COVID-19 CMS Blanket Waivers

By: William D. Kennedy

As part of sweeping exemptions aimed at facilitating all levels of healthcare during the coronavirus public health emergency, the Centers for Medicare and Medicaid Services (CMS) has been issuing waivers for a wide range of services. The waivers are aimed at facilitating telemedicine and relaxing non-clinical requirements for participation in the Medicare program. The waivers affect hospitals, long-term care facilities, skilled nursing facilities, home health agencies, hospice programs and facilities for individuals with intellectual disabilities. Retroactive to March 1, 2020, and running through the end of the COVID-19 emergency declaration, the waivers exempt providers from the normal process of seeking specific waivers to expand healthcare practices. All of the new flexibilities may be implemented during the duration of the declared public emergency, so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

The table below outlines the primary hospital related healthcare services for which waivers have been issued as of May 1, 2020. If and when new waivers or additional bulletins or guidance are issued, White and Williams will update the table to reflect the new information.

Regulated Person or Entity	CMS Waiver
Ambulatory Surgical Centers (ASCs)	**Physical Environment, Temporary Expansion Locations** • CMS will allow hospitals and ASCs to establish and operate any location meeting those conditions of participation for hospitals that continue to apply during the public health emergency. This waiver allows hospitals to change the status of their current provider-based department locations to the extent necessary as part of the state or local pandemic plan so long as the relevant location meets the conditions of participation and other requirements not waived by CMS. 42 CFR §482.41 and §485.623. **Medical Staff** • CMS is waiving the requirement that medical staff privileges must be periodically reappraised, and the scope of procedures performed in the ASC must be periodically reviewed. This will allow for physicians whose privileges will expire to continue practicing at the ASC, without the need for reappraisal, and for ASCs to continue operations without performing these administrative tasks during the Public Health Emergency (PHE). 42 CFR §416.45(b). **Anesthesia Services** • Waiving the requirements that a certified registered nurse anesthetist (CRNA) work under the supervision of a physician; CRNA supervision will be at the discretion of the hospital and state law. 42 CFR §482.52(a)(5) and §485.639(c)(2).
Critical Access Hospitals (CAHs)	**Discharge Planning** • Hospitals, psychiatric hospitals and CAHs need not comply with the usual discharge planning requirements which give patients (or families) the right to choose the necessary post-discharge care, ranging from home health through skilled nursing facilities and the

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	like. The hospital must merely comply with requirements to discharge patients to an appropriate facility. 42 CFR §482.43 (a)(8), §482.43(c), §482.61(e) and §485.642(a)(8). **Anesthesia Services** • Waiving the requirements that a certified registered nurse anesthetist (CRNA) work under the supervision of a physician; CRNA supervision will be at the discretion of the hospital and state law. 42 CFR §482.52(a)(5) and §485.639(c)(2). **Emergency Preparedness Policies and Procedures** • Surge site hospitals and CAHs are exempt from requirements to develop and implement policies and procedures for both emergency preparedness and communications. The requirement under the communication plan requires hospitals and CAHs to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This would not be an expectation for the surge site. 42 CFR §482.15(c)(1)–(5) and §485.625(c)(1)–(5). **Emergency Medical Treatment & Labor Act (EMTALA) Screening** • CMS is waiving the enforcement of EMTALA to allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location off-site from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. Section 1867(a) of the Social Security Act. **Number of Beds and Lengths of Stay** • CAHs may have more than the usual 25 beds and patients may remain longer than the usual 96 hours. 42 CFR §485.620. **Nursing Plans of Care – Nursing Services** • CMS is waiving the requirements which requires the nursing staff to develop and keep current a nursing care plan for each patient, and §482.23(b)(7), which requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present. 42 CFR §482.23(b)(4), (b)(7) and 42 CFR §485.635(d)(4). **Personnel Qualifications** • CMS is waiving the minimum personnel qualifications for clinical nurse specialists and physician assistants. 42 CFR §485.604(a)(2), §485.604(b)(1)–(3) and §485.604(c)(1)–(3). **Physical Plant** • Hospitals, psychiatric hospitals, and CAHs may use non-hospital buildings and spaces for patient care and quarantine sites, provided that the location is approved by the state and so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. 42 CFR §482.41 and §485.623. **Physician Presence** • CMS is waiving the requirement for CAHs that a physician be physically present as long as the physician is available "through direct radio or telephone communication, or

