we need to get these folks approved to do medical screening exams without having to go through a government governing body requirement. Also, we need the ability ability to expand

who we consider qualified medical professionals to include perhaps some license your class categories that are not typically approved Within.

37:35
Your organization or within your state Marty mentioned that under the distinct distinct part unit provision. You could put an acute care patients and a rehab unit. I want to make sure that you include in a waiver request that some of those things that you're required to do for rehab patients.

37:58
You have a waiver not to do for acute care patients who are being housed on that unit. Obviously know these patients are not going to be able to participate in an intensive rehab program. There is no need for the pre-admission screening to make sure that they can tolerate intensive rehab screening and obviously they should be excluded from your patient assessment instrument and your rehab Quality Reporting just some provisions.

38:28
To make sure that you ask for to expand your ability to use the distinct part rehab unit to house acute care patients and then don't get in trouble with having patience to did not meet rehab criteria.

38:45
People have made the comment that it's in a in a year two years when their audits and reviews of planes that you submit during this time. It is so very important to make sure we have clearly documented what we are doing and why we are going beyond the norm as an example. If you are housing a an acute care patient and rehab or rehab patient and acute care you need to make sure that you are clearly documenting in their medical record.

39:15
Why this is being done. The waiver was in place Etc. So that it is there for audit purposes in the future.

39:24
From a physical environment perspective. We are suggesting a few additional items that you might want to include from a waiver perspective. To use non hospital buildings to be used for patient care.

39:40
There is the ability to use alternative locations. But so far CMS seems to be very focused on Alternative Healthcare locations. We've heard even in New York that we are looking at using the Javits Center for providing patient care. We need to make sure that it is clear that this is approved and that we can be billing for patients who were not housed in hospital locations.

40:07
I mentioned earlier when we were talking about the DRCondition code that there was some action by the national uniform billing committee earlier this week. Related to billing requirements under COVID-19. And one thing that we did discuss was using non hospital buildings or space for patient care and how do you bill for that? And the because we do know that there is a requirement under the Medicare system that the address where the service was.

40:40
provided needs to be a part of your Pecos file. You need to have submitted that information on an 855 A and said these are all of the addresses and locations where I provide outpatient services

what the national uniform billing committee has recommended and this notice is on their website in order to meet patient needs many hospitals.

41:10
Health Systems of mu testing locations from hospitals to off campus facilities such as parking lots part football stadiums in such cases the end UBC recommends usage of the type of Bill 0 1 3 access your outpatient claim the main hospital address and the national provider identifier, and then when paired with a DRcondition code that that will allow the claim to bypass.

41:40
Site of service restrictions. We have asked the payers to allow that bypass and again, you would not be putting the physical address of where the service was provided if it was not on your Pecos file, but you would be there at merely using your hospitals physical address.

42:01
We are also suggesting that you asked for the opportunity to use technology video things like that too. And even some physical barriers to limit exposure to individuals within your organization as an example. If you do not need multiple people in a room.

42:24
Is there a way to connect via audio for discussion for that patients care and obviously that issue that we've been dealing with that we're starting to see many areas Implement and that is to be clear that you can provide exam and treatment of a patient who's in a vehicle as opposed to actually within your hospital.

42:47
Next slide okay other waivers that you might want to consider. We currently have a restriction on in Creek won't use of verbal orders and that they must be authenticated within 48 Hours. You might want to ask that that be waived because you might not get those verbal orders authenticated as quickly as you would expect to and again, they might be used a lot more frequently than your current policies would allow.

43:17
There is a current requirement that patients who are in the Intensive Care units who are restrained upon death of those of an individual you would have the next by the close of the next business day. You would have to report that patients death.

43:35
We are asking or suggesting that you consider a request for a waiver that if the patient Death was not tied. That's a bad word was not related to the use of the restraints that that not have to be reported as quickly there.

43:57
Be some leeway there. Asking for waiver of the completion of medical records within 30 days following discharge again, you might not have time to get this done, if you consider how long this has been going on and the work volume that you're HIM staff and pyhsicins are going through there is a requirement now in order to use standing orders that they be reviewed and approved by the medical staff and the hospital nursing and pharmacy leadership. I don't know that you have time to do that. I think we need to be able to waive that provision for implementation of standing orders suggestion that I have heard from some other state.

44:45

It's eliminating or waving the requirement for physical signature of a patient or patients representative on form such as the important message from Medicare that consent various clinical documentation items. You don't want to be going back and forth with patients and staff and pins.

