Issue Brief: Aligned Support on Legislative & Regulatory Changes to Extend COVID-19 Telehealth Flexibilities

June 18, 2020

I. INTRODUCTION

The COVID-19 public health emergency has required a swift and monumental response across several federal agencies and Congress. Through a combination of emergency powers, federal agencies have collectively issued over 600 temporary flexibilities and regulatory changes intended to bolster the U.S. response to the pandemic.[1]

With respect to the Department of Health and Human Services (HHS), many of the deregulatory measures issued thus far have been effectuated via section 1135 waiver authority. Section 1135 waivers allow the Secretary to temporarily modify or waive certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements during a public health emergency (PHE).[2]

On May 19, 2020, President Donald Trump signed an Executive Order (EO) intended to spur economic recovery following the pandemic-related shutdowns of local economies.[3] The EO directs federal agencies to identify which, if any, temporary flexibilities extended during the PHE could be made permanent to support economic recovery. Federal agencies are required to send any identified flexibilities to the Office of Management and Budget, the Assistant to the President for Domestic Health Policy, and the Assistant to the President for Economic Policy, though no due date was included.

Many stakeholders see this development as an opportunity to influence the national dialogue on the temporary health care flexibilities implemented in response to COVID-19 that ought to be made permanent. Among such flexibilities, health care stakeholders have especially homed in on the vast array of sweeping Medicare telehealth flexibilities as principle among flexibilities that should be made permanent.[4]

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[1] https://www.washingtonpost.com/climate-environment/citing-an-economic-emergency-trump-directs-agencies-across-government-to-waive-federal-regulations/2020/06/05/6a23546c-a0fc-11ea-b5c9-570a91917d8d_story.html
[2] https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx
[3] https://www.whitehouse.gov/presidential-actions/executive-order-regulatory-relief-support-economic-recovery/
[4] For a list of these flexibilities, reference: https://mypolicyhub.com/wp-content/uploads/2020/05/WHG_COVID-19-Federal-Telehealth-Flexibilities-Chart_5.14.2020.pdf

In light of this opportunity, Wynne Health Group developed the following tables to aid organizations in identifying which telehealth-related flexibilities under Medicare may be made permanent pursuant to the President's EO; which precise legislative or regulatory changes would be required to do so; which stakeholders are already aligned on these issues; and, where there may be existing support in Congress.

Overall, this resource demonstrates there is extensive support for making several Medicare telehealth flexibilities permanent, including those pertaining to Medicare's statutory originating and geographic site restrictions, newly eligible telehealth services, and waivers for audio-only technology.

II. MEDICARE TELEHEALTH FLEXIBILITIES THAT COULD BE MADE PERMANENT

The following table displays telehealth flexibilities resulting from the COVID-19 PHE that may be made permanent under the Administration's EO to promote economic recovery, as the U.S. continues its response to the pandemic. For each flexibility, the chart then briefly outlines what legislative or regulatory changes would be required to make such flexibilities permanent. We also include a list of key stakeholders that have communicated explicit support for making permanent each flexibility based, on public remarks. More detail on the public statements conveyed by aligned key stakeholders is delineated in section III.

Table 1: Legislative or Regulatory Changes Required to Make Temporary Telehealth Flexibilities Permanent

Medicare Telehealth Flexibility	Legislative or Regulatory Change Required to Make Permanent	Publicly Aligned Key Stakeholders
Legislative Changes Only		
Originating and Geographic Site Restrictions • Waives the originating site and rural requirements allowing beneficiaries to receive telehealth services in their home.	• Congress must amend section 1834(m)(4)(C)[5] by : (1) removing section (i) regarding originating site requirements (i.e., to ensure all Medicare beneficiaries – urban and rural – may access these services); and (2) including a beneficiary's home as a qualifying originating site in section (ii).	APA,[6] AAMC,[7] CHIME,[8] C-TAC,[9] APC[10]

[5] https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[6] American Psychiatric Association
[7] American Association of Medical Colleges
[8] College of Healthcare Information Management Executives
[9] Center to Transform Advanced Care
[10] American College of Physicians

