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# **HHS Fact Sheet: Telehealth Flexibilities and Resources and the COVID-19 Public Health Emergency**

As the Department of Health and Human Services (HHS or the Department) continues the process of transitioning away from the policies enabled by the COVID-19 emergency declarations, the Department would like to provide clarity regarding the future of federal flexibilities related to telehealth and tele prescribing to ensure that patients may continue

to access and receive the care that they need. Below is a Fact Sheet outlining key details of what will change and what will stay the same for patients and providers when the COVID-19 public health emergency (PHE) declared by the Secretary of HHS under Public Health Service Act section 319 (referred to below as the “COVID-19 PHE”) PHE ends. Congress extended many telehealth flexibilities under the Medicare program that people relied on during the COVID-19 PHE through the end of 2024 via the Consolidated Appropriations Act, 2023. HHS will share additional guidance on updates and timing relating to the continuation of these flexibilities. In addition, the Health Resources and Services Administration (HRSA) manages an HHS website, [www.Telehealth.HHS.gov](http://www.telehealth.hhs.gov) <<http://www.telehealth.hhs.gov>>, which will continue to be a resource for patients, providers, and states to get information about telehealth, such as telehealth best practices, policy and reimbursement updates, interstate licensure, broadband, funding opportunities, and events.

## **Healthcare Coverage and Telehealth**

### **Medicare and Telehealth**

During the PHE, individuals with Medicare had broad access to telehealth services, including in their homes, without the geographic or location limits that usually apply, as a result of Medicare telehealth waivers issued by the Secretary, which were facilitated by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, and the Coronavirus Aid, Relief, and Economic Security Act. Telehealth includes services provided through telecommunications systems (for example, computers) and allows health care providers to give care to patients remotely in place of an in-person office visit. The Consolidated Appropriations Act, 2023, extended many Medicare telehealth flexibilities for people with Medicare through December 31, 2024, such as:

- Access to telehealth services in any geographic area in the United States, rather than only in rural areas.
- Allowing patients to stay in their homes for telehealth visits that Medicare pays for rather than requiring travel to a health care facility.
- Certain Medicare telehealth visits can be delivered using audio-only technology (such as a telephone) if someone is unable to use both audio and video, such as a smartphone or computer.

Additionally, after December 31, 2024, when these flexibilities expire, some Accountable Care Organizations (ACOs) may offer telehealth services that allow doctors and other practitioners participating in the ACO to care for patients without an in-person visit, no matter where they live. If a health care provider participates in an ACO, individuals should check with them to see what telehealth services may be available. Medicare Advantage plans must cover the telehealth benefits covered by Medicare and may offer additional telehealth benefits. Individuals in a Medicare Advantage plan should check with their plan about coverage for telehealth services.

### **Medicaid, CHIP, and Telehealth**

States have a great deal of flexibility with respect to covering Medicaid and the Children's Health Insurance Program (CHIP) services provided via telehealth. As such, telehealth flexibilities vary by state: some are tied to the end of the COVID-19 PHE, some are tied to state PHEs and other state emergency declarations, and some had been offered by state Medicaid and CHIP programs long before the pandemic. After the end of the federal PHE, Medicaid and CHIP telehealth policies will continue to vary by state. The Centers for Medicare & Medicaid Services (CMS) encourages states to continue to cover Medicaid and CHIP services delivered via telehealth. To assist states with the continuation, adoption, or expansion of telehealth coverage and payment policies, CMS has released the State Medicaid & CHIP Telehealth Toolkit and a supplement that identifies for states the policy topics that should be addressed to facilitate widespread adoption of telehealth:

<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf> - PDF <<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>>;

<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf> - PDF <<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf>>.

### **Private Health Insurance and Telehealth**

As is currently the case during the COVID-19 PHE, coverage for telehealth and other remote care services will vary by private insurance plan after the end of the COVID-19 PHE. When it covers telehealth and other remote care services, private insurers may impose cost-sharing, prior authorization, or other forms of medical management on such services. For additional information on an insurer's approach to telehealth, patients should contact their insurer's customer service number located on the back of their insurance card.

