

May 2021



# Rural Crosswalk: *CMS Flexibilities to Fight COVID-19*



Paid for by the U.S. Department of Health and Human Services

## Rural Crosswalk: CMS Flexibilities to Fight COVID-19

Since the beginning of the COVID-19 Public Health Emergency (PHE), CMS has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states; 2) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home;<sup>1</sup> 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

This document highlights COVID-19 related provisions that CMS has issued and/or carried out during the Public Health Emergency (PHE) that impact Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), Rural Acute Care Prospective Payment System (PPS) Hospitals, and/or Medicare-certified Skilled Nursing Facilities (SNFs).

**\*\* Indicates items added or revised in the most recent update**

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<sup>1</sup> Telehealth and other virtual services are furnished by eligible clinicians paid under the Physician Fee Schedule. This document outlines telehealth and other virtual service waivers that affect clinicians practicing in the types of facilities included or who may have reassigned their billing rights to these facilities.

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Telehealth and Other Virtual Services

Telehealth and Other Virtual Services

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Beneficiary Location for Telehealth Services</b>	Medicare can pay for many types of office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence. Additionally, the HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. <sup>2</sup>	Yes	Yes	Yes	Yes	No
<b>Additional Telehealth Services Covered by Medicare</b>	Clinicians are allowed to provide more than 135 new telehealth services, including: emergency department visits, initial and subsequent observation, initial hospital care and hospital discharge day management, initial nursing facility visits, critical care services, intensive care services, therapy services. <sup>3</sup> On October 14, 2020, using a new expedited process, CMS added 11 new services to the Medicare telehealth services list. Medicare will begin paying eligible practitioners who furnish these newly added telehealth services effective immediately and for the duration of the PHE. These new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services.	Yes	Yes	Yes	Yes	Yes
<b>Virtual Check-Ins, Remote Evaluations, &amp; E-Visits</b>	Clinicians can provide virtual check-in, remote evaluation of patient-submitted video/images, and e-visit services to both new and established patients. These services were previously limited to established patients. Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits, virtual check-ins, and remote evaluations. A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients.	Yes	Yes	Yes	Yes	No
<b>Remote Patient Monitoring</b>	Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. <sup>4</sup>	Yes	Yes	Yes	Yes	No

<sup>2</sup> More information on this flexibility can be found here: <https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/factsheet-telehealth-2020.pdf>

<sup>3</sup> A complete list of all Medicare telehealth services can be found here: <https://www.cms.gov/Medicare/Medicare-General-information/Telehealth/Telehealth-Codes>

<sup>4</sup> More information on this flexibility can be found here: <https://www.cms.gov/files/document/covid-final-ifc.pdf>

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Telehealth and Other Virtual Services

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Removal of Frequency Limitations on Medicare Telehealth</b>	The following services no longer have limitations on the number of times they can be provided by Medicare telehealth: <ul style="list-style-type: none"> <li>• A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days;</li> <li>• A subsequent SNF visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days;</li> <li>• Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation.</li> </ul>	No	No	Yes	Yes	Yes
<b>Eligible Practitioners</b>	CMS is waiving the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.	Yes	Yes	Yes	Yes	Yes
<b>Practitioner Locations</b>	CMS is waiving the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.	Yes	Yes	Yes	Yes	Yes
<b>Allowing FQHCs and RHCs to Serve as Distant Sites for Telehealth</b>	FQHCs and RHCs may serve as distant site practitioners to furnish telehealth services. Medicare pays for these telehealth services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. These services are excluded from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.	Yes	Yes	No	No	No
<b>Physician Visits in SNFs/ Nursing Facilities</b>	CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.	No	No	No	No	Yes

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<b>Audio-Only Telehealth for Certain Services</b>	CMS is waiving the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.	Yes	Yes	Yes	Yes	Yes
<b>**Non-Physician Practitioner Billing (revised)</b>	During the COVID-19 PHE, non-physician practitioners who are eligible to bill Medicare directly, including registered dietitians and nutrition professionals, may bill for audio-only telephone assessment and management services: CPT codes 98966-98968 (Dates of service on or after March 1 until the end of the PHE).	Yes	Yes	Yes	Yes	No
<b>Hospital Outpatient Fees Accompanying Professional Services Furnished Via Telehealth</b>	When a physician or non-physician practitioner who typically furnishes professional services in the hospital outpatient department furnishes telehealth services during the COVID-19 PHE, they bill with a hospital outpatient place of service since that is likely where the services would have been furnished if not for the COVID-19 PHE. The physician or practitioner is paid for the service under the PFS at the facility rate, which does not include payment for resources such as clinical staff, supplies, or office overhead since those things are usually supplied by the hospital outpatient department. During the COVID-19 PHE, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the PFS for the originating site facility fee associated with the telehealth service.	No	No	Yes	Yes	No

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
 CMS Hospital Without Walls (Temporary Expansion Sites)

CMS Hospital Without Walls (Temporary Expansion Sites)

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Hospitals Able to Provide Care in Temporary Expansion Sites</b>	As part of the CMS Hospital Without Walls initiative, hospitals can provide hospital services in other healthcare facilities and sites that would not otherwise be considered to be part of a healthcare facility (such facilities would be re-enrolled as hospitals); or can set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. In the absence of waivers, hospitals are generally required to provide services to patients within their hospital departments.	No	No	Yes	Yes	No
<b>Off Site Patient Screening</b>	CMS is waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Active Labor Act, or EMTALA). This will allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with the state emergency preparedness or pandemic plan.	No	No	Yes	Yes	No
<b>Paperwork Requirements</b>	CMS is waiving certain specific paperwork requirements under this section only for hospitals which are considered to be impacted by a widespread outbreak of COVID-19. This allows hospitals to establish COVID-19 specific areas. Hospitals that are located in a state that has widespread confirmed cases would not be required to meet the following requirements: <ul style="list-style-type: none"> <li>• 42 CFR §482.13(d)(2) with respect to timeframes in providing a copy of a medical record.</li> <li>• 42 CFR §482.13(h) related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes.</li> <li>• 42 CFR §482.13(e)(1)(ii) regarding seclusion.</li> </ul>	No	No	No	Yes	No
<b>Physical Environment (Hospitals)</b>	CMS is waiving certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and CAHs as a result of COVID-19. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. States are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.	No	No	Yes	Yes	No

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Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Hospital Outpatient: Use of Provider-Based Departments as Temporary Expansion Sites</b>	<p>For the duration of the PHE related to COVID-19, CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 and the provider-based department requirements at 42 CFR §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting the conditions of participation for hospitals in operation during the PHE. This waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. CMS also is offering some additional flexibilities to furnish inpatient services under arrangements. These changes include:<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Adopting a temporary extraordinary circumstances relocation exception policy for on-campus PBDs and excepted off-campus PBDs that are relocating off-campus during the COVID-19 PHE. Under our existing extraordinary relocation exception policy, only relocating off-campus PBDs are eligible to request this exception.</li> <li>• Streamlining the process during the COVID-19 PHE for relocating PBDs to seek the extraordinary circumstances exception so they can start seeing patients and billing for services immediately in the relocated PBD.</li> <li>• Allowing PBDs to relocate into more than one PBD location, and allowing PBDs to partially relocate while still maintaining the original location. Hospitals can relocate PBDs to the patient's home and continue to receive the full OPSS payment amount under the extraordinary circumstances relocation exception policy.</li> </ul>	No	No	Yes	Yes	No
<b>CAH Length of Stay</b>	CMS is waiving the Medicare requirements that 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.	No	No	Yes	No	No
<b>CAH Status and Location</b>	CMS is waiving the requirement at 485.610(b) that the CAH be located in a rural area or an area being treated as rural, allowing the CAHs flexibility in the establishment of surge site locations. Waiving the requirement at 485.610(e) regarding off-campus and co-location requirements allows the CAH flexibility in establishing off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will remove restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities should be implemented so long as it is not inconsistent with State or emergency or pandemic plan.	No	No	Yes	No	No

<sup>5</sup> More information on this flexibility can be found here: <https://www.cms.gov/files/document/covid-19-regulations-waivers-enable-health-system-expansion.pdf>

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**CMS Hospital Without Walls (Temporary Expansion Sites)**