Full Payment Parity (i.e., Inclusive of Facility Fee) • Continues to reimburse providers billing for telehealth according to the payments they would have received had they furnished the services in-person[11] but also ensures that the "facility fee" is paid when the originating site is a beneficiary's home (for which a facility fee is currently precluded)[12].	• Congress must amend section 1834(m)(2)(B)[13] to require HHS to pay the facility fee that would otherwise be paid for a service furnished in a qualifying originating site, including for services provided to a beneficiary in his or her home.	AAMC, CHIME
Eligible Practitioners • Waives the requirements that specify the types of practitioners that may bill for Medicare telehealth services from the distant site. This allows previously ineligible health care professionals to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, and speech language pathologists.	• Congress must amend section 1834(m)(4)(E) and 42 CFR § 410.78(b)(2)[14] to broaden the list of practitioners eligible to furnish telehealth services under Medicare.	CHIME
Process for Adding Telehealth Services • Establishes a sub-regulatory process to modify the services included on the Medicare telehealth list.	• Congress must ust amend section 1834(m)(4)(F)(ii) to require HHS to establish a sub-regulatory process that allows the agency to add new telehealth codes on a rolling basis, as opposed to the annual basis explicitly codified in statute. (Note: This interpretation is a bit nuanced, since CMS may have some administrative discretion to implement a sub-regulatory process on a rolling basis that still, generally, fulfils its statutory annual payment update obligation).	CHIME

[11] Pursuant to section 1834(m)(2)(A): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[12] Pursuant to section 1834(m)(2)(B)(ii): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[13] https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[14] https://www.law.cornell.edu/cfr/text/42/410.78

Regulatory Changes Only		
Long-Term Care Facility Waiver • Waives the requirement for physicians and non-physician practitioners to perform in-person visits to allow for providers to furnish these services via telehealth.	• Regulatory change required but dependent on legislative changes. • HHS must amend 42 CFR § 483.30[15] to reflect that practitioners can perform in-person visits via telehealth. • This service must then be added to the list of Medicare-covered telehealth services via the Physician Fee Schedule or through any forthcoming sub-regulatory process for adding new telehealth services. • The impact of this change is also dependent on the legislative change to remove the originating site and geographic restrictions.	CHIME
Critical Access Hospital Waiver • Waives provisions related to telehealth, making it easier for telehealth services to be furnished to the hospital's patients through an agreement with an off-site hospital.	• HHS must amend 42 CFR § 482.12(a)(8-9)[16] and 42 CFR § 485.616(c)[17] to permanently waive the requirements around telehealth in order to facilitate easier access to care.	CHIME
Medicare Advantage (MA) and Part D Plan Waiver • Allows MA plans to make changes to their benefit packages regarding telehealth services in real-time (i.e., before the bid submission deadline).	• HHS must amend 42 CFR § 422[18] to state that MA plans may add telehealth services to their benefit packages on a rolling basis.	CHIME
Newly Eligible Telehealth Services • Includes new codes to the list of eligible Medicare telehealth services, including codes for emergency	• HHS is able to adopt new telehealth services for Medicare through its annual rulemaking process.	APA, AAMC, AMGA,[19] CHIME

[15] https://www.law.cornell.edu/cfr/text/42/483.30
[16] https://www.law.cornell.edu/cfr/text/42/482.12
[17] https://www.law.cornell.edu/cfr/text/42/485.616
[18] https://www.law.cornell.edu/cfr/text/42/part-422/subpart-C
[19] American Medical Group Association

department visits, observation services, nursing facility visits, home visits, inpatient neonatal and pediatric critical care, end-stage renal disease (ESRD) services, and more.	HHS currently does so through the Physician Fee Schedule.	
Interactive Communication System Clarification • Allows a temporary exception clarifying that mobile phones with audio and visual capabilities qualify as an "interactive telecommunications system" for the purposes of telehealth.	• HHS must amend 42 CFR § 410.78(a)(3)[20] to permanently include the clarifying language specifying that interactive telecommunications systems refer to equipment that includes audio and video equipment permitting real-time, two-way communication, such as mobile phones/computing devices.	AMGA, CHIME
Remote Patient Monitoring • Allows providers to use communication technology-based services (CTBS) – which are considered related to but separate from telehealth services – to both new and established patients. These include certain kinds of remote patient monitoring and remote interpretation of diagnostic tests.	• HHS must update the corresponding HCPCS codes to specify that providers may furnish these services to new patients through regulatory changes in the Physician Fee Schedule.	AAMC, CHIME, C-TAC
Opioid Treatment Programs (OTPs) • Allows OTPs to furnish periodic assessments via two-way interactive audio-visual communication technology or audio-only telephone calls, if the beneficiary lacks access to audio-video community technology, during the PHE.	• HHS must amend 42 CFR § 410.67(b)(3-4)[21] to permanently allow OTPs to furnish periodic assessments through audio-only technologies when beneficiaries do not have access to audio-video communication technologies.	CHIME

