What Do I Need to Know?

CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency

Based on current COVID-19 trends, the Department of Health and Human Services is planning for the federal Public Health Emergency for COVID-19 (PHE), declared under Section 319 of the Public Health Service Act, to expire at the end of the day on May 11, 2023. Thanks to the Administration's whole-of-government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from an emergency phase.

The emergency declarations, legislative actions by Congress, and regulatory actions across government, including by the Centers for Medicare & Medicaid Services (CMS), allowed for changes to many aspects of health care delivery during the COVID-19 PHE. Health care providers received maximum flexibility to streamline delivery and allow access to care during the PHE. While some of these changes will be permanent or extended due to Congressional action, some waivers and flexibilities will expire, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules.

This fact sheet will help you know what to expect at the end of the PHE so that you can continue to feel confident in how you will receive your health care. Please note that this information is not intended to cover every possible scenario.

This fact sheet will cover the following:

- COVID-19 vaccines, testing, and treatments;
- Telehealth services;
- Health Care Access: Continuing flexibilities for health care professionals; and
- Inpatient Hospital Care at Home: Expanded hospital capacity by providing inpatient care in a patient's home.

The Administration, States, and private insurance plans will continue to provide guidance in the coming months. As described in previous communications, the Administration's continued response is not entirely dependent on the COVID-19 PHE. There are significant flexibilities and actions that will not be affected as we transition from the current phase of our response. For more information on what changes and does not change across the Department, visit https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.

COVID-19 vaccines, testing, and treatments

Medicare

Vaccines: People with Medicare coverage will continue to have access to COVID-19 vaccinations without cost sharing after the end of the PHE.

Testing: Additionally, people with traditional Medicare can continue to receive COVID-19 PCR and antigen tests with no cost sharing when the test is ordered by a physician or certain other health care providers, such as physician assistants and certain registered nurses, and performed by a laboratory. People enrolled in Medicare Advantage (MA) plans can continue to receive COVID-19 PCR and antigen tests when the test is covered by Medicare, but their cost-sharing may change when the PHE ends. By law, Medicare does not generally cover over-the-counter services and tests. Current access to free over-the-counter COVID-19 tests will end with the end of the PHE. However, some Medicare Advantage plans may continue to provide coverage as a supplemental benefit.

Treatments: There is no change in Medicare coverage of treatments for those exposed to COVID-19 once the PHE ends, and in cases where cost sharing and deductibles apply now, they will continue to apply. Generally, the end of the COVID-19 PHE does not change access to oral antivirals, such as Paxlovid and Lagevrio.

Medicaid and CHIP

Vaccines, Testing, and Treatment: As a result of the *American Rescue Plan Act of 2021 (ARPA)*, states must provide Medicaid and CHIP coverage without cost sharing for COVID-19 vaccinations, testing, and treatments through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. If the COVID-19 PHE ends as expected on May 11, 2023, this coverage requirement will end on September 30, 2024.

After that date, many Medicaid and CHIP enrollees will continue to have coverage for COVID-19 vaccinations. After the *ARPA* coverage requirements expire, Medicaid and CHIP coverage of COVID-19 treatments and testing may vary by state.

Additionally, 18 states and U.S. territories have opted to provide Medicaid coverage to uninsured individuals for COVID-19 vaccinations, testing, and treatment. Under federal law, Medicaid coverage of COVID-19 vaccinations, testing, and treatment for this group will end when the PHE ends.

Private Health Insurance

Vaccines: Most forms of private health insurance must continue to cover COVID-19 vaccines furnished by an in-network health care provider without cost sharing. People with private health insurance may need to pay part of the cost if an out-of-network provider vaccinates them.

Testing: After the expected end of the PHE on May 11, 2023, mandatory coverage for over-the-counter and laboratory-based COVID-19 PCR and antigen tests will end, though coverage will vary depending on the health plan. If private insurance chooses to cover these items or services, there may be cost sharing, prior authorization, or other forms of medical management may be required.

