Hospice 1135 Waivers under the COVID-19 Public Health Emergency Provisions and Expiration Dates Highlighted

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https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf

Waiver	Provisions and Expiration Dates
Vaccines	
1. **Payment After the End of the PHE**	CMS will continue to pay approximately $40 per dose for administering COVID-19 vaccines in outpatient settings for Medicare beneficiaries **through the end of the calendar year that the PHE ends.** **Effective January 1, 2024**, CMS will set the payment rate for administering COVID-19 vaccines to align with the payment rate for administering other Part B preventive vaccines.
2. **Additional Payment for Administering the Vaccine in the Patient's Home**	An additional $35.50 per dose to administer COVID-19 vaccines in the home for certain Medicare patients. **Through December 31, 2023.** For vaccines requiring multiple doses, this payment applies for each dose in the series, including any additional or booster doses, and we geographically adjust the additional amount and administration rate based on where the provider or supplier administers the vaccine.
3. **Additional Payment for Administering the Vaccine in the Patient's Home After the End of the PHE**	CMS will continue to pay a total payment of approximately $75 per dose to administer COVID-19 vaccines in the home for certain Medicare patients through the end of the calendar year that the PHE ends. **Through December 31, 2023.**
Medicare Telehealth and Telecommunications Technology	
1. **Telecommunications Technology** Hospice providers can provide services to a Medicare patient receiving routine home care through telecommunications technology (e.g., remote patient monitoring; telephone calls (audio only and TTY); and two-way	

audio-video technology), if it is feasible and appropriate to do so. 2. **Visits on claim form:** Only in-person visits are to be recorded on the hospice claim. 3. **Hospice face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit**	This waiver will expire at the end of the PHE. The hospice face-to-face encounter is a statutory provision, first passed by the Congress in the CARES Act. Hospice face-to-face encounters can now be conducted via telehealth (i.e., two-way audio-video telecommunications technology that allows for real-time interaction between the hospice physician/hospice nurse practitioner and the patient). An additional statutory extension was included in the Consolidated Appropriations Act (CCA) of 2022, which allows the hospice face-to-face encounters to be conducted through telehealth until **December 31, 2024.**
Workforce	
1. **Training and Assessment of Aides** CMS has been waiving the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make **an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency.**	In accordance with section 1135(b)(5) of the Act, CMS is postponing completion of these visits. All postponed onsite assessments must be completed by these professionals **no later than July 10, 2023.** CMS will end this waiver at the conclusion of the PHE.
2. **Annual Training.** CMS is modifying the requirement at 42 CFR §418.100(g)(3), which **requires hospices to annually assess the skills and competence of all individuals furnishing care and provide in-service training and education programs where required.** This does not alter the minimum personnel requirements at 42 CFR §418.114. Selected hospice staff must complete training and have their competency evaluated in	CMS is **postponing the deadline for completing this requirement throughout the COVID-19 PHE until September 30, 2023**. CMS will end this waiver at the conclusion of the PHE.

accordance with unwaived provisions of 42 CFR Part 418.	
3. **Quality Assurance and Performance Improvement (QAPI)** CMS is modifying the requirement at 42 CFR §418.58 for Hospice and §484.65 for HHAs, which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. delivery most Published 9/1/2022 5 closely associated with COVID-19 and tracking adverse events during the PHE.	Specifically, CMS is modifying the requirements at §418.58(a)–(d) and §484.65(a)–(d) to **narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events.** This modification decreases burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain.
4. **Volunteer 5% Requirement** CMS has been waiving the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and anticipated quarantine.	In discussions with CMS, they stated that there will be no ramp up period for meeting the 5% volunteer requirement after the PHE has concluded. This waiver will terminate at the end of the COVID-19 PHE.
Reducing Administrative Burden	
1. **Comprehensive Assessments:** CMS has been waiving certain requirements for Hospice 42 CFR §418.54 related to update of the comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment (§418.54(d)). Hospices must continue to complete the required assessments and updates, however, the **timeframes for updating the assessment may be extended from 15 to 21 days**.	CMS will end this waiver at the conclusion of the PHE.
2. **Waive Non-Core Services:** CMS has been waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech language pathology.	CMS will end this waiver at the conclusion of the PHE.
3. **Specific Life Safety Code (LSC) for Hospice and CAHs:** CMS has been waiving and modifying particular waivers under 42 CFR §418.110(d) for inpatient hospice. Specifically, CMS is modifying these requirements as follows:	