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	electronic communication for consultation, assistance with medical emergencies, or patient referral." 42 CFR §485.631(b)(2). **Quality Assessment (QA) and Performance Improvement (PI) Programs** • CMS is waiving the regulations that require specific QA/PI programs; still, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. 42 CFR §482.21(a)–(d) and (f) and §485.641(a), (b) and (d). **Staff Licensure** • CMS is deferring staff licensure, certification or registration to state law. 42 CFR §485.608(d). **Status and Location** • CMS is allowing CAHs to establish non-rural, temporary locations by waiving the requirement that the CAH be located in a rural area, and allowing the CAH flexibility in establishing temporary off-site locations. 42 CFR §485.610(b) and (e). **Telemedicine** • CMS is waiving the provisions related to telemedicine, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care. . 42 CFR §485.616(c). **Physical Environment, Inspection, Testing & Maintenance (ITM)** CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. Specific physical environment waiver information: • Requirements for scheduled inspection, testing, and maintenance (ITM) frequencies and activities for facility and medical equipment are modified. 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs. • CMS is temporarily permitting facilities to adjust scheduled ITM frequencies and activities required by the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). The following LSC and HCFC ITM are considered critical are not included in this waiver: o Sprinkler system monthly electric motor-driven and weekly diesel engine driven fire pump testing. o Portable fire extinguisher monthly inspection. o Elevators with firefighters' emergency operations monthly testing. o Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.

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	○ 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. 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs.
Home Health Agencies (HHAs)	**Discharge Planning** • CMS is waiving the requirements to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. CMS is maintaining all other discharge planning requirements. 42 CFR §484.58(a). **In-Service Training** • CMS is modifying the requirement that each home health aide receives 12 hours of in-service training in a 12-month period. CMS is postponing the deadline for meeting this requirement throughout the COVID-19 Public Health Emergency (PHE) until the end of the first quarter after the declaration of the PHE concludes. 42 C.F.R. §484.80(d). **Medical Records** • For patient-requested copies of the clinical record, CMS is extending the 4-day deadline to 10 business days. 42 CFR §484.110(e). **Quality Assurance and Performance Improvement (QAPI)** • CMS is modifying the requirement which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. Specifically, CMS is modifying the requirements at §418.58(a)—(d) and §484.65(a)—(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain. 42 CFR §418.58 for Hospice and 42 CFR §484.65 for HHAs. **Training Aids** • CMS is waiving the requirement which require a hospice nurse or in the case of an HHA, a registered nurse or other appropriate skilled professional to make an annual onsite supervisory visit (direct observation) for each aide. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE. 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHA.

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	Comprehensive Assessment Reporting • For submission of comprehensive assessments, CMS is extending the 5-day time frame to 30-days; CMS is waiving the 30-day deadline for submission of the customary Outcome and Assessment Information Set. **Initial Assessments** • CMS is modifying its requirements to allow for remote or records-review initial assessments. 42 CFR §484.55(a). • CMS will relax which professional discipline must perform the assessment, but it expects HHAs to align needs of the patient to the proper professional discipline to the greatest extent possible. • Specifically, CMS will allow Occupational Therapists (OT) to perform initial and comprehensive assessment for patients with OT needs, not merely those patients for whom an OT-need is the basis for home healthcare. 42 CFR §484.55(a)(2) and §484.55(b)(3). • The existing regulations will continue to prevent OTs and other therapists from performing assessments in nursing-only cases. 42 CFR §484.55(a) and (b)(2). **Onsite Visits** • CMS is waiving the usual requirements of that a nurse conduct an onsite patient visit from every two (2) weeks and that a nurse or other professional conduct an onsite visit every two (2) weeks to oversee and review care by an aide, but virtual supervision is encouraged. 42 CFR §484.80(h). **Payment (Requests for Anticipated Payments)** • CMS is allowing Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment during emergencies.
Hospice	**Aide Training and Testing** • CMS is temporarily allowing hospices to utilize pseudo patients, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients for purposes of competency testing of hospice aides. 42 CFR §418.76(c)(1). • CMS is waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12-month period. 42 CFR §418.76(d). **Assessments** • The deadline for hospices to update comprehensive assessments of patients is extended from 15 to 21 days. 42 CFR §418.54 and 54(d). **Non-Core Services** • Hospices will not have to provide non-core services, including physical therapy, OT and speech-language pathology. 42 CFR §418.72

