

Frequently Asked Questions:

CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency

While some FAQs are relevant for all programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and private insurance, other questions are program specific as indicated below.

1. When is the COVID-19 Public Health Emergency expected to end?

Based on current COVID-19 trends, the Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency for COVID-19 (PHE) declared by the Secretary of the Department of Health and Human Services (Secretary) under Section 319 of the Public Health Service (PHS) Act to expire at the end of the day on May 11, 2023.

2. On April 10, 2023, the President signed H.J.Res.7. into law, which terminated the national COVID-19 emergency immediately. Did this end the COVID-19 PHE declared by the Secretary?

The PHE for COVID-19 declared by the Secretary under section 319 of the PHS Act is not the same as the COVID-19 National Emergency declared by President Trump in 2020, which ended when President Biden signed H.J.Res.7. Therefore, the end of the COVID-19 National Emergency generally does not impact current operations at HHS, and it does not impact the expected May 11, 2023, expiration of the federal PHE for COVID-19 or any associated unwinding plans. Further, any existing waivers currently in effect and authorized under section 1135 of the Social Security Act will remain in place until the end of the PHE for COVID-19 declared by the Secretary under section 319 of the PHS Act.

3. Many of the flexibilities and waivers in place are tied to emergency declarations, legislative actions by Congress, and regulatory actions across government. Can the Centers for Medicare & Medicaid Services (CMS) extend Medicare, Medicaid, and Marketplace flexibilities beyond May 11, 2023, when the Administration is planning to end the PHE?

Thanks to the Administration's whole-of-government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from an emergency phase. The emergency declarations, legislative actions by Congress, and regulatory actions across government, including by CMS, allowed for changes to many aspects of health care delivery during the COVID-19 PHE. Health care providers received maximum flexibility to streamline delivery and allow access to care during the PHE. While some of these changes will be permanent or have been extended due to Congressional action, some waivers and flexibilities will expire, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules.

CMS has released several documents that identify when waivers and flexibilities will end, as well as which waivers and flexibilities have been extended or will remain beyond the end of the PHE. To help individuals served by our programs know what to expect when the COVID-19 PHE ends, CMS released a [fact sheet](#) that highlights major impacts. CMS also released provider-specific [fact sheets](#) that will help the health care sector transition to non-emergency operations when the PHE ends. In addition, CMS developed a [roadmap](#) for the eventual end of the COVID-19 PHE and is sharing information on what health care facilities and providers can do to prepare for future emergencies.

Additionally, we are offering technical assistance to States overseeing Medicaid and CHIP programs and engaging in public education about the necessary steps to prepare for the end of the PHE, including guidance on the end of the Medicaid continuous enrollment condition and the expiration of many other temporary authorities adopted by states during the COVID-19 PHE. For additional information, visit [CMS.gov](https://www.cms.gov).

MEDICARE:

4. When the PHE ends, will people insured by Medicare pay for COVID-19 vaccines?

People with Medicare coverage will continue to have access to COVID-19 vaccinations without out-of-pocket costs after the end of the PHE.

Once the federal government is no longer purchasing or distributing COVID-19 vaccines, people with Traditional Medicare pay nothing for a COVID-19 vaccination if their doctor or other qualified health care provider accepts assignment for giving the shot. People with Medicare Advantage (MA) plans should contact their plan for details about payment for COVID-19 vaccines, but MA beneficiaries will pay nothing for a COVID-19 vaccination if they receive their vaccinations from an in-network provider.

5. How much will CMS pay health care providers to administer COVID-19 vaccines through the end of the 2023 calendar year?

Under the Medicare Part B preventive vaccine benefit, CMS will continue to pay approximately \$40 per dose for administering COVID-19 vaccines through the end of the calendar year in which the Secretary ends the Emergency Use Authorization (EUA) declaration for drugs and biologicals with respect to COVID-19. The COVID-19 EUA declaration has not ended. Note: The COVID-19 EUA declaration is distinct from, and not dependent on, the federal PHE for COVID-19, expected to expire on May 11, 2023, or the COVID-19 National Emergency that ended April 10, 2023.

