Ambulatory Surgery Centers (“ASCs”) Called to Relieve COVID-19 Patient Surge: CMS Hospital “Without Walls” Program

In order to equip the American healthcare system with the maximum flexibility to respond to the COVID-19 pandemic, CMS has issued a sweeping array of new rules and waivers of federal requirements to permit hospitals and health systems to coordinate healthcare delivery in their area.

1. Increase Hospital Capacity

Typically, CMS conditions of participation, EMTALA and provider-based rules require hospitals to provide services within their own buildings. But under the blanket waivers, hospitals will be able to transfer patients to outside facilities, such as ambulatory surgery centers (ASCs), inpatient rehabilitation hospitals, hotels, and dormitories, while still receiving reimbursements for hospital care. For instance, a hospital may use a local hotel to care for patients needing less intensive care, while using inpatient beds for COVID-19 patients.

In turn, ambulatory surgery centers (ASCs) may contract with local healthcare systems to provide hospital services, or they may enroll and bill as hospitals during the emergency declaration as long as they are not inconsistent with their State’s Emergency Preparedness or Pandemic Plan. These adjustments provide a lifeline to ASCs, many of which have closed or discontinued operations due to guidelines regarding safe delay of elective surgery during the COVID-19 pandemic.

Notably, hospitals are expected to exercise sufficient control over the services provided beyond their walls. If the ASC physician owners refer patients to the hospital or health systems, any contract or arrangement must keep in mind Stark Law and Anti-Kickback Law compliance concerns, to the extent that they have not been waived.

2. Broaden Patient Testing and Treatment Options

As part of the waivers, ambulances may transport patients to a wider rage of locations, including community mental health centers, federally qualified health centers (FQHCs), physician’s offices, urgent care facilities, ASCs or locations furnishing dialysis services (when an ESRD facility is not available).

People with Medicare have broader access to (and coverage for) respiratory devices and equipment, such as non-invasive ventilators, multi-function ventilators, respiratory assist devices, and continuous positive airway pressure (CPAP) devices.

For Medicare patients, CMS has agreed to pay laboratory technicians to travel to a beneficiary’s home to collect a specimen for COVID-19 testing, eliminating the need for travel to a healthcare facility for testing. Hospital and other entities are able to perform tests for COVID-19 at home and in other community-based settings, off site.

3. Expand and Protect the Healthcare Workforce

CMS has eased provider enrollment requirements and is allowing local private practice clinicians to obtain temporary privileges at the hospital, without undergoing a full medical staff/governing body review. CMS is permitting physicians whose privileges will expire to continue practicing at a hospital. Medical residents will also have more flexibility to provide services under the direction of the teaching physician.

Doctors may now directly care for patients at rural hospitals, across state lines or via phone, radio or online communication

without being physically present. Waivers of federal minimum personal qualifications has allowed clinical nurse specialists, nurse practitioners and physician assistants to work at rural hospitals, as long as they meet state licensure requirements.

In addition, CMS has lifted regulatory requirements regarding hospital personnel qualified to perform specific respiratory care procedures, allowing professionals to operate within the fullest extent of their licensure.

To address provider burnout in doctors, nurses and hospital staff on the frontlines, CMS is issuing a blanket waiver to allow hospitals to provide benefits and support, including multiple daily meals, laundry service for clothing and childcare services.

Within the hospital, CMS is permitting wider use of verbal orders (rather than written orders) and is eliminating paperwork requirements, so that providers may focus more on patient care. Hospitals will also have more time to provide patients a copy of their medical record.

4. Delay Medicare Program Audits and Oversight

Finally, CMS will suspend requesting additional information from providers, healthcare facilities and Medicare Advantage and Part D prescription drug plans. CMS is reprioritizing scheduled program audits in Medicare Advantage, Part D plans and Programs of All-Inclusive Care for the Elderly (PACE).

Complete list of applicable waivers.

References:

Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

CMS: COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

Medicaid: Section 1135 Waiver Flexibilities – California Coronavirus Disease 2019

Trump Administration Acts to Ensure U.S. Healthcare Facilities Can Maximize Frontline Workforces to Confront COVID-19 Crisis

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