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	Physical Environment, Inspection, Testing & Maintenance (ITM) CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. Specific Physical Environment Waiver Information: • Requirements for scheduled inspection, testing, and maintenance (ITM) frequencies and activities for facility and medical equipment are modified. 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs. • CMS is temporarily permitting facilities to adjust scheduled ITM frequencies and activities required by the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). The following LSC and HCFC ITM are considered critical are not included in this waiver: o Sprinkler system monthly electric motor-driven and weekly diesel engine driven fire pump testing. o Portable fire extinguisher monthly inspection. o Elevators with firefighters' emergency operations monthly testing. o Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing. o 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. 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs. **Quality Assurance and Performance Improvement (QAPI)** • CMS is modifying the requirement which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. Specifically, CMS is modifying the requirements at §418.58(a)—(d) and §484.65(a)—(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain. 42 CFR §418.58 for Hospice and 42 CFR §484.65 for HHAs. **Supervisory Onsite Visits** • Hospices are exempt from the usual requirements for a nurse to conduct an onsite supervisory visit every two (2) weeks, including the requirement for a nurse or other

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	professional to conduct an onsite visit every two (2) weeks to evaluate the performance of aides 42 CFR §418.76(h). **Training** • CMS is modifying the requirement for hospices to annually assess the skills and competence of all persons furnishing care and provide in-service training and education programs. CMS is postponing the deadline for completing this requirement until the end of the first full quarter after the declaration of the Public Health Emergency concludes. This does not alter the minimum personnel requirements at 42 CFR §418.114. Selected hospice staff must complete training and have their competency evaluated in accordance with unwaived provisions of 42 CFR Part 418. 42 CFR §418.100(g)(3). **Training, Aides** • CMS is waiving the requirement which require a hospice nurse or in the case of an HHA, a registered nurse or other appropriate skilled professional to make an annual onsite supervisory visit (direct observation) for each aide. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the Public Health Emergency. 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHA. **Volunteers** • CMS is waiving the requirement for hospices to use volunteers for at least 5% of patient care hours. 42 CFR §418.78(e).
Hospital/Health System	**Anesthesia Services** • Waiving the requirements that a certified registered nurse anesthetist (CRNA) work under the supervision of a physician; CRNA supervision will be at the discretion of the hospital and state law. 42 CFR §482.52(a)(5) and §485.639(c)(2). **Appraisal of Emergencies at Off-Campus Hospital Departments** • For surge facilities only, written policies and procedures for staff to use when evaluating emergencies are not required. 42 CFR §482.12(f)(3). **Discharge Planning** • Hospitals, psych hospitals and CAHs need not comply with the usual discharge planning requirements which give patients (or families) the right to choose the necessary post-discharge care, ranging from home health through skilled nursing facilities and the like. The hospital must merely comply with requirements to discharge patients to an appropriate facility. 42 CFR §482.43 (a)(8), §482.43(c), §482.61(e) and §485.642(a)(8). **Emergency Medicine** • Hospitals, psychiatric hospitals and CAHs may screen patients at off-site locations to prevent the spread of COVID-19; this is a waiver of Section 1867(a) of the EMTALA. **Emergency Preparedness Policies and Procedures** • Surge site hospitals and CAHs are exempt from requirements to develop and implement policies and procedures for both emergency preparedness and communications. (The requirement under the communication plan requires hospitals and CAHs to have specific

