

New CMS COVID-19 Blanket Waivers for Health Care Providers

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On March 30, 2020, the Centers for Medicare & Medicaid Services (“CMS”) published a compilation of COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (each, a “Blanket Waiver”). Section 1135 of the Social Security Act gives CMS the authority to issue waivers that ease requirements for providers affected by an emergency if: (1) the President makes an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the “Stafford Act”); and (2) the Secretary of the Department of Health and Human Services declares a Public Health Emergency (“PHE”), both of which have now occurred in light of COVID-19. CMS is permitted to issue both blanket waivers and provider/supplier requested waivers on a case-by-case basis. Blanket waivers apply to all applicable providers and suppliers, while individual waivers apply only to the requesting provider or supplier. A provider or supplier need not request a provider/supplier-specific waiver of a requirement if CMS has issued a blanket waiver addressing the same requirement.



It is important to note that 1135 waivers apply solely to federal requirements and **do not apply** to state licensure or other requirements. Any applicable state requirements (e.g., licensure) must also be addressed with the relevant state agency.

Another important note of caution is that these 1135 waivers often include specific details and requirements. It is critical for health care providers to review the waivers carefully before taking action under them. To that end, providers should visit the CMS Coronavirus Waivers & Flexibilities website, [here](#), to locate the specific guidance and requirements from CMS about the type of program waiver(s) being sought. CMS has provided numerous Frequently Asked Questions (“FAQ”) documents and provider-specific fact sheets that detail the details

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about and limits of the available waivers and flexibilities for each type of provider (hospital, skilled nursing facility, physicians, laboratories, home health providers, etc.). Additionally, this website contains links to all of the waivers provided in each state.

The following is a summary of the Blanket Waivers CMS has made available to providers and suppliers on March 30, 2020. These Blanket Waivers are retroactively effective back to March 1, 2020 and will continue through the end of the emergency declaration.

I. Hospital Waivers

The Blanket Waivers include significant regulatory relief for hospitals. The following is a summary of the hospital-specific Blanket Waivers, and [here](#) is a CMS Fact Sheet that was published for hospitals to further explain these specific Blanket Waivers:

a. Temporary Expansion Sites (a.k.a. Hospitals Without Walls)

Under this Blanket Waiver, hospitals are permitted to offer health care services in locations that are not currently part of the hospital. Previously, hospitals would have been required to meet Life Safety Code and other regulatory provisions and obtain approvals to provide services in a new location. This waiver will help hospitals set up temporary expansion sites to offer inpatient services (e.g., nursing, room and board) in locations such as shell space in a hospital, parking structures, dormitories and the like – as long as the hospital exercises control and oversees the services provided at the location, and as long as the location is approved by the state (to ensure safety and comfort for patients and staff).

CMS is also allowing currently enrolled ambulatory surgery centers (“ASCs”) to temporarily enroll as hospitals by calling the COVID-19 Provider Enrollment Hotline to complete and sign an attestation form in order to enroll and provide services during the PHE as a hospital. CMS also encourages other entities (e.g., freestanding emergency departments which are not currently allowed to enroll in Medicare) to call the COVID-19 Provider Enrollment Hotline to complete and sign an attestation form in order to enroll and provide services during the PHE. Further, CMS is allowing hospitals to change their provider-based locations to address patient needs, as well as allowing additional flexibilities related to inpatient services furnished under arrangements. Moreover, hospitals are permitted to screen patients at locations off of a provider’s campus, in order to avoid the spread of COVID-19. Further, for surge facilities in off campus departments, CMS is waiving the requirements to have policies and procedures for evaluating emergencies so these facilities do not need to focus time on drafting policies and procedures but rather can focus on patient care needs.

b. Relaxed Paperwork, Policies, Cost Reporting, Filing Deadlines and Enrollment Requirements

For hospitals that are impacted by a widespread outbreak of COVID-19, the timeframes for providing patients a copy of their medical records are waived, as are the requirements related to visitation and seclusion. Additionally, CMS is granting a 30-day post-discharge

requirement to complete medical records, CMS is waiving medical records department staffing requirements, and also waiving specific requirements for the form and content of the medical record and the medical record completion requirements. Further, verbal orders can be authenticated more than 48 hours after the fact (although read-back verification is still required). CMS is also waiving requirements to provide information about advanced directives to patients.

