WHG Tracker: COVID-19 PHE Temporary Flexibilities

April 18, 2022

Wynne Health Group (WHG) has compiled a chart that delineates a comprehensive set of temporary flexibilities pursuant to the COVID-19 public health emergency (PHE). Under current PHE conditions, the U.S. Department of Health and Human Services (HHS) is authorized under section 1135 of the Social Security Act to waive a range of Medicare and Medicaid requirements as a means for responding to public health emergencies. During this current PHE, HHS has waived several requirements enabling the health care system to respond more swiftly to the evolving pandemic. In brief, we capture flexibilities across the following domains:

As it stands now, except for those which Congress or the Administration have specifically addressed in legislation or regulation, most PHE flexibilities will expire once the PHE declaration ends. Currently, there is uncertainty about when the PHE will end. HHS has vowed to give states a 60-day notice to states prior to the end of the COVID-19 PHE – i.e., terminating the PHE or allowing the PHE to expire. While the PHE is currently set to end on April 16, HHS did not give notice that it intends to let the PHE expire, so we anticipate it will extend the PHE at least one more time until July 15. Given this, we expect HHS to give notice by May 16 if it plans to end the PHE in July. If it does not, we can expect HHS Secretary Becerra to extend the PHE another 90 days to October 13.

Many of these flexibilities have been in place since the early months of the pandemic and have reshaped the way health care providers and others deliver care in the United States. As a result, many are deliberating the extent to which federal policymakers should permit certain flexibilities to continue beyond the PHE. While the Medicare telehealth flexibilities have gained considerable attention with respect to the end of the PHE, many other critical flexibilities will also cease to be in effect once the PHE ends, including several across many different elements of Medicaid (while we outline these Medicaid flexibilities below, additional detail is available here).

To support these efforts, we display the range of PHE flexibilities currently in place and their end dates relative to the current PHE authorities. We also briefly indicate whether these flexibilities would require legislative or regulatory changes to be made permanent.

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Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
Medicare Telehealth Flexibilities			
Originating and Geographic Site Restrictions	Waives the originating site and rural requirements allowing beneficiaries to receive telehealth services in their home.	151-days following the end of the PHE	Legislative changes required.
Full Payment Parity (i.e., Inclusive of Facility Fee)	Continues to reimburse providers billing for telehealth according to the payments they would have received had they furnished the services in-person[1] but also ensures that the "facility fee" is paid when the originating site is a beneficiary's home (for which a facility fee is currently precluded)	End of PHE	Legislative changes required.
Eligible Practitioners	Waives the requirements that specify the types of practitioners that may bill for Medicare telehealth services from the distant site. This allows previously ineligible health care professionals to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, and speech language pathologists.	151-days following the end of the PHE	Legislative changes required.
Audio-only Technologies	Waives the video requirements of telehealth services to permit audio-only equipment to furnish services via audio-only technologies (i.e., telephones) for select services, including evaluation & management (E&M) services, and behavioral health counseling and educational services. Establishes a higher reimbursement rate for telephone E/M services based on crosswalks to the most analogous office/outpatient E/M codes.	151-days following the end of the PHE	Legislative and regulatory changes required.
Newly Eligible Telehealth Services	Includes new codes to the list of eligible Medicare telehealth services, including codes for emergency department visits, observation services, nursing facility visits, home visits, inpatient neonatal and pediatric critical care, end-stage renal disease (ESRD) services, and more.	End of PHE	Regulatory changes required.

[1] Pursuant to section 1834(m)(2)(A): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	Note: Some services originally added under emergency waiver authority have since been added to the Medicare telehealth list on a category 3 basis and will not lose covered status once the PHE ends. Those services that have not been added by CMS to the Medicare telehealth list, however, will no longer be covered once the PHE ends.		
Process for Adding Telehealth Services	Establishes a sub-regulatory process to modify the services included on the Medicare telehealth list.	End of PHE	Legislative changes required.
Federally Qualified Health Centers and Rural Health Clinics	Allows FQHCs and RHCs to furnish telehealth services.	151-days following the end of the PHE	Legislative changes required.
Long-Term Care Facility Waiver	Waives the requirement for physicians and non-physician practitioners to perform in-person visits to allow for providers to furnish these services via telehealth.	End of PHE	Regulatory changes required.
Critical Access Hospital Waiver	Waives provisions related to telehealth, making it easier for telehealth services to be furnished to the hospital's patients through an agreement with an off-site hospital.	End of PHE	Regulatory changes required.
Medicare Advantage (MA) and Part D Plan Waiver	Allows MA plans to make changes to their benefit packages regarding telehealth services in real-time (i.e., before the bid submission deadline).	End of PHE	Regulatory changes required.
Interactive Communication System Clarification	Allows a temporary exception clarifying that mobile phones with audio and visual capabilities qualify as an "interactive telecommunications system" for the purposes of telehealth.	End of PHE	Regulatory changes required.
Remote Patient Monitoring	Allows providers to use communication technology-based services (CTBS) – which are considered related to but separate from telehealth services – to both new and established patients. These include certain kinds of remote patient monitoring and remote interpretation of diagnostic tests.	End of PHE	Regulatory changes required.
Opioid Treatment Programs (OTPs)	Allows OTPs to furnish periodic assessments via two-way interactive audio-visual communication technology or audio-only	End of PHE	Regulatory changes required.

