

MEMORANDUM

**To:** American Academy of Physical Medicine & Rehabilitation  
**From:** Peter Thomas, Hannah Comeau, and Joseph Nahra  
**Date:** Updated March 20, 2023  
**Re:** Health Care Implications for End of COVID-19 Public Health Emergency Declaration

**Introduction**

Since January 2020, the United States has operated under a declared public health emergency (PHE) during the COVID-19 pandemic.<sup>1</sup> The Public Health Service Act, which provides the Secretary of Health and Human Services (HHS) with the authority to declare PHEs, requires such declarations to be renewed every 90 days if it is determined that the emergency still exists. The COVID-19 PHE has thus far been renewed thirteen times in the past three years. The declaration of a PHE provides HHS with numerous authorities and flexibilities to act in response, including making grants, entering into contracts, accessing funds from the Public Health Emergency Fund, waiving or modifying certain federal health program requirements, and much more.

During the COVID-19 PHE, Congress further expanded the Department's authority and instituted numerous temporary policies to enhance the federal response to the pandemic. These actions include—but are not limited to—the rapid expansion of telehealth, the implementation of waivers impacting health care providers (especially several specific to the post-acute care field), the increase of Medicaid eligibility and federal funding for services under that program, and the provision of coverage of COVID diagnostics and treatment. The vast majority of these policies are tied directly to the PHE declaration. As such, without additional legislative and/or regulatory action, policies in place prior to the pandemic will be reinstated shortly after the end of the PHE.

The COVID-19 PHE is now expected to terminate on May 11, 2023. CMS has provided [guidance](#), by specialty, regarding which COVID-19 flexibilities have either terminated already, will terminate with the end of the PHE, or extend beyond the PHE. Its most recent fact sheet is available [here](#). This memorandum provides an overview of some of the key impacts of the expiration of the PHE, as well as an outlook on some of those potentially temporary or permanent extensions of PHE-related waivers and flexibilities.

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<sup>1</sup> [Declaration of Public Health Emergency.](#)

## **Timing of PHE Expiration**

Recently, the Biden Administration announced that it would end the public health emergency on May 11, 2023.<sup>2</sup> HHS Secretary Xavier Becerra most recently extended the PHE on February 9, 2023.<sup>3</sup> The announcement of the intended expiration date in May fulfills the Biden Administration’s promise to provide stakeholders, especially state Medicaid programs, at least 60- days’ notice before allowing the PHE to expire. For providers, this means that all waivers and flexibilities directly resulting from the PHE—that have not since been separated (or “decoupled”) from their ties to the PHE— will expire in May, absent additional regulatory or legislative action. The Administration has, however, begun to more directly press states and providers to begin planning for the “unwinding” of PHE flexibilities—in particular, the expected deluge of changes to Medicaid enrollment.<sup>4</sup> HHS began hosting conference calls with health care stakeholders on Medicaid “unwinding” as early as June 2022.

While some health care stakeholders have pressed for an extension of the PHE until the country experiences an extended period of greater stability,<sup>5</sup> others in Congress have pressed the Administration to immediately begin the process of unwinding the PHE in order to “get America back to normal.”<sup>6</sup> The formal announcement of the expiration date came in response to the House passage of H.R. 382, a partisan bill that would immediately end the PHE on the date of the bill’s enactment.<sup>7</sup> Though the legislation passed the House on a party-line vote, the Senate is not expected to consider it on the floor.

## **Post-Acute Care Waivers During the PHE**

Using the agency’s own authorities and additional flexibilities granted by Congress, the Centers for Medicare and Medicaid Services (CMS) has implemented a series of blanket waivers for health care providers during the PHE. These include several important waivers impacting post-acute care (PAC) providers, the vast majority of which are scheduled to revert entirely upon lifting of the PHE, unless additional action is taken by CMS and/or Congress. Key waivers impacting the PAC field, and the status of those waivers, are summarized below.

**Three Hour Rule:** First, numerous important PHE waivers directly impact Inpatient Rehabilitation Facilities (IRFs). A full list can be found [here](#). Of particular importance is the so-called “three hour

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<sup>2</sup> [Statement of Administration Policy](#).