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	contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This would not be an expectation for the surge site. 42 CFR §482.15(c)(1)–(5) and §485.625(c)(1)–(5). **Extended Neoplastic Disease Care Hospitals** • CMS is allowing these hospitals to exclude inpatient stays where they admit or discharge patients from the usual greater than 20-day average length of stay requirement. Section 1886(d)(1)(B)(vi) of the EMTLA and §42 CFR 412.22(i). **Face Masks in Sterile Compounding Areas** • Face masks may be removed, retained and re-donned during the same shift of work within sterile compounding areas. CMS will not review the use and storage of masks under these requirements. 42 CFR §482.25(b) and §485.635(a)(3). **Food and Dietetic Services** • Hospitals are exempt from the usual requirement that a current, approved therapeutic diet manual be readily available to all medical, nursing and food service personnel. Such manuals would not need to be maintained at surge capacity sites. 42 CFR §482.28(b)(3). **Inpatient Rehab Facilities (IRFs)** • 60% Rule: CMS is allowing IRFs to exclude patients from the freestanding hospital's or distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60% rule") as long as the IRF admits a patient solely to respond to the COVID-19 emergency and the patient's medical record properly identifies the patient as such. • Three-Hour Rule: Per the CARES Act, the Secretary has waived the requirement of at least 15 hours of rehab therapy per week. **Medical Records** • CMS is waiving requirements for the organization and staffing of the medical records department, for the form, content, and the usual 30-day completion of the medical record, and for record retention requirements; these flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. 42 CFR §482.24(a)-(c). **Medical Staff Privileges** • Physicians whose privileges would have otherwise expired may continue to practice at their hospitals; new physicians may practice before the customary review by the credentialing committee, et al. 42 CFR §482.22(a)(1)-(4). **Nursing Plans of Care – Nursing Services** • CMS is waiving the requirements which requires the nursing staff to develop and keep current a nursing care plan for each patient, and §482.23(b)(7), which requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present. 42 CFR §482.23(b)(4), (b)(7) and 42 CFR §485.635(d)(4).

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	Orders (Verbal Orders, Standing Orders, Co-Signing Orders) • Hospitals will have greater flexibility to memorialize a physician's verbal orders to the nursing staff. • Frequent Verbal Orders Now Permitted: CMS is waiving the former prohibition on "frequent" verbal orders for drugs and biologicals. 42 CFR §482.23(c)(3)(i). • Verbal Orders Need Not be Signed By the Ordering Physician: CMS is waiving the requirement for prompt timing, dating and signing of the verbal order by the ordering or attending physician. 42 CFR §482.24(c)(2). • Preprinted/Electronic Standing Orders May Be Used: Hospitals may use standing orders, order sets and protocols for patient orders. 42 CFR §482.24(c)(3). • CAHs May Use Verbal Medication Orders Subsequently Co-Signed: CAHs may administer medication based on a verbal orders which are authenticated "as soon as possible" after the fact. 42 CFR §485.635(d)(3). **Patient Rights** • For hospitals in areas CMS deems to be impacted by a widespread outbreak do not have to comply with the usual requirements for providing patients copies of their medical records, the hospital's written policies regarding seclusion and/or visitation for COVID-19 patients. 42 CFR 482.13(d)(2), (e)(1)(iii) and (h). **Physical Environment, Temporary Expansion Locations** • CMS will allow hospitals and ASCs to establish and operate any location meeting those conditions of participation for hospitals that continue to apply during the public health emergency. This waiver allows hospitals to change the status of their current provider-based department locations to the extent necessary as part of the state or local pandemic plan so long as the relevant location meets the conditions of participation and other requirements not waived by CMS. 42 CFR §482.41 and §485.623. **Physical Plant** • Hospitals, psych hospitals, and CAHs may use non-hospital buildings and spaces for patient care and quarantine sites, provided that the location is approved by the state and so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. 42 CFR §482.41 and §485.623. **Physician Services to Medicare Patients** • CMS is waiving requirements which require that Medicare patients be under the care of a physician. This waiver may be implemented so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4). **Provision of Advanced Healthcare Directive Information** • Hospitals and CAHs are now exempt from the requirements to provide information about their advance directive policies to patients. §1902(a)(58) and 1902(w)(1)(A) of the Social Security Act (the Act) (for Medicaid), §(i) of the Act (for Medicare Advantage); and §1866(f) of the Act and 42 CFR §489.102 (for Medicare).