## **The Health Insurance Portability and Accountability Act (HIPAA) Rules and COVID-19**

During the COVID–19 PHE, health care providers subject to the HIPAA Privacy, Security, and Breach Notification Rules (HIPAA Rules) sought to communicate with patients and provide telehealth services for the first time through readily available remote communications technologies that may not have fully complied with the requirements of the HIPAA Rules. The HHS Office for Civil Rights (OCR) announced that, effective March 17, 2020, it would exercise its enforcement discretion and would not impose penalties for noncompliance with the HIPAA Rules against covered health care providers. Providers using any remote monitoring technology could use these technologies without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules. This exercise of discretion applied to telehealth provided for any reason, regardless of whether the telehealth service was related to the diagnosis and treatment of health conditions related to COVID–19.

On April 11, 2023, OCR announced that this notification of enforcement discretion will expire at 11:59 p.m. on May 11, 2023, due the expiration of the COVID-19 PHE. OCR will continue to support the use of telehealth after the PHE by providing a 90-calendar day transition period for covered health care providers to make any changes to their operations that are needed to provide telehealth in a private and secure manner in compliance with the HIPAA Rules. During this transition period, OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth. The transition period will be in effect beginning on May 12, 2023, and will expire at 11:59 p.m. on August 9, 2023.

For more information, please visit OCR’s website <<https://www.hhs.gov/ocr/index.html>> to view the Notice of Expiration of Certain Notifications of Enforcement Discretion Issued in Response to the COVID-19 Nationwide Public Health Emergency.

### **Tele-Behavioral Health and the COVID-19 PHE**

#### **Tele-Behavioral Health in Opioid Treatment Programs**

Since the start of the PHE, the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) has released guidance regarding several Opioid Treatment Program (OTP) regulatory flexibilities designed to help address the impact of social distancing on OTPs and their patients.

**Waived In-Person Physical Examinations:** SAMHSA exempted OTPs from the requirement to perform an in-person physical evaluation for any patient who will be treated by the OTP with buprenorphine if a program physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician, determines that an adequate evaluation of the patient can be accomplished via telehealth. SAMHSA has announced that it is extending this flexibility until May 11, 2024. The extension goes into effect on May 11, 2023, and SAMHSA has also proposed to make this flexibility permanent as part of a Notice of Proposed Rulemaking <https://www.samhsa.gov/newsroom/press-announcements/20221213/update-federal-rules-expand-access-opioid-use-disorder-treatment> it released in December of 2022.

**Take Home Doses:** In March 2020, SAMHSA issued an exemption to OTPs whereby a state could request “a blanket exception for all stable patients in an OTP to receive up to 28 days of Take-Home doses of the patient’s medication for opioid use disorder.” States could also “request up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication.”

In the three years since this exemption was granted, states, OTPs, and other stakeholders report <https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance> that it has resulted in increased treatment engagement and improved patient satisfaction with care, with relatively few incidents of misuse or medication diversion. SAMHSA has concluded that there is sufficient evidence that this exemption has enhanced and encouraged use of OTP services at a time of significant fentanyl-related overdose mortality. In April 2023, SAMHSA updated the guidance <https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance> in full by revising the standards applicable to OTP provision of methadone for unsupervised use.

This newly-revised April 2023 Guidance will be effective upon the expiration of the PHE and will remain in effect for the period of one year from the end of the PHE, or until such time that HHS publishes final rules revising 42 C.F.R part 8. A notice of proposed rulemaking has been published that proposes revisions to 42 C.F.R. part 8 entitled ‘Medications for the Treatment of Opioid Use Disorder’ (87 FR 77330), which SAMHSA is working to finalize.

