

Teaching Hospitals, Teaching Physicians and Medical Residents: CMS Flexibilities to Fight COVID-19

*** Indicates items added or revised in the most recent update*

Since the beginning of the COVID-19 Public Health Emergency, the Trump Administration has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states; 2) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Workforce

- *Application of Teaching Physician Regulations:* Under current rules, Medicare payment is made for services furnished by a teaching physician involving residents only if the physician is physically present for the key portion of the service or procedure or the entire procedure, where applicable. During the COVID-19 PHE, teaching physicians may use audio/video real time communications technology to interact with the resident through virtual means, which would meet the requirement that they be present for the key portion of the service, including when the teaching physician involves the resident in furnishing Medicare Telehealth services. Teaching physicians involving residents in providing care at primary care centers can provide the necessary direction, management and review for the resident's services using audio/video real time communications technology. Residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries, including levels 4-5 of an office/outpatient evaluation and management (E/M) visit, telephone E/M, care management, and communication technology-based services. These flexibilities do not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services. This allows teaching hospitals to maximize their workforce to safely take care of patients.

- *Resident Moonlighting:* Under current rules, Medicare considers the services of residents that are not related to their approved graduate medical education programs and performed in the outpatient department or the emergency department of a hospital as separately billable physicians' services. During the COVID-19 PHE, Medicare also considers the services of residents that are not related to their approved GME programs and furnished to inpatients of a hospital in which they have their training program as separately billable physicians' services.
- *Counting of Resident Time at Alternate Locations:* Existing regulations have specific rules on when a hospital may count a resident for purposes of Medicare direct graduate medical education (DGME) payments or indirect medical education (IME) payments. Normally, if the resident is performing activities with the scope of his/her approved program in his/her own home, or a patient's home, the hospital may not count the resident. During the PHE, a hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in a patient's home, but performing duties within the scope of the approved residency program and meets appropriate physician supervision requirements can claim that resident for IME and DGME purposes. This allows medical residents to perform their duties in alternate locations, including their own home or a patient's home, so long as such activities meet appropriate physician supervision requirements.
- *Graduate Medical Education (GME) Residents Training in Other Hospitals:* During the COVID-19 PHE, a teaching hospital that sends residents to other hospitals will be able to continue to claim those residents in the teaching hospital's IME and DGME FTE resident counts, if certain requirements are met. Those requirements include that 1) the teaching hospital sends the resident to the other hospital in response to the COVID-19 pandemic; 2) the time spent by the resident training at the other hospital is in lieu of time that would have been spent training at the sending hospital; and 3) the time that the resident spent training immediately prior to and/or subsequent to the time frame that the COVID-19 PHE was in effect was included in the FTE count for the sending hospital. Moreover, the presence of residents in non-teaching hospitals will not trigger establishment of IME and/or DGME FTE resident caps at those non-teaching hospitals. Specifically, for DGME, the presence of residents in non-teaching hospitals will not trigger establishment of PRAs at those non-teaching hospitals.
- *GME Affiliation Agreements Extended Deadline.* Due to the COVID-19 Public Health Emergency (PHE), under the authority of section 1135(b)(5) of the Social Security Act (the Act), CMS is waiving the July 1 submission deadline under 42 CFR 413.79(f)(1) for new Medicare GME affiliation agreements and the June 30 deadline under the May 12, 1998 Health Care Financing Administration Final Rule (63 FR 26318, 26339, 26341) for amendments of existing Medicare GME affiliation agreements. That is, during the COVID-19 PHE, instead of requiring that new Medicare GME affiliation agreements be submitted to CMS and the MACs by July 1, 2020 (for the academic year starting July 1,

2020), and that amendments to Medicare GME affiliation agreements be submitted to CMS and the MACs by June 30, 2020 (for the academic year ending June 30, 2020), CMS is allowing hospitals to submit new and/or amended Medicare GME affiliation agreements as applicable to CMS and the MACs by October 1, 2020. As under existing procedures, hospitals should email new and/or amended agreements to CMS at Medicare_GME_Affiliation_Agreement@cms.hhs.gov, and indicate in the subject line whether the affiliation agreement is a new one or an amended one.

