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# Report on Medicare Compliance Volume 31, Number 9. March 14, 2022
# Congress Extends Telehealth Coverage for 151 Days After PHE; Patients May Be at Home

By Nina Youngstrom

Congress has given telehealth services a new lease on life, at least for five months beyond the end of the COVID-19 public health emergency (PHE), in the $1.5 trillion bill that funds the federal government through September and sends emergency aid to Ukraine.[1] The bill extends Medicare coverage for telehealth services delivered in patients' homes, audio-only telehealth services and other flexibilities that are products of the PHE and its waivers. It was passed by the House March 9 and the Senate March 10 and is expected to be signed quickly by President Joe Biden.

"This is a huge vote for 'we like telehealth,'" said Allison Kassir, senior government relations advisor at King & Spalding in Washington, D.C. Without this measure in the 2022 Consolidated Appropriations Act (CAA), providers and patients faced an abrupt loss of broad Medicare coverage for telehealth services when the PHE ends, which could be as early as mid-April or maybe mid-July, depending on whether the improving COVID-19 picture again darkens. "It's a sharp cliff," Kassir noted. "Unless you legislate it, there is no gradual step down."

The telehealth provisions of the CAA guarantee Medicare coverage of core flexibilities for 151 days beginning the first day after the end of the PHE, Kassir said. "There is such bipartisan support for this," and in recent years, that's a rare thing, she noted. But telehealth "has been demystified." The two years of COVID-19 waivers of certain Medicare telehealth requirements "have been such a great test drive of this means of delivering care." The CAA provisions also set the stage for a standalone bill that could permanently expand telehealth services, although it's expected to include "guardrails" and other program integrity measures, Kassir said.

Congress covered a lot of telehealth ground. "The majority of PHE flexibilities are captured in this legislative extension," said Richelle Marting, an attorney in Olathe, Kansas. Perhaps the broadest stroke is the bill's definition of "originating site" to mean any site where an "eligible telehealth individual is located" when services are performed. Before the PHE, the originating site requirement generally restricted Medicare coverage to services delivered to patients at hospitals and other provider locations (not patient homes) by distant site practitioners (e.g., physicians). The COVID-19 waivers set aside the originating site requirement for telehealth services, allowing them to be delivered in patient homes, and the legislation would keep this flexibility going 151 days past the end of the PHE. Marting said it appears to be even more far-reaching than the waivers, allowing Medicare coverage of telehealth services delivered anywhere the patient is (e.g., a coffee shop, the patient's car, a library), solving many providers' concerns about whether these locations qualify as "home" under current PHE waivers.

But the legislation specifically doesn't allow Medicare to pay originating site fees for any new originating site locations covered by the legislation. She explained that Congress authorized the continuation for five months of payments to distant-site practitioners for telehealth services delivered to patients at their homes and other places that are not the usual, pre-PHE originating sites, but "locations that were not statutorily identified as originating sites before the PHE can't bill an originating site fee if they're only eligible as originating sites as a result of this new legislative extension." For example, "if there's a retail clinic or pharmacy, the patient could be

at those locations and still get a telehealth service, and the distant site professional can bill for it, but the retail clinic or pharmacy wouldn't be able to bill an originating site fee," Marting said. "The difference is, before COVID, the entire telehealth service would not be allowed if the patient was not at an eligible originating site."

## Audio-Only Telehealth Lives On Past the PHE

Also in the legislation, Medicare coverage of audio-only telehealth services, a benefit borne of the COVID-19 pandemic, stays afloat for five months after the PHE ends. Without this extension, coverage would have disappeared. Another flexibility that was set to expire at the end of the PHE but will continue courtesy of the 2022 CAA is hospice recertification by telehealth.

Congress also continued to include physical therapists, occupational therapists, speech-language pathologists and audiologists in the definition of distant site practitioners, as currently allowed by PHE waivers. And rural health centers and federally qualified health centers are now eligible as distant site practitioners for five months after the PHE ends.

In another move, Congress modified the in-person requirement affecting telehealth mental health services. The in-person requirement is not in the waivers; it flows from legislation creating new telehealth benefits for mental health services. The 2022 Medicare Physician Fee Schedule rule interpreted provisions in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act that unshackle substance use disorders (SUDs) and co-occurring mental health disorders from geographic limitations and allow the patient's home to be an originating site for telehealth, and that holds true when the PHE ends.[2]

The 2021 CAA extended this coverage beyond SUDs to allow the home to be an originating site for the diagnosis, evaluation and treatment of all mental health disorders—not just those co-occurring with an SUD. "A significant difference between the expanded services and the original SUD telehealth coverage, though, was a requirement for an in-person visit within six months of the first telehealth service and subsequent in-person visits every 12 months if providers had to rely on the 2021 Consolidated Appropriations Act's provisions allowing these services outside of rural areas and to patients at home," Marting said. "Those requirements would go into effect after the PHE ends, but don't apply if the telehealth service would already be covered under regular Medicare telehealth rules."

Now Congress has delayed the in-person visit requirement for telebehavioral health patients who are at home or outside a rural area. (Medicare telehealth coverage normally covers telehealth services only when delivered to patients in rural areas, but that also was waived during the PHE).

## Spending, Program Integrity Is On Their Minds

Although the legislation has no program integrity strings attached, it directs the Medicare Payment Advisory Commission (MedPAC) to study the expansion of telehealth stemming from the COVID-19 PHE and the increase in spending and report back to Congress with legislative and technical recommendations next year. Congress also directed the HHS Office of Inspector General to report on program integrity risks, with recommendations to prevent fraud, waste and abuse.

"My antenna started quivering at the instruction for OIG to do a report," Marting said. "As we move away from PHE status, this signals there will likely be more scrutiny on meeting all the documentation requirements for telehealth." For example, CMS previously added audio-only telebehavioral services as a permanent benefit, but Medicare only pays when "the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology." That's challenging from an operational and medical review perspective because

audio-only telebehavioral health is only covered when the patient is at home and the documentation must support the reasons why the beneficiary was unable to use or wouldn't use audio/visual technology, she said. "These requirements could be prime targets for program integrity review activities."

The program integrity guardrails will probably come into play if Congress enacts a more permanent expansion of telehealth, Kassir said. That includes the Telehealth Extension and Evaluation Act, a bill sponsored by Sens. Catherine Cortez Masto, D-Nev., and Todd Young, R-Ind., which extends the telehealth flexibilities for two years.[3]

The 151 days provided by the CAA show "there wasn't agreement on how to go forward on guardrails," but Congress didn't want patients to fall off a cliff post-PHE, Kassir said. The breathing room that providers and patients have now gives them a chance to convey to Congress the need to balance safeguards in future legislation with the risks they could inhibit patient access to telehealth services, she noted. "If I were a provider, I'd be on alert for examples of requirements," Kassir said. There could be "unintended consequences" to program integrity measures. "In the course of trying to get at fraud, you may be hurting people trying to benefit from telehealth."

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**1** Rules Committee Print 117–35 Text of the House Amendment to the Senate Amendment to H.R. 2471, March 8, 2022, https://bit.ly/3tRBk04.
**2** Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64,996 (November 19, 2021), https://bit.ly/3k020YY.
**3** Catherine Cortez Masto, "Cortez Masto & Young Introduce Bipartisan Legislation to Extend Coverage of Telehealth Services for Seniors," news release, February 7, 2022, https://bit.ly/34A12hv.