45:09
So if a patient can give verbal consent and then that be documented Patient gave verbal consent it's much better than passing things around from a pen perspective.

45:23
The last one here that I wanted to touch on this page related to your Advanced directives. We are not asking that you we are saying that you would still ask a patient if they have an advanced directive if there's an advance directive in place, but that hospitals be given and nursing homes and hospices and everyone else the requirement to provide information.

45:52
Related to a advance directives be eliminated during this time period it's really not something that you want to be raising. Yes, ask them if they have advanced directives, but do you have to go through the whole process of brochures and information explaining?

46:10
What is an advance directive the next slide just a few more things that we wanted to touch on number one wave timely filing we have of our 12 month period for timely filing right now. You might not be able to get all of your claims submitted and we need that extended. We would also urge this as it relates to payers other than Medicare and I say this as an example, when you have a requirement to build within a certain period of time systems aren't even necessarily ready in some states in some areas to get the correct conditions.

46:52
codes and modifiers on the claims the 60-day rule for processing overpayments you have identified that there is an overpayment within your organization. It needs to be returned to the Medicare program. We are because of cash flow issues the time that it takes to process and the resources committed to that if that 60-day will could be waived for the period of this Public Health Emergency, very important that you add.

47:25
ask for suspension of a lot of Medicare administrative contractor activities things related to recovery Auditors audits of the S10 worksheet the Medicare cost report reviews of The to midnight rule things like that that needs to be lifted right now. We don't need that. I am too. I will tell you that I have seen that many contractors are moving forward with audits of the S10 worksheet. I don't think that's really appropriate. I actually even saw a Mac that earlier this week sent a satisfaction survey out and I will tell you that was not the best thing right now.

48:17
And I don't think their response level is going to be in terms of the number of responses received is not going to be great. It's not a good time to send a survey like that.

48:27
And finally on here, we wanted to suggest that for critical access hospitals where there are payments that are owed related to Prior year cost reports and final settlements that there needs to

be some flexibility for those providers because of cash flow crunch right now again, allow them a little additional time. Would that Marty here are the addresses?

48:56
I'm sorry for The submitting your waiver request and then I will turn it to Marty the the types of waivers that Kathy has been discussing as opportunities really would be applicable across the board within a state and while most of the state waivers to this point have focused on Medicaid requirements. Certainly it is advisable to broaden these two additional Medicare.

49:27
Requirements under the waiver authority and so both the state agencies cancer. Sue the state hospital association's other provider organizations using their voice through these waiver application processes are great opportunities, but we're going to focus here on individual provider requests for waivers, which is focused particularly on the Stark waiver. If you have read an article that says the Stark law has been waived.

49:57
Pending the emergency. Please. Do not take action based on that. It is in fact a much more ordered process. The when secretary is are issued the order invoking the 1135 waivers. He authorized CMS to waive stock law sanctions, but only in circumstances as the agency determines is appropriate CMS has not issued any blanket waiver.

50:27
Regarding the Stark law presumably CMS and in his prior guidance CMS has indicated that it would review these requests on a case-by-case basis. It is unlikely though, not unheard of but unlikely we'll see a blanket Stark waiver Instead This is intended for Case by case review. And in fact in our research is deep as we could dig. We could only find one example of an emergency start waiver that related to Hurricane Katrina back in 2005.

50:55
So this is at least a Rusty process for CMS as it starts looking at these specific request for Stark waivers, but the fact that there have not been a lot before does not indicate there is not a need today American Hospital Association last week sent a letter to CMS oig Department of Justice asking them to suspend enforcement of Stark and anti-kickback given that would provide hospitals with a great field efficiency and flexibility as they meet the demands of this Public Health crisis.

51:27
AJ also in that letter urged CMS to adopt an interim final rule that would accept from the definition of compensation Arrangements any Financial relationship and to which a hospital entered into with a position to secure necessary goods and services to respond to the Public Health crisis to date CMS has not responded at least publicly to the AJ's request.

51:49
But at least these issues have been placed on their radar screen as we're talking with clients about the impact of the Covid-19 pandemic we're beginning to hear more and more concern with regard to both relationships with employed Physicians a Hospital employee positions, but also the status of independent physician practices those closely relate to the decision to cancel all elective surgery. So you have many practices that are almost nearly Idol as a result of that action. Obviously that's going to play significant.

