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Medicare Waivers and Flexibilities Post-Public Health Emergency

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*Updated with information from official CMS communications and rulemaking. Changes appear in ***bold italics.***

The Biden administration has announced that the federal public health emergency (PHE) will expire on May 11, 2023. ***President Biden ended the national emergency declaration for COVID-19 on April 10, 2023 but this does not affect the waivers put in place by CMS which are tied to the PHE directly.*** The administration and Congress have enacted many waivers and flexibilities to assist providers throughout the pandemic but only some of those policies have been extended past the federal PHE—either permanently or a for a set time period. Below is a summary of key flexibilities impacting hospital providers and their patients, including telehealth-related flexibilities.

Telehealth

The Consolidated Appropriations Act of 2023 (CAA 2023) has already extended many key telehealth waivers *through December 31, 2024*.

- Patients will be permitted to continue receiving telehealth services at any site at which they are located, including their homes.

- Any site in the United States at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system will be considered an originating site. ***Through 2024, any originating site at which the patient is physically located at the time of the telehealth visit may bill for an originating site facility fee (regardless of rural/urban status), but no site may bill for an originating site facility fee if a patient is at home.***

- ***The patient's home may be broadly defined to include an assisted living facility or skilled nursing facility.***

- Beginning in 2025, an originating site will be defined as it was pre-pandemic except changes that have been made in the last few years to include new provider types like rural emergency hospitals and to enact related legislation that permits telehealth visits at home for patients with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder.

- This applies to all services that are considered payable under the Medicare Physician Fee Schedule as of March 15, 2022. We expect this to apply to all services on the telehealth list in Categories 1 through 3 but will seek clarification in rulemaking.

- During the extension period, CMS must continue to provide coverage and payment for telehealth services identified as permissible via audio-only as of March 15, 2022.

- Qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists may furnish telehealth services.

- All telehealth flexibilities and related payment policies in place during the PHE for federally qualified health centers (FQHCs) and rural health clinics (RHCs) will continue through 2024.

- A controversial provision of the Consolidated Appropriations Act of 2021 that would have required patients that receive post-PHE telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder to have an in-person physician visit every six months is delayed until January 1, 2025.

- Periodic in-person physician visit requirements for hospice patients receiving virtual mental health visits from an FQHC or RHC will also be delayed through 2024 and hospice physicians or nurse practitioners may continue to conduct a face-to-face encounter via telehealth during this time.

Outstanding Telehealth Issues

- **CMS place of service (POS) billing policy:** During the PHE, CMS allows physicians to bill for services they provide out of their homes as if the service were provided in person at the hospital or clinic where they usually see patients. This place of service (POS) billing policy was extended in the CY 2023 PFS final rule to last through the latter of the end of CY 2023 or the end of the calendar year in which the PHE ends. More than 30 states have payment parity rules in place that mimic this policy and Congress is considering a two-year continuation of the POS reimbursement policy.

- **Physicians taking telehealth visits from their own homes:** Pre-pandemic enrollment policies from CMS called for physicians to report their home address on their Medicare enrollment if that is a place where they "typically" provide care. During the PHE, CMS allowed practitioners to render telehealth services from their home without reporting their home address and restoration of the pre-pandemic enrollment process could deter some physicians from providing telehealth from their

homes. ***CMS has indicated that the pre-pandemic policy will apply after May 11, 2023 but it is actively considering how to improve this policy to permit more telehealth flexibility while protecting physician privacy.***

- **Telehealth visits for prescribing controlled substances:** The Ryan Haight Act prohibited this virtual/telehealth prescribing of controlled substances back in 2008 and in 2010 created some telehealth exceptions along with a catch-all exception that would include whatever the Drug Enforcement Agency (DEA) defines as telehealth via regulation. ***On March 1, 2023 the DEA proposed a pair of rules that would create a permanent pathway for telehealth prescribing, but finalization is not expected prior to May 11.***

- **Office of Civil Rights (OCR) HIPPA enforcement discretion:** The OCR is exercising its enforcement discretion over certain patient protections in place through HIPAA. This has given providers flexibility for the telecommunication modalities used to offer telehealth services, for uses and disclosures of protected health information by business associates for public health and health oversight activities, and for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers or their business associates in connection with the good faith operation of a testing site and a web-based scheduling application for vaccinations. ***On April 11, OCR announced that while this enforcement discretion will expire on May 11, providers will be afforded another 90 days (until August 9, 2023) to come into compliance with HIPAA telehealth standards.***

- **State licensure flexibilities:** During the PHE, many states adopted flexible rules for physicians and other telehealth practitioners to become licensed across state lines to offer telehealth. Providers need to review each state's plan for lifting or making permanent these procedures that increased the scope of providers that can serve as distant site providers for Medicare telehealth purposes.

