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End of the Covid-19 Public Health Emergency

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Association of American Medical Colleges

COVID-19 Public Health Emergency

- COVID-19 public health emergency was declared January 2020 and extended multiple times
- PHE allowed waivers and flexibilities of rules/policies to enable access to care
- COVID-19 Public Health Emergency (PHE) Ends

May 11, 2023

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The Unwinding of the PHE: Where to Go for Updates

CMS Blog: Creating a Roadmap for the End of the COVID-19 Public Health Emergency

CMS Provider Specific Fact Sheets (2/24/2023)

CMS Open Door Forums

OIG Notice: COVID-19 PHE flexibilities End (3/10/2023)

PHE Hospital Waivers & Flexibilities

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Where *Hospital* PHE Flexibilities Came From

- 1135 Waivers: Section 1135 of the Social Security Act (SSA) allowed the Secretary of the Department of Health and Human Services (HHS) to temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements by creating "blanket waivers".
  - There is no application process for a blanket waiver. If issued, the blanket waivers applies across the board to everyone.
  - Requirements that can be waived include: CoPs, Licensure, Sanctions, Deadlines/Timetables, Payment Limitations
- EMTALA Waivers: During an emergency, sections of EMTALA (section 1867 of the SSA) may be waived.
- Additional Regulatory Guidance: CMS issued additional guidance throughout the pandemic to meet the needs of Hospitals and comply with newly enacted legislations such as the CARES Act.
- Additional Services Covered: Additional coverage was also created to cover services for COVID-19 expenses such as treatments (e.g., monoclonal antibodies) and vaccines.

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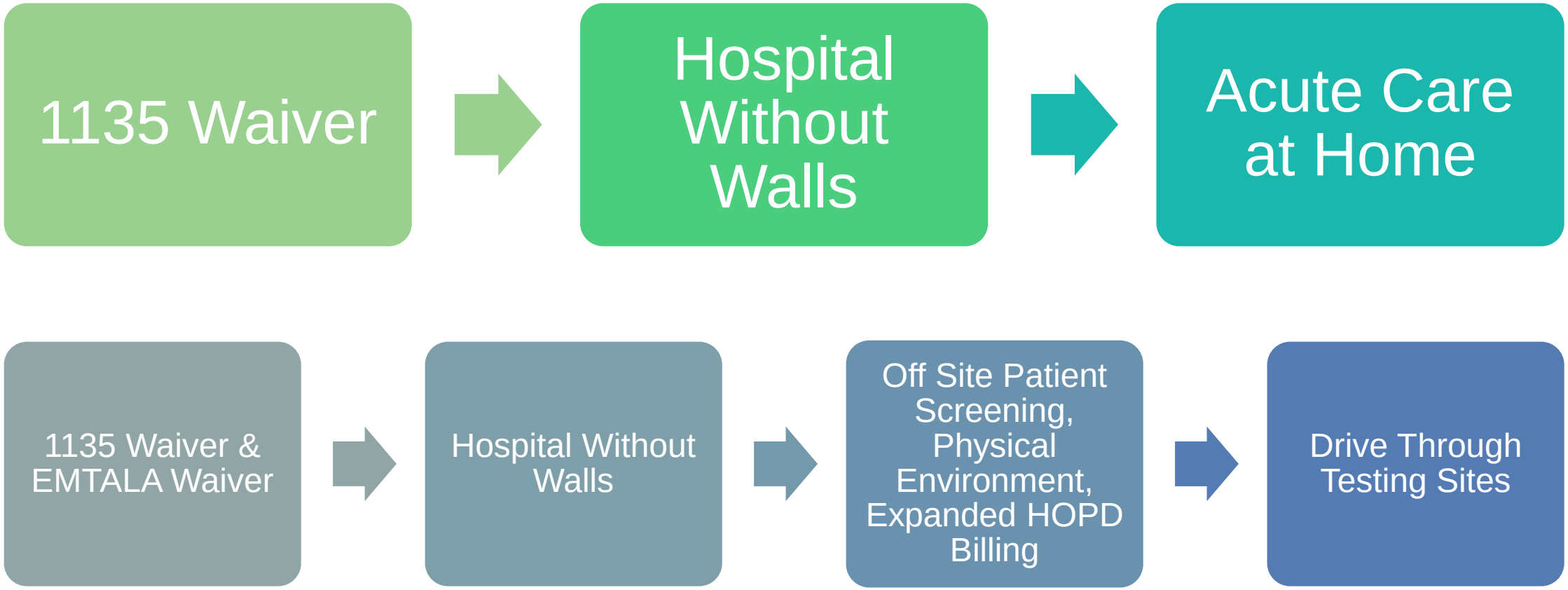
Waivers Worked Together to Create Flexibilities