a. Alcohol-based Hand-Rub (ABHR) Dispensers: We are waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area.	CMS will end this waiver at the conclusion of the PHE.
b. Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to **protect ABHR dispensers** against inappropriate use as required by 42 CFR §418.110(d)(4) for inpatient hospice.	CMS will end this waiver at the conclusion of the PHE.
4. **Fire Drills:** Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6.	Terminated waivers for fire drills at §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs; and §483.90(a) for SNF/NFs terminated on **6-6-2022** per QSO-22-15-NH & NLTC & LSC).
5. **Temporary Construction:** CMS has been waiving requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2.	(Terminated waivers for temporary construction at §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs; and §483.90(a) for SNF/NFs on **6-6-2022** per QSO-22-15-NH & NLTC & LSC).
Medicare Appeals in Traditional Medicare, Medicare Advantage (MA) and Part D	
1. **Allow extensions to file an appeal:** During the PHE, CMS has been allowing **Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program** (42 CFR 405.942 and 42 CFR 405.962) and MA and Part D plans, as well as the Part C and Part D Independent Review	When the PHE ends, these flexibilities will continue to apply consistent with existing authority and requests for appeals must meet the existing regulatory requirements.

Entity (IREs) (42 CFR 422.582 and 42 CFR 423.582) **to allow extensions to file an appeal.** Specifically, 42 CFR 422.582(c) and 42 CFR 423.582(c) allow a Part C or Part D plan to extend the timeframe for filing a request if there is good cause for the late filing. In addition, the Part D IRE may find good cause for late filing of a request for reconsideration.	
2. **Waive requirements for timeliness for requests for additional information to adjudicate claims:** During the PHE, CMS has been allowing **MACs and QICs** in the FFS program (42 CFR 405. 950 and 42 CFR 405.966), and the Part C and Part D IREs, to **waive requirements for timeliness for requests for additional information to adjudicate appeals.** In addition, under applicable regulations, MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest (42 CFR 422.568(b)(1)(i), 42 CFR 422.572(b)(1) and 42 CFR 422.590(f)(1)).	When the PHE ends, these flexibilities will continue to apply consistent with existing authority and requests for appeals must meet the existing regulatory requirements.
3. **Process appeals with incomplete Appointment of Representation forms:** During the PHE, CMS has been **allowing MACs and QICs in the FFS program** (42 CFR 405.910) and MA and Part D plans, as well as the Part C and Part D IREs, **to process an appeal even with incomplete Appointment of Representation forms** (see 42 CFR 422.561 and 42 CFR 423.560 for definitions of "representative"). However, any communication was sent only to the beneficiary.	When the PHE ends, **this flexibility will continue to apply, consistent with existing guidance for the MACs and QIC in the FFS program.** **For MA and Part D plans, as well as the Part C and Part D IREs, this flexibility will no longer apply.** The MA and Part D plans, as well as the Part C and D IREs, must process the appeals based on regulatory requirements (42 CFR 422.582(f)-(g), 42 CFR 423.582(e)-(f), 42 CFR 422.592(d)-(e), and 42 CFR 423.600(g)- (h)).
4. **Process appeals that don't meet required elements:** During the PHE, **CMS has been allowing MACs and QICs in the FFS program**	When the PHE ends, requests for appeals must meet the existing regulatory requirements.