Further, To ensure that hospitals and critical access hospitals focus on patient care and ensuring patients are discharged in an appropriate setting, as opposed to focusing on the paperwork and other regulatory obligations, CMS is waiving the detailed regulatory paperwork and other requirements related to discharge planning. For example, CMS recognizes that during the PHE, hospitals may not be able to use specific quality metrics and other data, or a comprehensive list of nursing homes in the area, to select a nursing home or home health agency. However, hospitals are still required to work with families to ensure that the discharge meets patients' care needs.



Further, CMS is waiving the entire condition of participation related to utilization review plans and committees, nursing care plans, having available a current therapeutic diet manual, developing and implementing emergency preparedness policies and procedures and communication plans, as well as waiving the detailed provisions governing a hospital's quality assessment and performance improvement program (although hospitals must still have such a program in place).

CMS has established a toll-free hotline for all providers as well as significant flexibilities in provider enrollment. See [here](#) for additional information from CMS on provider enrollment relief, as well as our previous blog post on this topic, available [here](#).

Further, CMS is waiving the signature and proof of delivery requirements for Part B drugs and durable medical equipment (although the delivery and the fact that a signature could not be obtained due to COVID-19 should be documented in the record).

Additionally, CMS is delaying the cost-report filing deadlines until June and July, and CMS is extending the data submission deadlines for hospitals on the reporting of occupational mix of employees until August 3, 2020. Further, Medicare Administrative Contractors ("MACs"), Qualified Independent Contractors ("QICs"), and Independent Review Entities ("IREs") are allowed to grant extensions to providers on appeals and are permitted to offer other flexibilities on filings and deadlines.

c. Critical Access Hospitals ("CAHs") Without Walls

CAHs are now permitted to exceed their 25 bed limit and the 96 hour length of stay limit.

CMS is also permitting CAHs to treat patients in urban areas (they typically must be located in a rural area) as needed in order to establish surge locations. Further, CMS is waiving the restrictions on CAHs' ability to establish off campus provider based locations, and to establish the normally restricted co-location arrangements with other providers. CMS is waiving the minimum personnel qualification requirements at CAHs for clinical nurse specialists, nurse practitioners and physician assistants, and CMS is deferring to the state for the requirements of staff licensure, certification or registration, which will allow more flexibility to CAHs in states where federal requirements are more stringent.

d. Distinct Part Units

CMS is also now allowing hospitals to house acute care patients in excluded distinct part units (as long as the unit's beds are appropriate for acute inpatients). Hospitals are permitted to bill for the care provided in the distinct part unit under the Inpatient Prospective Payment System. Providers should annotate in the medical record to explain that the care was provided in the distinct part unit due to capacity issues related to the PHE. Hospitals are also now permitted to provide care in acute care beds and units for patients who would normally be treated in distinct part psychiatric units or distinct part rehabilitation units, as long as the acute beds and units are appropriate for such patients. Hospitals should continue to bill under the Inpatient Psychiatric or Inpatient Rehabilitation Prospective Payment System for those patients, and annotate in the medical record to explain that the care was provided in the acute care unit due to capacity issues or other exigent circumstances related to the PHE.

e. Telemedicine

CMS is waiving telemedicine restrictions on hospitals and CAHs to make it easier for these providers to provide telemedicine for their patients through agreements with off-site hospitals, in order to improve access to specialty care.



f. Workforce

CMS is waiving the sterile compounding requirements to allow the re-use of face masks. CMS is also waiving the 2-year reappointment period for medical staff re-credentialing, the requirement that patients in a hospital be under the care of a physician (to allow other practitioners like physician assistants and APRNs to be used to the fullest extent possible), and CMS is waiving the requirement for CRNAs to work under the supervision of a physician. Further, CMS has stated that Hospitals do not have to designate in writing the personnel qualified to perform specific respiratory care procedures or the amount of supervision required for personnel to carry out those procedures.