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Key Hospital Flexibilities

Most Flexibilities for Hospitals fell into these buckets:

Hospital Without Walls	Payment & Coverage	Post-Acute Care
Acute Hospital Care at Home	Increased MS-DRG weights for COVID-19 patients	SNF 3-Day Requirement
Off-Site Patient Screening	Payment for monoclonal antibodies / COVID-19 vaccinations	PAC Swing Beds
Change in Physical Environment	IPPS New COVID-19 Technology Add-on Payment (NCTAP)	
Temporary Expansion Sites	**Policies & Procedures**	**Conditions of Participation (CoPs)**
Temporary Excepted Provider-based Department Relocation	Timing and Amount of Detail Required Waived for Several Items	A number of CoPs were waived in order to provide flexibility to address patient needs

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What Hospital Waivers Are Staying?

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Acute Hospital Care at Home (AHCaH)

Flexibility: Hospital Without Walls waiver allowed hospitals to provide services beyond their existing walls to help address the need to expand care capacity and to develop sites dedicated to COVID-19 treatment.

- AHCaH waives the 24-hour nursing requirement.
- Allows eligible hospitals to treat certain patients, who would otherwise be admitted to the hospital, in their homes and receive Medicare payment under Inpatient Prospective Payment System.

- **After PHE: Extended until December 31, 2024 (section 4140 of the Consolidated Appropriations Act, 2023)**

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Outpatient Hospital Billing for Behavioral Health Services

Flexibility: Allowed hospital outpatient departments (HOPDs) to provide services (not billed on 1500 claim form) virtually (via telemedicine) to a patient while the patient is a registered outpatient

- **After PHE**: Certain behavioral health services will be paid for under the Outpatient Prospective Payment System (OPPS).
  - Finalized in CY 2023 OPPS (87 FR 71748), payment for behavioral health services furnished remotely by HOPD clinical staff to patients in their homes.
  - CMS created OPPS specific codes to describe the services provided by hospital clinical staff to diagnose, evaluate, or treat a mental health disorder to beneficiaries in their homes.
  - ***There cannot be an associated physician fee schedule claim***.

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Medicaid Redeterminations “Unwinding”

Flexibility: Section 6008, Families First Coronavirus Response Act (FFCRA) [Pub.L. 116-127] provided for temporary increase of 6.2 percentage points Federal Medical Assistance Percentage (FMAP) during the COVID-19 public health emergency

- States claiming temporary FMAP increase must maintain enrollment and coverage of all Medicaid beneficiaries through the end of the months in which the COVID-19 PHE ends
- Continuous coverage requirements apply to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date

End of the PHE

- Medicaid redeterminations began April 1, 2023 (Sec. 5131 of the CAA, 2023)
- States have 12 months to initiate (rather than complete) full redeterminations for all enrollees who would have otherwise been subject to redetermination, 14 months to complete.
- States will be considered in compliance if it has initiated all renewals and other eligibility actions by the last month of the 12-month period.

Potential for loss of coverage among eligible individuals is very high

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What Hospital Waivers Are Expiring May 11, 2023?

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Hospitals Without Walls

Flexibility: Allowed hospitals to treat patients in alternate care settings outside the hospital (including the patient's home). The waivers allowed any non-hospital space to be used for patient care if the site was approved by the state and was consistent with the state's emergency preparedness and pandemic plan.

- Enabled through a 1135 Blanket Waiver.

- **After the PHE:** Patient care will need to take place within the hospitals' walls (exception for patients that qualify for Acute Hospital Care at Home).