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	telephone calls, if the beneficiary lacks access to audio-video community technology, during the PHE.		
EUAs/Vaccines			
Emergency use authorization (EUA) for COVID-19 vaccines	The FDA has three current EUAs for vaccines to prevent against COVID-19 infection.[2]	When the EUA declaration is terminated or specific EUAs are revoked	Pfizer and Moderna have received full approval for their vaccines. It is likely that other sponsors will pursue full approval
EUA for COVID-19 therapeutics	The FDA has issued EUAs for fifteen drug and non-vaccine biological products for the treatment of COVID-19.[3]	When the EUA declaration is terminated or specific EUAs are revoked	No transition planned has been outlined for COVID-19 therapeutics, but sponsors are likely to pursue full approval
Medical devices issued EUAs during the COVID-19 PHE	The FDA authorized the emergency use of unapproved products or unapproved use of an approved product for certain emergency circumstances.	When the EUA declaration is terminated	Sponsors have 180 days to seek full approval once the EUA declaration is terminated.[4]
Medical devices that fall within enforcement policies issued during the PHE	The FDA issued a series of enforcements polices that allowed for the marketing of devices otherwise not cleared or approved by the agency, including face masks, surgical masks,	180 days after the PHE expires or;	Sponsors may use the 180 days to come into compliance with regulatory requirements

[2] https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#vaccines
[3] https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs
[4] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/transition-plan-medical-devices-issued-emergency-use-authorizations-euas-during-coronavirus-disease

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	respirators, gowns and gloves, sterilizers, disinfectant devices, air purifiers, ventilators, and other respiratory devices	180 days after the final guidance is issued if it is issued after the end of the PHE[5]	
Provider Flexibilities			
Medicare-Only Provisions			
Over the Counter COVID-19 Tests	Allows Medicare Part B beneficiaries to obtain up to eight over the counter COVID-19 tests each calendar month from a participating pharmacy or health care provider with no cost sharing.	End of PHE	Regulatory
Quality Measure Suppression/Quality Reporting Flexibilities	In response to COVID-19, CMS adopted a measure suppression policy for hospitals and post-acute care providers participating in Medicare value-based purchasing and quality reporting programs (QRPs) (e.g., the Readmissions Reduction Program (HRRP)). The policy applies to specific measures and/or reporting timeframes adversely impacted by COVID-19.[6] CMS granted exceptions from and extensions for reporting and data submission requirements for clinicians and providers participating in Medicare QRPs.[7] However, with some exceptions, most remaining COVID-19 PHE-related flexibilities (e.g., flexibilities related to Merit-based Incentive Payment	For hospitals and PAC providers, end of PHE for the suppression of certain quality measures adversely impacted by COVID-19 or as stipulated in corresponding Medicare provider regulations.	Regulatory

[5] https://www.fda.gov/media/155038/download
[6] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-0
[7] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/966/QPP%20COVID-19%20Response%20Fact%20Sheet.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	System (MIPS)) are primarily extended via CMS' Extreme and Uncontrollable Circumstances (EUC) Exceptions policy.[8]	For clinicians and physicians participating in Medicare QRPs, exceptions generally granted on an EUC basis (some automatic, some via application).	
Part B Drugs	Allows Medicare payment for replacement of covered Part B prescription drug refills (for a quantity up to the amount originally dispensed) if the medication has been lost or deemed unusable due to a disaster or emergency. Also affords MACs discretion to reimburse for drug quantities that exceed usual supply limits and to allow payment for larger quantities of drugs if/when necessary. Also waives signature requirements for Part B drugs (and certain DMEPOS) requiring proof of delivery and/or a patient signature.	End of PHE	Regulatory
GME/Teaching Hospitals	Extends the submission deadline for certain new Medicare Graduate Medical Education (GME) affiliation agreements and certain amendments to existing Medicare GME affiliation agreements. *Note: In the CY 2022 Medicare PFS final rule, CMS clarified that, during the COVID-19 PHE, the teaching physician's time when they are present through audio/video (AV) real-time communications technology may also be included in the total time considered for each office/outpatient Evaluation &*	End of PHE	Regulatory

[8] https://qpp.cms.gov/mips/exception-applications

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	Management (E&M) visit level. Outside of the COVID-19 PHE, the teaching physician presence requirement can be met virtually only in residency training sites located outside a metropolitan statistical area (MSA).[9]		
Certain Workforce/Scope of Practice Issues	In the CY 2021 Medicare PFS final rule, CMS made permanent several workforce flexibilities provided during the COVID-19 PHE that allow non-physician practitioners (NPPs) to practice at the top of their license without additive Medicare programmatic restrictions. This included changes pertaining to: teaching physicians and resident "moonlighting" services; supervision of diagnostic tests by certain NPPs; pharmacists providing services incident to physicians' services; provision of maintenance therapy by physical therapy assistants (PTAs) and occupational therapy assistants (OTAs).	Permanent	N/A – Permanently Codified via Regulation
Hospitals – Including Psychiatric Hospitals; Critical Access Hospitals (CAHs), Including Cancer Centers; and Long-Term Care Hospitals (LTCHs)			
Nursing Services (Hospital at Home, AHCaH Initiative)[10]	Waives certain regulatory requirements of hospitals and CAHs requiring nursing services be provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any patient. In March 2020, CMS launched its temporary Hospitals Without Walls Program whereby hospitals can transfer patients to outside facilities – e.g., ASCs, IRFs, hotels, and dormitories – while still receiving Medicare hospital payments. [11] Building on this concept, in November 2020, CMS launched the Acute Hospital Care At	End of PHE	Legislative (w/ Corresponding Regulatory Changes)

