Home Health Agencies: CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

This CMS cross-cutting initiative focused on evaluating CMS-issued PHE waivers and flexibilities to prepare the health care system for operation after the PHE. This review happened in three concurrent phases:

1. CMS assessed the need for continuing certain waivers based on the current phase of the PHE. Since the beginning of the PHE, CMS has both added and terminated flexibilities and waivers as needed. In doing so, CMS considered the impacts on communities — including underserved communities — and the potential barriers and opportunities that the flexibilities may address.

2. CMS assessed which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing health care.

3. CMS is continuing to collaborate with federal partners and the health care industry to ensure that the health care system is holistically prepared for addressing future emergencies.

As CMS identified barriers and opportunities for improvement, the needs of each person and community served were considered and assessed with a health equity lens to ensure our analysis, stakeholder engagement, and policy decisions account for health equity impacts on members of underserved communities and health care professionals disproportionately serving these communities.

Please note: This fact sheet focuses on Medicare and Medicaid flexibilities only.

COVID-19 Vaccines

On October 28, 2020, CMS released an Interim Final Rule with comment period (IFC) announcing that Medicare Part B would establish coding and payment rates for COVID-19 vaccines and their administration as preventive vaccines, without cost-sharing, as soon as the Food and Drug Administration (FDA) authorized or approved the product through an

Emergency Use Authorization (EUA) or Biologics License Application (BLA). The IFC also implemented provisions of the CARES Act to ensure swift coverage of COVID-19 vaccines by private health insurance plans participating in the Health Insurance Marketplace, without cost sharing, from both in- and out-of-network providers, during the course of the public health emergency (PHE).

Payment After the End of the PHE

CMS will continue to pay approximately $40 per dose for administering COVID-19 vaccines in most outpatient settings for Medicare beneficiaries through the end of the calendar year in which the Secretary ends the EUA declaration for drugs and biologicals with respect to COVID-19. The EUA declaration is distinct from, and not dependent on, the PHE for COVID-19.

Effective January 1 of the year in which the EUA declaration ends, CMS will set the payment rate for administering COVID-19 vaccines to align with the payment rate for administering other Part B preventive vaccines, that is, approximately $30 per dose.

Additional Payment for Administering the Vaccine in the Patient's Home

In calendar year 2023, CMS will pay approximately $36 in addition to the standard administration amount (approximately $40) per dose to administer COVID-19 vaccines in the home for certain Medicare patients. For vaccines requiring multiple doses, this payment applies for each dose in the series, including any additional or booster doses. We also geographically adjust the additional amount and administration rate based on where you administer the vaccine. Starting January 1, 2023, we'll also annually update the additional in-home payment rate for administering the COVID-19 vaccine to reflect changes in costs related to administering preventive vaccines.

Additional Payment for Administering the Vaccine in the Patient's Home After the End of the PHE

We'll continue to pay a total payment of approximately $76 per dose to administer COVID-19 vaccines in the home for certain Medicare patients through calendar year 2023. The additional payment is not affected by the end of the PHE.

More information: COVID-19 vaccine toolkits

- Providers
  - Payment
  - Billing
  - Coding
- Health & Drug Plans
- State Medicaid programs

COVID-19 Monoclonal Antibodies

There are currently no COVID-19 monoclonal antibodies approved or authorized for use against the dominant strains of COVID-19 in the United States.

The FDA issued emergency use authorizations (EUA) for monoclonal antibody therapies used for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. The FDA also issued an EUA for a monoclonal antibody product used as a pre-exposure prophylaxis of COVID-19 in adults and pediatric patients with certain conditions.

During the EUA declaration for drugs and biologicals with respect to COVID-19, CMS covers and pays for these infusions or injections the same way it covers and pays for COVID-19 vaccines when furnished consistent with the EUA. There's also no beneficiary cost sharing and no deductible for COVID-19 monoclonal antibody products when providers administer them. In the event these products become approved or authorized for use, they will continue to be covered and paid under the Medicare Part B preventive vaccine benefit until the end of the calendar year in which the Secretary ends the EUA declaration. This coverage and payment will continue even if the PHE ends.