[20] https://www.law.cornell.edu/cfr/text/42/410.78
[21] https://www.law.cornell.edu/cfr/text/42/410.67

BOTH Legislative and Regulatory Changes Needed		
Audio-only Technologies • Waives the video requirements of telehealth services to permit audio-only equipment to furnish services via audio-only technologies (i.e., telephones) for select services, including evaluation & management (E&M) services, and behavioral health counseling and educational services. • Establishes a higher reimbursement rate for telephone E/M services based on crosswalks to the most analogous office/outpatient E/M codes.	• Legislative and regulatory changes required. • Congress must amend section 1834(m)(1)[22] to expressly permit HHS to furnish certain services via audio-only technologies if deemed appropriate. • CMS must then issue conforming regulatory changes (delineated at 42 CFR § 410.78(a)(3)[23]) to allow for a defined set of services to be furnished via audio-only technologies. • For audio-only payment parity, CMS must adjust the corresponding relative value units (RVUs) for each CPT/HCPCS code, likely through the annual Physician Fee Schedule rulemaking cycle.	APA, AAMC, AMGA, MHLG,[24] CHIME, C-TAC, APC

III. ALIGNED STAKEHOLDER PUBLIC STATEMENTS ON TELEHEALTH FLEXIBILITIES

Several stakeholders have spoken out in support of making permanent many of the broad expansions to telehealth during the COVID-19 pandemic. For example, in response to the PHE, the National Committee for Quality Assurance, Alliance for Connected Care, and the American Telemedicine Association announced a new joint taskforce to develop long-term recommendations for improving telehealth policy.[25] The taskforce will draw on the experience from plans, providers, consumer advocates, and health quality experts across the private, public, and non-profit sectors. Of note, two members on the panel include key administration officials – Nicholas Uehlecke, Federal Liaison at HHS, and Dr. Michelle Schreiber, Director of Quality Measurement & Value-Based Incentives Group at CMS. The taskforce intends to release its final recommendations in September 2020.

[22] https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[23] https://www.law.cornell.edu/cfr/text/42/410.78
[24] Mental Health Liaison Group
[25] http://connectwithcare.org/healthcare-leaders-form-taskforce-on-telehealth/

The chart below captures the public statements made by additional health care organizations who are in favor of retaining the COVID-19 telehealth flexibilities beyond the public health emergency. Generally, most stakeholders are supportive of removing the originating site and geographic location requirements and continuing to allow audio-only telephone telehealth services. Other flexibilities supported include expanding the Medicare approved telehealth list of services and maintaining increased payment for evaluation and management (E/M) telehealth services.

Table 2: Public Comments from Stakeholders in Support of Making Telehealth Flexibilities Permanent

Organization	Public Comments
CHIME[26]	CHIME broadly supports the changes enacted by Congress and the administration and wants them to be made permanent due to the value telehealth brings to patients and providers.
NAHC[27]	NAHC recommends the following: • Develop regulations that permanently allow the hospice face-to-face recertification to be completed using telehealth when appropriate; and • Clarify that hospice providers are permitted to use telecommunication technology to perform services.
APA[28]	APA recommends the following: • Remove limitations around originating site and geographical restrictions for mental health services; • Include all services on the expanded Medicare approved telehealth list, including group psychotherapy; • Maintain coverage and increase payment for telephone evaluation and management (E/M) services provided via telehealth; • Allow for the use of audio-only telephone communication for E/M behavioral health services; • Remove frequency limitation for existing telehealth services in inpatient settings and nursing facilities; and • Allow teaching physicians to provide direct supervision of medical residents remotely through telehealth.