[9] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule
[10] https://qualitynet.cms.gov/acute-hospital-care-at-home; and https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge
[11] https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	Home (AHCaH) Initiative, whereby eligible hospitals could apply for a waiver to treat eligible patients in their homes.[12]		
EMTALA	Waives certain hospital Emergency Medical Treatment & Labor Act (EMTALA) obligations. Allows hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital's campus.	End of PHE	Legislative
Verbal Orders	Waives several regulatory requirements to provide flexibility related to verbal orders where readback verification is required but authentication may occur later than 48 hours.	End of PHE	Regulatory
Reporting Requirements	Waives the requirement that hospitals report patients in an intensive care unit (ICU) whose death is caused by their disease but who required soft wrist restraints (e.g., to prevent pulling tubes/IVs) no later the close of business (COB) on the next business day. Hospitals must still report deaths where restraint may have contributed within the requisite period.	End of PHE	Regulatory
Patient Rights	Waives certain patient rights (e.g., timeframes for providing a copy of a medical record, patient visitation, etc.) only for hospitals considered to be impacted by a widespread COVID-19 outbreak.	End of PHE	Regulatory
Sterile Compounding	Waives regulatory requirements intended to conserve scarce mask supplies by allowing used face masks to be removed and retained in the compounding area and to be reused during the same work shift in the compounding area only.	End of PHE	Regulatory
Discharge Planning	Waives certain regulatory requirements of hospitals and CAHs to provide detailed discharge planning information to patients, their families, or their representatives. Also waives certain discharge planning regulatory requirements of hospitals related to post-acute care services.	End of PHE	Regulatory

[12] https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
Medical Staff	Waives certain regulatory requirements to alleviate workforce concerns regarding the physician credentialing and privileging process.	End of PHE	Regulatory
Medical Records	Waives certain regulatory requirements pertaining to medical record organization, staffing, and retention. Also affords flexibility in the completion of medical records within 30 days following hospital discharge.	End of PHE	Regulatory
Advance Directives	Waives certain regulatory requirements of hospitals and CAHs to provide information regarding advance directives to patients.	End of PHE	Regulatory
Physical Environment	Waives certain regulatory physical environment requirements to allow for increased flexibilities for surge capacity and patient quarantine because of COVID-19 (e.g., permits facility and non-facility not normally used for patient care to be used for patient care or quarantine).	End of PHE	Regulatory
Physician Services	Waives certain regulatory requirements stipulating that Medicare patients be under the care of a physician, i.e., allowing hospitals to leverage other practitioners as necessary.	End of PHE	Regulatory
Anesthesia Services	Waives regulatory requirements pertaining to certified registered nurse anesthetist (CRNA) supervision requirements. Applies to hospitals, CAHs, and ASCs.	End of PHE	Regulatory
Utilization Review	Waives certain regulatory requirements pertaining to utilization review (UR) hospital conditions of participation (CoPs) – e.g., evaluating the medical necessity of the patient's admission, duration of stay, and services provided.	End of PHE	Regulatory
Written Policies and Procedures for Appraisal of Emergencies at Off-Campus Hospital Departments	Waives certain regulatory requirements for surge facilities only pertaining to written policies and procedures for staff to use when evaluating emergencies.	End of PHE	Regulatory
Emergency Preparedness Policies and Procedures	Waives certain regulatory requirements of hospitals and CAHs regarding the development and implementation of specified emergency preparedness policies and procedures.	End of PHE	Regulatory
QAPI Program	Waives certain regulatory requirements of hospitals and CAHs pertaining to the Quality Assurance and Performance	End of PHE	Regulatory

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	Improvement (QAPI) program, while ensuring that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.		
Food and Dietetic Services	Waives regulatory requirements of surge hospitals to maintain a current therapeutic diet manual approved by the dietician and medical staff and readily available to all medical, nursing, and food service personnel.	End of PHE	Regulatory
Respiratory Care Services	Waives regulatory requirements of hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and accompanying personnel supervision requirements.	End of PHE	Regulatory
"Swing Bed" Providers	Waives regulatory requirements to allow hospitals to establish Skilled Nursing Facility (SNF) swing beds payable under the SNF prospective payment system (PPS) for patients who do not require acute care but are unable to find placement in a SNF provided certain criteria are met.	End of PHE	Regulatory
CAH-Specific Provisions	Delineates certain modifications to existing CAH requirements regarding personnel qualifications; staff licensure; status and location; and length of stay (LOS). For example, re: LOS, waives the requirements that CAHs limit the number of beds to 25 and that the LOS be limited to 96 hours. Also waives certain responsibilities of physicians in CAHs to allow the physician to perform direction and supervision responsibilities remotely, as appropriate.	End of PHE	Regulatory
LTCH-Specific Provisions	Waives certain site-neutral payment rate provisions for LTCHs such that all LTCH cases admitted during the COVID-19 PHE are paid the relatively higher LTCH PPS standard federal rate; and provides flexibility regarding the 25-day average LOS requirement.	End of PHE	Regulatory
Temporary Expansion Locations	Waives certain regulatory requirements to allow hospitals (and ASCs pursuant to certain criteria) to establish and operate as	End of PHE	Regulatory

