Issue Brief: Telehealth & Health Equity in Medicare

October 21, 2021

I. Introduction

The COVID-19 pandemic has reshaped the role of telehealth in the U.S. health care system. While the Medicare telehealth benefit remained largely unutilized prior to the pandemic, the need for health care amidst the COVID-19 shutdowns rendered telehealth the only viable option for many beneficiaries to access care.

To make access to telehealth available to all Medicare beneficiaries, the federal government exercised emergency waiver authority to temporarily remove statutory restrictions to Medicare telehealth coverage during the ongoing Public Health Emergency (PHE) period, including allowing beneficiaries to access telehealth services regardless of their geographic locations or site of care (such as the home).

However, Congress must pass legislation to formally waive these statutory restrictions if such flexibilities are to remain in effect once the PHE concludes. Over the past year, federal lawmakers have deliberated on whether and to what extent Congress should make telehealth available to Medicare beneficiaries post-COVID-19. They remain largely divided on whether the telehealth flexibilities should continue on a provisional, time-limited basis to allow for greater study of the effects of broad telehealth access, or whether Congress should make these flexibilities permanent.

While much of these federal deliberations touch on the equity implications of telehealth reform and how they would impact communities of color, less of the national discourse has focused on equity as a means for assessing the reforms in question. As such, this resource aims to serve as a preliminary starting point to facilitate equity-centered discussions on how possible Medicare telehealth reforms could impact communities of color.

Specifically, this resource applies an equity assessment framework to the following five Medicare telehealth proposals:

- Removing statutory geographic and originating site restrictions;
- Payment parity (between telehealth and in-person services);
- Audio-only visits;
- Access to broadband; and
- The Medicare telehealth services list.

In brief, our analysis finds that expanded coverage of telehealth services under Medicare stands to address racial and ethnic health disparities. However, certain policies, or features of policies, are needed to ensure that Medicare beneficiaries from minority backgrounds can meaningfully access care via telehealth.

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II. Overview of the Medicare Telehealth Benefit (Pre-PHE Flexibilities)

Telehealth is a modality of health care in which a patient and a health care provider can communicate with one another synchronously through a technology-enabled communication platform to address health care needs. Medicare began covering telehealth services for rural beneficiaries in 1999 and has since made only modest increases to coverage for beneficiaries. Except for some exceptions, Medicare fee-for-service (FFS) covers telehealth services furnished via a telecommunications system for certain services – such as professional consultations, office visits, and office psychiatry services – provided specified conditions are met.

Telehealth services must be delivered via an interactive audio and video telecommunications system that permits real-time (synchronous) communication between the physician[1] or qualified practitioner[2], the distant site, and the beneficiary, at an authorized originating site[3] (detailed below). The Centers Medicare & Medicaid Services (CMS) clarifies that "[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system."[4] In general, with limited exceptions (e.g., existing federal telemedicine demonstrations in Alaska and Hawaii), Medicare FFS does not reimburse for 'asynchronous' or 'store and forward' technology – i.e., where a patient's information is transmitted and viewed/read later by the distant site practitioner.[5]

In addition to the technological stipulations, Medicare coverage for telehealth services is broadly hampered by geographic and 'originating site' statutory requirements that limit telehealth reimbursement to beneficiaries located in rural areas – e.g., a county outside of a Metropolitan Statistical Area (MSA); or a rural Health Professional Shortage Area (HPSA) located in a rural census tract.[6]

Further, only eight types of health care settings (originating sites) are authorized to receive Medicare reimbursement for services on the list of Medicare telehealth services.[7] Authorized originating sites include: (1) the offices of physicians or practitioners; (2) hospitals; (3) critical access hospitals (CAHs); (4) rural health clinics (RHCs); (5) federally qualified health centers (FQHCs); (6) hospital-based or CAH-based renal dialysis centers (including satellites); (7) skilled nursing facilities (SNFs); and (8) community mental health centers (CMHCs).[8] Therefore, unless the originating site requirements are waived or modified, (e.g., via statutory changes or existing demonstration authority), a beneficiary's home does not typically qualify as an originating site.

[1] Defined at section 1861(r)): https://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-r
[2] Defined at section 1842(b)(18)(C): https://www.ssa.gov/OP_Home/ssact/title18/1842.htm#act-1842-b-18-c. Qualified distant site practitioners (subject to applicable state law) include, in addition to physicians, nurse practitioners (NPs) physician assistants (PAs); nurse-midwives; clinical nurse specialists (CNSs); certified registered nurse anesthetists (CRNAs); clinical psychologists (CPs) and clinical social workers (CSWs) (with some billing limitations re: psychiatric diagnostic interview examinations); and registered dietitians or nutrition professionals. See: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf.
[3] Defined at section 1834(m)(4)(C)(ii): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[4] Defined at 42 CFR §410.78: https://gov.ecfr.io/cgi-bin/text-idx?SID=8f5058c7546f10c9874b9afd0f5cecac&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_178
[5] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
[6] Refer to section 1834(m): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[7] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
[8] Defined at section 1834(m)(4)(C)(ii): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm

III. Telehealth & COVID-19

In response to the shutdowns that occurred during the early months of COVID-19, the federal government applied PHE waiver authority to broaden access to Medicare telehealth services to all beneficiaries, regardless of geographic location or site of care (including the beneficiary's home). In addition to authorizing all Medicare beneficiaries to access telehealth services, CMS also broadened the range of services that health care providers can furnish via telehealth; expanded the list of providers who are eligible to furnish telehealth services; increased reimbursement rates for telehealth to equal those of in-person services; authorized beneficiaries to access telehealth via audio-only technologies; and developed a more expedient, sub-regulatory process for adding services to the Medicare telehealth list.

Following these changes, Medicare telehealth utilization rates dramatically increased, especially as elective care was halted at the height of the shutdowns. Rates of telehealth utilization have decreased since local economies re-opened, though remain substantially higher than pre-pandemic levels.[9] As a result, many suspect that expanded access to telehealth will remain a feature of the Medicare benefit post-pandemic. However, there is disagreement around which aspects of the telehealth flexibilities should carry forward beyond the PHE, and to what extent these features should remain in effect (i.e., should they be expanded temporarily or be made permanent). Congress is especially divided on this issue, with multiple hearings this year featuring legislators supporting both permanent and time-limited expansions to the Medicare telehealth flexibilities.[10, 11] Stakeholders have since urged Congress to make permanent the Medicare telehealth flexibilities beyond the pandemic.[12]

Looking ahead, Congress will have act to pass legislation amending the current statute governing Medicare telehealth before the PHE ends if it wishes to continue those flexibilities for beneficiaries uninterrupted. As such, the eventual end of the PHE – which may now potentially occur in 2022 – will create a de facto deadline for legislative action as a stopgap for reform. However, Congress may decide to act before such a deadline arrives if an opportunity presents itself to do so. The earliest we may see telehealth reform legislation, then, could be at the end of 2021, depending on if a year-end omnibus occurs to fund the government through the end of the next fiscal year. Otherwise, legislative action on telehealth may occur in 2022. The current most likely vehicle for advancing Medicare telehealth expansion is Cures 2.0, which included several provisions that would ensure access to telehealth following the end of the PHE.[13]

[9] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality
[10] https://energycommerce.house.gov/committee-activity/hearings/hearing-on-the-future-of-telehealth-how-covid-19-is-changing-the
[11] https://waysandmeans.house.gov/legislation/hearings/health-subcommittee-hearing-charting-path-forward-telehealth
[12] https://www.americantelemed.org/policies/430-organizations-sent-letter-to-congress-on-post-covid-19-telehealth-priorities/
[13] https://degette.house.gov/media-center/press-releases/CURES2

IV. Telehealth: Health Equity Implications

A. The Health Equity Framework

The aim of this analysis is to examine the major Medicare telehealth policy proposals through an equity-focused lens. We believe this is a meaningful contribution to the current dialogue around telehealth, which includes mention of the equity components to telehealth reform as one component of the broader discussion, but which does not comprehensively examine the proposed reforms from a primarily equity perspective.

To complete such an analysis, we applied an equity assessment framework for public health laws and policies developed by the Network for Public Health Law.[14] The original assessment contains eight key questions that serve to identify potential issues in the design of proposed policies regarding equity implications and the potential impact of the proposed policies on different populations. The eight questions are as follows:

- What is the issue and how does the law or policy address it?
- How are community voices included in identifying and defining the issue and deciding what law or policy approach to take?
- What is the historical context of the issue?
- How does the law or policy impact different population groups?
- What are the known or expected outcomes of a given law or policy?
- What other options can achieve the same or similar outcome?
- Can the solution be successfully sustained?

Our analysis uses a slightly modified version of the equity assessment framework to analyze the health equity implications of five potential telehealth reforms under Medicare.[15] The five policy reforms we examine are proposals that would address:

- Geographic and originating site restrictions;
- Payment parity;
- Audio-only visits;
- Access to broadband; and
- The Medicare telehealth services list.

Each section begins with a brief overview of the policy proposal, followed by the health equity assessment, and concludes with a brief follow-on discussion.

[14] Equity Assessment Framework for Public Health Laws and Policies - Network for Public Health Law (networkforphl.org)
[15] The following analyses apply each of the original questions above except for the second question that examines how community voices were included in identifying and defining the policy issue and determining what approach to take. Given that the policy proposals we examined have been developed by Congress – likely in partnership with multiple groups and individuals – it is difficult to determine how legislators took community voices into account when developing these proposals. Instead, we include detail where possible to show what minority-representing groups have said in regard to the leading telehealth proposals throughout our analysis as a way to illustrate how marginalized communities view such proposals. We have also included results from studies that examined the effects of telehealth policies on underserved communities.

B. Policy-by-Policy Identification of Intersection with Health Equity

1. Geographic and Originating Site Restrictions

One of the most frequently discussed and supported telehealth changes during the pandemic is the temporary removal of geographic and originating site restrictions. Section 1832(m) of the Social Security Act (SSA) limited telehealth services reimbursable by Medicare to care that is provided in an eligible health care facility, called the originating site restriction, and in a rural area, called the geographic site restriction.

As previously mentioned, under the law, beneficiaries must live in a designated geographic HPSA outside of an MSA and then receive. As a result, access to telehealth is limited to a small subset of Medicare beneficiaries who still may not be able to access services if they cannot access an originating site. In a 2018 report, CMS said that the geographic and originating site restrictions were the largest barrier to expanding telehealth services, but the restrictions can only be changed through legislation.[16]

Along with other flexibilities, the CARES Act allowed CMS to waive the originating and geographic site requirements for the duration of the COVID-19 PHE.[17] The change was well-received by stakeholders, and policymakers have since introduced several proposals to permanently repeal or change the restrictions. The CONNECT for Health Act (S. 1512/H.R. 2903)[18,19] would remove geographic restrictions and allow a beneficiary's home to count as an originating site, and the Telehealth Modernization Act (S. 368/H.R. 1332)[20,21] would repeal both restrictions.

[16] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf
[17] https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf
[18] https://www.congress.gov/bill/117th-congress/senate-bill/1512?q=%7B%22search%22%3A%5B%22connect+for+health%22%5D%7D&s=1&r=2
[19] https://www.congress.gov/bill/117th-congress/house-bill/2903?q=%7B%22search%22%3A%5B%22connect+for+health%22%5D%7D&s=1&r=1
[20] https://www.congress.gov/bill/117th-congress/senate-bill/368?q=%7B%22search%22%3A%5B%22telehealth+modernization+act%22%5D%7D&s=2&r=1
[21] https://www.congress.gov/bill/117th-congress/house-bill/1332?q=%7B%22search%22%3A%5B%22telehealth+modernization+act%22%5D%7D&s=2&r=2

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Health Equity Analysis for Geographic and Originating Site Restrictions

What is the issue & how does the policy address it?

- Geographic and originating site restrictions limit telehealth accessibility to rural beneficiaries who can access qualifying "originating sites." Even if a beneficiary lives in a rural area, they may not be able to get to a health care facility to receive telehealth services.
- Removing these restrictions would allow beneficiaries in urban and rural areas who face challenges receiving in-person care such as a lack of affordable transportation, not being able to take time off work, needing childcare, or a shortage of the type of provider they are seeking.

What is the historical context of the issue?

- The restrictions were implemented in 1997 when partial telehealth coverage was authorized and telehealth was intended to help rural residents receive care from distant providers. However, many people who live in urban areas or areas not designated as a HPSA still face barriers to accessing health care services.
- The Bipartisan Budget Act of 2018 created exceptions to the geographic and originating site restrictions for treatment of end stage renal disease and acute stroke. The 2018 SUPPORT for Patients and Communities Act also required CMS to remove the geographic site restrictions and make the home an originating site for the provision of treatment for individuals with substance use disorders or co-occurring mental health issues. A new rule from the Consolidated Appropriations Act of 2021 will allow Medicare beneficiaries to use telehealth for diagnosis, treatment, or evaluation of mental health disorders at home without the geographic restrictions.

How does the policy impact different groups?

- With some exceptions, the health care facility that serves as an originating site is paid an originating site fee that is not furnished when the originating site is a beneficiary's home. However, in a letter of support for the CONNECT for Health Act, the American Hospital Association expressed support for removing the geographic and originating site restrictions.[22]
- Medicare beneficiaries living in non-rural or non-HPSA areas would be able to receive care through telehealth. All Medicare beneficiaries would be able to receive telehealth services from their home.
- Increased access to and provision of telehealth may make it easier for people to connect with providers, but without attention to other equity issues within telehealth such as language barriers, digital literacy, and internet access, some key populations may remain underserved. For example, one study out of California found that around 20 percent of older adults are "unready" to use even audio-only telehealth.[23] This would be especially concerning if some providers decreased in-person visits or non-emergency medical transportation became more difficult to access under the assumption that beneficiaries can use telehealth.
- A separate study found that Asian patients and non-English speaking patients used telehealth at lower rates, while Black, Latino, and patients with lower socio-economic statuses were less likely to specifically use video when accessing telehealth. Language barriers, biases in care delivery, and lack of access to broadband-enabled technology were all highlighted as drivers of lower utilization.
- One study conducted through a community-based participatory research approach found that, for Hispanic patients with Type 2 Diabetes, cultural incongruence was a driving factor for limiting acceptance and utilization of telehealth.[24]

What are the expected outcomes of the policy?

[22] https://www.aha.org/lettercomment/2021-05-03-aha-letters-support-bill-expand-access-medicare-telehealth-services
[23] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768772
[24] https://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/s12911-020-01346-0

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• Telehealth usage would likely significantly increase from pre-pandemic levels, especially in urban and suburban areas. The increased availability and convenience of telehealth could allow people who have difficulty getting to a doctor's office to receive regular care for telehealth-eligible conditions and services. If equity concerns are addressed in the policy's design, racial and ethnic minorities may be more likely to access care via telehealth post-pandemic.[25]	
What are other options that can achieve a similar outcome? • Short of fully repealing the geographic and originating site restrictions, the Medicare Payment Advisory Commission (MedPAC) recommends that Congress extend the flexibilities from the PHE for one to two years to allow study of the impact of the policy on telehealth affordability and access.[26]	**Can the solution be successfully sustained?** • There is broad support for the removal or modification of geographic and originating site restrictions, but oversight would be necessary to prevent fraud, waste, and abuse. • Removal of restrictions would be most effective if coupled with efforts to increase technology skills and access among beneficiaries. • Payment models that use a value-based approach would also be more likely to ensure sustainability of expanded access to telehealth as opposed to payment under the fee-for-service system.[27]

Removal of the geographic and originating site restrictions appears to be the most effective way to significantly expand telehealth access post-pandemic. Policymakers from both parties and CMS have expressed support for removing these restrictions, but MedPAC cautions that the financial and quality implications of telehealth are still unknown. Congress has been loosening geographic and originating site restrictions for specific patient groups and diagnoses for the last several years, indicating that the COVID-19 pandemic may have just accelerated an existing trend.

Importantly, while removing the geographic and originating site restrictions would make it possible for many more beneficiaries to receive reimbursable telehealth services at home, the policy does not address other equity issues that pertain to the actual provision of telehealth services. The following analyses addresses some of these issues.

[25] https://academic.oup.com/jamia/article/28/1/119/5902454
[26] http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch14_sec.pdf?sfvrsn=0
[27] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mitchell_HE_2021.03.02.pdf

2. Payment Parity

Payment parity in the context of telehealth refers to Medicare reimbursement for telehealth services equaling payment for in-person services. Medicare reimbursement consists of two primary factors: 1) the fee for the service being furnished; and 2) an add-on payment for the facility itself where the service is being provided. For the set of telehealth services currently authorized in statute (i.e., services furnished in a statutorily designated Originating Site), Medicare pays a service payment equal to the amount it would pay a provider furnishing the care in person. However, Medicare pays a lower facility fee add-on payment than it would have paid if a provider had furnished the care in person. As such, current payment for telehealth services is below parity compared to in-person payments for Medicare services.

Payments for telehealth services are even less if the service is delivered to beneficiaries from their homes. For certain services where the home is a qualifying originating site (e.g., certain SUD and dialysis services), statute currently states Medicare will not pay a facility fee for care delivered to beneficiaries in their homes, though clinicians will still receive a base payment for the service itself (called the non-facility or office rate, as stipulated in the Medicare Physician Fee Schedule (Medicare PFS)).

However, under emergency waiver authority, CMS is currently paying for telehealth services at parity with in-person services, in part by incorporating facility fee payments to providers based on the facility in which the provider furnishes the service. For example, if a physician normally treats patients in an outpatient hospital clinic, that provider will receive the facility fee associated with that site of care when delivering telehealth services to patients. This includes care for beneficiaries accessing telehealth from their home.

The question for policymakers and stakeholders is whether CMS will continue to pay for telehealth at parity with in-person services, meaning will providers still be paid a facility fee for care delivered to beneficiaries in the home. Importantly, this would require an act of Congress, as the current language in sec. 1834(m) referenced above would prevent CMS from paying providers at parity after the PHE flexibilities end.

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Health Equity Analysis for Payment Parity

What is the issue & how does the policy address it?

- Lower payments for telehealth discourage providers from more broadly adopting telehealth and making these services more available to beneficiaries. While this is limiting for all beneficiaries, communities of color and those in rural areas are more likely to benefit from access to telehealth.
- This is because transportation limitations, inability to take off work, lack of childcare, or other issues are alleviated when beneficiaries have access to telehealth. As such, to the extent lack of payment parity discourages providers from offering telehealth services, communities of color and rural beneficiaries are more likely to be negatively impacted.
- Ensuring payment parity for telehealth services will therefore promote access to care in communities that stand to disproportionately benefit from such access.

What is the historical context of the issue?

- Historically, CMS has paid less for telehealth than in-person services by either paying a lower facility fee or not paying a facility fee at all to providers furnishing a telehealth service.
- Rationale for lower telehealth reimbursement levels is that there is an overall lower cost to providing care via telehealth, such as lower overhead costs. Lower reimbursement for telehealth is also thought to deter against rampant overuse (and overpayment) for telehealth services.

How does the policy impact different groups?

- Again, lower payments for telehealth services may prevent providers from adopting telehealth since they would receive higher payments for delivering care in person. This lack of access would more negatively impact communities of color, who stand to benefit more from broader access to telehealth services. This is also true for rural communities.
- Dr. Ateev Mehrotra said during a House Ways & Means Roundtable Discussion on Telehealth that providers are currently unsure if they will be reimbursed for telehealth following the PHE and that, as a result, many are deciding that furnishing telehealth is "not worth it."[28]

What are the expected outcomes of the policy?

- Payment parity is expected to encourage more providers to invest in developing the infrastructure needed to furnish telehealth services to beneficiaries because payment levels would be interchangeable between telehealth and in-person care.
- This in turn would generate more access for beneficiaries who may not currently have access to telehealth where it was not sustainable for providers to furnish care via telehealth.
- Dr. Megan Mahoney of Stanford Health Care stated that providers can conduct more valuable assessments when delivered to patients in their homes via telehealth, as patients are more able to easily access their medications and supplements without having to memorize their doses or prescriptions.[29]

What are other options that can achieve a similar outcome?

- A shift to value-based purchasing arrangements would also better ensure providers are not overutilizing telehealth without the concern of setting precise payment rates for care delivered in-person or via telehealth.

Can the solution be successfully sustained?

- Guardrails against fraud, waste, and abuse would be necessary to protect against overspending.
- Dr. Mahoney reported they have not experienced an increase in overall health care utilization, and that telehealth appears to be

[28] https://waysandmeans.house.gov/roundtable-discussion-examining-role-telehealth-during-covid-19-and-beyond

[29] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mahoney_HE_2021.03.02.pdf

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	substitutive to in-person care, not additive.[30] A report from the Taskforce on Telehealth Policy included similar findings.[31]

While payment parity may not immediately appear as an equity-related issue, its inclusion in a telehealth reform package would better ensure that more providers are able to sustainably furnish telehealth services to beneficiaries. Given that access to telehealth services would have unique benefits for communities of color – removes the need for childcare or transportation services, e.g. – payment parity has a clear and important link to the health equity implications of telehealth expansion.

[30] *Ibid.*
[31] https://www.ncqa.org/wp-content/uploads/2020/09/20200914_Taskforce_on_Telehealth_Policy_Final_Report.pdf

3. Audio-Only Visits

Audio-only communication is a means of delivering telehealth services using an interactive telecommunications system that allows beneficiaries and providers to use only audio capacities such as a secure telephone line. CMS and private payers have historically not covered audio-only communication as a viable means of providing telehealth services, allowing only communication methods with audiovisual capabilities.

However, the COVID-19 pandemic prompted many changes to telehealth, including an emergency waiver authority under which CMS covers audio-only telecommunication for certain services at the same rate as audiovisual and in-person services. This change was more permanently mandated for certain services in statute in December of 2020 through the passage of the Consolidated Appropriations Act of 2021 (CAA), which amended the SSA to expand access to mental health services through telehealth.[32] CMS proposed regulatory changes in accordance with statute through the Calendar Year (CY) 2022 Medicare PFS to expand the definition of "interactive telecommunications system" to cover audio-only telecommunication for certain behavioral health services beyond the COVID-19 PHE.[33]

Now, stakeholders continue to engage policymakers to expand the applicability of audio-only telecommunications to services beyond behavioral health. Over 400 stakeholders signed a letter to Congress urging leaders to give CMS the authority to reimburse for audio-only services when deemed clinically appropriate.[34] Congressional leaders have proposed several bills giving the Secretary of Health and Human Services (HHS) greater leeway and flexibility to designate services as appropriate for audio-only telecommunications.

[32] https://www.congress.gov/bill/116th-congress/house-bill/133/text
[33] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf
[34] https://www.himss.org/sites/hde/files/media/file/2021/07/26/postcovid-telehealth-prioritiesgroup-letter-fin-w-signers.pdf

Health Equity Analysis for Audio-Only Visits

What is the issue & how does the policy address it?

- According to a survey fielded by MedPAC) from April to October 2020, 37 percent of Medicare beneficiaries had an audio-only telehealth visit during this period.[35]
- Audio-only visits allow patients with a lack of access to broadband or other barriers to accessing audiovisual telehealth services to participate in telehealth visits, thus expanding access to care for certain crucial services.

What is the historical context of the issue?

- Historically, CMS did not allow the use of audio-only communications. Telehealth services must be delivered via an interactive two-way audio and video telecommunications system permitting synchronous communication between the provider and beneficiary.
- During the pandemic, CMS waived the requirement for video technology and allowed audio-only communication for certain services including evaluation and management (E&M), behavioral health, and education services.
- In their March 2021 report, MedPAC recommended CMS to continue to temporarily cover audio-only communication for certain services such as E&M services and consider permanently allowing audio-only communication while examining any new evidence or data on quality and cost effects of audio-only telehealth.[36]

How does the policy impact different groups?

- In general, allowing patients to access care via audio-only platforms will benefit beneficiaries who are otherwise unable to access care via audio-visual technologies expands access to remote care. A strong limiter of access to audio-visual technologies is a lack of broadband service and broadband-enabled technologies. A recent study by the Joint Center for Political and Economic Studies found that 46 percent of Black individuals lacked home broadband compared to 28 percent of White individuals in many rural counties.[37]
- Section 123 of the CAA amended the Act to expand access to mental health services through telehealth. Thus, in the CY 2022 Medicare PFS proposed rule, CMS proposed several changes aiming to permanently increase beneficiary access to audio-only communications for certain behavioral health services. Specifically, CMS proposed to
  - Allow audio-only communications for the diagnosis, evaluation, or treatment of mental health disorders, limited to beneficiaries who are unable or does not wish to use two-way audio and video technology;
  - Allow RHCs and FQHCs to receive payments for audio-only mental health visits; and
  - Allow Opioid Treatment Programs (OTPs) to continue to provide therapy and counseling through audio-only mechanisms.
- These changes will expand access to mental health care, especially among rural communities and communities of color. However, CMS, as required by section 123 of the CAA, also proposes that the beneficiary receive an in-person service from the mental health care provider furnishing the audio-only telehealth within six months of the first telehealth service. This requirement may restrict some access to necessary mental health care for beneficiaries who experience barriers to in-person care. Stakeholders have urged policymakers to remove such requirements.
- Stakeholders remain interested in pressing Congress to allow audio-only care beyond mental health. Several bills, listed below, have been introduced with language permitting HHS to allow certain services to be furnished through audio-only means, if found to be clinically appropriate.

[35] http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf
[36] Ibid p. 466
[37] https://jointcenter.org/expand-internet-access-among-black-households/

o S. 1512/H.R. 2903 – CONNECT for Health Act of 2021[38,39] o H.R. 3447 – Permanency for Audio-Only Telehealth Act[40] o S. 1988 – Protecting Rural Telehealth Access Act[41] o H.R. 4040 – Advancing Telehealth Beyond COVID-19 Act of 2021[42] o H.R. 4012 – Expanding Access to Mental Health Services Act[43] • This language would give HHS the flexibility to expand the use of audio-only telehealth and thus continue to expand access to care, especially among rural communities and communities of color. • The National Community Reinvestment Coalition (NCRC) has advocated for payment parity between telephone-only and video-based telehealth visits.[44]
What are the expected outcomes of the policy? • Proposals that grant HHS increased flexibility to determine appropriate methods of telehealth per service type will allow HHS to make more services available for audio-only telehealth. • This is expected to increase access to care for populations with limited to no access to video and audio enabled devices, digital literacy, and internet bandwidth or broadband overall. These populations include rural and Tribal regions, individuals with low incomes, racial and ethnic minority communities, and elder individuals. • One study found that eliminating coverage of audio-only services following the pandemic would have a disproportionate impact on patients from underserved communities and would limit the ability of safety net providers to meet patients' needs.[45]

What are other options that can achieve a similar outcome?	Can the solution be successfully sustained?
• Increased access to broadband would allow beneficiaries who are not able to participate in audio-visual telehealth the opportunity to receive these services. • However, this option may not be inclusive of beneficiaries who face barriers such as a lack of digital literacy or are financially unable to access devices enabled with video capabilities.	• Yes. There may be increased concerns about program integrity, which may need to be strengthened in an appropriate manner that does not counteract the purpose of the policy by limiting beneficiary access to audio-only services.

As described in the above table, several pieces of legislation include provisions that would allow HHS to make determinations about covering audio-only telehealth for any clinically appropriate service. Most notably, the CONNECT for Health Act of 2021 includes a provision giving HHS flexibility on determinations as well as a provision eliminating the requirement for patients to have an in-person visit prior to receiving any telehealth service. Meanwhile, some states have made efforts to maintain flexibilities around audio-only telehealth. For

[38] https://www.congress.gov/bill/117th-congress/house-bill/2903
[39] https://www.congress.gov/bill/117th-congress/senate-bill/1512
[40] https://www.congress.gov/bill/117th-congress/house-bill/3447/text
[41] https://www.congress.gov/bill/117th-congress/senate-bill/1988/text
[42] https://www.congress.gov/bill/117th-congress/house-bill/4040/text
[43] https://www.congress.gov/bill/117th-congress/house-bill/4012/text
[44] https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123
[45] https://jamanetwork.com/journals/jama/fullarticle/2776166?guestAccessKey=1cbe677e-5cda-4394-9933-078d1fcfecaf&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=020221

example, Connecticut and South Dakota governors signed legislation enabling the use of audio-only telehealth modalities beyond the COVID-19 PHE.[46]

We conclude that the currently considered proposals for expanding the applicability of audio-only telecommunications would have a positive impact on health equity, expanding access to essential health care services for populations such as rural, lower-income, racial/ethnic minority, and elderly communities.

[46] https://www.nga.org/news/commentary/governors-lead-on-expanding-access-to-affordable-broadband-for-telehealth-services/

4. Access to Broadband

Beyond Medicare reimbursement and payment reforms, lawmakers are also considering policy changes that would increase funding for – and ultimately access to – broadband services and devices. While such reforms do not immediately impact whether beneficiaries can access health care services through telehealth platforms, they would create conditions wherein beneficiaries are more able to use the underlying technology necessary for telehealth to work.

The most recent set of proposals around broadband expansion are included in in Division F of the latest version of the bipartisan infrastructure package.[47] Though not identical, the general spirit behind these provisions resemble those included in the previously released Leading Infrastructure for Tomorrow's (LIFT) America Act (H.R. 1848), introduced by all House Energy and Commerce (E&C) Democrats.[48] Such proposals are also mirrored in President Biden's own infrastructure proposal, the American Jobs plan.[49] These bipartisan infrastructure proposals and the considerations surrounding them are explored in the framework analysis that follows.

[47] https://www.congress.gov/bill/117th-congress/house-bill/3684/text
[48] https://energycommerce.house.gov/newsroom/press-releases/ec-democrats-introduce-lift-america-act-that-invests-in-clean-energy
[49] https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/31/fact-sheet-the-american-jobs-plan/

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October 21, 2021

Health Equity Analysis for Broadband Expansion

What is the issue & how does the policy address it? • Lack of broadband access prevents individuals from utilizing telehealth. Efforts to expand broadband would allow more beneficiaries to capitalize on broader access to telehealth services under Medicare. • As of 2019, the Federal Communications Commission (FCC) estimates that 96 percent of the U.S. population were in areas with broadband coverage. This rate is lower for rural areas (82.7 percent) and Tribal lands (79.1 percent).[50] Independent reviews of the data suggest that access is even more limited. • In addition, the FCC estimates that approximately 23 percent of the U.S. has not adopted broadband for at least the lowest speed tier. The adoption rate is 71.8 percent for non-urban core areas and 81.4 percent for urban core areas. Adoption is at 55 percent for Tribal lands.
What is the historical context of the issue? • Broadband began replacing dial-up internet in the early 2000s. In 2000, approximately 8 million Americans had broadband at home. This increased to 200 million by 2009. During this time, Congress directed the FCC to develop a national strategy to achieve universal broadband access.[51] FCC noted in its strategy that "digital exclusion compounds inequities for historically marginalized groups," including racial minorities. • Since then, the FCC has worked to expand access to broadband infrastructure through promoting competition in the telecommunications marketplace and increasing investment in broadband infrastructure. Access to broadband has continued to increase overtime.
How does the policy impact different groups? • The broadband proposals included in the bipartisan infrastructure package would support broadband access for communities of color. For example, the package includes the following provisions addressing: o **Digital Equity Grants:** The bill would direct $2.75 billion to support states and local governments to plan for and execute on digital equity initiatives and efforts to spur greater adoption of broadband. States would receive funding and administer the grant for overseeing the state's Digital Equity Plan. Such projects would facilitate broadband adoption through activities including digital literacy training, workforce development, devices access programs, and other digital inclusion activities. o **Affordability:** The bill would create a permanent Affordable Connectivity Benefit, which would provide a $30 per month voucher for families with low-incomes to use toward an internet service plan. o **Expansion:** The bill would authorize $42.45 billion through formula-based funding to states to support broadband employment. Broadband projects through this program would have to meet a minimum upload/download speed of 11/20 mpbs. Additionally, states would have to implement plans to address all of their un- and under-served areas before states may use funding for additional purposes.
What are the expected outcomes of the policy? • These proposals are expected to increase the availability of broadband connectivity for populations with limited to no access to such services, including rural and Tribal regions.

[50] https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf
[51] https://transition.fcc.gov/national-broadband-plan/national-broadband-plan.pdf

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• In areas where broadband infrastructure exists but where affordability remains a barrier to access, these proposals are expected to support individuals in purchasing broadband services via subsidy programs and improved efforts to identify those who are eligible for such subsidies. • The American Medical Association (AMA) has stated that many Black and Latino patients will be limited from accessing the benefits of telehealth if broadband improvements are not made.[52] • The NCRC has also advocated for expanding low-cost or free broadband internet access.[53]	
What are other options that can achieve a similar outcome? • Alternative technologies, such as wireless internet, satellite, and mobile broadband could also serve to increase access to internet connectivity. • However, these alternatives could result in less reliable access than fixed broadband.	**Can the solution be successfully sustained?** • Such investments can be offset by other policies being considered that could save federal dollars (e.g., drug pricing). Proposed corporate tax code reforms would also offset the costs of broadband infrastructure investments.

Through the preceding analysis, we conclude that the current proposals for expanding access to broadband could support telehealth's ability to have a positive impact on health equity.

