End of the COVID-19 Public Health Emergency

COVID-19 Flexibilities that will end with the Public Health Emergency

- Coverage, Costs, and Payment for COVID-19 Testing, Treatments, and Vaccines
    - For people without insurance: There will no longer be a pathway through Medicaid for free COVID-19 testing, vaccines, or treatment.
    - For Medicare beneficiaries: Cost sharing requirements will apply for at-home tests, testing-related services, and all COVID-19 treatments when the PHE ends.
        - Based on changes in the CAA 2023, Medicare Part D plans are allowed to cover oral antivirals authorized for use by the FDA under an EUA, and when the US government-purchased supply of oral antivirals is depleted, or if Part D enrollees receive oral antivirals that are not obtained from the federally-purchased supply, Medicare Part D enrollees are expected to face varying cost sharing amounts for these treatments, since cost sharing varies across Part D plans.
    - For Medicaid and CHIP enrollees: Once the coverage period mandated by ARPA ends, treatments that have FDA approval will be covered but could be subject to cost sharing. However, coverage of treatments that are still under emergency use authorization (EUA) and do not have FDA approval will vary by state.
        - Coverage of tests provided without a physician's order, including at-home tests, will vary by state.
    - Privately insured individuals could incur additional out-of-pocket costs for tests and related services when the PHE ends.
        - People with private insurance who receive COVID-19 vaccines, including booster doses, from out-of-network providers could incur out-of-pocket costs when the federally purchased supply of vaccines is depleted.
- Other Medicaid and CHIP Flexibilities
    - Disaster-Relief State Plan Amendments (SPAs) allow HHS to approve state requests to make temporary changes to address eligibility, enrollment, premiums, cost-sharing, benefits, payments, and other policies differing from their approved state plan during the COVID-19 emergency. States may not make changes that restrict or limit payment, services, or eligibility or otherwise burden beneficiaries and providers.
        - End with the PHE or earlier date selected by state.
    - Section 1135 waivers allow HHS to approve state requests to waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure that sufficient health care items and services are available to meet the needs of enrollees served by these programs in affected areas.
        - No later than the end of the PHE, state dependent.
- Other Medicare Payment and Coverage Flexibilities

- CMS has issued many blanket waivers and flexibilities (Section 1135 waivers) for health care providers that are in effect during the COVID-19 PHE to prevent gaps in access to care for beneficiaries impacted by the emergency. These terminate with the end of the PHE.
- For the treatment of patients diagnosed with COVID-19, hospitals receive a 20% increase in the Medicare payment rate through the hospital inpatient prospective payment system, ends with PHE.
- The 3-day prior hospitalization requirement will no longer be waived for skilled nursing facility (SNF) stays for those Medicare beneficiaries who need to be transferred because of the effect of a disaster or emergency. Additionally, beneficiaries who may have recently exhausted their SNF benefits will no longer have renewed SNF coverage without first having to start a new benefit period. Ends no later than the end of the PHE.
- Medicare Part D plans (both stand-alone drug plans and Medicare Advantage drug plans) will no longer provide up to a 90-day (3 month) supply of covered Part D drugs to enrollees who request it.
- Prior Authorization for Part D Drugs: Part D Sponsors could waive prior authorization requirements at any time that they otherwise would apply it to Part D drugs used to treat or prevent COVID-19, if or when such drugs are identified. Part D Sponsors could also choose to waive or relax PA requirements at any time for other formulary drugs in order to facilitate access with less burden on beneficiaries, plans, and providers. This flexibility will ends with the end of the PHE.
- Critical Access Hospital Bed Count and Length of Stay: CMS has been waiving the Medicare requirements that Critical Access Hospitals (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 will terminate at the end of the COVID-19 PHE.
- 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 are 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.
- When the PHE ends, 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. This waiver will terminate at the end of the COVID-19 PHE. (more info here)

- Telehealth
  - OCR enforcement discretion for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies during the

COVID-19 nationwide public health emergency, which allows for widely accessible services like FaceTime or Skype to be used for telemedicine purposes, even if the service is not related to COVID-19. This ends with the end of the PHE.