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	Quality Assessment (QA) and Performance Improvement (PI) Programs • CMS is waiving the regulations that require specific QA/PI programs; still, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. 42 CFR §482.21(a)–(d) and (f) and §485.641(a), (b) and (d). **Reporting Deaths** • Hospitals may now report the deaths of ICU patients who required soft wrist restraints (typically applied to prevent pulling out IV lines) within standard time limits (instead of the next business day). 42 CFR §485.13(g)(1)(i-ii). **Respiratory Care** • Hospitals are exempt from the requirement to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. 42 CFR §482.57(b)(1). **Telemedicine** • CMS is waiving the provisions related to telemedicine, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care. 42 CFR §482.12(a)(8)–(9). **Utilization Review** • CMS is waiving certain requirements which normally require that hospitals participating in Medicare and Medicaid must have a utilization review plan that meets specified requirements. 42 CFR §482.1(a)(3) and 42 CFR §482.30.
Hospitals	**EMTALA Screening** • CMS is waiving the enforcement of EMTALA to allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location off-site from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. Section 1867(a) of the Social Security Act. **Psychiatric Units** • CMS is allowing acute care hospitals with psychiatric units (formally, "excluded distinct part inpatient psychiatric units") to relocate inpatients from the psychiatric unit to an acute care bed and unit as a result of a disaster or emergency. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for these patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the COVID-19 emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for. CMS, April 30, 2020.

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	Physical Environment, Inspection, Testing & Maintenance (ITM) CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled ITM frequencies and activities for facility and medical equipment. Specific Physical Environment Waiver Information: • Requirements for scheduled ITM frequencies and activities for facility and medical equipment are modified. 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs. • CMS is temporarily permitting facilities to adjust scheduled ITM frequencies and activities required by the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). The following LSC and HCFC ITM are considered critical and not included in this waiver: o Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing. o Portable fire extinguisher monthly inspection. o Elevators with firefighters' emergency operations monthly testing. o Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing. o 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 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs.
Inpatient Rehab Facilities	**Intensity of Treatment ("3 Hour Rule")** • The Secretary of Health has waived the payment requirement that patients of an inpatient rehabilitation facility receive at least 15 hours of therapy per week. 42 CFR § 412.622(a)(3)(ii), clarifying information provided in "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (CMS-1744-IFC) (85 Federal Register 19252, 19287, April 6, 2020) because the information in that rulemaking (CMS-1744-IFC) about Inpatient Rehabilitation Facilities was contemplated prior to the passage of the CARES Act.
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	**Community Outings** • CMS is authorizing the facility to implement social distancing precautions with respect to on and off-campus movement. CMS is lifting the requirement which requires facilities to provide social, religious, and community group activities. The federal and/or state emergency restrictions will dictate the level of restriction from the community based on whether it is for social, religious or medical purposes. CMS specifically notes that states

