

March 31, 2020

CMS Releases Waivers for COVID-19

Emergency declaration waivers related to flexibility on treatment location and telehealth, the physician self-referral law, workforce and administrative activities

The Centers for Medicare & Medicaid Services (CMS) yesterday released a [substantial number](#) of [new waivers](#) related to COVID-19. The waivers apply nationwide and are retroactive to March 1, 2020. They include waivers:

- Allowing hospitals to establish additional treatment locations;
- Expanding access to telehealth;
- Removing self-referral barriers to responding to COVID-19;
- Designed to allow for additional workforce capacity; and
- Eliminating certain administrative requirements.

Our Take: In a [statement](#), AHA said, CMS's hospitals without walls approach and emergency declaration is a critical lifeline in the fight against COVID-19. These tools will help ensure hospitals and health systems can provide the right treatment for patients in the right location. This includes providing care in non-traditional settings, remotely through telehealth and in appropriate outpatient facilities through easing of the Stark Law. CMS is also supporting the doctors, nurses and other caregivers on the front lines by increasing our ability to provide meals, laundry services and childcare for hospital and health system staff. The new waivers will allow hospitals to take care of the first responders who are taking care of us and our communities. Moreover, clinicians will be allowed to work across state lines, which will help to augment and relieve health care workers. We are very appreciative that CMS took quick and effective action, which provides much-needed relief for hospitals during this unprecedented time, including in rural areas served by critical access hospitals. We will continue to work on additional waiver suggestions to address additional areas that will equip us to have the flexibility to take timely and decisive action in serving our patients and communities.

Key Takeaways

New waivers related to COVID-19 include those designed to:

- Remove impediments to responding to COVID-19 through waivers of the Stark/physician self-referral law that can be relied on immediately by hospitals.
- Waive requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state.
- Expand telehealth flexibilities, allowing providers to reach many more patients remotely, including for home health, inpatient rehabilitation and hospice face-to-face assessments.
- Permit the use of non-hospital space for patient care and quarantine sites.
- Waive a series of CoPs, including discharge planning requirements, to increase provider flexibility.
- Waive requirements that a critical access hospital be in a rural area or an area being treated as rural.
- Implement statutory requirements to waive the IRF '3-hour' rule; however, CMS's conditional waiver falls short of what the law intended.

HIGHLIGHTS OF THE RESOURCES

Waivers Related to Treatment Location. In order to expand the capacity of the health care system, CMS has made waivers to allow hospitals and health systems to provide services in additional locations during the emergency. For example, CMS is waiving:

- Section 1867(a) of the Social Security Act related to the Emergency Medical Treatment & Labor Act (EMTALA), which will allow hospitals, critical access hospitals (CAHs), and inpatient psychiatric facilities (IPFs) to screen patients at an offsite location, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan;
- Certain Medicare conditions of participation (CoPs) and the provider-based department requirements to allow hospitals to establish and operate as part of the hospital any location meeting those CoPs for hospitals that continue to apply during the emergency. This waiver also allows hospitals to change the status of their current provider-based department locations to address the needs of hospital patients as part of the state or local pandemic plan;
- The CoP waivers above also will permit non-hospital buildings/space to be used for patient care and quarantine sites, provided that the location is approved by the state and not inconsistent with a state's emergency preparedness or pandemic plan;
- The requirement that a CAH be located in a rural area or an area being treated as being rural, allowing the CAH flexibility to establishment surge site locations;
- The requirements regarding a CAH's off-campus and co-location requirements, including the 35-mile drive requirement to next nearest hospital or CAH for off-campus locations, allowing the CAH flexibility in establishing temporary off-site locations;
- Clarifying that in cases where an inpatient rehabilitation facility's (IRF) intensive rehabilitation therapy program is impacted by the emergency (for example, due to staffing disruptions), the IRF should not feel obligated to meet the "3-hour Rule." This clarification stands in contrast to the Coronavirus Aid, Relief, and Economic Security (CARES) Act provision that [directed](#) the Secretary to fully waive the 3-hour Rule; and
- Restrictions in ambulance coverage, which will result in Medicare covering ambulance transportation to all destinations, from any point of origin, that are equipped to treat the condition of the patient.

Waivers Related to Telehealth. CMS is expanding access to telehealth, including by:

- Allowing the provision of evaluation and management services via audio-only phones.
- Allow practitioners to render telehealth services from their home, without reporting their home address on their Medicare enrollment, while continuing to bill from their currently enrolled location;
- Paying for more than 80 additional services when furnished via telehealth, including emergency department visits;
- Allowing "virtual check-ins" with physicians to be provided to new, as well as established patients;

- Allowing clinicians to provide remote patient monitoring services for acute conditions, whether for COVID-19 or for another condition;
- Allowing telehealth to fulfill many face-to-face visit requirements for patients in IRFs, home health and hospice;
- Allowing a physician determination that a Medicare beneficiary should not leave home because of a medical reason or COVID-19 to satisfy the home health “homebound” requirement; and
- Allowing hospice recertifications to be completed via telehealth, rather than a face-to-face visit.