Reference: 42 CFR 482 Subpart F

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Hospitals Without Walls: Off-Site Patient Screening

Flexibility: Partially waived the enforcement section of EMTALA to allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent spread of COVID-19.

  - Additional sub-regulatory guidance, also waived EMTALA requirement to allow for drive through testing sites, the use of telehealth, and clarified expectations for the triage and medical examination process.

- Through a 1135 Blanket Waiver this waived sections of EMTALA. This is an off shoot of Hospitals Without Walls.
- **After the PHE:** Hospitals will need to be in compliance with all sections of EMTALA.

Reference: 42 CRF 489.24; Section 1867(a) of the Social Security Act

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Hospital Without Walls: Physical Environment

Flexibility: Waived certain physical environment requirements under the Medicare CoPs to allow for increased flexibility in surge capacity and patient quarantine at hospitals, psychiatric hospitals, and CAHs. This allowed for space not typically used for patient care to be utilized if approved by the state.

- Enabled through a 1135 Blanket Waiver.

- **After the PHE:** Hospitals will need to be in compliance with all CoPs.

Reference: 42 CRF 482.41, 42 CFR 485.623; Section 1861(e)(9) of the SSA

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Hospitals Without Walls: Temporary Expansion Sites

Flexibility: Waived some hospital CoPs and provider-based departments (PBDs) requirements to allow hospitals to establish and operate as a part of the hospital at any location meeting the CoPs for hospitals in operation during the PHE. This also allowed hospitals to change the status of a PBD as needed to address patient needs.

- Enabled through a 1135 Blanket Waiver that waived hospital CoPs. **(42 CRF 482.41, 42 CFR 485.623, 42 CFR 413.65, Section 1861(e)(9) of the SSA)**
- ASCs were allowed to temporarily enroll as a hospital and provide hospital services to address capacity concerns while waiving the 24-hour limit. **(QSO-21-09-ASC)**
- Freestanding ED's were also eligible to participate in Medicare/Medicaid (**QSO-20-27-Hospitals)** and enroll as an ASC and then convert temporarily to a hospital during the PHE. **(42 CFR 482.23, 42 CFR 482.25, 42 CFR 482.42, 42 CFR 482.57)**
- **After the PHE:** Hospitals will need to be in compliance with all CoPs. ASCs will need to comply with CoPs if the wish to maintain hospital status or revert back to ASCs. Freestanding ED's will lose Medicare certification and will need revert back to Freestanding EDs.

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Temporary Expansion Sites: Temporary Extraordinary Circumstances Relocation Policy

Flexibility: Temporarily expanded the extraordinary circumstances relocation exception policy to include both on-campus and excepted off-campus PBDs that relocate (or partially relocate) to new off-campus locations, including to any temporary expansion locations (such as other sites or the patient's home, as applicable).

- Enabled through Regulatory Guidance.
- **After the PHE:** Excepted PBDs will need to return to their original location, or they will lose their excepted status and therefore be considered non-excepted PBDs and paid the PFS-equivalent rate.

Reference: 42 CFR 413.65; Section 1833(t)(21) of the SSA

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Temporary Expansion Sites: Temporary Extraordinary Circumstances Relocation Policy (Con't)

Provider-Based Department (PBD) Type	Non-PHE Payment Policy Before Relocation	Non-PHE Payment Policy if PBD Relocates Off-Campus (Absent Extraordinary Circumstance Relocation Approval)	Payment Policy During PHE Following Off-Campus Relocation
On-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	OPPS** (if extraordinary circumstance relocation request is approved)
Excepted* Off-Campus PBD	OPPS**	PFS-equivalent (treated as new location)	OPPS** (if extraordinary circumstance relocation request is approved)
Non-Excepted Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent
New (since pandemic) Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent

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Post-Acute Care: Ability for Hospitals to Offer Swing Beds

Flexibility: Allowed hospitals to establish subacute nursing facility (SNF) swing beds payable under the SNF prospective payment system to provide additional options for patients who no longer require acute care but are unable to find a placement in a SNF. Hospitals needed to meet specific criteria to qualify and had to call the Medicare Administrative Contractor (MAC) enrollment hotline to add swing bed services.