Treatments: The transition forward from the PHE will not change how treatments are covered, and in cases where cost sharing and deductibles apply now, they will continue to apply.

Access to Telehealth Services

Medicare and Telehealth

During the PHE, individuals with Medicare had broad access to telehealth services, including in their homes, without the geographic or location limits that usually apply as a result of waivers issued by the Secretary, facilitated by the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020,* and the *Coronavirus Aid, Relief, and Economic Security Act*. "Telehealth" includes services provided through telecommunications systems (for example, computers and phones) and allows health care providers to give care to patients remotely in place of an in-person office visit.

The *Consolidated Appropriations Act, 2023*, extended many telehealth flexibilities through December 31, 2024, such as:

- People with Medicare can access telehealth services in any geographic area in the United States, rather than only those in rural areas.
- People with Medicare can stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility.
- Certain telehealth visits can be delivered audio-only (such as a telephone) if someone is unable to use both audio and video, such as a smartphone or computer.

Medicare Advantage plans may offer additional telehealth benefits. Individuals in a Medicare Advantage plan should check with their plan about coverage for telehealth services. Additionally, after December 31, 2024 when these flexibilities expire, some Accountable Care Organizations (ACOs) may offer telehealth services that allow primary care doctors to care for patients without an in-person visit, no matter where they live. If your health care provider participates in an ACO, check with them to see what telehealth services may be available.

Medicaid, CHIP, and Telehealth

For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Coverage will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

To assist states with the continuation, adoption, or expansion of telehealth coverage, CMS has released the State Medicaid & CHIP Telehealth Toolkit and a supplement that identifies for states the policy topics that should be addressed to facilitate widespread adoption of telehealth: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.

Private Health Insurance and Telehealth

As is currently the case during the PHE, coverage for telehealth and other remote care services will vary by private insurance plan after the end of the PHE. When covered, private insurance may impose cost-sharing, prior authorization, or other forms of medical management on telehealth and other remote care services.

For additional information on your insurer's approach to telehealth, contact your insurer's customer service number located on the back of your insurance card.

COVID-19 Waivers and Administrative Flexibilities: How Health Care Providers and Suppliers are Affected

For specific details about how health care providers and suppliers should prepare for the end of the COVID-19 PHE, CMS has developed a series of provider-specific fact sheets at https://www.cms.gov/coronavirus-waivers. Below are items of high interest that affect many providers.

Standard Blanket Waivers for Disaster Responses

Blanket waivers generally apply to all entities in a provider category (e.g., all hospitals); these waivers have been made available to several categories of providers and will end at the end of the PHE.

CMS typically issues a standard group of "blanket waivers" in response to emergencies or natural disasters. These can include, for example:

- Waivers of the requirement for three-day prior inpatient hospitalization for Medicare coverage of a skilled nursing facility stay;

- Waivers of the requirements that Critical Access Hospitals (CAHs) limit the number of inpatient beds to 25 and general limitations on CAH lengths of stay to no longer than 96 hours on average;
- Waivers to allow acute care patients to be housed in other facilities, such as ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories;
- Other waivers.

These waivers were intended to temporarily expand health care capacity when needed and generally cannot be made permanent without a legislative change. Additional information about what blanket waivers were made available during the COVID-19 PHE is available here: https://www.cms.gov/coronavirus-waivers.

Hospital at Home

In response to the challenges faced by hospitals because of COVID-19, CMS implemented the Acute Hospital Care at Home initiative, a flexibility to allow hospitals to expand their capacity to provide inpatient care in an individual's home. Many hospitals and individuals participated in this initiative – there is broad geographic distribution of hospitals participating, ranging in size and services from small rural settings to large academic settings. The number of approved hospitals in each state varies.

