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Healthcare compliance in a post-pandemic world

by Larissa Morgan, Steve Lokensgard, and Jacob Hauschild

On January 31, 2020, pursuant to Section 319 of the Public Health Service Act, the secretary of the U.S. Department of Health & Human Services (HHS) determined that a public health emergency (PHE) exists due to the soaring number of COVID-19 cases in the United States. In March 2020, President Donald Trump issued a national emergency declaration according to Section 201 of the National Emergencies Act. Nobody knew at the time that the PHE would last 1,196 days, or the extent to which the pandemic would strain the country's healthcare system. Despite the best efforts of public health officials and healthcare providers, 102 million Americans would suffer from COVID-19, and 1.1 million would die. The pandemic was an event that happens once in a hundred years—an extreme situation requiring an extreme response.

The declaration of a national emergency and PHE gave the secretary of HHS, under Section 1135 of the Social Security Act, authority to waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements. A complete list of waivers was updated almost daily on the Centers for Medicare & Medicaid Services (CMS) website.[1] The flexibilities granted by CMS were designed to promote access to care and reduce the administrative burden on providers.

Both the national emergency and the PHE will cease at the end of the day on May 11, 2023. The fact that the pandemic lasted for over three years presents a special challenge for compliance officers. A report published in 2022 noted that in the previous five years, the average hospital turned over 100.5% of its workforce.[2] The average annual hospital turnover rate increased by 6.4% to 25.9%. The impact on hospitals is likely not a unique experience for other healthcare providers. This means that a significant percentage of the workforce can't just go back to business as usual because they were not around when the flexibilities were not in effect. Compliance officers will have a significant lift to educate their staff on changes required with the expiration of the PHE.

This article aims to identify key waivers that will continue or expire to assist compliance officers in adapting policies and procedures to the post-pandemic world. This article also focuses on certain types of providers and discusses only certain issues. CMS has published provider-specific fact sheets that identify flexibilities issued

during the pandemic and whether they will expire or continue, but these fact sheets are not comprehensive.[3] Other sources include the Consolidated Appropriations Act of 2023 (CAA)[4] and the 2023 Medicare Physician Fee Schedule (PFS).[5]

Physicians and other clinicians

CMS and other federal agencies have applied an array of waivers that have impacted how medical practices operate in nearly every setting. Many of these flexibilities will roll back immediately following the conclusion of the PHE; in contrast, others—namely, those related to telehealth—have been extended until at least the end of 2024.

Care in the traditional setting

Nonphysician practitioner diagnostic testing. During the PHE, CMS used the flexibility at 42 C.F.R. § 410.32(b) to allow nurse practitioners, clinical nurse specialists, certified nurse–midwives, and physician assistants to supervise diagnostic tests as authorized under state law.[6] Beginning at the end of the PHE, only physicians may supervise diagnostic X-ray tests, laboratory tests, and the other diagnostic tests contemplated by 42 C.F.R. § 410.32.

Locum Tenens 60-day limit. During the PHE, CMS modified the 60-day limit specified in section 1842(b)(6)(D)(iii) of the Social Security Act, allowing physicians or physical therapists to use the same substitute during the entire duration of their unavailability.[7] Beginning 61 days after the end of the PHE, the regular physician or physical therapist must use a different substitute or return to their practice for at least one day to reset the 60-day limit. This modified schedule applies to both reciprocal billing arrangements and fee-for-time compensation arrangements.

Licensing and provider enrollment. During the PHE, CMS made several temporary changes to licensing requirements, including: expediting enrollment for new and pending applications; allowing practitioners to cancel their opt-out status; permitting practitioners to render telehealth services from home without reporting their home address; and allowing licensed practitioners to bill Medicare for services provided outside of their state of enrollment. Immediately following the conclusion of the PHE, CMS will return to normal processing times for applications, opt-out statuses will only be cancellable within regulations, practitioners must resume reporting their home address on the Medicare enrollment, and regulations will continue to allow a deferral to state law for licensing. Compliance officers are advised to review updated state licensure requirements, as many states have made once-temporary flexibilities permanent.[8] For example, as of May 5, 2021, Arizona permanently allows healthcare providers licensed in another jurisdiction to practice telehealth with Arizona patients, assuming proper registration and compliance with other laws.

Supervision requirements. During the PHE, CMS modified the definition of direct supervision to allow for the "virtual presence" of the supervising clinician via synchronous audio and video technology to satisfy the "immediately available" requirement.[9] This modification of the definition will revert at the end of 2023.

Services provided by residents. Throughout the PHE, CMS waived existing regulations applicable to teaching physicians to permit such physicians to use audio/video real-time communication to supervise residents.[10] Following the PHE's expiration, teaching hospitals will only receive Medicare payment for services where a teaching physician is physically present for a main portion of services that involves residents, and where the physician is immediately available to provide care for the entire procedure, when necessary and applicable. Physicians teaching at residency training programs outside of a metropolitan statistical area—a "core area

containing a large population nucleus, together with adjacent communities that have a high degree of economic and social integration with that core"—would still be permitted to satisfy the physical presence requirement through audio/video real-time communications technology, except in certain high-risk, complex cases.[11]

In addition, during the PHE, physicians in primary care centers could supervise residents via telehealth and bill for all evaluation and management (E/M) services when residents provided the service. The flexibility will terminate upon the PHE's expiration, except for those teaching physicians at residency training sites outside of a metropolitan statistical area. The primary care exception will only allow a physician to bill for levels 1–3 E/M codes performed by a resident. To bill for levels 4–5, the physician must be physically present for the critical portion of the service performed by the resident.[12]