Maryland
Hospital Association

Summary of Medicare COVID-19 Waivers: Blanket Waivers, Fact Sheets, and Interim Final Rules

Contents

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Overview

Since the Secretary of Health and Human Services declared a nationwide public health emergency on Jan. 31 and subsequently renewed it on April 21, the Centers for Medicare & Medicaid Services (CMS) issued waivers offering flexibilities to Medicare providers and suppliers due to the COVID-19 pandemic. CMS maintains a website to catalogue these waivers but has not issued one central document itemizing all flexibilities it has granted.[1] Instead, the policy details for the waivers have been primarily spread among the emergency declaration blanket waivers document, provider-specific fact sheets, and two interim final rules.

This document includes the waivers most pertinent to hospital operations as of May 13. MHA will update this list when appropriate during the public health emergency.

Alternative Care Sites

CMS waivers for alternative care sites or temporary expansion sites, including their Hospitals Without Walls initiative, are aimed at increasing acute care capacity to prepare for COVID-19 case surges, as well as ensuring patient safety and appropriate levels of care. Hospitals are allowed broader flexibilities to furnish inpatient services—including routine services—outside of the hospital using arrangements. Many of these flexibilities interface with the telehealth waivers that start on Page 6.

General

- Certain elements of life safety codes were waived for placement of alcohol-based sanitizer dispensers, fire drills, and construction of walls and barriers between patients

Hospitals

- The 40% rule, which requires community mental health centers (CMHCs) to provide at least 40% of its items and services to individuals who are not eligible for Medicare benefits, is waived
- Ambulatory surgical centers (ASCs) may temporarily enroll as hospitals and provide hospital services to help address needs. CMS issued an attestation form for ASCs. ASCs cannot serve as both hospitals and ASCs simultaneously.

[1] U.S. Centers for Medicare & Medicaid Services, Coronavirus Waivers & Flexibilities, cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

- Hospitals can use internal capacity flexibly and establish and operate any location that meets conditions of participation as a hospital
    - Flexibility offered in using non-hospital buildings/spaces for patient care/quarantine sites to expand capacity
    - Permitted housing of acute care patients in excluded distinct units, such as inpatient rehabilitation or psychiatric care, where distinct part unit's beds are appropriate for acute care inpatients
- Expansion of extraordinary circumstances relocation exception policy to allow on-campus and excepted off-campus provider-based departments (PBDs) to temporarily relocate to alternative sites (including the patient's home) and still bill outpatient prospective payment system (OPPS) rates. PBDs may be relocated to multiple locations.
    - Hospitals must send an email request to their CMS Regional Office (RO) within 120 days of beginning to furnish and bill for services at the relocated PBD. However, hospitals may begin furnishing and billing for items and services prior to submitting this documentation to their RO.
- Certain outpatient services, including partial hospitalization programs (PHP), are permitted for temporary expansion to patient's home or CMHCs, with caveats for which services may be performed via telehealth or in-person, as well as billing modifications
- Allows skilled nursing facility (SNF) swing beds in hospitals to provide long-term care services to patients who no longer need acute care but are unable to find SNF placement. Claims will be paid under SNF prospective payment system.

Inpatient Rehabilitation Facilities (IRF)

- Flexibilities around the IRF 60% rule so IRFs may exclude patients from the inpatient population who are admitted solely in response to the emergency. Flexibility also applies to facilities in the process of becoming IRFs.
- Freestanding IRFs may work with acute care hospitals to provide surge capacity
- Medicare payment regulations that IRFs ensure patients are stable enough for treatment, need at least two types of therapy, and to develop plans of care do not apply to patients admitted to freestanding IRFs solely for surge capacity reasons in a Phase 1 or soon-to-be Phase 1 state. However, these requirements continue to apply to patients using the IRF's standard rehabilitation services.

Long-Term Care Facilities

- Non-SNF buildings may be temporarily certified and made available for use by a SNF if the SNF does not have enough space to isolate patients.

Workforce

CMS appears committed to ensuring all health care providers can practice at the top of their license, subject to state-specific restrictions and limitations. The workforce waivers are aimed at maximizing utilization of non-physician practitioners (NPP) and lessening supervision burdens on physicians. These waivers are also intended to reduce administrative burden in determining patient eligibility for Medicare benefits. Many of these flexibilities interface with the telehealth waivers starting on Page 6.

