

## CMS ISSUES NEW BLANKET WAIVERS, RULE TO EASE COVID-19 CARE

- *The IFR and new waivers are designed to facilitate care for COVID-19 patients.*
- *New flexibilities include relaxing hospital site-of-service requirements and identifying over 80 new services that may be provided via telehealth.*
- *The policies announced yesterday will expire when the public health emergency is over.*

Yesterday, the Centers for Medicare and Medicaid Services (CMS) issued several waivers of current law and an interim final rule (IFR) with comment period to **expand hospital flexibility to address the novel coronavirus (COVID-19) crisis** ([rule](#), [fact sheet](#), [press release](#)). The new policies, which will last the duration of the public health emergency, provide significant flexibilities to hospitals and other health care providers. These flexibilities include **new ability to provide telehealth services, relaxations on site-of-service requirements, flexibility on hospital facilities including allowing temporary structures and dormitories to be used as hospitals** without Federal Emergency Management Agency (FEMA) cooperation, and targeted relief in quality programs.

- **Background.** Health and Human Services (HHS) Secretary Alex Azar declared a public health emergency on Jan. 31, 2020 and President Trump declared a national emergency on Mar. 13, 2020. Additionally, Congress has now passed three packages addressing the COVID-19 pandemic, and many of the flexibilities authorized by Congress are implemented in this IFR. Federal agencies may issue IFRs and bypass notice-and-comment requirements under certain circumstances, including emergencies.

CMS Administrator Seema Verma said in a [press release](#) that the “**unprecedented temporary relaxation in regulation will help the healthcare system deal with patient surges** by giving it tools and support to create non-traditional care sites and staff them quickly.” The waivers and IFR are designed to waive administrative burdens and expand which sites can be used during the emergency to ensure that COVID-19 patients are not exposed to others.

### *Waivers*

A full summary of the waivers put in place to date can be found [here](#). **New waivers allow for medical staff in hospitals to access additional benefits and for hospitals to screen patients at offsite locations.** In addition CMS recently approved hundreds of waiver requests from health care providers, state governments, and state hospital associations in the following states: OH; TN; VA; MO; MI; NH; OR; CA; WA; IL; IA; SD; TX; NJ; and NC. These blanket waivers may obviate some future waiver requests from states. Key details on the new waivers are below:

- **Stark Law** — A [waiver](#) of certain sections of the Stark Law permits physician-owned hospitals to expand their bed count without incurring sanctions, waives restrictions on certain self-referrals, and allows hospitals to provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing, or child care services while the physicians and other staff are at the hospital providing patient care.
- **EMTALA** — A blanket waiver of section 1867(a) of the Emergency Medical Treatment and Labor Act (EMTALA) will allow hospitals to screen patients at offsite locations during the emergency to inhibit the spread of COVID-19.
- **Verbal Orders** — Verbal orders will be allowed to be used rather than written orders in many situations.

#### *IFR*

The 221-page IFR has not yet been put on display on the *Federal Register*. However, it will be effective the day it is displayed and its policies apply beginning March 1, 2020. While the **IFR is effective immediately, comments will be open for 60 days** after it is displayed in the *Federal Register* and may be subject to changes. Details from the IFR are below:

- **Telehealth** — The IFR adds to the Mar. 17 telehealth waiver authority and permits significantly expanded applications of telehealth services during the emergency. CMS identified over 80 additional services that may be provided via telehealth, including nursing facility initial and discharge visits, home visits, and evaluation services. A complete list of newly-payable telehealth services can be found in the IFR. Additionally, CMS is temporarily eliminating frequency limitations and other requirements associated with particular services provided via telehealth, and clarifying several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks. Changes announced include:
  - Medicare beneficiaries will be able to receive telehealth care at home or in a care facility;
  - Providers may evaluate beneficiaries who have audio phones only. CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health. During the pandemic, individuals can use commonly available interactive apps with audio and video capabilities (such as Skype or FaceTime) to visit with their clinician;
  - Home Health Agencies can provide more services to beneficiaries using telehealth, so long as it is part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care;
  - Federally-qualified health centers (FQHC) and Rural Health Centers (RHC) will be permitted to provide telehealth services to beneficiaries in their homes, consistent with the CARES Act;
  - Therapy services may be provided via telehealth, though they must be provided by a covered distant site practitioner — in other words, not a physical therapist, occupational therapist, or speech-language pathologist;

