

The Centers for Medicare & Medicaid Services (CMS)
Fact Sheet for State and Local Governments
CMS Programs & Payment for Care in Hospital Alternate Care Sites
FINAL May 26, 2020

Purpose

In response to the COVID-19 public health emergency (PHE), state and local governments, hospitals, and others are developing alternate care sites to expand capacity and provide needed care to patients. The term alternate care site (ACS) is a broad term for any building or structure that is temporarily converted or newly erected for healthcare use.¹ The Federal Healthcare Resiliency Task Force issued a [toolkit](#) to help state and local governments develop an ACS.

This document provides state and local governments developing alternate care sites with information on how to seek payments through CMS programs – Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) – for acute inpatient and outpatient care furnished at the site.

Key Takeaway

The easiest path to obtaining payments through CMS programs for covered health care services furnished at the ACS is for an already-enrolled hospital or health system to treat the ACS as a temporary expansion of their existing ‘brick-and-mortar’ location. In these circumstances the local hospitals and health systems operate, staff, and bill for care furnished at the ACS. State and local governments² that want to establish (meaning to develop or build) a hospital ACS, and be paid by CMS for furnishing covered hospital inpatient and outpatient services to enrolled beneficiaries, have three options:

1. hand over operation and billing for care delivered in the ACS to an enrolled hospital or health system;
2. enroll the ACS as a new hospital in CMS programs; or
3. if options (1) and (2) are not available, CMS would not make facility payments, but qualified and enrolled physicians or other non-physician practitioners could bill for covered (professional³) services that they furnish at the ACS.

Because some state and local governments may not be as familiar with the process to enroll in CMS programs as hospitals, they should contact their applicable CMS Regional Office (see *Appendix D*) to discuss this process. Additional information regarding new hospital enrollment and the flexibilities that existing hospitals and other providers have to expand capacity at ACSs during the PHE is below.

¹ These sites are often called “alternate care sites” (ACSs), but may also be referred to as “temporary expansion locations”, “temporary expansion sites”, “field hospitals”, or by other names. This paper uses the term “alternate care sites” to align with the language used in the Health Care Resiliency Task Force’s toolkit.

² The term “state and local governments” is used in this fact sheet to account for state, city, county, territorial and tribal governments and their respective agencies, including health departments.

³ When beneficiaries receive services at a traditional acute care hospital, Original Medicare will typically make two payments – one for the hospital inpatient or outpatient facility services (e.g. room and board or nursing) and one for professional services that physicians or non-physician practitioners furnish (e.g., evaluation and management). Under option 3, CMS would not make facility payments to the entity operating the ACS. However, even if the ACS does not enroll as a hospital, CMS may pay for professional services furnished to CMS beneficiaries at the ACS, as discussed in more detail in this fact sheet. In Medicaid/CHIP, specific benefit rules will also need to be followed.

About CMS Programs

Medicare is a federal health insurance program for people over 65, as well as certain young people with disabilities and those with End Stage Renal Disease (ESRD). Typically, beneficiaries have a choice between Original Medicare and Medicare Advantage. Medicare Advantage plans are a type of Medicare health plan offered by a private company that contracts with CMS to provide Medicare benefits. Beneficiaries in Medicare Advantage plans have their services paid for by the private plan and not Original Medicare. When “Medicare” is discussed in this paper, it is referring to Original Medicare, and not Medicare Advantage, unless otherwise noted.

Medicaid and CHIP provide health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid and CHIP are funded jointly by states and the federal government, and the programs are administered by states, according to federal requirements. Medicaid and CHIP generally provide comprehensive benefits to people who are determined eligible by states; some benefits are required and some are optional.

Approaches to Hospital ACS Operations & CMS Programs

Organizations have flexibility to develop ACSs in locations that best fit the needs of their community. Further, ACSs can provide a spectrum of health care services, from intensive care to primary care, depending on the capability of the site. Many organizations are using ACSs to create additional inpatient hospital capacity and are designing site operations to support care of COVID-19- patients and non-COVID-19 patients. There are three questions CMS⁴ uses to determine whether it will pay for covered hospital facility inpatient or outpatient services furnished to enrolled beneficiaries at an ACS.

1. Is the ACS operator already enrolled in CMS programs as an acute care hospital or other provider type⁵ that is able to furnish inpatient or outpatient care during the PHE?
2. Is the ACS operator contributing resources and responsible for the care being furnished to CMS beneficiaries at the ACS?
3. Is the ACS operator following the billing requirements of the applicable Medicare, Medicaid, or CHIP hospital payment system?

