End of the Public Health Emergency: What's Next?

MONTE SANDLER

With expiration of the national Public Health Emergency (PHE) as of May 11, the revenue cycle management (RCM) industry has to adjust to the "new normal." Some emergency declarations were tied to the end of the PHE and others are not. While not a comprehensive list, I've outlined some of the most urgent care-relevant changes below.

Payers Coverage for COVID-19 Testing, Treatments, and Vaccines

During the PHE, federally regulated health plans were mandated to cover COVID-19-related services, often without cost-sharing (ie, patient responsibility). This includes deductibles, co-insurance, and copays.

For private health insurance (eg, BCBS), the following changes will take place with the expiration of the PHE:

- Group health plans and individual health insurance plans will no longer *be required* to cover COVID-19 tests and testing-related services without cost-sharing or prior authorization or other medical management requirements. This includes over-the-counter (OTC) COVID-19 tests.
- Group health plans and individual health insurance (including grandfathered plans) will no longer *be required* to cover out-of-network (OON) providers for tests and related services when the patient has OON coverage.
- Plans and issuers will not be mandated to cover COVID-19 vaccines without cost-sharing even when provided by out-of-network providers.

None of this means coverage *must* change. It just means it is not mandated.

For Medicaid and Medicaid-managed care plans, coverage of coronavirus testing, including at-home, and

Monte Sandler is Chief Operating Officer of Experity.

COVID-19 treatment services without cost-sharing ends the last day of the first calendar quarter beginning 1 year after the end of the PHE (ie, September 30, 2024).

Beneficiaries in traditional Medicare and Medicare Advantage currently pay no cost-sharing for COVID-19 at-home testing, testing-related services, and certain treatments, including oral antiviral drugs like Paxlovid (nirmatrelvir tablets; ritonavir tablets). This all ends with the expiration of the PHE.

The government may continue to distribute free COVID-19 tests from the Strategic National Stockpile through the United States Postal Service, states, and other community partners while supplies last.

Medicaid Eligibility Ending

The Families First Coronavirus Response Act (FFCRA) prevented states from involuntarily removing anyone from coverage. To accomplish this, Congress boosted states' federal Medicaid match rates by 6.2 percentage points. While this was initially tied to the PHE, lawmakers changed that as part of the federal spending bill that passed in December.

As of April 1, 2023, states are able to start processing Medicaid redeterminations and disenrolling residents who no longer qualify for Medicaid. The plans will have 14 months to review the eligibility of their beneficiaries.

More than 92 million Americans were enrolled in Medicaid in December 2022. This is an increase of 31% since

February 2020, according to the most recent data available from the Centers for Medicare and Medicaid Services. A total of roughly 15 million people could be dropped from Medicaid when the continuous enrollment requirement ends, according to an analysis the Department of Health and Human Services released in August.

Here are examples of how two states will address this:

- Virginia Medicaid will send letters in the mail to current Medicaid members. These letters will contain information regarding their current health plan and, depending on their status, they may need to take further action. Medicaid members will need to update their mailing address and contact information.
- Texas Medicaid will handle this through an online portal. Medicaid members will receive a notice by mail, or email if they signed up to go paperless. The letter is from the Texas Health and Human Services Commission. It will be in a yellow envelope with the words ACTION REQUIRED in red. Beneficiaries will need to follow through on eligibility renewal instructions by visiting YourTexasBenefits.com.

Failure to complete these actions will result in loss of coverage. Temporary losses in coverage will occur. We should expect increased denials. It is imperative that practices check eligibility at time of service and make payment arrangements when appropriate. Patients may not be aware that they lost their coverage.