Effective January 1 of the year following the year in which the EUA declaration ends, CMS will set the payment rate for administering COVID-19 vaccines to align with the payment rate for administering other Part B preventive vaccines, which is currently approximately \$30 per dose.

These payment rates do not apply in settings that are paid at reasonable cost for preventive vaccines and their administration (for example, Federally Qualified Health Centers and Rural Health Clinics).

If someone is enrolled in an MA plan, the provider should submit claims for vaccine administration to the MA plan, and the amount the provider is paid for the vaccine administration service is determined by the contract between the MA plan and the provider if there is a contract. If there is no contract in place for COVID-19 vaccinations covered by the MA plan, the Medicare payment rate would apply.

6. When the PHE ends, will the additional payment for at-home COVID-19 vaccinations continue?

Medicare will continue to pay an additional amount of about \$36 in addition to regular administration fees for the administration of COVID-19 vaccines at home when the PHE ends. This additional Medicare payment for at-home COVID-19 vaccinations will continue through the end of calendar year 2023.

For individuals enrolled in a MA plan, provider payment rates are determined by the contract between the MA plan and the provider when such a contract is in place and may or may not include additional payments for at-home COVID-19 vaccinations. If there is no contract in place for vaccinations covered by the MA plan, the Medicare payment rate would apply.

7. When will the enforcement discretion end that allows mass immunizers to bill directly to Part B for vaccines furnished to Skilled-Nursing Facility (SNF) patients in a Medicare-covered stay?

Anticipating the end of the COVID-19 PHE on May 11, 2023, the enforcement discretion associated with this policy would end on June 30, 2023. Beginning on July 1, 2023, SNFs will be responsible for billing for vaccines furnished to SNF patients in a Part A stay. Third-party suppliers furnishing these vaccines under arrangement with the SNF would be required to seek payment from the SNF for their services, consistent with SNF Consolidated Billing regulations.

8. Will Medicare continue to cover treatment(s) for patients with COVID-19?

Yes. There is no change in Medicare coverage of treatments for those exposed to

COVID-19 once the PHE ends, and in cases where cost sharing and deductibles apply now, they will continue to apply. Generally, the end of the COVID-19 PHE does not change access to oral antivirals, such as Paxlovid and Lagevrio.

For individuals enrolled in a MA plan, the plans must cover treatments that Traditional Medicare covers, but they may require the individual to see a provider who is in the MA plan's network and may have different cost sharing than Traditional Medicare.

10. How will Medicare cover diagnostic testing for COVID-19?

People with Traditional Medicare can continue to receive COVID-19 PCR and antigen tests with no cost-sharing when the test is ordered by a physician or certain other health care providers, such as physician assistants and certain registered nurses, and performed by a laboratory.

People enrolled in MA plans can continue to receive COVID-19 PCR and antigen tests when the test is covered by Medicare, but their cost-sharing may change when the COVID-19 PHE ends.

Through the end of the COVID-19 PHE, Medicare covers and pays for over-the-counter (OTC) COVID-19 tests at no cost to people with Medicare Part B, including those with MA plans. The demonstration that allowed coverage and payment for OTC tests will end when the PHE ends on May 11; Medicare Advantage plans may continue to cover the tests, so check with your plan for details.

11. Can a pharmacy still perform COVID-19 testing and be paid by Medicare for it?

A pharmacy that acquires a CLIA certificate (including, for example, a certificate of waiver) can enroll with Medicare as a clinical diagnostic laboratory to conduct and bill for clinical diagnostic laboratory tests authorized under their certificate, and many pharmacies have done this to furnish and bill for COVID-19 diagnostic laboratory tests during the PHE. This is permissible under current permanent Medicare policies. After the PHE ends, the test must be ordered by a physician or certain other health care providers, such as physician assistants and nurse practitioners.

12. Will the waiver of the three-day hospital stay requirement prior to a SNF stay continue, or will it end with the PHE?

Many flexibilities, including the waiver of the Medicare three-day qualifying hospital stay (QHS) requirement prior to a Medicare-covered SNF stay, will no longer be in effect for the Medicare fee-for-service program once the PHE ends.

For any Medicare Part A-covered SNF stay which begins on or prior to May 11, 2023, without a QHS, that stay can continue for as long as the beneficiary has Part A SNF benefit days available and for as long as the beneficiary continues to meet the SNF level of care criteria (e.g., requiring daily skilled care). For any new Medicare Part A-covered SNF stay which begins after May 11, 2023, (including stays which experience a break in Part A coverage that exceeds three consecutive calendar days before resuming SNF coverage), these stays will require a QHS.

However, a doctor or other provider who is part of an Accountable Care Organization (ACO) may still be able to send their patients for a Medicare-covered SNF stay even if they have not stayed as an inpatient in a hospital for at least three consecutive days first. For someone to qualify for this benefit, the doctor or other provider has to decide that SNF care is needed and certain other eligibility requirements are met.

Additionally, MA plans may elect to furnish coverage of post-hospital SNF care in the absence of the prior qualifying hospital stay as part of their Medicare-covered services. MA enrollees should check their Evidence of Coverage document for coverage requirements related to SNF care.

13. When the PHE ends, can individuals continue to see providers virtually using telehealth?

Yes, in most cases. 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. These waivers were included as provisions of The *Consolidated Appropriations Act, 2023*, which extended many telehealth flexibilities through December 31, 2024, such as:

- People with Medicare can access telehealth services in any geographic area in the United States, rather than only in rural areas.
- People with Medicare can stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility.
- Certain 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).

However, if an individual receives routine home care via telehealth under the hospice benefit, this flexibility will end at the end of the PHE.

MA plans may offer additional telehealth benefits. Individuals in an MA plan should check with their plan about coverage for telehealth services. Additionally, after December 31, 2024, when these flexibilities expire, some ACOs may offer telehealth services that allow primary care doctors to care for patients without an in-person visit, no matter where they live.

14. At the end of the PHE, when can hospitals bill for:

- The originating site facility fee (HCPCS code Q3014)?**
- The clinic visit (HCPCS code G0463)?**
- Remote mental health services (HCPCS codes C7900 - C7902)?**

Following the anticipated end of the PHE (May 11, 2023):

- Hospitals cannot bill for this code after the PHE unless the beneficiary is located *within a hospital* and the beneficiary receives a *Medicare telehealth service from an eligible distant site practitioner*. Only in these cases can the hospital would bill for the originating site facility fee (HCPCS code Q3014). See question 17 for additional details.
- If the beneficiary is *within a hospital* and receives a *hospital outpatient clinic visit* (including a mental/behavioral health visit) from a practitioner in the same physical location, then the hospital would bill for the clinic visit (HCPCS code G0463).

iii. If the beneficiary is *in their home* and receives a *mental/behavioral health service from hospital staff through the use of telecommunications technology* and no separate professional service can be billed, then the hospital would bill for the applicable HCPCS C-code describing this service (HCPCS codes C7900 - C7902).

15. The Consolidated Appropriations Act, 2023 extended certain Medicare telehealth flexibilities through the end of CY 2024. Has the Hospitals Without Walls Initiative been extended as well?

No. The Hospitals Without Walls Initiative will expire with the PHE. The PHE is anticipated to end at the end of the day on May 11, 2023.

16. If the Hospitals Without Walls Initiative expires at the end of the day on May 11, 2023, why are beneficiaries able to receive mental/behavioral health services in their home from hospital staff through the use of telecommunications technology after that date?

The flexibilities currently in place under the Hospital Without Walls Initiative during the COVID-19 PHE allowed hospitals to bill for services furnished by hospital clinical staff to beneficiaries in their homes using telecommunications technology, because the home was considered a provider-based department of the hospital. The services included a subset of hospital outpatient therapy, counseling, and educational services, beyond just mental/behavioral health services.

After the PHE ends, in some circumstances, hospitals will continue to be able to bill for mental/behavioral health services furnished to beneficiaries in their homes by hospital staff using telecommunications technology permanently. This policy only applies when no separate professional service is billable, as finalized in the calendar year 2023 Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule (87 FR 71748). These services are considered “remote mental health services.”

