Running List of Federal Agency Waivers (not Medicaid)

March 15th, 2020

HIPAA Privacy Rule Waivers

- No Administrative Sanctions or Penalties for Non-Compliance with HIPAA Privacy Rule
    - For 72 hours following a hospital's implementation of a disaster protocol, the following requirements are waived
        - The requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care. See 45 CFR 164.510(b).
        - The requirement to honor a request to opt out of the facility directory. See 45 164.510(a).
        - The requirement to distribute a notice of privacy practices. See 45 CFR 164.520.
        - The patient's right to request privacy restrictions. See 45 CFR 164.522(a).
        - The patient's right to request confidential communications. See 45 CFR 164.522(b).

CMS/HHS Blanket Waivers (March 13, updated March 20)

Skilled Nursing Facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

- 42 CFR 483.20: This waiver provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).

Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission (Blanket waiver for all impacted agencies).

- To ensure the correct processing of home health emergency related claims, Medicare Administrative Contractors (MACs) are allowed to extend the autocancellation date of Requests for Anticipated Payment (RAPs).

Critical Access Hospitals

This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals).

Housing Acute Care Patients in Excluded Distinct Part Units

CMS has determined it is appropriate to issue a blanket waiver to inpatient prospective payment system (IPPS) hospitals that, as a result of the emergency, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The 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 emergency. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients.)

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of the 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 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 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 has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of the 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 (IRF) 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 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.

IRFs may exclude patients from the hospital's or 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 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In

addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

Care for Patients in Long-Term Care Acute Hospitals (LTCH)s.

CMS has determined it is appropriate to issue a blanket waiver to long-term care hospitals (LTCHs) to exclude patient stays where an LTCH 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.

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by the Emergency

CMS has determined it is appropriate to issue a blanket waiver where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency. For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at https://www.cms.gov/About-CMS/AgencyInformation/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf.

Medicare Advantage Plan or other Medicare Health Plan Beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged, lost, or unavailable in an emergency. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

Replacement Prescription Fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable or unavailable due to the emergency

Telehealth

Note: Unlike other claims for which Medicare payment is based on a "formal waiver," telehealth claims don't require the "DR" condition code or "CR" modifier. CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and

forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required.

When a telehealth service is billed under CAH Method II, the GT modifier is required. MLN Matters SE20011 Related CR N/A Page 5 of 7 Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required. Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries:

- Medicare telehealth visits
- Virtual check-ins
- e-visits

For more information, review the Medicare Telemedicine Health Care Provider Fact Sheet at: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-healthcare-provider-fact-sheet
and Medicare Telehealth Frequently Asked Questions at: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questionsfaqs-31720.pdf.

March 17th, 2020

Telehealth Expansion Waivers

- No Administrative Sanctions for Reducing or Waiving any Cost-Sharing Obligations
    - OIG will not subject physicians and other practitioners to OIG administrative sanctions for arrangements that satisfy both of the following conditions:
        - A physician or other practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with the then-applicable coverage and payment rules.
        - The telehealth services are furnished during the time period subject to the COVID-19 Declaration

- Waiver of Telehealth Geographic Limitation and Site Restriction

- Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.

- Non-Public Facing Remote Communication with Patients

  - OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19. (Such products include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype; but DO NOT include Facebook Live, Twitch, TikTok, and similar video communication applications)

- Pre-Existing Patient-Provider Relationship.

  - HHS will not enforce through audit the requirement that a pre-existing patient relationship be in place to take advantage of the waiver. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

- DEA – Prescribing Controlled Substances without In-Person Medical Evaluation

  - DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

    - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
    - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
    - The practitioner is acting in accordance with applicable Federal and State law

March 26-28, 2020

Enclosure – Additional Approved Waivers (As of March 28, only 32 States)

Hospitals, Psychiatric Hospitals, and CAHs:

- **Emergency Medical Treatment and Active Labor Act (EMTALA).** CMS is waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Active Labor Act, or EMTALA). This will allow hospitals, psychiatric hospitals, and

CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, in accordance with the state emergency preparedness or pandemic plan.

- **Verbal Orders.** CMS is waiving the requirements of §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. Specifically, the following requirements are waived:

  - §482.23(c)(3)(i)- If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently;

  - §482.24(c)(2) - All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient;

  - §482.24(c)(3)- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders. This would include all subparts at

    §482.24(c)(3).

  - §485.635(d)(3)- Although the regulation requires medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.

- **Reporting Requirements**. CMS is waiving the requirements at 42 C.F.R. §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 hospitals are focusing on increased care demands and patient care.

- **Patient Rights.** 42 C.F.R. §482.13. CMS is waiving requirements under this section only for hospitals which are considered to be impacted by a widespread outbreak of COVID-19. Hospitals that are located in a State which has widespread confirmed cases (i.e., 6-50 or more confirmed cases), as updated under the CDC States Reporting Cases of COVID- 19 to CDC at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in- us.html would not be required to meet the following requirements:

  - 42 C.F.R. §482.13(d)(2) with respect to timeframes in providing a copy of a medical record.

  - 42 C.F.R. §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 C.F.R. §482.13(e)(1)(ii) regarding seclusion.