Many acute care hospitals have established ACSs by converting existing non-clinical space for clinical use (e.g., cafeteria repurposed for care), as well as locations outside of the traditional hospital such as tents, retrofitted gymnasiums, convention centers, or other non-clinical locations. In these circumstances, the hospitals are already enrolled in CMS programs and are able to treat these locations as a temporary extension of their existing hospital footprint during the PHE under flexibility granted through so-called “[1135 waivers](#)” (additional information about these waivers is in *Appendix A*). CMS pays for inpatient and outpatient care furnished in these ACSs as if the care had been delivered in the hospital’s traditional “brick-and-mortar” locations. Hospitals must follow all applicable CMS coding and billing rules during the PHE.⁶

State and local governments have also established ACSs, often with (non-CMS) federal support. For example, state and local governments may seek reimbursement to develop ACSs from the Federal

⁴ Generally speaking, state Medicaid/CHIP programs would also use these questions to guide whether they would pay for covered inpatient or outpatient care at the ACS. However, state Medicaid/CHIP programs may have alternate approaches – ACSs should contact their state Medicaid agency for more information.

⁵ Other facilities include Long-Term Care Hospitals, Critical Access Hospitals, Inpatient Rehabilitation Facilities, and others. Additional information about the flexibilities these facilities have to furnish acute care during the PHE is in *Appendix C*.

⁶ <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

Emergency Management Agency's (FEMA) Public Assistance program (under Category B, emergency protective measures) which was authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Stafford Act). Other federal funding sources include the Department of Health and Human Services' (HHS's) Hospital Preparedness Program and the Centers for Disease Control and Prevention's Crisis Response Cooperative Agreement. Some state and local governments have also requested HHS deploy portable medical facilities called Federal Medical Stations, and provide clinical staff through the National Disaster Medical System.⁷ The Federal Healthcare Resiliency Task Force has [published a guide](#) to the funding opportunities state and local governments (as well as other organizations) can seek to establish and operate ACSs.

While some state and local governments operate acute care hospitals (e.g., certain county hospital and health systems), others may not be enrolled in CMS programs and, as a result, are not usually in a position to be paid immediately by Medicare or Medicaid/CHIP. However, state and local governments developing an ACS have options to seek payments through CMS programs for covered inpatient and outpatient services furnished to enrolled beneficiaries at the site.

- **Easiest Path* Partner with a hospital or health system:* State and local governments can establish the site and then hand over operations of the ACS to an enrolled hospital (or other provider temporarily certified as a hospital⁸), which can treat the ACS as a temporary extension of their brick-and-mortar location under [1135 waivers](#) and bill CMS and state Medicaid/CHIP programs for covered hospital services furnished to enrolled beneficiaries. Importantly, hospitals may assume operating responsibility and bill Medicare⁹ for inpatient and outpatient care furnished at the ACS even if a governmental entity provides some support. For example, the state/county emergency management agency or public health department may provide (or coordinate the provision of) staffing, dining, linens, or beds used in the ACS. In these circumstances, hospitals operating the site may seek payment on the claim for the services they provide (e.g. nursing), but are instructed not to seek payment on the claim for a service where they are not incurring the cost of the service (e.g. dining). Hospitals would also not reflect the costs of services provided such as staffing, dining, linens, or beds (where they did not incur the costs) on their Medicare cost reports.¹⁰ As noted previously, certain states and local governments may operate or be closely affiliated with certain hospital and health systems, including county-level health systems and those health systems owned by a state university. In these circumstances, these providers may be able to serve as an effective ACS partner. If not, state and local governments may also work with private non-profit or for-profit hospitals in their community. The enrolled hospital operating the site would need to ensure it continues to meet non-waived CMS and state requirements that remain in force during the PHE.¹¹
- *Enroll as a new hospital:* If the state or local government wants to operate the site or cannot find a hospital or health system partner, they can form a new entity and enroll that entity as a hospital in CMS programs. For example, the state of Maryland is pursuing the creation of a new hospital to provide care to COVID-19 patients at the Baltimore Convention Center. Though this option is

⁷ NDMS: <https://www.phe.gov/Preparedness/responders/ndms/ndms-teams/Pages/default.aspx/> FMS: <https://www.phe.gov/Preparedness/support/medicalassistance/Pages/default.aspx#fms>

⁸ Additional information on the flexibility that providers have to furnish hospital care during the PHE is in *Appendix C*. We also note that, in certain cases, state and local governments may have a state or locally-owned hospital that could operate the ACS.

⁹ Hospitals should contact their state Medicaid agency to determine any Medicaid/CHIP-specific payment requirements.