[26] https://chimecentral.org/chime-statement-on-making-telehealth-changes-permanent/
[27] https://www.nahc.org/wp-content/uploads/2020/05/Hon-Seems-Verma-Hospice-Use-of-Telecomunications-FINAL-1.pdf
[28] https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Federal/APA-Letter-CMS-Telehealth-Flexibilities-COVID-19-06012020.pdf

AAMC[29]	AAMC recommends the following: • Allow patients to receive telehealth services in any geographic location and at any site, including the patient's home; • Providers should receive the amount of Medicare Physician Fee Schedule payment as if the services had been provided in person; • CMS should expand the list of eligible telehealth services to include those added during the public health emergency; • Allow telehealth to be offered to new patients; • Allow audio-only telehealth services; • Remove Medicare and Medicaid requirements that physicians and non-physician practitioners be licensed in the state they are proving telehealth services; • For evaluation and management services, allow residents to provide telehealth services if supervision requirements are met.
AMGA[30]	AMGA recommends the following: • Allow the use of smartphones to facilitate a telehealth visit; • CMS should expand the list of eligible telehealth services to include those added during the public health emergency; and • Continuing the separate payment for audio-only telephone E/M services and the increase in payment
MHLG[31]	MHLG recommends that CMS establish a one-year transition period, beginning once the public health emergency ends, to retain the current telehealth flexibilities, including those relating to audio-only telehealth health, and plan to make certain flexibilities permanent.
C-TAC[32]	C-TAC recommends the following: • Paying for telehealth services in an expanded set of sites, including a patient's homes; • Allowing telehealth to be delivered via Skype, Zoom, and FaceTime; • Permitting the use of audio-only technologies; • Permitting providers to reduce or waive cost-sharing for telehealth;

[29] https://www.aamc.org/system/files/2020-05/ocomm-hca-aamclettertoCMS5132020.pdf
[30] https://cms.amga.org/AMGA/media/PDFs/Advocacy/Correspondence/CMS%20Correspondence/COVID19/cmts-on-cms-1744-ifc.pdf
[31] https://www.mhlg.org/wordpress/wp-content/uploads/2020/05/MHLG_Letter_on_Making_Telehealth_Flexibilities_Permanent_2020_5-27-2020.pdf
[32] https://www.thectac.org/2020/06/making-certain-covid-19-flexibilities-permanent-c-tac-responds-to-cms-rule/

	• Allowing providers to furnish CTBS to new patients; and • Telehealth expansions for Hospice, RHCs and FQHCs.
ACP[33]	ACP recommends the following: • Payment parity for telehealth services, including audio-only services; • Eliminating restrictions for geographic and originating site restrictions; • Telehealth cost-sharing waivers; • Flexibilities around direct supervision requirements for physicians at teaching hospitals; • Allowing providers to furnish CTBS to new patients; • Flexibilities around interstate licensure at the state-level; and • Facility fee payment for provider-based departments.

IV. RECENT AND POTENTIAL CONGRESSIONAL ACTION ON BROADENED TELEHEALTH ACCESS

A. CONGRESSIONAL ACTIVITY

On June 9, 2020, Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) released a white paper, "Preparing for the Next Pandemic" – a starting point for a legislative package to bolster the federal government's public health infrastructure and capacity.[34] Chairman Alexander, who is retiring this year, is highly motivated to pass pandemic preparedness legislation this year. In the white paper, he recognizes the progress made in expanding access to telehealth through the waived regulations and the need to ensure such capabilities are in place for continuity of care, including routine health care such as vaccinations, during a pandemic. Comments in response to the white paper are due June 26, 2020 and will be shared with both Democrats and Republicans on the Senate HELP Committee to inform legislation development.

The white paper includes the following recommendations that appears to signal strong interest in making some flexibilities discussed above permanent:

> ***RECOMMENDATION 4.1:*** *Get Americans back to their routine health care safely, and develop better plans for the future so that doctors and hospitals can continue to provide health care services and outpatient treatment during a pandemic.*
>
> ***RECOMMENDATION 4.2:*** *Ensure that the United States does not lose the gains made in telehealth.*

[33] https://www.acponline.org/acp_policy/letters/acp_letter_to_cms_regarding_extending_telehealth_policy_changes_after_the_phe_june_2020.pdf
[34] https://www.alexander.senate.gov/public/_cache/files/0b0ca611-05c0-4555-97a1-5dfd3fa2efa4/preparing-for-the-next-pandemic.pdf

During the June 17, 2020 Senate HELP Committee hearing on these telehealth flexibilities, members expressed a strong interest in hearing from stakeholders which flexibilities would be most helpful if made permanent.[35] Chairman Alexander specifically expressed interest in permanently removing the Medicare "originating site" restrictions and permanently adding the new set of telehealth services CMS temporarily included for purposes of the PHE. Stakeholder representatives then recommended the following additional flexibilities be made permanent:

- Flexibilities pertaining to state licensure issues;
- Allowing multiple non-physician practitioner types to furnish telehealth services;
- E-consult flexibilities allowing provider-to-provider consults to happen more easily;
- Payment parity for telehealth services;
- The use of audio-only technologies to deliver telehealth services; and
- Allowing providers to remotely prescribe controlled substances via telehealth encounters.