<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>Housing Acute Care Patients in Excluded Distinct Part Units</b>	CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatients. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.	No	No	No	Yes	No
<b>Telemedicine</b>	CMS is waiving the provisions related to telemedicine for hospitals and CAHs at 42 CFR 482.12(a)(8)-(9) and 42 CFR 485.616(c), making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.	No	No	Yes	Yes	No
<b>Inspection, Testing &amp; Maintenance (ITM) under the Physical Environment Conditions of Participation</b>	CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.	No	No	Yes	Yes	Yes
<b>Hospital-Only Remote Outpatient Therapy and Education Services</b>	Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational services as well as therapy services.	No	No	Yes	Yes	No
<b>Hospital Only Clinical Staff In-Person Services</b>	Hospital clinical staff must furnish certain services such as infusions and wound care in person given the nature of the services. Under interim final regulations and Hospitals without Walls: <ul style="list-style-type: none"> <li>• the beneficiary's home can be considered a provider-based department of the hospital for purposes of receiving outpatient services and the beneficiary would be registered as a hospital outpatient.</li> <li>• the hospital may bill for these services as hospital outpatient services, provided the PBD is an on campus or excepted off-campus PBD that relocated to the patient's home consistent with the extraordinary circumstances relocation exception policy.</li> </ul>	No	No	Yes	Yes	No

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Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Expanded Ability for Hospitals to Offer Long-term Care Services (“Swing-Beds”)</b>	Under section 1135(b)(1) of the Act, CMS is waiving the requirements at 42 CFR 482.58, “Special Requirements for hospital providers of long-term care services (“swing-beds”)” subsections (a)(1)-(4) “Eligibility”, to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. This waiver applies to all Medicare enrolled hospitals, except psychiatric and long term care hospitals that need to provide post-hospital SNF level swing-bed services for nonacute care patients in hospitals, so long as the waiver is not inconsistent with the state’s emergency preparedness or pandemic plan. The hospital shall not bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.	No	No	No	Yes	No
<b>Hospitals Classified as Sole Community Hospitals (SCHs)</b>	CMS is waiving certain eligibility requirements at 42 CFR § 412.92(a) for hospitals classified as SCHs prior to the PHE. Specifically, CMS is waiving the distance requirements at paragraphs (a), (a)(1), (a)(2), and (a)(3) of 42 CFR § 412.92, and is also waiving the “market share” and bed requirements (as applicable) at 42 CFR § 412.92(a)(1)(i) and (ii).	No	No	No	Yes	No
<b>Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)</b>	For hospitals classified as MDHs prior to the PHE, CMS is waiving the eligibility requirement at 42 CFR § 412.108(a)(1)(ii) that the hospital has 100 or fewer beds during the cost reporting period, and the eligibility requirement at 42 CFR § 412.108(a)(1)(iv)(C) that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods.	No	No	No	Yes	No

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 CMS Hospital Without Walls (Temporary Expansion Sites)

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Specific Life Safety Code (LSC) for Multiple Providers: Alcohol-based Hand-Rub (ABHR) Dispensers</b>	<p>CMS is waiving and modifying particular waivers under 42 CFR §482.41(b) for hospitals; §485.623(c) for CAHs; §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying these requirements as follows:</p> <p>Alcohol-based Hand-Rub (ABHR) Dispensers: We are waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area. Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §482.41(b)(7) for hospitals; §485.623(c)(5) for CAHs; §418.110(d)(4) for inpatient hospice; §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs.</p>	No	No	Yes	Yes	Yes
<b>Specific Life Safety Code (LSC) for Multiple Providers: Fire Drills</b>	<p>CMS is waiving and modifying particular waivers under 42 CFR §482.41(b) for hospitals; §485.623(c) for CAHs; §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying these requirements as follows:</p> <p>Fire Drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new, or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6.</p>	No	No	Yes	Yes	Yes

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Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>**Acute Hospital Care at Home</b> (added)	CMS is executing an innovative Acute Hospital Care At Home program, providing eligible hospitals with unprecedented regulatory flexibilities to treat eligible patients in their homes. <sup>6</sup> This program was developed to support models of at-home hospital care throughout the country that have seen prior success in several leading hospital institutions and networks, and reported in academic journals, including a major study funded by a Healthcare Innovation Award from the Center for Medicare and Medicaid Innovation. The program clearly differentiates the delivery of acute hospital care at home from more traditional home health services. While home health care provides important skilled nursing and other skilled care services, Acute Hospital Care at Home is for beneficiaries who require acute inpatient admission to a hospital and who require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis. To support these efforts, CMS has launched an online portal to streamline the waiver request process and allow hospitals and healthcare systems to submit the necessary information to ensure they meet the program's criteria to participate. <sup>7</sup> CMS will also closely monitor the program to safeguard beneficiaries by requiring hospitals to report quality and safety data to CMS on a frequency that is based on their prior experience with the Hospital At Home model.	No	No	Yes	No	Yes

<sup>6</sup> An approved list of hospitals can be found here: <https://www.cms.gov/files/document/covid-acute-hospital-care-home-program-approved-list-hospitals.pdf>

<sup>7</sup> More information is available at the online portal here: <https://qualitynet.cms.gov/acute-hospital-care-at-home>

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 CMS Facility Without Walls (Temporary Expansion Sites)

CMS Facility Without Walls (Temporary Expansion Sites)

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Temporary Expansion Locations for RHCs and FQHCs</b>	CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) for the duration of the PHE.	Yes	Yes	No	No	No
<b>Bed Count for Provider-Based RHCs and RHC Payment Limit</b>	RHCs that are provider-based to a hospital with fewer than 50 beds are exempt from the national RHC payment limit. For the duration of the PHE, the number of beds prior to the start of the PHE will be the official hospital bed count for application of this policy so that hospitals are not discouraged from increasing bed capacity if needed.	Yes	No	No	No	No
<b>Physical Environment (Long-Term Care Facilities)</b>	<p>CMS is waiving requirements related at 42 CFR 483.90, specifically the following:</p> <ul style="list-style-type: none"> <li>• Provided that the state has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is waiving requirements under § 483.90 to allow for a non-SNF building to be temporarily certified and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents, which may not be feasible in the existing SNF structure to ensure care and services during treatment for COVID-19 are available while protecting other vulnerable adults.</li> <li>• CMS believes this will also provide another measure that will free up inpatient care beds at hospitals for the most acute patients while providing beds for those still in need of care. CMS will waive certain conditions of participation and certification requirements for opening a NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location.</li> <li>• CMS is also waiving requirements under 42 CFR 483.90 to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity. Rooms that may be used for this purpose include activity rooms, meeting/conference rooms, dining rooms, or other rooms, as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department.</li> </ul>	No	No	No	No	Yes

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 CMS Facility Without Walls (Temporary Expansion Sites)

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>**Resident Roommates and Grouping</b> (revised)	<p>CMS is waiving the requirements in 42 CFR 483.10(e) (5) and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, to provide notice and rationale for changing a resident's room, and to provide for a resident's refusal a transfer to another room in the facility.</p> <p>Effective May 10, 2021, waived requirements in §483.10 (e)(6) were terminated.</p>	No	No	No	No	Yes
<b>**Resident Transfer and Discharge</b> (revised)	<p>CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(5)(i) and (iv), (c)(9), and (d) (with some exceptions) to allow a long term care facility to transfer or discharge residents to another LTC facility solely for the following cohorting purposes:</p> <ul style="list-style-type: none"> <li>• Transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents;</li> <li>• Transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19, as well as providing treatment or therapy for other conditions as required by the resident's plan of care; or</li> <li>• Transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days.</li> </ul> <p>Effective May 9, 2021, waived requirements in § 483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i) were terminated. Effective May 10, 2021, waived requirements in § 483.10 (c)(4)(ii) were terminated.</p>	No	No	No	No	Yes

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Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Transfers of COVID-19 Patients</b>	A long term care (LTC) facility can temporarily transfer its COVID-19 positive resident(s) to another facility, such as a COVID-19 isolation and treatment location, with the provision of services “under arrangements.” The transferring LTC facility need not issue a formal discharge in this situation, as it is still considered the provider and should bill Medicare normally for each day of care. The transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period. If the LTC facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes. The SNF should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should then bill Medicare appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.	No	No	No	No	Yes

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Patients Over Paperwork

Patients Over Paperwork

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Verbal Orders</b>	CMS is 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 read-back verification is still required but authentication may occur later than 48 hours.	No	No	Yes	Yes	No
<b>Reporting Requirements</b>	CMS is waiving reporting requirements at §482.13(g) (1)(i)-(ii) which require hospitals to report patients in an intensive care unit whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs, may be reported later than close of business next business day, provided any death where the restraint may have contributed is continued to be reported within standard time limits.	No	No	No	Yes	No
<b>Limit Discharge Planning for Hospital and CAHs</b>	CMS is waiving detailed regulatory requirements to provide information regarding discharge planning, as outlined in 42 CFR §482.43(a)(8), §482.61(e), and 485.642(a)(8). The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient’s representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), SNF, inpatient rehabilitation facility (IRF), and long term care hospital (LTCH) data on quality measures and data on resource use measures. The hospital must ensure that the post acute care data on quality measures and data on resource use measures is relevant and applicable to the patient’s goals of care and treatment preferences. During this PHE, a hospital may not be able to assist patients in using quality measures and data to select a nursing home or home health agency, but must still work with families to ensure that the patient discharge is to a post-acute care provide that is able to meet the patient’s care needs. CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).	No	No	Yes	Yes	No

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Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Modify Discharge Planning for Hospitals</b>	CMS is waiving certain requirements related to hospital discharge planning for post-acute care services at 42 CFR §482.43(c), so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is waiving certain requirements for those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services. CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).	No	No	No	Yes	No
<b>Detailed Information Sharing for Discharge Planning for Long-Term Care Facilities</b>	CMS is waiving the discharge planning requirement in §483.21(c)(1)(viii), which requires LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use. CMS is maintaining all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan address the resident's goals of care and treatment preferences.	No	No	No	No	Yes
<b>Medical Records</b>	CMS is waiving 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements. CMS is waiving requirements under 42 CFR §482.24(c)(4)(viii) and §485.638(a)(4)(iii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge and for CAHs that all medical records must be promptly completed.	No	No	Yes	Yes	No
<b>Clinical Records</b>	Pursuant to section 1135(b)(5) of the Act, CMS is modifying the requirement at 42 CFR §483.10(g)(2)(ii) which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident). Specifically, CMS is modifying the timeframe requirements to allow LTC facilities ten working days to provide a resident's record rather than two working days.	No	No	No	No	Yes

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<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>Flexibility in Patient Self Determination Act Requirements (Advance Directives)</b>	CMS is waiving the requirements at section 1902(a)(58) and 1902(w)(1)(A) for Medicaid, 1852(i) (for Medicare Advantage), and 1866(f) and 42 CFR 489.102 for Medicare, which require hospitals and CAHs to provide information about its advance directive policies to patients.	No	No	Yes	Yes	No
<b>Postponement of Application Deadline to the Medicare Geographic Classification Review Board</b>	Per requirements at section 1886(d)(10)(C)(ii) of the Social Security Act (the Act) and 42 CFR 412.256(a)(2), September 1, 2020 is the deadline to submit an application to the Medicare Geographic Classification Review Board (MGCRB) for FY 2022 reclassifications. These provisions require applications to be filed through OH CDMS <sup>8</sup> not later than the first day of the 13-month period preceding the Federal fiscal year for which reclassification is requested. Due to the COVID-19 PHE, under the authority of section 1135(b)(5) of the Act, CMS is postponing the September 1 deadline until 15 days after the public display date of the FY 2021 IPPS/LTCH final rule by the Office of the Federal Register.	No	No	No	Yes	No
<b>Utilization Review</b>	CMS is waiving these requirements at 42 CFR §482.1(a)(3) and 42 C.F.R §482.30, that requires that hospitals participating in Medicare and Medicaid to have a utilization review plan that meets specified requirements. CMS is waiving the entire Utilization Review CoP at §482.30, which requires that a hospital must have a utilization review (UR) plan with a UR committee that provides for review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/ emergency plan.	No	No	No	Yes	No
<b>Quality Assurance and Performance Improvement Program (Hospitals)</b>	CMS is waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated QAPI programs (for hospitals that are a part of a hospital system). These flexibilities, which apply to both hospitals and CAHs, should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program will remain.	No	No	Yes	Yes	No

<sup>8</sup> Applications can be filed here: <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/Electronic-Filing>

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<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>Quality Assurance and Performance Improvement Program (Long-Term Care Facilities)</b>	CMS is modifying certain requirements in 42 CFR §483.75, which requires long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data driven QAPI program. Specifically, CMS is modifying §483.75(b)–(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control.	No	No	No	No	Yes
<b>Nursing Services</b>	CMS is waiving the provision at 42 CFR 482.23(b)(4), 42 CFR 482.23(b)(7), and 485.635(d)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient, and the provision that requires the hospital to have policies and procedures in place establishing which outpatient departments are not required under to have a registered nurse present. In addition, we expect that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely unnecessary. These flexibilities apply to both hospitals and CAHs, and should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	Yes	Yes	No
<b>Food and Dietetic Service</b>	CMS is waiving the requirement at 42 CFR 482.28(b)(3) to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge capacity sites. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	No	Yes	No
<b>Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments</b>	CMS is waiving 482.12(f)(3) related to Emergency services, with respect to the surge facility(ies) only, such that written policies and procedures for staff to use when evaluating emergencies are not required for surge facilities. This removes the burden on facilities to develop and establish additional policies and procedures at their surge facilities or surge sites related to the assessment, initial treatment and referral of patients. These flexibilities should be implemented so long as they are not inconsistent with a state’s emergency preparedness or pandemic plan.	No	No	No	Yes	No

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Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Emergency Preparedness Policies and Procedures</b>	CMS is waiving 482.15(b) and 485.625(b), which requires the hospital and CAH to develop and implement emergency preparedness policies and procedures, and 482.15(c)(1)-(5) and 485.625(c)(1)-(5) which requires that the emergency preparedness communication plans for hospitals and CAHs to contain specified elements with respect to the surge site. The requirement under the communication plan requires hospitals and CAHs to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This would not be an expectation for the temporary expansion site.	No	No	Yes	Yes	No
<b>Cost Reporting</b>	CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The revised extended cost report due date for FYE 12/31/2019 will be August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020.	Yes	Yes	Yes	Yes	Yes
<b>3-day Prior Hospitalization for Coverage of a SNF Stay</b>	This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period.	No	No	No	No	Yes
<b>**Reporting Minimum Data Set for SNFs (revised)</b>	(This waiver was terminated effective May 10, 2021) CMS is waiving 42 CFR §483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.	No	No	No	No	Yes

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<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission</b>	CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. CMS originally granted an extension for hospitals nationwide affected by COVID-19 until August 3, 2020. Due to continued COVID-19 related concerns from hospitals about meeting this deadline, CMS is further extending this deadline to September 3, 2020. Hospitals must submit their occupational mix surveys along with complete supporting documentation to their MACs by no later than September 3, 2020. Hospitals may then submit revisions to their occupational mix surveys to their Medicare Administrative Contractors (MACs), if needed, by no later than September 10, 2020.	No	No	No	Yes	No
<b>Waive Pre-Admission Screening and Annual Resident Review (PASARR)</b>	CMS is waiving 42 CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed postadmission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review.	No	No	No	No	Yes
<b>Resident Groups</b>	CMS is waiving the requirements at 42 CFR 483.10(f)(5), which ensure residents can participate in-person in resident groups. This waiver would only permit the facility to restrict in-person meetings during the national emergency given the recommendations of social distancing and limiting gatherings of more than ten people.	No	No	No	No	Yes
<b>In-Service Training</b>	CMS is modifying the nurse aide training requirements at §483.95(g)(1) for SNFs and NFs, which requires the nursing assistant to receive at least 12 hours of in-service training annually. In accordance with section 1135(b)(5) of the Act, CMS is postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes.	No	No	No	No	Yes

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<b>Relaxed Enforcement of Certain Interoperability and Patient Access Final Rule Policies</b>	The Interoperability and Patient Access final rule includes policies that impact a variety of stakeholders. Recognizing that hospitals, including psychiatric hospitals and CAHs, are on the frontlines of the COVID-19 PHE, CMS is extending the implementation timeline for the admission, discharge, and transfer notification CoPs by an additional 6 months. In the version of the rule displayed on March 9, 2020 on the CMS website, it stated these CoPs would be effective 6 months after the publication of the final rule in the Federal Register. We have changed this in the final rule now displayed on the Federal Register to state that the new CoPs at 42 CFR Parts 482 and 485 will now be effective 12 months after the final rule is published in the Federal Register.	No	No	Yes	Yes	No
<b>“Stark Law” Waivers</b>	The physician self-referral law (also known as the “Stark Law”) prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law regulations. These blanket waivers apply to financial relationships and referrals that are related to the COVID-19 emergency. The remuneration and referrals described in the blanket waivers must be solely related to COVID-19 Purposes, as defined in the blanket waiver document. Under the waivers, CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. <sup>9</sup>	Yes	Yes	Yes	Yes	Yes
<b>Provider Enrollment</b>	CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment: <ul style="list-style-type: none"> <li>• Waive certain screening requirements.</li> <li>• Postpone all revalidation actions.</li> <li>• Expedite any pending or new applications from providers.</li> </ul>	Yes	Yes	Yes	Yes	Yes
<b>Relief in Quality Reporting Programs</b>	CMS is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs.	No	No	Yes	Yes	Yes

<sup>9</sup> More information on this flexibility can be found here: <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Spotlight>

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<b>Advance Beneficiary Notice of Noncoverage (ABN) Use Extension</b>	The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service - FFS) beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued to transfer potential financial liability to the Medicare beneficiary in certain instances. [Note: Skilled nursing facilities (SNFs) issue the ABN to transfer potential financial liability for items/services expected to be denied under Medicare Part B only.] The ABN, Form CMS-R-131, and instructions have been approved by the Office of Management and Budget (OMB) for renewal. Due to COVID-19 concerns, CMS has expanded the deadline for use of the renewed ABN, Form CMS-R-131 (exp. 6/30/2023). At this time, the renewed ABN will be mandatory for use on 1/1/2021. The renewed form may be implemented prior to the mandatory deadline.	Yes	Yes	Yes	Yes	Yes
<b>Volume Requirements for Certain National Coverage Determinations (NCDs)</b>	CMS will not enforce the procedural volume requirements contained in the NCDs for percutaneous left atrial appendage closure, transcatheter aortic valve replacement, transcatheter mitral valve replacement, and ventricular assist devices for facilities and providers that, prior to the PHE for COVID-19, met the volume requirements. This enforcement discretion ensures that beneficiaries will continue to have access to the services that are covered under these NCDs and applies only during the period of the PHE for COVID-19.	No	No	Yes	Yes	No
<b>Signature Requirements</b>	CMS is not enforcing signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19. <sup>10</sup>	No	No	Yes	Yes	No

<sup>10</sup> More information on this flexibility can be found here: <https://www.cms.gov/files/document/se20011.pdf>

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<b>Hospital Value-Based Purchasing (VBP) Program's Extraordinary Circumstances Exceptions (ECE) Policy</b>	CMS has the ability to grant exceptions to hospitals located in entire regions or locales, which could include the entire United States, without an ECE request form where we determine that the extraordinary circumstance has affected the entire region or locale. CMS is granting an exception for certain HVBP reporting requirements in light of the COVID-19 PHE as specified in the March 27, 2020 guidance memo. <sup>11</sup>	No	No	No	Yes	No

<sup>11</sup> The guidance memo can be found here: <https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf>

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<b>Medical Staff Requirements</b>	CMS is waiving the Medical Staff requirements at 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire 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 is waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process.	No	No	No	Yes	No
<b>Physician Services</b>	CMS is waiving 482.12(c), which requires that Medicare patients be under the care of a physician. This allows hospitals to use other practitioners, such as physician's assistant and nurse practitioners to the fullest extent possible. This waiver should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	No	No	No	Yes	No
<b>Anesthesia Services</b>	CMS is waiving requirements under 42 CFR §482.52(a)(5), §485.639(c) (2), and §416.42 (b)(2) that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician in paragraphs §482.52(a)(5) and §485.639(c)(2). CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, CAHs, and Ambulatory Surgical Centers (ASCs). These waivers will allow CRNAs to function to the fullest extent of their licensure, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	No	No	Yes	Yes	No
<b>Respiratory Care Services</b>	CMS is waiving the requirement at 42 CFR 482.57(b)(1) that hospitals designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	No	Yes	No
<b>CAH Minimum Personnel Qualifications</b>	CMS is 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 will still have to meet state requirements for licensure and scope of practice, but not additional Federal requirements that may exceed State requirements. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	Yes	No	No

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<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>CAH Staff Licensure Deferral</b>	CMS is 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. These flexibilities should be implemented so long as they are not inconsistent with a State or pandemic/emergency plan.	No	No	Yes	No	No
<b>Medicare Physician Supervision Requirements</b>	For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology. Also, “direct” physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and CAHs. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.	Yes	Yes	Yes	Yes	No
<b>Practitioner Locations</b>	CMS waives the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.	Yes	Yes	Yes	Yes	No
<b>Sterile Compounding</b>	CMS is waiving hospital sterile compounding requirements (also outlined in USP797) at 42CFR §482.25(b)(1) and §485.635(a)(3) to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. This will conserve scarce face mask supplies. CMS will not be reviewing the use and storage of facemasks under these requirements.	No	No	Yes	Yes	No
<b>Home Nursing Visits</b>	RHCs and FQHCs can provide visiting nursing services to a beneficiary’s home with fewer requirements, making it easier for homebound beneficiaries to receive care.	Yes	Yes	No	No	No

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<b>Responsibilities of Physicians in CAHs</b>	42 C.F.R. § 485.631(b)(2). CMS is 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 § 485.631(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 described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH.	No	No	Yes	No	No
<b>Certain Staffing Requirements for RHCs and FQHCs</b>	42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates.	Yes	Yes	No	No	No
<b>Physician Supervision of NPs in RHCs and FQHCs</b>	42 C.F.R. 491.8(b)(1). CMS is modifying the requirement that physicians must provide medical direction for the clinic’s or center’s health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center’s health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff.	Yes	Yes	No	No	No

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<b>Training and Certification of Nurse Aides</b>	CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d). CMS is waiving these requirements to assist in potential staffing shortages seen with the COVID-19 pandemic. To ensure the health and safety of nursing home residents, CMS is not waiving 42 CFR § 483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services. We further note that we are not waiving § 483.35(c), which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	No	No	No	No	Yes
<b>Physician Delegation of Tasks in SNFs</b>	42 C.F.R. 483.30(e)(4). CMS is waiving the requirement in § 483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gives physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who meets the applicable definition in 42 C.F.R. 491.2 or, in the case of a clinical nurse specialist, is licensed as such by the State and is acting within the scope of practice laws as defined by State law. We are temporarily modifying this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does not include the provision of § 483.30(e)(4) that prohibits a physician from delegating a task when the delegation is prohibited under State law or by the facility's own policy.	No	No	No	No	Yes
<b>Physician Visits in SNFs</b>	42 C.F.R. 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We are modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws.	No	No	No	No	Yes

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<b>Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)</b>	CMS is modifying 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 PHE expires. On the 61st day after the PHE 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.	Yes	Yes	Yes	Yes	No
<b>National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)</b>	To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during this PHE, the Chief Medical Officer or equivalent of a hospital or facility will have the authority to make those staffing decisions. <sup>12</sup>	No	No	Yes	Yes	No
<b>Requirement to Conduct Testing for Staff and Residents</b>	Under the new 483.80(h) CMS is requiring Long-Term Care (LTC) Facilities to test Staff and Residents. Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the Secretary.	No	No	No	No	Yes
<b>Providers who can Administer the COVID-19 Vaccine</b>	CMS is working to increase the number of providers that will administer a COVID-19 vaccine to Medicare beneficiaries when it becomes available, to make it as convenient as possible for America's seniors. New providers are now able to enroll as a "Medicare mass immunizers" through an expedited 24-hour process. The ability to easily enroll as a mass immunizer is important for some pharmacies, schools, and other entities that may be non-traditional providers or otherwise not eligible for Medicare enrollment. To further increase the number of providers who can administer the COVID -19 vaccine, CMS will continue to share approved Medicare provider information with states to assist with Medicaid provider enrollment efforts. CMS is also making it easier for newly enrolled Medicare providers also to enroll in state Medicaid programs to support state administration of vaccines for Medicaid recipients.	Yes	Yes	Yes	Yes	Yes

<sup>12</sup> More information on this flexibility can be found here: <https://www.cms.gov/files/document/covid-final-ifc.pdf>

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Workforce

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Paid Feeding Assistants</b>	<p>CMS is modifying the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants. Specifically, CMS is modifying the minimum timeframe requirements in these sections, which require this training to be a minimum of 8 hours. CMS is modifying to allow that the training can be a minimum of 1 hour in length. CMS is not waiving any other requirements under 42 CFR §483.60(h) related to paid feeding assistants or the required training content at 42 CFR §483.160(a)(1)-(8), which contains infection control training and other elements. Additionally, CMS is also not waiving or modifying the requirements at 42 CFR §483.60(h)(2)(i), which requires that a feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).</p>	No	No	No	No	Yes

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19  
Payment**

Payment

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>**Accelerated/ Advance Payments (revised)</b>	<p>In order to provide additional cash flow to healthcare providers and suppliers impacted by COVID-19, CMS expanded and streamlined the Accelerated and Advance Payments Program, which provided conditional partial payments to providers and suppliers to address disruptions in claims submission and/or claims processing subject to applicable safeguards for fraud, waste and abuse. Under this program, CMS made successful payment of over \$100 billion to healthcare providers and suppliers. As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, in light of direct payments made available through the Department of Health &amp; Human Services' (HHS) Provider Relief Fund. Distributions made through the Provider Relief Fund do not need to be repaid. For providers and suppliers who have received accelerated or advance payments related to the COVID-19 PHE, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance. Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC). On October 8, 2020, CMS announced amended terms for payments issued under the Accelerated and Advance Payment (AAP) Program as required by Congress. This Medicare loan program allows CMS to make advance payments to providers and are typically used in emergency situations. Under the Continuing Appropriations Act, 2021 and Other Extensions Act repayment will now begin one year from the issuance date of each provider or supplier's accelerated or advance payment.</p> <p>Repayment of COVID-19 Accelerated and Advance Payments began on March 30, 2021.</p>	Yes	Yes	Yes	Yes	Yes
<b>Price Transparency for COVID-19 Testing</b>	<p>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 to make public the cash price for such tests on their websites. Providers without websites will be 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.</p>	Yes	Yes	Yes	Yes	No

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19  
Payment**

<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>Enhanced Medicare Payments for New COVID-19 Treatments: Hospital Inpatient Stays</b>	In order to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments hospital during the COVID-19 PHE, the Medicare program will provide an enhanced payment for eligible inpatient cases that involve use of certain new products authorized or approved to treat COVID-19. The enhanced payment will be equal to the lesser of: (1) 65 percent of the operating outlier threshold for the claim; or (2) 65 percent of the cost of a COVID-19 stay beyond the operating Medicare payment (including the 20 percent add-on payment under section 3710 of the CARES Act) for eligible cases.	No	No	Yes	Yes	No
<b>Enhanced Medicare Payments for New COVID-19 Treatments: Hospital Outpatient Departments</b>	CMS wants to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments provided in a hospital outpatient setting during the COVID-19 PHE. Therefore, in this IFC, CMS has excluded FDA-authorized or approved drugs and biologicals (including blood products) authorized or approved to treat or prevent COVID-19 from being packaged into the Comprehensive Ambulatory Payment Classification (C-APC) payment when these treatments are billed on the same claim as a primary C-APC service. Instead, Medicare will pay for these drugs and biologicals separately throughout the course of the PHE.	No	No	Yes	Yes	No
<b>**Temporary Suspension of Medicare Sequestration (revised)</b>	The CARES Act temporarily lifted the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020, boosting payments for hospital, physician, nursing home, home health, and other care. <sup>13</sup> The Consolidated Appropriations Act, 2021, signed into law on December 27, 2020, extended the suspension period to March 31, 2021. An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, signed into law on April 14, 2021, extends the suspension period to December 31, 2021.	Yes	Yes	Yes	Yes	Yes
<b>Add-on Payment for Inpatient Hospital COVID-19 Patients</b>	The CARES Act increased the payment that would otherwise be made to a hospital for treating a patient admitted with COVID-19 by 20 percent. It would build on the Centers for Disease Control and Prevention (CDC) decision to expedite use of a COVID-19 diagnosis to enable better surveillance as well as trigger appropriate payment for these complex patients. This add-on payment would be available through the duration of the COVID-19 emergency period.	No	No	No	Yes	No

<sup>13</sup> More information on this flexibility can be found here: [https://www.finance.senate.gov/imo/media/doc/CARES%20Act%20Section-by-Section%20\(Finance%20Health\).pdf](https://www.finance.senate.gov/imo/media/doc/CARES%20Act%20Section-by-Section%20(Finance%20Health).pdf)

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19  
Payment**

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>COVID-19 Diagnostic Codes<sup>14</sup></b>	On February 13 and March 5, CMS announced new HCPCS codes for healthcare providers and laboratories to test patients for SARS-CoV2. Healthcare providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). A second new HCPCS code (U0002) 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC can also be used by laboratories and healthcare facilities. Both codes can be used to bill Medicare as well as by other health insurers that choose to utilize and accept the code. Effective April 1, 2020, for dates of service on or after February 4, 2020. Additionally, the AMA created CPT code 87635 for infectious agent detection by nucleic acid tests as well as CPT codes 86769 and 86328 for serology tests. Laboratories performing these tests may bill Medicare for services that occurred after their respective effective dates. There is no cost-sharing for Medicare patients. <sup>15</sup>	Yes	Yes	Yes	Yes	Yes
<b>High-Production Coronavirus Lab Tests<sup>16</sup></b>	CMS announced Medicare will nearly double payment for certain lab tests that use high-throughput technologies to rapidly diagnose large numbers of 2019 Novel Coronavirus (COVID-19) cases. <sup>17</sup> CMS created the new HCPCS codes U0003 and U0004 so that laboratories conducting testing that uses high-throughput technology can bill at this rate for dates of service on or after April 14, 2020.	Yes	Yes	Yes	Yes	Yes
<b>Antibody (Serology) Tests<sup>18</sup></b>	During the PHE, Medicare will cover FDA-authorized COVID-19 serology testing (a diagnostic test) for beneficiaries with known current or known prior COVID-19 infection or suspected current or suspected past COVID-19 infection. <sup>19</sup>	Yes	Yes	Yes	Yes	Yes

<sup>14</sup> The “COVID-19 Diagnostic Codes” flexibility applies only to Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified labs.

<sup>15</sup> More information and test pricing can be found here: <https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf>

<sup>16</sup> The “High-Production Coronavirus Lab Tests” flexibility applies only to Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified labs.

<sup>17</sup> The CMS announcement can be found here: <https://www.cms.gov/newsroom/press-releases/cms-increases-medicare-payment-high-production-coronavirus-lab-tests-0>

<sup>18</sup> The “Antibody (Serology Tests)” flexibility applies only to Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified labs.

<sup>19</sup> More information can be found here: <https://www.medicare.gov/coverage/coronavirus-disease-2019-covid-19-antibody-test>

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19  
Payment**

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>**COVID-19 Antibody Treatment</b> (revised)	<p>CMS announced that Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing during the PHE. CMS's coverage of monoclonal antibody infusions applies to bamlanivimab, which received an emergency use authorization (EUA) from the U.S. Food and Drug Administration.<sup>20</sup></p> <p>Starting March 24, 2021, the U.S. Government, in coordination with Eli Lilly and Company, stopped distributing bamlanivimab alone due to a sustained increase in COVID-19 viral variants in the U.S. that are resistant to bamlanivimab when administered alone. Instead of administering bamlanivimab alone, health care providers should consider using the other authorized monoclonal antibody therapies expected to retain activity against the viral variants: (1) Casirivimab and imdevimab, administered together; (2) Bamlanivimab and etesevimab, administered together.</p> <p>On May 6, 2021, CMS increased the Medicare payment rate for administering monoclonal antibodies to treat beneficiaries with COVID-19, continuing coverage under the Medicare Part B COVID-19 vaccine benefit. Beneficiaries pay nothing out of pocket, regardless of where the service is furnished – including in a physician's office, healthcare facility or at home. The national average payment rate will increase from \$310 to \$450 for most health care settings. In support of providers' efforts to prevent the spread of COVID-19, CMS will also establish a higher national payment rate of \$750 when monoclonal antibodies are administered in the beneficiary's home, including the beneficiary's permanent residence or temporary lodging (e.g., hotel/motel, cruise ship, hostel, or homeless shelter). The new national payment rate for at-home administration of monoclonal antibodies accounts for increased costs associated with the one-on-one nature of this care model. These higher national average payment rates reflect additional information provided to CMS about the costs of providing these services in a safe and timely manner, such as clinical staff and personal protective equipment. This action also means Medicare payments to providers and suppliers will be more aligned to their costs to administer these products.</p>	Yes	Yes	Yes	Yes	Yes
<b>COVID-19 Diagnostic Testing</b>	<p>Medicare will pay independent laboratories that send trained technicians to a beneficiary's home, including a nursing home, to collect a sample for COVID-19 diagnostic testing. Medicare will pay a collection fee and for the travel.</p>	No	No	No	No	Yes

<sup>20</sup> More information on this flexibility can be found here: <https://www.cms.gov/files/document/covid-medicare-mono-clonal-antibody-infusion-program-instruction.pdf>

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19  
Payment**

<b>Flexibility</b>	<b>Description</b>	<b>RHC</b>	<b>FQHC</b>	<b>CAH</b>	<b>Hospital</b>	<b>SNF</b>
<b>Enforcement Discretion Relating to Certain Pharmacy Billing</b>	CMS will allow Medicare-enrolled immunizers, including but not limited to pharmacies working with the United States, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare SNF residents. <sup>21</sup>	No	No	No	No	Yes
<b>**Procedure Codes for Therapeutics (revised)</b>	<p>In response to the COVID-19 PHE, CMS is implementing 12 new procedure codes to describe the introduction or infusion of therapeutics, including remdesivir and convalescent plasma, into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), effective August 01, 2020. These new codes, which go into effect August 1, will enable CMS to conduct real-time surveillance and obtain real-world evidence in how these drugs are working and provide critical information on their effectiveness and how they can protect patients. These codes can be reported to Medicare and other insurers may also use the codes to identify the use of COVID-19 therapies and help facilitate monitoring and data collection on their use.</p> <p>On November 30, 2020, CMS implemented 21 new procedure codes to describe the introduction or infusion of therapeutics, including monoclonal antibodies and vaccines for COVID-19 treatment, into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), also effective January 01, 2021.</p>	No	No	Yes	Yes	No
<b>Medicare Coverage of COVID-19 Testing for Nursing Home Residents (Medicare Advantage)</b>	<p>In general, Medicare covers reasonable and necessary laboratory tests with zero patient cost sharing. CMS specifically instructed Medicare Administrative Contactors and notified Medicare Advantage plans to cover COVID-19 laboratory tests in nursing homes. Starting on July 6, 2020, and for the duration of the PHE, consistent with sections listed below of CDC guidelines titled, "Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel," Original Medicare and Medicare Advantage plans will cover diagnostic COVID-19 lab tests and non-cover tests not considered diagnostic.<sup>22</sup></p> <ul style="list-style-type: none"> <li>• Viral Testing of Residents for SARS-CoV-2</li> <li>• Initial Viral Testing in Response to an Outbreak</li> <li>• Recommended testing to determine resolution of infection with SARS-CoV-2</li> <li>• Public health surveillance for SARS-CoV-2 Tests that are considered non-diagnostic are not covered.</li> </ul>	No	No	No	No	Yes

<sup>21</sup> More information can be found here: <https://www.cms.gov/files/document/snf-enforcement-discretion-letter.pdf>

<sup>22</sup> The CMS guidance can be found here: <https://www.cms.gov/files/document/hpms-memo-diagnostic-testing-nursing-home-residents-and-patients-coronavirus-disease-2019.pdf>

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19  
Payment**

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<p><b>**COVID-19 Vaccine Medicare Payment (revised)</b></p>	<p>On October 28, 2020, CMS released an IFC establishing that any vaccine that receives Food and Drug Administration (FDA) authorization, through an Emergency Use Authorization (EUA) or licensed under a Biologics License Application (BLA), will be covered under Medicare as a preventive vaccine at no cost to beneficiaries. The IFC also implements provisions of the CARES Act that ensure swift coverage of a COVID-19 vaccine by most private health insurance plans without cost sharing from both in and out-of-network providers during the course of the PHE. The Medicare payment rates for COVID-19 vaccine administration will be \$28.39 to administer single-dose vaccines. For a COVID-19 vaccine requiring a series of 2 or more doses, the initial dose(s) administration payment rate will be \$16.94, and \$28.39 for the administration of the final dose in the series. These rates will be geographically adjusted and recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. Medicare beneficiaries, those in Original Medicare or enrolled in Medicare Advantage, will be able to get the vaccine at no cost. For calendar years 2020 and 2021, Medicare will pay directly for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage (MA) plans. Providers should submit COVID-19 claims to Original Medicare for all patients enrolled in MA in 2020 and 2021. MA plans will not be responsible for reimbursing providers to administer the vaccine during this time. MA beneficiaries also pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.</p> <p>CMS increased the Medicare payment amount for administering the COVID-19 vaccine. Effective for COVID-19 vaccines administered on or after March 15, 2021, the national average payment rate for physicians, hospitals, pharmacies and many other immunizers will be \$40 to administer each dose of a COVID-19 vaccine.</p>	Yes	Yes	Yes	Yes	Yes

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Payment

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<p><b>**COVID-19 Vaccine: Check Medicare Eligibility</b> (added)</p>	<p>Starting April 16, in addition to screening your patients, you can check Medicare eligibility for COVID-19 vaccine administration history from Fee-for-Service (FFS) claims paid for calendar years 2020 and 2021. This includes Medicare Advantage patients. You can get the following eligibility information for each paid vaccine administration claim:</p> <ul style="list-style-type: none"> <li>• CPT or HCPCS codes</li> <li>• Date of service</li> <li>• National provider identifier for who administered the vaccine</li> </ul> <p>We can only provide this information if the provider billed Medicare for administering the vaccine. If your patients got vaccinated and the provider didn't submit a Medicare claim (like if they got vaccinated at a free event), ask your patients about their COVID-19 vaccination history.</p>	Yes	Yes	Yes	Yes	No

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Data Reporting

Data Reporting

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Requirement for Hospitals and CAHs to Report COVID-19 Data</b>	Hospitals and CAHs are to report information in accordance with a frequency and in a standardized format as specified by the Secretary during the PHE for COVID-19. <sup>23</sup> Failure to report the specified data needed to support broader surveillance of COVID-19 may lead to the imposition of the remedy to terminate a provider's participation from the Medicare and Medicaid programs.	No	No	Yes	Yes	No
<b>Required Facility Reporting</b>	Under §483.80(g), long-term care facilities are required to report COVID-19 cases in their facility to the CDC National Health Safety Network (NHSN) on a weekly basis. CDC and CMS will use information collected through the new NHSN Long-term Care COVID-19 Module to strengthen COVID-19 surveillance locally and nationally; monitor trends in infection rates; and help local, state, and federal health authorities get help to nursing homes faster. Nursing home reporting to the CDC is a critical component of the national COVID-19 surveillance system and to efforts to reopen America. The information will also be posted online for the public to be aware of how the COVID-19 pandemic is affecting nursing homes. In the August 21, 2020 Interim Final Rule with Comment Period, CMS is codifying enforcement actions for facilities noncompliance with this requirement. Failure to report will result in the imposition of a civil money penalty for each occurrence of non-reporting as follows: A civil money penalty of \$1,000 for the first occurrence, followed by \$500 added to the previously imposed civil money penalty for each subsequent occurrence, not to exceed the maximum amount set forth in § 488.408(d)(1)(iii). Facilities are also required to notify residents, their representatives, and families of residents in facilities of the status of COVID-19 in the facility, which includes any new cases of COVID-19 as they are identified.	No	No	No	No	Yes

<sup>23</sup> More information can be found here: <https://www.hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf>

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Data Reporting

Flexibility	Description	RHC	FQHC	CAH	Hospital	SNF
<b>**COVID-19 Vaccine Immunization Requirements for Residents and Staff</b> (added)	<p>On May 11, 2021, CMS published an interim final rule with comment period (IFC). This rule establishes Long-Term Care (LTC) Facility Vaccine Immunization Requirements for Residents and Staff. This includes new requirements for educating residents or resident representatives and staff regarding the benefits and potential side effects associated with the COVID-19 vaccine, and offering the vaccine. Furthermore, LTC facilities must report COVID-19 vaccine and therapeutics treatment information to the Centers for Disease Control and Prevention’s (CDC) National Healthcare Safety Network (NHSN). CMS will post the new information reported to the NHSN for viewing by facilities, stakeholders, or the general public on CMS’s COVID-19 Nursing Home Data website. CMS has also updated tools used by surveyors to assess compliance with these new requirements.</p>	No	No	No	No	Yes

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Additional Guidance

Additional Guidance

Resource	Description	RHC	FQHC	CAH	Hospital	SNF
<b>COVID-19 FAQs on Medicare Fee-for-Service (FFS) Billing</b>	CMS released a Frequently Asked Questions (FAQs) document to supplement previously released FAQs: 1135 Waiver FAQs and Without 1135 Waiver FAQs. The supplemental document can be found here: <a href="https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf">https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf</a>	Yes	Yes	Yes	Yes	Yes
<b>COVID-19 Provider Burden Relief FAQs</b>	CMS released a Frequently Asked Questions (FAQs) document regarding provider burden relief, which can be found here: <a href="https://www.cms.gov/files/document/provider-burden-relief-faqs.pdf">https://www.cms.gov/files/document/provider-burden-relief-faqs.pdf</a>	Yes	Yes	Yes	Yes	No
<b>Standards of Practice and Flexibilities for Hospitals</b>	CMS released a document providing guidance on infection control and prevention related to COVID-19. The guidance was targeted towards hospitals, psychiatric hospitals, CAHs, nursing homes, and outpatient providers, among others, and can be found here: <a href="https://www.cms.gov/files/document/qso-20-13-hospitals-cahs-revised.pdf">https://www.cms.gov/files/document/qso-20-13-hospitals-cahs-revised.pdf</a>	No	No	Yes	Yes	No
<b>Standards of Practice and Flexibilities for Outpatient Settings</b>	CMS released a document providing guidance on infection control and prevention related to COVID-19 in outpatient settings. The document includes FAQs and other considerations, and can be found here: <a href="https://www.cms.gov/files/document/qso-20-22-asc-corf-cmhc-opt-rhc-fqhcs.pdf">https://www.cms.gov/files/document/qso-20-22-asc-corf-cmhc-opt-rhc-fqhcs.pdf</a>	Yes	Yes	No	No	No
<b>Standards of Practice for Infection Control and Prevention of COVID-19 in Nursing Homes</b>	CMS released additional guidance for nursing homes to help them improve their infection control and prevention practices to prevent transmission of COVID-19. The guidance can be found here: <a href="https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf">https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf</a>	No	No	No	No	Yes
<b>Hospital Flexibilities under EMTALA</b>	CMS released guidance on the Emergency Medical Treatment and Labor Act (EMTALA) requirements for hospitals and CAHs, including screening obligations and stabilization, transfer, and recipient hospital obligations. The guidance can be found here: <a href="https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf">https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf</a>	No	No	Yes	Yes	No

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Additional Guidance

Resource	Description	RHC	FQHC	CAH	Hospital	SNF
<b>FAQs for Hospitals and CAHs regarding EMTALA</b>	CMS issued a set of Frequently Asked Questions (FAQs) clarifying requirements and considerations for hospitals and other providers related to EMTALA during the COVID-19 pandemic. The FAQs address questions around patient presentation to the Emergency Department, EMTALA applicability across facility types, qualified medical professionals, medical screening exams, patient transfer and stabilization, and telehealth, among others. The document can be found here: <a href="https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emptala-part-ii.pdf">https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emptala-part-ii.pdf</a>	No	No	Yes	Yes	No
<b>Requirements for Notification of Confirmed COVID-19 Among Resident and Staff in Nursing Homes</b>	CMS announced new regulatory requirements that will require nursing homes to inform residents, their families, and representatives of COVID-19 cases in their facilities. In addition, CMS will now require nursing homes to report cases of COVID-19 directly to the Centers for Disease Control and Prevention (CDC). This information must be reported in accordance with existing privacy regulations and statute. Finally, CMS will also require nursing homes to fully cooperate with CDC surveillance efforts around COVID-19 spread. More information can be found here: <a href="https://www.cms.gov/files/document/gso-20-29-nh.pdf">https://www.cms.gov/files/document/gso-20-29-nh.pdf</a>	No	No	No	No	Yes
<b>**Nursing Home Visitation Guidance (revised)</b>	Millions of COVID-19 vaccinations have been administered to nursing home residents and staff, and these vaccines have been shown to help prevent symptomatic SARS-CoV-2 infection (i.e., COVID-19). Therefore, CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), is updating its visitation guidance accordingly, but emphasizing the importance of maintaining infection prevention practices, given the continued risk of COVID-19 transmission. The guidance can be found here: <a href="https://www.cms.gov/files/document/gso-20-39-nh-revised.pdf">https://www.cms.gov/files/document/gso-20-39-nh-revised.pdf</a>	No	No	No	No	Yes
<b>Medicare Payments for COVID-19 Viral Testing in SNFs/Nursing Facilities</b>	CMS released a presentation that summarizes Medicare payments for COVID-19 viral testing in skilled nursing facilities and nursing facilities. The presentation can be found here: <a href="https://www.cms.gov/files/document/covid-medicare-payment-covid-19-viral-testing-flow-chart.pdf">https://www.cms.gov/files/document/covid-medicare-payment-covid-19-viral-testing-flow-chart.pdf</a>	No	No	No	No	Yes

**Rural Crosswalk: CMS Flexibilities to Fight COVID-19**  
Additional Guidance

Resource	Description	RHC	FQHC	CAH	Hospital	SNF
<b>COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes</b>	CMS is initiating a performance-based funding requirement tied to the CARES Act supplemental grants for State Survey Agencies. Further, CMS is providing guidance for the limited resumption of routine survey activities. CMS is also enhancing the penalties for noncompliance with infection control to provide greater accountability and consequence for failures to meet these basic requirements. The enhanced enforcement actions are more significant for nursing homes with a history of past infection control deficiencies, or that cause actual harm to residents or Immediate Jeopardy. Quality Improvement Organizations have been strategically refocused to assist nursing homes in combating COVID-19 through such efforts as education and training, creating action plans based on infection control problem areas and recommending steps to establish a strong infection control and surveillance program. More information can be found here: <a href="https://www.cms.gov/files/document/qso-20-31-all.pdf">https://www.cms.gov/files/document/qso-20-31-all.pdf</a>	No	No	No	No	Yes
<b>SNF Quality Reporting Program COVID-19 PHE Tip Sheet</b>	CMS released a tip sheet designed to assist SNF providers in understanding the status of the SNF Quality Reporting Program during the COVID-19 PHE. The document also provides is practical guidance to address quality data submission requirements starting July 1, 2020 now that the temporary QRP exemptions from the COVID-19 PHE have ended. The tip sheet can be found here: <a href="https://www.cms.gov/files/document/snfgrp-covid19phetipsheet-july2020.pdf">https://www.cms.gov/files/document/snfgrp-covid19phetipsheet-july2020.pdf</a>	No	No	No	No	Yes
<b>FAQs on COVID-19 Testing at SNFs/NFs</b>	CMS released a Frequently Asked Questions (FAQs) document regarding COVID-19 testing at SNFs and nursing homes. The document can be found here: <a href="https://www.cms.gov/files/document/covid-faqs-snf-testing.pdf">https://www.cms.gov/files/document/covid-faqs-snf-testing.pdf</a>	No	No	No	No	Yes
<b>Reporting of COVID-19 Clinical Trial Data through the Quality Payment Program</b>	CMS is encouraging clinicians who participate in the Quality Payment Program (QPP), such as physicians, physician assistants, nurse practitioners, and others, to contribute to scientific research and evidence to fight the COVID-19 pandemic. Clinicians may now earn credit in the Merit-based Incentive Payment System (MIPS), a performance-based track of QPP that incentivizes quality and value, for participation in a clinical trial and reporting clinical information by attesting to the new COVID-19 Clinical Trials improvement activity. This action will provide vital data to help drive improvement in patient care and develop innovative best practices to manage the spread of COVID-19 within communities. CMS has updated the Quality Reporting Document Architecture (QRDA) Category III Implementation Guide to include information for eligible clinicians on this new activity, which can be found here: <a href="https://ecqi.healthit.gov/sites/default/files/2021-CMS-QRDA-III-Eligible-Clinicians-and-EP-IG-508.pdf">https://ecqi.healthit.gov/sites/default/files/2021-CMS-QRDA-III-Eligible-Clinicians-and-EP-IG-508.pdf</a>	Yes	Yes	Yes	Yes	No

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Additional Guidance

Resource	Description	RHC	FQHC	CAH	Hospital	SNF
<b>Nursing Home 5 Star Quality Rating System updates and Nursing Home Staff Counts</b>	CMS published a memorandum, outlining changes to the Nursing Home 5 Star Quality Rating System and Nursing Home Staff Counts. For CMS's Nursing Home Compare website and Nursing Home Five Star Quality Rating System, CMS is holding the inspection domain constant temporarily due to the prioritization and suspension of certain surveys to ensure the rating system reflects fair information for consumers. CMS is also publishing a list of the average number of nursing and total staff that work onsite in each nursing home, each day, which will help direct adequate PPE and testing to nursing homes. The document can be found here: <a href="https://www.cms.gov/files/document/gso-20-34-nh.pdf">https://www.cms.gov/files/document/gso-20-34-nh.pdf</a>	No	No	No	No	Yes
<b>**Nursing Home Series for Front Line Clinicians and Staff</b> (added)	CMS is released the first episode in a series of short podcasts for frontline nursing home staff "CMS Beyond the Policy". The edition is titled "Nursing Home Series for Front Line Clinicians and Staff." The episode can be found here: <a href="https://www.cms.gov/podcast/nursing-home-series-front-line-clinicians-and-staff">https://www.cms.gov/podcast/nursing-home-series-front-line-clinicians-and-staff</a>	No	No	No	No	Yes
<b>**Coverage of Monoclonal Antibody Products to Treat COVID-19</b> (added)	CMS released the Coverage of Monoclonal Antibody Products to Treat COVID-19 infographic. The infographic can be found here: <a href="https://www.cms.gov/files/document/covid-infographic-coverage-mono-clonal-antibody-products-treat-covid-19.pdf">https://www.cms.gov/files/document/covid-infographic-coverage-mono-clonal-antibody-products-treat-covid-19.pdf</a>	No	No	Yes	Yes	Yes
<b>COVID-19 Vaccine Toolkits</b>	COVID-19 vaccine toolkits for providers, private health plans and state Medicaid programs can be found here: <a href="http://www.cms.gov/covidvax">www.cms.gov/covidvax</a>	Yes	Yes	Yes	Yes	Yes
<b>New COVID 19 Testing and Reporting Requirements</b>	CMS released a document describing new testing and reporting requirements for nursing homes, hospitals, and CLIA-certified labs. The toolkit can be found here: <a href="https://www.cms.gov/files/document/covid-ppt-nh-all-call.pdf">https://www.cms.gov/files/document/covid-ppt-nh-all-call.pdf</a>	Yes	Yes	Yes	Yes	Yes

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<b>Emergency Preparedness Testing Exercise Requirements Guidance</b>	CMS regulations for Emergency Preparedness require specific testing exercises be conducted to validate the facility's emergency program. During or after an actual emergency, the regulations allow for an exemption to the testing requirements based on real world actions taken by providers and suppliers. CMS developed a worksheet that presents guidance for surveyors, as well as providers and suppliers, with relevant scenarios on meeting the testing requirements in light of many of the response activities associated with the COVID-19 PHE. The worksheet and additional guidance can be found here: <a href="https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-related-emergency-preparedness-testing-exercise-requirements-coronavirus-disease-2019-covid">https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-related-emergency-preparedness-testing-exercise-requirements-coronavirus-disease-2019-covid</a>	No	No	Yes	Yes	No
<b>COVID-19 Guidance and Updates for Nursing Homes during COVID-19</b>	CMS compiled nursing home guidance in the form of: memos; non-memos; waivers and flexibilities; and data releases. The guidance can be found here: <a href="https://www.cms.gov/files/document/covid-guidance-and-updates-nursing-homes-during-covid-19.pdf">https://www.cms.gov/files/document/covid-guidance-and-updates-nursing-homes-during-covid-19.pdf</a>	No	No	No	No	Yes
<b>Tools to Streamline Certification for Labs Testing for COVID-19</b>	CMS released tools to reduce burdensome paperwork and authorization delays for laboratories seeking CLIA certification to test for COVID-19. CMS's quick-start guide helps laboratories with the application process for CLIA certification and includes information on the expedited review process implemented at the beginning of the PHE that allows labs to start COVID-19 testing before the official paper certificate arrives by postal mail. More information can be found here: <a href="https://www.cms.gov/files/document/laboratory-quick-start-guide-cms-clia-certification.pdf">https://www.cms.gov/files/document/laboratory-quick-start-guide-cms-clia-certification.pdf</a>	Yes	Yes	Yes	Yes	No
<b>**New Platform for Submissions of 1135 Waiver Requests and Inquiries (added)</b>	CMS announced a new web-based tool to assist Medicare/Medicaid-participating providers and suppliers in submission of 1135 Waiver requests and inquiries. With very limited exception, the new web system should be used for all 1135 waiver requests and/or PHE-related inquiries submitted on or after January 11, 2021. The platform can be found here: <a href="https://cmsqualitysupport.servicenow.com/cms_1135">https://cmsqualitysupport.servicenow.com/cms_1135</a>	Yes	Yes	Yes	Yes	Yes

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<b>Nursing Homes Best Practices Toolkit to Combat COVID-19</b>	CMS released a toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to these facilities, with additional resources to aid in the fight against the COVID-19 pandemic within nursing homes. The toolkit is comprised of best practices from a variety of frontline health care providers, Governors' COVID-19 task forces, associations and other organizations, and experts, and is intended to serve as a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19. The toolkit can be found here: <a href="https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf">https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf</a>	No	No	No	No	Yes
<b>CMS COVID-19 Stakeholder Engagement Calls</b>	CMS hosts recurring stakeholder engagement sessions to share information related to the agency's response to COVID-19. These sessions are open to members of the healthcare community and are intended to provide updates, share best practices among peers, and offer attendees an opportunity to ask questions of CMS and other subject matter experts. Recordings of these sessions are publicly available for those unable to attend, and can be found here: <a href="https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts">https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts</a>	Yes	Yes	Yes	Yes	Yes
<b>CMS Office of Minority Health (CMS OMH): COVID-19 Resources on Vulnerable Populations</b>	CMS OMH has compiled Federal resources on the 2019 Novel Coronavirus (COVID-19) to assist its partners who work with those most vulnerable--such as older adults, those with underlying medical conditions, racial and ethnic minorities, rural communities, and people with disabilities. Those resources can be found here: <a href="https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/COVID-19-Resources">https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/COVID-19-Resources</a>	Yes	Yes	Yes	Yes	Yes
<b>Interim Final Rules and Waivers</b>	CMS regularly updates a webpage that includes Interim Final Rules, waivers, and provider-specific fact sheets related to COVID-19, which can be found here: <a href="https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers">https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers</a>	Yes	Yes	Yes	Yes	Yes

## Rural Crosswalk: CMS Flexibilities to Fight COVID-19

Document Last Updated: **May 2021**