- Hospice providers can also provide services to a Medicare patient receiving routine home care through telehealth, if it is feasible and appropriate to do so; and
- Virtual Check-In services, or brief check-ins between a patient and their doctor by audio or video device, will be offered to patients that had an established relationship with their doctor and new patients. Clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition.
- **Remote Patient Monitoring** — CMS will allow, for the duration of the emergency, remote patient monitoring services to be provided to both a physician’s new and established patients. In addition, CMS is broadening the availability of remote evaluation services. Remote patient monitoring can be furnished for home health services to “optimize” care given during in-person visits. Remote patient monitoring services may not substitute for in-person visits. This appears to fulfill the CARES Act requirement for the Secretary to “consider ways to encourage the use of telecommunications systems, including for remote patient monitoring” for home health services.
- **Hospitals** — Hospitals will be allowed to transfer patients to outside facilities, including ambulatory surgery centers (ASC), hotels, and dormitories while still receiving Medicare hospital payments. In addition, ASCs may enroll in Medicare and bill as hospitals during the emergency.
- **OTPs** — The IFR allows therapy and counseling as part of an opioid treatment program (OTP) to be furnished via audio-only telephone calls during the pandemic. The 2020 payment rule concerning OTPs permitted such visits to be conducted via two-way real-time video connection, but this further loosens restrictions to ensure that individuals without such technology capabilities can receive care during the crisis.
- **Innovation Center Models** — CMS is creating flexibilities in certain Center for Medicare and Medicaid Innovation (CMMI) models, including the Medicare Diabetes Prevention Program (MDPP) and Comprehensive Joint Replacement (CJR) program, to ensure that beneficiaries enrolled in the program can continue to receive program services with the interruption caused by COVID-19.
- **Coverage Determinations** — During the emergency, national coverage determinations (NCD) and local coverage determinations (LCD) that require a face-to-face encounter for an item or service to qualify for coverage have those face-to-face encounter requirements waived. Additionally, CMS will not enforce clinical indications for coverage for respiratory, home anticoagulation management, and infusion pump NCDs and LCDs. Items such as home oxygen, continuous positive airway pressure devices, and infusion pumps will no longer need a documented clinical indication for the duration of the emergency.
- **Scope of Practice and Supervision** — Consistent with applicable state laws, the IFR allows supervision of resident physicians via telecommunication and permits services rendered by

a resident outside their graduate medical education program to be separately billable. Additionally, the IFR allows non-physician practitioners (NPP) to order home health services and relaxes supervision requirements on NPPs.

- **Ambulances** — For the duration of the emergency, Part B will reimburse ambulance transportation to any destination that may be equipped to treat the condition of the patient. These destinations may include: (1) a hospital; (2) a critical access hospital; (3) a skilled nursing facility (SNF); (4) a community mental health center; (5) an FQHC; (6) an RHC; (7) a physician office; (8) an urgent care facility; (9) an ambulatory surgical center; (10) alternative dialysis setting; (11) any locations furnishing dialysis services when an ESRD facility is not available; and (12) the beneficiary's home.
- **Star Ratings** — CMS is modifying the calculation of the 2021 and 2022 Star Ratings for Part D plans and Medicare Advantage to address the expected disruption to data collection and measure scores posed by the COVID-19 pandemic.
- **Reporting** — CMS will suspend requesting additional information from providers and plans and will reprioritize scheduled program audits to help providers focus on patient care during the emergency.