Of final note, on June 15, 2020, Sens. Brian Schatz (D-HI) and Roger Wicker (R-MS) led a bipartisan group of 30 Members in a letter to Majority Leader Mitch McConnell (R-KY) and Minority Leader Chuck Schumer (D-NY), calling for telehealth-related provisions from the CONNECT for Health Act that were included in the CARES Act to be made permanent.[36] These provisions include authorizing the HHS Secretary to waive telehealth requirements under Section 1834(m), allowing Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), and allowing the use of telehealth to recertify an individual's eligibility for hospice care.

B. ALIGNED LEGISLATION

The chart on the following page reflects major federal legislation that would make some of the relevant flexibilities permanent for certain telehealth services, or those furnished under specified conditions. Given the range of legislative activity on this front, this chart includes only bipartisan bills that would amend special payment rules for telehealth services pursuant to Section 1834(m).

[35] https://mypolicyhub.com/content_entry/committee-collects-input-on-making-pandemic-driven-telehealth-flexibilities-permanent/
[36] https://www.schatz.senate.gov/press-releases/schatz-wicker-lead-bipartisan-group-of-30-senators-in-calling-for-permanent-expansion-of-telehealth-following-covid-19-pandemic

Table 3: Key Legislation on Special Payment Rules Under Medicare for Telehealth

Bill	Summary	Sponsors & Status
CONNECT for Health Act of 2019 (S. 2741[37]/H.R. 4932[38])	**Waiver –** Authorizes the HHS Secretary to waive telehealth requirements (including but not limited to originating site requirements, geographic limitations, technology restrictions, service type limitations) if it would reduce Medicare spending without reducing quality of care or improve quality of care without increasing spending; or for telehealth services furnished in originating sites located in a high-need health professional shortage area (HPSA). **Mental Health –** Exempts mental health telehealth services (as determined by the HHS Secretary) from originating site requirements; and qualifies a Medicare beneficiary's home as an originating site for mental health telehealth services. **Emergency Medicare Care –** Exempts emergency medical care furnished through telehealth from geographic requirements applied to the following originating sites: critical access hospital, hospital, and skilled nursing facility. **Annual Update –** Requires the HHS Secretary to revise the statutorily mandated process for updating the list of telehealth services payable under the Medicare Physician Fee Schedule so that the criteria to add services prioritizes improved access to care **FQHCs, RHCs –** Adds FQHC and RHC to the lists of originating sites and distant sites. **Hospice Care** – Allows recertification for hospice care to be conducted through telehealth. **National Emergency –** Authorizes HHS Secretary to waive requirements for payment for telehealth services under Section 1834(m) during national emergencies.	Sen. Shatz; 33 cosponsors (17 R, 15 D, 1 I); referred to the Senate Finance Committee (SFC) Rep. Mike Thompson (D-CA); 44 cosponsors (23 D, 21 R); referred to the House Energy and Commerce (E&C) Health Subcommittee

[37] https://www.congress.gov/bill/116th-congress/senate-bill/2741
[38] https://www.congress.gov/bill/116th-congress/house-bill/4932

HEALTH Act of 2020 (H.R. 7187[39])	**FQHCs, RHCs –** Modifies payment rules for telehealth services furnished by FQHCs and RHCs: • Would classify FQHCs and RHCs as distant sites permanent, and therefore costs associated with the delivery of telehealth services by FQHCs or RHCs would be considered allowable Medicare costs under the prospective payment system; • Would eliminate originating site requirements for telehealth services furnished by an FQHC or RHC; • Would prohibit a facility fee from being paid to an FQHC or RHC that is serving as a distant site if it is also serving as the originating site. However, ff the FQHC or RHC is furnishing telehealth services to another codified originating site, then the FQHC or RHC would be paid the facility fee; and • Would require the HHS Secretary to revise 42 CFR § 405.2463 to state that telehealth services furnished by an FQHC or RHC are considered to constitute a visit to the FQHC or RHC.[40]	Reps. Glen Thompson (R-PA) and G.K. Butterfield (D-NC); referred to E&C and House Ways and Means (W&M) Committee
Rural Health Clinic Modernization Act of 2019 (S. 1037[41]/ H.R. 2788[42])	**RHCs** – Authorize RHCs to be the distant site for a telehealth visit. The bill would also expand the criteria for RHCs to include a facility located in an area that has been designated by the state governor and certified by the HHS Secretary as rural.	Sen. John Barrasso (R-WY); 7 cosponsors (4 D, 3 R); referred to SFC Rep. Adrian Smith (R-NE); 33 cosponsors (23 R, 10 D); referred to E&C Health Subcommittee