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	may have also imposed more restrictive limitations. State and federal restrictive measures should be made in the context of competent, person-centered planning for each client. 42 CFR §483.420(a)(11). • CMS is waiving the requirements that clients have the opportunity to participate in social, religious, and community group activities. CMS is authorizing the facility to implement social distancing precautions with respect to on and off campus movement. State and Federal restrictive measures should be made in the context of competent, person-centered planning for each client. 42 CFR §483.420(a)(11). **Disabilities** • CMS recognizes that active treatment will need to be modified. The requirements that each client must receive a continuous active treatment program is waived to the extent the requirements would violate current state and local requirements for social distancing, staying at home, and traveling for essential services only. In accordance with 42 CFR §483.440(c)(1), any modification to a client's Individual Program Plan (IPP) in response to treatment changes associated with the COVID-19 crisis requires the approval of the interdisciplinary team. For facilities that have interdisciplinary team members who are unavailable due to the COVID-19, CMS would allow for a retroactive review of the IPP (42 CFR §483.440(f)(2)) in order to allow IPPs to receive modifications as necessary during the COVID-19 crisis. **Modification of Adult Training Programs and Active Treatment** • CMS is waiving requirements that each client must receive a continuous active treatment program, including consistent implementation of a program of specialized and generic training, treatment, health services and related services. CMS is waiving those components of beneficiaries' active treatment programs and training that would violate current state and local requirements for social distancing, staying at home, and traveling for essential services only. All modifications to a client's IPP in response to treatment changes associated with the COVID-19 crisis requires the approval of the interdisciplinary team. For facilities that have interdisciplinary team members who are unavailable due to the COVID-19, CMS would allow for a retroactive review of the IPP under in order to allow IPPs to receive modifications as necessary based on the impact of the COVID-19 crisis. 42 CFR §483.440(c)(1), (f)(2). **Physical Environment, Inspection, Testing & Maintenance (ITM)** CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled ITM frequencies and activities for facility and medical equipment. Specific Physical Environment Waiver Information: • Requirements for scheduled inspection, testing, and maintenance (ITM) frequencies and activities for facility and medical equipment are modified. 42 CFR §482.41(d) for

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	hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs. • CMS is temporarily permitting facilities to adjust scheduled ITM frequencies and activities required by the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). The following LSC and HCFC ITM are considered critical are not included in this waiver: o Sprinkler system monthly electric motor-driven and weekly diesel engine driven fire pump testing. o Portable fire extinguisher monthly inspection. o Elevators with firefighters' emergency operations monthly testing. o Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing. o 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 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs. **Staffing** • CMS will allow the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that interfere with direct client care. DSS perform activities such as cleaning of the facility, cooking and laundry services; DSC perform activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills. 42 CFR §483.430(d)(3),(4). • CMS is waiving the requirements which requires the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that interfere with direct client care. (DSS perform activities such as cleaning of the facility, cooking and laundry services. DSC perform activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills.) During the time of this waiver, DCS may be needed to conduct some of the activities normally performed by the DSS. 42 CFR §483.430(c)(4), (d)(3). **Training** • CMS is waiving, in-part, the otherwise mandatory requirements related to routine staff training programs unrelated to the public health emergency. 42 CFR §483.430(e)(1) • CMS is not waiving requirements focusing on the clients' developmental, behavioral and health needs and being able to demonstrate skills related to interventions for inappropriate behavior and implementing individual plans. CMS is also not waiving initial training for new staff hires or training for staff around prevention and care for the infection control of COVID-19. 42 CFR §483.430(e)(2)-(4).
Long Term Care Facilities (LTCFs)	**Admission and Pre-Admission Screening**

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	• The usual 3-day prior hospitalization requirement is waived for coverage of a SNF stay for patients who experience dislocations, or are otherwise affected by COVID-19. Section 1812(f) of the Social Security Act. • For patients who recently exhausted their SNF benefits, a new SNF coverage period can be renewed without the patient first having to start a new benefit period for those beneficiaries who have been delayed or prevented commencing or completing the process of ending their current benefit period. • CMS will allow allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screenings, but on or before the 30th day of admission, any new nursing home patients with a mental illness or intellectual disability should be referred promptly by the nursing home to the state Preadmission Screen and Resident Review (PASARR) program for Level 2 Resident Review. 42 CFR §483.20(k). **Discharge Planning** • CMS is waiving the discharge planning requirement to 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. CMS is maintaining all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan address the resident's goals of care and treatment preferences. Section §483.21(c)(1)(viii) of the Social Security Act. **In-Service Training, Nurse Aides and Nurse Assistants** • CMS is modifying the nurse aide training requirements for SNFs and NFs which requires the nursing assistant to receive at least 12 hours of in-service training annually. CMS is postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the Public Health Emergency concludes. Section 483.95(g)(1) of the Social Security Act. **Medical Records** • CMS is modifying the requirement which requires long-term care facilities to provide, upon resident request, a copy of their records within two working days. **Quality Assurance and Performance Improvement (QAPI)** • CMS is modifying certain requirements for long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS is modifying §483.75(b)—(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. **Physical Environment, Inspection, Testing & Maintenance (ITM)** CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be