- *IME Payments Held Harmless for Temporary Increase in Beds:* During the COVID-19 PHE, CMS will hold teaching hospitals harmless from a reduction in IME payments due to beds temporarily added during the COVID-19 PHE by not considering such beds when determining IME payments.
- *Inpatient Psychiatric Facilities (IPFs) Teaching Status Adjustment Payments:* To ensure that teaching IPFs can alleviate bed capacity issues by taking patients from the inpatient acute care hospitals without being penalized by lower teaching status adjustments, we are freezing the IPFs' teaching status adjustment payments at their values prior to the PHE. For the duration of the COVID-19 PHE, a teaching IPF's teaching status adjustment payments will be the same as they were on the day before the COVID-19 PHE was declared.
- *Sterile Compounding:* CMS is waiving hospital sterile compounding requirements to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. This will conserve scarce face mask supplies. CMS will not be reviewing the use and storage of facemasks under these requirements.
- *Medical Staff Requirements:* CMS is waiving the Medical Staff requirements at 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice in the hospital before full medical staff/governing body review and approval to address workforce concerns related to COVID-19.
- *Physician services:* CMS is waiving 482.12(c)(1)-(2) and §482.12(c)(4), which requires that Medicare patients be under the care of a physician, and that a physician be on call at all times. This allows hospitals to use other practitioners, such as physician's assistant and nurse practitioners, to the fullest extent possible. This waiver should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
- *Anesthesia services:* CMS is waiving the requirements at 42 CFR 482.52(a)(5), 42 CFR 485.639(c)(2), and 42 CFR 416.42 (b)(2) that a certified registered nurse anesthetist

(CRNA) is under the supervision of a physician. CRNA supervision will be at the discretion of the hospital or Ambulatory Surgical Center (ASC), and state law. This waiver applies to hospitals, CAHs, and ASCs. These waivers will allow CRNAs to function to the fullest extent of their licensure, and should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.

- *Respiratory care services:* We are waiving the requirement at 42 CFR 482.57(b)(1) that hospitals 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. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan. Not being required to designate these professionals in writing will allow qualified professionals to operate to the fullest extent of their licensure and training in providing patient care for respiratory illnesses.
- *CAH Personnel qualifications:* CMS is waiving the minimum personnel qualifications for clinical nurse specialist, nurse practitioners, and physician assistants described at 42 CFR 485.604 (a)(2), 42 CFR 485.604 (b)(1-3), and 42 C.F.R 485.604 (c)(1-3). Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants will still have to meet state requirements for licensure and scope of practice, but not additional Federal requirements that may exceed State requirements. This will give States and facilities more flexibility in using clinicians in these roles to meet increased demand. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.
- *CAH staff licensure:* CMS is deferring to staff licensure, certification, or registration to State law by waiving the requirement at 42 CFR 485.608(d) that staff of the CAH be licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations. The CAH and its staff must still be in compliance with applicable Federal, State and Local laws and regulations, and all patient care must be furnished in compliance with State and local laws and regulations. This waiver would defer all licensure, certification, and registration requirements for CAH staff to the state, which would add flexibility where Federal requirements are more stringent. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.

CMS Hospitals Without Walls (Temporary Expansion Sites)

- *Hospitals Able to Provide Inpatient Care in Temporary Expansion Sites:* As part of the CMS Hospital Without Walls initiative, hospitals can provide hospital services in other healthcare facilities and sites not currently considered to be part of a healthcare facility or set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. Previously, hospitals were required to provide services to patients within their hospital departments, and have shared concerns about capacity for treating patients during the COVID-19 Public Health Emergency, especially those

requiring ventilator and intensive care services. CMS is providing additional flexibilities for hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations or sites not considered part of a healthcare facility such as hotels or community facilities. This flexibility will allow hospitals to separate COVID-19 positive patients from other non-COVID-19 patients to help efforts around infection control and preservation of personal protective equipment (PPE). For example, for the duration of the Public Health Emergency, CMS is allowing hospitals to screen patients at offsite locations, furnish inpatient and outpatient services at temporary expansion sites. Hospitals would still be expected to control and oversee the services provided at an alternative location.

- *Relaxing Conditions of Participation.* Under an additional initiative, CMS is relaxing certain conditions of participation (CoPs) for hospital operations to maximize hospitals ability to focus on patient care. The same initiative will also allow currently enrolled ambulatory surgical centers (ASCs), to temporarily enroll as hospitals and to provide hospital services to help address the urgent need to increase hospital capacity to take care of patients. Other interested entities, such as freestanding emergency departments, could pursue enrolling as an ASC and then pursue converting their enrollment to hospital during the PHE. ASCs that wish to enroll to receive temporary billing privileges as a hospital should call the COVID-19 Provider Enrollment Hotline to reach the contractor that serves their jurisdiction, and then will complete and sign an attestation form specific to the COVID-19 PHE. This document will be made available shortly. See <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf> for additional information.
- *Off Site Patient Screening:* CMS is waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Labor Act, or EMTALA). This will allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital’s campus to prevent the spread of COVID-19, so long as it is not inconsistent with the state emergency preparedness or pandemic plan.
- *Expanded Ability for Hospitals to Offer Long-term Care Services (“Swing-Beds”) for Patients Who do not Require Acute Care but do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth at 42 CFR 409.31:* Under section 1135(b)(1) of the Act, CMS is waiving the requirements at 42 CFR 482.58, “Special Requirements for hospital providers of long-term care services (“swing-beds”)” subsections (a)(1)-(4) “Eligibility”, to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF.

