ALLIANCE for CONNECTED CARE

COVID-19 Public Health Emergency Flexibilities

Updated February 22, 2023

Federal emergency powers generally stem from three key laws:

- The Public Health Service Act (PHSA);
- The National Emergencies Act (NEA); and
- The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).

Section 319 of PHSA allows the Department of Health and Human Services (HHS) Secretary to determine that "a public health emergency" exists and "take such actions as may be appropriate to respond to the public health emergency." The Declaration of a public health emergency (PHE) triggers executive powers, including authorizing the Secretary of HHS to waive or modify certain requirements of Medicare, Medicaid, Children's Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA), and other provisions related to certification or licensing of health care providers, sanctions related to physician referrals, deadlines, and other penalties.

The NEA provides a framework to apply when the President seeks to leverage certain powers or authorities during a national emergency. Regarding healthcare authorities, to establish waivers under Section 1135 of the Social Security Act, the HHS Secretary must declare a PHE ***and*** the President must declare a national emergency under the NEA or Stafford Act.

- A PHE under the PHSA was declared in January 2020 as a result of confirmed cases of 2019 Novel Coronavirus (COVID-19). Since then, the PHE Declaration has been renewed quarterly, and was most recently renewed on **January 11, 2023.**
- In March 2020 a national emergency was declared pursuant to the NEA and under Section 501(b) of the Stafford Act. In February 2022, the national emergency under NEA and Stafford were again extended beyond the previous expiration date of March 1, 2022. The emergency currently expires March 1, 2023.
- On January 30, 2023 a White House Statement of Administration Policy announced May 11, 2023 as the end date for **both** the COVID-19 national emergency and the public health emergency.

Below, we have compiled a list of key telehealth or related flexibilities or requirements that were authorized by HHS or the Centers for Medicare and Medicaid Services (CMS) using existing emergency authority or newly created by Congress through the course of the COVID-19 PHE. Many of the flexibilities are tied to the PHE and the national emergency declaration and will conclude with the termination of either. The exceptions are any provisions with differing timelines as mandated by statute and any policy changes implemented through interim final rules or administrative discretion (outlined on pages 9-11).

Note that the *Consolidated Appropriations Act of 2022*, which was signed into law on March 15, 2022 amended the sunset date for many flexibilities, including for telehealth. Additionally, the *Consolidated Appropriations Act of 2023*, which was signed into law on December 29, 2022, also amended the sunset date for several flexibilities, extending major telehealth flexibilities through December 31, 2024. End dates for each of the provisions listed are added in **red**, below.

Updated March 1, 2023

Policy Area	Authority	Flexibility	Original Authorizing Language/Description	Timing /Notes
Telemedicine	Section 1135 Waiver Authority	*Overview of 1135*	When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his/her regular authorities. For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure: - Sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods - Providers who give such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).	CMS Overview of Section 1135 Waivers; CRS Report
		Medicare: Waiver of Originating Site for Telehealth Reimbursement	Section 1135(b)(8), as added by the CARES Act, gives the Secretary the authority to waive requirements of 1834(m) for telehealth services furnished in any emergency area (or portion of such area) during any portion of any emergency period. Note: The Consolidated Appropriations Act of 2022 (P.L. 117-103) amended the current originating site definition and expanded it to mean any site in the United States at which the eligible telehealth individual is located at the time the service us furnished via a telecommunications system (without geographic restriction). There is also no facility fee.	Extended through December 31, 2024 as a result of the Consolidated Appropriations Act (CAA), 2023. Statute; HHS List of Telehealth flexibilities
		Medicare: Qualifying Providers	CMS waved the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. Note: The Consolidated Appropriations Act of 2022 (P.L. 117-103) temporarily added qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists as eligible providers to provide telehealth services.	Extended through December 31, 2024 as a result of the CAA 2023. Guidance; Billing Guidance
		Medicare: Payment Rates	Medicare pays the same amount for telehealth services as it would if the service were furnished in person. The telehealth waiver will be effective until the end of the PHE declared by the Secretary of HHS on January 31, 2020. Billing for the expanded Medicare telehealth services, as well as for the telephone assessment and management, telephone, evaluation and management services, and additional flexibilities for communications technology-based services (CTBS) are effective beginning March 1, 2020, and through the end of the PHE.	Will be extended through December 31, 2024 as a result of the CAA 2023. Tied to the PHE. Billing Guidance
		Medicare: Covered Services	CMS notes that under the emergency declaration and 1135 waivers, Medicare telehealth services include many services that are normally furnished in-person. These services are described by HCPCS codes and	Extended through December 31, 2024

