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COVID-19 Waivers: Some SNFs Refuse Hospital Patients Anyway; MA Coverage Is Better

By Nina Youngstrom

The uneasiness some skilled nursing facilities (SNFs) feel about accepting patients is reportedly slowing transfers from hospitals during the coronavirus pandemic, despite CMS's blanket waiver of its requirement that patients spend three days as hospital inpatients before the SNF admission. Because some SNFs don't think the waiver is triggered until the referring hospital is in the throes of the emergency, they're refusing patients without a qualifying three-day stay, and the "confusion" may persist until CMS clarifies "exactly" what the waiver means, according to an attorney who represents long-term care facilities.

"If you take the interpretation there has to be an actual crisis for beds, some SNFs are afraid to take those patients who don't have a qualifying three-day stay," said attorney Paula Sanders, with Post & Schell in Harrisburg, Pennsylvania. "I don't believe that was the intent of the waiver."

The blanket waiver "provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency," CMS said March 18 in *MLN Matters* SE20011 Revised.[1] With the perceived ambiguity of the language, Sanders said some of her SNF clients won't take the risk of accepting patients without a three-day stay, because they're worried Medicare auditors will determine the admission wasn't valid and try to recoup the money after the crisis abates. SNFs are not alone; some hospital case managers say their compliance departments won't let them use the waiver until they have CMS's authorization, said Ronald Hirsch, M.D., vice president of R1 RCM. "It's important to point out that this waiver applies to every nursing facility and critical access hospital and hospital across the nation. Nothing needs to be done to use this waiver for Medicare patients," he said.

Sanders and others are looking to CMS for elaboration on this and other waivers that were rolled out in mid-March. Sec. 1135 of the Social Security Act allows HHS to waive certain provisions of Medicare, Medicaid and the Children's Health Insurance Program when the HHS secretary declares a public health emergency and the president declares a national emergency.[2] The blanket waivers are broad in scope, but limited in time, said attorney Mark Polston, with King & Spalding in Washington, D.C., at a March 19 webinar held by the firm.

CMS makes it plain in the *MLN Matters*, which sets forth the other blanket waivers, that hospitals and other providers don't have to apply for blanket waivers related to COVID-19. But hospitals and other providers must request different, more specific waivers during the pandemic, such as individual waivers from certain aspects of the Emergency Medical Treatment and Labor Act (EMTALA) and Medicare conditions of participation.[3] CMS also announced waivers to help grease the wheels of payments by Medicare Advantage plans.

"We are in uncharted territory for everyone, including the government, so we are learning as we go," said attorney David Glaser, with Fredrikson & Byron in Minneapolis, Minnesota. "They are trying to help. But there is a lot of uncertainty."

A main thrust of the blanket waivers is to enable hospitals to increase their capacity, said attorney Christopher Kenny, with King & Spalding in Washington, D.C. CMS did that in several ways. For example, during the pandemic, hospitals are allowed to relocate patients from excluded, distinct-part inpatient psychiatric and inpatient rehabilitation units to acute-care beds. They should still bill Medicare under the psych and inpatient rehabilitation facility prospective payment systems, the *MLN Matters* noted.

Also, because of the CMS blanket waivers, critical access hospitals (CAHs) may have patients in more than 25 beds and increase the length of stay beyond 96 hours. "Are those visits going to be paid at the uncapped amount? The waiver is silent on that," Kenny said.

The blanket waivers for excluded-part units are based on cost-report categories, said attorney Judy Waltz, with Foley & Lardner in San Francisco. "This gives hospitals flexibility to use the space without worrying about the cost-report implications," she explained. Long-term acute care hospitals also have a blanket waiver during the COVID-19 emergency, which means they will be paid by Medicare even when patients are discharged within 25 days. While the Medicare two-midnight rule is still in effect and "there's no special COVID-19 DRG," CMS will pay outlier payments when patients with the coronavirus have expensive, long hospital stays, Kenny said.

The SNF waiver is the most significant blanket waiver, Waltz said. "It's heartfelt," she noted. "This is a recognition that beneficiaries are suffering." She understands, however, that given their vulnerability, SNFs may hope patients complete three-day stays "and are in better shape by the time they get to the SNFs." But the blanket waiver at least solves the payment problem.