Hospitals

- Revisions made to variety of teaching physician and moonlighting regulations
- Supervision requirement for non-surgical extended duration therapeutic services reduced to minimum level of general supervision, even during initiation of the service
- Licensed practitioners practicing within their scope of practices, including nurse practitioners (NP) and physician assistants (PA), can order Medicaid home health services
- Definition of "direct supervision" revised to allow for direct supervision using real-time interactive audio and video technology
- No need to designate in writing the qualified personnel to perform specific respiratory care procedures and necessary level of supervision
- Physicians with privileges that will expire soon may continue to practice, and new physicians may practice before full medical staff review and approval
- Medicare patients do not need to be under the care of a physician; hospitals may fully use other NPPs (such as PAs and NPs), so long as their use is not inconsistent with state’s emergency preparedness or pandemic plan
- Flexibility for verbal orders where read-back verification is still required, but authentication may now take longer than 48 hours
- Flexibility in completing records within 30 days of discharge
- Waiver of requirement that nursing staff develop and keep nursing care plans for patients
- Supervision of certified registered nurse anesthetists (CRNA) is at the discretion of the hospital or ambulatory surgical center (ASC)
- Modifying the 60-day limit for substitute billing arrangements (locum tenens) to allow a physician or physical therapist (PT) to use the same substitute for the entire time they are unavailable to provide services during the COVID-19 PHE, plus an additional period of no more than 60 days after PHE expires

- PTs and occupational therapists (OTs) may delegate performance of maintenance therapy to PT assistants or OT assistants when clinically appropriate
- Therapy notes made by other HCPs (including therapy students) do not have to re-documented by therapists; notes only need to be reviewed and verified.

Inpatient Rehabilitation Facilities (IRFs)

- Flexibility in adhering to the three-hour rule, which requires all patients receive at least 15 hours of therapy weekly as normal staffing shifts may be disrupted
- Flexibility for IRFs to provide care in a hospital-based or freestanding IRF for all patients admitted during the PHE
- Physicians are not required to conduct and document post-admission evaluations for patients admitted during the PHE because it covers much of the same information that is in the patient screen at intake and the plan of care

Home Health

- Required annual on-site visit conducted by a registered nurse (RN) or other skilled professional may be postponed, but must be conducted within 60 days after the end of the PHE
- Deadline for home health aides to receive 12 hours of in-service training is postponed until the first full quarter following the end of the health emergency
- Any rehabilitation professionals may perform initial and/or comprehensive assessments, regardless of whether the service establishes eligibility for patient to receive home care
- Suspension of the two-week aide supervision requirement where the RN checks to ensure the aide is providing care consistent with the plan of care; virtual supervision is encouraged
- Allowed 30 days to complete comprehensive assessments; however, OASIS data must be submitted before submitting final claims to receive payment
- PAs, NPs, clinical nurse specialists (CNS) permitted to establish and periodically review home health plan of care; Medicaid requirements aligned to permit this flexibility
- Certified nurse midwives (CNM), NPs, CNSs or PAs may establish home health agency policies governing benefit administration
- Items and services furnished by NPs, CNSs, PAs in home health agency may be paid under prospective payment service

Long-Term Care Facilities

- Temporary emergency coverage of SNF services without a qualifying hospital stay (i.e., waiver of three-day prior hospitalization requirement) permitted
- Physicians may delegate tasks that are otherwise required to be performed by the physician to NPs, CNSs, or PAs; however, physicians cannot delegate tasks that are prohibited from delegation by law.
- Deadline for nursing aides to receive 12 hours of in-service training is postponed until the first full quarter after the PHE.
- Requirement waived where a nursing facility or SNF cannot employ anyone for longer than four months unless they met training and certification requirements. Full-time nurse aides must still be competent to provide nursing services. Full-time nurse aides must also demonstrate competency in skills and techniques for resident care.
- Pre-Admission Screening and Resident Review (PASRR) suspended for new residents for 30 days. After 30 days, new patients admitted with a mental illness or intellectual disability should receive assessment as soon as resources are available.
- Paid feeding assistants' minimum training hours reduced to one hour

Telehealth

CMS issued waivers to make telehealth easier to access, reducing the amount of social interaction and face-to-face contact required for beneficiaries to obtain needed health services regardless of whether they are related to COVID-19 treatment. In addition to supplementing the covered telehealth services list and updating payment amounts, waivers have also allowed for audio-only delivery of services if audio and video technology is unavailable.

Hospitals

- Elimination of originating site requirements during public health emergency
- Services added to list of services that can be furnished via telehealth and billed to Medicare (over 80 new codes, including emergency departments and home visits), retroactive to March 1
- Limitations on how frequently telehealth may be used for subsequent hospital care services in inpatient (once every three days) and nursing facilities (once every 30 days) settings removed

