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CMS Greenlights Certain Telebehavioral Health Services Beyond the Public Health Emergency and Provides Important Incentives for Further Investment

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The COVID-19 Global Pandemic compelled the Centers for Medicare and Medicaid Services ("CMS") to revamp its approach to regulating telehealth services and temporarily embrace the modality as a practical treatment option. In the CY2022 Physician Fee Schedule ("Final Rule") published last week, CMS recognized the pervasive public satisfaction with telehealth during this grand experiment and greenlit expanded Medicare reimbursement for various telehealth services, including certain telebehavioral health services. CMS recognized that providing coverage for such services until a definitive date (the end of 2023) would allow providers to develop the clinical support required to pursue permanent approval for such services. Psychologists, mental health therapists, other behavioral health providers, investors, and other stakeholders should take note of the additional telehealth opportunities created by the Final Rule.

Key Changes

In the Final Rule, CMS announced two key regulatory changes likely to promote wider use of telehealth for behavioral health services.

Extended Timeframe for Reimbursement

First, CMS announced that it is extending the timeframe under which Medicare will reimburse for all temporarily authorized telehealth services ("Category 3 Telehealth Services"). In 2020, CMS exercised its waiver authority to add certain services to the "CMS Telehealth List" solely for the duration of the public health emergency ("PHE"), thereby allowing Medicare to reimburse for such services when they were provided via telehealth technologies during the PHE and through the calendar year in which the PHE ended. In the Final Rule, CMS just announced that any services it previously authorized to be provided via telehealth during the PHE on a temporary (Category 3) basis may continue to be provided via telehealth until the end of the 2023 calendar year and paid for by

Medicare.

Consequently, all providers—including behavioral health providers—have an extended, definitive timeframe in which they may continue to provide Category 3 Telehealth Services via telehealth to Medicare beneficiaries. They also have an extended opportunity to continue to develop clinical arguments for the services' permanent addition to the "CMS Telehealth List" on a Category 1 or Category 2 basis while obtaining reimbursement for such services. This development presents a tremendous opportunity for behavioral health providers and investors to continue to invest in telehealth technology and to develop the clinical evidence to support the addition of specific telehealth services to the CMS Telehealth List permanently.

Relaxed Criteria for Diagnosis, Evaluation and Treatment

Second, CMS significantly relaxed its reimbursement criteria for telehealth services furnished "for purposes of diagnosis, evaluation, or treatment of a mental health disorder." Typically, Medicare only pays for telehealth services provided in compliance with the telehealth conditions of participation set forth in Section 1834(m) of the Social Security Act (the "Act") and its implementing regulations at 42 C.F.R. §414.65 and 42 C.F.R. §410.78. In short, historically Medicare pays for Medicare Part B services provided via telehealth which appear on the CMS Telehealth List, are provided by a qualified practitioner who appears at a qualifying distant site and is treating a patient who is enrolled in Medicare Part B and presents at a qualifying originating site, assuming the parties use an interactive telecommunications system permitting two-way, real-time interactive communications between the patient and distant site practitioner in conformance with state and federal privacy laws.[1]

The Final Rule, however, authorizes Medicare payment for telehealth services furnished "for purposes of diagnosis, evaluation or treatment of a mental health disorder" on a permanent basis (even after the PHE ends) under the following relaxed criteria.[2]

- First, CMS permanently allowed audio-only visits (i.e., the use of audio-only technology for telehealth encounters for the diagnosis, evaluation or treatment of mental health conditions, including, in this instance, for substance use disorders) when the patient's home[3] serves as the originating site for the encounter, the telehealth provider has audio-visual technical capabilities for the encounter, yet the patient either is not capable of or does not consent to a video encounter. Previously, CMS used waiver authority under the Act to temporarily waive the requirement that telehealth services be furnished via two-way, audio-visual communications systems during the PHE for certain behavioral health and counseling services.[4] Now, the Final Rule makes this waiver permanent for qualifying services provided to patients who are in their home. For all services other than qualifying mental health services, CMS is continuing to require two-way, audio-visual communications technology.[5] For example, for patients presenting from another location for telehealth services (like a physician's office, hospital, or another facility), broadband technologies permitting audio-visual encounters are presumed accessible and are, therefore, required.

