Memorandum

May 11, 2021

Overview of Recent Telehealth Developments & Section-by-Section Summary of CONNECT For Health Act of 2021

I. Executive Summary

As federal policymakers continue to discuss the future of telehealth post-pandemic, a number of bills have been introduced and re-introduced on ways to expand access to telehealth under Medicare. To support a fuller understanding of these developments, WHG has collated a list of the key telehealth bills that have been introduced during the current legislative session with some additional commentary on the trajectory of the federal telehealth discussion.

In addition, WHG has developed a section-by-section summary of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021. While the bill has been introduced in previous legislative sessions, the current version is updated to reflect the changes to the telehealth landscape as a result of the COVID-19 pandemic.

The CONNECT for Health Act of 2021 bill serves as an important marker of how Congress might move to permanently expand telehealth post-pandemic. However, some lawmakers and stakeholders have also emerged in support of a more measured and time-limited expansion of telehealth as a way to study its longer-term effects on equity, outcomes, quality, and access before enacting permanent expansions. Continued conversations on this issue will continue to reveal how Congress may act on the future of telehealth, which may further crystallize by the year's end.

II. Overview of Recent Telehealth Developments in 2021

Congress appears to agree telehealth should continue in a more expanded form post-pandemic, but continues to deliberate on the extent to which telehealth should be expanded. Both the House Energy & Commerce Subcommittee on Health and the House Ways & Means Subcommittee on Health convened hearings recently along these lines, with members and witnesses both questioning whether:

1. Telehealth expansions should continue broadly and permanently following the pandemic; or
2. Congress should authorize a temporary, time-limited expansion that allows policymakers to understand the effects of telehealth post-pandemic on equity, access, cost, and quality before authorizing any permanent expansions.

Notably, the second option aligns with recent commentary from the Medicare Payment Advisory Commission (MedPAC), which suggested Congress should take a more reserved and calculated approach to telehealth expansion. MedPAC's work on this front has appeared to gain traction among a number of members, with many directly citing the recent analysis as reason to move forward with a temporary expansion.

Despite this recent uptick in interest for temporary telehealth expansion, the major bills on post-pandemic telehealth expansion continue to feature provisions that would broadly and permanently expand the COVID-19

telehealth flexibilities once the public health emergency (PHE) ends. Some bills also include provisions that would expressly direct HHS and other entities to study the impact of this telehealth expansion on care delivery and Medicare spending. However, our scan of telehealth bills introduced in the current Congress did not reveal any yet that would only temporarily expand the COVID-19 telehealth flexibilities after the PHE to allow for further study on the impacts of telehealth expansion in a post-pandemic environment.

A round-up of key bills in the current Congress follows.

Broad Telehealth Expansion

- **CONNECT for Health Act** (full text here; press release here; WHG full summary in the following section of this resource) – The bill would broadly expand telehealth flexibilities through notable provisions such as:
    - Permanently removing the statutory geographic and originating site restrictions at sec. 1834(m) of the Social Security Act, which would include making a beneficiary's home an eligible originating site;
    - Allowing federally qualified health centers and rural health clinics to continue using telehealth services following the pandemic;
    - Authorizing HHS to waive any of the telehealth restrictions present under sec. 1834(m);
    - Allowing for the waiver of telehealth restrictions during public health emergencies; and
    - Requiring further study on how telehealth has been used during the public health emergency.

- **Telehealth Modernization Act (H.R. 1332/S. 368) –** The bill would make many of the COVID-19 PHE flexibilities post-pandemic permanent, including:
    - Removing the geographic and originating site restrictions at sec. 1834(m) of the Social Security Act;
    - Expanding the range of health care providers that can be reimbursed by Medicare for furnishing telehealth services to any health care professional eligible to bill Medicare;
    - Including the range of services added to the Medicare telehealth list under emergency waiver authority permanently after the PHE ends;
    - Retaining the sub regulatory process for adding services to the Medicare telehealth list on a more expedited basis; and,
    - Enhancing telehealth services for use by federal qualified health centers, rural health clinics, hospices, and for home dialysis.

- **Ensuring Telehealth Expansion Act of 2021 (H.R. 341) –** Of primary note, the bill would amend the Social Security Act to remove the geographic originating site restrictions and allow any site to count as an originating site. The bill would further authorize HHS to waive any requirements currently in place under section 1834(m) of the Social Security Act, including existing limitations on the types of providers that can furnish telehealth services under Medicare. The bill would also enhance telehealth services for federally qualified health centers, rural health clinics, home dialysis centers, and hospice.

