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Categories:

[Blogs](#)

[Coronavirus Response](#)

[Team](#)

[Health Law Matters](#)

Guidance Specifically for Rural and Critical Access Hospitals During the COVID-19 Pandemic

The Coronavirus Aid, Relief and Economic Security (CARES) Act and the Centers for Medicare and Medicaid Services (CMS) provided both monetary and regulatory relief to rural and critical access hospitals (CAHs) during the COVID-19 public health emergency. Because of their small size, rural location and resultant inability to attract a sufficient supply of practitioners and provide adequate care to populations in need, CAHs are always afforded greater flexibility than hospitals located inside Metropolitan Statistical Areas (MSAs). Now the CARES Act and CMS guidance have taken it a step further. The Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy received \$180 million in aid, with \$150 million of that to be directed to hospitals and awarded through the Small Rural Hospital Improvement Program (SHIP). Eligible hospitals can be nonprofit or for-profit, but must be acute care, with 49 beds or less, and located in a rural area (outside an MSA) or treated as rural, pursuant to the regulations.

The CARES Act offers CAHs accelerated payments up to 125% of their revenue during the past six months (as opposed to 100% of revenue for three months for general acute care hospitals), with just a few requirements that must be satisfied. The CAH must:

- Request a specific amount from their Medicare Administrative Contractor (MAC), using the form on the MAC's website;
- Have billed Medicare within the last six months;
- Not be in bankruptcy;
- Not be under investigation for program integrity violations; and
- Not be delinquent in repaying any overpayments.

MACs will review requests and issue payments within seven days, and repayment for CAHs starts one year from the date the payment is issued.

In addition to financial assistance, the CARES Act and CMS guidance (and waivers) have eased many other burdens for hospitals and, in particular, CAHs, with the goal of enabling hospitals to efficiently and effectively care for more patients. That goal is accomplished by expanding the number of locations where patients can receive care; reducing paperwork to permit caregivers to focus on patients; and increasing the number of providers and expanding their capabilities.

Under normal circumstances, a CAH is only permitted to have 25 inpatient beds and keep patients for a maximum of 96 hours. During this emergency, CMS has removed both of those limitations. A CAH may add temporary locations that need not be rural or satisfy the requirement that they be located at least 35 miles from another hospital. The intent is to create a “CAH without walls,” thereby providing care for more patients in a greater coverage area.

The CARES Act expanded coverage even further by allowing more flexibility in the use of telehealth. New, as well as established, patients may now receive telehealth in pretty much any location, including their home. And the service can be provided by any number of professionals including physicians, nurse practitioners, clinical psychologists and licensed social workers. As long as the communication is interactive, including both audio and visual, telehealth can be used for office visits, emergency room (including medical screening examinations), inpatient, home health and skilled nursing facilities. The provider may waive the patient’s copayment or deductible but should bill the service as s/he would have, had it been provided in person. In some instances when both audio and visual communication is not possible, audio may suffice but must be billed using a different set of codes and will be reimbursed differently.

A physician is normally required to be physically present at a CAH at all times, but during this crisis that requirement has been waived. The physician need only be reachable electronically or via telephone. Minimum federal qualification requirements for nurse practitioners, physician assistants and clinical nurse specialists have also been waived, with all licensure requirements deferred to the states.

In addition to the foregoing flexibilities specifically afforded CAHs, the general waivers by CMS that apply to all hospitals likewise apply to CAHs. Many involve temporary revisions to the Hospital Conditions of Participation. Briefly, they include:

- Other buildings, besides the hospital, may be used for provision of care if approved by the state;
- Alternate locations may enroll as temporary hospitals and bill as provider-based;
- EMTALA screenings may occur at off-site locations;
- Physicians may continue to practice after their privileges expire;
- Patients need not be “under the care of a physician,” but may be managed by an NP or PA;
- Verbal orders need not be authenticated within 48 hours;
- Medical records may be completed within 30 days of discharge;
- The requirement of a nursing plan for every patient is suspended;
- Detailed discharge planning is not required;
- No information on advance directives is required to be provided to each patient;
- Reports on restraint deaths need not be filed immediately;
- UR planning and committee requirements are waived;
- QAPI detail requirement waived;
- CRNAs may act independently, without physician supervision; and
- No written designation is required for personnel providing respiratory therapy.

For more information please contact [Rhonda Frey](#) or any attorney in Frost Brown Todd’s [Health Care Innovation](#) Industry Team.

To provide guidance and support to clients as this global public-health crisis unfolds, Frost Brown Todd has created a [Coronavirus Response Team](#). Our

attorneys are on hand to answer your questions and provide guidance on how to proactively prepare for and manage any coronavirus-related threats to your business operations and workforce.

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