- Enabled through a 1135 Blanket Waiver.

- **After the PHE:** Hospitals will need to remove swing beds.

Reference: 42 CRF 482.58; Section 1135(b)(1) of the Social Security Act

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Post Acute Care: SNF 3-Day Prior Hospitalization Requirement

Flexibility: Temporarily waived the requirement for a 3-day prior hospitalization for coverage of a SNF stay. In addition, for certain beneficiaries who exhausted their SNF benefits, the waiver authorized renewed SNF coverage without first having to start and complete a 60-day "wellness period" (that is, the 60-day period of non-inpatient status that is normally required in order to end the current benefit period and renew SNF benefits).

- Enabled through a 1135 Blanket Waiver.
- **After the PHE:** Hospitals and SNFs will need to comply with all requirements for coverage.

Reference: 42 CRF 409.30(a)(1); Section 1812(f) of the Social Security Act

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Payment: Increase in COVID-19 MS-DRG Relative Weights

Flexibility: Hospitals received a 20% increase to the MS-DRG relative weights for Medicare payment through the hospitals' IPPS payment for patients that were COVID-19 positive.

- An adjustment factor was used on discharges of patients with a principle or secondary diagnosis of COVID-19 using the following ICD-10-CM diagnostic codes:
  - For discharges occurring on or after April 1, 2020, through the duration of the COVID-19 PHE period: U07.1
  - For discharges occurring on and after January 27, 2020, and on or before March 31, 2020: code B97.29
- Enabled through Sub-Regulatory Guidance (Memo) in response to Section 3710 of the CARES Act **(42 CRF 412.60)**
- **After the PHE:** The MS-DRG relative weight for COVID-19 hospitalized patients will return to its normal rate.

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Payment: COVID-19 Monoclonal Antibodies & COVID Vaccinations

Flexibility: Provided reimbursement for the cost of infusion or injection of monoclonal antibodies and COVID-19 vaccinations when consistent with an EUA without beneficiary cost sharing or deductible. CMS did not cover if health care setting received infusions / vaccinations for free. If purchased from a manufacturer, then Medicare reimbursed at reasonable cost or 95% of the average wholesale price.

- CMS also created Part B coverage for COVID-19 vaccinations and OPPS separate payments for New COVID-19 treatments. (**42 CRF 410.152, Section 1861(s)(10) of the SSA, Section 3713 of the CARES Act, Section 1833(t) of the SSA**)
- Enabled through Regulatory Guidance (**42 CFR 440.30**)

- **After the PHE: Effective Jan 1, 2024**, (*end of calendar year in which the EUA ends*), CMS will pay for these treatments as they normally pay for other biological products or similar treatments.
  - CMS will pay $40 per dose of administering COVID-19 vaccines in the outpatient setting through the end of 2023. Then starting Jan 1, 2024, CMS will set a new payment rate that aligns with other Part B preventative services.

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Payment: IPPS COVID-19 NTAP

Flexibility: CMS established a New COVID-19 Technology Add-On (NCTAP) payment for cases involving the use of Medicare IPPS

- Enabled through Regulatory Guidance
- **After the PHE:** Proposal in FY 2024 IPPS, expiration of the NCTAP effective September 30, 2023 (end of FY 2023) for products eligible for the NCTAP. No NCTAP would be made for discharges on or after October 1, 2023 (beginning of FY 2024).

Reference: Section 3710 of the CARES Act; FY 2024 IPPS proposed rule

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Recap: What Does This Mean for Hospitals?

After May 11, 2023, hospitals will need to be back in compliance with Conditions of Participation and EMTALA requirements as required pre-pandemic.

