What You Need to Know: Ending of the Federal Public Health Emergency

Because the COVID-19 federal Public Health Emergency (PHE) ended on May 11, 2023, some of the COVID-19 and telehealth flexibilities have or will expire. Further federal or state action would be required to reinstate them.

Disclaimer: This document is a resource and does not serve as billing advice or legal guidance. Consult your own legal counsel. Citations were captured 5/2/2023-5/4/2023.

Note: The following are Centers for Medicare & Medicaid Services (CMS) Waiver Updates pertaining to all health plans offered by Commonwealth Care Alliance, CCA Health California, CCA Health Michigan, and CCA Health Rhode Island.

1. **Off Site Patient Screening:** CMS had been waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Labor Act, or EMTALA). This allowed hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, while consistent with the state emergency preparedness or pandemic plan. **This waiver terminated at the end of the COVID-19 PHE.**[1]

2. **Hospital-Only Clinical Staff In-Person Services:** Hospital clinical staff must furnish certain services, such as infusions and wound care, in person, given the nature of the services. There is no separate professional claim for these services. During the PHE:
    - The beneficiary's home was considered a provider-based department of the hospital for purposes of receiving these outpatient services, and the beneficiary would be registered as a hospital outpatient.
    - These services required a health professional to furnish the service (e.g., drug administration).
    - These services required an order by a physician or qualified non-physician practitioner (NPP) and had to be supervised by a physician or other NPP appropriate for supervising the service, given their hospital admitting privileges, state licensing, and scope of practice consistent with the requirements in 42 CFR § 410.27.
    - The hospital could bill for these services as hospital outpatient services and be paid for them under the Outpatient Prospective Payment System (OPPS),

[1] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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rather than at the lower Physician Fee Schedule (PFS)-equivalent rate under the PFS, provided the Provider-Based Department (PBD) was an on campus or excepted off-campus PBD that relocated to the patient's home, applied, and was approved for an extraordinary circumstances relocation exception.

These flexibilities were terminated at the end of the PHE.[2]

3. **Verbal Orders:** CMS had been waiving the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to allow for additional flexibilities related to verbal orders where readback verification was still required but authentication could occur later than 48 hours. This allowed for more efficient treatment of patients in a surge situation. ***CMS ended this waiver at the conclusion of the PHE.***[3]

4. **Paperwork Requirements:** CMS had been waiving certain specific paperwork requirements only for hospitals that were considered to be impacted by a widespread outbreak of COVID-19. This allowed hospitals to establish COVID-19 specific areas. ***This waiver terminated at the end of the PHE.*** Hospitals that are located in a state that had widespread confirmed cases were not required to meet the following requirements:

    a. 42 CFR §482.13(d)(2) with respect to timeframes in providing a copy of a medical record.
    b. 42 CFR §482.13(h) related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes.
    c. 42 CFR §482.13(e)(1)(ii) regarding seclusion.[4]

5. **Patient Rights:** CMS is waiving requirements under 42 CFR §482.13 ***only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19***. Hospitals that are located in a state that has widespread confirmed cases (i.e., 51 or more confirmed cases*), as updated on the CDC website at CDC States Reporting Cases of COVID-19, would not be required to meet the following requirements:
    - 42 CFR §482.13(d)(2) — With respect to timeframes in providing a copy of a medical record.

[2] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf
[3] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf
[4] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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- 42 CFR §482.13(h) — Related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes.
- 42 CFR §482.13(e)(1)(ii) — Regarding seclusion.

6. ***The waiver flexibility is based on the number of confirmed cases as reported by the CDC and will be assessed accordingly when COVID-19 confirmed cases decrease.***[5]

   Sterile Compounding: CMS had been waiving hospital sterile compounding requirements (also outlined in USP797) at 42CFR § 482.25(b)(1) and § 485.635(a)(3) to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. This conserves scarce face mask supplies. CMS has not been reviewing the use and storage of facemasks under these requirements. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[6]

7. **Limit Discharge Planning for Hospital and CAHs**: To allow hospitals and CAHs more time to focus on increasing care demands, discharge planning has focused on ensuring that patients are discharged to an appropriate setting with the necessary medical information and goals of care. CMS had been waiving detailed regulatory requirements to provide information regarding discharge planning, as outlined in 42 CFR §482.43(a)(8), §482.61(e), and 485.642(a)(8). The hospital, psychiatric hospital, and CAH was still required to assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) data on quality measures and data on resource use measures. The hospital was required to ensure that the post-acute care data on quality measures and data on resource use measures were relevant and applicable to the patient's goals of care and treatment preferences. During this public health emergency, a hospital may not have been able to assist patients in using quality measures and data to select a nursing home or home health agency but still had to work with families to ensure that the patient discharge is to a post-acute care provider that is able to meet the patient's care needs. ***CMS ended this waiver at the conclusion of the PHE.***[7]

8. **Modify Discharge Planning for Hospitals:** Patients must continue to be discharged to an appropriate setting with the necessary medical information and

[5] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf
[6] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf
[7] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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goals of care. To address the COVID-19 pandemic, CMS had been waiving certain requirements related to hospital discharge planning for post-acute care services at 42 CFR §482.43(c), so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS had been waiving certain requirements for those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services or transferred to an IRF or LTCH for specialized hospital services. For example, a patient may not be able to receive a comprehensive list of nursing homes in the geographic area but must still be discharged to a nursing home that is available to provide the care that is needed by the patient. ***CMS ended this waiver at the conclusion of the PHE.***[8]

9. **Medical Staff Requirements:** CMS had been waiving the Medical Staff requirements at 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges would have expired to continue practicing at the hospital, and for new physicians to be able to practice in the hospital, before full medical staff/governing body review and approval, to address workforce concerns related to COVID-19. ***This waiver ended at the conclusion of the COVID-19 PHE.***[9]

10. **Medical Records:** CMS had been waiving 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements. CMS had been waiving these requirements under 42 CFR §482.24(c)(4)(viii) and §485.638(a)(4)(iii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge, and for CAHs that all medical records must be promptly completed. This flexibility allowed clinicians to focus on the patient care at the bedside during the pandemic. ***CMS ended this waiver at the conclusion of the PHE.***[10]

11. **Flexibility in Patient Self Determination Act Requirements (Advance Directives)**: CMS had been waiving the requirements at section 1902(a)(58) and 1902(w)(1)(A) for Medicaid, 1852(i) for Medicare Advantage, and 1866(f) and 42 CFR 489.102 for Medicare, which require hospitals and critical access hospitals (CAHs) to provide information about their advance directive policies to patients. CMS waived this requirement to allow for staff to more efficiently deliver care to a

[8] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf
[9] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf
[10] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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larger number of patients. ***This waiver terminated at the end of the COVID19 PHE.***[11]

12. **Physical Environment:** CMS had been waiving certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and CAHs as a result of COVID-19. CMS had been permitting facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. This allowed for increased capacity and promotes appropriate cohorting of COVID-19 patients. States remained subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation. ***This waiver terminated at the end of the COVID-19 PHE.***[12]

13. **Anesthesia Services**: CMS had been waiving the requirements, at 42 CFR 482.52(a)(5),42 CFR 485.639(c)(2) and 42 CFR 416.42 (b)(2), that a certified registered nurse anesthetist (CRNA) be under the supervision of a physician. CRNA supervision has been at the discretion of the hospital or ambulatory surgical center (ASC) and state law. This waiver applied to hospitals, CAHs, and ASCs. These waivers allowed CRNAs to function to the fullest extent of their licensure and had been implemented while remaining consistent with a state or pandemic/emergency plan. ***This expired at the end of the COVID-19 PHE.***[13]

14. **Utilization Review:** CMS had been waiving the requirements at 42 CFR §482.1(a)(3) and 42 CFR §482.30 that require hospitals participating in Medicare and Medicaid to have a utilization review plan that meets specified requirements. CMS had been waiving the entire Utilization Review (UR) Condition of Participation (CoP) at §482.30, which requires that a hospital must have a UR plan with a UR

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[11] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[12] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf
Please note that consistent with the integration mandate of Title II of the ADA and the Olmstead vs LC decision, states are obligated to offer/provide discharge planning and/or case management/transition services, as appropriate, to individuals who are removed from their Medicaid home- and community-based services under these authorities during the course of the public health emergency, as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services/case management and/or discharge planning would be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit.