Telehealth

The Consolidated Appropriations Act, 2023 (CAA) extended expanded coverage for telehealth services through December 31, 2024. For Medicare and Medicare Advantage plans, these flexibilities include:

- Coverage in any geographic area, rather than patient's living in rural areas only.
- Patients can remain in their homes for telehealth, rather than needing to travel to a healthcare facility.
- Telehealth visits can be delivered via smartphone in lieu of equipment with both audio and video capability.
- The expanded list of Medicare-covered services that can be provided via telehealth will continue.
- Rural health clinics (RHC) can provide telehealth services as a distant site provider, rather than being limited to an originating site.

During the PHE, coverage and/or access to telehealth services were expanded for Medicaid and Medicaid Managed Plans in all 50 states and the District of Columbia (DC). States have broad authority to cover telehealth without federal approval, including flexibilities for allowable populations, services and payment rates, providers, technology, and managed care requirements. Changes will vary by state. Some may be tied to either the federal and/or state PHE. Most states have made, or plan to make, some Medicaid telehealth flexibilities permanent.

"Medicare never priced the CPT code and gave it a status of Bundled Code, so it was rarely paid. The elimination of its use should have no impact on urgent care."

All states and DC temporarily waived some aspects of state licensure requirements, so that providers with equivalent licenses in other states could practice via telehealth.

Changes to these waivers will also vary by state. In some states, these waivers are still active and tied to the end of the PHE; in others, they have expired. Some states have made allowances for long-term or permanent interstate telemedicine.

During the PHE, the U.S. Department of Health & Human Services waived penalties for HIPAA violations against healthcare providers who serve patients in good faith through everyday communications. This allowed for widely accessible services like FaceTime or Skype to be used for telemedicine purposes, even if the service is not related to COVID-19. This ends with the expiration of the PHE.

Also ending with the PHE is the ability of providers registered with the Drug Enforcement Administration to use telemedicine to issue prescriptions for controlled substances to patients without an in-person evaluation, if they meet certain conditions.

Emergency Use Authorizations (EUA)

An EUA is a mechanism to facilitate availability and use of medical countermeasures that are determined to be safe and effective but have not yet been formally approved by the U.S Food and Drug Administration. This allowed for expedited availability of laboratory tests, vaccines, and treatments related to COVID-19. This emergency declaration remains in effect until terminated by the Secretary of the Department of HHS (ie, not May 11, 2023, with the other declarations). So, the use of those tests, vaccines, and treatments that have not yet been officially approved may continue.

A declaration under the Public Readiness and Emergency Preparedness (PREP) Act provided liability immunity for activities related to the administration of covered

COVID-19 medical countermeasures, except for claims involving "willful misconduct." For a PREP Act emergency determination, HHS must specify an end date which, in this case, will be October 1, 2024, in most cases.

Coding

Any coding changes will be based on the date of service, so adjustments may be needed.

Requirements to report modifier CS will also no longer exist when the PHE ends.

CS Cost-sharing waived for specified COVID-19 testing-related services that result in an order for, or administration of, a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics and Federally Qualified Health Centers *during the COVID-19 public health emergency.*

This modifier should no longer be appended to evaluation and management codes starting May 12, 2023.

CPT 99072 will still be an active code but, with the end of the pandemic, the elements of the description of the code will not be met so it is no longer billable.

99072 Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other nonfacility service(s), when performed *during a Public Health Emergency*, as defined by law, due to respiratory-transmitted infectious disease

Medicare never priced the CPT code and gave it a status of Bundled Code, so it was rarely paid. The elimination of its use should have no impact on urgent care.

While the changes above stand as of this writing, Congress and states are considering legislation that may impact the dates quoted. Variances can be expected across states and health plans similar to 2020.

Let's hope the end of the PHE is easier than the beginning. ■

JUCM CAREERCENTER
THE JOURNAL OF URGENT CARE MEDICINE
Recruit Urgent Care Professionals online at JUCM CareerCenter
Tools for Employers
• Post Jobs Online
• Manage Resumes
• Track Job Performance
• Upgrade Opportunities
Post an Urgent Care Job Today!
Carissa Riggs
860-926-3498 | carissa.riggs@communitybrands.com