

## APPENDIX

### TELEHEALTH: Policies that waived telehealth requirements or otherwise expanded access to telehealth care

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
Expansion of services for which telehealth is permitted, including substance use disorder (SUD), co-occurring mental health (MH)	85 FR 19230 (2020); 85 FR 84472 (2020); CAA 2021	Timing varies; initially expanded 3/1/20; first permanent change made by the Centers for Medicare and Medicaid Services (CMS) 1/1/21; additional permanent changes effective upon expiration of the public health emergency (PHE)	Individuals with MHSUD are able to receive care via telehealth that was not previously covered
Increased rates for telehealth evaluation and management (E&M) to equal face-to-face E&M	85 FR 27550 (2020)	3/1/20 until end of PHE	Providers may be more willing to provide telehealth services under increased rates that equal face-to-face E&M rates. Those with MHSUD may therefore have expanded access to telehealth services.
Expansion of types of providers allowed to provide telehealth services (e.g., physical therapists, occupational therapists, speech language pathologists)	CMS (2021) (1135 waiver)	3/1/20, C17151 days after PHE ends (2022 CAA)	The types of providers that can furnish telehealth services are expanded to include all health care professionals eligible to bill Medicare. Individuals with MHSUD may therefore see providers not included in statutory definition of practitioner.
Congress expanded access to telehealth services in Medicare to allow beneficiaries with SUD diagnosis to receive mental health services to treat the SUD or co-occurring mental health disorder via telehealth, including from beneficiary's home	85 FR 19230 (2020); CAA 2021	3/1/20–151 days after PHE ends; a slight modification of this policy, requiring face-to-face visits within 6 months of first telehealth appt, after the PHE ends	Individuals with MHSUD can receive mental health services via telehealth, including from beneficiary's home
Urban locations and patient homes added to telehealth locations	CMS (2021) (1135 waiver); 85 FR 19230 (2020)	3/1/20–151 days after PHE ends (2022 CAA)	Individuals with MHSUD are able to receive telehealth services in urban areas and at home
Remote physiologic monitoring (RPM) allowed for both acute and chronic conditions and for patients with only one disease	Coronavirus Aid, Relief, and Economic Security (CARES) Act; 85 FR 19230 (2020); 85 FR 27550 (2020)	3/1/20 until end of PHE	Individuals with MHSUD may benefit from RPM as part of their overall care; this change expands RPM coverage
CARES Act allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) as telehealth distant sites	CMS (2021) (1135 waiver); CARES Act	3/1/20, 151 days after PHE ends (2022 CAA)	Temporary expansion allows beneficiaries with MHSUD to have expanded access to telehealth services in additional locations
Telehealth frequency limits removed for certain follow-up services	CARES Act; 85 FR 19230 (2020)	3/1/20 until end of PHE	Individuals with MHSUD included in this waiver of frequency limits, meaning these follow-up services are not limited for MHSUD patients following up via telehealth

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
New codes for audio-only telehealth	85 FR 19230 (2020)	3/1/20, 151 days after PHE ends (2022 CAA)	Individuals with MHSUD may be able to receive audio-only telehealth care, including counseling and therapy, during the PHE
Audio-only telehealth by opioid treatment programs (OTPs)	85 FR 19230 (2020); CAA 2021	3/1/20 (permanent, in limited manner after PHE)	Audio-only telehealth
Providers can waive cost-sharing requirements for telehealth services	85 FR 19230 (2020); OIG 2020	3/1/20 until end of PHE	Individuals with MHSUD may have cost-sharing obligations reduced or waived, because providers do not face sanctions for taking these actions during the pandemic
Health Insurance Portability and Accountability Act (HIPAA) violation penalties waived for providers using two-way audio/visual (AV) tech in good faith	85 FR 19230 (2020); HHS (2021)	3/1/20 until end of PHE	Individuals with MHSUD are not affected directly by this policy, but their providers may feel more comfortable providing services via telehealth if HIPAA violations are not a concern
CMS paused audits of telehealth patients, which effectively allowed “new” patients to receive telehealth services	CMS (2021) (1135 waiver); see also: CMS (2020)	3/1/20 until end of PHE	Individuals with MHSUD who are not established patients may be able to receive services delivered via telehealth
Hospitals and community mental health centers (CMHCs) can provide certain outpatient care (therapy, counseling, education) via telehealth	85 FR 27550 (2020)	3/1/20 until end of PHE	Individuals with MHSUD can receive outpatient care via telehealth, including some therapy and counseling delivered by hospitals and CMHCs

## MEDICARE PART D: Policies that shaped application or implementation of Part D

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
Part D insurance plans are required to allow enrollees to obtain the total supply prescribed for a covered Part D drug up to a 90-day supply	CARES Act	3/1/20 until end of PHE	Individuals with MHSUD who are enrolled in Part D and receiving prescribed medication may be able to obtain larger amounts of medication
Part D sponsors are required to relax “refill-too-soon” rules, adding flexibility for when patients can obtain refills	CARES Act	3/1/20 until end of PHE	Individuals with MHSUD who are enrolled in Part D and receiving prescribed medication may be able to obtain refills sooner than usual.
Part D sponsors are permitted to voluntarily relax any plan-imposed policies that may discourage certain methods of delivery, such as by mail or home delivery	CMS (2021) (1135 waiver)	Unclear (reiteration/encouragement of existing policy)	If Part D sponsor relaxes mail or home delivery policies, individuals with MHSUD may have expanded access to certain medications

**STAFFING: Policies that created or enhanced staffing flexibility for hospitals and other facilities**

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
When physician supervision is required, supervision can be provided virtually. For the duration of the PHE, CMS is changing the definition of “direct supervision” to allow supervision to be provided via real-time audio and video technology. CMS added a policy in the 2021 Physician Fee Schedule (PFS) that allowed teaching physicians to meet requirements for billing for services involving residents through virtual presence, so long as the services are furnished in residency training sites located outside of an urban metropolitan statistical area (MSA).	85 FR 19230 (2020); 85 FR 84472 (2020)	3/1/20 until end of PHE (supervision); reiterated 1/1/21, billing provisions for rural areas made permanent	Individuals with MHSUD may be able to get services more rapidly or from different providers because supervision does not have to be in-person
CMS allowed all levels of office/outpatient E&M visits to be furnished by resident and billed by teaching physician during PHE, under primary care exception. Permanent change allowing Medicare to make payment to the teaching physician when the resident furnishes an expanded array of services under the primary care exception permanent for residency training sites that are located outside of an MSA; the permanent expanded array of services is limited to Medicare-approved telehealth services, communication-technology based services and inter-professional consults.	85 FR 19230 (2020); 85 FR 27550 (2020); 85 FR 84472 (2020)	3/1/20, 4/30/20, 1/1/21 (end date varies. Some permanent, some end with the PHE)	This change involves a series of services that that may be relevant for patients with MHSUD, but in particular, one of the included services for the PHE is psychiatric service (provided by resident under remote supervision of teaching physician)
Physicians in hospitals and skilled nursing facilities (SNFs) can delegate tasks previously required to be performed by physician to others (physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialist (CNSs))	CMS (2021) (1135 waiver)	3/1/20–5/7/22	Individuals with MHSUD who need a service normally requiring a physician may be able to receive that service from an alternate provider (PA, NP, CNS) under supervision of physician.
Requirement that physicians and nonphysician practitioners (NPPs) be licensed in the state where providing services is waived under certain conditions	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	This waiver could expand availability of MHSUD care, both in-person and telehealth
Requirement that, for FQHCs and RHCs, physicians provide medical direction for the clinic’s or center’s health care activities and consultation for and supervision of health care staff is modified with respect to NPs. Physicians still must be available in person, telehealth, or remote communication for supervision, etc.	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Nurse practitioners may be able to offer expanded care to all individuals, including those with MHSUD, because they are freed from certain limitations
Requirement that Medicare patients be under care of physician is waived. Patients can be under care of PA or NP to fullest extent possible.	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Individuals with MHSUD may see their hospital care modified and expanded as they can now be under care of PA or NP, not just physician
Broad flexibility for all members of the medical team (including physicians, residents, nurses, and students) to add documentation to medical record	85 FR 19230 (2020); 85 FR 27550 (2020); 85 FR 84472 (2020)	Permanent	Because of this flexibility, patients – including those with MHSUD – may have their medical record updated more quickly, which could facilitate care coordination