In order to qualify for this waiver, hospitals must:

- Not use SNF swing beds for acute level care.

- Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
- Be consistent with the state's emergency preparedness or pandemic plan.

Hospitals must call the CMS Medicare Administrative Contractor (MAC) enrollment hotline to add swing bed services. The hospital must attest to CMS that:

- They have made a good faith effort to exhaust all other options;
- There are no skilled nursing facilities within the hospital's catchment area that under normal circumstances would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the COVID-19 public health emergency (PHE);
- The hospital meets all waiver eligibility requirements; and
- They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

This waiver applies to all Medicare enrolled hospitals, except psychiatric and long term care hospitals that need to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan. The hospital shall not bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

- *Paperwork Requirements:* CMS is waiving certain specific paperwork requirements only for hospitals which are considered to be impacted by a widespread outbreak of COVID-19. This allows hospitals to establish COVID-19 specific areas. Hospitals that are located in a state that has widespread confirmed cases would not be required to meet the following requirements:
 - 42 CFR §482.13(d)(2) with respect to timeframes in providing a copy of a medical record.
 - 42 CFR §482.13(h) related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes.
 - 42 CFR §482.13(e)(1)(ii) regarding seclusion.
- *Physical Environment:* CMS is waiving certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at hospitals,

psychiatric hospitals, and critical access hospitals (CAH) as a result of COVID-19. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. This allows for increased capacity and promotes appropriate cohorting of COVID-19 patients. States are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation¹.

- *Temporary Expansion Sites.* For the duration of the PHE related to COVID-19, CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 (as noted above) and the provider-based department requirements at 42 CFR §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting the conditions of participation for hospitals in operation during the PHE. This waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the State or local pandemic plan. This waiver will enable hospitals to meet the needs of Medicare beneficiaries. CMS also is offering some additional flexibilities to furnish inpatient services under arrangements.
- *Critical Access Hospital Length of Stay:* CMS is waiving the Medicare requirements that Critical Access Hospitals (CAHs) limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation regarding number of beds and length of stay at 42 CFR §485.620.
- *CAH Status and location:* CMS is waiving the requirement at 485.610(b) that the CAH be located in a rural area or an area being treated as rural, allowing the CAHs flexibility in the establishment of surge site locations. Waiving the requirement at 485.610(e) regarding off-campus and co-location requirements allows the CAH flexibility in establishing off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will remove restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities should be implemented so long as they are not inconsistent with State or emergency or pandemic plan.

¹Please note that consistent with the integration mandate of Title II of the ADA and the *Olmstead vs LC* decision, States are obligated to offer/ provide discharge planning and/or case management/ transition services, as appropriate, to individuals who are removed from their Medicaid home and community based services under these authorities during the course of the public health emergency as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services/ case management and/or discharge planning would be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit.

- *Housing Acute Care Patients in Excluded Distinct Part Units:* CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatients. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.
- *Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital:* CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part 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 (IPF PPS) for such 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 Public Health 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.
- *Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital:* CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of a disaster or emergency, need 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 medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.
- *Telemedicine:* CMS is waiving the provisions related to telemedicine for hospitals and CAHs at 42 CFR 482.12(a)(8)-(9) and 42 CFR 485.616(c), 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.

