Telehealth Policy Update

2023 Consolidated Appropriations Act Extends Select Telehealth Flexibilities

Summary: The Consolidated Appropriations Act, 2023 (2023 CAA) (Public Law 117-328), signed into law on December 29, 2022, funds US government operations for fiscal year 2023 and provides roughly $1.7 trillion in overall spending. The 2023 CAA extends certain key telehealth flexibilities instituted during the public health emergency (PHE) through **December 31, 2024**, effectively untying these flexibilities from the continued existence of the PHE. The Consolidated Appropriations Act, 2022 (2022 CAA) (Public Law 117-103), enacted in March 2022, had previously extended many of these policies for 151 days (approximately five months) after the end of the PHE. While the 2023 CAA decouples the extension of many telehealth flexibilities from the PHE and provides extended coverage through December 31, 2024, other telehealth policies remain tied to the PHE and will expire if additional legislative or regulatory action is not taken. **The Administration announced on January 30, 2023, its intent to end the PHE on May 11, 2023**.

The charts below outline key 2023 CAA telehealth provisions within their broader policy context and highlight certain telehealth policies that require further action to be extended beyond the PHE or made permanent. For a detailed list of PHE-related telehealth flexibilities, see our previous analysis here. For a more detailed analysis of additional health-related provisions in the 2023 CAA, see our analysis here.

Action Needed: Additional legislative or regulatory actions are still required to ensure continued telehealth access for patients and providers after the PHE ends.

TELEHEALTH FLEXIBILITIES ADDRESSED IN THE 2023 CAA		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**2023 CAA PROVISION**
Qualifying Providers Medicare limits the types of healthcare providers eligible to provide telehealth services from a distant site to the following: ▪ Physicians ▪ Nurse practitioners ▪ Physician assistants ▪ Nurse-midwives ▪ Clinical nurse specialists	The Centers for Medicare & Medicaid Services (CMS) expanded the types of healthcare professionals that can furnish distant site telehealth services to include all providers that are eligible to bill Medicare for their professional services. The expanded list of healthcare providers includes the following (in addition to the providers listed in the left column): ▪ Physical therapists ▪ Occupational therapists	**Section 4113(b) of the 2023 CAA extends the expanded list of qualifying telehealth providers through December 31, 2024.** Note: Section 302 of the 2022 CAA had previously extended the expanded list of

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▪ Certified registered nurse anesthetists ▪ Clinical psychologists (CPs) and clinical social workers (CSWs) [Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or be reimbursed for CPT codes 90792, 90833, 90836 and 90838.] ▪ Registered dietitians and nutrition professionals.	▪ Speech language pathologists. Source: COVID-19 Emergency Declaration Blanket Waivers	qualifying telehealth providers for the 151-day period after the PHE ends.
Originating Site and Geographic Location Medicare requires that a beneficiary receive telehealth services at a designated healthcare facility or rural site (originating site) in certain geographic locations.	The originating site requirement is waived. Patients can be anywhere, including their home. Sources: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Sec. 102) Coronavirus Aid, Relief, and Economic Security (CARES) Act (Sec. 3703) FAQs	**Section 4113(a) of the 2023 CAA extends the waiver of the originating site and geographic location requirements through December 31, 2024.** Note: Section 301 of the 2022 CAA had previously extended the waiver of originating site and geographic restrictions for the 151-day period after the PHE ends.
Mental Telehealth Services: In-Person Requirement Before the PHE, telehealth treatment for substance abuse disorders (and co-occurring mental health disorders) was already exempted from the Medicare originating site and geographic restrictions. Telemental health treatment for other conditions, such as anxiety and depression, were not exempt from these restrictions.	In the Consolidated Appropriations Act, 2021 (2021 CAA), Congress removed geographic restrictions and added a Medicare beneficiary's home as a permissible originating site for the diagnosis, evaluation and treatment of a mental health disorder. Medicare beneficiaries can access telemental services from home for mental health needs in addition to substance use (and co-occurring mental health) disorders. However, Congress also imposed an **in-person requirement** for these flexibilities: the beneficiary must have an in-person visit with her healthcare provider within the six months prior to the	**Section 4113(d) of the 2023 CAA delays implementation of the in-person visit requirement through December 31, 2024, meaning that beneficiaries can continue to access telemental services from home until January 1, 2025, without needing to have an in-person visit with their provider before beginning treatment.** Note: Section 304 of the 2022 CAA had previously delayed implementation of the in-person visit requirement for telemental services for the 152-day period after the PHE ends. In the CY 2023 PFS final rule, CMS had aligned delay of

