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Report on Medicare Compliance Volume 32, Number 5. February 06, 2023
PHE and Many of Its Waivers Will End May 11, Ushering in Uncertainty, Compliance Risk

By Nina Youngstrom

When the COVID-19 public health emergency (PHE) expires May 11, along with many of its waivers and flexibilities, health care organizations may be left with unanswered questions and/or unintended consequences. For example, will Medicare pay for skilled nursing facility (SNF) admissions when patients were admitted without a three-day inpatient hospital stay during the PHE but discharged after?

That's one of the gray areas that has come up now that the Biden administration announced Jan. 30 that after almost three years, it will end the PHE, said Martie Ross, a consulting principal at PYA.[1] The waiver of the three-day qualifying stay was intended to help with COVID-19 patient volumes, but it's unclear what happens with Medicare reimbursement if a SNF stay straddles the PHE. "CMS will have to come out and say it's OK as long as you came in during the PHE," Ross noted. The loss of that waiver without CMS guidance has her most concerned because it affects hospitals, SNFs and patients. "That could be a mess," she said. "That's the obvious one that we need CMS to step in on."

The current PHE extension was scheduled to expire in mid-April and HHS tacked on another month partly to give providers more time to adapt to a post-waiver world, according to a statement from the White House. "Hospitals and nursing homes that have relied on flexibilities enabled by the emergency declarations will be plunged into chaos without adequate time to retrain staff and establish new billing processes, likely leading to disruptions in care and payment delays, and many facilities around the country will experience revenue losses." The statement also said it opposes a bill passed Feb. 1 by Republicans in the House (H.R. 382) to immediately end the PHE, which the American Hospital Association said is not expected to be taken up by the Senate.

Now hospitals and other providers will start to run the waiver obstacle course. "The first bucket everyone has to prepare for are the flexibilities that will go away the day the PHE ends," said Richelle Marting, an attorney and certified coder in Olathe, Kansas. Many waivers will disappear because apparently CMS is ready to revert to the pre-PHE status quo for various reasons, including program integrity and quality of care. Other waivers will stick around because they were extended by CMS rulemaking or by Congress in the 2022/2023 Consolidated Appropriations Act (CAA). For example, the 20% add-on payment for COVID-19 MS-DRGs will continue through the end of the year in which the PHE ends, which we now know is 2023. CMS also will continue to pay about $40 for administering COVID-19 vaccines in outpatient settings and higher rates for vaccines administered in patient homes through the end of the year.

For telehealth, the picture is rosier because the 2023 CAA again removed rural-area requirements and expanded originating sites, which means Medicare will continue to pay for certain covered telehealth services everywhere in the country and in patient homes and other locations, such as retail clinics and schools, through Dec. 31, 2024. The law also rescued audio-only telehealth services and dropped the in-person visit requirement before certain mental health telehealth services.

Look for Another Regulation to Match 2023 CAA

But the CAA is not a blank check. For example, critical access hospitals won't be able to serve as distant site providers for telehealth services on May 12, Marting noted. And remote patient monitoring and remote therapeutic monitoring will again only be available to established patients, not new patients, the way it was before the PHE, she said. Medicare will again require a minimum period of 16 days of remote patient monitoring per month for billing purposes instead of the two days permitted during the PHE for COVID-19 patients, Marting said.

The wrinkle is that CMS policy only reflects the 151 days past the end of the PHE that Congress authorized for major swaths of telehealth coverage in the 2022 CAA, Marting said. Now that Congress in December pushed the telehealth flexibilities through 2024, CMS must catch up before the PHE ends, and perhaps that's one reason why the Biden administration gave providers more runway. "CMS will have to update its policy to match the new legislation," Marting explained. "I expect either an interim final rule or this year's Medicare Physician Fee Schedule [MPFS] to be finalized early so the final policy is announced before the 151-day period ends mid-October."

