

CMS Continues to Make Sweeping Regulatory Changes to Facilitate COVID-19 Response

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Federal and state agencies continue to deliver tools and information to help healthcare providers respond to the COVID-19 pandemic since the President declared the COVID-19 outbreak [a national emergency](#). The declaration gave the Secretary of the U.S. Department of Health and Human Services (“HHS”) authority to temporarily waive or modify certain requirements of federal healthcare programs. As such, the Centers for Medicare & Medicaid Services (“CMS”), an HHS agency, has issued updated guidance for nursing homes, home health agencies, hospitals, and emergency departments, which we covered [here](#).

More recently, CMS issued temporary regulations that, among other things, allow hospitals to increase capacity, remove barriers to providing patient care and employing additional providers, and promote greater use of telehealth.

Increased Hospital Capacity

CMS [announced](#) that it would allow healthcare systems and hospitals to temporarily provide patient care or COVID-19 testing in non-hospital buildings and spaces. This includes setting up testing and screening sites in parking lots and drive-through centers if needed. Relatedly, CMS will allow ambulatory surgery centers (“ASCs”) that have cancelled elective surgeries due to the pandemic to be used for patient care and quarantine sites so long as the location is approved by the state and ensures the safety and comfort of patients and staff.

CMS also granted waivers, as we discussed [here](#), to allow physician-owned hospitals to temporarily increase their number of licensed beds, operating rooms, and procedure rooms to accommodate COVID-19 patient surge. Such expansion would typically be restricted by the Stark Law and Section 6001 of the Affordable Care Act.

In addition, to maximize use of inpatient beds for COVID-19 patients, hospitals can now transfer patients needing less intensive care to alternative locations, such as inpatient rehabilitation hospitals, hotels, and dormitories, while still receiving hospital payments under Medicare. New rules will also allow hospitals to set up (1) triage centers to direct patients to those alternative sites, and (2) special purpose facilities, clinics, and dialysis centers to treat COVID-19 patients—both of which reflect CMS’s efforts to prevent patients with other non-COVID-19 health needs from becoming infected.

Further, ambulances can now transport patients to a wider range of locations when other transportation is not medically appropriate. These locations include mental health centers, federally qualified health centers (“FQHCs”), physicians’ offices, urgent care facilities, ASCs, and any locations providing dialysis services.

Flexibility in Increasing Healthcare Workforce and Reducing Practice Restrictions

CMS [announced](#) several waivers that will allow a rapid increase in healthcare providers to deal with surges in COVID-19 patients. For example, CMS has relaxed supervision requirements such as that for services requiring direct supervision by a physician or other practitioner, physician supervision can be provided virtually using real-time audio-video technology, and non-physicians (such as physician assistants, nurse practitioners, and nurse anesthetists) can care for Medicare patients and order certain tests and medications that previously only a physician could order, subject to state law requirements. Medical students will also have more flexibility to provide services under the direction of their teaching physicians.

In addition, direct physician supervision will not be required for non-surgical extended-duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Rather, a physician will be able to provide a *general* level of supervision where the physician's immediate availability in the office suite is not required.

Further, CMS is dramatically relaxing provider enrollment requirements so that providers can immediately begin treating patients and be reimbursed for such treatment. Specifically, CMS is temporarily suspending certain Medicare enrollment screening requirements including site visits and finger-printing for non-certified Part B suppliers, physicians, and non-physician practitioners. CMS is also expediting new and pending applications from providers, postponing all revalidation actions, and allowing licensed providers to bill Medicare for services provided outside of their state of enrollment.

Easier Reimbursement for Providers

The Coronavirus Aid, Relief, and Economic Security ("CARES") Act, recently signed into law, injects \$100 billion into the Public Health and Social Services Emergency Fund to reimburse "eligible health care providers" for "health care related expenses or lost revenues that are attributable to coronavirus." "Eligible health care providers" means "public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities . . . as the Secretary [of HHS] may specify . . . that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." This definition includes hospitals, physician practices, long-term care providers, and certain outpatient clinics.

Compounding the financial strain on healthcare facilities due to the cancellation of elective and non-essential medical procedures, many healthcare facilities are also facing financial difficulties due to the need to train additional staff, increase staffing levels, construct or retrofit facilities, and expand telehealth capabilities. As part of implementing the CARES Act, CMS [announced](#) that it is temporarily expanding its accelerated and advance payment program to a broader group of Medicare providers and suppliers. Advance payments of funds provided by the CARES Act will help address cashflow concerns for healthcare facilities that must respond to the COVID-19 pandemic.