**CARE CONDITIONS: Policies that affected the structure or nature of care (e.g., facility)**

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
Subset of therapy and educational services, including partial hospitalization services, permitted to be eligible to be provided remotely by the hospital clinical staff so long as they are furnished to a patient in the hospital, which may include the patient's home if the hospital considers the beneficiary's home to be a provider-based department of the hospital	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Individuals with MHSUD receiving outpatient behavioral health services may be able to receive these services from hospital clinical staff remotely and/or from home
Acute care hospitals are permitted to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit if the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care.	CMS (2021) (1135 waiver)	3/1/20 until end of PHE	Inpatient psychiatric patients may receive care in acute care beds and units, if it is conducive to safe care
Clarified which providers can provide services in psych hospitals, including "licensed practitioners" (PAs, NPs, psychologists, CNSs, etc.)	85 FR 19230 (2020)	3/1/20; permanent	As a result of this change, beneficiaries with MHSUD can receive care from a wider array of providers/professionals in psychiatric hospitals
Certain in-person services are eligible to be provided remotely by the hospital clinical staff so long as they are furnished to a patient in the hospital, which may include the patient's home if the hospital considers the beneficiary's home to be a provider-based department of the hospital	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Individuals with MHSUD may be able to receive certain services (including drug administration, infusions, and wound care) remotely, including at home, when these services were previously required to be provided in person
Requirements for hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to provide information regarding discharge planning are waived	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	When discharged, individuals with MHSUD may not receive information as detailed as during pre-pandemic discharges regarding quality measures and resource use measures for post-acute care services. CMS's waiving of this requirement was intended to expedite safe discharge and movement of patients across care settings.
CMS waived certain requirements related to discharge planning for postacute care (PAC) services, so that patients must continue to be discharged to an appropriate setting with the necessary medical information and goals of care, but may not receive all information, such as a list of PAC providers	CMS (2021) (1135 waiver)	5/1/20 until end of PHE; terminated for long term care facilities 5/7/22	When discharged, individuals with MHSUD must be discharged to an appropriate care setting, but may not receive information about potential providers or other details provided in the prepandemic period
All hospital utilization review (UR) requirements waived	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Hospitals will not have to devote as many resources to UR during the PHE, which may increase access to MHSUD care for patients. It could also lead to low-value care

## Policies affecting skilled nursing facilities (SNFs)

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
SNF physician visits can be conducted via telehealth	CMS (2021) (1135 waiver)	3/1/20–5/7/22	Individuals with MHSUD who are residing in an SNF can have telehealth appointments for services that are normally required to be in-person visits
SNF physician visits can be delegated to NP, PA, or CNS who is not employee of facility and is working in collaboration with physician and is licensed in state and working within scope of state law	CMS (2021) (1135 waiver)	3/1/20–5/7/22	If an individual with MHSUD is residing in an SNF, they may be able to have greater access to care if NP, PA, or CNS is able to visit before a physician is able to visit

## Policies affecting critical access hospitals (CAHs)

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
Requirement that CAH have doctor of medicine (MD) or doctor of osteopathy (DO) physically present to provide medical direction, consultation, supervision is waived, but must be available through direct radio, telephone, or electronic communication for consultation, referral, assistance	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Individuals with MHSUD receiving care at a CAH – facilities that may have psychiatric beds – may have expanded access to care because an MD or DO can supervise, consult on, and direct care remotely

## Policies affecting community mental health centers (CMHCs)

Brief summary	Authority/level	Dates	Mental health and substance use disorder (MHSUD) example
Waived policy that prohibited partial hospitalization services in patient homes. Can temporarily furnish these services using telecommunication tech in other locations, including homes.	CMS (2021) (1135 waiver)	3/1/20 until end of PHE	Individuals with MHSUD can receive partial hospitalization services and other CMHC services in their home using telecommunication technology
Waived the requirement that a CMHC provides at least 40 percent of its items and services to individuals who are not eligible for Medicare benefits	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	Medicare beneficiaries with MHSUD may have greater access to appropriate care because this waiver will facilitate timely discharge to CMHCs from inpatient psychiatric units and allow PHP services at CMHC without regard to insurance status. This may mean that beneficiaries have increased access at the expensive of patients not enrolled in Medicare.
CMHC's Quality Assurance and Performance Improvement (QAPI) programs modified by waiving detailed requirements for the QAPI program's organization and content	CMS (2021) (1135 waiver)	5/1/20 until end of PHE	CMHCs are still required to have an effective, CMHC-wide, data-driven QAPI program, but the detailed requirements for QAPI program organization and content are waived, freeing up the CMHC to shape its QAPI in a way that responds to the specific circumstances of the PHE. Patients with MHSUD may see their care affected by these decisions.

## Sources

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