CMS doesn't pay for the COVID-19 monoclonal antibody product when a health care setting has received it for free. If a health care setting purchased the product from the manufacturer, Medicare pays the reasonable cost or 95% of the average wholesale price.

More information:

Payment After the End of the PHE

Effective January 1 of the year following the year in which the Secretary ends the EUA declaration for drugs and biologicals with respect to COVID-19, CMS will pay for monoclonal antibodies used for the treatment or for post-exposure prophylaxis of COVID-19:

- As we pay for biological products under .
- Through the applicable payment system, using the appropriate coding and payment rates, similar to the way we pay for administering other complex biological products.

Monoclonal antibodies that are used for pre-exposure prophylaxis prevention of COVID-19 will continue to be paid under the Part B preventive vaccine benefit if they meet applicable coverage requirements.

COVID-19 VEKLURY™ (remdesivir)

As of April 25, 2022, VEKLURY™ (remdesivir) is approved for the treatment of COVID-19. The federal government didn't purchase a supply of remdesivir. Medicare Part B provides payment for the drug and its administration under the applicable Medicare Part B payment policy when a facility or practitioner provides it in the outpatient setting, according to the FDA approval. In most cases, the Medicare patient's yearly Part B deductible and 20% co-insurance apply.

Medicare Coverage for Over-the-Counter COVID-19 Tests. On April 4, 2022, Medicare implemented a demonstration program to allow people with Medicare to receive up to eight tests per calendar month at no cost. This is the first time that Medicare has covered an over-the-counter, self-administered, test. This new initiative enables people with Medicare Part B, including those enrolled in a Medicare Advantage plan, to receive tests at no cost from providers and suppliers who are eligible to participate. Pharmacies and other health care providers interested in participating in this initiative can get more information here: https://www.cms.gov/COVIDOTCtestsProvider. **This program will end at the end of the COVID-19 public health emergency.**

Medicare Telehealth and Telecommunications Technology

- Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, as long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-person visits outlined on existing or new plans of care. Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and two-way audio-video technology that allows for real-time interaction between the clinician and patient. **This provision is permanent beyond the COVID-19 PHE. Home health services furnished using telecommunication systems are required to be included on the home health claim beginning July 1, 2023.**

- The required face-to-face encounter for home health can be conducted via telehealth (i.e., 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient) when the patient is at home. After the PHE ends, the Consolidated Appropriations Act, 2023 provides for an extension for the flexibility to allow the home to be an originating site through December 31, 2024.

Reducing Administrative Burden

- *"Homebound" Definition*: A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit. This is not a change in the definition of homebound and is irrespective of the COVID-19 PHE.

- *Detailed Information Sharing for Discharge Planning for Home Health Agencies*. CMS has been waiving the requirements of 42 CFR §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing

data that includes, but is not limited to, (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. This temporary waiver provides facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements. **CMS will end this waiver at the conclusion of the COVID-19 PHE.**

- *Plans of Care and Certifying/Recertifying Patient Eligibility*: In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with state law. These physicians/practitioners can: 1) order home health services; 2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care); 3) certify and re-certify that the patient is eligible for Medicare home health services. These changes, effective March 1, 2020, provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. Specifically, for Medicare, these changes are effective for Medicare claims with a "claim through date" on or after March 1, 2020. **This provision has been made permanent beyond the COVID-19 public health emergency and is codified in the regulations at 42 CFR 409.43.**

- *Clinical Records*: In accordance with section 1135(b)(5) of the Act, CMS extended the deadline for completion of the requirement at 42 CFR §484.110(e), which requires HHAs to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). Specifically, CMS has allowed HHAs ten business days to provide a patient's clinical record, instead of four. **CMS will end this waiver at the conclusion of the COVID-19 PHE.**

- *Training and Assessment of Aides***:** CMS has been waiving the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency. In accordance with section 1135(b)(5) of the Act, we are postponing completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE. **CMS will end this waiver at the conclusion of the COVID-19 PHE.**

- *Twelve-hour annual in-service training requirement for home health aides***:** CMS is modifying the requirement at 42 CFR §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period. In accordance with section 1135(b)(5) of the Act, we are 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. This will allow aides and the registered nurses (RNs) who teach in-service training to spend more time delivering

direct patient care and additional time for staff to complete this requirement. **This flexibility will end at the conclusion of the PHE and return to pre-PHE requirements at the end of the calendar year that the PHE ends.**

- *Quality Assessment and Performance Improvement (QAPI)***:** CMS has modified the requirements at 42 CFR §418.58 for Hospice and §484.65 for HHAs, which require these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. Specifically, CMS has modified the requirements at §418.58(a)–(d) and §484.65(a)–(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. This modification has decreased burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care delivery most closely associated with COVID-19 and to track adverse events during the PHE. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain. **CMS will end this waiver at the conclusion of the COVID-19 PHE.**

- *Waive Onsite Visits for HHA Aide Supervision***:** CMS has been waiving the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the two-week aide supervision by a registered nurse for home health agencies' requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver. CMS will end this waiver at the conclusion of the PHE. **Of note, as a part of the CY 2022 Home Health Prospective Payment System Final Rule (CMS 1747-F), CMS finalized the provision for aide supervision for patients receiving skilled care every 14 days to now allow for one virtual visit per 60-day episode per patient and only in rare circumstances. For patients receiving non-skilled care, the registered nurse must make an onsite, in person visit every 60 days to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs; semi-annually the nurse will make a supervisory direct observation visit for each patient to which the aide is providing services.**

- *Reporting*: CMS is providing relief to HHAs on the timeframes related to OASIS transmission through the following 1) extending the five-day completion requirement for the comprehensive assessment to 30 days; and 2) waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE. We are now allowing 30 days for the completion of the comprehensive assessment. HHAs must submit OASIS data prior to submitting their final claim in order to receive Medicare payment. **CMS will end this waiver at the conclusion of the COVID-19 PHE.**

- *Home Health Quality Reporting Program*: HHAs are exempted from the Home Health Quality Reporting Program reporting requirements. The time period covered by this exemption was October 1, 2019 through June 30, 2020. HHAs that did not submit data for those quarters will not have their annual market basket percentage increase reduced by two percentage points. **CMS delayed the compliance dates for collecting and reporting the Transfer of Health Information quality measures and certain standardized patient assessment data elements (SPADEs) adopted for the HH Quality Reporting Program. HHAs are required to begin collecting the Transfer of Health Information quality measures and certain SPADEs on January 1, 2023.**

- *Original Home Health Value Based Purchasing (HHVBP) Model:* CMS implemented a policy to align HHVBP data submission requirements under the original HHVBP Model with any exceptions or extensions granted for purposes of the Home Health Quality Reporting Program during the PHE for the COVID-19 pandemic, as well as a policy for granting exceptions to the New Measures data reporting requirements under the HHVBP Model during the PHE for the COVID-19 pandemic.

- *Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients:* CMS has been waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary waiver allowed any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. **Of note, as a part of the CY 2022 Home Health Prospective Payment System Final Rule (CMS 1747-F), CMS finalized changes to § 484.55(a) and (b)(2) to permanently allow occupational therapists to complete the initial and comprehensive assessments for patients, in accordance with Division CC, section 115 of CAA 2021.**

Medicare appeals in Traditional Medicare, Medicare Advantage (MA) and Part D

- During the PHE, CMS has been allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program (42 CFR 405.942 and 42 CFR 405.962) and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs) (42 CFR 422.582 and 42 CFR 423.582) to allow extensions to file an appeal. Specifically, 42 CFR 422.582(c) and 42 CFR 423.582(c) allow a Part C or Part D plan to extend the timeframe for filing a request if there is good cause for the late filing. In addition, the Part D IRE may find good cause for late filing of a request for reconsideration. When the COVID-19 PHE ends, these flexibilities will continue to apply consistent with existing authority and requests for

appeals must meet the existing regulatory requirements.

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966), and the Part C and Part D IREs, to waive requirements for timeliness for requests for additional information to adjudicate appeals**.** In addition, under applicable regulations, MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest, due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest (42 CFR 422.568(b)(1)(i), 42 CFR 422.572(b)(1) and 42 CFR 422.590(f)(1)).

When the COVID-19 PHE ends, these flexibilities will continue to apply consistent with existing authority and requests for appeals must meet the existing regulatory requirements.

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405.910) and MA and Part D plans, as well as the Part C and Part D IREs, to process an appeal even with incomplete Appointment of Representation forms (see 42 CFR 422.561 and 42 CFR 423.560 for definitions of “representative”). However, any communication was sent only to the beneficiary. When the COVID-19 PHE ends, this flexibility will continue to apply, consistent with existing guidance for the MACs and QIC in the FFS program. For MA and Part D plans, as well as the Part C and Part D IREs, this flexibility will no longer apply. The MA and Part D plans, as well as the Part C and D IREs, must process the appeals based on regulatory requirements (42 CFR 422.582(f)-(g), 42 CFR 423.582(e)-(f), 42 CFR 422.592(d)-(e), and 42 CFR 423.600(g)-(h)).

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966) and MA and Part D plans, as well as the Part C and Part D IREs, to process requests for appeal that don’t meet the required elements, but instead use information that is available (42 CFR 422.562 and 42 CFR 423.562). **When the COVID-19 PHE ends, requests for appeals must meet the existing regulatory requirements.**

  During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966) and MA and Part D plans, as well as the Part C and Part D IREs, to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied. **When the PHE ends, these flexibilities may only be provided consistent with existing regulatory authority.**

- *COVID-19 Accelerated and Advance Payments (CAAP)*: For the most up to date information related to the CAAP Program please visit https://www.cms.gov/medicare/covid-19-accelerated-and-advance-payments.

- *Provider Enrollment*: During the PHE, CMS has established toll-free hotlines for physicians, non-physician practitioners, and Part A certified providers and suppliers who have established isolation facilities to enroll and receive temporary Medicare billing privileges. **When the PHE ends, the hotlines will be shut down.** Additionally, CMS has provided the following flexibilities for provider enrollment:

  - *Screening requirements:*
    - Site Visits: CMS waived provider enrollment site visits for moderate and high-risk providers/suppliers. ***(This waiver terminated on 07-06-2020 and CMS, in accordance with 42 CFR §§ 424.517 and 424.518, resumed all provider enrollment site visits.)***

    - *Fingerprint-based criminal background checks:* CMS waived the requirement for fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high-risk categories of providers and suppliers (e.g., newly-enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs). ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 CFR § 424.518, resumed requesting fingerprints for all newly enrolling high-risk providers and suppliers.)***

  - *Application Fees:* CMS waived the collection of application fees for institutional providers who are initially enrolling, revalidating, or adding a new practice location. ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 CFR § 424.514, resumed collecting application fees.)***

  - *Revalidation:* CMS postponed all revalidation actions. This did not prevent a provider who wants to submit a revalidation application from doing so; MACs processed revalidation applications. ***(This waiver terminated on 10/31/2021 and CMS resumed a phased-in approach to revalidation activities; revalidation letters began being mailed again in November 2021 with due dates in early 2022.)***

  - *Expedited Enrollment:* CMS expedited any pending or new applications from providers and suppliers, including physicians and non-physician practitioners received on or after March 1, 2020. **When the PHE ends, CMS will resume normal application processing times.**

Cost Reporting

- Providers who continue to experience the impacts of the PHE and require additional time to file their cost report may submit a request to their MAC in accordance with our regulation at 42 CFR 413.24 (f)(2)(ii). The MAC has the authority to grant up to a 60-day extension of the due date for filing a cost report if the provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as the PHE.

COVID-19 Diagnostic Testing

- If a patient is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, could obtain the sample to send to the laboratory for COVID-19 diagnostic testing.

Workforce

- *Ordering Medicaid Home Health Services and Equipment:* Medicaid home health regulations now allow non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy, or speech pathology and audiology services, in accordance with state scope of practice laws.

- *Waived onsite visits for both HHA Aide Supervision*: CMS has been waiving the requirements at 42 CFR 484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision requirement at 42 CFR §484.80(h)(1) by a registered nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.

- *Certification for Payment of Medicare Home Health Services*: As required under section 3708 of the CARES Act, CMS has been allowing nurse practitioners, clinical nurse specialists and physician assistants to certify the need for home health services as defined under 42 CFR § 424.507(b)(1) payment requirements for covered Part A or Part B home health services.

Reducing Administrative Burden

- *"Stark Law" Waivers:* The physician self-referral law (also known as the "Stark Law") 1) prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family

member) has a financial relationship, unless the requirements of an applicable exception are satisfied; and 2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for any improperly referred designated health services. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law. These blanket waivers applied 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. During the PHE, CMS permitted certain referrals and the submission of related claims that would otherwise violate the Stark Law, if all requirements of the waivers were met. **When the COVID-19 PHE ends, the waivers will terminate and physicians and entities must immediately comply with all provisions of the Stark Law.**

Flexibilities under the "Stark Law" waivers have included:

- Hospitals and other health care providers could pay above or below fair market value for the personal services of a physician (or an immediate family member of a physician), and parties could pay below fair market value to rent equipment or purchase items or services. For example, a physician practice could rent or sell needed equipment to a hospital at a price below what the practice could charge another party. Or, a hospital could provide space on hospital grounds at no charge to a physician who is willing to treat patients who sought care at the hospital but were not appropriate for emergency department or inpatient care.
- Health care providers could support each other financially to ensure continuity of health care operations. For example, a physician owner of a hospital could make a personal loan to the hospital without charging interest at a fair market rate so that the hospital could make payroll or pay its vendors.
- Hospitals could provide benefits to their medical staff, such as multiple daily meals, laundry service to launder soiled personal clothing, or child care services while the physicians were at the hospital and engaging in activities that benefited the hospital and its patients.
- Health care providers could offer certain items and services that were solely related to COVID-19 purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non-monetary compensation cap. For example, a home health agency could provide continuing medical education to physicians in the community on the latest care protocols for homebound patients with COVID-19, or a hospital could provide isolation shelter or meals to the family of a physician who was exposed to the novel coronavirus while working in the hospital's emergency department.
- Physician-owned hospitals could temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law. For example, a physician-owned

hospital could temporarily convert observation beds to inpatient beds to accommodate patient surge during the COVID-19 pandemic in the United States.

- Some of the restrictions regarding when a group practice could furnish medically necessary designated health services (DHS) in a patient's home were loosened. For example, any physician in the group could order medically necessary DHS that were furnished to a patient by one of the group's technicians or nurses in the patient's home contemporaneously with a physician service that was furnished via telehealth by the physician who ordered the DHS.
- Group practices could furnish medically necessary MRIs, CT scans, or clinical laboratory services from locations like mobile vans in parking lots that the group practice rented on a part-time basis.

Additional Guidance

- The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers .

- CMS has released guidance to describe standards of practice for infection control and prevention of COVID-19 in home health agencies at https://www.cms.gov/files/document/qso-20-18-hha.pdf.

- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.