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# Which Health Care Rules Are Already Waived Under the President's Emergency Declaration?

Last Friday, President Trump declared the spread of COVID-19 to be a national emergency, ushering in new flexibilities for federal health care programs to address the crisis. Within hours of the announcement, the Centers for Medicare & Medicaid Services (CMS) announced nearly a dozen new flexibilities for patients, providers, suppliers and healthcare workers. These waivers have immediate effect throughout the country. This alert explains the authority for these waivers, and which national waivers are currently in effect.

## **Background**

When the president declares a national emergency and the Secretary of Health and Human Services declares a public health emergency, the federal government can waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) rules under section 1135 of the Social Security Act. These are called "1135 waivers" and are put in place to ensure that healthcare services are available to meet the needs of individuals, and that providers can be reimbursed for providing those services. This 1135 waiver authority only applies to federal requirements and does not apply to state requirements.

The same day President Trump declared a national emergency, Friday, March 13, 2020, CMS immediately announced 11 categories of "blanket waivers" that are available. CMS has the authority to implement specific waivers or modifications under the 1135 authority on a "blanket" basis, when a determination has been made that all similarly situated providers in the emergency area needed such a waiver or modification. In these instances, the provider should still notify the State Survey Agency and CMS Regional Office if operating under these modifications to ensure proper payment. Some reporting requirements may be suspended for providers operating under a blanket waiver &mdash; providers should contact the CMS Regional Office for more information on what reporting requirements are suspended. The waivers last through the duration of the emergency period.

In addition to these blanket waivers, participants in federal healthcare programs can request additional flexibilities under 1135 waiver authority by contacting their CMS Regional Office.

For Medicaid and CHIP, states may request additional flexibilities through 1135 waivers. Examples include the ability to permit out-of-state providers to render services, temporarily suspend certain provider enrollment and revalidation

requirements to promote access to care, allow providers to provide care in alternative settings, waive prior authorization requirements, and temporarily suspend certain pre-admission and annual screenings for nursing home residents.

**Blanket Waivers Currently Available**

CMS has waived 11 categories of federal requirements thus far, in reaction to the emergency declaration:

1. **Skilled Nursing Facilities (SNF).** CMS is waiving the requirement for three-day prior hospitalization for coverage of a SNF stay, and provides temporary coverage for those who need to be transferred as a result of the emergency. For certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. CMS is waiving 42 CFR 483.20 to provide relief to SNFs on the time frame requirements for Minimum Data Set assessments and transmission.
2. **Critical Access Hospitals (CAH).** CMS is waiving the requirements that CAHs limit the number of beds to 25 and that the length of stay be limited to 96 hours.
3. **Housing Acute Care Patients.** Due to capacity issues related to the emergency, CMS will allow acute care hospitals to house acute care inpatients in excluded distinct part units, where those beds are appropriate for an acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record accordingly.
4. **Durable Medical Equipment (DME).** Where DME is lost, destroyed, irreparably damaged or otherwise rendered unusable, contractors can waive requirements such that the face-to-face requirement, new physician's order and new medical necessity documents are not required. Suppliers must still include a narrative description explaining why the equipment must be replaced.
5. **Care for Inpatient Psychiatric Unit Patients in the Acute Care Unit.** CMS will allow acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the reasons for the relocation, i.e., capacity, in the medical record.
6. **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital.** CMS will allow acute care hospitals with excluded distinct part inpatient rehabilitation units to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the Inpatient Rehabilitation Facility Prospective Payment System for such patients and annotate the reasons for the relocation, i.e., capacity, in the medical record.
7. **Supporting Care for Patients in Long-Term Care Acute Hospitals.** Allows a long-term care hospital to exclude patient stays from the 25-day average length of stay requirement, in instances where an long-term care acute hospital admits or discharges patients in order to meet the demands of the emergency.
8. **Home Health Agencies.** Provides relief to Home Health Agencies on the time frames related to OASIS Transmission. Allows Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.
9. **Provider Locations.** CMS waives requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid during the duration of the emergency.
10. **Provider Enrollment.** CMS is establishing a toll-free hotline for non-certified Part B suppliers, physicians and

non-physician practitioners to enroll and receive temporary Medicare billing privileges. CMS waives screening requirements pertaining to application fees (42 C.F.R 424.514); criminal background checks (42 C.F.R 424.518) and site visits (42 C.F.R 424.517). CMS has also postponed all revalidation actions, will allow licensed providers to render services outside of their state of enrollment, and will expedite any pending or new applications from providers.

11. **Medicare appeals in Fee for Service, MA and Part D.** CMS will grant extensions to file an appeal, waive timeliness for requests for additional information to adjudicate the appeal; will process the appeal even with incomplete forms; will process requests for appeal that don't meet the required elements using information that is available, and will utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

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