Subject to the conditions identified below, the updated April 2023 Guidance will offer an exemption from the unsupervised take-home medication requirements of 42 C.F.R. § 8.12(i). Specifically, OTPs taking advantage of this exemption, may provide unsupervised take-home doses of methadone in accordance with the following time in treatment standards:

- In treatment 0-14 days, up to 7 unsupervised take-home doses of methadone may be provided to the patient
- For Treatment days 15-30, up to 14 unsupervised take-home doses of methadone may be provided to the patient
- From 31 days in treatment, up to 28 unsupervised take-home doses of methadone may be provided to the patient

SAMHSA has previously announced that it will extend this flexibility until May 11, 2024. States will need to affirmatively register their concurrence with this specific exemption in order for OTPs within the state to utilize it. States, or State Opioid Treatment Authorities authorized to act on behalf of the state, may, at any time following the issuance of this guidance, register their concurrence with this exemption by submitting a written concurrence to the Division of Pharmacological Therapies <<https://www.samhsa.gov/medications-substance-use-disorders/about-dpt>> mailbox. To ensure a seamless transition from the flexibility issued during the COVID-19 public health emergency to this guidance, states are encouraged to do this no later than May 10, 2023. If a state previously did not utilize the exemption announced on March 16, 2020, then the state may still submit a written concurrence.

SAMHSA has also proposed to make this flexibility permanent as part of a Notice of Proposed Rulemaking released in December of 2022. Since this exemption was granted, states, OTPs, and other stakeholders report that this flexibility has resulted in improved patient satisfaction with care, and increased patient engagement. The support for this flexibility has been overwhelmingly positive, and reports from the State Opioid Treatment Authorities and individual OTPs suggest that this measure has encouraged and enhanced care, while decreasing stigma associated with opioid use disorder (OUD).

## **Drug Enforcement Administration (DEA) Rules and the PHE**

Since March 2020, HHS and DEA have allowed practitioners to prescribe schedule II-V controlled substances (“controlled medications”) pursuant to a telemedicine visit without conducting an initial in-person medical evaluation. Additionally, DEA has waived the requirement for practitioners to obtain a DEA registration in the state where a patient is located, as long as the practitioner is authorized to prescribe controlled medications via telemedicine in both the state in which the practitioner is registered with DEA and the state in which the patient is located. Collectively, these are referred to as the “controlled medications telemedicine flexibilities.”

In March 2023, DEA solicited comments on two notices of proposed rulemaking for the controlled medicines telemedicine flexibilities. These proposals are intended to facilitate broader access to controlled medications, including for individuals who have initiated treatment under the flexibilities. DEA, in concert with SAMHSA, plans to promulgate final rules by November 11, 2023.

As of the end of the PHE and while they consider revisions to the proposed rules based on public feedback, DEA and SAMHSA have issued a temporary rule

<https://www.samhsa.gov/newsroom/press-announcements/20230509/dea-extend-covid19-telemedicine-flexibilities-prescribing-controlled-medications> extending the controlled substance telemedicine flexibilities through November 11, 2023. Further, practitioners who have established relationships with patients via telemedicine on or before November 11, 2023, may continue prescribing controlled medications to these patients without conducting an in-person medical evaluation and without respect to whether the practitioner is registered with DEA in the state in which the patient is located until November 11, 2024.

## **Licensure for Tele-Behavioral Health**

During the COVID-19 PHE, many health care providers were able to deliver telehealth services across state lines through state-issued license waivers - PDF

<https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensure-requirements-covid-19.pdf> [↗](#) [↗](#) </disclaimer.html>. To use tele-behavioral health to its fullest extent, states can

facilitate the delivery of telehealth across state lines through licensure portability.

Licensure portability <https://telehealth.hhs.gov/licensure/getting-started-licensure/> is the ability of a health care professional licensed in one state to practice health care in another state

through a transfer, recognition, or issuance of a license with minimal barriers and restrictions. Expanding licensure portability increases access to health care services and helps improve continuity of care for patients.