- **Sterile Compounding.** 42 C.F.R. §482.25(b)(1) and §485.635(a)(3). CMS is waiving these requirements in order 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 which will help with the impending shortage of medications. While USP797 also outlines this, CMS will not be reviewing the use and storage of facemasks under these requirements.

- **Detailed Information Sharing for Discharge Planning for Hospitals and CAHs:** CMS is waiving the requirement to provide detailed information regarding discharge planning as outlined in 42 C.F.R. §482.43(a)(8), §482.61(e), and 485.642(a)(8), described below:

  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, HHA, SNF, IRF, or 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.

- **Discharge Planning for Hospitals.** 42 C.F.R. §482.43(c) CMS is waiving all the requirements and subparts related to post-acute care services, 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 the requirement that 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, the hospital must:

  - §482.43(c)(1) include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient.

  - §482.43(c)(2) must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post- discharge services and that,

  - §482.43(c)(3) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

- **Medical Staff.** 42 C.F.R. §482.22(a) and §485.627(a).CMS is waiving these requirements to allow for physicians whose privileges will expire to continue practicing at the hospital or CAH and for new physicians to be able to practice in the hospital or CAH before full medical staff/governing body review and approval.

- **Medical Records Timing.** 42 C.F.R. §482.24(c)(4)(viii) and §485.638(a)(4)(iii). CMS is waiving these requirements 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. This would not apply to the requirements at §482.13(a) for hospitals and at §485.608(a) for CAHs to receive information about the presence of a policy regarding the facility's recognition of advanced directives.

- **Physical Environment:** CMS is waiving certain requirements under the Medicare conditions at 42 C.F.R. §482.41 and §485.623 to allow for flexibilities during hospital, psychiatric hospital, and CAH surges. CMS will permit non-hospital buildings/space to be used for patient care and quarantine sites, provided that the location is approved by the State (ensuring safety and comfort for patients and staff are sufficiently addressed). This allows for increased capacity and promotes appropriate cohorting of COVID-19 patients.

Skilled Nursing Facilities

- **Staffing Data Submission:** CMS is waiving 42 CFR 483.70(q) to provide relief to long term care facilities on the requirements for submitting staffing data through the Payroll- Based Journal system.

- **Waive Pre-Admission Screening and Annual Resident Review (PASARR):** CMS is waiving the following requirements related to PASARR for nursing home residents who may also have a mental illness or intellectual disability (42 CFR §483.106(b)(4)).

    - Level I screens are not required for residents when they are being transferred between NFs (inter-facility transfers) and staff cannot enter nursing facilities due to quarantine. If the NF is not certain whether a Level I evaluation had been conducted at the resident's transferring/evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake. If there is not enough information to complete a Level I evaluation, the NF must document this in the resident's case files. Level II evaluations and determinations are also not required preadmission when residents are being transferred between NFs. Residents who are transferred will receive a post admission review which must be completed as resources become available.

- **Physical Environment.** Provided that the State has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is waiving requirements under §483.90 to allow for a non-SNF buildings to be temporarily certified as and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents which may not be feasible in the existing SNF structure to ensure care and services during treatment for COVID-19 is available while protecting other vulnerable adults. CMS

believes this will also provide another measure that will free up inpatient care beds at hospitals for the most acute patients while providing beds for those still in need of care. CMS will revise processes, as necessary, to facilitate certification and surveys of these sites under this waiver. Waiver of certain conditions of participation and certification requirements for opening a NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location**.**

- **Resident Groups.** CMS is waiving the requirements at §483.10(f)(5) which allow for residents to have the right to participate in-person in resident groups. This waiver would only permit the facility to restrict having in-person meetings during the national emergency given the recommendations of social distancing and limiting gatherings of more than ten people. Refraining from in-person gatherings will help prevent the spread of COVID-19.

- **Training and Certification of Nurse Aids** CMS is waiving the requirements at§483.35(d) which requires that a SNF and NF may not employ anyone for longer than 4 months unless they met the training and certification requirements under §483.35(d).

  CMS is waiving these requirements to assist in potential staffing shortages seen with the COVID-19 pandemic.

Home Health Agencies

- **Reporting**: Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. **(Approved on 3/13/2020- Clarified)** This waiver includes:

  - Extension of the 5-day completion requirement for the comprehensive assessment

  - Waives the 30-day OASIS submission requirement

- **Home Health 42 C.F.R. § 484.55(a).** Home health agencies can perform initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment while supporting infection control and reducing impact on acute care and long-term care facilities. This will allow for maximizing coverage by alreadyscarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

Hospice:

- **Waive requirement for hospices to use volunteers**. CMS is waiving the requirement that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and anticipated quarantine. (42 CFR §418.78(e)).
- **Comprehensive Assessments**: CMS is waiving certain requirements for Hospice (§418.54) related to update of the comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment (§418.54(d)). Hospices must continue

to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.

- **Waive Non-Core Services**: CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at §418.72 for physical therapy, occupational therapy, and speech-language pathology.

Home Health & Hospice:

- **Waived onsite visits for both HHA and Hospice & Aide Supervision**: CMS is waiving the requirements at 42 CFR 418.76 (h) and 484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan as this may not be physically possible for a period of time. This waiver is also temporarily suspending 2-week aide supervision requirement at 42 CFR §484.80(h)(1) by a registered nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.

4833-6998-4439 v.1