- Exceptions
  - Acute Hospital Care at Home
  - Outpatient Billing for Behavioral Health (OPPS)

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Hospital Flexibilities Ending May 11, 2023

- Hospital Without Walls: Allowed Inpatient Services Furnished Outside the Hospital, Expanded Outpatient Hospital Billing for Expansion Sites
- CoPs: Waived - Reporting Requirements for COVID-19 cases, Utilization Review, Delay in death reporting where restraints were used but not the root cause, Allowed for Hospital and CAH Telemedicine, and flexibilities for administering COVID-19 Vaccines
- Temporary Expansion Sites: Housed Patients in Different Distinct Units than Assigned, Allowed for Partial Hospitalization Services Outside the Hospital
- Policies and Procedures: Waived written procedure requirements for Appraisal of Emergency at Off Campus Department, Nursing Services, Emergency Preparedness Polices and Procedures for new sites, and allowed timeline flexibilities for Medical Records and Patient Rights Paperwork
- Post-Acute Care: Allowed for Limited Details in Discharge Planning
- Payment & Coverage: Allowed for Modified Ordering Requirements, Medicare Coverage for Antibody (serology) tests, Rapid Coverage of Preventative Services for COVID-19
- Other: Postponed the Application Deadline for Medicare Geographic Classification Review Board, Allowed leniency with 340B Eligibility if impacted by COVID-19 (Expired Dec. 31, 2022)

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Links to COVID-19 Hospital Resources

CMS Coronavirus Flexibilities Landing Page: https://www.cms.gov/coronavirus-waivers

Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs (PDF):

https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

Teaching Hospitals, Teaching Physicians and Medical Residents (PDF):

https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf

CMS Table of PHE Waivers for Medicare: https://www.cms.gov/files/document/1-medicare-covid-19-phe-waivers-flexibilities.pdf

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Residents

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Primary Care Exception

Ends May 11:

During the PHE, CMS added additional services to the primary care exception. (E/M level 4-5; 99495-96 (transitional care management); 99421-23 (online digital E/M services); 99452 (interprofessional internet consult) G2010, G2012 (virtual check-in)

Beginning May 12:

The primary care exception includes level 1-3 E/M services, annual visits, interprofessional internet consults, and virtual check ins.

E/M levels 4-5 may not be provided by a resident under the primary care exception.

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Residents and Moonlighting

Permanent Policy:

CMS enabled residents to furnish and separately bill for inpatient physicians' services provided outside the scope of their approved GME program (i.e., moonlighting), provided that (i) the services are identifiable physicians services and meet the conditions for payment of physicians services to beneficiaries by providers, (ii) the resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed, and (iii) the services can be separately identified from those services that are required as part of the approved GME program.

Residents Training in Other Hospitals

Ends May 11:

During the PHE, a teaching hospital that sends residents to other hospitals has been able to continue to claim those residents in the teaching hospital's IME and DGME FTE resident counts, if certain requirements are met.

1) the teaching hospital sends the resident to the other hospital in response to the COVID-19 pandemic;

2) the time spent by the resident training at the other hospital is in lieu of time that would have been spent training at the sending hospital; and

3) the time that the resident spent training immediately prior to and/or subsequent to the time frame that the COVID-19 PHE has been in effect has been included in the FTE count for the sending hospital.

Additionally, during the PHE, the presence of residents in non-teaching hospitals has not triggered establishment of IME and/or DGME FTE resident caps at those non-teaching hospitals. Specifically, for DGME, the presence of residents in non-teaching hospitals has not triggered establishment of PRAs at those non-teaching hospitals

Residents Training in Other Hospitals

Beginning May 12:

A teaching hospital that sends residents to other hospitals cannot claim those residents in its IME and DGME resident counts. In addition, the presence of residents training in a new residency program at a non-teaching hospital may trigger establishment of IME and/or DGME FTE resident caps at those nonteaching hospitals and for DGME the presence of residents may trigger establishment of per resident amounts at those non-teaching hospitals.

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Indirect Medical Education (IME) Payments Held Harmless

Ends May 11:

IME Payments Held Harmless for Temporary Increase in Beds: During the PHE, CMS held teaching hospitals harmless from a reduction in IME payments due to beds temporarily added during the Covid-19 PHE, by not considering these beds when determining IME payments.