Patients Over Paperwork

- ***“Stark Law” Waivers:*** The physician self-referral law (also known as the “Stark Law”) prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law regulations. These blanket waivers apply to financial relationships and referrals that are related to the COVID-19 emergency. The remuneration and referrals described in the blanket waivers must be solely related to COVID-19 Purposes, as defined in the blanket waiver document. Under the waivers, CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. These flexibilities include:
 - Hospitals and other health care providers can pay above or below fair market value for the personal services of a physician (or an immediate family member of a physician), and parties may pay below fair market value to rent equipment or purchase items or services. For example, a physician practice may be willing to rent or sell needed equipment to a hospital at a price that is below what the practice could charge another party. Or, a hospital may provide space on hospital grounds at no charge to a physician who is willing to treat patients who seek care at the hospital but are not appropriate for emergency department or inpatient care.
 - Health care providers can support each other financially to ensure continuity of health care operations. For example, a physician owner of a hospital may make a personal loan to the hospital without charging interest at a fair market rate so that the hospital can make payroll or pay its vendors.
 - Hospitals can provide benefits to their medical staffs, such as multiple daily meals, laundry service to launder soiled personal clothing, or child care services while the physicians are at the hospital and engaging in activities that benefit the hospital and its patients.
 - Health care providers may offer certain items and services that are solely related to COVID-19 Purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non-monetary compensation cap. For example, a home health agency may provide continuing medical education to physicians in the community on the latest care protocols for homebound patients with COVID-19, or a hospital may provide isolation shelter or meals to the family of a physician who was exposed to the novel coronavirus while working in the hospital’s emergency department.

- Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the COVID-19 pandemic in the United States.
- Some of the restrictions regarding when a group practice can furnish medically necessary designated health services (DHS) in a patient's home are loosened. For example, any physician in the group may order medically necessary DHS that is furnished to a patient by one of the group's technicians or nurses in the patient's home contemporaneously with a physician service that is furnished via telehealth by the physician who ordered the DHS.
- Group practices can furnish medically necessary MRIs, CT scans or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis.
- *Verbal Orders*: CMS is waiving the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to allow for additional flexibilities related to verbal orders where read-back verification is still required but authentication may occur later than 48 hours. This will allow for more efficient treatment of patients in a surge situation.
- *Reporting Requirements*: CMS is waiving reporting requirements at §482.13(g) (1)(i)-(ii) which require hospitals to report patients in an intensive care unit whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs may be reported later than close of business next business day, provided any death where the restraint may have contributed is continued to be reported within standard time limits. Due to current hospital surge, we are waiving this requirement to ensure that hospitals are focusing on increased care demands and patient care.
- *Limit Discharge Planning for Hospital and CAHs*: To allow hospitals and CAHs more time to focus on increasing care demands, discharge planning will focus on ensuring that patients are discharged to an appropriate setting with the necessary medical information and goals of care. CMS is waiving detailed regulatory requirements to provide information regarding discharge planning, as outlined in 42 CFR §482.43(a)(8), §482.61(e), and 485.642(a)(8). The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long term care hospital (LTCH) data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. During this public health emergency, a hospital may not be

able to assist patients in using quality measures and data to select a nursing home or home health agency, but must still work with families to ensure that the patient discharge is to a post-acute care provide that is able to meet the patient's care needs.

- *Modify Discharge Planning for Hospitals:* Patients must continue to be discharged to an appropriate setting with the necessary medical information and goals of care. To address the COVID-19 pandemic, CMS is waiving certain requirements related to hospital discharge planning for post-acute care services at 42 CFR §482.43(c), so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is waiving certain requirements for those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services. For example, a patient may not be able to receive a comprehensive list of nursing homes in the geographic area, but must still be discharged to a nursing home that is available to provide the care that is need by the patient.
- *Medical Records:* CMS is waiving 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements. CMS is waiving these requirements under 42 CFR §482.24(c)(4)(viii) and §485.638(a)(4)(iii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge and for CAHs that all medical records must be promptly completed. This flexibility will allow clinicians to focus on the patient care at the bedside during the pandemic.
- *Flexibility in Patient Self Determination Act Requirements (Advance Directives):* CMS is waiving the requirements at section 1902(a)(58) and 1902(w)(1)(A) for Medicaid, 1852(i) (for Medicare Advantage), and 1866(f) and 42 CFR 489.102 for Medicare, which require hospitals and CAHs to provide information about its advance directive policies to patients. We are waiving this requirement to allow for staff to more efficiently deliver care to a larger number of patients.
- *Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission:* CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. CMS granted an extension for data submission for hospitals nationwide affected by COVID-19 until August 3, 2020. Due to continued COVID related concerns from hospitals about meeting this deadline, CMS is further extending this deadline to September 3, 2020. Hospitals must submit their occupational mix surveys along with complete supporting documentation to their MACs by no later than September 3, 2020. Hospitals may then submit revisions to their occupational mix surveys to their MACs, if needed, by no later than September 10, 2020.