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			paid under the Physician Fee Schedule. These services may be provided to patients by physicians and certain non-physician practitioners regardless of the patient's location.	as a result of the CAA 2023. Tied to the PHE. Billing Guidance
		Medicare: Audio Only	CMS waived the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone E&M services, and behavioral health counseling and educational services • Medicare payment for the telephone evaluation and management visits (CPT codes 99441-99443) is equivalent to the Medicare payment for office/outpatient visits with established patients effective March 1, 2020. After the PHE ends, the Consolidated Appropriations Act, 2023 provides for an extension for this flexibility through December 31, 2024. • When clinicians have furnished an evaluation and management (E/M) service that otherwise would have been reported as an in-person or telehealth visit, using audio only technology, practitioners have been able to bill using these telephone E/M codes provided that it is appropriate to furnish the service using audio-only technology and all of the required elements in the applicable telephone E/M code (99441-99443) description are met. After the PHE ends, the Consolidated Appropriations Act, 2023 extends availability of the telehealth services that can be furnished using audio-only technology through December 31, 2024.	Extended through December 31, 2024 as a result of the CAA 2023. Clinician guidance; General guidance; Billing FAQ
		Medicare: Direct Supervision	CMS notes that for the duration of the PHE, it has revised the definition of direct supervision to include a virtual presence through the use of interactive telecommunications technology, for services paid under the Physician Fee Schedule as well as for hospital outpatient services. The revised definition of direct supervision also applies to pulmonary, cardiac, and intensive cardiac rehabilitation services during the PHE. Additionally, CMS changed the supervision requirements from direct supervision to general supervision, and to allow general supervision throughout hospital outpatient non-surgical extended duration therapeutic services. General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. General supervision may also include a virtual presence through the use of telecommunications technology but CMS notes that even in the absence of the PHE general supervision could be conducted virtually, such as by audio-only telephone or text messaging. The changes to supervision rules are effective for services beginning March 1, 2020, and last for the duration of the COVID-19 Public Health Emergency. In the 2023 PFS, CMS noted that this flexibility is currently set to return to pre-PHE rules at the end of the calendar year that the PHE ends. Additionally, CMS notes that it plans to continue to gather information on this topic. Additional guidance can be found here.	Still a temporary flexibility, but extended through CY2023 through the PFS. Billing Guidance

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			Special provision for teaching physicians: After the PHE, only teaching physicians in residency training sites located outside of a metropolitan statistical area may meet the presence for the key portion requirement through audio/video real-time communications technology. After the PHE, teaching physicians can bill for levels 4-5 of an office/outpatient evaluation and management (E/M) visit furnished by residents in these primary care centers only when the teaching physician is physically present for the key portion of the service. *Special provision for behavioral health:* In the 2023 PFS, CMS finalized its proposal to allow general supervision (including through telehealth) under the incident-to billing regulation for behavioral health services. *Special provisions for CPT Code 99211* – CMS specified that the level one E/M visit can be billed when clinical staff assess a patient and collect a specimen for a COVID-19 diagnostic test for both new and established patients. After the PHE, the usual requirement for billing the level one E/M code (when clinical staff perform services incident to the services of the billing physician or practitioner for an established patient) apply (2/1/2023 Physician Guidance).	Teaching Hospital Guidance Permanent Special supervision provisions for 99211 ends with PHE
		Medicare: Established Patient Requirement	To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. CMS will make payments for telehealth services furnished to both new and established patients for the duration of the PHE. Starting March 1 and for the duration of the PHE, RPM services can be furnished to both new and established patients. CMS ordinarily requires an initiating visit for RPM services, similar to other care management services, but this requirement may be satisfied via a telehealth visit. Regardless, for the duration of the PHE, CMS is not requiring patients to be established patients in order to receive RPM services. Patients that receive RPM services can be established or new. When the PHE ends, clinicians must once again have an established relationship with the patient prior to providing RPM services (2/1/2023 Physician Guidance).	Tied to the PHE, ends May 11, 2023. Fact Sheet; Billing Guidance
		Medicare: Provider Address/ Enrollment	CMS waived requirements to allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. The waiver will continue through December 31, 2023. Care Compare - Providers who have concerns with their practice location information being displayed publicly can contact Care Compare at: QPP@cms.hhs.gov to provide an alternate address or have their home address suppressed. This is a temporary approach. Moving forward, CMS is in the process of updating CMS-8551 enrollment forms to allow providers to	The waiver will continue through December 31, 2023. Guidance