However, once the beneficiary’s home is no longer considered a provider-based department of the hospital after the end of the PHE, the hospital staff will no longer be able to bill for other outpatient services furnished to beneficiaries in the home.

Notably, in accordance with the *Consolidated Appropriations Act, 2023*, eligible distant site physicians and practitioners may still be able to bill as a Medicare telehealth service under the Medicare physician fee schedule for professional services furnished via telehealth to individuals in their homes through December 31, 2024.

17. After the end of the PHE, can hospitals bill for the originating site facility fee (HCPCS code Q3014) when a beneficiary is not in the hospital but a hospital-based outpatient department physician furnishes a Medicare telehealth service and the hospital provides administrative and clinical support?

No. Following the anticipated end of the PHE (May 11, 2023), hospitals will no longer be able to bill HCPCS code Q3014 to account for the resources associated with administrative support for a professional Medicare telehealth service.

18. Following the end of the PHE, can hospitals bill for outpatient physical/occupational therapy services provided to beneficiaries in their homes through telecommunication technology by hospital employed physical therapists, occupational therapists, and speech language pathologists?

The waivers that currently allow for these flexibilities were under the CMS Hospitals Without Walls Initiative that will expire at the end of the PHE.

During the PHE, under these waivers, a subset of counseling, therapy, and educational services have been eligible to be provided remotely by the hospital clinical staff, as long as they were furnished to a patient in the hospital, which may have included the patient's home, if the home was considered a provider-based department of to the hospital during the PHE.

In context of the anticipated end of the PHE, we have received a number of inquiries from interested parties regarding the expiration of this policy, including questions about whether policies other than the expiring waivers are relevant. We recognize the urgency of the questions and they are currently under review.

19. What impact will the end of the COVID-19 PHE have on the reporting requirements imposed on nursing homes, hospitals, and critical access hospitals?

Nursing home COVID-19 vaccination reporting requirements for nursing home residents and staff will continue until CMS takes other regulatory action. All of the other non-vaccine COVID-19 reporting requirements are in effect through December 2024. Regardless of the COVID-19 PHE, nursing homes are still required to have an effective infection prevention and control program, which is a longstanding requirement to prevent the transmission of infectious diseases (which would include COVID-19).

In the August 10, 2022, Fiscal Year 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule, CMS revised the hospital and critical access hospitals (CAHs) infection prevention and control Condition of Participation so that hospitals and CAHs will continue to report on a reduced number of COVID-19 data elements after the conclusion of the COVID-19 PHE until April 30, 2024, unless the Secretary establishes an earlier end date.

20. At the end of the PHE, how will CMS' review contractors conduct medical reviews for claims billed during the PHE based on approved waivers or flexibilities?

CMS contractors (Medicare Administrative Contractors, Recovery Audit Contractors, and Supplemental Medical Review Contractors) conduct medical reviews on a very small percentage

of Medicare Fee-for-Service claims each year. During the PHE, CMS and its contractors applied flexibilities across claim types. All claims will be reviewed using the applicable rules and restrictions that were in place at the time of the date(s) of service on the claim. For example, during the PHE, CMS has not enforced certain National Coverage Decision (NCD) and Local Coverage Decision (LCD) requirements that otherwise would have restricted coverage for certain durable medical equipment (DME) items. Once the PHE ends, CMS will primarily focus DME medical reviews on claims with dates of service post-PHE, for which clinical coverage requirements apply. We note that we may still review the claims for certain DME items, as well as other items or services furnished during the PHE, if needed to address aberrant billing behaviors or potential fraud. If this were to occur, the appropriate review contractor website would be updated with the review topic. The HHS-Office of the Inspector General may perform reviews as well, if necessary. The Comprehensive Error Rate Testing (CERT) program will continue to review a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and payment rules in place at the time of the date(s) of service on the claim.

