COVID-19 Healthcare Law Update: CMS 1135 Waivers in the Wake of COVID-19

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In the wake of the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) has issued a number of blanket 1135 waivers.

What Is An 1135 Waiver?

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act, and the Secretary of Health and Human Services declares a public health emergency under Section 319 of the Public Health Service Act, under Section 1135 of the Social Security Act (SSA) the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in SSA programs in the emergency area and time periods, and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

These waivers typically end no later than the termination of the emergency period, or sixty days from the date the waiver or modification is first published, unless the Secretary extends the waiver by notice for additional periods of up to sixty days, up to the end of the emergency period. Additionally, the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* regulation applicable to all seventeen provider types, also requires inpatient providers to have policies and procedures that address the facility's role under an 1135 waiver.

These policies and procedures may include what a facility would do if it had to provide care at an approved alternate site, processes related to how it would let the community know that it is operating at a different care site, and any reporting that may be necessary if it were under an approved 1135 waiver.

The 1135 waiver authority applies only to federal requirements and does not apply to state requirements for licensure or conditions of participation.

Current CMS COVID-19 1135 Waivers

Skilled Nursing Facilities: CMS is waiving the requirement at Section 1812(f) of the SSA for a three day prior hospitalization for coverage of a skilled nursing facility (SNF) stay for those people who need to be transferred as a result of the effect of a disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, the waiver authorizes renewed SNF coverage without first having to

start a new benefit period. Second, CMS is waiving 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

Critical Access Hospitals: CMS is waiving the requirements that critical access hospitals limit the number of beds to twenty-five, and that the length of stay be limited to ninety-six hours.

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 inpatient. The Inpatient Prospective Payment System 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.

Durable Medical Equipment: Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacement 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.

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital: CMS is permitting acute care hospitals 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 pandemic. 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 permitting acute care hospitals 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 pandemic. 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. CMS is waiving requirements to allow inpatient rehabilitation facilities (IRF) to 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 if an IRF admits a patient solely to respond to the pandemic and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, CMS would

also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

Supporting Care for Patients in Long-Term Care Acute Hospitals: A long-term care hospital (LTCH) will be permitted to exclude patient stays where the LTCH admits or discharges patients in order to meet the demands of the pandemic from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

Home Health Agencies: This waiver provides relief to home health agencies on the timeframes related to OASIS Transmission and allows Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment RAPs during the pandemic.

Provider Enrollment: Toll-free hotlines have been opened for non-certified Medicare Part B suppliers, physicians and nonphysician practitioners to enroll and receive temporary Medicare billing privileges. Additionally, the following screening requirements have been waived:

- Application Fee
- Finger-based criminal background checks
- Site visits - 42 C.F.R 424.517

Further, all revalidation actions have been postponed, licensed providers are permitted to render services outside of their state of enrollment (but be aware of separate state requirements that may not have been similarly waived) and any pending or new applications from providers are to be waived.

Medicare appeals in Fee-for-Service, Medicare Advantage and Part D: The following temporary changes have been made:

- Extension of time to file an appeal
- Waive timeliness for requests for additional information to adjudicate the appeal
- Processing the appeal even with incomplete Appointment of Representation forms, but communicating only to the beneficiary
- Process requests for appeal that do not meet the required elements using information that is available
- Utilizing all flexibilities available in the appeal process as if good cause requirements are satisfied.

What Should Providers Do?

Despite the blanket waivers above, the provider should still notify the applicable State Survey Agency and applicable CMS Regional Office if operating under these waivers to ensure proper payment. This is especially important given that CMS's current description of the waived requirements is vague, creating possible ambiguities and questions. Additionally, CMS permits healthcare providers to request individual 1135 waivers for certain requirements if no blanket waiver is available.

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