[39] https://www.congress.gov/bill/116th-congress/house-bill/7187
[40] https://www.law.cornell.edu/cfr/text/42/405.2463
[41] https://www.congress.gov/bill/116th-congress/senate-bill/1037
[42] https://www.congress.gov/bill/116th-congress/house-bill/2788

BETTER Act of 2019 (H.R. 3417[43])	**Mental Health –** Provides Medicare coverage for mental health telehealth services (defined as CPT codes 90834 and 90837 for individual psychotherapy); and modifies payment rules for these services: • Would be exempt from originating site requirements; • Would qualify a Medicare beneficiary's home as an originating site; • Would waive originating site facility fees; and • Would require physician or other eligible practitioner to furnish an in-person initial clinical assessment within six-month period (and reassessment at a frequency determined by the HHS Secretary) prior to provision of these services to qualify for reimbursement.	House W&M Committee Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX); reported favorably by W&M Committee (41-0), 6/29/19
EASE Behavioral Health Services Act (H.R. 5473[44])	**Behavioral Health** – Exempts behavioral health services (including initial patient evaluations, follow-up medical management, and other related services) furnished through telehealth from geographic requirements on originating sites	Rep. Gus Bilirakis (R-FL); 3 cosponsors (2 D, 1 R); referred to E&C Health
SEE MORE Act (S. 2020[45])	**Chronic Eye Disease** – Exempts remote imaging for chronic eye disease (including but not limited to diabetic eye disease and glaucoma) furnished through telehealth from originating site requirements and originating site facility fees.	Senate Aging Committee Ranking Member Bob Casey (D-PA) and Senate Finance Committee Chairman Chuck Grassley (R-IA); referred to SFC

V. CONCLUSION

On balance, the changes that would lead to the greatest impact – and that have higher levels of stakeholder support – are those that would require legislative action. These are, namely, permanent removal of the geographic and originating site restrictions, payment parity for services, and adding audio-only technologies as coverable platforms for furnishing telehealth services. Fortunately, these changes also appear to have burgeoning congressional support, as evidenced by the currently active bills in Congress and the remarks from Chairman Alexander during the recent Senate

[43] https://www.congress.gov/bill/116th-congress/house-bill/3417
[44] https://www.congress.gov/bill/116th-congress/house-bill/5473
[45] https://www.congress.gov/bill/116th-congress/senate-bill/2020

HELP hearing on telehealth. As such, seeking the permanence of these key telehealth flexibilities will require stakeholders to continue calling for congressional action.

Distinct from those efforts, is the push to add the services newly made eligible via telehealth to the Medicare telehealth list. This is possible to do via the annual rulemaking process per current administrative authority (e.g., by including these services for addition to the Medicare telehealth list in the forthcoming Physician Fee Schedule). However, the impact of adding these services to the Medicare telehealth list would still be curbed by the overarching restrictions to telehealth's reach – most notably, the geographic and originating site restrictions – which further adds importance to the need for congressional action.

The real impetus for congressional action is the termination of the public health emergency period, as doing so would trigger the expiration of telehealth flexibilities effectuated via section 1135 waiver authority. However, the end of the pandemic remains a moving target as the coronavirus continues to circulate and rear its head in new "hot spots" amid economic re-openings. Come the end of the PHE, the HHS Secretary is authorized to prolong these flexibilities for up to 60 days.

Still, Congress is highly motivated to take up legislation that would make permanent certain telehealth flexibilities – likely before the November election, as it would provide Members (especially those facing touch reelections) a health care win to tout on the campaign trail. With Congress adjourned for the entire month of August and the broadly represented Taskforce on Telehealth Policy slated to deliver its final recommendations in early September, lawmakers appear likely to take action in September before again breaking for recess in October. In the meantime, we expect discussions and negotiations to continue over the summer.

We hope this is a helpful overview of the legislative and regulatory changes required to make the COVID-19 telehealth-related flexibilities permanent, and the landscape of support for doing so across lawmakers and stakeholder organizations. Please don't hesitate to reach out to Wynne Health Group with any questions or assistance with advocacy on this issue.