21. What does this mean for medical review of DME supplies or ongoing DME rental claims?

For certain DME supplies and ongoing rental items provided during the PHE, CMS allowed certain flexibilities and has not enforced certain NCD and LCD requirements. We note that statutory and regulatory requirements for DME items remained applicable. Since medical need for supplies and ongoing rentals is typically established and documented when the item is initially provided, we plan to primarily focus our medical reviews on claims with initial dates of service after the COVID-19 PHE. We may still review these DME items, as well as other items or services rendered during the COVID-19 PHE, if needed to address aberrant billing behaviors or potential fraud. All claims will be reviewed using the applicable rules in place at the time of the claim dates of service. In the event that claim review occurs, CMS or its contractors (Medicare Administrative Contractors, Recovery Audit Contractors and the Supplemental Medical Review Contractors) will provide additional information based on the supply or rental item selected for review.

22. Since Continuous Glucose Monitors (CGMs) and related supplies require a face-to-face follow up within six months, how will CMS review contractors conduct medical review for CGMs that were initially obtained during or prior to the PHE?

When evaluating for compliance with the face-to-face requirement, the Medicare Administrative Contractors, Supplemental Medical Review Contractors, and the Recovery Audit Contractors will generally focus on CGM claims with dates of service six months beyond the end of the PHE to ensure the treating practitioner had an in-person visit or a Medicare-allowed telehealth visit with the beneficiary. Therefore, potential medical reviews for CGMs (for which we did not enforce certain NCD and LCD requirements that otherwise would have restricted coverage) would focus on the six months after the anticipated end of the PHE (May 11, 2023), and every six months thereafter. In other words, the treating practitioner visit will be used to assess beneficiary adherence to their CGM regimen and diabetes treatment plan. All claims will be reviewed using the applicable rules for the claim dates of service.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

23. What is the end of the Medicaid continuous enrollment condition, and is it tied to the end of the PHE?

No. The end of the continuous enrollment condition for individuals enrolled in Medicaid is no longer linked to the end of the COVID-19 PHE. Instead, it ended on March 31, 2023.

In March 2020, Congress enacted the *Families First Coronavirus Response Act* (FFCRA), which made a temporary increase in the federal medical assistance percentage (FMAP) available to states that met certain conditions, including a condition under which states had to maintain the enrollment of any person enrolled in Medicaid as of or after March 18, 2020 (continuous enrollment condition). Primarily due to the continuous enrollment condition, Medicaid enrollment has [grown substantially compared to before the pandemic](#), and the [uninsured rate](#) has dropped. [As of December 2022](#), over 92 million people were enrolled in Medicaid and CHIP.

On December 29, 2022, President Biden signed into law the *Consolidated Appropriations Act, 2023* (CAA, 2023). This legislation ended the continuous enrollment provision on March 31, 2023. The CAA, 2023 also phases down the FFCRA temporary FMAP increase until December 31, 2023. All states, including states that accept the FFCRA temporary FMAP increase, began to return to normal eligibility operations as soon as April 1, 2023. This process includes restarting Medicaid and CHIP eligibility renewals for all enrollees and terminations of coverage for individuals who are no longer eligible. States have up to 12 months to return to normal eligibility and enrollment operations. All states must meet certain reporting and other requirements during this return to normal enrollment and eligibility operations regardless of whether states continue to claim the FFCRA temporary FMAP increase.

It is a top CMS priority that people retain coverage, whether through Medicaid, CHIP, Marketplace, Medicare, or employer-sponsored health insurance. In an effort to minimize the number of people who lose Medicaid or CHIP coverage, CMS is working with states and stakeholders to inform people currently enrolled in Medicaid and CHIP about renewing their coverage and exploring other available health insurance options if they no longer qualify for Medicaid or CHIP, including through the Marketplaces. To find information about how to renew Medicaid or CHIP in your particular state, please visit our [interactive map at Medicaid.gov](#). Additional information and resources can be found on CMS' [Medicaid Unwinding web page](#).

24. When the PHE ends, will Medicaid continue to cover COVID-19-vaccines, testing, and treatments?

Generally, yes. As a result of the *American Rescue Plan Act of 2021* (ARPA), states must provide Medicaid and CHIP coverage, without cost-sharing, for COVID-19 vaccinations, testing, and treatments through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. If the COVID-19 PHE ends as expected on May 11, 2023, this coverage requirement will end on September 30, 2024.