II. Long-Term Care, Skilled Nursing Facilities, and Nursing Facility Waivers

The Blanket Waivers provide a number of flexibilities related to nursing services. See [here](#) for the CMS fact sheet published specifically for long term care facilities. CMS is waiving the 3-day prior hospitalization requirement for coverage of a skilled nursing facility (“SNF”) stay, waiving the timeframe requirements for certain data submission for SNFs and long-term care (“LTC”) facilities, and allowing nursing homes to suspend pre-admission screening and annual resident review assessments.

Certain physical environment requirements are now waived, allowing for expanded use of non-SNF buildings or non-resident rooms in a LTC facility for patients in certain emergency circumstances. To promote social distancing: requirements that residents participate in-person in resident groups are waived; requirements related to room-sharing and moving a resident’s room are waived for the purpose of grouping or separating residents with respiratory illness symptoms and/or residents with a confirmed COVID-19 diagnosis from residents without these symptoms or diagnosis; and physicians and non-physician practitioners may conduct visits through telehealth options when previously the visits were required to be in-person.

CMS is also partially waiving training and certification requirements required for nurse aids employed for longer than four months at a facility in order to assist with potential staffing shortages. CMS has waived certain resident transfer and discharge requirements in particular circumstances, though advance notification and receiving facility agreements are generally still required, and related care planning requirements are also waived in certain circumstances.

Additionally, CMS is delaying the cost-report filing deadlines until June and July, and CMS is extending the data submission deadlines for hospitals on the reporting of occupational mix of employees until August 3, 2020. Further, Medicare Administrative Contractors (“MACs”), Qualified Independent Contractors (“QICs”), and Independent Review Entities (“IREs”) are allowed to grant extensions to providers on appeals and are permitted to offer other flexibilities on filings and deadlines.

III. Home Health, Hospice, ESRD, and DMEPOS Waivers

CMS has provided FAQ documents on these waivers for home health, [here](#); for hospice, [here](#); for ESRD Facilities, [here](#); and for DME Suppliers, [here](#). Under the Blanket Waivers, CMS provided extensions for home health, hospice, and ESRD providers to complete certain assessment required for Medicare reimbursement. CMS also waived certain home health, hospice and ESRD in-person assessment, visit, and supervision requirements to reduce the need for ordinary course check-ins and to allow for greater use of telehealth. In addition, hospices are relieved of the requirement to provide non-core hospice services, such as physical therapy, occupational therapy, and speech-language pathology. In providing additional flexibility in timing and in-person visits, CMS’s goal is to support containment efforts for at-risk populations and to free up professional resources to focus on treatment of those infected with coronavirus and to focus on operations related to the pandemic.

In addition, CMS is waiving certain routine audits, maintenance, and certification requirements for ESRD Facilities and ESRD Facility staff. Again, CMS is attempting to free up resources and provide flexibility to support providers' focus on pandemic-related efforts. CMS authorized the establishment of Special Purpose Renal Dialysis Facilities ("SPRDF") to mitigate transmission among the at-risk population. Such facilities do not require a federal survey to be completed before providing services. CMS is allowing physicians that are appropriately credentialed at a certified dialysis facility to provide care at a "designated isolation location" such as a SPRDF without separate credentialing. Dialysis services may now also be provided in nursing homes and SNFs, so long as the services and necessary equipment and supplies are provided by personnel of the resident's usual Medicare-certified dialysis facility.

In an effort to expedite supply of and reimbursement for DMEPOS, CMS is waiving the replacement requirements (such as the face-to-face requirement, a new physician's order, and new medical necessity documentation) for DMEPOS that are lost, destroyed, irreparably damaged, or otherwise rendered unusable. DMEPOS suppliers must still provide a narrative description about why the equipment must be replaced.