Under the *Consolidated Appropriations Act, 2023*, the Acute Hospital Care at Home initiative has been extended through December 31, 2024. Hospitals can continue to apply to participate in the initiative. If an individual is receiving care in a participating hospital and meets the requirements to receive inpatient care at home, they can continue to do so.

Nurse Aide Training for Nursing Homes

To help nursing homes address staffing shortages during the pandemic, CMS provided a blanket waiver for the nurse aide training and certification requirements to permit nurse aides to work for longer than four months without completing their training. As these nurse aides provided much-needed care, this waiver allowed facilities to employ individuals beyond four months in a nurse aide role even though they might not have completed a state-approved Nurse Aide Training and Competency Evaluation Programs (NATCEP) or Competency Evaluation Program (CEP).

CMS ended this waiver in 2022 and noted that it is critical for aides to be trained and certified so they have the skills to meet nursing home residents' needs. However, in cases where barriers to certification existed due to workforce shortages, CMS granted individual, time-limited waivers to help facilities retain staff while continuing to seek training and certification.

All nursing aide training emergency waivers for states and facilities will end at the end of the PHE, which is expected on May 11, 2023. At that time, facilities will have four months (i.e., until September 10, 2023) to have all nurse aides who are hired prior to the end of the PHE complete a state-approved NATCEP/CEP. Nurse aides hired after the end of the PHE will have up to four months from their date of hire to complete a state-approved NATCEP/CEP.

Virtual Supervision

To allow more people to receive care during the PHE, CMS temporarily changed the definition of "direct supervision" to allow the supervising health care professional to be immediately available through virtual presence using real-time audio/video technology instead of requiring their physical presence. CMS also clarified that the temporary exception to allow immediate availability for direct supervision through virtual presence also facilitates the provision of telehealth services by clinical staff "incident to" the professional services of physicians and other practitioners. This flexibility will expire on December 31, 2023.

Scope of Practice

Certified Registered Nurse Anesthetist - Anesthesia services

CMS currently waives the requirement that a certified registered nurse anesthetist (CRNA) must be under the supervision of a physician, instead permitting CRNA supervision at the discretion of the hospital or Ambulatory Surgical Center (ASC) and state law. This waiver applies to hospitals, CAHs, and ASCs. These waivers allow CRNAs to function to the fullest extent of their licensure when this is occurring consistent with a state or pandemic or emergency plan.

CMS will end this emergency waiver at the end of the PHE, which is expected to be on May 11, 2023, but states may apply waive the requirement. To apply for an exemption in a state, based on the standards set forth in the final rule published on November 13, 2001 (66 Fed. Reg. 56762), the Governor of the state must send a request to CMS. In the letter, the Governor of the state must attest that they consulted with the State Boards of Medicine and Nursing about issues related to access to and quality of anesthesia services and concluded that it is in the best interest of the citizens of the state to opt-out of the current supervision requirements and that the opt-out is consistent with state law.

Health and Safety Requirements

A significant number of emergency waivers related to health and safety requirements will expire at the end of the PHE, which is expected to be on May 11, 2023. For example, during the PHE, the time frame to complete a medical record at discharge was extended because the large volume of patients being treated would result in the clinician being away from direct patient care for

extended periods of time. Typically, a patient's medical records are required to be completed at discharge to ensure there are no gaps in patients' continuity of care. This means each provider should have the most up-to-date understanding of their patients' medical records.

Medicaid Continuous Enrollment Condition

The continuous enrollment condition for individuals enrolled in Medicaid is no longer linked to the end of the PHE. Under the *Families First Coronavirus Response Act*, states claiming a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) have been unable to terminate enrollment for most individuals enrolled in Medicaid as of March 18, 2020, as a condition of receiving the temporary FMAP increase.

As part of the *Consolidated Appropriations Act, 2023*, the continuous enrollment condition will end on March 31, 2023. The temporary FMAP increase will be gradually reduced and phased down beginning April 1, 2023 (and will end on December 31, 2023). For more information, visit Medicaid.gov/unwinding.