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# Special Bulletin

February 7, 2023

# Public Health Emergency to End May 11

*AHA outlines implications for hospitals and other providers*

The White House announced Jan. 30 it would simultaneously end the COVID-19 national emergency and public health emergency (PHE) declarations on May 11. Hospitals and health systems have approximately 100 days to prepare for the restoration of waived requirements and other changes in policy and practice.

This Special Bulletin highlights the key changes for hospital operations at the end of the COVID-19 PHE. It is not an exhaustive list. Members are encouraged to review the Centers for Medicare & Medicaid Service's (CMS') complete list of waivers that will be ending on May 11.

At the same time, AHA is advocating for the retention of some flexibilities and amendment of others in a letter sent today to Health and Human Services (HHS) Secretary Xavier Becerra. AHA is urging the Administration to retain flexibilities that are necessary for continued recovery from the pandemic and to make permanent those that have been essential for more effective, patient-centered care delivery. We will continue to work closely with the Administration and Congress to further demonstrate the need for and provide analysis supporting continuation of key waivers, such as those outlined in our letter.

During the next few weeks, AHA will distribute additional analyses regarding the ending of the PHE and other tools to assist members in preparing for the end of the PHE.

**KEY HIGHLIGHTS**

The end of the national emergency declaration and PHE will mean:

- Significant changes in payment for many COVID-19 related services;
- Significant changes in how hospitals and health systems could use expansion sites for the care of COVID-19 patients or to keep non-COVID positive patients isolated;
- The return of regulatory requirements that were waived to ease burdens on the health care system allowing staff to focus on caring for COVID-19 patients, or in the past year, from the tripledemic of COVID-19, influenza and RSV; and
- Varying implementation timelines for reinstating regulatory requirements and other operational changes.

## AHA Take

Our nation has been tested by the COVID-19 pandemic more than it has with any other crisis in the past 75 years. Federal agencies put in place numerous flexibilities, provided support for vaccines and therapeutics, and took significant steps to support health care providers who were working to save lives amidst this crisis. After three years of pandemic flexibilities, the return to “normal” will require changes across many parts of hospitals and health systems, and that work should begin now. However, some of the COVID-19 PHE flexibilities led to care that better met the needs of patients and often led to better outcomes. Therefore, federal and state agencies should take this opportunity to reexamine programs and policies and take action to eliminate or amend those necessary to support better, safer and more patient-centered care.

Critical changes in programs and policies that are set in motion by the PHE ending are highlighted below.

## KEY CHANGES PROMPTED BY THE ENDING OF THE COVID-19 PHE

The end of the PHE will trigger the wind down of most PHE-specific programs and flexibilities, including those put in place by CMS, the Food and Drug Administration (FDA), the Drug Enforcement Agency (DEA) and other bodies. However, their end dates will vary. While many of these programs and waivers will conclude on May 11 simultaneously with the emergency declarations, others will remain in place through as late as Dec. 31, 2024. As a result, the official end of the COVID-19 PHE will impact hospital and health system operations for an extended period.

### Key PHE-related Provisions Ending May 11, 2023

The following policies and programs will end on the last day of the PHE, currently set for May 11, 2023.

1. Use of temporary expansion sites (such as convention centers, vacant stores, tents or others allowed under the Hospital Without Walls program) and spaces within the hospital that do not conform to the conditions of participation requirements for patient rooms, such as conference rooms and surgical suites.
2. Use of provider-based departments that were relocated to settings outside the hospital, including patients’ homes, after receipt of an extraordinary circumstances waiver and that provide education and therapy services to hospital outpatients.
3. Skilled nursing facility (SNF) beds available for patients not meeting SNF requirements.
4. EMTALA waiver allowing hospitals to redirect patients from their emergency departments to screening tents for COVID-19 testing.
5. Flexibility on limit of 25 beds for Critical Access Hospitals (CAHs) and the 96-hour rule for average length of stay.

6. Reduced information requirements for post-acute care discharge to a SNF, rehabilitation center, long-term care hospital or home health agency.
7. Flexibility to not have a separate nursing plan of care for each patient.
8. Permission from the Drug Enforcement Agency to prescribe controlled substances without an in-person visit.
9. Medicare's 20% add on payments for patients diagnosed with COVID-19 to offset the cost of complex COVID-19 patient care.
10. Free COVID-19 at-home tests and no cost sharing for testing services and therapeutics for Medicare beneficiaries (including those in Medicare Advantage plans) and those enrolled in private coverage. After the PHE ends, patient cost sharing will be required except for Medicaid beneficiaries who have at least an additional year of tests and therapeutics access at no cost. Additionally, Medicare will continue to pay $40 for COVID-19 vaccines administered in outpatient settings through Dec. 31, 2023.
11. State option to provide Medicaid eligibility for certain uninsured individuals to cover COVID-19 testing, testing-related services, vaccination and treatment coverage at 100% federal match.
12. Health plan requirements to reimburse out-of-network providers for COVID-19 vaccines and testing.

**Key PHE-related Provisions Ending Dec. 31, 2023**

The following policies and flexibilities end on Dec. 31, 2023, the last day of the year in which the PHE expires.

1. Enhanced federal funding to state Medicaid programs of 6.2% (See note below for additional details on Medicaid coverage).
2. Reimbursement for cardiac, intensive cardiac and pulmonary rehabilitation services provided via telehealth under the physician fee schedule.
3. Reimbursement parity for services performed via telehealth that typically would have been performed in person.
4. Permission for physicians and non-physician practitioners to directly supervise diagnostic services virtually through audio/video real-time communications technology (excluding audio-only).

**Key PHE-related Provisions Ending at a Future Date**

1. Liability immunity for use of countermeasures for COVID-19 will end Oct. 1, 2024, which is the end of the Public Readiness and Emergency Preparations (PREP) Act declaration.
2. Certain telehealth flexibilities that congress extended through Dec. 31, 2024:
    - Waiver of geographic and location requirements
    - Reimbursement for telehealth services furnished by physical therapists, occupational therapists, speech language pathologists and audiologists

- Reimbursement for audio-only services
- Reimbursement for telehealth services furnished by federally qualified health centers and rural health clinics
- Use of telehealth to recertify eligibility for hospice

Additionally, implementation of the in-person visit requirement for initiation of tele-behavioral health services is delayed until the end of 2024.

3. Acute Care Hospital at Home program, which congress extended through Dec. 31, 2024.
4. Food and Drug Administration (FDA) emergency use authorizations (EUAs) for drugs and devices do not have a specified ending. The FDA has the authority to extend these EUAs at its discretion to ensure continued availability of effective testing, vaccination and therapeutics. Further information has been requested from the agency, but there is no indication it intends to end any of the EUAs soon.
5. Hospital COVID-19 data reporting requirements that were instituted in 2020. The CMS condition of participation (CoP) requiring hospitals and CAHs to submit certain data related to COVID-19 to HHS was originally set to expire at the conclusion of the PHE. However, in the FY 2023 Inpatient Prospective Payment System final rule, CMS revised the CoP to require hospitals to continue reporting COVID-19-related data after the conclusion of the PHE through Apr. 30, 2024, unless the Health and Human Services Secretary establishes an earlier end date.

**Note about Medicaid Coverage and Eligibility Redetermination**

To assist states in their PHE response and support access to coverage and care, Congress provided enhanced federal funding to state Medicaid programs of 6.2 percentage points. Originally, this funding was linked to the PHE and required that states meet a number of conditions, including providing continuous eligibility. States, therefore, have not conducted eligibility redeterminations for the entirety of the PHE. However, Congress, in the Consolidated Appropriations Act of 2023, decoupled these provisions from the PHE.

**Enhanced federal funding is now set to wind down** each quarter, beginning on April 1 to 5 percentage points, 2.5 percentage points on July 1, and 1.5 percentage points on October 1, and sunset on Jan. 1, 2024. States also are authorized to resume Medicaid redeterminations as of April 1 and, if necessary, disenrollment. Enrollment in Medicaid and the Children's Health Insurance Program has reached more than 90 million, and some estimates suggest that 15 million could lose coverage during the redetermination process. We encourage members to engage with their state Medicaid agencies, state hospital associations and community-based partners on ways to help facilitate this process and ensure minimal coverage loss. We also encourage you to review a set of AHA resources here.

## FURTHER QUESTIONS

If you have further questions, contact Mark Howell, AHA's director of policy, at mhowell@aha.org or Nancy Foster, AHA's vice president for quality and patient safety policy, at nfoster@aha.org.