COVID-19 Treatment and Coverage

- **Higher hospital reimbursement for COVID-19 patients:** Hospitals currently receive a 20 percent add-on for Medicare COVID-19 inpatient admissions, which is tied to the public health emergency. The CARES Act required CMS to issue this additional payment for all *discharges* of individuals with a COVID-19 diagnosis that occurs during the PHE.

- **Higher reimbursement for novel treatments:** The New COVID-19 Treatments Add-on Payment (NCTAP) offers additional reimbursement to hospitals for patients that receive certain novel COVID-19 treatments. This payment policy applies to the same type of discharges that receive the 20 percent add-on payment. ***The FY 2024 IPPS proposed rule confirmed that this program will expire at the end of fiscal year 2023.*** After that, CMS will pay for monoclonal antibodies as it does for other biological products and providers will be able to use existing new technology add-on payment and outlier avenues for high-cost treatments.

- **Vaccine administration:** CMS will continue to pay approximately $40 per dose for administering COVID-19 vaccines in outpatient settings for Medicare beneficiaries through the end of calendar year 2023. It will also continue its policy to reimburse at-home administrations higher, for a total payment of approximately $75 per dose, for certain Medicare patients through the end of calendar year 2023. Effective January 1, 2024, CMS will set the payment rate for administering COVID-19 vaccines to align with the payment rate for administering other Part B preventive vaccines.

Flexible Hospital Operations

- **Hospital at home:** CMS has allowed hospitals to provide acute care to beneficiaries outside of facilities through its Hospital at Home program, including more than 90 health systems in 34 states. The Consolidated Appropriations Act of 2023 extended this program through the end of 2024 and permitted participating hospitals to apply to CMS for any waivers necessary to continue in the program. Some states have issued blanket waivers of their own regulatory requirements but only for hospitals participating in the CMS program. Providers should check to make sure state waivers will continue through 2024 as well.

- **Alternative care space:** Through an interim final rule, CMS waived certain requirements under the Medicare conditions of participation at §§ 482.41 and 485.623, and the provider-based department requirements at § 413.65, to the extent necessary, to permit hospitals to establish and operate as part of the hospital any location meeting those non-waived conditions of participation for hospitals that continue to apply during the PHE. This regulatory waiver has not been extended beyond the federal PHE, except that hospitals participating in the Hospital at Home model may request waivers such as this to continue operating in that program. Some state licensing entities have waived their regulations in a similar way but have tied those waivers directly to the PHE.

- **Supervision requirements:** Direct supervision with a supervising clinician's "virtual presence" via real-time audio-visual technology has only been extended through the end of calendar year 2023. CMS has made permanent in the CY 2021 OPPS final rule the option for general rather than direct supervision at the initiation of non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. That same rule made permanent the option for the treating physical or occupational therapist who develops or is responsible for the maintenance program or plan to delegate the performance of the related maintenance therapy services to a therapy assistant when clinically appropriate.

- **E-Visits for new patients:** During the PHE, clinicians can provide remote evaluation of patient video/images and virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. ***After May 11, this option will only be available to established patients.*** In addition, licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. This has not been extended.

- **Evaluation and management:** During the PHE, Medicare payment for the telephone-only evaluation and management (E/M) visits (CPT codes 99441-99443) has been equivalent to the Medicare payment for office/outpatient visits with established patients. Stakeholders requested these codes be added to the Medicare telehealth services list permanently, but CMS rejected the suggestion in the CY 2023 PFS final rule, and telephone E/M services may only continue through the end of calendar year 2024 unless this care is specifically permitted for patients with a substance use disorder or co-occurring mental health diagnosis.

- **Remote patient monitoring:** CMS has permitted clinicians to bill for remote patient monitoring (RPM) services furnished to both new and established patients and to patients with both acute and chronic conditions. When the PHE ends, clinicians must have an established relationship with the patient prior to providing RPM services, but CMS will allow RPM services to be furnished to patients with both acute and chronic conditions; the pre-pandemic policy required an initiating visit before RPM services could be billed. CMS's section 1135 waiver over the CPT code descriptions will also expire, eliminating the current ability of clinicians to bill codes 99453 and 99454 when as few as two days of data were collected if the patient was diagnosed with, or was suspected of having, COVID-19. When the PHE ends, clinicians may only bill for these services when at least 16 days of data have been collected.

- **Face-to-face visits:** To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require an in-person, face-to-face visit for evaluations and assessments—such as for Medicare patients with end-stage renal disease (ESRD) who are on home dialysis—providers must again adhere to those frequency requirements after the end of the PHE.

- **Other hospital conditions of participation:** These flexibilities and other conditions of participation (CoP) waivers outlined by CMS in interim final rules during the spring of 2020 *have not* been continued past the expiration of the PHE:
    - *Screening emergency patients*: CMS waived enforcement of EMTALA to permit emergency patients to be screened off-site.
    - *Discharge planning***:** CMS waived detailed discharge planning requirements for hospitals and post-acute-care providers.
    - *Orders and signatures*: CMS has allowed hospitals greater use of verbal orders, extended timelines for completing medical records, and waived utilization review requirements, among other things.
    - *Skilled nursing facility three-day waiver***:** CMS has allowed Medicare coverage of nursing home stays without Medicare beneficiaries first spending three days in a hospital.

Long-Term Acute-Care Hospitals

- **Discharge payment percentage calculation:** The CARES Act directed CMS to waive the requirement for an LTCH to maintain a discharge payment percentage (DPP) that is at least 50 percent during the COVID-19 PHE period. For the purposes of calculating an LTCH's DPP, all

admissions during the COVID-19 PHE period will be counted in the numerator of the calculation – that is, will be counted as discharges paid the LTCH Prospective Payment System (PPS) standard federal payment rate. The usual 50 percent calculation returns after the PHE ends ***and is calculated on the cost reporting period by the MACs.***

- **25-day length of stay calculation:** CMS has issued a blanket waiver of the requirement for LTCHs to maintain an average length of stay of 25 days where an LTCH admits or discharges patients to meet the demands of the PHE. For all LTCH cost reporting periods that include the PHE, MACs shall not calculate an average length of stay under the requirement at § 412.23(e)(2). The MAC will resume standard practice for evaluation of average length-of-stay requirement beginning with the hospital's first cost reporting period that does not include the PHE blanket waiver period.

- **Site-neutral payment policy:** The CARES Act provides a waiver of the application of the site-neutral payment rate for those LTCH admissions that are in response to the PHE. All LTCH cases admitted during the PHE period have been paid the relatively higher LTCH PPS standard federal rate, and when the PHE ends all LTCH admissions except those that meet the requirements for exclusion from the site-neutral rate will be subject to the site-neutral payment rate. ***Services provided to patients admitted prior to May 11 but discharged after that date will be reimbursed the LTCH PPS rate.***

Inpatient Rehabilitation Facilities and Units

- **Relocating patients outside of the excluded unit:** CMS has allowed acute care hospitals with excluded distinct part inpatient rehabilitation units to relocate inpatients from the excluded unit to an acute care bed and continue to bill for inpatient rehabilitation services under the IRF PPS. When the PHE ends, inpatients receiving rehabilitation services paid under the IRF PPS and furnished by the excluded distinct part rehabilitation unit of an acute care hospital cannot be housed in an acute care bed.

- **Flexibility regarding the 60% Rule:** During the PHE, CMS has been allowing IRFs to exclude patients from the freestanding hospitals, or excluded distinct part 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% 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. When the PHE ends, all inpatients will again be included in the freestanding hospital's or unit's inpatient population for purposes of calculating the 60% rule.

Patient Cost-Sharing

- **Testing:** Private health plans and Medicare are required to cover COVID-19 tests without cost-sharing only during the PHE, including a limited number of at-home tests per month, but after the PHE this testing will follow the plans' general coverage rules related to clinical diagnostic testing.

Medicaid and CHIP programs must cover testing and related services, including at-home tests, through the end of the last day of the first quarter that begins one year after the PHE ends (September 30, 2024) and then these tests will be considered mandatory only when ordered by a physician or provided in a facility.

- **Treatments:** Medicare beneficiaries will face cost-sharing requirements for most COVID-19 treatments, including monoclonal antibody treatments. Medicaid and CHIP programs are required to cover all drugs and biological products for the treatment or prevention of COVID–19 with no cost-sharing through September 30, 2024 and then cost-sharing and utilization limits may apply. Private insurers have already begun removing voluntary waivers of out-of-pocket costs for COVID-19 treatment and there is no federal law to require it.

- **Vaccines:** Most private health plans will be required by the Affordable Care Act to continue providing recommended COVID-19 vaccines and related appointments at no cost. Medicare will continue providing vaccines and boosters without cost-sharing. State Medicaid programs will continue to receive 100 percent federal matching funds to cover vaccine administration through September 30, 2024.

State Waivers

- **Appendix K for home and community-based services:** States could apply to CMS for waivers of certain requirements of their Medicaid home and community-based programs, including managed care programs. Among other things, this option allowed many states to expand the home-based workforce and permit family members and legal guardians to serve as paid caregivers for Medicaid enrollees who needed assistance at home. When the PHE ends, states will have six months to make their Appendix K expansions permanent by requesting changes to their existing HCBS Section 1915(c) waiver with CMS.

- **Physician and practitioner licensing:** During the PHE, CMS has waived the Medicare requirement that a physician or non-physician practitioner must be licensed in the state in which they are practicing if the physician or practitioner 1) is enrolled as such in the Medicare program, 2) has a valid license to practice in the state reflected in their Medicare enrollment, 3) is furnishing services in a state in which the emergency is occurring, and 4) is not affirmatively excluded from practice in the state or any other state. When the PHE ends, current regulations will continue to allow for a deferral to state law.

Conclusion

Please contact us with any questions on the flexibilities discussed above or for further information about COVID-19 policies that were not highlighted in the document.