Waivers Related to the Stark/Physician Self-referral Law. CMS issued 18 waivers from sanctions under the Stark/Physician self-referral law that address a wide array of specific types of transactions or referrals related to the COVID-19 outbreak in the United States. In waiving the sanctions, CMS makes clear that items and services delivered on the basis of a referral permitted under the waivers are reimbursable under the program. CMS also provided 19 concrete examples of situations to which the waivers would apply. The remuneration and referrals described in the blanket waivers must be solely related to “COVID-19 Purposes.” For purposes of the blanket waivers, COVID-19 purposes means:

- Diagnosis or medically necessary treatment of COVID-19 for any patient or individual, whether or not the patient or individual is diagnosed with a confirmed case of COVID-19;
- Securing the services of physicians and other health care practitioners and professionals to furnish medically necessary patient care services, including services not related to the diagnosis and treatment of COVID-19, in response to the COVID-19 outbreak in the United States;
- Ensuring the ability of health care providers to address patient and community needs due to the COVID-19 outbreak in the United States;
- Expanding the capacity of health care providers to address patient and community needs due to the COVID-19 outbreak in the United States;
- Shifting the diagnosis and care of patients to appropriate alternative settings due to the COVID-19 outbreak in the United States; or
- Addressing medical practice or business interruption due to the COVID-19 outbreak in the United States in order to maintain the availability of medical care and related services for patients and the community.

The following are examples of remuneration, referrals, or conduct that may fall within the scope of the blanket waivers set forth in section II of this blanket waiver document:

- A hospital provides meals, comfort items (for example, a change of clothing), or onsite child care with a value greater than \$36 per instance to medical staff physicians who spend long hours at the hospital during the COVID-19 outbreak in the United States.
- An entity provides nonmonetary compensation to a physician or an immediate family member of a physician in excess of the \$423 per year limit (per physician or immediate family member), such as continuing medical education related to the COVID-19 outbreak in the United States, supplies, food, or other grocery

items, isolation-related needs (for example, hotel rooms and meals), child care or transportation.

CMS waivers also will permit physician-owned hospitals to increase their number of beds without incurring sanctions.

The waivers may be used without notifying CMS.

Waivers Related to Workforce. In order to allow hospitals and health systems to expand the health care workforce, CMS has allowed additional flexibility by taking actions during the emergency, including:

- Waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. Specifically, CMS will waive the physician or non-physician practitioner licensing requirements when a provider is: 1) enrolled as such in the Medicare program; 2) possesses a valid license to practice in the state which relates to his or her Medicare enrollment; 3) is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area. The agency notes that it cannot waive state or local licensure requirements. As such, for the physician or non-physician practitioner to avail him or herself of the waiver under the conditions described above, the state also would have to waive its licensure requirements;
- Waiving requirements to allow for physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review;
- Deferring to state law for licensure, certification or registration of CAH staff to provide maximum flexibility for CAHs to use all available clinicians;
- Amending the teaching physician regulations to allow the requirement for the presence of a teaching physician to be met, at a minimum, through direct supervision by interactive telecommunications technology, including when the medical resident is quarantined at home;
- Amending graduate medical education (GME) regulations to allow a hospital to continue to claim a resident for indirect medical education (IME) and direct GME purposes when, during an emergency situation, the resident is performing approved residency patient care duties from home or from a patient's home;
- Permitting wider use of verbal, rather than written orders by hospital doctors; and
- Waiving requirements that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician; instead, CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, CAHs and Ambulatory Surgical Centers (ASCs).

Waivers Related to Administrative Activities. In order to further expand health care capacity, CMS is eliminating certain administrative requirements during the emergency, including:

- Waiving the discharge planning requirements that hospitals, CAHs and IPFs provide patients with detailed information regarding the quality and resource use at available post-acute care providers;
- Waiving the discharge planning requirements that hospitals provide patients with a list of all post-acute care providers available to the patient, inform the patient of their freedom of choice, and identify any home health agency or skilled-nursing facility in which the hospital has a disclosable financial interest;
- Waiving the requirement that hospitals report patients in an intensive care unit whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/IVs, no later than the close of business on the next business day;
- Allowing hospitals more time to provide patients a copy of their medical record, only for those hospitals in a state with 51 or more conformed COVID-19 cases;
- Waiving the requirement that hospitals have written policies on processes and visitation of patients in COVID-19 isolation, only for those hospitals in a state with 51 or more conformed COVID-19 cases;
- Covering respiratory-related devices and equipment for any medical reason – typically, they are only covered in certain circumstances.
- Extending the Comprehensive Care for Joint Replacement (CJR) model by three months, so that it now ends March 31, 2021, and ensuring that the model’s “extreme and uncontrollable” circumstances policy applies to this emergency, which will help ensure that CJR hospitals are not unfairly penalized for providing COVID-related care;
- Ensuring that the Medicare Shared Savings Program’s “extreme and uncontrollable” circumstances policy applies to this emergency, which will help ensure that model participants are not unfairly penalized for providing COVID-related care;

In addition, CMS acknowledges that possible changes might be needed to address issues that may arise for Alternative Payment Model (APM) participants in light of the current emergency. It states that it will consider undertaking additional rulemaking, including possibly another interim final rule, to amend or suspend APM policies as necessary.

Further Questions

If you have questions, please contact AHA at 800-424-4301.