- DEA-registered providers can use telemedicine to issue prescriptions for controlled substances to patients without an in-person evaluation, if they meet certain conditions.
  - Ends with end of PHE, unless DEA specifies an earlier date.
- Using the waiver authority under section 1135 of the Act during the PHE, CMS had permitted clinicians to bill for remote patient monitoring (RPM) services furnished to both new and established patients, and to patients with both acute and chronic conditions. When the PHE ends, clinicians must once again have an established relationship with the patient prior to providing RPM services. However, CMS will continue to allow RPM services to be furnished to patients with both acute and chronic conditions (pre-PHE, an initiating visit was required before RPM services could be billed).
- During the PHE, RPM could be reported for as few as 2 days for COVID patients. The reporting requirement will revert to 16 days after the PHE ends.
- Removal of Frequency Limitations on Certain Medicare Telehealth Services
  - Using section 1135 waiver authority, on an interim basis during the PHE, CMS removed the frequency restrictions for the following listed codes furnished via Medicare telehealth. These restrictions were established through rulemaking and implemented through systems edits.
  - After the PHE, all applicable rules for furnishing these services, unless otherwise specified, will once again take effect:
    - A subsequent inpatient visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
    - A subsequent skilled nursing facility visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 14 days (CPT codes 99307-99310).
    - Critical care consult codes could be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).
- Hospital Originating Site Facility Fee for Professional Services Furnished Via Telehealth: After the PHE ends, this flexibility, to bill the telehealth service provided in the patient's home as if it was provided at the hospital, will end.

- Other Medicare Flexibilities
  - Resident supervision:
    - During the COVID-19 public health emergency (PHE), the Center for Medicare and Medicaid Services (CMS) made changes to the Medicare billing requirements that enabled payment to teaching physicians when residents provide services to patients (in person or via telehealth) that are supervised virtually by the teaching physician, making it easier for individuals to receive care.

- After the COVID-19 PHE ends, CMS will allow payment for virtual supervision of residents by teaching physicians only when the patient and resident are located in a rural area. When telehealth services are provided by residents, virtual supervision by the teaching physician will only be allowed in rural areas.

- Scope:
  - Pharmacists: CMS had 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 flexibility is currently set to return to pre-PHE rules when the PHE ends.
  - Hospital Services: CMS had waived requirements at § 482.12(c)(1)-(2) and (4) that Medicare patients in the hospital must be under the care of a physician. This has allowed hospitals to use other practitioners, such as physician assistants and nurse practitioners, to the fullest extent possible. This waiver is required to be implemented in accordance with a state's emergency preparedness or pandemic plan and ends upon the conclusion of the PHE.
  - Anesthesia services: CMS has 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) is 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 applies to hospitals, CAHs, and ASCs. These waivers allow CRNAs to function to the fullest extent of their licensure and has been implemented while remaining consistent with a state or pandemic/emergency plan. CMS will end this waiver at the conclusion of the COVID-19 PHE.
  - CAH Personnel qualifications: CMS has 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 C.F.R 485.604(c)(1)- (3). Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants still have to meet state requirements for licensure and scope of practice, but not additional federal requirements that may exceed state requirements. This gives states and facilities more flexibility in using clinicians in these roles to meet increased demand. These flexibilities have been implemented while remaining consistent with a state or pandemic/emergency plan. CMS will end this waiver at the conclusion of the COVID-19 PHE.
  - CAH staff licensure: CMS has 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 must still be in compliance with applicable federal, state and local laws and

regulations, and all patient care must be furnished in compliance with state and local laws and regulations. This waiver defers all licensure, certification, and registration requirements for CAH staff to the state, which adds flexibility where federal requirements are more stringent. This flexibility has been implemented while consistent with a state or pandemic/emergency plan. This waiver will terminate at the end of the COVID-19 PHE.