Beginning May 12:

For cost reporting periods that begin after the end of PHE, a hospital may no longer exclude beds temporarily added during the Covid-19 PHE for determination of IME payments

Provider Reimbursement Manual, Dec. 2022, P. 40-192

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Telehealth

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Telehealth: Location of the Patient

Ends December 31, 2024:

- Payment is provided for telehealth services in any geographic area including the patient's home

Beginning January 1, 2025:

- Telehealth can only be covered in rural locations and at originating sites which were defined as facilities, such as hospitals, physician offices, SNFs (except for mental health and substance abuse services)
- Telehealth can no longer be provided to patients in their home (except for mental health and substance abuse services)

Telehealth: Mental Health Services

Permanent

- Mental health services can be provided in any geographic region and the patient's home permanently
- Treatment for substance use disorder and co-occurring mental health disorders can be provided in any geographic region and the patient's home permanently

Beginning January 1, 2025

- The patient must be seen in-person within 6 months prior to the telehealth visit. Those who have been receiving mental heath telehealth services during the PHE *do not* have to satisfy this requirement.
- A subsequent in-person visit each 12 months is required for mental health services. Exceptions to the 12-month requirement are allowed when the 'burdens' outweigh the "benefits". Any exception must be documented in the patient's medical record.
- In-person visit requirement can be met by physicians in same specialty and group practice.

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Who Can Provide Telehealth?

Coverage and Payment for telehealth is limited to distant site practitioners

The practitioner may provide the services from their home or from a facility setting (e.g., hospital).

Permanent:

- Physicians, nurse practitioners, physician's assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, social workers, registered dieticians, and nutrition professionals (bill on 1500/837P)

May Provide Telehealth Services Until December 31, 2024:

- Physical therapists, occupational therapists, audiologists, and speech language pathologists

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Telehealth Payment to the Facility

Ends May 11, 2023

- Payment for telehealth facility site fee (unless the patient is receiving telehealth services in the hospital)
  - (Q3014) Telehealth originating site facility fee
  - (G0463) Hospital outpatient clinic visit for assessment and management of a patient
- Telehealth services by practitioners or auxiliary personal employed in a *provider-based setting* billed on the hospital institutional claim form (UB-04) are no longer paid (except for behavioral health services).

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Telehealth: Payment Rates

Until December 31, 2023

- Payment for office-based telehealth services is paid as if the service has been furnished in-person, and therefore payment is made at the non-facility-based rate (this is the same as the in-person rate for office-based services)

Beginning January 1, 2024

- Payment for telehealth services will be paid at the facility rates for telehealth office-based services (approximately 25-30% less than the in-person office-based rates)

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Medicare Telehealth Modifiers

Modifier	Use	Date Applicable
Modifier 95	Providers will continue to bill with modifier 95 along with the POS code corresponding to where the service would have been furnished in-person	Ends December 31, 2023
POS 02	Telehealth provided other than in patient's Home (Use POS 02 along with modifier 95)	On and after January 1, 2024
POS 10	Telehealth Provided in Patient's Home (Use POS 10 along with modifier 95)	On and after January 1, 2024
FR	Supervising practitioners FR modifier when they provide direct supervision for a service using virtual presence through audio/ video	Continued

Telehealth Audio-only

Ends December 31, 2024

- Medicare payment for audio-only services ends (except for mental health services)

Audio-only Modifiers

Modifier	Use	Date Applicable
CPT Modifier 93/FQ	Services furnished using audio-only communications technology/audio-only behavioral health	On and after January 1, 2023

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Telehealth List

Until December 31, 2023:

- All services currently on the telehealth list will remain available for payment
- The Telehealth List can be viewed here:

https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes

- The 2024 Physican Fee Schedule expected to make changes to the telehealth list

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Telehealth: Reporting Home Address

Permanent:

- The practitioner may provide the services from their home or from a facility setting (e.g., a hospital).

Beginning January 1, 2024

- Practitioners will be required to report their home address on the Medicare enrollment if providing services from their home. (This may be addressed in future rule-making)

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Payment to FQHC and RHC

Ends December 31, 2024:

- Medicare payment for telehealth services furnished by FQHCs and RHCs

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Frequency Limitations on Telehealth

Setting	During PHE	After May 11
Hospitals	Frequency limit of once every 3 days for subsequent inpatient hospital visits furnished by telehealth was removed during PHE.	Frequency limit of telehealth once every 3 days will apply
Skilled Nursing Facilities	Frequency limit of once every 30 days for subsequent skilled nursing facilities visits provided by telehealth was removed during PHE.	Frequency limit on telehealth in skilled nursing facilities visits is permanently changed to once every 14 days.