Among other benefits, licensure portability allows states to retain regulatory authority while giving health care providers the ability to serve more patients, allowing patients to receive care from a larger network of health care providers, and helping states to improve access to care for rural and underserved communities. Licensure compacts

<https://telehealth.hhs.gov/licensure/licensure-compacts/> are agreements between states that streamline the process and allow providers to submit a single application to practice in participating states. Licensure compacts may ease the burden and decrease wait time for health care providers to practice across state lines, preserve state regulatory oversight, and retain health care provider fees to state licensure boards. Licensure compacts are helpful for both in-person and telehealth services. Existing licensure compacts include: the Audiology and Speech-Language Pathology Interstate Compact <https://aslpcompact.com/> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), Counseling Compact <https://counselingcompact.org/> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), Emergency Medical Services Compact <https://www.emscompact.gov/the-compact/what-is-the-ems-compact>, the Interstate Medical Licensure Compact, the Nurse Licensure Compact <https://www.ncsbn.org/compacts/nurse-licensure-compact.page> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), the Occupational Therapy Compact <https://otcompact.org/> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), the Physical Therapy Compact <https://ptcompact.org/> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), and the Psychology Interjurisdictional Compact, with the potential to expand to other professions.


The behavioral health crisis and shortage of behavioral health providers, including for substance use disorder treatment, has demonstrated the need for an increase in cross-state licensure efforts. There are several opportunities for states to take advantage of federal resources to support an expansion of telehealth through interstate licensure:

HHS, through HRSA, tripled support to the Federation of State Medical Boards and the Association of State and Provincial Psychology Boards, which created the Interstate Medical Licensure Compact, the Provider Bridge <https://www.providerbridge.org/> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), the Psychology Interjurisdictional Compact <https://psypact.org/page/practiceunderpsypact> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), and the Multi-Discipline Licensure Resource <https://licensureproject.org/> [↗](#) [↗](#) [↗](#) [↗](#) [↗](#), respectively, through the Licensure Portability Grant Program <https://www.hrsa.gov/rural-health/topics/telehealth>.




In addition, a new licensure resource <<https://telehealth.hhs.gov/licensure/>> shares the latest information on licensing across state lines, licensure compacts, and licensure for behavioral health professionals. This resource has the latest guidance on how to practice legally and ethically across state lines and encourages the uptake of licensure models that increase access to health care.

## **Broadband Access**

Broadband internet connections play a key role in helping underserved communities and individuals utilize telehealth services. To expand broadband access for households and states, Congress appropriated \$3.2 billion through the Consolidated Appropriations Act of 2021 to the Federal Communications Commission (FCC) to establish the Emergency Broadband Benefit Program <<https://www.usac.org/about/emergency-broadband-benefit-program/>>  </disclaimer.html> (EBB Program) that helped low-income households to pay for broadband access and internet-enabled devices.

On November 15, 2021, the Infrastructure Investment and Jobs Act (IIJA) <<https://www.congress.gov/bill/117th-congress/house-bill/3684>> provided \$65 billion in funding for broadband, of which \$48.2 billion will be administered by the Department of Commerce's National Telecommunications and Information Administration (NTIA) in the new Office of Internet Connectivity and Growth. The IIJA also provided the FCC with \$14.2 billion to modify and extend the (EBB Program) to the Affordable Connectivity Program (ACP) and \$2 billion to the Department of Agriculture to establish cooperatives to offer broadband.

Several broadband programs include:

- The FCC's Affordable Connectivity Program, which helps eligible households pay for Internet services and internet connected devices.
- The FCC's Lifeline program <<https://www.lifelinesupport.org/>>  </disclaimer.html>, which also helps eligible households access phone or internet service at a lower monthly cost; and
- The NTIA's Broadband Equity Access and Deployment and State Digital Equity Planning Grant Programs, which provide support to states to expand access to high-speed Internet.

- The NTIA’s Tribal Broadband Connectivity Program <https://broadbandusa.ntia.doc.gov/news/latest-news/ntias-role-implementing-broadband-provisions-2021-infrastructure-investment-and> which extends the funding from the Consolidated Appropriations Act of 2021 to provide tribal governments with funds for broadband deployment, telehealth, distance learning, broadband affordability, and digital inclusion on tribal lands.
- The Department of Agriculture’s <https://crsreports.congress.gov/product/pdf/if/if11918> the ReConnect Program and the Rural Broadband Program Distance Learning, Telemedicine, and Broadband Program.

These broadband programs will help improve patients’ access to Internet services and devices that are needed for telehealth services thereby reduce disparities and economic burden in accessing video and technology-enabled health care services.

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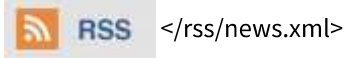
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