52:27
Financial pressure on those practices so we here and this slide identify a number of different circumstances that we believe a hospital would pursue a financial arrangement with the position. But where there will be star considerations that need to be addressed either by navigating carefully the existing Stark exceptions or in fact peeling to CMS for specific relief in a circumstance to provide a waiver of Stark enforcement activity.

52:56
The other piece of this although not specifically authorized in 1135. We have the question of the Civil monetary penalties act and its prohibition on beneficiary inducements. We know that if you improperly offer anything of value to a beneficiary, that one would assume likely to influence our selection of Provider that's exposing you that to liability of $10,000 per prohibited inducement, but here there are legitimate needs.

53:26
To provide renumeration to patients relating the quarantine. For example, are we going to provide housing or meals or other assistance to individuals in quarantine and then similarly as we expand Telehealth capacity, we're going to need to meet the technology Gap and may be necessary to provide smartphones or tablets to patients that they can use Telehealth or provide monitoring devices as we discharged patients from hospitals. Can we going to be able to monitor them appropriately to ensure?

53:56
Their condition also providing personal assistants sending those assistants out to assist patients with Telehealth visits all of these potentially bring into play the issue of beneficiary inducements another area where CMS if not necessarily exercising authority Under 1135 could impact exercise its discretionary enforcement authority. So opportunities there as well. So how would you make these individual waiver requests? It is a matter of submitting.

54:26
In a written request to the appropriate CMS regional office that slide previously the Kathy highlighted gave you the email appropriate email address based on your state CMS encourages you to copy the state survey agency when you submit these requests that they are aware of activity that you're pursuing and there is no form unlike or states where CMS has published its checkbox template for requesting Medicaid waivers. We do not have an equivalency for providers that are pursuing.

54:57
Waivers around specific Financial Arrangements, but CMS has identified here that your waiver request should include certainly contact information your Medicare provider number but critically providing a brief summary of why you need the waiver. What's the scope of the issue of what impact it is having on your ability to respond to the emergency or the long-term negative effects potentially could have on your medical community.

55:20
And then what specifically is your requested relief one would think that a Broad, please excuse any violation of the Stark law is not going to be received very well, but instead providing a very specific defined action list for CMS to take CMS has said previously that it intends to act on emergency waiver request within two to three days of receipt that most likely will be pushed back given the volume that they're likely to receive.

55:50
But in most instances waiver requests are granted on a retroactive basis data that request so Only that would provide some reach there as well.

55:58
So that's where we are today on a section 1135 waivers in terms of blanket waivers in terms of opportunities for states to request a waiver specific waivers both to the Medicaid Program as well as other program requirements the opportunities for individual providers to pursue waivers to insulate Financial Arrangements, they believe necessary to enhance it and even you will their response to the COVID-19 emerges See, we're not stopping in terms of trying to provide relevant information for you. Our next webinar is scheduled for tomorrow afternoon. This is a very less technical much more practical approach to Telehealth. We've been hearing from a lot of physician practices that have not previously stood up a Telehealth capability. And so we want to provide some really practical here's how to select technology. Here's how to address processes. Here's how to engage patients. That's our intention tomorrow. And then though we didn't even have time to create.

56:56
The slide but one day we'll be announcing. It will be announcing webinar from Monday to address the health care relevant provision of the CARES Act. That's that compromise legislation. I'm here to trillion dollars in relief a related to COVID-19 emergency and there we know there's a hundred and thirty billion tag for hospitals. We know that there's over 300 billion in new SBA Loans that can support independent physician practices and other providers. We're going to spend our weekend figuring out.

57:26
How those Provisions work and provide you some really practical guidance on how you're going to be able to Avail yourselves of those opportunities. So I have left a whopping three minutes for questions. I apologize for that. But there's just a lot of content here can open up the phone lines. But please we have done our best to respond to comments questions that we've received written. We should today post the QA responses related to the Telehealth webinar will do our best to turn this around as well.

57:55
We have time for just one question and we're going our first and only question will be does the three day prior hospitalization waiver apply to hospital swing bed services.

58:19
This is Kathy. It is my understanding that there was a clarification issued. I believe it was Monday that that clarified that it did apply to swing beds.

58:35
I will we will make sure that in the final Q&As that we posted we get you the actual link to that.

58:45
Thank you. And thanks to our presenters Marty Ross and Kathy Reep. If you have any questions, their presentation, then contact information will be emailed to you along with the recording of today's webinar. Also, if PYA can provide assistance, please call or email us. You may also visit our website www.pyapc.com for more details about our specific areas of expertise or just subscribe to receive PYA Insights. Thank you for joining us and have a great rest of your day.