Hospices and Telehealth Services

During COVID-PHE	After PHE Ends
During PHE, hospice providers could provide services to a Medicare patient receiving routine home care through telecommunications technology (e.g. remote patient monitoring, telephone calls, and audio-video) if feasible and appropriate	Ends May 11, 2023
Face to face encounters for patient recertification for Medicare hospice benefit can be conducted via telehealth	Ends December 31, 2024

Cost Sharing Obligations

Beginning May 12, 2023

- OIG will enforce cost sharing requirements (e.g., coinsurance and deductible.)

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HIPAA Compliance

Beginning August 10, 2023

- Telehealth platforms must be HIPAA compliant.
- Until that date OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers that make a *good faith provision of telehealth*

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DEA Proposed Rule Prescribing Controlled Substances (Mar. 31st)

Schedule II Controlled Substances and Schedule III-V Narcotics (exception Buprenorphine)	Schedule III-V Non-Narcotics and Buprenorphine for the Treatment of Opioid Use Disorder	Non-Controlled Medication
• Initial in-person visit required before prescribing through telemedicine • Once in-person visit requirement is met can be prescribed though telemedicine (as permitted by state/federal law)	• Providers would be able to prescribe a 30-day supply through telemedicine without the initial in-person visit (as permitted by state/federal law) • An in-person visit would be required for refills passed the 30-days	• No Change • Providers can prescribe without in-person visit (as permitted by state/federal law)

In-person visit may be satisfied by ***qualified telemedicine referral:*** *written report or 3- party audio-video visit*

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180-day Grace Period for Existing Telemedicine Relationships

- Proposed Rule would extend the in-person waiver an additional 180 days (until Nov 2023) for patients that have already received their prescriptions via telemedicine during the PHE.
- The 180-day extension applies to all schedule II-V controlled substances.

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State Licensure Laws and Telehealth

Most States Passed Legislation/Regulations allowing practice across state lines temporarily during PHE.

State Medicaid programs allowed coverage of Telehealth services during public health emergency.

Federation of State Medical Boards: Tracking of state activity
https://www.fsmb.org/advocacy/covid-19/

https://connectwithcare.org/wp-content/uploads/2022/04/Telehealth-and-Licensure-Flexibilities-During-COVID-19-and-Current-State-of-Emergency-Waivers-April-18-2022.png

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Practicing Across State Lines

Practitioner must comply with requirements of state where patient is located

Different approaches to enabling delivery across state lines

- **Full and active license required**
- **Licensure waiver under state of emergency**
- **Interstate Licensure Compacts:** streamline licensing process for physicians and health care professionals so they can practice medicine in multiple states
- **Telehealth Registration (e.g., Florida and New Jersey)**
- **Reciprocity (for adjoining states, e.g., Pennsylvania)**

Telehealth vs. Communication-Based Technology Services Key Distinctions

Telehealth

- Services with an in-person equivalent
- (geographic restrictions, in the home restrictions apply except for mental and substance abuse telehealth)

Communication Technology-based services

- Reimbursable services that use telehealth technologies
- Examples: remote physiologic monitoring (RPM), e-consults, virtual check in, remote evaluation, e-visits, chronic care management
- No geographic restrictions and patient may be in home

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Virtual Check-Ins and E-visits

After May 11, 2023

- May only be provided to established patients (not new patients)
- Consent can be obtained at the time of the service
- Can be provided by NPPs including LCSWs, PTs, OTs, and SLPs
- No geographic limitations
- Coinsurance will be enforced

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Remote Patient Monitoring

After May 11, 2023

- RPM services can only be provided to established patients (can no longer be provided to new patients).
- To bill RPM services (99453 and 99454), must collect 16 days of data (during the PHE, 2 days of data collection was allowed if patient diagnosed with/suspected of having COVID-19)
- No geographic restrictions
- Coinsurance will be enforced

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Virtual Direct Supervision

Until Dec. 31, 2023, services requiring direct supervision may be provided using real-time, interactive audio/video technology (excluding audio only).