After that date, many Medicaid and CHIP enrollees will continue to have coverage for COVID-19 vaccinations. After the ARPA coverage requirements expire, Medicaid and CHIP coverage of COVID-19 treatments and testing may vary by state.

Additionally, 18 states and U.S. territories have opted to provide Medicaid coverage to uninsured individuals for COVID-19 vaccinations, testing, and treatment. Under federal law, Medicaid coverage of COVID-19 vaccinations, testing, and treatment for this group will end when the PHE ends.

25. What Medicaid telehealth flexibilities will end, and what flexibilities will remain in place?

No flexibilities will end. For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Medicaid and CHIP telehealth policies will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

To assist states with the continuation, adoption, or expansion of telehealth coverage, 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.

PRIVATE INSURANCE

26. What is the “Unwinding SEP,” and how can consumers qualify?

CMS has announced a temporary Special Enrollment Period (SEP) for qualified individuals and their families who are losing Medicaid or CHIP coverage due to the end of the continuous enrollment condition. During this process, known as “unwinding,” millions of individuals could lose their Medicaid or CHIP coverage and need to transition to other forms of coverage, including through the Marketplaces.

Due to the volume of individuals who could lose their Medicaid or CHIP coverage, state Medicaid and CHIP agencies may be unable to provide timely information about the termination of coverage and alternative plan options that would enable consumers to make an informed decision about their health care coverage options within 60 days. For example, a consumer may need clarity as to whether a loss of Medicaid or CHIP coverage was procedural, such as a failure to update information, or due to ineligibility, before deciding whether to pursue Marketplace coverage.

Additionally, many Medicaid and CHIP beneficiaries may have moved or changed addresses since last receiving communications from their state. As a result, they may not receive termination notices from their state Medicaid or CHIP agency within 60 days or at all. Given these exceptional circumstances, CMS has made this SEP, also referred to as the “Unwinding SEP,” available so consumers can maintain coverage.

The Unwinding SEP will allow individuals and families in states with Marketplaces served by the [HealthCare.gov](https://www.healthcare.gov) platform to enroll in Marketplace coverage. Marketplace-eligible consumers who submit a new application or update an existing [HealthCare.gov](https://www.healthcare.gov) application between March 31, 2023, and July 31, 2024, and attest to a last day of Medicaid or CHIP coverage during the same time period will be eligible for the Unwinding SEP. Consumers who are eligible for the Unwinding SEP will then have 60 days after they submit their application to select a plan with coverage that will start on the first day of the month after they select a plan. Consumers will not be required to submit documentation of a qualifying life event to receive the Unwinding SEP.

27. What impact will the end of PHE have on private insurance coverage of vaccines?

Most forms of private health insurance, including all Affordable Care Act-compliant plans, must continue to cover without cost-sharing COVID-19 vaccines furnished by an in-network health care provider. People with private health insurance may need to pay part of the cost if an out-of-network provider vaccinates them.

28. What impact will the end of the PHE have on private insurance coverage of COVID-19 diagnostic testing?

Mandatory coverage for over-the-counter and laboratory-based COVID-19 PCR and antigen tests will end after the expected end of the PHE on May 11, 2023, though coverage will vary depending on the health plan. If private insurance chooses to cover these items or services, there may be cost sharing, prior authorization, or other forms of medical management may be required.

29. What impact will the end of the PHE have on private insurance coverage of treatments?

Nothing. The transition forward from the PHE will not change how treatments are covered, and in cases where cost sharing and deductibles apply now, they will continue to apply.

30. What is the impact of the end of the use of telehealth in private insurance?

Nothing. As is currently the case during the PHE, coverage for telehealth and other remote care services will vary by private insurance plan after the end of the PHE. When covered, private insurance may impose cost-sharing, prior authorization, or other forms of medical management on telehealth and other remote care services. For additional information on your insurer's approach to telehealth, contact your insurer's customer service number located on the back of your insurance card.