Typhoon Mawar Blanket Waivers for Health Care Providers in Guam

CMS is empowered to take proactive steps to help providers through waivers issued pursuant to section 1135 of the Social Security Act (the Act) as well as, where applicable, authority granted under section 1812(f) of the Act. As a result, the following 1135 section blanket waivers are in effect through the end of the public health emergency declaration, or the need for a particular waiver is no longer present. Despite the availability of blanket waivers, suppliers and providers should strive to return to their normal practice as soon as possible.

These waivers DO NOT need to be submitted via the CMS 1135 Waiver Portal (https://cmsqualitysupport.servicenowservices.com/cms_1135) or via notification to the CMS Survey & Operations Group.

Hospitals and Psychiatric Hospitals, including Cancer Centers and Long-Term Care Hospitals (LTCHs)

- **Emergency Medical Treatment & Labor Act (EMTALA).** CMS is waiving the enforcement of section 1867(a) of the Act. This will allow hospitals and psychiatric hospitals to screen patients at a location offsite from the hospital's campus, so long as it is not inconsistent with a state's emergency preparedness plan. Waivers of sanctions under the Emergency Medical Treatment and Labor Act (EMTALA) in the emergency area end 72 hours after the implementation of the hospital's disaster plan.

- **Medical Staff.** CMS is waiving requirements under 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 before full medical staff/governing body review and approval to address workforce concerns related to the emergency. CMS is waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process.

- **Physical Environment.** CMS is waiving **certain** physical environment requirements under the hospital and psychiatric hospital conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow increased flexibilities for surge capacity and patient quarantine as a result of the emergency. This includes the relocation of inpatients from an excluded distinct part psychiatric unit to an acute care bed for psychiatric hospitals. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care, 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 plan. 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 segregation [1]. **Note** that requests under this blanket waiver need to be evaluated on case-by-case basis to ensure the appropriateness of the waived requirements given the public health emergency (PHE) at a given time.

- **Telemedicine.** CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a)(8)– (9) for hospitals, 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 patients, including access to specialty care.

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 plan.

Hospitals must call their CMS Medicare Administrative Contractor (MAC) 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 SNFs 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 PHE;
- The hospital meets all waiver eligibility requirements; and

[1] Please 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.

- They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, when the PHE ends, or when the need for the waiver is no longer present, 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 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 if 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.

- **Medical Records.** CMS is waiving requirements under 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, and these flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness plan. CMS is waiving §482.24(c)(4)(viii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge from a hospital. This flexibility will allow clinicians to focus on the patient care at the bedside during the PHE.

- **Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments.** CMS is waiving 42 CFR §482.12(f)(3), emergency services, with respect to surge facilities 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 may be implemented so long as they are not inconsistent with a state's emergency preparedness plan.

- **Emergency Preparedness Policies and Procedures.** CMS is waiving 42 CFR §482.15(b) which requires the hospital to develop and implement emergency preparedness policies and procedures, and §482.15(c)(1)– (5) which requires that the emergency preparedness communication plans for hospitals to contain specified elements with respect to the surge site. The requirement under the communication plan requires hospitals to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals, and volunteers. This would not be an expectation for the surge site. This waiver applies to hospitals and removes the burden on facilities to establish these policies and procedures for their surge facilities or surge sites.

- **Temporary Expansion Locations.** CMS will waive certain requirements under the Medicare conditions of participation at 42 CFR §482.41 (as noted elsewhere in this waiver document) and the provider- based department requirements at §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals that continue to apply during the PHE. This extends to any entity operating as a hospital (whether a current hospital establishing a new location) so long as the relevant location meets the conditions of participation and other requirements not waived by CMS. This waiver will enable hospitals to meet the needs of Medicare beneficiaries.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Temporary Expansion Locations**. CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to temporarily expand service locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements at 42 CFR §491.5(a)(1) and (2). When the PHE ends or if the need for this waiver is no longer present, if a clinic elects to continue providing services in at the temporary location, it must independently enroll the location in the RHC Medicare program and meet all applicable requirements.

Skilled Nursing Facilities (SNFs)

- **3-Day Prior Hospitalization.** Using the authority under Section 1812(f) of the Act, CMS may issue a separate waiver of the statutory requirement for a 3-day prior inpatient hospitalization for coverage of a SNF Part A stay, which provides temporary emergency coverage of SNF services without a qualifying inpatient hospital stay, for those people who experience dislocations, or are otherwise affected by the public health emergency (declared by the Secretary under section 319 of the Public Health Service Act) that serves as the basis for the associated section 1135 blanket waivers. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes a one-time renewal of SNF coverage without first having to start a new benefit period (this portion of the waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

- **Physician Visits in Skilled Nursing Facilities/Nursing Facilities.** CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

- **Physical Environment.** CMS is waiving requirements under 42 CFR 483.90 to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity. Rooms that may be used for this purpose include activity rooms, meeting/conference rooms, dining rooms, or other rooms, as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness plan, or as directed by the local or state health department.

- **Reporting Minimum Data Set (MDS).** CMS is waiving the requirements at 42 CFR §483.20 (b)(2) to provide relief to SNFs on the **timeframes** in which they must conduct a comprehensive assessment and collect MDS data. CMS is **not** waiving the requirements for facilities to conduct the assessment and collect MDS data at 42 CFR 483.20(b)(1).

- **Waive Pre-Admission Screening and Annual Resident Review (PASARR).** CMS is waiving 42 CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review.

Home Health Agencies (HHAs)

- **Reporting.** CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below**:**
    - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
    - Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.

- **Initial Assessments.** CMS is waiving the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment for them while reducing the impact on acute care and long- term care facilities. This will allow for maximizing coverage by already scarce physician, and advanced practice clinicians, and allow those clinicians to focus on caring for patients with the greatest acuity.

End-Stage Renal Dialysis (ESRD) Facilities

- **Ability to Delay Some Patient Assessments.** CMS is **not** waiving subsections (a) or (c) of 42 CFR §494.80, but is waiving the following requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to the dialysis facility. Specifically, CMS is waiving the "on-time" requirements for the initial and follow up comprehensive assessments within the specified timeframes as noted below. This waiver applies to assessments conducted by members of the interdisciplinary team, including: a registered nurse, a physician treating the patient for ESRD a social worker, and a dietitian. These waivers are intended to ensure that dialysis facilities are able to focus on the operations related to the Public Health Emergency. Specifically, CMS is waiving:
    - §494.80(b)(1): An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.
    - §494.80(b)(2): A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90.
- **Time Period for Initiation of Care Planning and Monthly Physician Visits.** CMS is modifying two requirements related to care planning, specifically:
    - 42 CFR §494.90(b)(2): CMS is modifying the requirement that requires the dialysis facility to implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This modification will also apply to the requirement for monthly or annual updates of the plan of care within 15 days of the completion of the additional patient assessments.
    - §494.90(b)(4): CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.
- **Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded.** CMS authorizes the establishment of SPRDFs under 42 CFR §494.120 to address access to care issues among this vulnerable population. Approval as a Special Purpose Renal Dialysis Facility related to the PHE does not require Federal survey prior to providing services.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to 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.

  This also allows CMS to temporarily extend the 10-business day deadline required in section 1847(b)(3)(C) of the Act, 42 CFR 414.422(f), and the DMEPOS competitive bidding contracts to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30 business days to provide notice to the Competitive Bidding Implementation Contractor of any subcontracting arrangements. CMS will notify DMEPOS Competitive Bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. Note: CMS will provide notice of any changes to reporting timeframes for future events.

Provider Enrollment

- **Non-Waiver CMS Action.** Establish toll-free hotlines for certain providers to enroll and receive temporary Medicare billing privileges. The hotlines are implemented, as needed, based on the natural disaster.

- Postpone all revalidation actions.

- 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.

- Allow opted-out physicians and non-physician practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.

- Postpone provider enrollment site visits for moderate and high-risk providers/suppliers.

- Waive fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high-risk categories of providers and suppliers (e.g., newly enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs, Skilled Nursing Facilities).

- Waive the collection of application fees.

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 by damage due to the disaster or emergency.

Ambulatory Surgical Centers (ASCs)

- **Medical Staff.** 42 CFR 416.45(b). CMS is waiving the requirement at § 416.45(b) that medical staff privileges must be periodically reappraised, and the scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. 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 PHE. This waiver will improve the ability of ASCs to maintain their current workforce during the PHE.