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	maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. Specific Physical Environment Waiver Information: • Requirements for scheduled inspection, testing, and maintenance (ITM) frequencies and activities for facility and medical equipment are modified. 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs. • CMS is temporarily permitting facilities to adjust scheduled ITM frequencies and activities required by the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). The following LSC and HCFC ITM are considered critical 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 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs. **Physical Environment** • Provided that the state has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is allowing non-SNF buildings to be temporarily certified and available for isolation for COVID-19-positive residents. • CMS will waive certain conditions of participation and certification requirements for opening a nursing facility if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location. • CMS is also waiving requirements to temporarily allow a long-term care facility to use non-resident space for residents to help with surge capacity. This includes activity rooms, meeting/conference rooms and dining rooms, as long as residents can be kept safe, comfortable and other applicable requirements for participation are met. 42 CFR §483.90. **Physician Services** • Physician Delegation of Tasks in SNFs. CMS will allow physicians to delegate any tasks to any duly qualified PA, NP or clinical nurse specialist. Still, the task delegated must continue to be under the supervision of the physician.

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	• Exception: Physicians are still prohibited from delegating that which is prohibited from delegation under state law or by the facility's own policy. 42 CFR §483.30(e)(4). • Physicians may delegate any required physician visit to a PA or NP or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician and who is licensed by the state and performing within the state's scope of practice laws. 42 CFR §483.30(c)(3),(4), (f). • Note: the facility must still be able to provide physician services 24 hours a day. **Physician Visits** • CMS is waiving the requirement for physicians and non-physician practitioners to perform in-person visits so as to allow for telehealth options. 42 CFR §483.30. **Reporting Minimum Data Set** • CMS is waiving the usual 14-day timeframe for Minimum Data Set assessments and transmission. 42 CFR §483.20 **Resident Groups** • CMS is waiving the requirements which normally ensure that residents can participate live in resident groups. 42 CFR §483.10(f)(5). **Resident Roommates and Grouping** • CMS is waiving the "notice," "consent" and "right to refuse" provisions that apply to grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19. 42 CFR 483.10(e) (5), (6), and (7). **Staffing and Data Submission** • CMS is waiving the quarterly requirements for submitting staffing data through the Payroll-Based Journal system. 42 CFR §483.70(q). **Training and Certification of Aides** • CMS is waiving the requirements which prohibit a SNF or NF from employing anyone for longer than four months without meeting certain training and certification requirements. CMS is not waiving the prohibition on hiring a nurse aide for more than four months on a full-time basis unless that individual is competent to provide nursing and nursing related services. • CMS will still require facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs. 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)). **Transfers and Discharges** • CMS is waiving a myriad of requirements (with some exceptions) to allow a long-term care (LTC) facility to transfer or discharge residents to another LTC facility solely for the following cohorting purposes: • Transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents;

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	• Transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19; or • Transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days. • Exceptions and Requirements: The transferring facility must receive confirmation from the receiving facility. The confirmation may be in writing or verbal with the transferring facility documenting the date, time and person receiving the confirmation. • Note that 42 CFR §483.10 ("Resident Rights"), CMS is only waiving the requirement, under §483.10(c)(5) for advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to §483.10 are not waived. • Similarly, in 42 CFR §483.15 (Admission, Transfer, Discharge), CMS is only waiving the requirement for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable. 42 CFR § 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv) and (d). • In §483.21 (Comprehensive Person-Centered Care Planning), CMS is only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes related to COVID-19. Receiving facilities should complete the required care plans as soon as practicable. • These requirements are also waived when transferring residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements." In these cases, the transferring LTC facility is still considered the "provider," so it need not issue a formal discharge. The transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period. 42 CFR 483.10(c)(5); 483.15(c) (3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i).
Long-Term Care Hospitals (LTCH)	**25-Day Average Length of Stay** • CMS has issued a blanket waiver to long-term care hospitals (and applicants for LTCH status) to exclude patient stays where the facility admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs. CMS, April 30, 2020. **Site Neutral** The Secretary of Health has waived section 1886(m)(6) of the Social Security Act relating to certain site neutral payment rate provisions for long-term care hospitals (LTCHs). Specifically: • Section 3711(b)(1) of the CARES Act waives the payment adjustment under section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a discharge payment percentage (DPP) for the period that is at least 50 percent during the COVID-19 public health emergency period. Under this provision, for the purposes of calculating an LTCH's DPP,