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			indicate a clinical, administrative, or home address location -- enabling segmentation of that information that should not be disclosed publicly (e.g. via Physician Compare).	
		Medicare: Acute Hospital Care at Home Waiver	The CAA, 2023 amended and extended the Acute Hospital Care at Home Initiative, as currently authorized under CMS waivers and flexibilities, through December 31, 2024. This includes the waiver of telehealth requirements under the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, Strengthening Public Health Act of 2022, such that an originating site shall include the home or temporary residence of the individual.	Extended through December 31, 2024 as a result of the CAA 2023.
		Medicare: Licensure	CMS waived requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS allowed licensed physicians and other practitioners to bill Medicare for services provided outside of their state of enrollment. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state, which relates to his or her Medicare enrollment; 3) is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area. *Note that this provision does not change state law requirements – many of which have reverted to pre-pandemic status.* CMS has determined that, when the PHE ends, CMS regulations will continue to allow for a total deferral to state law. Thus, there is no CMS-based requirement that a provider must be licensed in its state of enrollment (2/1/2023 Guidance).	Tied to the PHE, will end May 11, 2023. Guidance
	PREP Act	Licensure	The 2005 Public Readiness and Emergency Preparedness Act (PREP Act) authorizes HHS to make declarations that provide immunity from liability in certain emergency circumstances. On December 3, 2020, HHS published Amendment 4 to the PREP Act to preclude state and local governments from enforcing more restrictive policies that keep "qualified persons" from administering countermeasures recommended by a PREP Act declaration. Specifically, this allows for interstate practice of telemedicine to improve public health outcomes in an emergency. This amendment provides liability protection when delivering specific COVID-19 related services, expands telehealth access, and makes it easier to treat and prevent COVID-19. PREP Act immunity is tied to the PREP Act Declaration, rather than the PHE Declaration, and the White House's announcement therefore does not impact the protections offered under the PREP Act. While the PREP Act Declaration and its liability protections are effective until either (1) the PREP Act Declaration is formally revoked; or (2) October 1, 2024, it does not appear that the protections under this amendment apply and therefore will end with the PHE. See here for PREP Act guidance.	Tied to the PHE, will end May 11, 2023. Notice of 4th Amendment

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	CARES Act & Enforcement Discretion	Pre-deductible Coverage of Telehealth for HDHP Plans	Under the CARES Act, a high deductible health plan (HDHP) temporarily can cover telehealth and other remote care services without a deductible, or with a deductible below the minimum annual deductible otherwise required by law. Telehealth and other remote care services also are temporarily included as categories of coverage that are disregarded for the purpose of determining whether an individual who has other health plan coverage in addition to an HDHP is an eligible individual who may make tax-favored contributions to his or her HSA. Thus, an otherwise eligible individual with coverage under an HDHP may still contribute to an HSA despite receiving coverage for telehealth and other remote care services before satisfying the HDHP deductible, or despite receiving coverage for these services outside the HDHP. CMS will not take enforcement action against any health insurance issuer that amends its catastrophic plans to provide pre-deductible coverage for telehealth services, even if the specific telehealth services covered by the amendment are not related to COVID-19. This enforcement discretion will also apply for the period during which either the COVID-19 public health emergency declaration or national emergency declaration is in effect. CMS would continue to take enforcement action against any health insurance issuer that attempts to limit or eliminate other benefits under a catastrophic plan to offset the costs of providing pre-deductible coverage for telehealth services.	Extended through December 31, 2024 as a result of CAA 2023. *CMS enforcement discretion ongoing.*
		Telehealth as an Excepted Benefit	On June 23, 2020, the Departments of Labor, HHS and Treasury jointly issued an FAQ pertaining to the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security (CARES) Act and other health coverage issues. Specifically, it stated that the agencies would take a non-enforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan for the duration of the PHE. This allowed employers to offer stand-alone telehealth benefits in addition to traditional health care plans, enabling workers such as seasonal and part-time workers to access telehealth benefits. The treatment of telehealth services as an excepted benefit is temporary and will expire at the end of the PHE on May 11, 2023 without action by Congress.	Tied to PHE, ends May 11, 2023. FAQ
	Enforcement Discretion	HIPAA	During the pandemic, Medicare-covered providers were able to use any non-public facing application to communicate with patients without risking any federal penalties, even if the application wasn't in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HHS Office for Civil Rights (OCR) exercised its enforcement discretion to not impose penalties for noncompliance with the regulatory requirements under the HIPAA Privacy, Security and Breach Notification Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This flexibility will end at the end of the PHE on May 11.	Tied to PHE, ends May 11, 2023. Guidance; OCR will maintain discretion through the PHE.

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			OCR has issued guidance to help health care providers and health care plans bound by HIPAA Rules understand how they can use remote communication technologies for audio-only telehealth post-COVID-19 public health emergency.	
		Cost-Sharing Waiver	Ordinarily, if physicians or practitioners routinely reduce or waive costs owed by Federal health care program beneficiaries, including cost-sharing amounts such as coinsurance and deductibles, they would potentially implicate the Federal anti-kickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries. OIG issued a policy statement notifying providers that it will not enforce these statutes if providers choose to reduce or waive cost-sharing for telehealth visits during the COVID-19 PHE.	Tied to PHE, ends May 11, 2023. Policy Statement, Fact Sheet
		Individual and Group Markets – Mid-Year Changes	Issuers in the individual and group markets are generally not permitted to modify a health insurance product mid-year. However, to facilitate the nation's response to COVID-19, CMS will not take enforcement action against any health insurance issuer in the individual or group market that makes mid-year changes to the health insurance product to provide greater coverage for telehealth services or to reduce or eliminate cost-sharing requirements for telehealth services, even if the specific telehealth services covered by the change are not related to COVID19.	Tied to the PHE, ends May 11, 2023. Guidance
	Consolidated Appropriations Act, 2022	*Medicare*: FQHCs and RHCs	CAA 2022 initially amended Section 1834(m)(8) of the Social Security Act (42 U.S.C. 1395m(m)(8) to extend the CARES Act telehealth payment structure for federally qualified health centers (FQHCs) and rural health clinics (RHCs) for 151 days after the PHE ends. CAA 2023 extended this flexibility through December 31, 2024.	Extended through December 31, 2024 as a result of the CAA 2023.
		Medicare: In-person requirement for mental health	Section 1834(m)(7)(B)(i) of the Social Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is amended to delay the in-person requirements under Medicare for mental health services furnished through telehealth and telecommunications technology for 151 days after the PHE ends, until the day that is the 152 day after the end of the emergency period. In-person requirements for rural health clinics and federally qualified health centers shall not apply prior to the day that is the 152 day after the end of the PHE.	Extended through December 31, 2024, as a result of the CAA 2023.
		Medicare: Hospice recertification	Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)) is amended to extend the CARES Act provision allowing for the use of telehealth to conduct face-to-face encounters prior to recertification of eligibility for hospice care during an emergency period for 151 days after the end of the PHE.	Extended through December 31, 2024 as a result of the CAA 2023.
	Other	Prescribing Controlled Substances	While a prescription for a controlled substance issued by means of the Internet (including telemedicine) must generally be predicated on an in-person medical evaluation (21 U.S.C. 829(e)), the Controlled Substances Act contains certain exceptions to this requirement. One such exception occurs when the Secretary of Health and Human Services has declared a public health emergency under 42 U.S.C. 247d (section 319 of the Public Health Service Act), as set forth in 21 U.S.C. 802(54)(D). Secretary Azar declared such a public health emergency with regard to COVID-19 on January 31, 2020. On March 16, 2020, the Secretary, with the concurrence of the Acting DEA Administrator, designated that the telemedicine allowance under section 802(54)(D) applies to all schedule II-V controlled substances in all areas of the United States. Accordingly, as of March 16, 2020, and continuing for as long as the Secretary's	Tied to the PHE, ends May 11, 2023. Information; Buprenorphine Guidance *Note that while this is currently a PHE*