IV. Practitioner Licensure, Provider Enrollment, Appeals, and Medicaid/CHIP Waivers

CMS has provided a specific fact sheet describing the waivers and flexibilities available for physicians and other clinicians, available [here](#). The Blanket Waivers are intended to ease the burden on the health system in order to allow providers to focus on patient care. To that end, CMS is temporarily waiving the Medicare reimbursement requirements that out-of-state practitioners be licensed in the state in which they are providing services when they are licensed in another state when the following four conditions are met:

1. The practitioner must be enrolled in Medicare;
2. The practitioner must have a valid license to practice in the state which relates to his or her Medicare enrollment;
3. The services must be furnished, whether in-person or remote 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. The practitioner must not be excluded in any state that is part of the PHE.

Please note that the foregoing Medicare reimbursement waiver for licensure does not waive state or local licensure requirements. As a result, providers must review the state licensure requirements in each jurisdiction prior to delivering telehealth to patients in that location. Please see the blog post we published on this topic of telehealth opportunities [here](#).

Additionally, CMS has taken a number of steps to ease the provider enrollment requirements. See [here](#) for additional information from CMS on provider enrollment relief, as well as our previous blog post on this topic, available [here](#). CMS has set up a hotline for physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges. Additionally, CMS has taken the following steps to facilitate the

enrollment of providers in the wake of the COVID-19 outbreak, including:

- Waiver of certain screening requirements, including application fees, background checks, and site visits;
- Postponement of revalidation actions;
- Allowing licensed providers to render services outside their state of enrollment;
- Expediting pending or new applications;
- Easing telehealth restrictions; and
- Allowing physicians and non-physician practitioners to terminate opt-out status early and enroll in Medicare.

Regarding appeals, the new waivers grant broad powers to MACs, QICs, and IREs to relax the requirements of federal regulations regarding the appeals process in FFS, and Parts C and D. MACs, QICs, and IREs are instructed to allow extensions to file an appeal and to permit the waiver of requests for timeliness requirements for additional information to adjudicate appeals. MACs, QICs, and IREs are now allowed to process an appeal even with incomplete Appointment of Representation forms as outlined in federal regulations. Additionally, MACs, QICs, and IREs can now process appeals that do not meet the required elements of those same federal regulations. MACs, QICs, and IREs are given broad flexibility with respect to other parts of the appeals process so long as good cause requirements are satisfied.

Finally, regarding Medicaid and CHIP, the new waivers permit states to request approval that certain statutes and implementing regulations be waived under section 1135. To request such an approval, states may submit an 1135 waiver request directly to their Center for Medicaid and CHIP Services (CMCS) state lead or Jackie Glaze, Acting Director, Medicaid and CHIP Operations Group, Center for Medicaid and CHIP Services at CMS by e-mail (Jackie.Glaze@cms.hhs.gov) or by letter. CMS sets forth a number of examples of the kinds of requests that states can make under this waiver, including:

- Waiver of prior authorization requirements for FFS programs;
- Waiver of out-of-state requirements for providers to provide care to another state's Medicaid enrollees impacted by COVID-19;
- Temporary suspension of provider enrollment and revalidation requirements to increase access to care;
- Temporary waiver of state licensure requirements;
- Temporary suspension of requirements for pre-admission and annual screening requirements for nursing home residents.

CMS encourages states to assess their needs and take advantage of these waivers. To assist states with the waiver request process and provide additional guidance, CMS released the Medicaid and CHIP Disaster Response Toolkit, which can be found [here](#). Further, the CMS Coronavirus Waivers & Flexibilities website, [here](#), contains a link to each state's request for waivers and the responses from CMS.

V. Stark Waivers

On the same date, CMS also issued much-anticipated Blanket Waivers of sanctions

under the federal physician self-referral law, or “Stark Law,” for “COVID-19 Purposes.” These Blanket Waivers are set forth [here](#). Please see our separate post, available [here](#), with detailed information about these Stark Law Blanket Waivers.

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If you have questions about the new CMS waivers, please contact the authors or your regular Dorsey & Whitney LLP attorney. Dorsey is closely monitoring 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](#).