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	part of the hospital any location meeting applicable hospital CoPs (i.e., those not waived during the PHE).		
COVID-19 Vaccination COPs	Modifies CoPs regarding the preparation and administration of drugs to allow for hospital and community administration of COVID-19 vaccines.	End of PHE (though presumably will be continued)	Regulatory
Housing Acute Care Patients in the IRF or IPF Excluded Distinct Part Units	Allows acute care hospitals to, due to a disaster or emergency, house acute care inpatients in excluded distinct part units, such as distinct part unit inpatient rehabilitation facilities (IRFs) or inpatient psychiatric facilities (IPFs).	End of PHE	Regulatory
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed due to a disaster or emergency.	End of PHE	Regulatory
Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient rehabilitation units to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed due to a disaster or emergency.	End of PHE	Regulatory
Care for Patients in Extended Neoplastic Disease Care Hospitals	Affords flexibility to neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges from the greater than 20-day average LOS requirement.	End of PHE	Regulatory
Post-Acute Care (PAC) Providers			
IRFs	Provides IRFs with flexibility to comply with the “60 percent rule” (relative to the threshold to receive payment as an IRF); and the requirement that IRF patients generally receive at least 15 hours therapy/week (“3-hour rule”). *Note: In the FY 2021 IRF PPS final rule, CMS permanently eliminated the post-admission physician evaluation, reasoning that much of this information is contained in the pre-admission screening and the patient’s plan of care. Prior to the PHE and this change, IRFs were required to conduct a post-admission*	End of PHE unless otherwise specified	Regulatory

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	physical evaluation within the first 24 hours of the patient's admission to the IRF.[13]		
SNFs and NFs	Waives several regulatory requirements including requirements pertaining to the following: a 3-day prior hospitalization for coverage of a SNF stay; pre-admission screening and annual resident review (PASARR); resident participation in in-person resident groups; training and certification of nurse aides; physician visits in SNFs/NFs; resident roommates and grouping; resident transfer and discharge under certain circumstances; physician services (e.g., physician delegation of tasks in SNFs); QAPI flexibilities; nurse aide in-person training; detailed discharge planning; clinical records; paid feeding assistants; and more recent stipulations regarding the Director of Food and Nutrition Services.	End of PHE unless specified to end by CMS sooner (i.e., on or around May 7, 2022 or June 7, 2022) pursuant to CMS guidance issued in April 2022[14]	Regulatory
HHAs	Waives several regulatory requirements pertaining to initial assessments, allowing home health agencies (HHAs) to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review; and certain requirements stipulating that a nurse conduct an onsite visit every two weeks. Other provisions allow occupational therapists (OTs), physical therapists (PTs), and speech language pathologists (SLPs) to perform the initial and comprehensive assessment for all patients. Certain relief is also afforded to HHAs allowing Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies; certain OASIS reporting flexibilities; modifications regarding the 12-hour annual in-service training requirement of home health aides; detailed	End of PHE unless otherwise specified	Regulatory

[13] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-inpatient-rehabilitation-facility-irf-prospective-payment-system-pps-cms-1729-f#:~:text=Currently%2C%20except%20during%20the%20COVID,still%20appropriate%20for%20IRF%20admission

[14] https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	information sharing for discharge planning; and flexibility regarding the provision of a patient's clinical record within a stipulated timeframe. Certain other flexibilities extend to HHAs *and* hospices, including training and assessment of aides and QAPI. *Note: In the CY 2021 HHA PPS final rule, CMS codified the COVID-19 driven change requiring that a home health plan of care include any provision of remote patient monitoring (RPM) or other services furnished via telecommunications systems, and that the plan of care include how the use of this technology addresses patient-needs and goals included in the care plan.*[15] *More recently, CMS permanently codified in the CY 2022 HHA PPS final rule COVID-19 driven waivers related to home health aide supervision and the use of telecommunications for unplanned occurrences and new hospice survey and enforcement elements.*[16]		
Hospice	Delineates several flexibilities extended to hospice providers including requirements regarding volunteer use; comprehensive assessments; non-core services; onsite visits for hospice aide supervision; hospice aide competency testing allowing use of pseudo patients; 12-hour annual in-service training requirement for hospice aides; and other annual training requirements. Certain other flexibilities extend to HHAs *and* hospices, including training and assessment of aides and QAPI.	End of PHE unless otherwise specified (e.g., certain waivers slated to end sooner pursuant to CMS guidance issued in April 2022)[18]	Regulatory

