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Making Telehealth Flexibilities Permanent: Legislation or Regulation?

The list below represents what actions would be necessary to maintain or extend telehealth flexibilities that were implemented during the COVID-19 public health emergency.

Legislation

Telehealth Flexibility	Detail
Provider/patient location	
Geographic and originating site requirements. During the PHE, providers may deliver telehealth services to patients in their homes and other locations and in any area of the country (waiver of the geographic and originating site requirements).	Section 1834(m) of the Social Security Act (the Act) restricts the delivery of telehealth services to certain rural areas of the country (geographic site restrictions) and certain physical locations such as hospitals and physicians' offices (originating site restrictions). Section 3703 of the CARES Act (H.R. 748) gave the Secretary the authority to waive this and all other requirements of Sec. 1834(m) during the PHE. Legislation would be required to permanently remove these restrictions from statute.
Eligible providers and facilities	
RHCs and FQHCs. During the PHE, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) may serve as distant sites for the provision of telehealth services.	This flexibility was established in Section 3704 of the CARES Act (H.R. 748), which added a paragraph to Section 1834(m) instructing the Secretary to pay for telehealth services that are furnished via a telecommunications system by an FQHC or an RHC, subject to certain requirements. Legislation would be required to permanently retain the ability of RHCs and FQHCs to serve as distant sites for the provision of telehealth services,
Additional practitioners. During the PHE, all health care professionals who are eligible to bill Medicare for their professional services (including physical therapists, occupational therapists, speech language pathologists, and others) may deliver and bill for services provided via telehealth.	Section 1834(m)(4)(E) limits payment for telehealth services to physicians and a limited set of non-physician practitioners under the Medicare physician fee schedule. In its general waiver document, CMS used its authority under the CARES Act to waive this limitation so as to expand the types of health care professionals that can furnish distant site telehealth services. A change in legislation would be necessary to permanently allow this expanded list of providers to deliver and bill for telehealth services or to give the Secretary authority to determine

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Telehealth Flexibility	Detail
	which practitioners may deliver and bill for different telehealth services.
Hospital outpatient billing for telehealth. During the PHE, hospitals, including critical access hospitals (CAH), may bill the outpatient perspective payment system (OPPS) or otherwise applicable payment system for therapy, education and training services furnished remotely by hospital clinical staff to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital. Examples of such services include counseling, psychotherapy, group therapy and partial hospitalization program services.	Section 1834(m)(1) limits payment for telehealth services to physicians and a limited set of non-physician practitioners under the Medicare physician fee schedule. In CMS-5531-IFC, published in the Federal Register on May 8, CMS used its waiver authority to overcome this limitation by enabling hospital clinical staff to meet through telehealth the requirements of delivering certain outpatient services (subject to certain restrictions). This change allows hospital outpatient departments (HOPDs) to bill for services as if they were delivered in person. However, to permanently allow HOPDs to bill the OPPS or CAHs to use Method I billing for telehealth services, a change in legislation would be necessary, either to codify this in statute or to give the Secretary authority to determine which providers may deliver and bill for different telehealth services.
Types of services	
Audio-only communication. During the PHE, providers may deliver certain Medicare telehealth services via audio-only communication.	CMS has interpreted the Section 1834(m) description of telehealth services as "services that are furnished via a telecommunications system" to indicate that Medicare telehealth services must be furnished using video technology. CMS used its authority during the COVID-19 pandemic to waive this requirement for a subset of Medicare telehealth services (including some of those that were newly added during the pandemic). However, permanently allowing those and any other services to be delivered via audio-only connection would require legislation, either to codify in statute that telecommunications services can, in certain instances, include audio-only communication or to give the Secretary authority to allow certain services to be delivered via audio-only connection.
Hospice and home health face-to-face requirements. During the PHE, allow to be performed via telehealth (1) the face-to-face visit for the purpose of recertification of Medicare hospice services and (2) the home health face-to-face encounter.	The flexibility for hospice face-to-face requirements to be met via telehealth is found in Section 3706 of the CARES Act (H.R. 748). The corresponding flexibility for home health services is found in CMS's FAQ document. A statutory change would be needed to remove the Affordable Care Act mandate requiring a face-to-face encounter by a physician to certify a patients' need for

Telehealth Flexibility	Detail
	home health services. [Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act; 42 CFR § 424.22(a)(1).]
Hospice and home health delivery of care. During the PHE, allow professionals that provide home health and hospice services (including nurses and therapists) to do so via telehealth and bill accordingly.	CMS established this flexibility in CMS-1744-IFC, the interim final rule published April 6, 2020 in the Federal Register. However, new statutory authority would be needed to extend beyond the public health emergency the use of telehealth under home health benefit.
Billing, payment and coverage for telehealth services	
Part B Facility Fee. Allow hospitals to bill the originating site facility fee for telehealth services paid under the Medicare physician fee schedule and furnished by hospital-based providers to Medicare patients registered as hospital outpatients, including when the patient is located at home.	Section 1834(m)(2)(B)(ii) prohibits the payment of a facility fee if the originating site is a patient's home. In CMS-5531-IFC, CMS used its waiver authority and a complex process to allow hospitals to bill the originating site facility fee for services furnished to patients at home; however, a permanent change to this policy would require legislation to either remove this prohibition from statute or authorize the Secretary to waive it as appropriate.
Telehealth technologies	
COVID-19 Telehealth Program. Provides funds to eligible healthcare providers to support connected care services provided to patients at their homes or mobile locations. The program funds approved applications for telecom services, information services and devices needed to provide telehealth to COVID-19 and non-COVID-19 patients.	The FCC expects the $200 million fund to be full committed by mid-July. Legislation would be required to extend the program through additional funding and direct the FCC to expand the program to all hospitals, including for-profit facilities.

