

CMS Expands Emergency Declaration Blanket Waivers for Health Care Providers

May 5, 2020 – *Dorsey Health Law*

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As we described in our [prior blog post](#), on March 30, 2020, the Centers for Medicare & Medicaid Services (“CMS”) published multiple COVID-19 Blanket Waivers for Health Care Providers. CMS announced another round of Blanket Waivers on April 30, which are available [here](#). These waivers provide additional flexibility to health care providers responding to the COVID-19 pandemic by expanding access to telehealth services and giving providers and facilities relief from many reporting and audit requirements so they can focus on patient care.

The following is a summary of the new Blanket Waivers available to providers. These Blanket Waivers are retroactively effective back to March 1, 2020 and will continue through the end of the emergency declaration.

Flexibility for Medicare Telehealth Services

- Eligible Practitioners
 - CMS is expanding the types of health care practitioners who may be reimbursed for providing Medicare telehealth services to all practitioners who are eligible to bill Medicare for non-telehealth services. Thus, physical therapists, occupational therapists, speech language pathologists, and others may now furnish and receive reimbursement for Medicare telehealth services.
- Audio-Only Telehealth for Certain Services
 - CMS is now permitting more services to be provided by audio-only technology. Several evaluation and management services, behavioral health counseling, and educational services no longer require a two-way, real-time interactive



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communication between the patient and practitioner. For a list of billing codes for these audio-only services, please review the CMS list of Medicare telehealth services, available [here](#).

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- Certain Staffing Requirements
 - In an effort to address potential staffing shortages, CMS is waiving the requirement that certain practitioners (NP, PA, or certified nurse-midwife) be available to furnish patient care services at least 50 percent of the time a Rural Health Clinic operates. However, a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist must still be available to furnish patient care services at all times the Rural Health Clinic operates.

Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

- Quality Assurance and Performance Improvement (QAPI)
 - CMS is modifying QAPI program requirements to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the PHE.
- In-Service Training
 - Nursing assistants will now have more time to complete their required 12 hours of in-service training. CMS has extended the deadline for completing this training until the end of the first full quarter after the declaration of the PHE concludes.
- Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities
 - In order to help long-term care facilities expedite the discharge and movement of residents among care settings, CMS is waiving the discharge planning requirement that facilities must assist residents and their representatives in selecting a post-acute care provider using data such as standardized patient assessment data, quality measures, and resource use. All other discharge planning requirements remain in place.
- Clinical Records
 - - Long-term care facilities may now take ten working days to provide a resident a copy of their records after requested. Previously, facilities were required to provide a copy within two working ways when requested by the resident.

Home Health Agencies (HHAs)

- Training Requirement for Home Health Aides
 - Medicare conditions of participation for HHAs state that each Home Health Aide must receive 12 hours of in-



service training every 12 months. To give both aides and the nurses that provide the training more time to perform patient care, this training requirement is postponed, and the new deadline for aide in-service training is the end of the first full quarter after the declaration of the PHE concludes.

- Detailed Information for Discharge Planning
- - The requirement to provide patients with detailed information regarding discharge planning in selecting a post-acute care provider (such as quality and resource use measures of potential providers) is temporarily waived during the PHE. All other discharge planning requirements remain applicable.
- Clinical Records
 - HHAs may take ten business days to provide a patient with copies of their medical records, instead of four business days.

Hospice

- Training Requirement for Home Health Aides
 - Hospice conditions of participation requiring the annual assessment and in-service training and education of all individuals furnishing care is postponed until the end of the first full quarter after the declaration of the PHE concludes.

HHAs and Hospice

- Onsite Supervisory Visits
- - For both HHAs and Hospices, the condition of Medicare participation that requires a registered nurse (or for HHA any other appropriate skilled professional) to make an annual onsite supervisory visit for each aide is postponed. Postponed onsite assessments must be completed no later than 60 days after the expiration of the PHE.
- Quality Assurance and Performance Improvement (QAPI)
 - To allow HHAs and Hospices to focus on COVID-19 effort, the requirement that HHAs and Hospices maintain an effective, ongoing, data-driven QAPI program is modified to narrow the scope of the mandated QAPI program to infection control issues. Remaining QAPI activities should focus on adverse events.

Ambulatory Surgical Centers (ASCs)

- Medical Staff
 - During the PHE, CMS is waiving the ASC conditions of coverage requiring ASCs to periodically reappraise medical staff privileges. This will allow physicians whose privileges will expire to continue practicing at the ASC without the need for reappraisal.

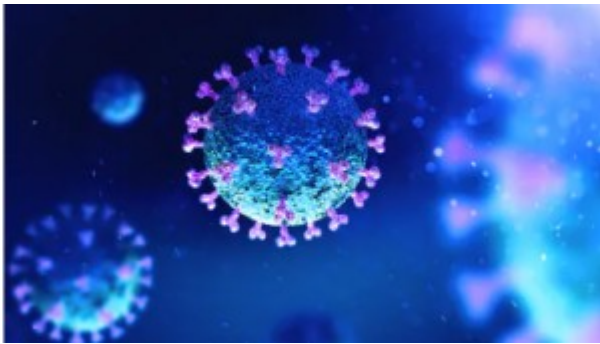
Community Mental Health Centers (CMHCs)

- Quality Assurance and Performance Improvement (QAPI)
 - While maintaining the general requirement that CMHCs maintain an effective,

ongoing, data-driven QAPI program, CMS is waiving the specific detailed requirements for QAPI program organization and content to provide flexibility for CMHCs to focus QAPI resources on circumstances that arise during the PHE. CMHC modifications to QAPI programs must be consistent with a state's emergency preparedness or pandemic plan.

- Home Services
 - CMS is waiving the prohibition on CMHCs providing partial hospitalization services and other CMHC services in an individual's home. This will allow clients to safely shelter in place during the PHE while receiving needed care and services from the CMHC. CMHCs must still assess client needs, implement and update each client's individualized active treatment plan, and promote client rights, including a client's right to file a complaint.
- 40% Rule
 - To promote access to services, the requirement that CMHCs provide at least 40% of their items and services to individuals who are ineligible for Medicare benefits is waived.

Physical Environment for Multiple Providers/Suppliers

- Inspection, Testing & Maintenance (ITM) under the Physical Environment Conditions of Participation: CMS is waiving the following physical environment requirements for Hospitals, CAHs, inpatient hospices, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19.
- - Requirements to maintain facilities and equipment to ensure an acceptable level of safety and quality are temporarily modified as necessary to permit these facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.
 - These facilities may adjust scheduled ITM frequencies and activities required by the applicable Life Safety Codes and Health Care Facilities Codes. The following are not included in this waiver:
 - Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing.
 - Portable fire extinguisher monthly inspection.
 - Elevators with firefighters' emergency operations monthly testing.
 - Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.
 - Means of egress daily inspection in areas that have undergone construction, repair, alterations or additions to ensure its ability to be used instantly in case of emergency.

- Requirements to have an outside window or outside door in every sleeping room are waived to permit these providers to utilize space not normally used for patient care for temporary care or quarantine.

If you have any questions about the CMS Blanket Waivers, please contact the authors or your regular Dorsey & Whitney attorney. We continue to closely monitor the rapidly evolving legal landscape related to the COVID-19 pandemic. You can access Dorsey's health law blog related to health law updates, available [here](#). You can also access Dorsey's coronavirus resource center, which contains a wide variety of legal resources related to the coronavirus outbreak, available [here](#).