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			designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met: - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and - The practitioner is acting in accordance with applicable Federal and State laws. Additionally, qualifying practitioners can prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation Drug Enforcement Administration March 1, 2023 Notice of Proposed Rulemaking Summary	*flexibility, permanent statutory authority exists under the SUPPORT Act (Public Law 115-271, Section 3232)* *Rulemaking announced on March 1 that would end most flexibility.*
	State Authority	Medicaid	CMS issued guidance to states encouraging them to use existing authority to expand access to telehealth services under their Medicaid and CHIP programs. CMS notes that states are not required to submit a SPA to pay for services delivered via telehealth if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting. States may submit a coverage SPA to describe services delivered via telehealth and would need an approved state plan payment methodology to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face setting. During the PHE, 51 states issued guidance to expand coverage and/or access to telehealth and introduced licensure flexibility; 43 have payment parity for at least some services; 20 issued guidance to waive or lower telehealth copays. Several states have begun to roll back their emergency declarations and state telehealth flexibilities.	Guidance; Fact Sheet; FAQs; Informational Bulletin
Medicare Provider Enrollment & Appeals	Section 1135/ Section 1812(f)	Medicare	**Non-Waiver CMS Action:** CMS has a toll-free hotline for physicians and non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges. - Allow licensed providers to render services outside of their state of enrollment. - Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. As noted above, this waiver will continue through December 31, 2023.	Tied to the PHE, ends May 11, 2023. Guidance The location flexibility will continue through December 31, 2023. Guidance
Permissive Actions for	Enforcement Discretion	MA, Part D, and Medicare-	On January 14, 2022, CMS informed MA Organizations, Part D sponsors, and Medicare-Medicaid Plans that they will extend the flexibilities discussed in the December 28, 2020, HPMS memo titled "Contract Year 2021 Coronavirus Disease 2019 (COVID-19) Permissive Actions FAQ" in contract year 2022. CMS will	CMS stated they will continue these flexibilities for the

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Managed Care Orgs		Medicaid Plans	continue these flexibilities for the duration of the COVID-19 Public Health Emergency (2/1/2023 MA and Part D Guidance). Flexibilities discussed in the memo referenced above include: - CMS will continue its policy of relaxed enforcement in connection with the prohibition on mid-year benefit enhancements. - CMS will continue to allow MAOs to waive or reduce enrollee cost-sharing for beneficiaries enrolled in their Medicare Advantage plans who are impacted by the outbreak as outlined in the May 22, 2020 HPMS memo, where the waiver or reduction in cost-sharing is tied to the COVID-19 outbreak. - CMS will continue to exercise its enforcement discretion regarding the administration of MAOs' plan benefit packages as approved by CMS until it is determined that the exercise of this discretion is no longer necessary in conjunction with the COVID-19 outbreak. - CMS will continue to take these special circumstances presented by the COVID-19 outbreak into account when conducting MOC monitoring or oversight activities. - CMS will continue to allow MAOs to implement a Rewards and Incentive Program for enrollees in connection with the COVID-19 outbreak, as previously stated in the set of questions and answers published on May 13, 2020 under the title "Updated Guidance for Medicare Advantage Organizations." - CMS will continue its policy of relaxed enforcement in connection with actions Part D sponsors deem reasonable and necessary to keep their enrollees and employees safe and curb the spread of the virus, while still ensuring beneficiary access to needed Part D drugs (as referenced in the section titled "Additional Flexibilities" in the May 22, 2020 HPMS memo, "Information Related to Coronavirus Disease 2019 - COVID-19") for the duration of the COVID-19 PHE. - CMS will continue its policy of relaxed enforcement in connection with prospective waivers or reductions of Part C and Part D premiums referenced in the October 15, 2020 HPMS memo, "Waiver of Premiums Related to COVID-19 Permissive Actions – Questions and Answers," for the duration of the PHE.	duration of the COVID-19 Public Health Emergency through May 11. 2023. HPMS Memo to MA plans, Part D sponsors, and Medicare-Medicaid plans; HPMS on other permissible flexibilities
Medicaid Section 1135 Waivers	Section 1135	Provider Qualification & Enrollment	During the PHE, states may request 1135 waiver flexibility for the following circumstances: - Permit out-of-state providers with equivalent licensing in another state to provide care to another state's Medicaid enrollee impacted by the emergency. - Allow service provision in alternative settings, including unlicensed facilities. - Modify clinic facility requirements to allow services to be provided from practitioner's location via telehealth and/or in alternative settings, such as beneficiaries' homes, outdoors, schools, or other community-based locations. The Secretary of the Department of Health and Human Services (HHS) ability to use 1135 waivers will end along with the declared national emergency.	Tied to the PHE emergency, will end May 11, 2023. Medicaid.gov Section 1135 COVID-19 Request Template and Guidance, approved 1135 waiver applications posted on the Federal