¹⁰ Section 1862(a) of the Social Security Act and Medicare Claims Processing Manual 100-04, Chapter 32, Transmittal 67: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf>

¹¹ Additional information regarding CMS rules in effect during the PHE is available here: <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

available to state and local governments, it may entail additional complexity and take longer than working with an existing hospital to assume responsibility for the site. To ensure beneficiary safety and to reduce the potential for waste, fraud, and abuse, new hospitals must follow certain steps to enroll in both Medicare and the state's Medicaid/CHIP programs. Information regarding the Medicare enrollment steps is in *Appendix B*. States wanting to pursue this pathway to operate an ACS should contact their applicable CMS Regional Office to further discuss the process (contact information is available in *Appendix D*) and contact their state Medicaid agency to determine any additional Medicaid/CHIP enrollment requirements.

- *Not enroll as a hospital; clinicians, such as physicians and other non-physician practitioners, could seek payment for covered professional services:* State and local governments not wanting to enroll a new hospital could engage a medical group to furnish and bill for the professional services furnished to enrolled beneficiaries at an ACS – but the state/locality may have to find separate funding for many other hospital-related services if the state/locality wanted the ACS to function similarly to a hospital. Original Medicare and state Medicaid/CHIP programs generally pay hospitals for: 1) inpatient and outpatient *facility* services furnished to enrolled beneficiaries and 2) separately pay physicians and other non-physician practitioners for *professional* services, regardless of the setting where the covered professional service was furnished.¹² Said differently, when a beneficiary is admitted to a hospital, there are typically Medicare facility claims (for the hospital's services) and Medicare professional claims (for the professional's services, such as patient evaluation and management). During the PHE, Medicare will pay physicians and non-physician practitioners for covered professional health care services furnished to enrolled beneficiaries at ACSs. Similar to hospitals, physicians and non-physician practitioners seeking payment for care furnished to Medicare beneficiaries must be enrolled in Medicare; and likewise practitioners seeking payment from their state Medicaid programs must be enrolled with such state and follow specific program coverage and payment rules. State and local governments that are not able to enroll as a hospital could partner with CMS-enrolled physicians or non-physician practitioners who would be able to furnish and bill for ambulatory care at the ACS.

Multi-Hospital/Organization Approaches

It is important to note that, if state and local governments expect to partner with *more than one private hospital to provide services at an ACS*, they should contact their CMS Regional Office if they are interested in being paid by Medicare or Medicaid for hospital services furnished to Medicare or Medicaid beneficiaries at the site. A full list of CMS Regional Office contacts is in *Appendix D*. Under this scenario, where more than one hospital or health system operates the ACS, CMS would need additional information to determine whether it could pay for services at that location. For example, CMS would need to know if there were distinct clinical spaces to provide a safe environment for their patients.

Medicaid and CHIP Considerations

If ACSs are operated through the options presented in this paper, federal regulations would allow State Medicaid and CHIP agencies to pay for covered services provided in them. That said, each ACS should also reach out to the State Medicaid Agency to understand any state-based direction.

¹² Please note that the applicable payment systems under Medicaid may vary by state, however this is typically how payments work under the Original Medicare. States and local governments should contact their Medicaid agency to determine any specific Medicaid/CHIP payment requirements.

APPENDIX A: Hospital Requirements & 1135 Waivers

General Hospital Requirements

Under federal law, hospitals must meet CMS requirements in order to bill Medicare or Medicaid for covered inpatient or outpatient hospital services furnished to Medicare or Medicaid / CHIP beneficiaries.

- *Conditions of Participation:*¹³ These health and safety standards are the foundational requirements that organizations must achieve to enroll as a hospital and furnish hospital care to CMS beneficiaries. The Conditions of Participation include requirements for the types of services the hospital must provide – such as pharmacy, laboratory, radiologic, 24/7 nursing services and room and board – as well as structural requirements regarding its nursing and medical staff, quality improvement and others. Hospitals are subject to initial and periodic surveys verifying that they meet these requirements.
- *Enrollment:* Hospitals must enroll in the Medicare program and identify key information about their organization prior to furnishing and billing for hospital care. During the PHE, CMS streamlined certain enrollment requirements. For example, during the PHE new hospitals can call their applicable Medicare Administrative Contractor to establish temporary billing privileges for the duration of the PHE, instead of completing a paper or electronic CMS-855A application.¹⁴ Once the PHE has expired, these hospitals must be in full compliance with enrollment and certification requirements for hospitals. States may have separate enrollment requirements for their Medicaid programs.
- *Billing Rules:* Generally speaking, Medicare and Medicaid will pay for reasonable and necessary inpatient and outpatient services for enrolled beneficiaries. However, depending on the type of hospital and the services furnished, payments may vary. For example, Medicare pays certain acute care hospitals differently than it does critical access hospitals.¹⁵ Hospitals must follow the appropriate billing rules to be paid for care.