[13] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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committee that provides for review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities were implemented while remaining consistent with a state or pandemic/emergency plan. Removing these administrative requirements allowed hospitals to focus more resources on providing direct patient care. ***CMS ended this waiver at the conclusion of the PHE.*** [14]

15. **Written Policies and Procedures for Appraisal of Emergencies at Off-Campus Hospital Departments:** CMS had been waiving 482.12(f)(3) related to Emergency services, with respect to the surge facility(ies) only, such that written policies and procedures for staff to use when evaluating emergencies were not required for surge facilities. This removed the burden on facilities to develop and establish additional policies and procedures at their surge facilities or surge sites related to the assessment, initial treatment, and referral of patients. These flexibilities were implemented while remaining consistent with a state's emergency preparedness or pandemic plan. ***CMS ended this waiver at the conclusion of the PHE.***[15]

16. **Emergency Preparedness Policies and Procedures:** CMS had been waiving 482.15(b) and 485.625(b), which require the hospital and CAH to develop and implement emergency preparedness policies and procedures, and 482.15(c)(1)-(5) and 485.625(c)(1)-(5), which require that the emergency preparedness communication plans for hospitals and CAHs contain specified elements with respect to the surge site. The requirement under the communication plan requires hospitals and CAHs to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This has not been an expectation for a temporary expansion site. These waivers removed the burden on facilities to establish these policies and procedures for their surge facilities or surge sites. ***CMS ended these waivers at the conclusion of the PHE.*** [16]

17. **Quality Assessment and Performance Improvement (QAPI) Program:** CMS had been waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation and setting of priorities for the program's performance improvement activities, and integrated QAPI programs (for hospitals that are a part of a hospital system). These flexibilities, which applied to both hospitals and CAHs, had been implemented while remaining consistent with a

[14] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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state's emergency preparedness or pandemic plan. While this waiver decreased burden associated with the development of a hospital or CAH Quality Assurance and Performance Improvement (QAPI) program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. This waiver applied to both hospitals and CAHs. ***CMS ended this waiver at the conclusion of the PHE.***[17]

18. **Nursing Services:** CMS had been waiving the provision at 42 CFR 482.23(b)(4), 42 CFR 482.23(b)(7), and 485.635(d)(4), which require the nursing staff to develop and keep current a nursing care plan for each patient, and the provision that requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present. These waivers allowed nurses increased time to meet the clinical care needs of each patient and allowed for the provision of nursing care to an increased number of patients. These flexibilities applied to both hospitals and CAHs and had been implemented while remaining consistent with a state or pandemic/emergency plan. ***CMS ended this waiver at the conclusion of the PHE.***[18]

19. **Food and Dietetic Service**: CMS had been waiving the requirement at 42 CFR 482.28(b)(3) to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals have not needed to be maintained at surge capacity sites. These flexibilities were implemented while remaining consistent with a state or pandemic/emergency plan. Removing these administrative requirements allowed hospitals to focus more resources on providing direct patient care. ***CMS ended this waiver at the conclusion of the PHE.*** [19]

20. **Critical Access Hospital Bed Count and Length of Stay**: CMS had been waiving the Medicare requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation regarding number of beds and length of stay at 42 CFR §485.620. ***This waiver terminated at the end of the COVID-19 PHE.***[20]

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[17] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[18] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[19] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[20] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

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21. **Respiratory Care Services**: CMS has been waiving the requirement at 42 CFR 482.57(b)(1) that hospitals designate, in writing, the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. This flexibility was implemented while remaining consistent with a state or pandemic/emergency plan. Not being required to designate these professionals in writing allowed qualified professionals to operate to the fullest extent of their licensure and training in providing patient care for respiratory illnesses. ***This expired at the end of the COVID-19 PHE.***[21]

22. **Expanded Ability for Hospitals to Offer Long-term Care Services** (Swing Beds) for Patients Who do not Require Acute Care but do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth at 42 CFR 409.31: Under section 1135(b)(1) of the Act, CMS had been waiving the requirements at 42 CFR 482.58, "Special Requirements for hospital providers of long-term care services (swing beds)" subsections (a)(1)-(4) "Eligibility" to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care, but were unable to find placement in a SNF. In order to qualify for this waiver, hospitals had to have:
    - Not used SNF swing beds for acute level care.
    - Complied with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
    - Been consistent with the state's emergency preparedness or pandemic plan.

    Hospitals had to call the CMS Medicare Administrative Contractor (MAC) enrollment hotline to add swing-bed services. The hospital had to attest to CMS that:
    - They made a good faith effort to exhaust all other options.
    - There are no SNFs within the hospital's catchment area that under normal circumstances would have accepted SNF transfers but were currently not willing to accept or able to take patients because of the COVID-19 PHE.
    - They met all waiver eligibility requirements.
    - They had a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever was earlier.

    This waiver applied to all Medicare-enrolled hospitals (except psychiatric and long-term care hospitals that need to provide post-hospital SNF level swing-bed services for nonacute care patients in hospitals) consistent with the state's emergency preparedness or pandemic plan. The hospital could not bill for SNF PPS payment

[21] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver was permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital had to have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever was earlier. ***This waiver terminated at the end of the COVID-19 PHE.***[22]

23. **CAH Personnel Qualifications:** CMS had been waiving the minimum personnel qualifications for clinical nurse specialist, nurse practitioners, and physician assistants described at 42 CFR 485.604(a)(2), 42 CFR 485.604(b)(1)-(3), and 42 CFR 485.604(c)(1)- (3). Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants still had to meet state requirements for licensure and scope of practice but not additional federal requirements that may exceed state requirements. This gave states and facilities more flexibility in using clinicians in these roles to meet increased demand. These flexibilities were implemented while remaining consistent with a state or pandemic/emergency plan. ***This expired at the end of the COVID-19 PHE.***[23]

24. **CAH Staff Licensure:** CMS had been deferring to staff licensure, certification, or registration to state law by waiving the requirement at 42 CFR 485.608(d) that staff of the CAH be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations. The CAH and its staff still had to be in compliance with applicable federal, state and local laws and regulations, and all patient care had to be furnished in compliance with state and local laws and regulations. This waiver deferred all licensure, certification, and registration requirements for CAH staff to the state, which added flexibility where federal requirements are more stringent. This flexibility was implemented while consistent with a state or pandemic/emergency plan. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[24]

25. **Responsibilities of Physicians in CAHs:** 42 CFR § 485.631(b)(2). CMS had been waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § (b)(2) that a physician be

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[23] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[24] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding sub-regulatory guidance that further describes communication between CAHs and physicians and assures an appropriate level of physician direction and supervision for the services provided by the CAH. This allowed the physician to perform responsibilities remotely, as appropriate. This also allowed CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed. ***CMS ended this waiver at the conclusion of the PHE.***[25]

26. **CAH Status and Location**: CMS had been waiving the requirement at 485.610(b) that the CAH be located in a rural area, or an area being treated as rural, allowing the CAHs flexibility in the establishment of surge site locations. Waiving the requirement at 485.610(e) regarding off-campus and co-location requirements allowed the CAH flexibility in establishing off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers removed restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities were implemented consistent with state or emergency or pandemic plans. ***This expired at the end of the COVID-19 PHE.***[26]

27. **Postponement of Application Deadline to the Medicare Geographic Classification Review**: Per requirements at section 1886(d)(10)(C)(ii) of the Social Security Act (the Act) and 42 CFR 412.256(a)(2), September 1, 2020, was the deadline to submit an application to the Medicare Geographic Classification Review Board (MGCRB) for FY 2022 reclassifications. These provisions required applications to be filed through OH CDMS (https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/MGCRB/Electronic-Filing) not later than the first day of the 13-month period preceding the federal fiscal year for which reclassification is requested. Due to the COVID-19 PHE, under the authority of section 1135(b)(5) of the Act, CMS postponed the September 1 deadline until 15 days after the public display date of the FY 2021 IPPS/LTCH final rule by the Office of the Federal Register. ***CMS did not modify the respective September 1 deadline for submission of applications for FY 2023 or FY 2024 reclassifications to the MGCRB due to the COVID-19 PHE.*** [27]

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[25] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

[26] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

[27] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf
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28. **Care for Patients in Extended Neoplastic Disease Care Hospitals:** For the duration of the PHE, CMS issued a program participation requirement waiver to extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allowed these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital related costs under the reasonable cost-based reimbursement rules. ***At the end of the COVID-19 PHE, Extended Neoplastic Disease Care Hospitals were required to comply with the 20-day average length of stay requirement at § 412.23(i)(1).***[28]

29. **Long-Term Care Hospitals - Site Neutral Payment Rate Provisions:** As required by section 3711(b) of the CARES Act, during the PHE due to COVID-19, certain provisions of section 1886(m)(6) of the Social Security Act were waived relating to certain site neutral payment rate provisions for long-term care hospitals (LTCHs).
    - Section 3711(b)(1) of the CARES Act waived the payment adjustment under section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a discharge payment percentage (DPP) for the period that is at least 50% during the COVID-19 PHE period. For the purposes of calculating an LTCH's DPP, all admissions during the COVID-19 PHE period were counted in the numerator of the calculation. In other words, LTCH cases that were admitted during the COVID-19 PHE period were counted as discharges paid the LTCH PPS standard Federal payment rate. At the end of the COVID-19 PHE, the payment adjustment under section 1886(m)(6)(C)(ii) of the Act is applied for LTCHs that do not have a DPP for the period that is at least 50%.
    - Section 3711(b)(2) of the CARES Act provided a waiver of the application of the site neutral payment rate under section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that were in response to the PHE and occurred during the COVID-19 PHE period. Under this provision, all LTCH cases admitted during the COVID-19 PHE period (that is, admissions occurring on or after January 27, 2020, through May 11, 2023) were paid the relatively higher LTCH PPS standard Federal rate.

[28] https://www.cms.gov/files/document/long-term-care-hospital-extended-neoplastic-disease-care-hospitals-cms-flecibilities-fight-covid-19.pdf

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When the COVID-19 PHE ended, all LTCH admissions, except those that met the requirements for exclusion from the site-neutral rate, became subject to the site-neutral payment rate under section 1886(m)(6)(A)(i) of the Act. [29]

30. Conditions of Participation (CoP) for COVID-19 Vaccinations. Under the authority afforded by Section 1135 of the Social Security Act, for the duration of the PHE, CMS modified the following regulation to allow additional practitioner types to administer the COVID-19 vaccine:

> **§ 482.23 Condition of participation:**
> Nursing services. (c) Standard: Preparation and administration of drugs. (3) With the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with state law and hospital policy, and who is responsible for the care of the patient. To allow for hospital and community administration of COVID-19 vaccines, the following highlighted language is being incorporated into this regulation for the duration of the PHE:
>
> **§ 482.23 Condition of participation:**
> Nursing services**.** (c) Standard: Preparation and administration of drugs. (3) With the exception of influenza, pneumococcal, and COVID-19 vaccines (either currently approved by the FDA or authorized under an FDA Emergency Use Authorization), which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with state law and hospital policy, and who is responsible for the care of the patient.[30]

<u>Multiple/Other Provider Types</u>

31. Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs): During the PHE, for hospitals classified as MDHs prior to the beginning of the emergency period, and hospitals that became newly classified as MDHs during the PHE without the application of this wavier, CMS had been waiving the eligibility requirement at 42 CFR § 412.108(a)(1)(ii) that the hospital has 100 or fewer beds during the cost reporting period, and the eligibility requirement at 42 CFR §

[29] https://www.cms.gov/files/document/long-term-care-hospital-extended-neoplastic-disease-care-hospitals-cms-flecibilities-fight-covid-19.pdf

[30] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

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412.108(a)(1)(iv)(C) that at least 60% of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods. CMS had been waiving these requirements for the duration of the PHE to allow these hospitals to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients. ***When the COVID-19 PHE ended, MACs resumed their standard practice for evaluation of all eligibility requirements.*** [31]

32. **Hospitals Classified as Sole Community Hospitals (SCHs)**: During the PHE, CMS waived certain eligibility requirements at 42 CFR § 412.92(a) for hospitals classified as SCHs prior to the beginning of the emergency period. Specifically, during the PHE, CMS waived the requirements at paragraphs (a), (a)(1), (a)(2), and (a)(3) of 42 CFR § 412.92, and also waiving the "market share" and bed requirements (as applicable) at 42 CFR § 412.92(a)(1)(i) and (ii). CMS has been waiving these requirements for the duration of the PHE to allow these hospitals to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients. ***When the COVID-19 PHE ended, MACs resumed their standard practice for evaluation of all eligibility requirements.***[32]

33. **CMS Hospitals Without Walls (Temporary Expansion Sites)**

- **Hospitals Able to Provide Care in Temporary Expansion Sites:** As part of the CMS Hospital Without Walls initiative during the PHE, hospitals could provide hospital services in other hospitals and sites that otherwise would not have been considered part of a healthcare facility or could set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. During the PHE, CMS provided additional flexibilities for hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations, such as hotels or community facilities. During the PHE, hospitals were expected to control and oversee the services provided at an alternative location. ***When the PHE ended, hospitals and CAHs were required to provide services to patients within their hospital departments, pursuant to Hospital and CAH conditions of participation at 42 CFR part 482 and part 485, Subpart F, respectively.***

[31] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

[32] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

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- **Relaxing Conditions of Participation:** CMS permitted ambulatory surgical centers (ASCs) to temporarily enroll as hospitals and to provide hospital services to help address the urgent need to increase hospital capacity to take care of patients. Other interested entities, such as independent, freestanding, emergency departments (IFEDs), could pursue temporarily enrolling as an ASC during the PHE. As of December 1, 2021, no new ASC or new IFED requests to temporarily enroll as hospitals were being accepted. See https://www.cms.gov/files/document/provider-enrollment-relief-faqscovid-19.pdf for additional information. When the PHE ended, ASCs must decide either to meet the certification standards for hospitals at 42 CFR part 482, or to return to ASC status. If they chose to return to ASC status, they could only be paid under the ASC payment system for services on the ASC Covered Procedures List. ***When the PHE ended, IFEDs could not bill Medicare for services as their temporary Medicare certification would end.*** [33]

34. CMS made several changes to support hospitals so they can more effectively respond to the COVID-19 PHE. During the PHE, these changes included:

- Adopting a temporary extraordinary circumstances relocation exception policy for on-campus PBDs and excepted off-campus PBDs that are relocating off campus during the COVID-19 PHE. Under CMS' prior extraordinary relocation exception policy, only relocating off-campus PBDs were eligible to request this exception.

- Streamlining the process during the COVID-19 PHE for relocating PBDs to seek the extraordinary circumstances exception so they can start seeing patients and billing for services immediately in the relocated PBD.

- Allowing PBDs to relocate into more than one PBD location and allowing PBDs to partially relocate while still maintaining the original location. Hospitals can relocate PBDs to the patient's home and continue to receive the full OPPS payment amount under the extraordinary circumstances relocation exception policy.

- The temporary extraordinary circumstances relocation policy established in the May 8, 2020 Interim Final Rule with Comment (IFC) (85 FR 27567 through 27568) will end following the end of the COVID-19 PHE. PBDs that hospitals chose to permanently relocate off-campus would be considered

[33] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

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new off-campus PBDs billing after November 2, 2015, and, therefore, would be required to bill using the "PN" modifier for hospital outpatient services furnished from that PBD location and would be paid the PFS-equivalent rate once the COVID-19 PHE ends.

- Following the COVID-19 PHE, hospitals may seek an extraordinary circumstances relocation exception for excepted off-campus locations that have permanently relocated, but these hospitals would need to follow the standard extraordinary circumstances application process we adopted in CY 2017 and file an updated CMS-855A enrollment form to reflect the new address(es) of the PBD(s).

    - CMS' standard relocation exception policy only applies to excepted off-campus PBDs that relocate; on-campus PBDs that wish to permanently relocate off-campus are not able to receive an extraordinary circumstances relocation exception under the standard extraordinary circumstances relocation request process now that the COVID-19 PHE has ended.

    - Hospitals should not rely on having relocated the off-campus PBD during the COVID-19 PHE as the reason the off campus PBD should be permanently excepted following the end of the COVID-19 PHE. In other words, the fact that the off-campus PBD relocated in response to the pandemic will not, by itself, be considered an "extraordinary circumstance" for purposes of a permanent relocation exception, although CMS Regional Offices will continue to have discretion to approve or deny relocation requests for hospitals that apply after the COVID-19 PHE, depending on whether the relocation request meets the requirements for the extraordinary circumstances' exception.

    - Following the COVID-19 PHE, if temporarily relocated off-campus PBDs do not go back to their original location, they will be considered to be non-excepted PBDs and paid the PFS-equivalent rate.

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Provider-Based Department (PBD) Type	Non-PHE Payment Policy Before Relocation	Non-PHE Payment Policy if PBD Relocates Off-Campus (Absent Extraordinary Circumstance Relocation Approval)	Payment Policy During PHE Following Off-Campus Relocation
On-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	OPPS** (if extraordinary circumstance relocation request is approved)
Excepted* Off-Campus PBD	OPPS**	PFS-equivalent (treated as new location)	OPPS** (if extraordinary circumstance relocation request is approved)
Non-Excepted Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent
New (since pandemic) Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent

*PBD department relocations must receive extraordinary circumstances relocation approval and the relocation must not be inconsistent with state emergency preparedness or pandemic plan. Because the COVID-19 PHE has ended, these relocated PBD are expected to shut down or return to their original location; otherwise, they will be paid the PFS-equivalent rate unless, at the discretion of the CMS Regional Office, they are granted a permanent extraordinary circumstances relocation exception under our normal policy.

**While all other services provided at an excepted off-campus provider-based department would be paid at the OPPS rate, the clinic visit service is paid at the PFS-equivalent rate when performed at an off-campus provider-based department, regardless of whether that department is excepted.[34]

35. **Supervision Requirements for Non-Surgical Extended Duration Therapeutic Services:** During the PHE, direct supervision had not been required at the initiation of non-surgical extended duration therapeutic services provided in hospital

[34] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

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outpatient departments and critical access hospitals. Instead, a general level of supervision could be provided for the entire duration of these services, so the supervising physician or practitioner has not been required to be immediately available. ***In the CY 2021 OPPS/ASC final rule, CMS made this provision permanent, so this policy remains in effect (85 FR 85866***).[35]

36. **Medicare Nonphysician Practitioners:** CMS created the flexibility at 42 CFR § 410.32(b), on an interim basis during the PHE, to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and physician assistants (PAs) to supervise diagnostic tests as authorized under state law and licensure. These practitioners continue the required statutory relationships with supervising or collaborating physicians. ***In the CY 2021 PFS final rule, CMS made these flexibilities permanent and added certified registered nurse anesthetists (CRNAs) to the above list of nonphysician practitioners allowed to supervise diagnostic tests as authorized under state law and licensure (85 FR 84590-84592)***.[36]

37. **Physical Therapists and Occupational Therapists:** The treating physical or occupational therapist who develops, or is responsible for, the maintenance program or plan has been able to delegate the performance of the related maintenance therapy services to a therapy assistant when clinically appropriate. This has freed up the therapist to furnish other needed services during the PHE requiring their evaluative and assessment skills. ***This flexibility has been made permanent via CY 2021 rulemaking, allowing physical and occupational therapists to delegate maintenance therapy services to their therapy assistants as clinically appropriate in the same manner that rehabilitation services are delegated.***[37]

38. **Pharmacists:** CMS has been allowing pharmacists, as well as other health care professionals who are authorized to order lab tests under the state scope of practice and other relevant laws, to order COVID-19 tests for Medicare beneficiaries during the PHE. This does not mean that these pharmacists and other health care professionals have been able to enroll in the Medicare program to furnish and bill for services they furnish to beneficiaries; rather, it has allowed Medicare to pay for tests that they order. ***This expired at the end of the COVID-19 PHE.***[38]

39. **Teaching Physicians:** During the PHE, services furnished by a resident in a teaching setting could be billed by a teaching physician who was present during the key portion of the service. If the training setting was located outside of a metropolitan

[35] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
[36] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
[37] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
[38] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

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statistical area (MSA), the teaching physician could have a virtual presence through audio/video real-time technology. During the PHE, this virtual presence of the teaching physician is allowed for all teaching settings. Under the so-called primary care exception at 42 CFR 415.174, a teaching physician may bill for certain services when they direct and review the care furnished by up to four residents at a time. For all teaching settings during the PHE, teaching physicians may direct care and review services each resident provides during or at once after each visit virtually. ***Now that the PHE has ended, teaching physicians only in residency training sites located outside of a MSA may direct, manage, and review care furnished by residents through audio/video real-time communications technology.*** *Note: This policy does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services. This allowed teaching hospitals to maximize their workforce to safely take care of patients.*[39]

40. **National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs):** To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during the PHE, the Chief Medical Officer or equivalent of a hospital or facility had the authority to make those staffing decisions. ***This waiver ended upon the conclusion of the PHE.***[40]

41. **Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital:** During the PHE, CMS waived requirements to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital would continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for such patients and annotate the medical record to indicate the patient was a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the COVID-19 PHE. This waiver was utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this included assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for. ***As of the end of the PHE, inpatients receiving psychiatric services paid under the IPF PPS and furnished by the excluded distinct part psychiatric unit of an acute care hospital cannot be housed in an acute care bed and unit.***[41]

[39] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

[40] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

[41] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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42. **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital:** During the PHE, CMS waived requirements to allow acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital would continue to bill for inpatient rehabilitation services under the Inpatient Rehabilitation Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver could be utilized where the hospital's acute care beds were appropriate for providing care to rehabilitation patients and such patients continues to receive intensive rehabilitation services. ***As of the end of the PHE, inpatients receiving rehabilitation services paid under the IRF PPS and furnished by the excluded distinct part rehabilitation unit of an acute care hospital cannot be housed in an acute care bed and unit.***[42]

43. **Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs)**: CMS determined it was appropriate to issue a blanket waiver to long-term care hospitals (LTCHs) where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement at § 412.23(e)(2), which allowed these hospitals to participate in the LTCH PPS. In addition, during the applicable waiver time period, CMS determined it was appropriate to issue a blanket waiver to hospitals not yet classified as LTCHs, but seeking classification as an LTCH, to exclude patient stays where the hospital admitted or discharged patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which must be met in order for these hospitals to be eligible to participate in the LTCH PPS. Hospitals should have added the "DR" condition code to applicable claims.[43]

44. **Specific Life Safety Code (LSC) for Hospice and CAHs:** CMS had been waiving and modifying particular waivers under 42 CFR §418.110(d) for inpatient hospice. Specifically, CMS is modified these requirements as follows:

    - Alcohol-based Hand-Rub (ABHR) Dispensers: CMS waived 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

[42] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[43] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

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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 ended this waiver at the conclusion of the PHE.***

- Fire Drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, CMS permitted a documented orientation training program related to the current fire plan, which considers current facility conditions. The training had to instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures, and the fire protection devices in their assigned area. ***This waiver terminated on June 6, 2022.***[44]

45. Physical Environment: CMS waived certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and critical access hospitals (CAH) as a result of COVID-19. CMS permitted facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location was approved by the state (ensuring that safety and comfort for patients and staff were sufficiently addressed) and was consistent with the state's emergency preparedness or pandemic plan. This allowed for increased capacity and promoted appropriate cohorting of COVID-19 patients. States were 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. ***This waiver terminated at the end of the COVID-19 PHE.***[45]

46. Practitioner Locations: During the PHE, CMS waived the Medicare requirement that a physician or non-physician practitioner must be licensed in the state in which they are practicing if the physician or practitioner 1) is enrolled as such in the Medicare program, 2) has a valid license to practice in the state reflected in their Medicare enrollment, 3) is furnishing services — whether in person or via telehealth — in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the state or any other state that is part of the section 1135 emergency area. A physician or non-physician practitioner could seek an 1135-based licensure waiver from CMS by contacting the provider enrollment hotline for the Medicare Administrative Contractor that serviced their geographic area. This waiver did not have the effect of waiving state or local licensure requirements, or any requirement

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

[45] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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specified by the state or a local government as a condition for waiving its licensure requirements. ***CMS originally implemented the waiver out of an abundance of caution; however, it turned out that regulations that existed before the PHE allowed for a deferral to state law.***[46]

47. **Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens):** CMS modified the 60-day limit in section 1842(b)(6)(D)(iii) of the Social Security Act to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an additional period of no more than 60 continuous days after the public health emergency expires. ***On the 61st day after the PHE ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock.*** *The modified timetable applies to both types of substitute billing arrangements under Medicare fee-for-service (i.e., reciprocal billing arrangements and fee-for-time compensation arrangements, formerly known as locum tenens).*

    - **Note:** Under the Medicare statute, only 1) physicians and 2) physical therapists who furnish outpatient physical therapy services in a health professional shortage area (HPSA), a medically underserved area (MUA), or a rural area can receive Medicare fee-for-service payment for services furnished by a substitute under a substitute billing arrangement. In addition, Medicare can pay for services under a substitute billing arrangement only when the regular physician or physical therapist is unavailable to provide the services. Finally, as provided by law, a regular physician or physical therapist who has been called or ordered to active duty as a member of a reserve component of the U.S. armed forces may continue to use the same substitute for an unlimited time even after the emergency ends.[47]

48. **Counting of Resident Time at Alternate Locations**: Existing regulations have specific rules on when a hospital may count a resident for purposes of Medicare direct graduate medical education (DGME) payments or indirect medical education (IME) payments. Normally, if the resident is performing activities within the scope of his/her approved program in his/her own home, or a patient's home, the hospital may not count the resident. During the COVID-19 PHE, a hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in a patient's home but performing duties within the scope of the approved residency program and meeting appropriate physician supervision requirements, could claim

[46] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
[47] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

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that resident for IME and DGME purposes. This allowed medical residents to perform their duties in alternative locations, including their own home or a patient's home, as long as such activities meet appropriate physician supervision requirements. ***With the end of the COVID-19 PHE, a hospital may not count a resident for purposes of Medicare DGME payments or IME payments if the resident is performing activities within the scope of his/her approved program in his/her own home, or a patient's home.***[48]

49. **Graduate Medical Education (GME) Residents' Training in Other Hospitals:** During the COVID-19 PHE, a teaching hospital that sent residents to other hospitals was able to continue to claim those residents in the teaching hospital's IME and DGME FTE resident counts, if certain requirements were met. Those requirements included that 1) the teaching hospital sends the resident to the other hospital in response to the COVID-19 pandemic; 2) the time spent by the resident training at the other hospital is in lieu of time that would have been spent training at the sending hospital; and 3) the time that the resident spent training immediately prior to and/or subsequent to the time frame that the COVID-19 PHE was in effect was included in the FTE count for the sending hospital. Moreover, the presence of residents in non-teaching hospitals did not triggered establishment of IME and/or DGME FTE resident caps at those non-teaching hospitals. Specifically, for DGME, the presence of residents in non-teaching hospitals did not trigger establishment of PRAs at those non-teaching hospitals. ***With the end of the COVID-19 PHE, a teaching hospital that sends residents to other hospitals cannot claim those residents in its IME and DGME FTE resident counts.*** *Also, with the end of the COVID-19 PHE, the presence of residents in non-teaching hospitals triggers establishment of IME and/or DGME FTE resident caps at those non-teaching hospitals (and for DGME, it triggers establishment of PRAs at those non-teaching hospitals).*[49]

50. **IME Payments Held Harmless for Temporary Increase in Beds:** During the COVID-19 PHE, CMS held teaching hospitals harmless from a reduction in IME payments due to beds temporarily added during the COVID-19 PHE, by not considering such beds when determining IME payments. ***With the end of the COVID-19 PHE, any added beds will be considered in determining the hospital's IME payments.***[50]

[48] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[49] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[50] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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51. **Provider Enrollment:** During the PHE, CMS 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. ***The hotlines were shut down at the end of the PHE.***

    Additionally, CMS provided the following flexibilities for provider enrollment during the PHE:

    - Screening requirements: Site Visits: CMS waived provider enrollment site visits for moderate and high-risk providers/suppliers*. This waiver was terminated on July 6, 2020 and CMS, in accordance with 42 CFR §§ 424.517 and 424.518, resumed all provider enrollment site visits.*
    - Fingerprint-based criminal background checks: CMS waived the requirement for fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high-risk categories of providers and suppliers (e.g., newly enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs). *This waiver was terminated on October 31, 2021 and CMS, in accordance with 42 CFR § 424.518, resumed requesting fingerprints for all newly enrolling high-risk providers and suppliers.*
    - 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 was terminated on October 31, 2021 and CMS, in accordance with 42 CFR § 424.514, resumed collecting application fees.*
    - 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 was terminated on October 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.*
    - 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. ***CMS resumed normal application processing times when the PHE ended.***
      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 (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. ***When the PHE ended, this waiver terminated, and***

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opted-out practitioners are not able to cancel their opt-out statuses earlier than the applicable regulation at 42 CFR § 405.445 allows for.

- Reporting Home Address: During the PHE, CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. ***This waiver will continue through December 31, 2023.***
- 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, even with the end of the PHE, CMS regulations 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.***
- Student Documentation: In the CY 2020 Physician Fee Schedule (PFS) final rule, CMS adopted simplified medical record documentation requirements for physicians and certain nonphysician practitioners to allow the billing clinician to review and verify, rather than re-document, information added to the medical record by any member of the health care team. During the PHE, this principle applied across the spectrum of all Medicare-covered services and also applied to therapists so that they may review and verify, rather than redocument, notes added to the medical record by any other member of the health care team, including therapy or other students. ***These simplified medical record documentation requirement policies were finalized and will continue to be in effect.***[51]

52. Price Transparency for COVID-19 Testing: In an Interim Final Rule with Comment Period (IFC) issued October 28, 2020, CMS implemented the CARES Act requirement that providers of a diagnostic test for COVID-19 to make public the cash price for such tests on their websites. Providers without websites have been required to provide price information in writing within two business days upon request and on a sign posted prominently at the location where the provider performs the COVID-19 diagnostic test, if such location is accessible to the public. Noncompliance may result in civil monetary penalties up to $300 per day. After the PHE, in accordance with the CARES Act, this special price transparency requirement will terminate. ***Price transparency requirements under other laws and regulations will continue to apply.***[52]

53. "Stark Law" Waivers: The physician self-referral law (also known as the "Stark Law") 1) prohibits a physician from making referrals for certain designated health

[51] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
[52] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

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services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless the requirements of an applicable exception are satisfied; and 2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for any improperly referred designated health services. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law. These blanket waivers applied to financial relationships and referrals that are related to the COVID-19 emergency. The remuneration and referrals described in the blanket waivers must be solely related to COVID-19 purposes, as defined in the blanket waiver document. During the PHE, CMS permitted certain referrals and the submission of related claims that would otherwise violate the Stark Law, if all requirements of the waivers were met. ***These waivers terminated with the end of the PHE. Physicians and entities must immediately comply with all provisions of the Stark Law.***

Flexibilities under the "Stark Law" waivers have included:

- Hospitals and other health care providers could pay above or below fair market value for the personal services of a physician (or an immediate family member of a physician), and parties could pay below fair market value to rent equipment or purchase items or services. For example, a physician practice could rent or sell needed equipment to a hospital at a price below what the practice could charge another party. Or a hospital could provide space on hospital grounds at no charge to a physician who is willing to treat patients who sought care at the hospital but were not appropriate for emergency department or inpatient care.
- Health care providers could support each other financially to ensure continuity of health care operations. For example, a physician owner of a hospital could make a personal loan to the hospital without charging interest at a fair market rate so that the hospital could make payroll or pay its vendors.
- Hospitals could provide benefits to their medical staff, such as multiple daily meals, laundry service to launder soiled personal clothing, or childcare services while the physicians were at the hospital and engaging in activities that benefited the hospital and its patients.
- Health care providers could offer certain items and services that were solely related to COVID-19 purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non-monetary compensation cap. For example, a home health agency could provide continuing medical education to physicians in the community on the latest care protocols for homebound patients with COVID-19, or a hospital could provide isolation shelter or meals to the family of a physician who was exposed to the novel coronavirus while working in the hospital's emergency department.

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- Physician-owned hospitals could temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law. For example, a physician-owned hospital could temporarily convert observation beds to inpatient beds to accommodate patient surge during the COVID-19 pandemic in the United States.
- Some of the restrictions regarding when a group practice could furnish medically necessary designated health services (DHS) in a patient's home were loosened. For example, any physician in the group could order medically necessary DHS that were furnished to a patient by one of the group's technicians or nurses in the patient's home contemporaneously with a physician service that was furnished via telehealth by the physician who ordered the DHS
- Group practices could furnish medically necessary MRIs, CT scans, or clinical laboratory services from locations like mobile vans in parking lots that the group practice rented on a part-time basis.[53]

54. **Housing Acute Care Patients in Excluded Distinct Part Units:** During the PHE, CMS waived requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatients. The Inpatient Prospective Payment System (IPPS) hospital bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency. ***As of the end of the PHE, acute care hospitals cannot bill for acute care inpatients housed in excluded distinct part units.***[54]

Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

55. **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 provided temporary emergency coverage of SNF services without a qualifying hospital stay. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorized 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-

[53] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf
[54] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

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inpatient status that is normally required in order to end the current benefit period and renew SNF benefits). This waiver applied 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 had 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 was the continued skilled care in the SNF rather than the emergency that was preventing the beneficiary from beginning the 60-day "wellness period." ***This waiver terminated at the end of the COVID-19 PHE.***[55]

56. **Waive Pre-Admission Screening and Annual Resident Review (PASRR):** CMS allowed states and nursing homes to suspend these assessments for new residents for 30 days. After 30 days, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should have received the assessment as soon as resources become available. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[56]

57. **Transfers of COVID-19 Patients:** During the PHE, a long term care (LTC) facility could temporarily transfer its COVID-19 positive resident(s) to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements." The transferring LTC facility did not need to issue a formal discharge in this situation, as it was still considered the provider and still billed Medicare normally for each day of care. The transferring LTC facility was then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period. This was consistent with CDC guidance and helped residents with COVID-19 by placing them into facilities that are prepared to care for them. It also helped residents without COVID-19 by placing them in facilities without other COVID-19 residents, thus helping to protect them from being infected.

    If the LTC facility did not intend to provide services under arrangement, the COVID-19 isolation and treatment facility was the responsible entity for Medicare billing purposes. The SNF followed the procedures described in 40.3.4 of the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c06.pdf) to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility then billed Medicare appropriately for the type of care it was providing for the beneficiary. If the COVID-19 isolation and treatment facility was not yet an enrolled provider, the facility enrolled through the provider enrollment hotline for the Medicare Administrative Contractor

[55] https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf
[56] https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf

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that services their geographic area to establish temporary Medicare billing privileges.[57]

58. **Resident Roommates and Grouping**: CMS waived the requirements in 42 CFR 483.10(e)(5), (6), (note that Section (6) was terminated on May 10, 2021 per QSO-21-17), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waived a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, and to provide for a resident's refusal a transfer to another room in the facility. This aligned with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents.[58]

59. **Established new requirements for Long Term Care Facilities to Conduct SARS-CoV-2 Testing for Staff and Residents:** Under 483.80(h) CMS required Long-Term Care (LTC) Facilities to test Staff and Residents. Specifically, facilities were required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the Secretary of HHS. This rule was intended to enhance efforts to keep COVID-19 from entering and spreading through nursing homes. These regulations were effective on September 2, 2020. Applicability date: ***These regulations were applicable for the duration of the PHE for COVID–19. Note that 42 CFR 488.447, which allows CMS to assess penalties for failure to comply with the requirements to report weekly to the CDC pursuant to §483.80(g)(1)-(2), is applicable one year beyond the expiration of the PHE for COVID–19.***[59]

Home Health Agencies (HHAs) and Hospice

60. **Initial Assessments.** CMS waived the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. This allowed patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long-term care facilities. This allowed for maximizing coverage by already scarce physician, and advanced practice clinicians, and allowed those clinicians to focus on caring for patients with the greatest acuity.[60]

[57] https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf
[58] https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf
[59] https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf
[60] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

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61. **Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients:** CMS has been waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary waiver allowed any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. Of note, ***as a part of the CY 2022 Home Health Prospective Payment System Final Rule (CMS 1747-F), CMS finalized changes to § 484.55(a) and (b)(2) to permanently allow occupational therapists to complete the initial and comprehensive assessments for patients, in accordance with Division CC, section 115 of CAA 2021.***[61]

62. **Twelve-Hour Annual In-Service Training Requirement for Home Health Aides:** CMS modified the requirement at 42 CFR §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period. In accordance with section 1135(b)(5) of the Act, postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. This allowed aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care and additional time for staff to complete this requirement. ***This flexibility ended at the conclusion of the PHE and returns to pre-PHE requirements at the end of 2023.***[62]

63. **Detailed Information Sharing for Discharge Planning for Home Health Agencies.** CMS waived the requirements of 42 CFR §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. This temporary waiver provided facilities the ability to expedite discharge and movement of residents among care settings. ***CMS maintained all other discharge planning requirements. CMS ended this waiver at the conclusion of the COVID-19 PHE.***[63]

[61] https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf
[62] https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf
[63] https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf

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64. **Clinical Records:** In accordance with section 1135(b)(5) of the Act, CMS extended the deadline for completion of the requirement at 42 CFR §484.110(e), which requires HHAs to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). *Specifically, CMS allowed HHAs ten business days to provide a patient's clinical record, instead of four*. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[64]

65. **Plans of Care and Certifying/Recertifying Patient Eligibility:** In addition to a physician, section 3708 of the CARES Act allowed a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with state law. These physicians/practitioners can: 1) order home health services; 2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care); 3) certify and re-certify that the patient is eligible for Medicare home health services. These changes, effective March 1, 2020, provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. Specifically, for Medicare, these changes are effective for Medicare claims with a "claim through date" on or after March 1, 2020. ***This provision has been made permanent beyond the COVID-19 PHE and is codified in the regulations at 42 CFR 409.43.***[65]

66. **Training and Assessment of Aides:** CMS waived the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §84.80(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 postponed completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE (July 10, 2023). ***CMS ended this waiver at the conclusion of the PHE.***[66]

67. **Quality Assessment and Performance Improvement (QAPI):** CMS modified 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. Specifically, CMS modified 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

[64] https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf
[65] https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf
[66] https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf

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that remaining activities should continue to focus on adverse events. This modification decreased burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care delivery most closely associated with COVID-19 and tracking adverse events during the PHE. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data driven quality assessment and performance improvement program remained***. CMS ended this flexibility at the conclusion of the PHE.***[67]

68. **Waived requirement for hospices to use volunteers:** CMS waived the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). This flexibility is set to return to pre-PHE requirements at the end of the calendar year that the PHE ends. ***This waiver terminates at the end of the COVID-19 PHE.***[68]

69. **Comprehensive Assessments:** CMS waived certain requirements for Hospice 42 CFR §418.54 related an to update of the comprehensive assessments of patients. This waiver applied the timeframes for updates to the comprehensive assessment (§418.54(d)). Hospices were required to continue to complete the required assessments and updates; however, the timeframes for updating the assessment could be extended from 15 to 21 days. ***CMS ended this waiver at the conclusion of the PHE.***[69]

70. **Waive Non-Core Services:** CMS waived 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 ended this waiver at the conclusion of the PHE.***[70]

71. **Waive Onsite Visits for HHA Aide Supervision:** CMS waived the requirements at 42 CFR §484.80(h), which requires a nurse to conduct an onsite visit every two weeks. This included waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not have been physically possible for a period of time. This waiver also temporarily suspended the two-week aide supervision by a registered nurse for home health agencies' requirement at §484.80(h)(1), but virtual supervision was encouraged during the period of the waiver. ***CMS ended this waiver at the conclusion of the PHE.*** *Of note, as a part*

[67] https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf
[68] https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf
[69] https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf
[70] https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf

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of the CY 2022 Home Health Prospective Payment System Final Rule (CMS 1747-F), CMS finalized the provision for aide supervision for patients receiving skilled care every 14 days to now allow for one virtual visit per 60-day episode per patient and only in rare circumstances. For patients receiving non-skilled care, the registered nurse must make an onsite, in person visit every 60 days to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs; semi-annually the nurse will make a supervisory direct observation visit for each patient to which the aide is providing services.[71]

72. **Hospice Aide Competency Testing Allows Use of Pseudo Patients:** CMS waived the requirement in § 418.76(c)(1) that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient. This modification allowed hospices to utilize pseudo patients, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient. This increased the speed of performing competency testing and allowed new aides to begin serving patients more quickly without affecting patient health and safety during the PHE. *Of note, as a part of the FY 2022 Hospice Wage Index and Payment Rate Update Final Rule (CMS-1754-F), CMS finalized the hospice aide requirements to allow the use of the pseudo-patient for conducting hospice aide competency evaluations. CMS also finalized the hospice aide supervision requirements to address situations when deficient practice is noted, and remediation is needed related to both deficient and related skills, in accordance with §418.76(c).*[72]

73. **12-hour Annual In-service Training Requirement for Home Health Aides.** CMS modified the requirement at 42 CFR §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period. ***In accordance with section 1135(b)(5) of the Act, CMS postponed the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes (September 30, 2023).*** *This allowed aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care and additional time for staff to complete this requirement.*[73]

74. **Annual Training.** CMS modified 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. Pursuant to section 1135(b)(5) of the Act, CMS postponed the deadline for

[71] https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf
[72] https://www.cms.gov/files/document/hospice-cms-flexibilities-fight-covid-19.pdf
[73] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

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completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. This did not alter the minimum personnel requirements at 42 CFR § 418.114. Selected hospice staff still had to complete training and have their competency evaluated in accordance with unwaived provisions of 42 CFR Part 418. ***CMS ended this waiver at the conclusion of the PHE.***[74]

End-Stage Renal Dialysis (ESRD) Facilities

75. **Training Program and Periodic Audits**: CMS waived the requirement at 494.40(d) related to the condition on Water & Dialysate Quality. Specifically, on-time periodic audits for operators of the water/dialysate equipment were waived to allow for flexibilities. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[75]

76. **Emergency Preparedness**: CMS waived the requirements at §494.62(d)(1)(iv), which requires ESRD facilities to demonstrate as part of their Emergency Preparedness Training and Testing Program that, at a minimum, its patient care staff maintains current CPR certification. *CMS waived the requirement for maintenance of CPR certification during the COVID-19 emergency due to the limited availability of CPR classes*. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[76]

77. **Ability to Delay Some Patient Assessments:** To ensure that dialysis facility staff could focus on the increased care demands related to the COVID-19 pandemic, CMS waived certain requirements at §494.80(b) related to the frequency of assessment for patients admitted to the dialysis facility. CMS waived the "on–time" requirements for the initial and follow-up comprehensive assessments within the specified timeframes, as noted below. This waiver applied to assessments conducted by members of the interdisciplinary team, including: a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. CMS did not waive subsections (a) or (c) of 42 CFR §494.80. CMS maintained expectations for conducting the assessment, ensuring the adequacy of the dialysis treatment, and assessing the patient's needs when there is a change in condition.

    Specifically, CMS waived:

    - §494.80(b) (1): An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility) within the latter of 30calendar days or 13 outpatient hemodialysis sessions beginning with the

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

[75] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

[76] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

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first outpatient dialysis session. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***

- §494.80(b) (2): A follow-up comprehensive reassessment must occur within three months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[77]

78. Time Period for Initiation of Care Planning and Monthly Physician Visits: CMS modified two requirements related to care planning, specifically:

- §494.90(b)(2): CMS modified the requirement that the dialysis facility implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This modification also applied to the requirement for monthly or annual updates to the plan of care within 15 days of the completion of the additional patient assessments. CMS waived the time requirement for plan of care implementation during the time period of the national emergency. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***
- §494.90(b)(4): CMS modified the requirement that the ESRD dialysis facility ensure that all dialysis patients be seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient was receiving in-facility dialysis. CMS waived the requirement for a monthly in-person visit if the patient was considered stable and also recommended exercising telehealth flexibilities, e.g., phone calls, to ensure patient safety. ***The Consolidated Appropriations Act, 2023 provides for an extension of this telehealth flexibility through December 31, 2024.***[78]

79. Dialysis Home Visits to Assess Adaptation and Home Dialysis Machine Designation: CMS waived the requirement at 494.100(c)(1)(i), which requires the periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel, for more information on existing flexibilities for in-center dialysis patients to receive their dialysis treatments in the home or long-term care facility, reference QSO-20-19-ESRD. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[79]

[77] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

[78] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

[79] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

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80. **Home Dialysis Machine Designation — Clarification:** The ESRD Conditions for Coverage (CfCs) do not explicitly require that each home dialysis patient have their own designated home dialysis machine. The dialysis facility is required to follow FDA labeling and manufacturer's directions for use to ensure appropriate operation of the dialysis machine and ancillary equipment. Dialysis machines must be properly cleaned and disinfected to minimize the risk of infection based on the requirements at 42 CFR 494.30 Condition: Infection Control if used to treat multiple patients.[80]

81. **Special Purpose Renal Dialysis Facilities (SPRDF) designation expanded:** During the PHE, CMS authorized the establishment of SPRDFs to address access to care issues due to COVID-19 and the need to mitigate transmission among this vulnerable population. This did not include the normal determination regarding whether there was a lack of access to care as that standard was automatically met during the nationwide PHE. Approval as a Special Purpose Renal Dialysis Facility does not require federal survey prior to providing services. ***CMS ended this flexibility at the conclusion of the COVID-19 PHE.***[81]