[15] https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-calendar-year-2021-payment-and-policy-changes-home-health-agencies-and-calendar-year
[16] https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-calendar-year-2022-home-health-prospective-payment-system-rate-update-home-health
[18] https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	Note: CMS permanently codified in its FY 2022 Hospice Wage Index and Payment Update final rule certain PHE-related hospice CoP flexibilities including: permitting skill competencies to be assessed by observing a new hospice aide performing the skill with either a patient or a pseudo-patient as part of a simulation; and stipulating that if an area of concern is verified during a hospice aide training by the hospice during an on-site visit, the hospice must conduct, and the aide must complete, a competency evaluation of the deficient skill and all related skills.[17]		
Other Providers and Suppliers			
SCHs and MDHs	Waives certain eligibility requirements (e.g., number of beds) for hospitals classified as Sole Community Hospitals (SCHs) or Medicare-Dependent, Small Rural Hospitals (MDHs) prior to the COVID-19 PHE to meet the needs of their community, provide for increased capacity, etc.	End of PHE	Regulatory
RHCs and FQHCs	Waives certain staffing, physician supervision of nurse practitioners (NP), and temporary expansion location requirements of rural health clinics (RHCs) and federally qualified health centers (FQHCs).	End of PHE	Regulatory
ESRD Facilities	Delineates several flexibilities extended to End-Stage Renal Dialysis (ESRD) facilities, including those pertaining to: modification of the time period for initiation of care planning and monthly physician visits; provision of renal dialysis to ESRD patients residing in nursing homes, long-term care (LTC) facilities, assisted living facilities (ALFs) and similar facilities, as licensed by the state (along with a clarification of corresponding billing procedures); waiver of certain training and periodic audits; deference of equipment maintenance and fire safety	End of PHE unless otherwise specified (e.g., certain waivers slated to end sooner pursuant to CMS guidance issued in April 2022)[20]	Regulatory

[17] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-hospice-payment-rate-update-final-rule-cms-1754-f
[20] https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	inspections; waiver of certain emergency preparedness requirements (e.g., maintenance of CPR certifications among patient care staff); delay of some patient assessments; waiver of requirements stipulating the periodic monitoring of the patient's home adaptation; clarification of home dialysis machine designation; expansion of Special Purpose Renal Dialysis Facilities (SPRDFs) designation to address access to care issues due to COVID-19 and mitigate transmission of COVID-19 among this vulnerable population; modification of dialysis patient care technician (PCT) certification; and transferability of physician credentialing to allow physicians credentialed at a certified dialysis facility to provide care at designated isolation locations without separate credentialing at that facility. *Note: In the CY 2021 ESRD PPS final rule, CMS codified a provision for the duration of the PHE essentially holding harmless ESRD facilities that would otherwise qualify for the low-volume payment adjustment (LPVA) if they experience an increase in treatment amounts in 2020 due to COVID-19.*[19]		
DMEPOS	Permits Medicare Administrative Contactors (MACs) to waive certain replacement requirements when Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered not usable. Pauses the requirement to send a prior authorization (PA) request for certain DMEOS items and supplies and waives signature requirements for certain DMEPOS (and Part B drugs) requiring proof of delivery and/or a patient signature.	End of PHE	Regulatory

[19] https://www.cms.gov/newsroom/fact-sheets/medicare-program-end-stage-renal-disease-prospective-payment-system-payment-renal-dialysis-services

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	Note: CMS revised DME fee schedule amounts to account for the COVID-19 PHE pursuant to the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).[21]		
ASCs	Delineates various flexibilities for Ambulatory Surgical Centers (ASCs), including those pertaining to the reappraisal or review of medical staff privileges and scope of procedures performed; and the waiver of certain nursing services or ASCs enrolling as hospitals during the PHE as part of the Hospitals Without Walls Program.[22]	End of PHE	Regulatory
ICF/IIDs	Stipulates various flexibilities for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID), including staffing flexibilities; suspension of community outings; suspension of mandatory training requirements; and modification of adult training programs and active treatment.	End of PHE unless otherwise specified (e.g., certain waivers slated to end sooner pursuant to CMS guidance issued in April 2022)[23]	Regulatory
CMHCs	Stipulates various flexibilities for community mental health clinics (CMHCs), including those pertaining to waiver of QAPI requirements; provision of partial hospitalization services and other CMHC services in an individual's home; and the waiver of the requirement that CMHCs provide at least 40 percent of its items and services to individuals ineligible for Medicare benefits.	End of PHE	Regulatory
Ground Ambulance Services	Authorizes Medicare reimbursement for ground ambulance services furnished in response to a 911 call to patients who	End of PHE	Legislative (e.g., Ambulance TIP

[21] https://www.cms.gov/newsroom/fact-sheets/medicare-durable-medical-equipment-prosthetics-orthotics-and-supplies-dmepos-final-rule-cms-1738-f
[22] https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge
[23] https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	were not transported to Medicare-permitted destinations (e.g., local emergency department (ED)) due to community-wide emergency medical service (EMS) protocol to preserve health system capacity during the PHE (i.e., Ambulance Treatment-in-Place (TIP)). Also modifies the data collection and reporting period for certain ground ambulance organizations.		Provisions) and Regulatory (e.g., Data Collection and Reporting Requirements)
Provisions Impacting Multiple Providers and Suppliers			
Physical Environment	Waives certain physical environment requirements for hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs reduce disruption to patient care and potential COVID-19 transmission. This includes certain inspection, testing, and maintenance (ITM) requirements for facilities and medical equipment.	End of PHE	Regulatory
LSC	Waives and modifies certain Specific Life Safety Code (LSC) waivers for hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs, including provisions regarding alcohol-based hand-rub (ABHR) dispensers; fire drills (given quarantine guidance); and temporary construction (e.g., to permit temporary walls and barriers between patients).	End of PHE	Regulatory
Miscellaneous			
Practitioner Locations	Waives requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state, when certain conditions are met.	End of PHE	Regulatory
Provider Enrollment	Waives several requirements associated with provider enrollment, including the application fee, criminal background checks, site visits, revalidation actions, and others.	End of PHE	Regulatory
Locum Tenens	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time they are unavailable to provide services during the public health emergency.	60 days following the end of the PHE	Legislative
Appeals	Allows Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) in Medicare fee for	End of PHE	Regulatory