<sup>3</sup> [COVID-19: Renewal of Determination that a Public Health Emergency Exists \(hhs.gov\)](#).

<sup>4</sup> [Creating a Roadmap for the End of the COVID-19 Public Health Emergency | CMS](#) (CMS press release regarding its plan to support a resiliency- and recovery-based healthcare system following the PHE); [Health Care System Resiliency fact sheet \(cms.gov\)](#) (CMS’ strategic plan); [National Quality Strategy \(cms.gov\)](#) (CMS National Quality Strategy); [CMS Framework for Health Equity 2022–2032](#) (discussing priorities for promoting health equity over the next ten years); [Unwinding and Returning to Regular Operations after COVID-19 | Medicaid](#) (specifically provides unwinding guidance regarding forthcoming changes impacting Medicaid enrollment).

<sup>5</sup> [Letter to Secretary Becerra](#).

<sup>6</sup> [Letter to President Biden and Secretary Becerra](#).

<sup>7</sup> [H.R. 382, the Pandemic is Over Act](#).

rule” waiver which is set to expire at the end of the PHE. The *Coronavirus Aid, Relief, and Economic Security (CARES) Act* includes a requirement during the PHE that CMS waive the “three-hour rule” for IRFs. Prior to the PHE, IRFs were required to use an “intensity of therapy” standard to assess whether patients were appropriate for admission to an IRF. This equated into a requirement that beneficiaries participate in at least three hours per day (or 15 hours per week) of skilled rehabilitation therapy. This requirement has been wholly waived during the PHE so that IRFs can accept patients even if they are not expected to receive the required three hours. On August 26, 2022, Representatives Joe Courtney (D-CT) and Glenn “GT” Thompson (R-PA) introduced H.R. 8746, the *Access to Inpatient Rehabilitation Therapy Act*. This legislation would maintain the three-hour rule in its pre-pandemic form upon admission of the patient, but would grant more flexibility for the treating rehabilitation physician to prescribe a broader mix of skilled therapeutic services as the patient recovers and prepares for discharge to home or another setting of care.

PAC stakeholders, including AAPM&R, have met with CMS to discuss avenues to permanently expand the three-hour rule after the PHE ends, so that IRFs do not automatically “snap back” to the most restrictive version of the rule after the PHE. If agency action is not taken, stakeholders are likely to work with Congress to reintroduce the *Access to Inpatient Rehabilitation Therapy Act* in the 118<sup>th</sup> Congress to ensure that patients in IRFs are able to access the full slate of skilled therapies deemed necessary by the rehabilitation team.

**60 Percent Rule:** Another IRF-specific waiver concerns the “60 Percent” Rule. Typically, freestanding rehabilitation hospitals and rehabilitation units of acute care hospitals must have at least 60 percent of their patients admitted annually under 13 qualifying conditions in order to qualify for reimbursement under the IRF prospective payment system (PPS). During the PHE, CMS has allowed IRFs to exclude patients who are solely admitted “to respond to the emergency” (i.e., patients admitted as acute care overflow patients, etc.) from their population for purposes of calculating the 60 percent threshold. *Following the PHE, IRFs must once again include these patients in their population count.* Additional PHE waivers created more flexibility for inpatient rehabilitation patients to receive care from acute care beds so long as those beds are “appropriate for providing care to rehabilitation patients” and that those patients “continue to receive intensive rehabilitation services.”<sup>8</sup> Immediately following the PHE, these rehabilitation patients will no longer be permitted to receive care from acute care beds.

**Skilled Nursing Facility Waivers:** Several notable waivers also impact the post-acute care field in the areas of Skilled Nursing Facilities (SNFs), home health, and durable medical equipment (DME). For instance, CMS waived the typical three-day prior hospitalization requirement for coverage of SNF services. PHE waivers also allow for hospitals that provide long-term care services to utilize swing beds to accommodate patients *not* receiving acute care—and who otherwise qualify for SNF placement—but are unsuccessful in finding such a placement. Additionally, the Pre-Admission Screening (PAS) and Annual Resident Review (PASARR) is no longer a requirement for SNFs

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<sup>8</sup> [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers \(cms.gov\)](https://www.cms.gov/medicare/coverage/policies/2020s/2020-01-01-coverage-determinations/covid-19-emergency-declaration-blanket-waivers-for-health-care-providers).

during the PHE. As such, CMS has permitted nursing homes to admit new residents and conduct Level one screening post-admission. Under this waiver, nursing homes should refer new residents with intellectual disability or mental illness to the state PASARR programing for Level two review. Also of note is that several PHE waivers relating to nursing homes have *already been terminated*.<sup>9</sup>

**Home Health and Durable Medical Equipment Waivers:** In the context of home health, CMS waived the requirement that only “rehabilitation skilled professionals” may perform initial checks and assessments under circumstances when “only therapy services are ordered.”<sup>10</sup> So long as it complies with state law, Speech Language Pathologists (SLPs), Occupational Therapists (OTs), and Physical Therapists (PTs) may perform these comprehensive assessments for Medicare patients. CMS has finalized a [rule](#) which extends many of these flexibilities to remain in place after the PHE has ended. Regarding DME, CMS has given DME Medicare Administrative Contractors the option to waive replacement requirements for DME that has, in some form, been rendered unusable by the patient. These include “the face-to-face requirement, a requirement for a new physician’s order to obtain replacement DME, and a requirement to obtain new medical necessity documentation” to obtain replacement DME.<sup>11</sup> These waivers last throughout the duration of the PHE.

**Broader PAC Waivers:** Some PHE waivers impact the post-acute care field—along with healthcare providers in general—more broadly. These “blanket waivers” were implemented for the primary purpose of “streamlin[ing] delivery and allow[ing] access to care during the PHE.”<sup>12</sup> For instance, there has been a waiver of requirements regarding the provision of detailed discharge information to patients—or their representatives—and their caregivers in selecting a post-acute care facility. The purpose of this waiver is to streamline the discharge process during the PHE and, thus, this waiver will terminate at the end of the PHE. Similarly impacting all post-acute care facilities is the suspension of several medical review and auditing requirements.<sup>13</sup> A full list of blanket waivers for health care providers made available during the PHE can be found on CMS’ [website](#).

## **Telehealth Expansion**

Early in the PHE, Congress granted CMS additional authority to dramatically expand the availability of telehealth, including tele-rehabilitation, in the Medicare program. Medicaid and most private payers quickly followed suit. This resulted in CMS making telehealth services available to the vast majority of the population in rapid fashion. At the end of 2022, Congress acted to extend these flexibilities for an additional two years (through the end of 2024), uncoupling the telehealth expansion from the PHE. The prevalence of telehealth is likely to be one of the most wide-ranging, long-term impacts of the pandemic on the health care system.

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<sup>9</sup> [Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers \(cms.gov\)](#).

<sup>10</sup> [COVID 19 Home Health Fact Sheet for IFC 2 \(cms.gov\)](#).

<sup>11</sup> [Durable Medical Equipment, Prosthetics, Orthotics and Supplies: CMS Flexibilities to Fight COVID-19](#).

<sup>12</sup> [CMS PHE Fact Sheet](#)

<sup>13</sup> [Federal Register: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency](#).

Prior to the PHE, Medicare beneficiaries faced several statutory restrictions on their use of telehealth. These included a geographic restriction, which limited beneficiaries eligible to receive telehealth services to only those located in rural [or underserved] areas; the originating site restriction, which required beneficiaries to receive telehealth services in an approved healthcare setting, (i.e., *not* in their own homes); and the provider billing restriction that limited providers eligible to bill Medicare patients for telehealth services to only physicians. Additionally, only certain services were included in the approved telehealth list.

In the [\*Coronavirus Preparedness and Response Supplemental Appropriations Act\*](#), Congress granted CMS temporary authority to waive each of these requirements. As a result, CMS waived existing provider restrictions to allow all providers who are eligible to bill Medicare for their professional services the ability to furnish telehealth services as well. The expanded list of providers includes PTs, OTs, SLPs, audiologists, and others. CMS is limited in what they can do to preserve the current treatment of telehealth and tele-rehabilitation without Congressional intervention.

CMS also dramatically expanded the list of services that could be provided via telehealth.<sup>14</sup> This flexibility for approving services for telehealth is one of the few areas where CMS has authority to act beyond the end of the PHE without additional Congressional action. In the 2023 Medicare Physician Fee Schedule proposed rule, CMS added several services temporarily available under the PHE to a temporary “Category III” list of services that will be approved for telehealth reimbursement through the 2023 calendar year at the least, and the agency will propose a similar list for the following year as well through the next Physician Fee Schedule. The purpose of this is to allow more time for collection of data that could support CMS’ eventual inclusion of these services as permanent additions to the Medicare telehealth services list.<sup>15</sup> Finally, to better serve certain patient demographics, audio-only telehealth visits are permitted through the duration of the PHE even though this would normally fail to comply with HIPAA requirements. The HHS Office of Civil Rights (OCR) previously issued [guidance](#) clarifying how providers may use remote communication technologies for audio-only telehealth after the conclusion of the PHE.

In the [\*Consolidated Appropriations Act\*](#) (CAA) of 2022, Congress temporarily extended CMS’ authority to continue all current telehealth flexibilities for 151 days after the end date of the PHE declaration. Most recently, in the [\*Consolidated Appropriations Act, 2023\*](#), Congress extended all current Medicare telehealth flexibilities through December 31, 2024. Over the next two years, Congress will likely consider measures to permanently extend some or all of the pandemic-era telehealth flexibilities, but the current extension means Congressional action will likely happen closer to the end of 2024.

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<sup>14</sup> Available for download at [List of Telehealth Services | CMS](#).

<sup>15</sup> [Calendar Year \(CY\) 2023 Medicare Physician Fee Schedule Proposed Rule | CMS](#).

## **Additional Health Care Impacts**

**Medicaid:** The pandemic also prompted a significant expansion of enrollment criteria for Medicaid coverage. This, combined with a Federal Medical Assistance Percentage (FMAP) increase of 6.2% which goes directly to the states, which the [\*Families First Coronavirus Response Act\*](#) authorized, has resulted in large numbers of new enrollees in state Medicaid programs across the country. In recent months, CMS has dedicated significant resources to preparing states for the “unwinding” of the PHE with regard to this expanded enrollment, including hosting webinars, publishing resources, and outlining template strategies for redeterminations of eligibility. The expanded Medicaid eligibility was also uncoupled from the PHE in the 2022 year-end omnibus. The FMAP increase will be phased out beginning April 1, 2023, with the increase fully eliminated by the end of 2023. All states are required to develop plans for unwinding the expanded enrollment, and states will be allowed to begin culling their enrollment beginning in April. Some states are expected to move quickly while others will likely take the full 12 months available to them to completely dismiss those who are no longer eligible from the program.

**Direct Supervision:** In general, Medicare pays for “incident to” services that are performed under the direct supervision of a physician. Prior to the PHE, “direct supervision” required the physician to be present in the office suite and immediately available to provide direction and assistance throughout the performance of the service. In response to the COVID-19 PHE, CMS temporarily relaxed this direct supervision requirement, allowing the supervising physician or practitioner to be immediately available through virtual presence via real-time audio *and* video technology. Accordingly, during this time period, the physician or other supervising practitioner does not need to be physically present at the location where procedures are performed provided that they are immediately available through real-time audio and video technology. This flexibility applies to both “incident-to” services and diagnostic tests. On January 1, 2024, “pre-PHE” direct supervision requirements will be reinstated.

**Medicare Remote Patient Monitoring (RPM) Services:** During the PHE, requirements related to RPM were relaxed, allowing clinicians to bill for RPM services provided to both established and new patients, and to patients with both acute and chronic conditions. After the PHE ends on May 11, 2023, clinicians must have an established relationship with the patient prior to providing RPM services. However, RPM services may continue to be provided to patients with both acute and chronic conditions. In addition, clinicians may only bill for certain services pertaining to RPM when at least 16 days of data have been collected.

**COVID Services and the IPPS:** COVID-19 diagnostics, treatment, and vaccines have also largely been made available on a temporary basis during the pandemic. Much of this was also made possible through Emergency Use Authorizations (EUAs), which are authorized under section 564 of the Federal Food, Drug, and Cosmetic Act when “there is a public health emergency that has a significant potential to effect national security or the health and security of United States citizens

living abroad[.]”<sup>16</sup> COVID-19 has also brought sizable increases in Inpatient Prospective Payment System (IPPS) rates for acute care hospitals that use an Electronic Health Record system and report quality data (i.e. participate in an IQR program), including data regarding COVID-19. The most recent increase, for the 2023 calendar year, was set at 4.3%.<sup>17</sup> Notably, the Section 564 declaration is not directly coupled with the expiration of the PHE, and the Food & Drug Administration has stated that it expects the emergency authorizations for COVID tests, vaccines, and treatments to remain available after May 2023.

However, the end of the PHE will result in changes to federal payers’ coverage of COVID-19 testing and treatment. For Medicare beneficiaries, CMS will continue to pay approximately \$40 per dose for administering COVID-19 vaccines in outpatient settings through the end of the calendar year in which the PHE ends (i.e., December 31, 2023). Effective January 1, 2024, the Medicare payment rate for COVID-19 vaccines will align with the current payment rate for other preventative vaccines covered under Part B. Additionally, after the PHE ends, Medicare will require all COVID-related testing performed by a laboratory to be ordered by a physician or other practitioner.

Finally, individuals with private health insurance coverage or group health plans can be reimbursed for the purchase of over-the-counter COVID-19 diagnostic tests, as required by the Biden Administration since January 2022. Insurance companies and health plans must offer reimbursement for up to eight at-home tests per covered individual, per month, during the PHE. As soon as the PHE ends, this requirement will lapse, and insurance companies may institute their own coverage policies (or lack thereof) for over-the-counter tests.

## **Conclusion**

Significant modifications to the U.S. health care system have resulted from the COVID-19 pandemic and declaration of the associated PHE. Many of these increased flexibilities are broad, impacting nearly every part of the system while others are more targeted—for instance, those aimed at providing flexibility to the post-acute care field. Though regulatory and legislative action has extended some of these flexibilities to this date and beyond the end of the PHE, many waivers and flexibilities are still set to expire with the end of the PHE on May 11, 2023. To alter this result, further Congressional and Executive Branch action is needed.

CMS will continue to update the public as unwinding procedures continue; the agency is expected to host “office hours” and stakeholder calls aimed at providing additional information as it unfolds.

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<sup>16</sup> [Coronavirus Disease 2019 \(COVID-19\) Emergency Use Authorizations for Medical Devices | FDA](#).

<sup>17</sup> [FY 2023 Hospital Inpatient Prospective Payment System \(IPPS\) and Long-Term Care Hospital Prospective Payment System \(LTCH PPS\) Final Rule — CMS-1771-F | CMS](#).

## Primary References:

1. [Creating a Roadmap for the End of the COVID-19 Public Health Emergency | CMS.](#)
2. [Health Care System Resiliency fact sheet \(cms.gov\).](#)
3. [Unwinding and Returning to Regular Operations after COVID-19 | Medicaid.](#)
4. [Inpatient Rehabilitation Facilities: CMS Flexibilities to Fight COVID-19.](#)
5. [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers \(cms.gov\).](#)
6. [Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers \(cms.gov\).](#)
7. [Durable Medical Equipment, Prosthetics, Orthotics and Supplies: CMS Flexibilities to Fight COVID-19.](#)
8. [List of Telehealth Services | CMS.](#)
9. [Guidance: How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio-Only Telehealth | HHS.gov.](#)
10. [Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap | HHS.gov.](#)