



End of COVID Emergency Will Usher in Changes Across the U.S. Health System

Changes will affect nursing home and hospital staffing, delivery of addiction treatment and COVID data reporting.

March 29, 2023 By Rachana Pradhan and Kaiser Health News

The Biden administration's decision to end the COVID-19 public health emergency in May will institute sweeping changes across the health care system that go far beyond many people having to [pay more](#) for COVID tests.

In response to the pandemic, the federal government in 2020 suspended many of its rules on how care is delivered. That transformed essentially every corner of American health care — from hospitals and nursing homes to public health and treatment for people recovering from addiction.

Now, as the government prepares to reverse some of those steps, here's a glimpse at ways patients will be affected:

Training Rules for Nursing Home Staff Get Stricter

The end of the emergency means nursing homes will have to meet higher standards for training workers.

Advocates for nursing home residents are eager to see the old, tougher training requirements reinstated, but the industry says that move could worsen staffing shortages plaguing facilities nationwide.

In the early days of the pandemic, to help nursing homes function under the virus's onslaught, the federal government relaxed training requirements. The Centers for Medicare & Medicaid Services (CMS) instituted a national policy saying nursing homes needn't follow regulations requiring nurse aides to undergo at least 75 hours of state-approved training. Normally, a nursing home couldn't employ aides for more than four months unless they met those requirements.

Last year, CMS decided the relaxed training rules would no longer apply nationwide, but states and facilities could ask for permission to be held to the lower standards. As of March, 17 states had such exemptions, according to CMS — Georgia, Indiana, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, and Washington — as did 356 individual nursing homes in

Arizona, California, Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Michigan, Nebraska, New Hampshire, North Carolina, Ohio, Oregon, Virginia, Wisconsin, and Washington, DC.

Nurse aides often provide the most direct and labor-intensive care for residents, including bathing and other hygiene-related tasks, feeding, monitoring vital signs, and keeping rooms clean. Research has shown that nursing homes with [staffing instability](#) maintain a lower quality of care.

Advocates for nursing home residents are pleased the training exceptions will end but fear that the quality of care could nevertheless deteriorate. That's because [CMS has signaled](#) that, after the looser standards expire, some of the hours that nurse aides logged during the pandemic could count toward their 75 hours of required training. On-the-job experience, however, is not necessarily a sound substitute for the training workers missed, advocates argue.

Adequate training of aides is crucial so "they know what they're doing before they provide care, for their own good as well as for the residents," said Toby Edelman, a senior policy attorney for the Center for Medicare Advocacy.

The American Health Care Association, the largest nursing home lobbying group, released a [December survey](#) finding that roughly four in five facilities were dealing with moderate to high levels of staff shortages.

Treatment Threatened for People Recovering From Addiction

A looming rollback of broader access to buprenorphine, an important medication for people in recovery from opioid addiction, is alarming patients and doctors.

During the public health emergency, the Drug Enforcement Administration (DEA) said providers could prescribe certain controlled substances virtually or over the phone without first conducting an in-person medical evaluation. One of those drugs, buprenorphine, is an opioid that can prevent debilitating withdrawal symptoms for people trying to recover from addiction to other opioids. Research has shown using it [more than halves](#) the risk of overdose.

Amid a national epidemic of opioid addiction, if the expanded policy for buprenorphine ends, "thousands of people are going to die," said Ryan Hampton, an activist who is in recovery.

The DEA in late February [proposed regulations](#) that would partly roll back the prescribing of controlled substances through telemedicine. A clinician could use telemedicine to order an initial 30-day supply of medications such as buprenorphine, Ambien, Valium, and Xanax, but patients would need an in-person evaluation to get a refill.

For another group of drugs, including [Adderall, Ritalin, and oxycodone](#), the DEA proposal would institute tighter controls. Patients seeking those medications would need to see a doctor in person for an initial prescription.

David Herzberg, a historian of drugs at the University at Buffalo, said the DEA's approach reflects a

fundamental challenge in developing drug policy: meeting the needs of people who rely on a drug that can be abused without making that drug too readily available to others.

The DEA, he added, is “clearly seriously wrestling with this problem.”

Hospitals Return to Normal, Somewhat

During the pandemic, CMS has tried to limit problems that could arise if there weren't enough health care workers to treat patients — especially before there were COVID vaccines when workers were at greater risk of getting sick.

For example, CMS allowed hospitals to make broader use of nurse practitioners and physician assistants when caring for Medicare patients. And new physicians not yet credentialed to work at a particular hospital — for example, because governing bodies lacked time to conduct their reviews — could nonetheless practice there.

Other changes during the public health emergency were meant to shore up hospital capacity. Critical access hospitals, small hospitals located in rural areas, didn't have to comply with federal rules for Medicare stating they were limited to 25 inpatient beds and patients' stays could not exceed 96 hours, on average.

Once the emergency ends, those exceptions will disappear.

Hospitals [are trying to persuade](#) federal officials to maintain multiple covid-era policies beyond the emergency or work with Congress to change the law.

Surveillance of Infectious Diseases Splinters

The way state and local public health departments monitor the spread of disease will change after the emergency ends, because the Department of Health and Human Services won't be able to require labs to report COVID testing data.

Without a uniform, federal requirement, how states and counties track the spread of the coronavirus will vary. In addition, though hospitals will still provide COVID data to the federal government, they may do so less frequently.

Public health departments are still getting their arms around the scope of the changes, said Janet Hamilton, executive director of the Council of State and Territorial Epidemiologists.

In some ways, the end of the emergency provides public health officials an opportunity to rethink COVID surveillance. Compared with the pandemic's early days, when at-home tests were unavailable and people relied heavily on labs to determine whether they were infected, testing data from labs now reveals less about how the virus is spreading.

Public health officials don't think “getting all test results from all lab tests is potentially the right strategy anymore,” Hamilton said. Flu surveillance provides a potential alternative model: For

influenza, public health departments seek test results from a sampling of labs.

“We’re still trying to work out what’s the best, consistent strategy. And I don’t think we have that yet,” Hamilton said.

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