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	telemental treatment. The 2021 CAA also delegated authority to the US Department of Health and Human Services (HHS) Secretary to impose additional in-person requirements as deemed necessary. Under the 2021 CAA, the in-person requirement would become effective when the PHE ends.[1] The CY 2022 Physician Fee Schedule (PFS) final rule also requires that subsequent in-person visits be furnished at least every 12 months. There are certain exceptions, including a practitioner's determination (which must be documented in the patient's medical record) that the risks and burdens outweigh the benefits associated with furnishing the in-person visit. If the original practitioner who provided the telemental visit is unavailable, the in-person visit can be provided by the practitioner's colleague in the same subspecialty and within the same group. The CY 2023 PFS final rule delayed implementation of these additional requirements until the 152nd day after the PHE ends. Source: 2021 CAA (Sec. 123) CY 2022 PFS Final Rule CY 2023 PFS Final Rule	its additional in-person requirements with the 2022 CAA provisions. **As a result, while the statutory in-person requirement has now been delayed through December 31, 2024, via the 2023 CAA provisions, the CMS requirements are delayed only for the 152-day period after the PHE ends, leading to a potential misalignment of the statutory and regulatory in-person requirements.**
Originating Site Facility Fee Certain facilities (where the patient is located) qualify for a telehealth originating site facility fee. For CY	CMS pays a telehealth originating site facility fee to the hospital for Medicare beneficiaries receiving telehealth services in their home or other temporary expansion site **when the beneficiary's home or temporary expansion**	**Section 4113(a) of the 2023 CAA limits payment of this facility fee to the *original* originating sites (see far left column) from the end of the PHE through December 31, 2024. In other words, the originating site facility fee**

[1]Because Medicare beneficiaries could already access mental telehealth treatment for substance abuse (and co-occurring mental health) disorders regardless of their location prior to the PHE, these services are not subject to the CAA in-person requirement.

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2023, the rate is set at $28.64. Qualifying sites include the following: ▪ Physician and practitioner offices ▪ Hospitals ▪ Critical access hospitals (CAHs) ▪ Rural health clinics (RHCs) ▪ Federally qualified health centers (FQHCs) ▪ Hospital-based or CAH-based renal dialysis centers (including satellites) ▪ Skilled nursing facilities ▪ Community mental health centers ▪ Renal dialysis facilities ▪ Homes of beneficiaries with end-stage renal disease receiving home dialysis ▪ Mobile stroke units.	**site is a provider-based department (PBD) of the hospital, and the beneficiary is registered as an outpatient of the hospital** for purposes of receiving telehealth services billed by the physician or practitioner. Source: CMS Interim Final Rule (2)	**payment policy will revert to the pre-PHE policy for that period and will not include such locations as the patient's home or temporary expansion sites when the patient's home or temporary expansion site is a PBD of the hospital and the patient is a registered outpatient.** Note: Section 301 of the 2022 CAA had previously limited payment of the originating site facility fee to the original originating sites (see far left column) for the 151-day period after the PHE ends.
Audio-Only Telehealth Services Medicare typically does not cover certain services provided via telephone (audio-only).	CMS allows reimbursement for certain audio-only evaluation and management (E/M) telephone codes for new and established Medicare patients. Opioid treatment programs may also conduct therapy and counseling sessions through audio-only telephone calls. CMS increased payments for certain telephone E/M services (99441–99443) to match payments for similar office/outpatient visits (99212–99214). CMS also added these telephone E/M codes to the list of Medicare telehealth services. Because services on that list must be furnished using both audio and video, CMS waived requirements that these telephone E/M codes be provided using video. Sources: CMS Interim Final Rule	**Section 4113(e) of the 2023 CAA permits the provision of telehealth services through audio-only telecommunications through December 31, 2024.** Note: Section 305 of the 2022 CAA had previously directed the HHS Secretary to continue coverage of and payment for telehealth services furnished through audio-only telecommunications systems during the 151-day period after the PHE ends.

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	CMS Interim Final Rule (2) Note: In the CY 2022 PFS Final Rule, CMS amended the regulatory definition of "interactive telecommunications system" for purposes of Medicare telehealth services to include audio-only communication technology under certain circumstances for mental health services furnished to established patients in their homes. These services are subject to the same in-person visit requirements set forth by the 2021 CAA that apply to mental health services delivered via other types of telehealth when the patient is located in the home (see the Mental Telehealth Services - In-Person Requirement section for additional detail regarding these requirements and delays of implementation). Source: CY 2022 PFS Final Rule	
Federally Qualified Health Centers and Rural Health Clinics FQHCs and RHCs are prohibited from serving as distant site telehealth providers and therefore cannot qualify for the distant site payment. Reimbursable codes are limited in scope.	FQHCs and RHCs can be distant sites and can be reimbursed at an amount comparable to the PFS amount. CMS also expanded telehealth codes that FQHCs and RHCs may use for reimbursement and allows these to be applied to new and established patients. Sources: CARES Act (Sec. 3704) CMS Interim Final Rule	**Section 4113(c) of the 2023 CAA permits FQHCs and RHCs to continue providing telehealth services through December 31, 2024.** Note: Section 303 of the 2022 CAA had previously extended the flexibilities applied to FQHCs and RHCs as distant site providers of telehealth services for the 151-day period after the PHE ends, meaning that FQHCs and RHCs could still provide telehealth services to beneficiaries during that period.

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PRE-PHE POLICY	**POLICY DURING THE PHE**	**2023 CAA PROVISION**
Hospital at Home The Medicare hospital Conditions of Participation require hospitals to provide 24/7 nursing services to patients, and require a registered nurse be immediately available for patient care, onsite at the hospital. Source: 42 CFR §482.23(b) and (b)(1)	As part of the broader initiative to allow hospitals to provide care outside their walls and still receive hospital reimbursement rates for that care, CMS created the Acute Hospital Care at Home (AHCAH) program, which enables participating hospitals to provide inpatient-level care for certain specified conditions to patients in their homes. The AHCAH program allows hospitals to treat more than 60 different acute conditions, such as asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease, appropriately and safely in patients' homes with proper monitoring and treatment protocols. Source: Acute Hospital Care at Home Waiver Program	**Section 4140 of the 2023 CAA extends the current AHCAH program through December 31, 2024.**
***Health Savings Account (HSA)-Eligible High Deductible Health Plan (HDHP) Coverage of Telehealth Services** Prior to the PHE, enrollees in HSA-eligible HDHPs typically had to meet their deductible before certain telehealth services would be covered. *Note: This is not a Medicare issue.	The CARES Act created a safe harbor allowing HSA-eligible HDHP enrollees to have telehealth services covered on a first-dollar basis. In other words, enrollees did not need to meet their deductible before telehealth services would be covered. The statutory safe harbor was not tied to the PHE and expired on December 31, 2021. Section 307 of the 2022 CAA reinstated the safe harbor from April 1, 2022, through December 31, 2022. During this period, HSA-eligible HDHP enrollees again had telehealth services covered on a first-dollar basis without having to meet their deductible first. However, because the safe harbor originally expired on December 31, 2021, and the 2022 CAA extended coverage period began on April 1, 2022, there was a gap in coverage from January 1, 2022, through March 31, 2022. As a result, during that period, HDHPs could not provide telehealth services to participants who had not yet satisfied their minimum deductible ($1,400 for individuals and	**Section 4151 of the 2023 CAA extends the safe harbor period through December 31, 2024. This extension will allow HDHPs with plan years beginning after December 31, 2022, and before January 1, 2025, to rely on the safe harbor and continue coverage of telehealth services. Unlike the previous extension (see middle column), this extension does not create a gap in coverage. Therefore, HDHPs can continue to cover telehealth services on a first-dollar basis without disqualifying HDHP participants from making HSA contributions.** The Telehealth Expansion Act of 2023 (H.R. 1843/S. 1001) would make this change permanent.