Emergency 1135 Waivers & Health System Flexibility

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS), under authority in section 1135 of the Social Security Act can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements on a provider-by-provider, geographic, or other broad-scale basis. These actions are commonly referred to as “1135 waivers”. Under its *Hospitals Without Walls* initiative, CMS waived several Medicare conditions of participation at 42 CFR Part 482 and provider-based rules at 42 CFR §413.65 on a national basis. These so-called “blanket” waivers give hospitals flexibilities to respond to the COVID-19 PHE and to furnish care in ACSs, including retrofitted locations (e.g., tents, gymnasiums, and even the patient’s home). Broadly speaking, these waivers streamline the process for hospitals that are already enrolled in the Medicare program to expand access to care. **The waivers do not, however, eliminate enrollment, survey, and billing requirements for brand new hospitals that wish to furnish care to beneficiaries.** CMS has temporarily modified physician supervision requirements, physical environment, and telehealth payment policies to promote access to care during the PHE. Additional information regarding the waivers and CMS emergency rulemaking is available here: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.

¹³ Additional information regarding CMS’ hospital Conditions of Participation is available here: <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals>, here: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals>, and here: <https://www.cms.gov/files/document/covid-hospitals.pdf>

¹⁴ <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf>

¹⁵ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS>; and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsh.pdf>

In the provision of all services, including under an 1135 waiver, recipients of HHS funds must comply with federal civil rights non-discrimination requirements on the basis of race, color, national origin, disability, age, sex, and exercise of conscience and religious freedom rights. States are also still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.

APPENDIX B: Medicare Hospital Enrollment

Prior to furnishing and billing Medicare for inpatient or outpatient hospital care delivered to Medicare beneficiaries, a new hospital must enroll in the Medicare program. This enrollment has three critical steps: the hospital must obtain a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System, the hospital must submit an enrollment application to Medicare, and the hospital must undergo a survey demonstrating that it meets the conditions of participation. Additional information regarding these steps is below.

Step 1: Obtain NPI

- New hospitals are required to obtain a new NPI from NPPES. Applying for an NPI is a process separate from Medicare enrollment. To obtain an NPI, the new hospital may apply online at <https://NPPES.cms.hhs.gov>.
- For NPI purposes, sole proprietors and sole proprietorships are considered to be “Type 1” providers. Organizations (e.g., corporations, partnerships) are treated as “Type 2” entities. As a result, new hospitals will want to seek “Type 2” NPIs.
- It is the new hospital’s responsibility to determine if it has “subparts.” A subpart is a component of the organization that furnishes healthcare and is not itself a legal entity. If the new hospital does have subparts, it must determine if it should obtain its unique NPIs for those subparts.

Step 2: Enrollment Application

- New hospitals (as well as other new institutional providers) are required to submit a [CMS 855A enrollment application](#) to their applicable Medicare Part A/B Medicare Administrative Contractor (MAC).¹⁶ As noted below, providers may also enroll via the MAC’s hotline, though they may be required to complete a paper or electronic application following the end of the PHE.
- The CMS 855A enrollment application requires new hospitals to submit certain identifying and administrative information to Medicare, including the new hospital’s tax identification number, the location(s) where the hospital will furnish care, information about the new hospital’s ownership and control, and information about the individuals managing the new hospital.
- Importantly, CMS requires new hospitals to obtain all necessary state licenses, certifications or other approvals before enrolling and treating Medicare beneficiaries. This information must also be included in the new hospital’s 855A enrollment application. We believe that many states may have streamlined licensing requirements during the PHE.
- The CMS 855A enrollment applications can be submitted via paper (e.g., mail or fax) or through Medicare’s [Provider Enrollment, Chain and Ownership System](#) (PECOS). Providers may also enroll via the MAC’s hotline, though they may be required to complete a paper or electronic application following the end of the PHE.
- Once the application is submitted the applicable MAC reviews the application. Due to the COVID-19 PHE, CMS is expediting enrollment application reviews. Reviews for applications submitted by phone or through PECOS will typically be completed within 7 calendar days or less. Reviews for applications submitted via paper (e.g., mail or fax) will be completed within 14 calendar days or less.