82. **Furnishing Dialysis Services on the Main Premises:** ESRD requirements at §494.180(d) require dialysis facilities to provide services directly on its main premises or on other premises that are contiguous with the main premises. CMS waived this requirement to allow dialysis facilities to provide service to its patients in nursing homes, long-term care facilities, assisted living facilities, and similar types of facilities, as licensed by the state (if applicable). CMS continued to require that services provided to these patients or residents be under the direction of the same governing body and professional staff as the resident's usual Medicare-certified dialysis facility. Further, in order to ensure that care was safe, effective, and was provided by trained and qualified personnel, CMS required that the dialysis facility staff furnish all dialysis care and services; provide all equipment and supplies necessary; maintain equipment and supplies in the off-premises location; and complete all equipment maintenance, cleaning, and disinfection using appropriate infection control procedures and manufacturer's instructions for use. ***CMS ended this waiver at the conclusion of the COVID-19 PHE.***[82]

83. **Dialysis Patient Care Technician certification:** CMS modified the requirement at § 494.140(e)(4) for patient care dialysis technicians, which requires certification under a state certification program or a national commercially available certification

[80] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf
[81] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf
[82] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

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program within 18 months of being hired as a dialysis patient care technician for newly employed dialysis patient care technicians. CMS allowed patient care technicians to continue working even if they have not achieved certification within 18 months or have not met on-time renewals. ***CMS ended this flexibility at the conclusion of the COVID-19 PHE.***[83]

84. **Transferability of Physician Credentialing:** CMS modified the requirement at §494.180(c)(1), which requires that all medical staff appointments and credentialing are in accordance with state law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists. CMS allowed physicians who are appropriately credentialed at a certified dialysis facility to provide care at designated isolation locations (or separate COVID-19- only facilities designed to mitigate transmission of the virus) without separate credentialing at that facility. This was implemented while remaining consistent with a state's emergency preparedness or pandemic plan. ***CMS ended this flexibility at the conclusion of the COVID-19 PHE.***[84]

85. **Clarification for billing procedures:** Typically, ESRD beneficiaries are transported from an SNF/NF to an ESRD facility to receive renal dialysis services. In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities were temporarily permitted to furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center billed Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center also applied condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition. The ESRD provider had their trained personnel administer the treatment in the SNF/NF. In addition, the provider followed the CFCs. In particular, under the CFCs is the requirement that to use a dialysis machine, the FDA-approved labeling must be adhered to (§ 494.100) and it must be maintained and operated in accordance with the manufacturer's recommendations (§ 494.60) and follow infection control requirements at (§ 494.30). ***CMS ended this billing guidance at the conclusion of the COVID-19 PHE.***[85]

[83] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

[84] https://www.cms.gov/files/document/end-stage-renal-disease-facilities-cms-flexibilities-fight-covid-19.pdf

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Intermediate Care Facility for Individuals with Intellectual Disabilities

86. **Staffing Flexibilities:** CMS waived the requirements at 42 CFR §483.430(c)(4), which requires the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) were not required to perform support services that interfere with direct client care. DSS perform activities such as cleaning the facility, cooking, and laundry services. DSC perform activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills. During the time of this waiver, DCS may have been needed to conduct some of the activities normally performed by the DSS. This allowed facilities to adjust staffing patterns while maintaining the minimum staffing ratios required at §483.430(d)(3). ***CMS ended this flexibility at the conclusion of the COVID19 PHE.***[86]

87. **Suspension of Community Outings:** CMS waived the requirements at 42 CFR §483.420(a)(11), which requires clients to have the opportunity to participate in social, religious, and community group activities. The federal and/or state emergency restrictions dictated the level of restriction from the community based on whether it is for social, religious, or medical purposes. States may also have imposed more restrictive limitations. CMS authorized the facility to implement social distancing precautions with respect to on and off-campus movement. State and federal restrictive measures should have been made in the context of competent, person-centered planning for each client. ***CMS ended this flexibility at the conclusion of the COVID-19 PHE.***[87]

88. **Suspend Mandatory Training Requirements**: CMS waived, in part, the requirements at 42 CFR § 483.430(e)(1) related to routine staff training programs unrelated to the PHE. CMS did not waive 42 CFR §483.430(e)(2)-(4), which requires focusing on the client's developmental, behavioral and health needs and being able to demonstrate skills related to interventions for inappropriate behavior and implementing individual plans. CMS also did not waive initial training for new staff hires or training for staff around prevention and care for the infection control of COVID-19. It is critical that new staff gain the necessary skills and understanding of how to effectively perform their role as they work with this complex client population and that staff understand how to prevent and care for clients with COVID-19. ***CMS ended this flexibility at the conclusion of the COVID-19 PHE.***[88]

89. **Modification of Adult Training Programs and Active Treatment:** CMS recognized that during the PHE, active treatment would need to be modified. The requirements at 42 CFR §483.440(a)(1) require that each client must receive a

[86] https://www.cms.gov/files/document/intermediate-care-facility-individuals-intellectual-disabilities.pdf
[87] https://www.cms.gov/files/document/intermediate-care-facility-individuals-intellectual-disabilities.pdf
[88] https://www.cms.gov/files/document/intermediate-care-facility-individuals-intellectual-disabilities.pdf

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continuous active treatment program, which includes consistent implementation of a program of specialized and generic training, treatment, health services and related services. CMS waived those components of beneficiaries' active treatment programs and training that would violate current state and local requirements for social distancing, staying at home, and traveling for essential services only. For example, although day habilitation programs and supported employment are important opportunities for training and socialization of clients at intermediate care facilities for individuals with developmental disabilities, those programs posed too high of a risk to staff and clients for exposure to a person with suspected or confirmed COVID-19. In accordance with §483.440(c)(1), any modification to a client's Individual Program Plan (IPP) in response to treatment changes associated with the COVID-19 crisis required the approval of the interdisciplinary team. For facilities that had interdisciplinary team members who are unavailable due to COVID-19, CMS allowed for a retroactive review of the IPP under 483.440(f)(2) in order to allow IPPs to receive modifications as necessary based on the impact of the COVID-19 crisis. Active treatment programs and IPPs must be revised or updated no later than 60 days after the expiration of the PHE. ***CMS ended this flexibility at the conclusion of the COVID-19 PHE.***[89]

Ambulatory Surgical Centers (ASCs)

90. Medical Staff: CMS waived requirements under 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges would expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review and approval to address workforce concerns related to COVID-19. ***CMS waived §482.22(a) (1)-(4) regarding details of the credentialing and privileging process.***[90]

91. Relaxing Conditions of Participation: Under an additional initiative, CMS relaxed certain conditions of participation (CoPs) for hospital operations to maximize hospitals' ability to focus on patient care. The same initiative also allowed enrolled ambulatory surgical centers (ASCs) to temporarily enroll as hospitals and to provide hospital services to help address the urgent need to increase hospital capacity to take care of patients. Other interested entities, such as independent freestanding emergency departments (IFEDs), could pursue enrolling as an ASC and then pursue converting their enrollment to hospital during the PHE. As of December 1, 2021, no new ASC or new IFED requests to temporarily enroll as hospitals have been accepted. Refer to https://www.cms.gov/files/document/qso-22-03-asc-hospital.pdf for more information. ***Now that the PHE has ended, ASCs can only be paid under***

[89] https://www.cms.gov/files/document/intermediate-care-facility-individuals-intellectual-disabilities.pdf

[90] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

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the ASC payment system for services on the ASC Covered Procedures List. IFEDs cannot bill Medicare for services as their temporary Medicare certification has ended.[91]

92. Nursing Services: CMS waived the requirements at 42 CFR §482.23(b)(4), which require the nursing staff to develop and keep current a nursing care plan for each patient, and §482.23(b)(7), which requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present. These waivers allowed nurses increased time to meet the clinical care needs of each patient and allowed for the provision of nursing care to an increased number of patients. ***These flexibilities applied to both hospitals and CAHs §485.635(d)(4), and could be implemented as long as they were consistent with a state's emergency preparedness or pandemic plan.***[92]

Inpatient Rehabilitation Facilities (IRF)

93. Post-Admission Evaluations: Physicians are no longer required to conduct and document post-admission evaluations for Medicare patients. The post-admission evaluation covers much of the same information as continues to be included in the pre-admission screening of the patient and the patient's plan of care. This reduction in burden gives more time for physicians to take care of patients. ***Removal of this requirement is permanent as of October 1, 2020.***[93]

94. Flexibility for Inpatient Rehabilitation Facilities Regarding the 60% Rule: During the PHE, CMS allowed IRFs to exclude patients from the IRF freestanding hospitals or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60% rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, this exception also applied to facilities not yet classified as IRFs, but that were attempting to obtain classification as an IRF. ***As the COVID-19 PHE has ended, all inpatients are again included in the IRF freestanding hospital's or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60% rule").***[94]

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[91] https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

[92] https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

[93] https://www.cms.gov/files/document/inpatient-rehabilitation-facilities-cms-flexibilities-fight-covid-19.pdf

[94] https://www.cms.gov/files/document/inpatient-rehabilitation-facilities-cms-flexibilities-fight-covid-19.pdf

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95. **IRF Teaching Status Adjustment Payments:** To ensure that teaching IRFs could alleviate bed capacity issues by taking patients from inpatient acute care hospitals without being penalized by lower teaching status adjustments, CMS froze the IRFs' teaching status adjustment payments at their values prior to the PHE. For the duration of the COVID-19 PHE, an IRF's teaching status adjustment payments was the same as they were on the day before the COVID-19 PHE was declared. ***CMS terminated this policy at the end of the COVID-19 PHE.***[95]