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	$2,800 for families in 2022) without providing disqualifying coverage for HSA contributions. Source: CARES Act (Sec. 3701)	

TELEHEALTH FLEXIBILITIES NOT ADDRESSED IN THE CAA 2023	
TELEHEALTH FLEXIBILITY	**FURTHER ACTION REQUIRED**
Licensure During the PHE, CMS waived Medicare and Medicaid requirements that physicians and non-physician practitioners be licensed in the state where they are providing services when the following four conditions are met: ▪ The provider is enrolled as such in the Medicare program. ▪ The provider possesses a valid license to practice in the state that relates to the provider's Medicare enrollment. ▪ The provider furnishes services—whether in person or via telehealth—in a state in which the PHE is occurring in order to contribute to relief efforts in a professional capacity. ▪ The provider is not affirmatively excluded from practice in the state or in any other state that is part of the 1135 emergency area. Note: Practitioners must continue to comply with state licensure requirements. Sources: 1135 Waiver CMS Interim Final Rule	42 USC 1395m(m)(1) permits the Secretary to pay for telehealth services that are furnished by a "physician" or a "practitioner" as those terms are defined in 42 USC § 1395x(r) and 42 USC § 1395u(b)(18)(C), respectively. In turn, those statutory provisions require the provider to be "legally authorized" to practice the profession under state law, which would require compliance with state licensure requirements. Because the underlying requirement is set forth in statute and the authority to waive the requirement is similarly statutorily limited to periods of emergency, CMS would not be permitted to waive these licensing requirements more broadly without congressional action.
Home Dialysis During the PHE, the CARES Act provided the Secretary with the authority to waive the statutory requirement that a face-to-face evaluation be conducted before a beneficiary can begin home dialysis (codified at 42 USC § 1395rr(b)(3)(B)(iii)). Per regulation, a clinical examination of the patient's vascular access site must be furnished through a face-to-face encounter. During the PHE, CMS has allowed a telehealth encounter to replace the face-to-face evaluation for the clinical examination of the vascular access site for end-stage renal disease patients. Source:	Because face-to-face evaluations are a statutory requirement and the CARES Act only provides the Secretary with the authority to waive them during the PHE, Congress would have to pass additional legislation to make this change permanent. Unlike the home dialysis evaluation requirements, the face-to-face vascular access site examination requirement was promulgated via regulation and can similarly be removed via regulation. Additional regulatory action would be required to make the removal permanent.

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TELEHEALTH FLEXIBILITY	**FURTHER ACTION REQUIRED**
CARES Act (Sec. 3705)	
Hospital Without Walls Initiative During the PHE, CMS launched the Hospitals Without Walls Initiative, a broad range of waivers and flexibilities to allow hospitals to treat patients in alternate care settings outside the hospital, including the patient's home. CMS's waivers allow any non-hospital space to be used for patient care as long as the site is approved by the state and is consistent with the state's emergency preparedness or pandemic plan, to ensure patient and provider safety. CMS also issued broad waivers of Medicare coverage rules for services provided via telemedicine to enhance access to necessary care for hospital patients. These waivers have allowed services that would typically be provided in a hospital outpatient setting, such as cardiopulmonary rehabilitation services, to be provided via telemedicine while the patient is located in his home.	Because the Hospitals Without Walls Initiative flexibilities are regulatory waivers currently tied to the PHE and expire when the PHE does, congressional action could extend or make these flexibilities permanent.
Enforcement Discretion for Telecommunications Modalities During the PHE, the HHS Office for Civil Rights (OCR) has maintained a policy of enforcement discretion for telehealth providers, allowing telehealth providers to use a broader range of remote communications products even if those products do not fully comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. OCR recently clarified via an FAQs document that this enforcement discretion will remain in effect until the HHS Secretary declares that the PHE no longer exists or upon the expiration date of the declared PHE, whichever event occurs first. OCR will issue advance notice to the public before modifying its enforcement discretion policy. Sources: Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID–19 Nationwide Public Health Emergency FAQs on Telehealth and HIPAA during the COVID-19 Nationwide Public Health Emergency	On April 11, 2023, OCR issued guidance indicating this non-enforcement discretion will be extended for 90-days after the end of the PHE (through August 9, 2023). OCR indicated it is giving extra transition time for covered health care providers to come into compliance with HIPAA Rules when using telehealth services.
Controlled Substances Telehealth Prescribing During the PHE, providers have been able to prescribe controlled substances via telehealth without first conducting an in-person examination. This flexibility	On February 24, 2023, the US Drug Enforcement Administration (DEA) issued two proposed rules (the Telemedicine Controlled Substance Proposed Rule and the Telemedicine Buprenorphine Proposed Rule) that would establish additional potential pathways for the prescription of certain

