Telehealth Policy Update

Omnibus Spending Package Extends Select Telehealth Flexibilities

Summary: The $1.5 trillion omnibus spending package, passed by the House on March 9, 2022, by the Senate on March 10, 2022, and signed into law by the President on March 15, 2022, extends certain telehealth flexibilities related to the public health emergency (PHE) for 151 days (approximately five months) after the PHE ends. While the legislation extends many key telehealth flexibilities, there are many telehealth waivers tied to the PHE that the legislation does not address. Additional work will still be required to ensure a smooth post-PHE telehealth transition.

The charts below outline key omnibus telehealth provisions within their broader telehealth policy context and telehealth flexibilities not addressed in the bill that would require further congressional action to be extended or made permanent. For a detailed list of PHE-related telehealth flexibilities, see our previous analysis.

TELEHEALTH FLEXIBILITIES ADDRESSED IN THE OMNIBUS BILL		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**OMNIBUS 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 ▪ 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.	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 ▪ Speech language pathologists. Source: COVID-19 Emergency Declaration Blanket Waivers	**Section 302: Extends the expanded list of qualifying telehealth providers**, to include the following, for the 151-day period after the PHE ends: ▪ Occupational therapists ▪ Physical therapists ▪ Speech language pathologists ▪ Audiologists.

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TELEHEALTH FLEXIBILITIES ADDRESSED IN THE OMNIBUS BILL		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**OMNIBUS PROVISION**
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 301: Extends the waiver of originating site and geographic restrictions** for the 151-day period after the PHE ends. Beneficiaries can still receive telehealth services from any site, including the home, during this period.
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, however, were not exempt from these restrictions.	In the Consolidated Appropriations Act, 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 telemental treatment. Under the 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. Sources: CAA (Sec. 123) CY 2022 PFS Final Rule	**Section 304: Delays implementation** of the in-person visit requirements for telemental services for a 152-day period after the PHE ends. In other words, the in-person visit requirement will not go into effect until approximately five months after the PHE ends.

[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.

TELEHEALTH FLEXIBILITIES ADDRESSED IN THE OMNIBUS BILL		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**OMNIBUS PROVISION**
Originating Site Fee Certain facilities (where the patient is located) qualify for a telehealth originating site fee. For CY 2022, the rate is set at $27.59. 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 (SNFs) ▪ Community mental health centers ▪ Renal dialysis facilities ▪ Homes of beneficiaries with end-stage renal disease (ESRD) receiving home dialysis ▪ Mobile stroke units.	CMS pays a telehealth originating site fee to the facility for Medicare beneficiaries receiving telehealth services in their home or other temporary expansion site, if the beneficiary's home or temporary expansion site is a provider-based department 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)	**Section 301: Limits payment of this facility fee** to the original originating sites (see far left column) for the 151-day period after the PHE ends. In other words, the originating site facility fee payment policy reverts to the pre-PHE policy for this period. **Note:** This provision does not appear to address the payment rate policy for facility versus non-facility distant site provider locations. It only addresses the facility fee payment policy for originating site providers. Prior to the PHE, telehealth services were typically paid at the (lower) facility rate, regardless of the provider type. For example, services provided by a physician's office (non-facility provider) would still be reimbursed at the (lower) facility rate. During the PHE, CMS has paid the (higher) non-facility rate even when the services are provided by non-facility locations (*e.g.*, a physician's office).
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	**Section 305: Directs the HHS Secretary to continue coverage and payment for telehealth services furnished through audio-only** telecommunications systems during the 151-day period after the PHE ends.

TELEHEALTH FLEXIBILITIES ADDRESSED IN THE OMNIBUS BILL		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**OMNIBUS PROVISION**
	video, CMS waived requirements that these telephone E/M codes be provided using video. Sources: CMS Interim Final Rule 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 CAA and the CY 2022 Final Rule 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). Source: CY 2022 PFS Final Rule	
Federally Qualified Health Centers and Rural Health Clinics Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (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 will allow these to be applied to new and established patients. Sources: CARES Act (Sec. 3704) CMS Interim Final Rule	**Section 303: Extends the flexibilities applied to FQHCs and RHCs** as distant site providers of telehealth services for the 151-day period after the PHE ends. FQHCs and RHCs can still provide telehealth services to beneficiaries during that period.

TELEHEALTH FLEXIBILITIES ADDRESSED IN THE OMNIBUS BILL		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**OMNIBUS PROVISION**
***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 would 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. Source: CARES Act (Sec. 3701)	**Section 307: Reinstates the safe harbor from April 1, 2022 through December 31, 2022.** During this period, HSA-eligible HDHP enrollees will again have telehealth services covered on a first-dollar basis, without having to meet their deductible first. **Note:** Because the safe harbor expired on December 31, 2021, and the new coverage period begins on April 1, 2022, there is currently a gap in coverage from January 1, 2022 through March 31, 2022.

TELEHEALTH FLEXIBILITIES NOT ADDRESSED IN THE OMNIBUS BILL THAT WOULD REQUIRE ADDITIONAL CONGRESSIONAL ACTION		
PRE-PHE POLICY	**POLICY DURING THE PHE**	**FURTHER ACTION REQUIRED**
Licensure Medicare requires that providers be licensed in the state in which the patient is located. Medicaid requirements vary by state.	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 statutory action.
Home Dialysis Home dialysis requires face-to-face evaluation of the patient. Clinical examination of the vascular access site must be furnished through a face-to-face encounter.	The CARES Act waived the face-to-face requirement during the PHE. CMS allows a telehealth service to replace the face-to-face encounter for the clinical examination of the vascular access site for ESRD. Source: CARES Act (Sec. 3705)	The CARES Act provided the Secretary with the authority to waive the statutory requirement for a nephrologist to conduct a face-to-face evaluation of a home dialysis patient during the PHE (codified at 42 USC § 1395rr(b)(3)(B)(iii)). Because face-to-face visits 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.