- Responsibilities of physicians in CAHs: 42 C.F.R. § 485.631(b)(2). CMS has 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 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, assures an appropriate level of physician direction and supervision for the services provided by the CAH. This allows the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed. CMS will end this waiver at the conclusion of the PHE.

- 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 has had the authority to make those staffing decisions. This waiver ends upon the conclusion of the PHE.
- CMS has exercised enforcement discretion and has not enforced the current clinical indications in LCDs for therapeutic continuous glucose monitors during this public health emergency. This change is intended to permit more COVID-19 patients with diabetes to better monitor their glucose and adjust insulin doses from home. This waiver ends upon the conclusion of the PHE.
- Medicare provider enrollment:
  - 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. When the PHE ends, CMS will resume normal application processing times.
  - Opt-Out Enrollment: CMS allowed practitioners to cancel their opt-out status early and enroll in Medicare to provide care to more patients. When the PHE ends, this waiver will terminate and opted-out practitioners will not be 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. When the PHE ends, practitioners will be required to resume reporting their home address on the Medicare enrollment.

- "Stark Law" Waivers: 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. When the PHE ends, the waivers will terminate and physicians and entities must immediately comply with all provisions of the Stark Law.
- Verbal Orders: CMS has 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 is still required but authentication may occur later than 48 hours. This has allowed for more efficient treatment of patients in a surge situation. CMS will end this waiver at the conclusion of the PHE.
- Medical Staff Requirements: CMS has 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. CMS has been waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process. CMS will end this waiver at the conclusion of the COVID-19 PHE.

- Immigration
  - End of Title 42 and return to processing all noncitizens under the Department's Title 8 immigration authorities. To this effect, DHS announced new border enforcement measures to improve border security, limit irregular migration, and create additional safe and orderly processes for people fleeing humanitarian crises to lawfully come to the United States.

COVID-19 Flexibilities that end prior to the end of the Public Health Emergency:

- Medicaid Coverage and Federal Match Rates
  - For continuous enrollment: the Consolidated Appropriations Act, 2023 (CAA) delinks the continuous enrollment provision from the Public Health Emergency and ends continuous enrollment on ***March 31, 2023***.
    - States will then be able to start processing Medicaid redeterminations and disenrolling residents who no longer qualify, starting **April 1**. They have 14 months to review the eligibility of their beneficiaries.
- Licensure/telehealth
  - All states and D.C. temporarily waived some aspects of state licensure requirements as part of the PHE, so that providers with equivalent licenses in other states could practice via telehealth.

        - in some states; these waivers are still active and tied to the end of the PHE, in others they have expired. Some states have made allowances for long-term or permanent interstate telemedicine.
- Nutrition
    - The Consolidated Appropriations Act, 2023 terminates emergency allotments (EA) (supplements) through SNAP after the issuance of **February 2023** benefits, except for those states that have already ended the EA (i.e., Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Missouri, Montana, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee and Wyoming).

COVID-19 Flexibilities that continue past the end of the Public Health Emergency:

- Coverage, Costs, and Payment for COVID-19 Testing, Treatments, and Vaccines
    - For Medicare beneficiaries, Coverage of COVID-19 vaccines will continue at no cost due to statutory changes made by the CARES Act that added coverage of COVID-19 vaccines to Medicare Part B. Clinical diagnostic testing is also covered at no cost.
        - Oral antivirals for COVID-19 that otherwise meet the statutory requirements for Part D coverage at section 1860D-2(e) of the Social Security Act must be covered by Part D plans, as a formulary product or through the formulary exception process, immediately upon FDA approval.
        - CMS will continue to pay a total payment of approximately $75 per dose to administer COVID-19 vaccines in the home for certain Medicare patients through the end of the calendar year that the PHE ends (**end of 2023**). Note: The Calendar Year 2023 Physician Fee Schedule proposed rule includes proposals that could impact these policies, and we anticipate issuing the final rule later this year.
        - Effective January 1 of the year following the year that the PHE ends (**January 1, 2024**), CMS will pay for monoclonal antibodies:
            - As they pay for biological products under Section 1847A of the Social Security Act.
            - Through the applicable payment system, using the appropriate coding and payment rates, similar to the way they pay for administering other complex biological products. Note: The Calendar Year 2023 Physician Fee Schedule proposed rule includes proposals that could impact these policies, and we anticipate issuing the final rule later this year.
    - For Medicaid and CHIP enrollees, coverage of COVID-19 vaccines will continue as a mandatory benefit for both children and adults.
        - No longer tied to PHE; provisions in the IRA require Medicaid and CHIP programs to cover all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for adults, including the COVID-19 vaccine, and vaccine administration without cost sharing as a mandatory Medicaid benefit (coverage