- Second, CMS is permitting the patient's home[6] to serve as a qualifying originating site for telehealth encounters for the diagnosis, evaluation or treatment of a mental health disorder, ***provided that*** the in-person visit requirement outlined below is met. CMS also waived the application of the other telehealth geographic restrictions for patients' homes.[7]

- Third, CMS requires that such services be preceded and followed by a qualifying in-person visit by the same practitioner at requisite intervals. Specifically, the practitioner furnishing the

telehealth services must: (i) have also furnished an item or service in-person to the patient (i.e., without use of telehealth technologies) within 6 months prior to the first time the provider furnished telehealth services to the patient; and (ii) furnish in-person services to such patient every 12 months after a telehealth service. CMS noted, however, that the "same practitioner" can include either (i) the physician or practitioner who furnished the in-person, non-telehealth service; or (ii) a physician or practitioner who is in the same specialty and subspecialty and in the same group as the one performing the telehealth services. Thus, the telehealth practitioner can rely on another practitioner in his/her group to provide in-person services.

Take Away

With these significantly relaxed criteria, qualified behavioral health providers[8] will be able to continue to provide teletherapy to patients in their homes and are authorized to use audio-only technologies for such sessions beyond the PHE's expiration. The Final Rule's changes should promote continued access to services for existing patient populations and also broaden the overall population serviceable by behavioral health providers in the future as patients seek care from their home. Finally, CMS' tone in the Final Rule suggests greater acceptance of the importance of telehealth in rendering behavioral health care in a more accessible fashion, which providers, investors and other stakeholders could seize upon to standup enhanced, permanent telebehavioral health service offerings in the near term.

FOOTNOTES

[1] *See* 42 C.F.R. §410.78(b).

[2] Even though Medicare may authorize reimbursement for telehealth services meeting the conditions in 42 C.F.R. 414.65 and 410.78, state laws and regulations may impose additional criteria for telehealth services, which must be adhered to for lawful performance and Medicare reimbursement.

[3] CMS defines "home" for such purposes to include the patient's home, other temporary lodging (e.g. hotel, homeless shelter, etc.), or somewhere the patient travels a short distance away to obtain privacy or for other personal reasons.

[4] Social Security Act, Section 1135 Waiver (effective March 6, 2020).

[5] CMS noted that mental health services are different than most other services on the telehealth list in that they primarily involve verbal conversation between the patient and provider and visualization of the patient is less necessary.

[6] *See* Endnote iii (CMS defines "home" for such purposes to include the patient's home, other temporary lodging (e.g., hotel, homeless shelter, etc.), or somewhere the patient travels a short distance away to obtain privacy or for other personal reasons.

[7] Meaning, if the patient is presenting from a patient's home for such services, the home doesn't have to be located in one of the qualifying locations provided by 41 C.F.R. §410.78(b)(4): a health professional shortage area that is either outside of a Metropolitan Statistical Service Area ("MSA") or within a rural census tract of an MSA as determined by the Office of Rural Health Policy of the Health Resources and Services Administration as of December 31 of the preceding calendar year, nor does

the home need to be located in a county that is not included in a MSA as defined in Section 1886(d)(2)(D) of the Act as of December 31 of the preceding calendar year.

[8] The Final Rule didn't address broadening the definition of eligible practitioner beyond the standard Medicare telehealth requirement found at 42 C.F.R. §410.78(b)(2). Medicare allows the following providers to provide telehealth services under standard criteria: physicians, physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, psychiatrists, clinical social workers, registered dietitians and nutrition professionals, certified registered nurse anesthetists.

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