The rule is necessary to fill in some blanks, Ross noted. For example, Medicare has been paying for telehealth services delivered by physicians at the higher nonfacility rate during the PHE instead of the lower facility rate it paid pre-pandemic. In the final 2023 MPFS rule, CMS said it would continue to pay the higher nonfacility rate for 151 days after the end of the PHE. It's another unanswered question whether CMS will continue to do so now that Congress again extended many telehealth services, Ross said.

Looking Ahead to Post-PHE Policies

To help piece together the post-PHE puzzle, providers will have to comb through the lists of waivers and flexibilities. Fortunately, in August "CMS did a nice job of publishing a series of fact sheets by provider type," Ross noted.[2] They won't work as a checklist and must be updated to incorporate the 2023 CAA's extensions of flexibility for telehealth and Acute Hospital Care at Home, but the fact sheets "tell you what to worry about," she said.

Ross recommends a "point person" owning the list (probably a compliance officer). The point person will track when each regulatory flexibility ends, identify the owner of the process and ensure the process returns to the organization's standard operating procedure. There may be some zigs and zags, Ross cautioned. The owner of the process (e.g., the manager of a department) may not know whether a policy was changed in response to a waiver or whether operations changed but nobody bothered to modify the written version because of the pandemic turmoil. And with the turnover in health care, it may be hard to pin down who knows what and it may be preferable to focus on ensuring the policy is consistent with the post-PHE conditions of participation and other regulations, Ross said. "The compliance officer needs to be savvy enough to say, 'Here is the rule.'" For example, when the waivers are gone, verbal orders again must be authenticated in 48 hours. The conversation with the health information management department would go something like this: "Does the current practice comply with what the rules will be again? If not, we need a process to make sure it's streamlined by May 11."

Enrollment 'Backlog Could Develop Quickly'

The May 11 expiration of certain waivers and flexibilities will gum up the works. For example, a change to a telehealth-related provider enrollment waiver runs the risk of creating a backlog, Marting said. As explained in an October fact sheet, "CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. When the PHE ends, practitioners will be required to resume reporting their home address on the Medicare enrollment," which fascinates Marting.[3] It can take CMS a couple months to add a practice location,

so providers who deliver telehealth from home need to submit their enrollment amendments now, she said. "The clock is ticking and it takes 45 to 60 days to get enrolled," Marting said. "If that many providers are submitting updates in a short amount of time, a backlog could develop quickly."

Another is the waiver of in-person visits before prescribing controlled substances during a telehealth visit, Marting said. "As with the SNF three-day admission policy, it's unclear how the Drug Enforcement Administration will handle prescriptions for controlled substances that were first issued during the PHE, when a refill after the PHE is required," she said.

CMS has also sunset physician supervision via telehealth for incident-to billing at the end of the year the PHE terminates, which obviously is now 2023. "If it's a program integrity matter, that will all stay in place," Ross said. CMS made this move in the final 2023 MPFS rule. "On Jan. 1, you go back to the physical presence requirement for supervision [in person]. CMS looked at that and said, 'We are not ready to change that rule.'"

CMS addressed the waivers and flexibilities mostly in successive MPFS rules, she noted. "There's less of that in the" inpatient and outpatient prospective payment system rules. CMS also so far has not seized the opportunity to prune the conditions of participation, which in many cases formed the basis for waivers and flexibilities. "The Trump administration said it wanted to do regulatory relief in the conditions of participation and there were a few things around the edges, but it was a great message without a lot of delivery," Ross said. "Is there interest in CMS revitalizing that effort and cleaning up the regulatory provisions or is it just business as usual three years later?" The jury is out.

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1 Executive Office of the President, Office of Management and Budget, "Statement of Administration Policy: H.R. 382 – A bill to terminate the public health emergency declared with respect to COVID-19; H.J. Res. 7 – A joint resolution relating to a national emergency declared by the President on March 13, 2020," January 30, 2023, https://bit.ly/40n5hoL.
2 Centers for Medicare & Medicaid Services, "Coronavirus waivers & flexibilities," last modified February 1, 2023, http://bit.ly/3JCmh4C.
3 Centers for Medicare & Medicaid Services, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, updated October 13, 2022, https://go.cms.gov/3BsxLAx.