of ACIP-recommended vaccines for children in Medicaid and CHIP was already required).
        - States will continue to cover COVID-19 tests that are ordered by a physician and provided in an office or similar setting.
            - Ends last day of the first calendar quarter beginning one year after end of PHE (**March 31, 2024**).
    - The vast majority of people with private insurance will continue to have coverage of COVID-19 vaccines at no cost from in-network providers, due to the Affordable Care Act (ACA) and statutory changes made by the CARES Act.
        - Because there is no federal law specifically addressing how COVID-19 treatment should be covered by private insurance, there would be no change with the end of the PHE.
- Medicaid Coverage and Federal Match Rates
    - The Consolidated Appropriations Act, 2023 also phases down the enhanced federal funding through **December 31, 2023**.
- Other Medicaid and CHIP Flexibilities
    - COVID-19 Section 1115 demonstration waivers allow HHS to approve state requests to operate Medicaid programs without regard to specific statutory or regulatory provisions to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.
        - **60 days after the PHE ends or earlier** date approved by CMS.
    - Section 1915(c) Appendix K waivers allow HHS to approve state requests to amend Section 1915(c) or Section 1115 HCBS waivers to respond to an emergency. For example, states can modify or expand HCBS eligibility or services, modify or suspend service planning and delivery requirements, and adopt policies to support providers.
        - **No later than six months after the PHE ends.**
- Other Medicare Payment and Coverage Flexibilities
    - Medicare Advantage plans are required to cover services at out-of-network facilities that participate in Medicare, and charge enrollees who are affected by the emergency and who receive care at out-of-network facilities no more than they would face if they had received care at an in-network facility.
        - Per new Medicare rules finalized by CMS in 2022, **ends 30 days after the latest applicable end date of PHE, national emergency, or state disaster declaration** (when multiple declarations apply to the same geographic area), i.e., ends when all sources that declared a disaster or emergency that include the service area have declared an end; or there is no longer a disruption to access of health care.
    - Enhanced Medicare Payments for New COVID-19 Treatments: until **the end of the FY in which the COVID-19 PHE ends,** the Medicare program has provided an enhanced payment for eligible inpatient cases that involve use of certain new products authorized or approved to treat COVID-19 (86 FR 45162). The enhanced payment is equal to the lesser of: 1) 65% of the operating outlier threshold for the claim; or 2) 65% of the costs

