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CMS Ends Certain Nonhospital Waivers; Separate Workflows May Smooth the 'Great Unwind'

CMS said April 7 that it's ending certain COVID-19 waivers for skilled nursing facilities (SNFs), inpatient hospices, intermediate care facilities for individuals with intellectual disabilities and end-stage renal disease facilities, with staggered terminations of 30 and 60 days.[1]

But "applicable waivers will remain in effect for hospitals and critical access hospitals," according to a memo from David Wright, the director of the CMS Quality, Safety & Oversight Group. The Biden administration has promised to give the industry 60 days' notice of the expiration of the COVID-19 public health emergency (PHE), which will turn many of the waivers and flexibilities to dust. Hospitals and other providers will then return to compliance with pre-PHE regulatory requirements.

"It would be challenging to do that in less than 60 days," said Martie Ross, a consultant with PYA. Some of what she calls the "great unwind" has already begun and some has been deferred.

In the memo, CMS said some waivers for SNFs and nursing facilities (NFs) will be history in 30 days from the date of the memo, including the waivers that let physicians delegate tasks they must perform personally to a physician assistant, nurse practitioner, or clinical nurse specialist and that allow physicians and nonphysician practitioners to perform in-person visits via telehealth. Other waivers will be gone in 60 days. For example, end-stage renal disease facilities will again be required to do

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on-time preventive maintenance of dialysis machines, and nurse aides in SNFs and NFs must have 12 hours of in-service training annually.

The sunsetting of certain waivers is not the only way the times are changing. "A rush of local and state emergency declarations have now been terminated," Ross noted. And the Health Resources and Services Administration program for the uninsured stopped accepting claims for COVID-19 testing or treatment March 11 and did the same for vaccines April 5, Ross said March 23 at a webinar sponsored by the firm.[2]

But Medicare telehealth services got a reprieve for 151 days past the end of the PHE in the 2022 Consolidated Appropriations Act (CAA)—although Medicare coverage for virtual services will continue beyond that date.[3] Telehealth isn't always what people think it is. There's a distinction between telehealth and virtual services, and ensuring compliance requires an understanding of the difference. "Telehealth is the use of technology to allow a service to be performed that would otherwise be a face-to-face encounter," Ross noted. It's a substitute. By comparison, virtual services—including care management, remote patient monitoring, virtual (telephonic) check-ins and e-visits (with no related evaluation and management [E/M] services)—don't have equivalent face-to-face services.

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Ross said telehealth services are often referred to as 1834(m) services because Medicare coverage is authorized in Sec. 1834 of the Social Security Act with five restrictions:

1. Patients must receive telehealth services at a health care facility, such as a hospital (i.e., originating site), which doesn't include the patient's home.
2. Patients must be residents of rural areas.
3. Services are only covered when provided by certain distant site practitioners (e.g., physician, nonphysician practitioners, clinical psychologists).
4. Medicare only covers a relatively small universe of telehealth services (about 100 codes).
5. Services must be delivered using audio and video for real-time interactive communications.

CMS and HHS set aside many of the restrictions for the PHE. For example, telehealth services may be delivered in a patient's home. "CMS also allowed outpatient departments to deliver certain services via telehealth," Ross said. "It would meet the requirements of hospital services even though hospital personnel were not directly interacting with the patient."

They are among the 200 or so modifications or waivers of regulatory requirements. Some waivers and flexibilities will end the day after the PHE expires. Others, like many telehealth services, will live on because of the CAA, which continues many telehealth flexibilities for five months after the PHE is over. For example, the originating and rural site requirements won't apply, which means telehealth services can be delivered in all parts of the country and when patients are at home, and Medicare will keep covering certain audio-only telehealth.

Critical Access Hospitals Are Out of Luck

"That leaves us with a technical analysis of what won't be there when the PHE ends," Ross said. "It's critical to understand where we will be at." For example, after the PHE, services delivered by telehealth in hospital outpatient departments and critical access hospitals won't be covered. And once again, physicians must be licensed in the states where the patients receiving telehealth services are located. "Hopefully, more states will look to the interstate compact, which allows licensed practitioners in one state to practice in another state without having to pursue a second licensure," Ross said. "As more states adopt that, it potentially becomes more meaningful to have that exception."

Also falling by the wayside after the PHE: telehealth for in-person medical evaluation for prescription of controlled substances and direct supervision for incident-to billing of in-person services. "If you're performing services in person, you would revert back to the rule that the billing practitioner must be physically present in the

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office and available immediately to provide assistance" to the nonphysician practitioner performing services incident to the physician, she said. CMS provided a little window of opportunity by extending the use of telehealth for direct supervision through the end of 2022. Another waiver coming to an end is teaching physicians' use of telehealth for the key and critical portions of services at residency training sites beyond metropolitan statistical areas. And Medicare will stop paying for subsequent inpatient visits every three days and critical care consults once a day when delivered by telehealth, she said.

Payments for certain telehealth codes (category 3) will disappear after Dec. 31, 2023. They include initial hospital care, home visits for new patients, medical nutrition therapy and many others. Reimbursement will no longer be at the nonfacility rate, which was designed to "compensate practices for telehealth-associated costs," Ross explained.

The universe of virtual services isn't subject to 1834(m)'s limits on telehealth coverage. But some waivers and flexibilities apply to them. For example, Medicare allows physicians to bill for remote physiologic monitoring (RPM) delivered two to 15 days a month during the PHE to patients with actual or suspected cases of COVID-19. Patients with other conditions must have 16 or more days of monitoring. Another important PHE flexibility is providing RPM to new patients, regardless of the number of days of monitoring or the condition being monitored, but that goes away after the PHE, when Medicare requires providers to deliver the services to established patients. (*RMC* reported recently that a CMS official said the same flexibility doesn't extend to remote therapeutic monitoring.)[4] Medicare covers other virtual services for both new and established patients during the PHE, Ross said. Post-PHE, only services for established patients will be covered.

Unwinding Has 'Two Separate Workstreams'

Now that the reckoning is near—the end of the PHE—Ross recommends that hospitals and other providers look at this as "two separate workstreams: waivers for capacity and waivers for regulatory burden."

The waivers for capacity are about returning your facilities to pre-PHE operations. To the extent you made modifications for surge capacity, reconfigured hospital units, used outpatient facilities for inpatient hospital care or established quarantine units, "all that needs to return to normal," Ross said. It's a good idea to have this in the works because "we have been in this for two years, so roots grow deep quickly."

She thinks addressing the waivers on regulatory burden will be the steeper hill to climb. They're very broad, and "we have become used to them." They include the manner in which verbal orders are authenticated, requirements for the nursing plan of care, how medical records are authenticated, the manner in which respiratory care services are provided, the operations of the utilization review and the quality assurance and performance improvement program, and the information sharing requirements of discharge planning.

Keeping track of compliance with the waiver withdrawal will require a close personal relationship with CMS's list of the waivers.[5] "It will become your guide for re-establishing normal operations," Ross said.

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Keep in mind CMS may make some waivers permanent in forthcoming regulations.

Finally, Ross said, the end of the PHE means many people may lose Medicaid coverage. States are forbidden to disenroll people from Medicaid during the PHE unless they request disenrollment, move out of the state or die under a provision in the CARES Act, she explained. In return, the federal share of their Medicaid spending was increased 6.2%. When the PHE is over, state Medicaid agencies "will be required to initiate disenrollment or determine whether enrollees are qualified to continue in the program," she explained. "They have 12 months to return to normal." Ross predicts this will affect providers because there will be growth in the uninsured.

Contact Ross at mross@pyapc.com. ✧

Endnotes

1. CMS, "Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers," memorandum, Ref: QSO-22-15-NH & NLTC & LSC, April 7, 2022, https://go.cms.gov/3LMH3fr.
2. Martie Ross, "The Great Unwind: Preparing for the End of the Federal Covid-19 Public Health Emergency," PYA, March 23, 2022, https://bit.ly/3JwgxFT.
3. Nina Youngstrom, "Congress Extends Telehealth Coverage for 151 Days After PHE; Patients May Be at Home," *Report on Medicare Compliance* 31, no. 9 (March 14, 2022), https://bit.ly/3CMtkCe.
4. Nina Youngstrom, "CMS: RPM's PHE Flexibilities Don't Extend to RTM; Number of Days Required Is Still Iffy," *Report on Medicare Compliance* 31, no. 6 (February 14, 2022), https://bit.ly/3Kwlgst.
5. CMS, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, updated November 29, 2021, https://go.cms.gov/3BsxLAx.