Regulation

Telehealth Flexibility	Detail
Provider/patient location	
Providers at home. During the PHE, providers providing telehealth services from their homes do not need to update their Medicare enrollment to include their home location (nor must their clinic/group practices do so if the provider has reassigned his/her benefits).	Provider enrollment requirements are regulatory, found at 42 CFR 424.516. During the pandemic, sub-regulatory guidance established this waiver by clarifying that providers do not have to update their enrollments. CMS could make this guidance permanent under its regulatory authority.

Telehealth Flexibility	Detail
Eligible providers and facilities	
Direct supervision. During the PHE, allow direct supervision to be provided using real-time, interactive audio and video technology.	The regulations governing supervision requirements appear at 42 CFR § 410.26. In CMS-1744-IFC, CMS revised the definition of direct supervision (410.26(a)(2)) to allow the necessary presence of the physician for direct supervision to include virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. CMS could permanently retain this flexibility through rulemaking.
Types of services	
Additional telehealth services. During the PHE, provide payment for more than 135 additional services when furnished via telehealth and allow additional services to be added on a subregulatory basis to the list of Medicare telehealth services.	In the calendar year 2002 Medicare physician fee schedule final rule, CMS established that PFS annual rulemaking would serve as the process for adding and deleting services from the Medicare telehealth list. However, in CMS-1744-IFC, the agency added more than 80 additional services to that list and in CMS-5531-IFC it changed the process for adding any additional services to a subregulatory approach that would not require notice-and-comment rulemaking. CMS has continued to add services to the approved Medicare telehealth list of services during the PHE. CMS could use its regulatory authority to permanently retain the expanded list of approved Medicare telehealth services and permanently retain the subregulatory process for adding codes to the list of approved Medicare telehealth services.
Virtual check-ins and e-visits. During the PHE, virtual check-ins and e-visits may be used for new patients (in addition to established patients).	Virtual check-ins and e-visits were created by CMS in the calendar year 2019 Medicare physician fee schedule final rule. The flexibility for these services to be used for new patients was published in CMS-1744-IFC. CMS could use its regulatory authority to continue to allow virtual check-ins and e-visits to be used for new and established patients.
Remote Patient Monitoring (or "remote physiological monitoring") (RPM). During the PHE, allow RPM to be used for new patients (in addition to established patients) and for acute conditions (in addition to chronic conditions).	Through annual rulemaking, CMS has finalized payment for several RPM codes, but they were available only to established patients and generally understood to be available only for the monitoring of chronic conditions. CMS-1744-IFC clarified that RPM can be used for acute conditions, including, but not limited to, COVID-19, and extended the use of RPM to new patients. (CMS-5531-IFC

Telehealth Flexibility	Detail
	made other changes to implement this flexibility.) CMS could use its regulatory authority to continue to allow RPM to be used for both new and established patients and for both acute and chronic conditions.
Billing, payment and coverage for telehealth services	
Payment for telehealth as if delivered in-person. During the PHE, CMS will pay for Medicare telehealth services as if they were delivered in person by instructing physicians and practitioners who bill for Medicare telehealth services to report the place-of-service (POS) code that would have been reported had the service been furnished in person.	Before the PHE, practitioners billed for telehealth services with POS code 02 to signify telehealth. In CMS-1744-IFC, CMS instructed providers to instead use the POS code they use when they provide services in person and append the -95 modifier to services delivered via telehealth. CMS, through its regular rulemaking activities, could retain these modified billing instructions going forward so as to continue paying for telehealth services as if they were delivered in person.
Physical examination. During the PHE, CMS has waived the requirement for a history and/or physical examination to bill office/outpatient evaluation and management (E/M) visits delivered via telehealth, such that these visits can be provided for any patient via telehealth and such that the office/outpatient E/M level selection for these services when furnished via telehealth can be based solely on the level of medical decision-making or time spent by the provider on the day of the visit.	Through the calendar year 2020 Medicare physician fee schedule final rule, CMS established a similar policy to this waiver through which E/M level selection can occur based on medical decision-making or time, beginning in calendar year 2021. This waiver was established in the CMS-1744-IFC rule and could be easily factored into future CMS annual rulemaking.
Consent to treat. During the PHE, annual consent for telehealth treatment may be obtained at the same time, and not necessarily before the time, that services are furnished.	In its fact sheet on flexibilities to fight COVID-19 for physicians and other clinicians, CMS clarified that beneficiary consent should not interfere with the provision of non-face-to-face services and that annual consent may be obtained at the same time, and not necessarily before, services are furnished. CMS could retain this approach to consent through its rulemaking authority.
Recording HCCs. During the PHE, providers may capture diagnoses impacting risk adjustment during telehealth visits.	In response to the PHE, CMS released a risk adjustment FAQ in which it indicated any service provided through telehealth that is reimbursable under applicable state law and otherwise meets applicable risk adjustment data submission standards may be submitted to issuers' External Gathering Data Environments (EDGE) servers for purposes of the HHS-operated risk adjustment program. CMS could use its regulatory authority to retain this policy.

Telehealth Flexibility	Detail
Frequency limitations. During the PHE, certain subsequent inpatient and nursing facility visits and critical care consultations provided via telehealth will not be subject to previously established frequency limitations.	In CMS-1744-IFC, CMS used its regulatory authority to remove frequency limitations from certain visits provided via telehealth. CMS uses its annual rulemaking authority to establish these frequency limitations, as part of its process for adding services to the Medicare telehealth list. CMS could use this same authority to remove frequency limitations.