of the case beyond the operating Medicare payment (including the 20% add-on payment under section 3710 of the CARES Act) for eligible cases.
    - RHCs and FQHCs can report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way in-person visits are reported and reimbursed, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. Payment under HCPCS code G2025 will no longer apply to medical or mental health visits furnished via telehealth. This payment policy for mental health visits was made permanent for RHCs and FQHCs in the CY 2022 PFS final rule.
- Other Private Insurance Coverage Flexibilities
    - Extension of election and notice deadlines for COBRA, other group health plan provisions: group health plans subject to ERISA or the Internal Revenue Code must disregard "the Outbreak Period" (defined as the period beginning March 1, 2020 and ending 60 days after the end of the COVID-19 National Emergency **(July 10, 2023), or such other end date announced**) in determining the following periods and dates:
        - the 60-day election period for COBRA continuation coverage.
        - the date for making COBRA premium payments.
        - the deadline for employers to provide individuals with notice of their COBRA continuation rights.
        - the 30-day (or 60-day in some cases) Special Election Period (SEP) to request enrollment in a group health plan.
        - the timeframes for filing claims under the plans claims-processing procedures.
        - the deadlines for requesting internal and external appeals for adverse benefit determinations.
- Telehealth
    - Consolidated Appropriations Act, 2023 extended Telehealth flexibilities through **December 31, 2024**
        - Flexibilities include:
            - Medicare beneficiaries in any geographic area can receive telehealth services, rather than beneficiaries living in rural areas only.
            - Beneficiaries can remain in their homes for telehealth visits reimbursed by Medicare, rather than needing to travel to a health care facility.
            - Telehealth visits can be delivered via smartphone in lieu of equipment with both audio and video capability.
            - An expanded list of Medicare-covered services can be provided via telehealth.
            - Federally qualified health centers and rural health clinics can provide telehealth services to Medicare beneficiaries (i.e., can be distant site providers), rather than limited to being an originating site provider for telehealth (i.e., where the beneficiary is located).
    - Based on changes in the Consolidated Appropriations Act of 2021, Medicare has permanently removed geographic restrictions for mental health and substance use services and permanently allows beneficiaries to receive those services at home.

Medicare also now permanently covers audio-only visits for mental health and substance use services.
    - Medicaid telehealth flexibilities vary by state.
        - As of summer 2022, most states have adopted, or plan to adopt, Medicaid telehealth expansions, including permanent adoption of telehealth policies enacted during the COVID-19 pandemic. However, some states report limitations to telehealth policies that had been temporarily expanded during the pandemic. In these states, enrollees may lose access to certain services delivered via telehealth and/or to other telehealth flexibilities (such as audio-only telehealth).
    - Opioid Treatment Programs (OTPs): During the PHE, patient counseling and therapy services have been provided by telephone in cases where two-way interactive audio-video communication technology is not available to the beneficiary, and all other applicable requirements are met. This flexibility has been made permanent for OTPs in the CY 2022 PFS final rule.
- Licensure
    - All states and D.C. temporarily waived some aspects of state licensure requirements as part of the PHE, so that providers with equivalent licenses in other states could practice via telehealth.
        - in some states; these waivers are still active and tied to the end of the PHE, in others they have expired. Some states have made allowances for long-term or permanent interstate telemedicine.
    - 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, when the PHE ends, CMS regulations will 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.
- Liability Immunity to Administer Medical Countermeasures
    - Liability immunity has been extended to providers based on the Public Readiness and Emergency Preparedness (PREP) Act emergency declaration to allow for greater delivery of and access to medical countermeasures. For example, liability immunity has been extended to:
        - pharmacists and pharmacy interns to administer COVID-19 vaccines (and other immunizations) to children between the ages of 3 and 18, pre-empting any state law that had age limits.
        - healthcare providers licensed in one state to vaccinate against COVID-19 in any state.
        - physicians, registered nurses, and practical nurses whose licenses expired within the past five years to administer COVID-19 vaccines in any state.
    - End of PREP Act declaration specified duration: **October 1, 2024** (with some exceptions, e.g., manufacturers have an additional 12 months to dispose of covered countermeasures and for others to cease administration and use).
- Access to Medical Countermeasures through FDA Emergency Use Authorization

- The FDA has issued EUAs for hundreds of COVID-19 tests, numerous COVID-19 treatments, including antiviral agents and monoclonal antibodies, and three COVID-19 vaccines (Pfizer, Moderna, and Johnson & Johnson). EUAs allow medical countermeasures to be available to the public before formal FDA approval.
    - End of § 564 emergency declaration (to be determined by the Secretary).
        - **The timing to conclude the EUA is to be determined; it will not conclude on May 11, 2023, with the other declarations.**