"If hospitals are full of people who have nowhere to go because nursing homes with beds won't accept them, that's going to be a big problem," Hirsch said. CMS may have to step in. He also understands SNFs' reluctance; they operate with a limited supply of registered nurses and personal protective equipment, and their residents generally are at high risk of coronavirus infection. Meanwhile, in response to a submission to CMS's mailbox for questions about the 1135 waiver, CMS said that swing beds don't qualify for the SNF waiver, according to Hirsch. "If a facility does determine a waiver for the three-day inpatient admission requirement for swing beds is needed, the facility can submit an individual waiver," CMS wrote.

MA Waiver: Out-of-Network Providers Get a Break

In another waiver document,[4] CMS gave Medicare Advantage (MA) plans "flexibilities" that should be helpful to providers and beneficiaries. Providers should find MA plans more receptive to their claims for tests and treatments for COVID-19, said attorney Jim Boswell, with King & Spalding in Atlanta, Georgia. For one thing, when patients enrolled in an MA plan are screened and/or treated in a hospital that doesn't participate in that MA plan, the hospital must be paid during the national emergency. "Medicare Advantage plans have to treat services rendered to out-of-network patients as covered if the service is covered under Medicare Part A and B," Boswell explained. MA plans can't insist on the patient being seen by an in-network provider.

"Equally extraordinary is that the out-of-network provider in that situation can seek payment directly from CMS through the Medicare administrative contractor if the Medicare Advantage organization does not pay the provider for the service," he said, and CMS would settle up with the MA plan through adjustment of CMS payments. The 1135 waiver also expands coverage. For example, MA plans must pay for inpatient stays as regular hospital stays even if they're provided in an inpatient rehabilitation facility because of the pandemic, Boswell said.

Hospitals Must Request Specific EMTALA Waivers

As potentially powerful as the blanket waivers are for some hospitals, Alex Laham, chief risk officer at Lawrence

General Hospital, sees more potential in the individual waivers. "The blanket waivers that were granted by CMS are helpful for coordination of care, billing and easing restrictions on patient flow. However, for our hospital specifically, we are focused on the EMTALA waivers to ensure we are fully prepared to handle any potential influx of patients," he said.

CMS permits providers to individually seek relief under Sec. 1135 and has provided guidance on how to submit requests.[5] The categories for these waivers are set forth on a Public Health Services website and include certain aspects of EMTALA, the Medicare conditions of participation, the Stark Law and HIPAA.

"Current advice from the regional CMS office is to apply for 1135 waivers that are not already covered by the blanket waivers, if we feel that it's required for our organization. We will be looking to submitting an application for waiver if CMS does not issue a global EMTALA waiver in the coming days," Laham said.

For example, the EMTALA waiver could allow hospitals to transfer unstable patients if the hospital doesn't have the capacity or capability to treat them, although it's only for the COVID-19 pandemic, said attorney Catherine Greaves, with King & Spalding in Austin, Texas. "HHS made it clear they won't consider them waivers if hospitals use them to discriminate based on the patient's ability to pay, so don't ask payment questions." These and the other individual waivers only apply if the hospital and the state have instituted their emergency protocols, she said. Otherwise, CMS warned hospitals in a March 9 memo[6] they must follow EMTALA during the COVID-19 pandemic, although they can use alternate sites to screen patients.

Even with all the HHS guidance, Glaser said sometimes in a crisis, "regulatory things take a back seat." Infection control is the priority. For example, if a hospital sets up a tent in the parking lot to treat patients, will it meet Joint Commission standards? "You try, but if people are going to die if you don't do it, then you do it," he said.

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1 CMS, "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)," *MLN Matters* SE20011 Revised, March 18, 2020, https://go.cms.gov/3b1ckZQ.
2 42 U.S.C. § 1320b-5 .
3 "Not the Blanket Waivers: HHS Lists Waivers Hospitals Would Have to Ask For," *Report on Medicare Compliance* 29, no. 11 (March 23, 2020).
4 CMS, "Information Related to Coronavirus Disease 2019 - COVID-19," HHS, March 10, 2020, https://go.cms.gov/3dhkqzq.
5 CMS, "1135 Waiver Request: Communication Method-Best Practice," https://go.cms.gov/33xshEs.
6 Nina Youngstrom, "CMS EMTALA Memo: Hospitals Must Accept COVID-19 Patients; Alternate Sites May Be OK," *Report on Medicare Compliance* 29, no. 10 (March 16, 2020), http://bit.ly/38PUCqL.