¹⁶ A current map of A/B MAC regions is available here: <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-Jurisdiction-Map-Jun-2019.pdf> . A list of the current MACs by state is available here: <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf>

Step 3: Survey

- New hospitals must demonstrate through a survey that they meet Medicare’s hospital Conditions of Participation¹⁷ that are in effect during the PHE. Certain conditions have been waived under CMS’ 1135 waiver authority discussed in more detail above. A list of the Conditions of Participation that are waived during PHE is available here: <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>
- Hospitals can obtain a survey from a state survey agency or an accreditation organization (AO) with a Medicare-approved hospital program. We encourage new hospitals to work with CMS Regional Office staff (please see *Appendix D* for contact information) and the applicable agency within their state government to determine the quickest way to obtain a survey. In certain cases, CMS is temporarily allowing surveys to be conducted remotely by AOs to ensure organizations can respond to the pandemic. Please also note that the state agency that issues hospital licenses may be different than the agency that conducts the certification survey.
- Based on the survey results, the state agency or AO makes a recommendation for approval or denial (a certification of compliance or noncompliance) to the CMS Regional Office.
- The CMS Regional Office makes the final decision regarding program eligibility. The CMS Regional Office also works with the HHS Office of Civil Rights to obtain necessary Civil Rights clearances. If approved, the provider must typically sign a provider agreement.

¹⁷ <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals>

APPENDIX C: Frequently Asked Questions for Alternate Care Sites Initial Survey and Certification

1. Question: To request an initial certification survey, does a prospective provider or supplier work through their state, CMS or both?

Answer: Alternate care sites that want to participate as a Medicare certified hospital provider have two options to obtain an initial certification survey to demonstrate compliance with applicable Medicare Conditions of Participation (CoPs) for hospitals. The prospective hospital may obtain Medicare certification through the state survey agency (SA) process or through accreditation by a private, national accreditation organization (AO) with a CMS-approved hospital program.

Prior to any Medicare survey activity, the prospective hospital must obtain an operating license as a hospital in their state. Licensure requirements in the states may be more restrictive than those of Medicare and the hospital would be required to meet those requirements in addition to the Medicare CoPs.

2. Question: Are all surveys performed by the state or a private accreditation organization?

Answer: All surveys will be performed by either the SA or AO prior to approval of Medicare certification. A key difference between using an AO instead of the SA is that AOs have a fee associated with their accreditation services, although AOs may be able to perform their surveys sooner than the state. These fees and services can vary among AOs and they may have additional accreditation requirements that could exceed Medicare CoPs.

3. Question: Does CMS require surveyors to follow a standard approach to inspections or is the survey process determined locally by the state or accreditation organization?

Answer: CMS has a standard survey process which surveyors must use to determine compliance. This process is specified in the [CMS State Operations Manual Appendix A](#), which is used by SAs as their standards for survey activity of hospitals. AO survey processes have been approved as meeting or exceeding CMS standards, and may vary from the SA based on their accreditation standards. Additional survey methodology flexibilities have been offered during the public health emergency (PHE) to assist states and AOs in performing surveys and increasing access to healthcare.

4. Question: Can alternate care sites that wish to enroll as hospitals start the Medicare enrollment application process with CMS before getting a survey?

Answer: Yes, prospective hospital providers must submit an enrollment application, the form [CMS-855A](#), as the first step in seeking Medicare certification, which should be done before getting a survey. Alternate care sites that wish to enroll as hospitals should contact their Regional Office first, which can direct them to the appropriate Medicare Administrative Contractor to discuss enrollment. A list of regional offices and their contact information is in Appendix E of this document.

5. Question: Has CMS made any changes to the survey process as a result of the section 1135 waivers in place during the public health emergency (PHE)?

Answer: CMS has waived certain Conditions of Participation during the PHE under the authority in section 1135 of the Social Security Act. Alternate care sites that wish to enroll as hospitals will not be required by the surveyors to demonstrate compliance with any CoPs that have been waived. However, we note that the

waivers are only in effect through the end of the PHE or may be modified or terminated before the end of the PHE. Additionally, there have been flexibilities granted for how surveys are performed during the PHE – more information on these flexibilities can be found in the “survey and certification” section of [this webpage](#).

6. Question: Does CMS have any standard approach to inspecting an alternate care site for conditions of participation or is that a locally made decision by the inspectors?

Answer: CMS requires all alternate care sites that wish to become a Medicare or Medicaid certified hospital to meet all Medicare hospital CoPs that have not otherwise been waived during the PHE. State survey agencies and AOs must assess hospitals’ compliance with these CoPs.

APPENDIX D: Provider Flexibilities & Medicare Payment for Health Care Services Furnished at an ACS

Under the 1135 waivers and two interim final rules with comment periods¹⁸, CMS has given significant flexibility to health care providers to respond to the COVID-19 PHE by expanding access and furnishing patient care in ACSs. Some non-hospital providers, as described below, may be temporarily certified as hospitals to build capacity during the PHE. State and local governments could partner with organizations that use these flexibilities to furnish and bill for hospital care in a state or local government-developed ACS. To the extent that states partner with providers using these flexibilities, states should ensure that they have examined their legal and regulatory regimes and have made any changes necessary to allow for providers managing ACSs to furnish the full breadth of services intended by the state.

Partner that Assumes Operating Responsibility From State, Local, Territorial or Tribal Government	Prerequisites to furnishing care at off-campus state/locality-developed ACS	Covered Health Care Services Medicare Will Pay For at ACS	Professional Services Also Billed?
Acute Care Hospital	<ul style="list-style-type: none"> • 1135 Waivers • Develop remote “provider-based”¹⁹ location of the hospital at the ACS 	<ul style="list-style-type: none"> • Inpatient hospital care • Outpatient hospital care • Specific payments would depend on hospital type²⁰ and arrangement 	<ul style="list-style-type: none"> • Professional services can be furnished and billed for separately. • Professionals should use place of service codes “19” or “21” depending on whether the ACS is considered an outpatient or inpatient facility.
Long-Term Care Hospital	<ul style="list-style-type: none"> • 1135 Waivers • Develop remote location of the hospital at the ACS 	<ul style="list-style-type: none"> • Inpatient hospital care • Payments made through the LTCH Prospective Payment System 	<ul style="list-style-type: none"> • Professional services can be furnished and billed for separately using place of service code “21”.
Inpatient Rehabilitation Facility	<ul style="list-style-type: none"> • 1135 Waivers • Develop remote location of the hospital at the ACS 	<ul style="list-style-type: none"> • Inpatient hospital care • Payments made through the IRF Prospective Payment System 	<ul style="list-style-type: none"> • Professional services can be furnished and billed for separately using place of service code “21”.
Ambulatory Surgical Center to Hospital Conversion	<ul style="list-style-type: none"> • 1135 Waivers • Temporarily enroll in Medicare as a hospital at own location • Develop remote “provider-based” location of the converted hospital at the ACS 	<ul style="list-style-type: none"> • Inpatient hospital care • Outpatient hospital care • Payments would be made under the Inpatient Prospective Payment System and the Outpatient Prospective Payment System 	<ul style="list-style-type: none"> • Professional services can be furnished and billed for separately. • Professionals should use place of service codes “19” or “21” depending on whether the ACS is considered an outpatient or inpatient facility.
Licensed Independent Freestanding Emergency	<ul style="list-style-type: none"> • 1135 Waivers 	<ul style="list-style-type: none"> • Inpatient hospital care • Outpatient hospital care 	<ul style="list-style-type: none"> • Professional services can be furnished and billed for separately.

¹⁸ March 30, 2020 Emergency Interim Final Rule with Comment: <https://www.cms.gov/files/document/covid-final-ifc.pdf> / April 30, 2020 Emergency Interim Final Rule with Comment: <https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>

¹⁹ The terms “provider-based entity” and “remote location of the hospital” are defined at 42 CFR § 413.65.

²⁰ Acute care hospitals may be paid under the Inpatient Prospective Payment System. Hospitals may also be exempt from the prospective payment systems and rather paid on a cost-basis, such as Critical Access Hospitals, PPS-Exempt Cancer Hospitals, and Children’s Hospitals.

Departments to Hospital Conversion	<ul style="list-style-type: none"> Temporarily enroll in Medicare as a hospital at own location Develop remote “provider-based” location of the converted hospital at the ACS 	<ul style="list-style-type: none"> Payments would be made under the Inpatient Prospective Payment System and the Outpatient Prospective Payment System 	<ul style="list-style-type: none"> Professionals should use place of service codes “19” or “21” depending on whether the ACS is considered an outpatient or inpatient facility.
Physicians and Medical Groups	<ul style="list-style-type: none"> Waivers not necessary ACS cannot be considered a hospital inpatient or outpatient location and no facility claim can be submitted to Medicare 	<ul style="list-style-type: none"> Professional services furnished in “non-facility” location Professionals should use place of service codes “11” to identify practice location Services paid under the Medicare Physician Fee schedule 	N/A

Additional Detail Regarding Each Option

Acute Care Hospital – New Provider-based Department: CMS waived several Medicare Conditions of Participation at 42 CFR Part 482 and provider-based rules at 42 CFR § 413.65 for the duration of the COVID-19 PHE. These waivers give hospitals flexibilities to respond to the COVID-19 PHE and to furnish care in ACSs, including retrofitted locations (e.g., tents, gymnasiums, and other temporary locations). This temporary expansion must not be inconsistent with the state’s emergency preparedness or pandemic plan. In the March 30, 2020 interim final rule with comment period, CMS established a temporary policy to allow hospitals to furnish routine inpatient care “under arrangements” with other providers (85 FR 19278-19280). Importantly, state and local governments that want to partner with an existing hospital could hand-off operations of the ACS to the hospital, where it would be provider-based location of the hospital. Hospitals would need to ensure they could continue to meet the Conditions of Participation that remain in effect during the PHE, continue to exercise sufficient control and responsibility over the use of hospital resources in treating patients, and obtain any state licensing requirements or other approvals as necessary. During the PHE, if the hospital intends to bill Medicare for the services under the main hospital, no additional provider enrollment actions are required (for example, hospitals do not need to submit an updated CMS 855A enrollment form for the ACS).

Long-term Care Hospital (LTCHs) – New Remote Location: The same waivers and rule flexibilities provided to acute care hospitals (described directly above) also apply to LTCHs. In addition, CMS has implemented Section 3711(b) of the CARES Act (P.L. 116-136) which requires CMS to waive the LTCH 50% rule (requiring that at least 50% of patients meet LTCH criteria), as well as the site-neutral payment rate (lower rate applied when LTCH criteria not met) during the PHE.²¹ Importantly, state and local governments that want to partner with an existing hospital could hand-off operations of the ACS to the LTCH, which would in turn need to make the ACS a remote location of the LTCH. LTCHs would also need to ensure they could continue to meet the Conditions of Participation that remain in effect during the PHE, as well as obtain any state licensing requirements or other approvals as necessary. During the PHE, if the LTCH intends to bill Medicare for the services under the main hospital, no additional provider enrollment actions are required (for example, LTCHs do not need to submit an updated CMS 855A enrollment form for the ACS).

²¹ <https://www.cms.gov/files/document/MM11742.pdf>

Inpatient Rehabilitation Facility (IRF) – New Remote Location: The same waivers and rule flexibilities provided to acute care hospitals and LTCHs (described directly above) also apply to IRFs. In addition, CMS has implemented Section 3711(a) of the CARES Act (P.L. 116-136), which requires CMS to waive the requirement that IRF patients generally receive at least 15 hours of therapy per week. In the May 8, 2020 interim final rule (85 FR 27550), CMS further modified the IRF coverage and classification requirements for freestanding IRF hospitals to exclude patients admitted solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the PHE.

Importantly, state and local governments that want to partner with an existing hospital could hand-off operations of the ACS to the IRF, which would in turn need to make the ACS a remote location of the IRF. IRFs would also need to ensure they could continue to meet the Conditions of Participation that remain in effect during the PHE, as well as obtain any state licensing requirements or other approvals as necessary. During the PHE, if the IRF intends to bill Medicare for the services under the main hospital, no additional provider enrollment actions are required (for example, IRFs do not need to submit an updated CMS 855A enrollment form for the ACS).

Ambulatory Surgical Center to Hospital Conversion: To create capacity to treat additional patients during the PHE, CMS is allowing Medicare-certified Ambulatory Surgical Centers to temporarily enroll as a hospital. This temporary expansion must not be inconsistent with the state’s emergency preparedness or pandemic plan. CMS has developed a streamlined enrollment process for Ambulatory Surgical Centers that want to enroll as hospitals during the PHE. Specific information about this new streamlined enrollment process can be found here: <https://www.cms.gov/files/document/qso-20-24-asc.pdf>. Interested Ambulatory Surgical Centers can use the provider enrollment hotline to contact the Medicare Administrative Contractor serving their jurisdiction to enroll as a hospital pursuant to a streamlined enrollment and survey and certification process as long as no Immediate Jeopardy (IJ)-level deficiencies were found within the previous three years for the Ambulatory Surgical Center, or if IJ-level deficiencies were found, they were subsequently removed through the normal survey process, and the relevant location meets the Conditions of Participation and other requirements for hospitals not waived by CMS.²² Ambulatory Surgical Centers that temporarily enroll as hospitals would then bill only under the applicable hospital payment systems. The Ambulatory Surgical Center would be required to function as an acute care hospital, not solely as a hospital outpatient surgical department. Importantly, state and local governments that want to partner with an existing Ambulatory Surgical Center-converted-hospital could hand-off operations of the ACS to the new hospital, where such local government ACS would be a remote “provider-based” location of the hospital for inpatient or outpatient services.