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TELEHEALTH FLEXIBILITY	**FURTHER ACTION REQUIRED**
will expire when the PHE ends, requiring providers to adhere to stricter pre-PHE prescribing rules. In most cases, patients would again need to be located in a physician's office or a hospital registered with the US Drug Enforcement Agency (DEA) to be prescribed a controlled substance via telehealth.	controlled substances in limited quantities via telehealth without an initial in-person medical examination. As detailed in our analysis of the proposed rules shortly after their publication, the proposed rules would expand the use of telemedicine for prescribing controlled substances compared with pre-PHE requirements while simultaneously re-establishing certain barriers many patients face in accessing in-person care and the barriers that telehealth providers without physical practice locations face in providing care by requiring at least one in-person visit. More than 35,000 comments to the Telemedicine Controlled Substance Proposed Rule were posted on Regulations.gov. The timeline between the end of the comment period (March 31, 2023) and the end of the PHE (May 11, 2023) leaves a mere six weeks for DEA to digest comments, issue a final rule and make providers aware of new requirements that may be effective as early as May 11, 2023. Coupled with the volume of public comments, this compressed timeline will be a challenge for the DEA and providers, as well as patients, who are now awaiting the final rule.
Reimbursement of Medicare Telehealth Services Reimbursement of Medicare telehealth services that are not included in Categories 1, 2, or 3 of the telehealth reimbursement list will be allowed through December 31, 2023. Codes in Category 3 will also be reimbursable through December 31, 2023. Some Category 3 codes may eventually be incorporated into Category 1 (services that are similar to services already on the permanent telehealth list) or Category 2 (services for which there is sufficient evidence to show that the service can be provided safely and effectively via telehealth), allowing for permanent Medicare reimbursement. Source: CMS Update: List of Telehealth Services CY 2023 PFS Final Rule	Via rulemaking, CMS could extend the reimbursement period for services that are not included in Categories 1, 2, or 3 to align with 2023 CAA provisions, such that these services would be reimbursed through December 31, 2024. CMS could also align the reimbursement period of services currently included in Category 3 with the 2023 CAA extensions, such that Category 3 services would also be reimbursed through December 31, 2024.

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TELEHEALTH FLEXIBILITY	**FURTHER ACTION REQUIRED**
Direct Supervision – Virtual Presence Virtual presence for direct supervision is currently available through the end of the calendar year in which the PHE ends. Source: CY 2023 PFS Final Rule	CMS could make permanent the policy that virtual presence can satisfy direct supervision requirements via future rulemaking, or CMS could align virtual presence for direct supervision with the 2023 CAA extensions through December 31, 2024.
Telehealth as an Excepted Benefit Under ERISA Under current law, when telehealth or remote care services are provided by an employer, the benefit is considered a "group health plan" under ERISA, which triggers several mandates. If these mandates are unmet, the employer is subject to per-day, per-violation penalties, unless otherwise specified. Neither telehealth nor remote care services are currently included among the excepted benefits under ERISA. This prevents the employer from offering these services to all employees, not just full-time employees who elect coverage in an employer's plan. During the PHE, the US Departments of Labor, HHS and the Treasury have extended a nonenforcement policy that allows telehealth and remote care services to be treated as an excepted benefit. On June 23, 2020, the departments jointly issued an FAQ pertaining to the Families First Coronavirus Response Act, the CARES Act and other health coverage issues. The FAQ stated that the agencies would take a nonenforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan.	Congressional action is necessary to permanently allow telehealth to be considered an excepted benefit under ERISA. The Telehealth Benefit Expansion for Workers Act of 2023 (H.R. 824) would amend the Public Health Service Act, the Employee Retirement Income and Security Act of 1974, and the Internal Revenue Code of 1986 to treat telehealth services as excepted benefits.