- **Protecting Access to Post-COVID-19 Telehealth Act of 2021 (H.R. 366) –** The bill would remove the geographic and originating site restrictions present in Section 1834(m) of the Social Security Act, and would explicitly allow a beneficiary's home to count as an originating site. The bill would also require HHS to study the impacts of telehealth expansion during the COVID-19 PHE on Medicare spending and health care delivery (analogous to the reporting requirements included in H.R. 1406, as outlined below).

Mandated Telehealth Reporting

- **COVID-19 Emergency Telehealth Impact Reporting Act of 2021 (H.R. 1406)** – The bill would require HHS – in partnership with the Medicare Payment Advisory Commission (MedPAC) and Medicare and CHIP Payment and Access Commission (MACPAC) – to analyze the impact of the temporary telehealth flexibilities during the PHE. The report would specifically have to estimate the impact of telehealth expansion on health care delivery and Medicare spending.

- **KEEP Telehealth Options Act of 2021 (S. 620)** – The bill would direct HHS, MedPAC, and MACPAC to conduct studies and report to Congress on the effects temporary telehealth expansions during the COVID-19 PHE. The bill would also require MedPAC and MACPAC to product recommendations to Congress on: potential ways to improve telehealth services; how to expand telehealth; and ways to address fraudulent activity associated with telehealth.

Since many of the pandemic-driven flexibilities will expire with the end of the current public health emergency (PHE) – which President Biden said will continue through the year's end – Congress may face pressure to enact any longer-term telehealth flexibilities prior to PHE's conclusion. We expect these conversations to coincide with related legislative discussions around broadband expansion (e.g., here), which will assume an even more important role if telehealth access is broadened to Medicare beneficiaries in all geographies.

III. Section-by-Section Summary of CONNECT For Health Act of 2021

Below, please find a section-by-section summary of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021 (full text here; press release here). While the bill has been introduced in previous legislative sessions, the current version is updated to reflect the changes to the telehealth landscape as a result of the COVID-19 pandemic. Key updates to the latest version include:

- Permanently removing the statutory geographic and originating site restrictions at sec. 1834(m) of the Social Security Act, which would include making a beneficiary's home an eligible originating site;
- Permitting the HHS Secretary to temporarily add services to the Medicare telehealth list if there is a reasonable likelihood of these services providing a clinical benefit and improved access to care;
- Allowing federally qualified health centers and rural health clinics to continue using telehealth services following the pandemic;
- Authorizing HHS to waive any of the telehealth restrictions present under sec. 1834(m);
- Allowing for the waiver of telehealth restrictions during public health emergencies; and
- Requiring further study on how telehealth has been used during the public health emergency.

We hope the following summary is helpful. Please let us know if you have any additional questions.

Title I – Removing Barriers to Telehealth Coverage

- **Expanding the Use of Telehealth Through Waiver Requirements (sec. 101)** – Beginning on or after Jan. 1, 2022, this section authorizes the Secretary of the U.S. Department of Health and Human Services (HHS) to waive any requirement that pertains to Medicare payment of telehealth services. The HHS Secretary may only do so if they determine such waiver would not adversely impact quality of care. Specifically, HHS may waive requirements that pertain to the following:
    - Requirements relating to qualifications for an originating site;
    - Geographic requirements (other than applicable State law requirements, including licensure requirements);
    - Limitations on the type of technology that may be used to furnish telehealth services;
    - Limitations on the types of practitioners eligible to furnish telehealth services (though the practitioner must be Medicare enrolled);
    - Limitations on the specific services designated as telehealth, though HHS must determine the services are clinically appropriate to deliver remotely; and
    - Any other limitation on furnishing telehealth as deemed appropriate.

- **Removing Geographic Requirements for Telehealth Services (sec. 102)** – This section eliminates the requirement that telehealth services may only be furnished to beneficiaries receiving care in a rurally designated area. This would be effective on the date the bill goes into effect.

- **Expanding Originating Sites (sec. 103)** – This section authorizes a beneficiary's home as a qualifying originating site, meaning beneficiaries may receive telehealth from their homes. It would also allow the HHS Secretary to include any other site as an originating site, and to establish requirements for furnishing telehealth at any of these added sites to provide for beneficiary and program integrity protections. Finally, the section would prohibit the payment of a facility fee for any new originating sites added in this way and would maintain this prohibition for services received in the home.

- **Use of Telehealth in Emergency Medical Care (sec. 104)** – This section would lift the geographic originating site restrictions for telehealth services used for emergency medical care (as determined by the HHS Secretary).

- **Improvements to the Process for Adding Telehealth Services (sec. 105)** – This section directs the HHS Secretary to review the current statutory process that allows HHS to add or delete services to the Medicare telehealth list on an annual basis, and directs the HHS Secretary to revise the process such that the criteria for modifying the list prioritizes improved access to care through clinically appropriate telehealth services. The section also authorizes the HHS Secretary to add services that have a reasonable likelihood of providing a clinical benefit and improved access to care on a temporary basis.