- (For example, virtual supervision of “incident to” services” provided by clinical personnel allowed)

CMS is considering whether to extend this policy beyond Dec. 31, 2023.

Supervision of Residents and Telehealth

During the PHE	After the PHE (permanently)
Presence of teaching physician during key portion of service furnished by resident can be met using audio/visual real-time communications technology. Teaching physician must be observing real time.	Supervision policy in effect during pandemic will be made permanent for rural sites only (non-metropolitan statistical areas).
Primary Care Exception: Teaching physicians may remotely direct primary care furnished by residents, and remotely review resident-provided services during or after visit, using audio/visual real-time communications technology.	Supervision policy in effect during pandemic will be made permanent for rural sites only (non-metropolitan statistical areas).
Residents and Telehealth: Permits use of audio/visual real-time communications technology to establish presence of a teaching physician when resident furnishes telehealth services to beneficiaries.	Policy during the pandemic will be made permanent for rural sites only (non-metropolitan statistical areas). Audio only services will not be covered by Medicare

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Fraud and Abuse Laws: Waivers End May 11, 2023

Self-Referral (Stark II) Law: During PHE, certain waivers of self-referral laws were allowed

- Hospitals and other providers could pay above or below fair market value to rent equipment or receive services from physicians

Anti-Kickback Laws: During PHE, OIG exercised enforcement discretion to not impose administrative sanctions under Anti-Kickback Statute for certain renumeration related to COVID-19.

AAMC Resource: Waivers and Flexibilities Chart

Red	Flexibility/Waiver Expires May 11, 2023 (End of the PHE)
Yellow	Flexibility/Waiver Expires August 10, 2023
Blue	Flexibility/Waiver Expires December 31, 2023 (End of CY 2023)
Sky Blue	Flexibility/Waiver Expires End December 31, 2024 (End of CY 2024)
Green	Permanent Policy

Leg=Legislation (Congress)
Reg=Regulation (HHS)

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Updated 4/11/2023

COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities: Status Update

The Biden Administration announced its intent to end the COVID-19 national emergency and public health emergency (PHE) declarations on May 11, 2023. These emergency declarations have given the federal government the authority to waive or modify regulatory and other requirements during the PHE. The Table below provides an overview of some of the flexibilities and waivers impacting teaching hospitals and physicians during the PHE, and their status after the PHE ends. As noted, some of these waivers and flexibilities will expire on May 11, 2023, some will be in effect until December 31, 2023, some will be in effect until December 31, 2024, and others were made permanent. The Table indicates whether legislative or regulatory action would be needed to change these policies. A comprehensive list of all the waivers and flexibilities is available on CMS's website.

New Updates: HIPAA Compliance, Reporting Address of the Location of Provider, Originating Site Fee for Hospitals, Prescribing Controlled Substances and Telehealth List. *An overstrike indicates language/policies that CMS has deleted or modified since the last version of this chart.*

Waivers/Flexibilities from PHE	Action Needed (Leg, Reg)	Status after PHE
Telehealth		
Patient Location: During the PHE, the rural and originating site requirements for telehealth services are waived. These waivers allow patients to receive telehealth in any geographic region and in their homes. Prior to the PHE telehealth would only be covered in rural locations and at originating sites- which were defined as facilities, such as hospitals, physician offices, SNFs. Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, P.L. 116-123 § 101 (Mar. 6, 2020	Leg	After December 31, 2024, originating site requirements and rural requirements for telehealth go back into effect (except for mental health and substance abuse services). Beginning Jan. 1, 2025, telehealth will only be covered in rural areas and the patient may not be in his/her home). Consolidated Appropriations. Act, 2023 (Section 4113(a)) Mental health services can be provided in any geographic region and the patient's home permanently. Consolidated Appropriation Act, 2022

AAMC Resource: Waivers and Flexibilities Chart

A comprehensive list of all the waivers and flexibilities is available on CMS's website at https://www.cms.gov/blog/creating-roadmap-end-covid-19-public-health-emergency

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QUESTIONS?

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