- *****Postponement of Application Deadline to the Medicare Geographic Classification Review Board.*** Per requirements at section 1886(d)(10)(C)(ii) of the Social Security Act (the Act) and 42 CFR 412.256(a)(2), September 1, 2020 is the deadline to submit an application to the Medicare Geographic Classification Review Board (MGCRB) for FY 2022 reclassifications. These provisions require applications to be filed through OH CDMS (<https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/Electronic-Filing>) not later than the first day of the 13-month period preceding the Federal fiscal year for which reclassification is requested.

Due to the COVID-19 Public Health Emergency (PHE), under the authority of section 1135(b)(5) of the Act, CMS is postponing the September 1 deadline until 15 days after the public display date of the FY 2021 IPPS/LTCH final rule by the Office of the Federal Register.

- ***Utilization review.*** CMS is waiving these requirements at 42 CFR §482.1(a)(3) and 42 C.F.R §482.30 that requires that hospitals participating in Medicare and Medicaid to have a utilization review plan that meets specified requirements. CMS is waiving the entire Utilization Review CoP at §482.30, which requires that a hospital must have a utilization review (UR) plan with a UR committee that provides for review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan. Removing these administrative requirements will allow hospitals to focus more resources on providing direct patient care.
- ***Quality assessment and performance improvement program.*** CMS is waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated QAPI programs (for hospitals that are a part of a hospital system). These flexibilities, which apply to both hospitals and CAHs, should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. We expect any improvements to the plan to focus on the Public Health Emergency. While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and

CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. This waiver applies to both hospitals and CAHs.

- *Nursing services:* CMS is waiving the provision at 42 CFR 482.23(b)(4), 42 CFR 482.23(b)(7), and 485.635(d)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient, and the provision that requires the hospital to have policies and procedures in place establishing which outpatient departments are not required under to have a registered nurse present. These waivers allow nurses increased time to meeting the clinical care needs of each patient and allows for the provision of nursing care to an increased number of patients. In addition, we expect that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely unnecessary. These flexibilities apply to both hospitals and CAHs, and should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.
- *Food and dietetic service:* CMS is waiving the requirement at 42 CFR 482.28(b)(3) to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge capacity sites. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan. Removing these administrative requirements will allow hospitals to focus more resources on providing direct patient care.
- *Written policies and procedures for appraisal of emergencies at off campus hospital departments:* CMS is waiving 482.12(f)(3) related to Emergency services, with respect to the surge facility(ies) only, such that written policies and procedures for staff to use when evaluating emergencies are not required for surge facilities. This removes the burden on facilities to develop and establish additional policies and procedures at their surge facilities or surge sites related to the assessment, initial treatment and referral of patients. These flexibilities should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
- *Emergency preparedness policies and procedures:* CMS is waiving 482.15(b) and 485.625(b), which requires the hospital and CAH to develop and implement emergency preparedness policies and procedures, and 482.15(c)(1)-(5) and 485.625(c)(1)-(5) which requires that the emergency preparedness communication plans for hospitals and CAHs to contain specified elements with respect to the surge site. 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 temporary expansion site. This waiver removes the burden on facilities to establish these policies and procedures for their surge facilities or surge sites.

- **Signature Requirements:** CMS is waiving signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.
- **Accelerated/Advance Payments:** In order to provide additional cash flow to healthcare providers and suppliers impacted by COVID-19, CMS expanded and streamlined the Accelerated and Advance Payments Program, which provided conditional partial payments to providers and suppliers to address disruptions in claims submission and/or claims processing subject to applicable safeguards for fraud, waste and abuse. Under this program, CMS made successful payment of over \$100 billion to healthcare providers and suppliers. As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, in light of direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund. Distributions made through the Provider Relief Fund do not need to be repaid. For providers and suppliers who have received accelerated or advance payments related to the COVID-19 Public Health Emergency, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance. Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC).
- **Cost Reporting:** CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The revised extended cost report due date for FYE 12/31/2019 will be August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020.
- **Provider Enrollment:** CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment:
 - Waive certain screening requirements.
 - Postpone all revalidation actions.
 - Expedite any pending or new applications from providers.

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR

562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);
- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available 42 CFR § 422.562, 42 CFR § 423.562.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Additional Guidance

- The Interim Final Rules and waivers can be found at: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers> .
- CMS has released guidance to describe standards of practice and flexibilities within the current regulations for hospitals (including critical access hospitals and psychiatric hospitals) at <https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2>.
- CMS guidance also addresses hospital flexibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to establish alternate testing and triage sites to address the pandemic at <https://www.cms.gov/files/document/qso-20-15-hospitalcahemtala.pdf>.
- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at <https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf>