American Hospital Association™
Advancing Health in America

Special Bulletin

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CMS Releases Additional Waivers for COVID-19

Emergency declaration waivers related to testing, treatment location, telehealth, workforce and administrative activities

The Centers for Medicare & Medicaid Services (CMS) yesterday released a number of new waivers related to COVID-19. The waivers apply nationwide and are generally retroactive to March 1, 2020. They include waivers that expand access to COVID-19 testing, including serological and antibody tests; expand flexibility around treatment locations; expand access to telehealth; allow for additional workforce capacity; and eliminate certain administrative requirements.

Our Take: America's hospitals and health systems appreciate CMS issuing additional regulatory waivers, urged by the AHA, which will help provide needed tools, flexibility and relief in the fight against COVID-19. In particular, we are pleased that CMS will allow teaching hospitals to increase their number of temporary beds without facing reduced payments for indirect medical education. We also thank CMS for expanding telehealth services for patients, mitigating financial penalties for ACOs because of costs associated with responding to the pandemic, and ensuring that certain hospital outpatient departments that relocate off-campus have the resources needed to continue delivering care. The AHA looks forward to working with CMS on additional waiver suggestions so hospitals and health systems on the front lines can provide the right care in the right location.

Key Takeaways

New waivers related to COVID-19 include those designed to:

- Allow teaching hospitals to increase their number of temporary beds without facing reduced indirect medical education payments.
- Allow certain provider-based hospital outpatient departments that relocate to continue to be paid at the full outpatient prospective payment system rate, rather than the reduced site-neutral rate.
- Make numerous adjustments to the accountable care organization program to account for the emergency, including so that ACOs' losses will be mitigated.
- Waive certain coverage and classification requirements to enable freestanding inpatient rehabilitation facilities to accept patients from acute-care hospitals experiencing a surge, even if the patients do not require rehabilitation care.
- Waive limitations on the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services.

HIGHLIGHTS OF THE RESOURCES

Waivers Related to COVID-19 Diagnostic Testing. CMS issued several waivers to help ensure testing is more accessible, including by:

- Allowing any health care professional authorized to do so under state law to order COVID-19 diagnostic laboratory tests (including serological and antibody tests);
- Paying hospitals and practitioners to assess and collect laboratory samples for COVID-19 testing, and make separate payment when that is the only service the patient receives; and
- Covering certain serology (antibody) tests, which may aid in determining whether a person may have developed an immune response, under Medicare and Medicaid.

Waivers Related to Treatment Location. In order to expand the capacity of the health care system, CMS has made waivers to allow hospitals and health systems to provide services in additional locations during the emergency. For example, CMS is:

- Formalizing its prior waiver of the inpatient rehabilitation facility (IRF) 3-hour rule, which requires that IRF patients generally receive at least three hours of therapy a day, five days a week.
- Waiving certain requirements for qualifying "surge patients" who will be paid an IRF prospective payment system (PPS) rate when they are treated in a freestanding IRF in a qualifying area. The rule outlines specific parameters, including local surge criteria, for when this waiver applies and gives guidance on documentation and billing. The following requirements will be waived effective March 1, 2020, for these patients, including those who do not require traditional IRF services:
    - Pre-admission screenings;
    - Clinical supervision by a rehabilitation physician, including visits at least three days per week;
    - Oversight by an interdisciplinary team;
    - A plan of care; and
    - Active and ongoing therapeutic intervention of multiple therapy disciplines.
- Allowing payment for outpatient hospital services, such as wound care, drug administration, and behavioral health services, that are delivered in temporary expansion locations.
- Allowing certain provider-based hospital outpatient departments that relocate from on- to off-campus, or from one off-campus location to another, to request a temporary exception to continue to be paid at the full OPPS rate, rather than the reduced site-neutral rate. Importantly, hospitals also may relocate outpatient departments to more than one off-campus location, or partially relocate off-campus while still furnishing care at the original site.
- Allowing payment for certain partial hospitalization services that are delivered in temporary expansion locations, including patients' homes.
- Allowing Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in their homes.

Waivers Related to Telehealth. CMS is expanding access to telehealth, including by:

- Waiving limitations on the types of health care professionals that can furnish telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.
- Allowing hospitals to bill the originating site facility fee for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.
- Allowing hospitals to bill for therapy, education and training services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital. Examples of such services include counseling, psychotherapy, group therapy and partial hospitalization program services.
- Changing its process during the emergency so that it can add, on a sub-regulatory basis, new services to the list of Medicare services that may be furnished via telehealth.
- Formalizing the Coronavirus Aid, Relief, and Economic Security (CARES) Act provision that authorizes payment for Medicare telehealth services provided by rural health clinics and federally qualified health clinics acting as distant sites.
- Broadening providers' ability to furnish services via audio-only communication. Specifically, CMS added the audio-only evaluation and management (E/M) service codes authorized in its March 30 interim final rule to the list of Medicare telehealth services and waived the requirement that Medicare telehealth services be provided via video-capable technology for the telephonic E/M services and for behavioral health counseling and educational services. Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. CMS also is increasing payments for these telephone visits to match payments for similar office and outpatient visits, retroactive to March 1, 2020.
- CMS's bundled payment program for opioid treatment plans includes add-on payments for performing periodic assessments of treatments and services. CMS will now permit these assessments to be performed either by two-way audio/video technology, or by audio only.

Waivers Related to Workforce. In order to allow hospitals and health systems to expand the health care workforce, CMS has allowed additional flexibility by taking actions during the emergency, including:

- Allowing teaching hospitals to claim under their fulltime equivalent resident count those residents that it sends to another hospital during the emergency associated with COVID-19, and not penalizing hospitals without teaching programs that accept these residents;
- Waiving a requirement for ambulatory surgery centers to periodically reappraise medical staff privileges during the COVID-19 emergency declaration. This will

allow physicians and other practitioners whose privileges are expiring to continue taking care of patients.

Waivers Related to Administrative Activities. In order to further expand health care capacity, CMS is eliminating certain administrative requirements during the emergency, including by:

- Allowing teaching hospitals to increase their number of temporary beds without facing reduced indirect medical education payments.
- Allowing hospital systems that include rural health clinics to increase their bed capacity without affecting the rural health clinic's payments.
- Allowing inpatient psychiatric facilities and IRFs to admit more patients without facing reduced teaching status payments.
- Making adjustments to the ACO financial methodology to account for COVID-19.
    - This includes mitigating losses proportional the number of months in the calendar year affected by the emergency, which began in January 2020. These adjustments also will exclude from shared savings calculations Part A and B payment amounts for an episode of care for treatment of COVID-19, triggered by an inpatient service.
    - Forgoing the annual application cycle for 2021; as such, ACOs whose participation is set to end this year will have the option to extend for another year, under their existing historical benchmark.
    - Giving ACOs in the "BASIC" track the option to maintain their current risk level for 2021, instead of being advanced automatically to the next risk level. However, ACOs that choose this option will be automatically advanced to the risk level they would been at for performance year (PY) 2022 without the 2021 deferral. For example, an ACO participating in Level B of the BASIC track can choose to stay in Level B for PY 2021, but will be automatically advanced to Level D for PY 2022.
- Including in the definition of primary care services used to determine beneficiary assignment codes that represent remotely provided primary care services, including virtual check-ins, e-visits and telephonic E/M services.
- Permitting states operating a Basic Health Program (BHP) to submit revised BHP Blueprints for temporary changes tied to the COVID-19 public health emergency that are not restrictive and could be effective retroactive to the first day of the COVID-19 public health emergency declaration.
- Data reporting for new transfer of health information measures, and certain standardized patient assessment data elements (SPADEs) were scheduled to begin on Oct. 1, 2020 for long-term care hospitals (LTCHs), IRFs and skilled nursing facilities (SNFs), and Jan. 1, 2021 for home health agencies. CMS is now delaying the reporting of these data to either one full fiscal year (IRFs, SNFs and LTCHs), or one full calendar year (HH agencies) after the end of the COVID-19 public health emergency. In addition, CMS is granting a reporting exception for measures specific to HH value-based purchasing (VBP) demonstration program.
- CMS clarifies that it has the authority to grant regional and national reporting extensions and exceptions for the VBP program, and that hospitals would not need to submit request forms to receive such exceptions. These changes help the hospital VBP extraordinary circumstances exception (ECE) policy align better with other CMS programs.

Further Questions
If you have questions, please contact AHA at 800-424-4301.