96. **Intensity of Therapy Requirement ("Three-Hour Rule"):** The Coronavirus Aid, Relief, and Economic Security (CARES) Act required the Secretary to waive § 412.622(a)(3)(ii) (commonly referred to as the "three-hour rule"), the criterion that patients treated in inpatient rehabilitation facilities generally receive at least 15 hours of therapy per week. The waiver of this requirement for all beneficiaries treated in a hospital-based or freestanding IRF provided flexibility for IRFs to provide care for patients during the PHE for the COVID-19 pandemic. IRFs should have still strived to provide typical IRF levels of care (i.e., inpatient rehabilitation versus acute care hospital care) for beneficiaries admitted during the COVID-19 PHE who required and could benefit from IRF levels of care. ***This waiver expired at the end of the COVID-19 PHE.***[96]

97. **Standards to Rehabilitate Patients:** Medicare payment regulations require IRFs to meet certain standards to rehabilitate patients, including providing interdisciplinary care, ensuring that admitted patients are stable enough for rehabilitation therapy and need at least two types of therapy, and providing close medical supervision by a rehabilitation physician. During the PHE, these standards did not have to apply to patients who are admitted to freestanding IRFs solely for surge capacity reasons in a state (or region, as applicable) that satisfied all of the following, as determined by applicable state and local officials:

    - All vulnerable individuals continue to shelter in place,
    - Individuals continue social distancing,
    - Individuals avoid socializing in groups of more than 10,
    - Non-essential travel is minimized,
    - Visits to senior living facilities and hospitals are prohibited, and
    - Schools and organized youth activities remain closed.

    The standard IRF requirements would continue to apply to patients admitted for the IRFs' standard rehabilitative services.

[95] https://www.cms.gov/files/document/inpatient-rehabilitation-facilities-cms-flexibilities-fight-covid-19.pdf
[96] https://www.cms.gov/files/document/inpatient-rehabilitation-facilities-cms-flexibilities-fight-covid-19.pdf

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During the PHE, freestanding IRFs took advantage of these flexibilities for some of their beneficiaries (those who were surge patients from inpatient hospitals) while continuing to provide standard IRF-level care for those beneficiaries who would benefit from IRF-level care and would otherwise receive such care in the absence of the PHE. ***This waiver expired at the end of the COVID-19 PHE.***[97]

Community Mental Health Clinics (CMHCs)

98. **Quality Assessment and Performance Improvement (QAPI) Program:** CMS waived 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated QAPI programs (for hospitals that are a part of a hospital system). These flexibilities, which applied to both hospitals and CAHs, were implemented while remaining consistent with a state's emergency preparedness or pandemic plan. While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program remained. ***This expired at the end of the COVID-19 PHE.***[98]

99. **Forty Percent Rule:** CMS waived the requirement at § 485.918(b)(1)(v) that a CMHC provides at least 40% of its items and services to individuals who are not eligible for Medicare benefits. Waiving the 40% requirement facilitated appropriate timely discharge from inpatient psychiatric units and prevented admissions to these facilities, because CMHCs have been able to provide PHP services to Medicare beneficiaries without restrictions on the proportion of Medicare beneficiaries that they are permitted to treat at a time. This allowed communities greater access to health services, including mental health services. ***This expired at the end of the COVID-19 PHE.***[99]

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

100. **Certain staffing requirements:** CMS waived the requirement in the second sentence of 42 CFR §491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50% of the time the RHC and FQHC operates. CMS did not waive the first sentence of

[97] https://www.cms.gov/files/document/inpatient-rehabilitation-facilities-cms-flexibilities-fight-covid-19.pdf
[98] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf
[99] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

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§491.8(a)(6), which requires a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This assisted in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE. **This waiver terminated at the end of the COVID-19 PHE.**[100]

101. **Home Nursing Visits:** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) were able to provide visiting nursing services to a beneficiary's home with fewer requirements, making it easier for beneficiaries to get care from their home.
    - Any area typically served by the RHCs and any area included in the FQHC's service area plan was determined to have a shortage of home health agencies, and a request for this determination has not been required;
    - Any RHC/FQHC visiting nurse service solely to obtain a nasal or throat culture has not been considered a nursing service because it does not require the skills of a nurse to obtain the culture, as the specimen could have been obtained by an appropriately trained medical assistant or laboratory technician; and
    - The revised definition of "homebound" would have applied to patients receiving visiting nursing services from RHCs and FQHCs.

    As the COVID-19 PHE has ended, RHCs and FQHCs located in an area that has not been determined to have a current HHA shortage and seeking to provide visiting nurse services must make a written request along with written justification that the area it serves meets the required conditions and that the definition of "homebound" will not apply to patients receiving visiting nursing services from RHCs and FQHCs.[101]

102. **Physician supervision of Nurse Practitioners in RHCs and FQHCs:** CMS modified the requirement at 42 CFR 491.8(b)(1) that physicians must provide medical direction for the clinic or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continued to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allowed RHCs and

[100] https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

[101] https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

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FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks. ***This flexibility is currently set to return to pre-PHE requirements at the end of 2023.***[102]

103. **Bed Count for Provider-Based RHCs and RHC Payment Limit:** Prior to April 1, 2021, RHCs that were provider-based to a hospital with fewer than 50 beds were exempt from the national RHC payment limit. In an Interim Final Rule with Comment Period (IFC) issued May 8, 2020, CMS allowed these provider-based RHCs to continue to receive the payment amounts they would have otherwise received in the absence of the PHE. To do so, CMS has allowed, during the PHE, that the number of beds prior to the start of the PHE would be the official hospital bed count for application of the exemption policy so that hospitals were not discouraged from increasing bed capacity if needed. On December 27, 2020, section 130 of the Consolidated Appropriations Act of 2021 (CAA, 2021) provided special payment rules for certain provider-based RHCs with fewer than 50 beds). In accordance with the CAA, 2021, CMS continued to allow for increased hospital bed counts, as described in the May 8, 2020, IFC. ***The bed count flexibility terminated when the COVID-19 PHE ended. As such, when Medicare Administrative Contractors (MACs) apply the rate-setting process, they no longer use the number of beds from the cost reporting period to the start of the PHE as the official hospital bed count when determining if an RHC retains its specified provider-based RHC status.***[103]

104. **Temporary Expansion Locations:** CMS waived the requirements at 42 CFR §491.5(a)(3)(iii), which require RHCs and FQHCs to be independently considered for Medicare approval if services are furnished in more than one permanent location. During the PHE, CMS temporarily waived this requirement, removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand service locations to meet the needs of Medicare beneficiaries. This flexibility included areas that may be outside of the location requirements, at 42 CFR § 491.5(a)(1) and (2), for the duration of the PHE. ***CMS ended this waiver at the conclusion of the PHE.***[104]

[102] https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

[103] https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

[104] https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

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Telehealth:

For telehealth visits and communications, ensure you are using platforms and/or equipment that are HIPAA-compliant and ensure privacy for our members.

For Massachusetts and Rhode Island plans, see CCA's Telehealth/ Telemedicine Payment Policy for additional details.

Massachusetts-Specific Requirements:

1. **Maximizing Availability of Physician Assistants:** In order to maximize health care provider availability and to respond to increased healthcare needs during the PHE, employers of physician assistants could allow qualified physician assistants in good standing to practice without designating a supervising physician and without preparing and signing prescriptive practice or scope of practice guidelines, provided the following conditions were satisfied:
    a. The physician assistant is employed by a physician, group of physicians, or healthcare facility where physician assistants and physicians work together to provide patient care.
    b. The employer and the physician assistant determine the services provided by the physician assistant are within the education, training, experience, and competencies of the physician assistant.
    c. The physician assistant is not utilized as the sole medical personnel in charge of emergency services, outpatient services, or any other clinical service. Nothing in this Order shall allow a physician assistant to practice independently outside of a physician practice or healthcare facility. The physician assistant's supervising physician is not responsible for practice pursuant to this Order. For the purposes of this Order, "in good standing" shall include a license that is subject to non-disciplinary conditions but shall not include a license that is on probation, revoked, cancelled, surrendered, suspended, or subject to disciplinary restrictions. All applicable statues, regulations, and guidance not inconsistent with this Order remain in effect.

This Order was in effect until the PHE was terminated by the Governor.[105]

[105] https://www.mass.gov/doc/order-of-the-commissioner-of-public-health-covid-19-public-health-emergency-order-no-2022-02.pdf

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2. **Massachusetts Agencies Posted Guidance** on various topics for providers and care givers in the state, including infection control procedures and staff testing requirements. ***Some of this guidance is already expired.***[106]

Rhode Island-Specific Requirements:

Rhode Island posted guidance on various topics for providers and care givers in the state, including infection control procedures and staff testing requirements. ***Some of this guidance is already expired.***[107]

[106] https://www.mass.gov/info-details/covid-19-public-health-guidance-and-directives#health-care-professionals-

[107] https://covid.ri.gov/healthcare-professionals/information-healthcare-providers

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