We remind states that while we recognize services provided by the Ambulatory Surgical Center-converted-hospital as full hospital services for purposes of Medicare payment, state licensure or other regulations may prevent these facilities from performing certain services within their capabilities. We encourage states to ensure that their regulations have been appropriately adjusted to allow these facilities to furnish the full range of services for which they are appropriately resourced for the duration of the public health emergency.

Licensed Independent Freestanding Emergency Department to Hospital Conversion: Due to their existing infrastructure, independent freestanding emergency departments (ED), which have no hospital affiliation and are specifically licensed by the state to operate independently to provide emergency services, have been identified as a resource to assist in expanding capacity for inpatient and outpatient hospital services

²² <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid19.pdf>

for patients requiring a higher level of care. Currently, only four states license independent freestanding EDs to operate without hospital affiliation: Colorado, Delaware, Rhode Island, and Texas.

Working in coordination with their State and State's pandemic plan, licensed independent freestanding EDs may begin participating in Medicare and Medicaid to help address the need to increase hospital capacity to provide additional care to patients during the PHE in the following ways:

- As hospital-affiliated EDs under the 1135 emergency waiver;
- As Medicaid-certified clinics under the state's clinic benefit; and
- As a Medicare-certified hospital by temporarily enrolling in Medicare as a hospital through the attestation process developed under the 1135 emergency waiver.
- As a physician practice

CMS has developed a streamlined enrollment process for licensed independent freestanding EDs that want to enroll as hospitals during the PHE. Specific information about this new streamlined enrollment process can be found here: <https://www.cms.gov/files/document/qso-20-27-hospital.pdf>. Interested eligible EDs can use the provider enrollment hotline to contact the Medicare Administrative Contractor serving their jurisdiction to enroll as a hospital.

We remind states that, while we recognize services provided by the freestanding ED-converted-hospital as full hospital services for purposes of Medicare payment, state licensure or other regulations may prevent these facilities from performing certain services within their capabilities. We encourage states to ensure that their regulations have been appropriately adjusted to allow these facilities to furnish the full range of services for which they are appropriately resourced for the duration of the public health emergency.

Physicians and Medical Groups: Medicare pays physicians and non-physician practitioners for covered professional health care services furnished to Medicare beneficiaries. During the PHE, Medicare-enrolled physicians and non-physician practitioners can bill Medicare for covered professional services that are furnished to Medicare beneficiaries at ACSs, including gymnasiums, or other non-clinical locations. In the case when the ACS is considered part of a hospital, physicians and non-physician practitioners would use the applicable place of service code depending on whether the ACS is furnishing outpatient (place of service code "19") or inpatient care (place of service code "21"). However, when the ACS is not enrolled as part of a hospital or other facility, and no facility claim is being submitted to Medicare, physicians and non-physician practitioners should use place of service code "11" for a non-facility practice location. When a covered professional service is furnished in non-facility locations, Medicare payments are typically increased to account for the higher practice expense required to furnish the service. As a result, state and local governments with expansion sites that are not able to enroll as hospitals or other Medicare facility types could partner with Medicare-enrolled physicians or non-physician practitioners to be able to furnish and bill for ambulatory care at the ACS.

APPENDIX E: CMS Regional Office Contact List

Region	Regional Office Location	Contact	States served by the Region
Region 1	Boston	ROBOSORA@cms.hhs.gov	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Region 2	New York	RONYCORA@cms.hhs.gov	New Jersey, New York
Region 3	Philadelphia	ROPHIORA@cms.hhs.gov	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Region 4	Atlanta	ROATLORA@cms.hhs.gov	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Region 5	Chicago	ROCHIORA@cms.hhs.gov	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region 6	Dallas	RODALORA@cms.hhs.gov	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region 7	Kansas City	ROKCMORA@cms.hhs.gov	Iowa, Kansas, Missouri, Nebraska
Region 8	Denver	ROREAORA@cms.hhs.gov	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region 9	San Francisco	ROSFOORA@cms.hhs.gov	Arizona, California, Hawaii, Nevada, Pacific Territories
Region 10	Seattle	ROSEA_ORAZ@cms.hhs.gov	Alaska, Idaho, Oregon, Washington
Region 11	Puerto Rico	prfo@cms.hhs.gov	Puerto Rico, US Virgin Islands