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	service, as well as Medicare Advantage and Part D Independent Review Entities (IREs), to allow an extension to file an appeal.		
FMAP Increases			
COVID-19 Vaccine Administration	Requires coverage of COVID-19 vaccines and their administration, without cost-sharing, for all Medicaid and CHIP enrollees, 100 percent FMAP.[24]	Last day of the first quarter that begins one year after the last day of the PHE	Legislative change needed to maintain 100 percent FMAP. However, coverage without cost-sharing will continue for all children, regardless of Medicaid expansion status, and adults in expansion states. Legislative change needed to universally require adult coverage without cost-sharing of all vaccines recommended by the Advisory Committee on Immunization Practices, including COVID-19 vaccine.[25]
Medicaid Expansion Incentive	Provides an 8-quarter 5 percentage point FMAP increase to a state that expands Medicaid.[26]	Not linked to PHE, available	Legislative change required.

[24] Sections 9811 and 9821 of ARPA, P.L. 117-2, https://www.congress.gov/bill/117th-congress/house-bill/1319; CMS SHO# 21-004, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf
[25] https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-2-Vaccine-Access-for-Adults-Enrolled-in-Medicaid.pdf
[26] Section 9814 of ARPA, P.L. 117-2, https://www.congress.gov/bill/117th-congress/house-bill/1319; CMS SHO# 21-004, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
		for 8-quarter period.	
Continuous Medicaid Coverage + Maintenance of Effort	States receive 6.2 percent FMAP increase during the PHE if they meet five criteria related to continuous Medicaid coverage and maintenance of effort regarding Medicaid enrollment processes, premiums, and benefits. See details in the next section below.	End of the month when the PHE ends	Legislative change required
Additional Federal Funding for Urban Indian Organization (UIOs) and Native Hawaiian Health Care Systems (NHHCSs)	Provides 100 percent FMAP for medical assistance expenditures for services received through UIOs, Native Hawaiian Health Centers (NHHCs), and NHHCSs.[27]	Not linked to PHE, available through March 31, 2023.	Legislative change required.
Medicaid Continuous Coverage/Redetermination			
Continuous Medicaid Coverage + Maintenance of Effort Requirements	FFRCA provides a 6.2% increased FMAP to states that provide continuous Medicaid coverage regardless of changes in circumstances for most Medicaid beneficiaries enrolled as of or after March 18, 2020. The continuous eligibility requirement does not apply to persons that are only presumptively eligible for Medicaid. To receive this, states must also meet Maintenance of Efforts (MOE) requirements including not implementing higher premiums or more restrictive eligibility standards or processes than were in place on January 1, 2020 and covering COVID testing and therapies without cost-sharing.	End of the month when the PHE ends. States have up to 12 months after the end of the PHE to complete redeterminations and renewals.	Legislative change required
Medicaid HCBS Waivers			

[27] Section 9815 of ARPA, https://www.congress.gov/bill/117th-congress/house-bill/1319; CMS SHO# 21-004, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
HCBS Flexibilities	Expanded LTSS eligibility and benefits such as coverage for LTSS services provided by telehealth. States can pursue these flexibilities utilizing a Section 1915(c) Appendix K waiver.[28,29,30]	Depends upon state agreement with CMS. 6 months after PHE ends, if state requested CMS approval for that timeline. Otherwise, one year from the Appendix K effective date, or earlier depending upon date chosen by the state.	Regulatory or legislative
Increased FMAP for HCBS	The American Rescue Plan created a 10% FMAP increase for HCBS from April 1, 2021-March 31, 2022 for states that opt into it and maintain at least the spending level they had as of April 1, 2021. The funding could be used to "enhance, expand, or strengthen" Medicaid HCBS services such as expanding covered services, providing access to the COVID vaccine, conducting COVID outreach and education, paying for direct staffing or increasing wages, recruiting HCBS staff, and more.	States can spend enhanced funds until March 31, 2024.	Legislative
Medicaid LTSS Flexibilities			
Expanded LTSS Eligibility	Expanded Medicaid eligibility criteria for LTSS for seniors and persons with disabilities including expanded functional or	Depends upon the authority	Regulatory or legislative

[28] https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html
[29] https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf
[30] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	financial eligibility. Select states also increased the total number of HCBS waiver enrollees served.	utilized by the state to expand LTSS. See above. Additional details regarding state approaches and timelines available here.[31]	
Streamlined Enrollment	Streamlined enrollment processes for Medicaid LTSS.		
Reduced LTSS Premiums and/or Cost-Sharing	Reduced premiums and/or cost-sharing for Medicaid LTSS benefits.		
New LTSS Benefits; Relaxed Benefit Utilization Requirements	States added new LTSS Medicaid benefits, increased service utilization limits and/or relaxed prior authorization requirements.		
Provider Payments	Increased provider payment rates for LTSS, including adopt of retainer payments and/or increased institutional payment rates.		
Modified Provider Qualifications	Modified provider qualifications to increase access to care.		
Medicaid Reimbursement Increases			
Advance and Interim Payments	Allows states to make periodic interim or advance payments to providers for services furnished, subject to final reconciliation, under state plan authority. CMS will consider such SPAs on an expedited basis.[32]	End of PHE for disaster relief SPAs	Regulatory change required.
Upper Payment Limit (UPL) Adjustments	Allows states to submit UPL demonstration adjustments to include additional costs or payments related to the COVID-19 pandemic.	End of PHE	Regulatory change required.
Payment Rates and Methodology	Allows states to use the disaster relief SPA to adjust payment methodologies and increase payments. This can include, but is not limited to, increasing payments for providers with an influx of Medicaid patients, accounting for decreases in service utilization but increases in cost per unit.	End of PHE	Regulatory change required.
Directed Payment Through MCOs	States can direct managed care plans to temporarily enhance provider payments under the contract to assist with the state's response to COVID-19. COVID-19-specific flexibilities include: payments may be directed at specific providers such as FQHCs, dental, or behavioral health providers; payments must be developed and implemented with a 2-sided risk mitigation	Ability to direct payments not tied to PHE. COVID-19 flexibilities will end at end of PHE.	Regulatory change required to continue flexibilities related to COVID-19.

[31] https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19/
[32] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	strategy; and states are allowed to apply directed payments retrospectively to the start of the contract rating period.[33]		
Retainer Payments	Allows states to make retainer payments to certain habilitation and personal care providers. Payments are not tied to the provision of services and allow providers to continue to be paid for certain services when circumstances such as social distancing measures prevent enrollees from receiving services. States may also direct managed care plans to provide retainer payments.	Retainer payments authorized through section 1915(c) waivers not tied to PHE. Retainer payments authorized through section 1115 waivers will end at end of PHE.[34]	Regulatory change required.
Other Medicaid Flexibilities			
Streamlined Medicaid application and enrollment processes; Modified eligibility rules; Medicaid premiums eliminated or waived.	CMS provided and approved an array of flexibilities related to enrollment, eligibility and benefits in response to the pandemic. States used 5 types of Medicaid emergency authorities to make these changes.[35,36] The end date of the change depends upon the authority used. 1. Disaster-Relief SPA: *Temporary changes to eligibility, enrollment, premiums, cost-sharing, or benefits.*	Disaster-Relief SPA: End of PHE or earlier depending on the state's choice Traditional SPA: Continues until	Depends upon the mechanism used (SPA, Section 1115 waiver, etc.)

[33] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf
[34] https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html
[35] https://www.kff.org/coronavirus-covid-19/issue-brief/state-actions-to-facilitate-access-to-medicaid-and-chip-coverage-in-response-to-covid-19/
[36] https://www.kff.org/medicaid/issue-brief/how-have-states-used-medicaid-emergency-authorities-during-covid-19-and-what-can-we-learn/

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
	2. Traditional SPA: *Changes to eligibility groups, benefits, provider reimbursement methodologies, and administration.* 3. Section 1115 Demonstration Waivers: *Allows Medicaid programs to be run without compliance with statutory or regulatory requirements.* 4. Section 1135 Waiver: *Flexibilities related to Medicaid, CHIP and Medicare to ensure access during the PHE.* 5. Section 1915(c) Appendix K Waiver: *Changes to HCBS eligibility or services in response to PHE.*	the state amends or terminates it; Section 1115 Demonstration Waivers: 60s after the PHE ends or earlier depending per state agreement with CMS Section 1135 Waiver: End of the PHE or earlier Section 1915(c) Appendix K Waiver: 6 months after PHE ends	
Prior Authorization Suspension	Provides the option for states to suspend Medicaid FFS prior authorization requirements.[37]	End of PHE	Legislative changes required.
Pre-Existing Prior Authorization Extension	Provides the option for states to require Medicaid FFS providers to extend pre-existing authorizations through which a beneficiary has previously received prior authorization.	End of PHE	Legislative changes required.
Provider Enrollment	Provides the option for states to waive several requirements associated with provider enrollment, including the application fee, criminal background checks, site visits, revalidation actions, and others.	Six months after end of PHE[38]	Legislative changes required.

[37] Table 1, https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html
[38] https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
Expedited Fair Hearings	Provides the option for states to allow managed care enrollees to bypass health plan appeal and proceed to a state fair hearing.	End of PHE	Legislative changes required.
Fair Hearing Request Extended Deadline	Provides the option for states to permit extensions of the deadline for filing appeals to request a state fair hearing.	End of PHE	Legislative changes required.
Premiums and Cost Sharing	Allows states to suspend premiums and other cost-sharing such as copayments, deductibles, coinsurance, and enrollment fees in Medicaid and CHIP.[39]	End of PHE	Regulatory changes required.
Expansion of Presumptive Eligibility Parameters	Presumptive eligibility (PE) extended to additional eligibility groups including to non-MAGI eligible groups for hospital PE; increased number of allowable PE periods within each 12-month period; state Medicaid agency permitted to determine PE for MAGI-based groups; additional entities allowed to determine PE for certain populations.	End of PHE for states that utilized a Disaster Relief SPA; otherwise based on state agreement with CMS	Regulatory, legislative, or state SPA
Extend redetermination period or delay eligibility changes based on changes in circumstances for CHIP	Altered CHIP eligibility to allow for longer redetermination periods or continued eligibility despite change in circumstances	End of PHE for states that utilized a Disaster Relief SPA	Regulatory, legislative, or state SPA
Self-attestation accepted for all eligibility criteria except citizenship or immigration status	Permits states to accept self-attestation as proof of all eligibility criteria except for citizenship and immigration status when electronic sources or documentation are otherwise unavailable.	Depends on mechanism used by state (Disaster-relief SPA, etc.)	Regulatory or legislative
Extension of the period to verify immigration status	Extends the “reasonable opportunity period” for verifying immigration status as part of Medicaid applications	End of PHE for states that utilized a Disaster Relief SPA;	Regulatory, legislative, or potentially state choice with SPA approval