- **Federally Qualified Health Centers and Rural Health Clinics (sec. 106)** – This section permanently authorizes Federally Qualified Health Centers (FQCHs) and rural health clinics (RCHs) to receive payment for furnished telehealth services as distant site providers.

- **Native American Health Facilities (sec. 107)** – This section eliminates the geographic and originating site restrictions for facilities of the Indian Health Service or the Native Hawaiian health care system. The section also prohibits the provision of a facility fee for Native American facilities.

- **Waiver of Telehealth Requirements During Public Health Emergencies (sec. 108)** – This section permanently allows the HHS Secretary to waive telehealth restrictions during a public health emergency through technical corrections clarifying the definition of an "emergency area" and an "emergency period."

- **Use of Telehealth in Recertification for Hospice Care (sec. 109)** – This section makes permanent the current emergency-authorized ability for hospices to use telehealth to satisfy the face-to-face requirement for recertifying a beneficiary for the hospice benefit. The section also directs the Comptroller General of the United States to submit a report to Congress evaluating the impact of this permanent change on the number and percentage of beneficiaries recertified for the Medicare hospice benefit and the appropriateness for hospice care of the patients recertified through the use of telehealth.

Title II – Program Integrity

- **Clarification for Fraud and Abuse Laws Regarding Technologies Provided to Beneficiaries (sec. 201)** – This section clarifies that the definition of remuneration (in terms of waiver of coinsurance, and deductible amounts and transfers of items or services for free or other than fair market value) does not include the provision of technologies to Medicare beneficiaries for the purposes of telehealth services,

remote patient monitoring, or other services furnished through the use of technologies if the technologies offered are not part of an advertisement, solicitation, or any other requirements specified by the HHS Secretary.

- **Additional Resources for Telehealth Oversight (sec. 202)** – This section authorizes the appropriation of $3 million to the HHS Inspector General for fiscal years (FYs) 2022-2026 to conduct audits, investigations, or other oversight and enforcement activities with respect to telehealth services and other related services (such as remote patient monitoring).

- **Provider and Beneficiary Education on Telehealth (sec. 203)** – Within six months of passage, this section directs the HHS Secretary to develop and distribute to beneficiaries and health care providers education resources and training sessions on the requirements of furnishing telehealth services, as well as on topics such as:

    - Requirements for payment for telehealth services;
    - Telehealth-specific health care privacy and security training;
    - Utilizing telehealth to engage and support underserved, high-risk, and vulnerable patient populations; and
    - Other topics as deemed fit by the HHS Secretary.

  The section further requires that these trainings account for age, sociodemographic, geographic, cultural, cognitive, and linguistic differences in how individuals interact with technology. Last, the section directs the HHS Secretary to consider whether requiring quality improvement organizations (QIOs) to provide technical assistance, education, and training on telehealth services.

Title III – Data and Testing of Models

- **Study on Telehealth Utilization During the COVID-19 Pandemic (sec. 301)** – This section directs the HHS Secretary to conduct a study assessing the impact of the telehealth flexibilities authorized under temporary waiver authority during the COVID-19 pandemic on a number of areas, including

    - Health care utilization rates, quality, and health outcomes;
    - Audio-only telehealth utilization rates;
    - Waivers of state licensure requirements;
    - The technologies used to deliver or receive telehealth;
    - Challenges that providers faced in furnishing telehealth;
    - The investments needed for providers to sufficiently provide telehealth services; and
    - Any other information deemed important by the HHS Secretary.

  An interim version of the report is due to Congress within 180 days of the bill's passage. The final report to Congress is due within one year of the bill's enactment. The final report must also include an estimate of total spending on telehealth under Medicare and under Medicare as well (to the extent feasible), and should also involve stakeholder input.

- **Analysis of Telehealth Waivers in Alternative Payment Models (sec. 302)** – This section directs the HHS Secretary to begin including in its biennial report to Congress an analysis of waivers related to telehealth under Center for Medicare and Medicaid Innovation (CMMI) authority, and their impact on quality and spending.

- **Model to Allow Additional Health Professionals to Furnish Telehealth Services (sec. 303)** – This section directs the HHS Secretary to consider testing CMMI models that allow physical, speech, or occupational therapists, physical or occupational therapy assistants, licensed certified social workers, registered respiratory therapists, qualified audiologists, and other provider types to furnish telehealth services.

- **Testing of Models to Examine the Use of Telehealth Under the Medicare Program (sec. 304)** – This section directs the HHS Secretary to consider testing models that examine the use of telehealth under Medicare.

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