To qualify for accelerated or advance payments, a provider or supplier must (a) have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form; (b) not be in bankruptcy; (c) not be under active medical review or program integrity investigation; and (d) not have any outstanding delinquent Medicare overpayments. CMS has already begun accepting and processing advance payment requests and anticipates payments will be issued within seven days of a request. A [CMS fact sheet](#) outlines the process for requesting accelerated or advance payment.

CMS also [announced](#) that it will issue blanket waivers of the Stark Law to permit certain financial arrangements between physicians and healthcare providers implemented in response to the

pandemic that would otherwise violate the Stark Law. As examples, the blanket waivers would now allow hospitals to:

- provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing, and child care services;
- pay physicians above contract rates for providing care to COVID-19 patients in hazardous or challenging environments;
- rent office space or equipment from physician practices at below fair market value or at no charge; and
- provide telehealth equipment or personal protective equipment to physicians and physician practices at below fair market value or at no charge.

The waivers are discussed in greater detail [here](#).

Greater Use of Telehealth

The CARES Act also (i) reauthorizes the Health and Resource Service Administration's Telehealth Resource Center grant programs at \$29 million a year through 2025, (ii) boosts support for expanded broadband services, encourages the use of remote patient monitoring for home health services in Medicare, and (iii) funds new telehealth initiatives for the Indian Health Services and Department of Veterans Affairs. The statute also provides for new telemedicine allowances at FQHCs, rural health clinics, and hospices.

CMS is supplementing the CARES Act's telehealth measures by, [among other things](#), allowing [more than 80 additional services](#) to be provided by telehealth, including emergency department visits, initial nursing facility visits, home visits, and critical care services, and by removing limitations on how frequently telehealth services can be provided.

CMS is also allowing providers to offer virtual check-in services and remote patient monitoring services to [both new and established patients](#); such services were previously only available for patients with an established relationship with their physician. For example, remote patient monitoring can now be used to monitor a new patient's oxygen saturation levels using pulse oximetry. In addition, a broad range of providers can now deliver certain services by telephone (CPT codes 98966-98968; 99441-99443). Importantly, CMS will allow providers to bill for telehealth visits at the same rate as in-person visits. For more information, see our telehealth article [here](#).

Reduced or Eliminated Paperwork Requirements

CMS is temporarily reducing or eliminating paperwork requirements. For example, CMS is waiving signature and proof-of-delivery requirements for Part B drugs and durable medical equipment when a signature cannot be obtained. CMS is also waiving restrictions on verbal orders and reporting requirements for patients who died from disease in an intensive care unit while in wrist restraints. Moreover, hospitals will not be required to have written policies on processes and visitation of COVID-19 patients in isolation. This will allow hospitals and providers to focus on providing patient care and addressing increased care demands rather than worrying about penalties associated with untimely or incomplete documentation.

CMS has also indicated it will not enforce clinical requirements for coverage indicated in National and Local Coverage Determinations for respiratory devices, home anticoagulation equipment, and infusion pumps, including non-invasive ventilators, multi-function ventilators, respiratory assist devices, and continuous positive airway pressure devices for obstructive sleep apnea.

Further, CMS [announced](#) relief from reporting requirements for providers and facilities participating in Medicare quality reporting programs, including extending deadlines for data submission for provider programs and eliminating the data submission requirement for the period from January 1, 2020, through June 30, 2020, for hospital and post-acute care programs.

In addition to the regulatory changes outlined above, CMS has also [granted waivers to most states](#) (including Texas) under Section 1135 of the Social Security Act, which provides states with greater flexibility in administering their Medicaid programs. States with waivers may bypass certain prior authorization requirements, temporarily enroll out-of-state providers, cease provider revalidation, extend fair hearing and appeal times, and deliver care in alternative settings.

In Texas, Governor Greg Abbott recently [issued an executive order](#) to postpone all elective medical procedures so that the limited number of hospital beds and medical supplies can be used to address COVID-19 cases. Governor Abbott has also waived certain statutory regulations to [fast-track temporary licensing](#) for out-of-state medical professionals, [remove licensing barriers](#) for advance practice registered nurses, permit retired nurses or nurses with inactive licenses to return to active status, and [permit nursing students to provide care](#). In addition, he has temporarily suspended regulations to [support continued pharmacy operations](#) and allow pharmacists to [conduct telephonic consultations](#).

If you have questions about COVID-19 and compliance and enforcement, please contact a member of our Healthcare and Life Sciences Practice Group below. You can also review our [COVID-19 Resources page](#) and the [CMS website](#) for more information.