(42 CFR 405. 950 and 42 CFR 405.966) and MA and Part D plans, as well as the Part C and Part D IREs, to process requests for appeal that don't meet the required elements, but instead use information that is available (42 CFR 422.562 and 42 CFR 423.562).	
5. **Good cause requirements met:** During the PHE, **CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966) and MA and Part D plans, as well as the Part C and Part D IREs, to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.**	When the PHE ends, these flexibilities will continue to apply, consistent with existing regulatory authority.
Provider Enrollment	
1. **Toll free hotline:** During the PHE, CMS has established toll-free hotlines for physicians, non-physician practitioners, and Part A certified providers and suppliers who have established isolation facilities to enroll and receive temporary Medicare billing privileges.	When the PHE ends, the hotlines will be shut down.
2. **Screening requirements - Site Visits:** CMS waived provider enrollment site visits for moderate and high risk providers and suppliers.	This waiver terminated on **07-06-2020** and CMS, in accordance with 42 C.F.R. §§ 424.517 and 424.518, resumed all provider enrollment site visits.
3. **Application Fees:** CMS waived the collection of application fees for institutional providers who are initially enrolling, revalidating, or adding a new practice location.	This waiver terminated on **10/31/2021** and CMS, in accordance with 42 C.F.R. § 424.514, resumed collecting application fees.
4. **Revalidation:** CMS postponed all revalidation actions. This did not prevent a provider who wants to submit a revalidation application from doing so; MACs processed revalidation applications.	This waiver terminated on **10/31/2021** and CMS resumed a phased-in approach to revalidation activities; revalidation letters began being mailed again in October 2021 with due dates in early 2022.)
5. **Expedited Enrollment:** CMS expedited any pending or new applications from providers and suppliers, including physicians and non-physician practitioners received on or after March 1, 2020.	When the PHE ends, CMS will resume normal application processing times.
6. **Opt-Out Enrollment:** CMS allowed practitioners to cancel their opt-out status early and enroll in Medicare to provide care to more patients. CMS also allowed MACs to accept opt-out cancellation requests via email, fax, or phone call to the hotline. CMS allowed a provider to submit an application	When the PHE ends, this waiver will terminate and opted-out practitioners will not be able to cancel their opt-out statuses earlier than the applicable regulation at 42 CFR 405.445 allows for.

(an 855-I or 855-R for example) to cancel their opt-out. Providers were not required to submit a written notification to cancel their opt-out status.	
7. **State Licensure:** During the PHE, CMS allowed licensed physicians and other practitioners to bill Medicare for **services provided outside of their state of enrollment**. CMS has determined that, when the PHE ends, CMS regulations will continue to allow for a total deferral to state law. Thus, there is no CMS-based requirement that a provider must be licensed in its state of enrollment.	CMS has determined that, when the PHE ends, CMS regulations will continue to allow for a total deferral to state law. Thus, there is no CMS-based requirement that a provider must be licensed in its state of enrollment.
Cost Reporting	
1. **Cost Reporting.** CMS delayed the filing deadline for all provider types impacted during the COVID-19 PHE, including hospitals, SNFs, HHAs, hospices, ESRDs, RHCs, FQHCs, CMHCs, OPOs, histocompatibility labs, and home office cost statements, with a fiscal year ending on or between October 31, 2019 through December 31, 2020. Providers that continue to experience the impacts of the COVID-19 PHE and require additional time to file their cost report ending after December 31, 2020, they may submit a request to their MAC in accordance with our regulation at 42 CFR 413.24 (f)(2)(ii).	Fiscal year ending on or between October 31, 2019 through December 31, 2020. Providers that continue to experience the impacts of the COVID-19 PHE and require additional time to file their cost report ending after December 31, 2020, they may submit a request to their MAC in accordance with our regulation at 42 CFR 413.24 (f)(2)(ii). The MAC has the authority to grant up to a 60 day extension of the due date for filing a cost report if the provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as the COVID-19 PHE.
Nursing Facilities	
1. **Three-Day Prior Hospitalization** Using the statutory flexibility under Section 1812(f) of the Social Security Act, **CMS temporarily waived the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay. This waiver provides temporary emergency coverage of SNF services without a qualifying hospital stay. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes a onetime renewed SNF coverage without first having to start and complete a 60-day "wellness period" (that is, the 60-day period of non-inpatient status that is normally required in**	Three-day prior hospitalization waiver will terminate at the end of the COVID-19 PHE.

order to end the current benefit period and renew SNF benefits). This waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the 60-day "wellness period" that would have occurred under normal circumstances. By contrast, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the Section 1812(f) waiver, as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60-day "wellness period."8	

Additional Guidance

The Interim Final Rules and waivers can be found at: https://www.cms.gov/aboutcms/emergency-preparedness-response-operations/current-emergencies/coronaviruswaivers

CMS has released guidance to describe standards of practice for infection control and prevention of COVID-19 in hospices at https://www.cms.gov/files/document/qso-20-16- hospice.pdf

CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/files/document/guidance-memoexceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf

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