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CMS Issues Summary of Blanket Waivers in Place Through the End of the Emergency Declaration

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The Centers for Medicare & Medicaid Services (CMS) recently issued a 29-page summary of the numerous blanket waivers issued to provide flexibilities to health care providers combating the COVID-19 pandemic.

CMS implements blanket waivers, as opposed to individual, specifically-requested waivers, when a determination has been made that all similarly situated providers in an emergency area need such a waiver or modification. Once approved, these blanket waivers apply automatically to all applicable providers and suppliers and do not require a request to be sent or notification made to CMS.

Alternatively, providers and suppliers can submit requests for individual 1135 waivers. These requests must include a justification for the waiver and expected duration of the modification requested. They are reviewed on a case-by-case basis.

“It’s all hands on deck during this crisis,” said CMS Administrator Seema Verma. “All frontline medical professionals need to be able to work at the highest level they were trained for. CMS is making sure there are no regulatory obstacles to increasing the medical workforce to handle the patient surge during the COVID pandemic.”

The following blanket waivers have a retroactive effective date of March 1, 2020, and will remain in effect until the end of the declared nationwide public health emergency. Please keep in

mind that these waivers only apply to federal requirements, and do not impact state requirements, which would require a separate state waiver.

These waivers provide additional flexibilities for:

- Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs), including Cancer Centers and Long-Term Care Hospitals (LTCHs)
  - Emergency Medical Treatment & Labor Act (EMTALA)
  - Verbal Orders
  - Reporting Requirements
  - Patient Rights
  - Sterile Compounding
  - Detailed Information Sharing for Discharge Planning for Hospitals and CAHs
  - Limiting Detailed Discharge Planning for Hospitals
- Medical Staff
- Medical Records
- Flexibility in Patient Self Determination Act Requirements (Advance Directives)
- Physical Environment
- Telemedicine
- Physician Services
- Anesthesia Services
- Utilization Review
- Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments
- Emergency Preparedness Policies and Procedures
- Quality Assessment and Performance Improvement Program
- Nursing Services
- Food and Dietetic Services
- Respiratory Care Services
- CAH Personnel Qualifications
- CAH Staff Licensure
- CAH Status and Location
- CAH Length of Stay

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- Temporary Expansion Locations
- Responsibilities of physicians in CAHs
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
  - Certain Staffing Requirements
  - Physician Supervision of Nurse Practitioners (NP) in RHCs and FQHCs
- Housing Acute Care Patients in the Inpatient Rehabilitation Facility (IRF) or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units
- Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital
- Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital
- Flexibility for IRFs Regarding the "60 Percent Rule"
- Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission
- Supporting Care for Patients in LTCHs
- Care for Patients in Extended Neoplastic Disease Care Hospitals
- Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)
  - 3-Day Prior Hospitalization
  - Reporting Minimum Data Set
  - Staffing Data Submission
  - Waive Pre-Admission Screening and Annual Resident Review (PASARR)
  - Physical Environment
  - Resident Groups
  - Training and Certification of Nurse Aides
  - Physician Visits in Skilled Nursing Facilities/Nursing Facilities
  - Resident roommates and grouping
  - Resident Transfer and Discharge
  - Physician Services
- Home Health Agencies (HHAs)
  - Requests for Anticipated Payment (RAPs)
  - Reporting
  - Initial Assessments
  - Waive Onsite Visits for HHA Aide Supervision

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  - Allow Occupational Therapists (OTs) to Perform Initial and Comprehensive Assessment for All Patients
- Hospice
  - Waive Requirement for Hospices to Use Volunteers
  - Comprehensive Assessments
  - Waive Non-Core Services
  - Waived Onsite Visits for Hospice Aide Supervision
  - Hospice aide competency testing allow use of pseudo patients
  - 12-hour Annual In-service Training Requirement for Hospice Aides
- End-Stage Renal Dialysis (ESRD) Facilities
  - Training Program and Periodic Audits
  - Defer Equipment Maintenance & Fire Safety Inspections
  - Emergency Preparedness
- Ability to Delay Some Patient Assessments
- Time Period for Initiation of Care Planning and Monthly Physician Visits
- Dialysis Home Visits to Assess Adaptation and Home Dialysis Machine Designation
- Home Dialysis Machine Designation – Clarification
- Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded
- Dialysis Patient Care Technician (PCT) Certification
- Transferability of Physician Credentialing
- Expanding Availability of ESRD to Nursing Home Residents
- Clarification for Billing Procedures
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Practitioner Locations
- Provider Enrollment
- Medicare Appeals in Fee for Service (FFS), Medicare Advantage (MA) and Part D
- Medicaid and CHIP (as of 3/13/2020)
- Blanket Waivers of Sanctions Under the Physician Self-Referral Law (also known as the “Stark Law”)

These blanket waivers are designed to prevent gaps in access to care for Medicare beneficiaries in the wake of the emergency. Detailed information about each of these waivers can be found in the CMS summary and on the CMS Coronavirus Waivers & Flexibilities page.

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