[39] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
		otherwise based on state agreement with CMS	
Residency requirements altered for persons temporarily out of state due to the emergency	Allows states to expand the definition of temporary absence for individuals out of state due to the emergency. Also allows for temporary coverage of non-resident individuals in the state.	End of the PHE or as agreed between state and CMS in Disaster Relief SPA; otherwise based on state agreement with CMS	Regulatory, legislative, or potentially state choice with SPA approval
Altered timeframes for families to complete CHIP renewals	State opportunity to extend or delay the timeframes families have to completing CHIP renewals.	End of the PHE or as agreed between state and CMS in Disaster Relief SPA	Regulatory; legislative
Waive requirements for timely processing of Medicaid applications and / or renewals	Timeliness requirements for processing Medicaid applications and renewals waived or altered.	End of the PHE or as agreed between state and CMS in Disaster Relief SPA	Regulatory, legislative
Alternations to Medicaid and/or CHIP premiums or cost-sharing	Eliminated, waived, or delayed Medicaid and / or CHIP cost-sharing such as enrollment fees, premiums, deductibles, or coinsurance.	End of the PHE or as agreed between state and CMS in Disaster Relief SPA	Regulatory, legislative, potentially SPA

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
Modified Medicaid benefits	Adjusted existing benefits such as by waiving prior authorization requirements	End of the PHE or as agreed between state and CMS in Disaster Relief SPA; otherwise based on state agreement with CMS	Regulatory, legislative, or potentially state choice with SPA approval
COVID Tests, Treatments and Vaccines Without Cost-Sharing	Required coverage without cost sharing for COVID-19 tests, treatments, and vaccines for Medicaid enrollees	End of the quarter when the PHE ends	Regulatory, legislative, or state choice with SPA approval
Modified prescription drug coverage	Altered prescription drug coverage by increasing the maximum supply allowed, allowing for early refills, making exceptions or modifications to the preferred drug list, waiving or altering prior authorization requirements or other flexibilities.	End of the PHE or as agreed between state and CMS in Disaster Relief SPA; otherwise based on state agreement with CMS	Regulatory, legislative, or state choice with SPA approval
Medicaid Coverage for COVID Testing and Related Services for the Uninsured	States can opt to extend Medicaid eligibility to uninsured persons on a limited basis exclusively for COVID testing and related services. Expenses are covered by 100% FMAP. (CMS guidance)	End of PHE	Regulatory, legislative, or state choice with SPA approval
Extended Deadline for Updates to Access Monitoring Review Plans (AMRPs)	States are required under 42 CFR 447.203(b)(5) to update AMRPs every three years. The next deadline is October 1, 2022. CMS is exercising enforcement discretion to delay the deadline to October 1, 2024.[40]	Delayed to October 1, 2024	Regulatory

[40] https://www.medicaid.gov/federal-policy-guidance/downloads/cib03312022.pdf

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
Nutrition			
Pandemic Electronic Benefit Transfer (P-EBT)	Allows children to receive temporary emergency nutrition benefits loaded on EBT cards to purchase food. Also provides benefits to young children in households participating in SNAP whose covered childcare facility is closed, or who live in the area of schools that are closed or have reduced hours.	The Secretary of USDA can allow P-EBT during any school year during a public health emergency. Current guidance allows P-EBT specifically for the 2021-2022 school year.	Legislative Change unless there is an active public health emergency.
Seamless Summer Option (SSO) and Summer Food Service Operations (SFSO)	Allowed schools to operate under the Summer Food Service Program (SFSP) or National School Lunch Program Seamless Summer Option (SSO). Schools operating under SSO can provide meals to all children free of charge (universal school meals).	June 30, 2022	Legislation
Time Limit for Able-Bodied Adults Without Dependents (ABAWDs)	Suspended the time limit for ABAWD beneficiaries participating in SNAP. Prior to the pandemic, ABAWDs were limited to no more than 3 months of benefits over a 3-year period if they did not work (unless exempt).	Expires at the end of the month after the month during which the PHE ends.	Legislation
Housing			
Temporary Halt in Residential Evictions to Prevent the Further Spread of COVID-19	Prevented renters in communities experiencing a substantial or high level of community transmission of COVID-19 from being evicted for nonpayment of rent.	The Supreme court struck down the eviction moratorium on august 26, 2021.	Legislative change, per Supreme Court decision.

Flexibility	Description	End Date	Regulatory/Legislative Changes Needed to Make Permanent?
Emergency Rental Assistance	States can use the funding to provide assistance to eligible households through rental assistance programs. $25 billion was included in the Consolidated Appropriations Act of 2021 (CAA), and an additional $21.5 billion was included in the American Rescue Plan (ARP).	Funds from the CAA were available through December 31, 2021 but beginning September 30, 2021 HHS was directed to funds and reallocate them to grantees that had obligated at least 65 percent of their original funding. The ARP funding is available until September 30, 2027.	Legislative