- Workforce (Medicare)
    - Medicare Physician Supervision Requirements: CMS has temporarily modified the regulatory definition of direct supervision, which requires the supervising physician or practitioner to be "immediately available" to furnish assistance and direction during the service, to include "virtual presence" of the supervising clinician through the use of real-time audio and video technology. This flexibility is currently set to return to pre-PHE rules at the end of the calendar year that the PHE ends (**December 31, 2023**).
    - Supervision Requirements for Non-Surgical Extended Duration Therapeutic Services: During the PHE, direct supervision has not been required at the initiation of non-surgical extended duration therapeutic services provided in hospital 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 after the PHE ends, this policy will stay in effect (85 FR 85866).
    - Medicare Nonphysician Practitioners: We created the flexibility at 42 CFR § 410.32(b), on an interim bases 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.
    - Modification of 60-day limit for Substitute Billing Arrangements (Locum Tenens): CMS has 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 public health emergency 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.

- Other Medicare flexibilities
    - 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 public health emergency, this principle has applied across the spectrum of all Medicare-covered services, and has 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 after the PHE ends.
    - Medicare Acute Hospital Care at Home Program through the end of next year (**end of 2024**).
- Nutrition
    - WIC: Most active social distancing waivers, all active food package substitution waivers, and active vendor minimum stocking requirements waivers are extended until 90 days after the end of the PHE (**August 9, 2023**).
    - SNAP: The Families First Coronavirus Response Act, temporarily extended SNAP's three-month time limit for jobless adults without a child at home to receive SNAP. These people will remain eligible for SNAP without having to report that they're working or in job training for an average of 20 hours a week, as they normally would. The suspension lasts through the month after the month in which the Secretary of Health and Human Services lifts the public health emergency (**end of June 2023**).
- Resident Supervision Requirements Under Medicare
    - Virtual Supervision Continued only in Rural Areas: CMS finalized policy that allows teaching physician to meet the requirements to bill through virtual presence when furnishing services involving residents in rural training setting. The patients' medical record must include documentation of how and when the teaching physician was present during the key portion of the service or in the case of the primary care exception, immediately after the service.
    - Telehealth Exception Continued only in Rural Areas: CMS has also finalized policy that allows teaching physicians to bill for telehealth services when a resident located in a rural training site furnishes services to a beneficiary who is in a separate location within the same rural area as the residency training site. A resident located in rural training site may also furnish telehealth services to a beneficiary who is located in a different rural location. In these cases, the teaching physician is present, through interactive, audio/video real-time communications technology (excluding audio-only), in a third

location, either within the same rural training site as the resident or outside of that rural training site. When a resident furnishes Medicare telehealth services in a rural residency training site and the teaching physician is present using interactive, audio/video real-time communications technology (excluding audio-only), the patient's medical record must clearly reflect how and when the teaching physician was present during the key portion of the service.

- Primary Care Exception Partially Continued: After the COVID-19 PHE, the primary care exception will once again be limited to services of lower and mid-level complexity (CPT 99201- 99203, 99211-99213 and HCPCS G0402, G0438, G0439). However, services under the primary care exception are expanded permanently to include online digital evaluation and management services (CPT 99421–99423), interprofessional telephone/internet/electronic health record consultation (CPT 99452), remote evaluation of recorded video and/or images submitted by an established patient (HCPCS G2010) and brief communication technology-based service (HCPCS G2012).

Relevant AMA policy/report following end of the PHE

- **Preventing Coverage Losses After the Public Health Emergency Ends (CMS Report 3-A-22)** found here starting on page 209 (more relevant policy contained in the report starting on page 215 in that link).
  - RECOMMENDATIONS from the report:
    - The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:
    - 1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
      - a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
      - b. Individuals should only be auto-transitioned in health insurance coverage if they are 16 eligible for coverage options that would be of no cost to them after the application of any subsidies.
      - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
      - d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.

    - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    - f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods.
- 2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage.
- 3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.
- 4. That our AMA reaffirm Policy H-290.982, which calls for states to streamline Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts.
- 5. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of care.
- 6. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails.