COVID-19 PHE Unwinding Liberalizations

CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, because of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be used where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

CMS is waiving requirements to allow IRFs to exclude patients from the hospitals or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the 60 percent rule) if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

For Dual members with cost share protection the State pays the cost share - following each State's payment methodology (lessor of, Medicare rate balance, or other unique payment methodology). Cost share protected Members cannot be billed for the cost share.

Hospitals Able to Provide Care in Temporary Expansion Sites. As part of the CMS Hospital Without Walls initiative during the PHE, hospitals could provide hospital services in other hospitals and sites that otherwise would not have been considered part of a healthcare facility or could set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. During the PHE, CMS provided additional flexibilities for hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations, such as hotels or community facilities. During the PHE, hospitals are expected to control and oversee the services provided at an alternative location.

When the PHE ends, effective May 11,2023 hospitals and CAHs will be required to provide services to, patients within their hospital departments, pursuant to Hospital and CAH conditions of participation at 42 C.F.R. part 482 and part 485, Subpart F, respectively.

CMS Hospitals without Walls Initiative. CMS finalized OPPS payment after the PHE ends for behavioral health services furnished remotely by clinical staff of hospital outpatient departments. This flexibility does not depend on considering the beneficiary's home to be a

part of the hospital. Additionally, CMS clarified that these services will not be recognized as partial hospitalization services but will be available to beneficiaries in a partial hospitalization program.

Consistent with the CMS Hospitals without Walls Initiative, during the PHE, hospitals may provide behavioral health and education services furnished by hospital-employed counselors or other professionals who cannot bill Medicare directly for their professional services. This includes partial hospitalization services. These services may be furnished to a beneficiary in their home when the beneficiary is registered as an outpatient of the hospital and the hospital considers the beneficiary's home to be a provider-based department of the hospital.

After the PHE, these services will no longer be able to be paid when provided in the patient's home.

$0 Cost Share for COVID-19 testing- related services. For Dual members with cost share protection the State pays the cost share - following each State's payment methodology (lessor of, Medicare rate balance, or other unique payment methodology). Cost share protected Members cannot be billed for the cost share.

For more information, please utilize the below communication from CMS:

- https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

Beginning May 12, 2023, members will be covered as follows:

- COVID-19 vaccines, including boosters: $0, in-network and out-of-network (no change)
- COVID-19 antiviral medications or treatments, like Paxlovid™: $0 for these prescriptions while the government supply is available (no change)
- COVID-19 lab tests: $0, in network. If a member has a plan with out of network (OON) benefits, OON cost share will apply.
- COVID-19 over the counter (OTC) tests: Will only be covered if the plan includes the OTC benefit.
- COVID-19 treatment: Plan cost share will apply