

Public Health Emergency Ends May 11

Implications for RHCs

The COVID-19 Public Health Emergency (PHE) initially declared on January 27th, 2020, will conclude on May 11, 2023. Please note: this is a separate emergency declaration from the COVID-19 National Emergency declared by the President that can be ended via a joint resolution from Congress. For a full explanation of these provisions, please review the recent [NARHC webinar](#).

At the onset of the PHE, many waivers and flexibilities were granted across the health care industry to reduce administrative burden, increase access to care, and more. Since then, many of the flexibilities have been granted permanent coverage, or given a new timeline separate from the PHE. This article will cover RHC-specific waivers, then discuss the status of some healthcare-wide flexibilities, including what is officially expiring in May, as well as what other provisions now operate on separate calendars.

RHC Specific Waivers

The conclusion of the PHE will end the below waivers:

- Certain Staffing Requirements. 42 CFR 491.8(a)(6).
 - During the PHE, CMS waived the requirement that a NP, PA, or CNM be available to furnish patient care services at least 50% of the time the RHC is operating.
- Temporary Expansion Locations. 42 CFR §491.5(a)(3)(iii).
 - During the PHE, CMS waived the requirement that RHCs be separately considered for Medicare survey and certification if services were expanded into more than one permanent location, including areas that would not typically meet RHC location requirements. Upon termination of the PHE, these expanded locations will be subject to location requirements and separate survey and certification.
- Bed Count for Provider-Based RHCs
 - During the PHE, CMS permitted provider-based RHCs subject to their clinic-specific, grandfathered upper-payment limit to increase their hospital bed count to 50+ without losing their grandfathered status. At the conclusion of the PHE, grandfathered RHCs must lower their bed count or lose their grandfathered payment status.
- Home Nursing Visits
 - During the PHE, CMS removed the requirement that RHCs in an area without a current home health area shortage needed a written request and justification in order to provide home nursing services.
- Virtual Communication Services
 - During the PHE, CMS allowed for online digital evaluation and management services (99421, 99422, and 99423) to be reimbursed under G0071. After the PHE, G0071 should only be used for [G2012 and G2010](#). This was one of the first telecommunications flexibilities granted to RHCs during COVID, but the passing of the CARES Act allowed many more services to be done via telehealth during the PHE and beyond.

Additionally, while some Medicare telehealth policies were extended past the PHE (read more below), the [enforcement discretion](#) that allows telehealth services to be provided through non-HIPAA-secure communications technology will end immediately after the PHE ends. The HIPAA privacy rule will not prevent providers from offering covered [audio-only telehealth services](#), however.

Other waivers ending at the conclusion of the PHE include the 20% hospital payment increase for treatment of patients with COVID-19, as well as numerous [blanket waivers](#) in place for healthcare providers broadly, including Stark Law waivers.

One RHC specific waiver that will be concluding this year, but not until December 31, 2023, is the Physician Supervision of NPs in RHCs and FQHCs at 42 CFR 491.8(b)(1). During the PHE, CMS waived the requirement that physicians provide medical direction for the RHCs' nurse practitioners, to the extent permitted by state law. **This waiver will end on 12/31/2023, not immediately when the PHE concludes.** Note: the RHC Burden Reduction Act recently introduced in the Senate would make this permanent for both NPs and PAs if passed. Learn more [here](#).

Telehealth

While originally linked to the PHE, many Medicare telehealth flexibilities will remain past May 11th, including RHCs ability to serve as distant site providers through December 31, 2024. As a reminder, mental health services provided via telehealth are permanently covered, and paid the RHC All-Inclusive Rate, although the occasional in-person requirement has also been delayed through December 31, 2024. Medical telehealth services should continue to be billed G2025 and will be reimbursed at \$98.27 in 2023. Please visit [NARHC.org](https://www.narhc.org) for more details on RHC telehealth.

Medicaid

The “Medicaid Redetermination” policy, requiring every state to reevaluate all Medicaid beneficiaries’ eligibility for the first time since COVID-19 began, is no longer tied to the PHE. While each state will have a [different process](#), many states began disenrolling beneficiaries on April 1, 2023.

Individuals who have moved or whose contact information has changed over the last three years are at greater risk of unnecessarily losing coverage if their state is unable to reach them to redetermine eligibility.

A recent [Urban Institute](#) survey highlighted that over 60% of adult Medicaid beneficiaries were unaware of the upcoming redetermination. CMS has released a [Communications Toolkit](#) to assist stakeholders in reminding their patients and communities of key messages to update contact information, check their mail, and complete the renewal forms in a timely manner.

Commercialization of COVID-19 Products

Since the start of the PHE, insurers have been required to cover COVID-19 testing, vaccines, and treatment without cost-sharing. Many of these patient protections will expire on May 11th.

Once the federal government’s purchased supply has been expended, vaccines, tests, etc. will transition to commercial products. With this, patients may have cost sharing responsibilities, and in theory, there may also be supply and demand challenges, and all of this will vary by payor.

For RHCs, COVID-19 vaccines and their administration will continue to be paid at 100% of reasonable cost via the cost report. Monoclonal antibody products and their administration will be paid at 100% of reasonable cost through the RHC cost report as well, when they are approved/authorized.

Here is a [full breakdown](#) of the current status of vaccines, treatments, and tests, as well as what the end of the federal supply and associated protections could bring across payor types.

The HRSA RHC COVID-19 Supply Programs that offer free, direct access to COVID-19 vaccines, therapeutics, and testing supplies are also not tied to the PHE. For more details on enrollment and what remains available, please visit [NARHC.org](https://www.narhc.org).

Emergency Use Authorizations and the PHE

A similar, but separate determination made by the HHS Secretary is related to the issuance of [Emergency Use Authorizations](#), or EUAs. These authorizations allow for the Food and Drug Administration (FDA) to authorize medical products, or medical products for other uses under less stringent criteria than is typically required for approval. Throughout the pandemic, HHS issued EUAs for vaccines, tests, and treatments. It’s important to note that these determinations are separate from the COVID-19 PHE, and if they are terminated at a later date, the HHS Secretary will provide advanced notice prior to the end of that flexibility.

Finally, the [CMS COVID-19 Health Care Staff Vaccination](#) mandate will remain in effect post-PHE. CMS has not announced any changes, nor a sunset date, for the mandate at this time.

PHE Ends May 11 continued...

The COVID-19 PHE has lasted over three years and has impacted the healthcare industry in significant ways that will remain long after the official declaration has expired. With any questions on these provisions or the PHE coming to an end, please contact Sarah Hohman, NARHC Director of Government Affairs, at Sarah.Hohman@narhc.org.

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