- Expanded availability of remote evaluation, virtual check-in, and online digital evaluation and management (E/M) codes and non-physician practitioner (NPP) online assessment and management codes
- Remote physiologic monitoring services may be furnished to new patients as well as established patients
- Audio-only E/M services will be paid with work relative value units (RVU); these services may be provided to both established and new patients
- Payment for audio-only E/M services paid using new RVU codes based on time requirements
- Level selection for office/outpatient E/M services performed via telehealth should use times listed in CPT code description to identify level selection
- Office/outpatient E/M level selections for telehealth visits can be based on medical decision-making or time; no requirements for these services regarding documentation of history and/or physical exam in medical record
- If beneficiary's home or temporary expansion site is considered to be the a provider based department and the beneficiary is an outpatient for purposes of receiving telehealth services—and the practitioner normally practices at hospital outpatient department—then the hospital may bill under physician fee schedule (PFS) for the originating site facility fee
- Hospitals can receive telemedicine services through an agreement with an off-site hospital
- Hospital staff may provide therapy and educational services remotely or in-person to a beneficiary, which may include the patient's home if it has been designated as provider-based to the hospital
- Certain partial hospitalization program (PHP) services (individual psychotherapy, patient education, and group psychotherapy) permitted to be furnished via audio-only (if audio/visual connection is unavailable) to patient’s home. Services may be performed by hospital-based PHP providers and community mental health centers.
- All Medicare beneficiaries across the country may receive telehealth services; this applies to new and established patients
- Audio-only communications can be used for telephone E/M services, and behavioral health counseling and educational services. Other services must be done using two-way audio and video equipment.
- All HCPs that can furnish distant telehealth services are eligible to bill Medicare so PTs, OTs, and speech language pathologists (SLPs) can use telehealth to provide services.

    - Licensed clinical social workers, clinical psychologists, PTs, OTs, and SLPs may provide e-visits.
- Clinicians can provide remote evaluation of patient video/images and virtual check-in services to both new and established patients
- Opioid treatment providers (OTPs) can provide patient counseling and therapy services by audio-only only if the beneficiary lacks access to a two-way system. Periodic patient assessments may be done with audio and video communication.
- CMS may update the covered telehealth services list regularly without requiring public notice and comment
- Relaxation of RPM services reporting requirements to periods of time that are fewer than 16 of 30 days, but no less than two days

Inpatient Rehabilitation Facilities (IRFs)

- Telehealth may be used to conduct required face-to-face visits three times per week throughout the Medicare Part A fee-for-service patient's visit.

Home Health

- Expanded permitted use of telecommunications technology under home health benefit and hospice benefits
- Services can be provided using telecommunications within 30-day care period if it is ordered and does not replace any needed in-person visits. Only in-person visits can be reported on the home health claim.
- Initial assessments can be conducted remotely or by record review to determine if a patient is homebound

Long-Term Care Facilities

- Physicians and non-physician practitioners may use telehealth
- Physicians may delegate any required physician visits to an NP, certified nurse specialist (CNS), or PA, who is working in collaboration with the physician; these visits can be conducted via telehealth

Discharge

CMS relaxed discharge and/or transfer protocols so patients can move more efficiently through the continuum of care to create needed hospital capacity and protect non-infected patients from COVID-19.

General

- Expanded list of permissible ambulance destinations to include all destinations from any point of origin equipped to treat the conditions of the patient
- Home may be an appropriate destination for patients discharged under quarantine

Hospitals

- Not required to provide list of available post-acute care (PAC) facilities or inform patient of ability to choose PAC provider, but providers must focus on finding the appropriate setting for the patient

Home Health

- Flexibility on providing detailed discharge information to expedite discharge and movement of patients among care settings

Long-Term Care Facilities

- Long term care facilities may transfer or discharge residents to another facility solely for patient cohorting based on the following categories: patients with respiratory symptoms and confirmed COVID positive; patients without respiratory symptoms and confirmed COVID negative; patients without respiratory symptoms
- Transfer/discharge requirements are only waived if the transferring facility receives confirmation that the receiving facility agrees to accept the resident; confirmation may be verbal but must be documented
- Flexibility given in providing written notice of a transfer/discharge
- Flexibility provided regarding detailed information sharing for discharges from a long-term care facility

COVID-19 Testing

Given the rapidly evolving landscape for COVID-19 diagnostic tests, CMS' testing waivers are geared toward establishing payment structures to cover the new processes and procedures that accompany testing. Some of these initiatives interface with workforce flexibilities starting on Page 4, especially with regards to who may order and/or administer COVID-19 diagnostic services.

General

- Medicare will pay independent labs for specimen collection (pays specimen collection fee and travel allowance)
- NPs, Clinical Nurse Specialists (CNSs), PAs, and Certified Nurse Midwives (CNMs) may order, furnish directly, and supervise performance of diagnostic tests during the public health emergency
- COVID-19 tests are covered when ordered by any health care provider (HCP), rather than only the treating HCP
- Ordering requirement for flu or respiratory syncytial virus testing to rule out other sources of infection removed
- Flexibilities available for Medicaid lab services to cover self-collected tests and tests not administered at doctor's office
- FDA-approved serology tests will be covered under benefit category of "diagnostic lab tests"
- Medicare will pay for COVID-19 specimen collection by physicians, non-physician practitioners (NPPs), and hospitals for all patients (not just established patients).
- If lab testing is done without a physician or NPP's order, then the lab must notify patient directly of results.

Hospitals

- New HCPCS code created for hospitals (C9803) for clinic visits dedicated to specimen collection without any other primary services furnished at the same time

Long-Term Care Facilities

- Facilities must notify residents and representatives about the status of COVID-19 in the facility, including any new cases