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			During the PHE, CMS issued guidance to states encouraging them to use existing authority to expand access to telehealth services under their Medicaid and CHIP programs. However, in a fact sheet, shared alongside a letter to Governors, HHS Secretary Becerra clarified that "this flexibility was available prior to the COVID-19 PHE and will continue to be available after the COVID-19 PHE ends."	Disaster Resources page of Medicaid.gov.

Appendix I – Timeline of Key Dates

Below is a table that summarizes the various telehealth policies currently in place and their expected end dates based on the differing timelines as mandated by statute and any policy changes implemented through interim final rules or administrative discretion.

May 11, 2023	October 11, 2023	December 31, 2023	December 31, 2024	Permanent
Prescribing Controlled Substance via Telemedicine				
Established Patient Requirements				
Cost-Sharing Waiver				
HIPAA				
Individual and Group Markets				
Managed Care Organizations				
Medicaid Section 1135 Waivers				
State Licensure Flexibilities				
Telehealth as an Excepted Benefit				
Service Codes Allowed During COVID-19 PHE				
Codes Added to Medicare Telehealth Services List on a Category 3 Basis				
Direct Supervision				
Facility Fee Rate				
Provider Address/Enrollment				
Removing Geographic Requirements and Expanding Originating Sites for Telehealth Services				
Expanding Practitioners to Furnish Telehealth Services				
Expanding Telehealth Services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)				
Delaying the In-Person Requirements Under Medicare for Mental Health Services Furnished Through Telehealth and Telecommunications Technology				
Allowing for the Furnishing of Audio-Only Telehealth Services				
Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care During Emergency Period				
Extension of HDHP-HSA Safe Harbor for Absence of Deductible for Telehealth				
Extending Acute Hospital Care at Home Waivers and Flexibilities				
Audio-only Telehealth for Mental Health in Certain Circumstances				
Buprenorphine Prescribing via Telemedicine for Opioid Treatment Programs (OTP)				
State Authority through Medicaid				
General Supervision Under Incident-to Billing for Behavioral Health				

Appendix II - Recognizing that additional context is helpful for some of these areas, below is a few noted telehealth-related policies outside federal emergency powers with indicated deadlines in red:

- *Service Codes Allowed During COVID-19 PHE*
  - On February 13, 2023, CMS released an updated list of services payable under the Medicare Physician Fee Schedule to clarify that the services will be available through the end of CY 2023 (December 31, 2023). CMS anticipates addressing updates to the list for CY 2024 and beyond through the CY 2024 Physician Fee Schedule rules. (During the COVID-19 PHE, CMS notes that under the emergency declaration and 1135 waivers, Medicare telehealth services include many services that are normally furnished in-person. These services are described by HCPCS codes and paid under the Physician Fee Schedule. These services may be provided to patients by physicians and certain non-physician practitioners regardless of the patient's location.)[1]
- *Facility Fee Rate*
  - In the 2023 PFS, CMS abandoned its proposal to pay telehealth at the facility rate following the 151-day period. It finalized a proposal to continue to allow for payment be made for Medicare telehealth services at the rate that ordinarily would have been paid under the PFS if the services were furnished in-person, through the latter of the end of the of CY 2023 or the end of the calendar year in which the PHE ends (December 31, 2023).

[1]This is an update from the 2023 PFS, where CMS finalized its proposal to continue to include on the Medicare Telehealth Services List the services that are currently set to be removed from the list when the PHE ends (that is, those not currently added to the list on a Category 1, 2, or 3 basis) for the 151-days after the PHE ends. These changes may have been made in response to an Alliance letter to CMS urging CMS to preserve beneficiary access to telehealth services.