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	all admissions during the COVID-19 public health emergency period will be counted in the numerator of the calculation, that is, LTCH cases that were admitted during the COVID-19 public health emergency period will be counted as discharges paid the LTCH PPS standard Federal payment rate. • Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site neutral payment rate under section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the public health emergency and occur during the COVID-19 public health emergency period. Under this provision, all LTCH cases admitted during the COVID-19 public health emergency period will be paid the relatively higher LTCH PPS standard Federal rate.
Out-of-State Practitioners	**Location** CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are already licensed in another state. CMS will waive the requirements when the following four conditions are met: • the physician must be enrolled as such in the Medicare program • the physician must have a valid license to practice in the state which relates to their Medicare enrollment • the physician is furnishing services —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 • the physician is not affirmatively excluded from practice in the state or any other state that is part of the emergency area. For the physician or non-physician practitioner to avail themselves of this waiver, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state. CMS, April 30, 2020.
Physicians, Physical Therapists	***Locum Tenens*, 60-Day Limit Waived** • CMS is modifying the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time they are unavailable to provide services during the COVID-19 emergency plus an additional period of no more than 60 continuous days after the Public Health Emergency expires. Section 1842(b)(6)(D)(iii) of the Social Security Act.
Providers	**Enrollment in Medicare** • CMS has a toll-free hotline for physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges without the typical application fees, background checks and other administrative steps. This will allow physicians and other 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. Providers should contact the hotline for the Medicare Administrative Contractor (MAC) that services their geographic area. The designated MACs are identified at

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	https://www.cms.gov/Medicare/MedicareContracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf. **Telehealth Expansion of Billable Providers** • CMS is waiving the requirements of which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. All health care professionals eligible to bill Medicare for their professional services can furnish distant site telehealth services. The expansion allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, and speech language pathologists. Section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2). **Telehealth, Limited Exception for Audio-Only** • CMS is waiving the video requirements of for telehealth services to allow for audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3).
Psychiatric Hospitals	**Discharge Planning** • Hospitals, psych hospitals and CAHs need not comply with the usual discharge planning requirements which give patients (or families) the right to choose the necessary post-discharge care, ranging from home health through skilled nursing facilities and the like. The hospital must merely comply with requirements to discharge patients to an appropriate facility. 42 CFR §482.43 (a)(8), §482.43(c), §482.61(e) and §485.642(a)(8). **EMTALA Screening** • CMS is waiving the enforcement of EMTALA to allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location off-site from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. Section 1867(a) of the Social Security Act. **Physical Plant** • Hospitals, psych hospitals, and CAHs may use non-hospital buildings and spaces for patient care and quarantine sites, provided that the location is approved by the state and so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. 42 CFR §482.41 and §485.623.
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	**Physician Supervision of NPs** • CMS has modified the requirement that physicians must provide medical direction to allow for telehealth and other remote communications. 42 CFR 491.8(b)(1).

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	Staffing Requirements • CMS is waiving the requirement that a nurse practitioner, physician assistant or certified nurse-midwife be available to furnish patient care services at least 50% of the time the RHC and FQHC operates. 42 CFR 491.8(a)(6). **Temporary Expansion Locations** • CMS will allow RHCs and FQHCs to operate in more than one permanent location without separate Medicare approval. 42 CFR §491.5(a)(1),(2),(3).

If you have questions or would like further information, please contact William Kennedy (kennedyw@whiteandwilliams.com; 215.864.6816) or another member of our Healthcare Group.

As we continue to monitor the novel coronavirus (COVID-19), White and Williams lawyers are working collaboratively to stay current on developments and counsel clients through the various legal and business issues that may arise across a variety of sectors. Read all of the updates here.