On the issue of broadband infrastructure itself, an infusion of over $40 billion to expand broadband in un- and underserved areas could connect the millions of individuals in rural and Tribal regions that still lack internet access to the benefits of telehealth. The proposal as written in the draft infrastructure package would require a majority of the broadband development projects to produce networks that deliver connections of at least 100 mbps, which is generally considered to be a high-speed connection. This would bring the affected rural and Tribal regions in line with speeds available to over 90 percent of Americans.

Regarding broadband adoption, the proposals also stand to benefit communities of color and individuals with low-incomes by making broadband more affordable. A permanent benefit program that ensures predictable access to broadband internet services for families would substantially improve individuals with low-incomes to cross the digital divide.

However, the time it may take to implement such provisions and fully expand broadband access to more individuals may necessitate shorter-term solutions, such as more robust coverage of audio-only services. Moreover, expanding access to broadband infrastructure and affordability would still not obviate broader issues pertaining to digital literacy among patients and cultural competence among providers, which also impact rates of broadband uptake and telehealth utilization among communities of color.

[52] https://www.ama-assn.org/press-center/press-releases/ama-equity-must-be-baked-expansion-telehealth
[53] https://ncrc.org/the-expansion-of-telemedicine-underscores-existing-disparities-in-healthcare-access/

5. Medicare Telehealth Services List

As part of the initial COVID-19 response, CMS also implemented a new, expedited process for adding covered services to the Medicare telehealth list.[54] Under normal conditions, CMS makes additions to the telehealth list once per year through annual Medicare PFS rulemaking process. However, in a May 2020 interim final rule that included an expansive set of new flexibilities for the COVID-19 response, the agency added a sub-regulatory process to modify the services included on the Medicare telehealth list on a more frequent basis outside the standard rulemaking process (though the services added in this way would only remain on the list for the duration of the public health emergency).[55] CMS used this expedited process for the first time in October 2020, adding 11 new services to the Medicare telehealth list.[56]

Stakeholders have expressed support for making this expedited process permanent, including the American Telemedicine Association (ATA)[57] and the College of Healthcare Information Management Executives (CHIME).[58] Leading telehealth legislation (i.e., the CONNECT for Health Act of 2021), that would make the COVID-19 telehealth flexibilities permanent, direct HHS to evaluate the current process for adding services to the Medicare telehealth list (as outlined in section 1834(m)) and to make any recommendations for improving such process.[59] Such recommendations could include adopting the more agile process implemented temporarily during the COVID-19 PHE.

Regarding the criteria CMS uses when adding new services to the Medicare telehealth list, CMS considers a set of conditions to determine whether there is a "clinical benefit" associated with the proposed new telehealth service. This is outlined in each annual rulemaking cycle for the Medicare PFS. Per CMS, examples of clinical benefit include:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services;
- Treatment option for a patient population without access to clinically appropriate in-person treatment options;
- Reduced rate of complications;
- Decreased number of future hospitalizations or physician visits; and
- Reduced recovery time, among others.

Though not included in any prominent proposals, HHS could consider including in the process for adding telehealth services the importance of health equity considerations when determining whether to cover newly proposed telehealth services, especially since accounting for health equity can have important effects on clinical outcomes for underserved communities and communities of color. Doing so would also align with the Biden-Harris Administration's government-wide approach to health equity.[60]

[54] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
[55] https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf
[56] https://www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicaid-and-medicare
[57] https://www.help.senate.gov/imo/media/doc/Kvedar.pdf
[58] https://chimecentral.org/chime-statement-on-making-telehealth-changes-permanent/
[59] https://www.schatz.senate.gov/download/connect-for-health-act-2021-summary
[60] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

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October 21, 2021

Health Equity Analysis for Making Additions to the Medicare Telehealth List

What is the issue & how does the policy address it?

- Currently, CMS adds services to the Medicare telehealth list once per year through the annual Medicare PFS rulemaking process.
- If telehealth is greatly expanded in communities of color following the pandemic, CMS may find that a more agile process for adding telehealth services would better support the agency in meeting the diverse needs of Black and Brown populations.

What is the historical context of the issue?

- CMS developed the process for adding services to the Medicare telehealth list beginning with its CY 2003 Medicare PFS final rule.
- Since then, CMS added 109 Medicare telehealth services before the PHE. During the PHE, CMS added an additional 162 telehealth services on a temporary basis.

How does the policy impact different groups?

- The current process for adding telehealth services only allows CMS to consider additions once a year, which limits how swiftly the agency may add coverage of new telehealth services when evidence suggests coverage would positively impact beneficiaries. Slowing access to telehealth services would have a disproportionate effect on beneficiaries who face health disparities and who would disproportionately benefit from access to certain telehealth services.
- Moreover, the criteria by which CMS determines whether to add a service to the Medicare telehealth list does not consider health disparities in its determination of whether the service would yield a positive clinical benefit.
- Not considering health equity when determining whether to add new services to the Medicare telehealth list could have a disproportionate impact on communities of color who face health disparities, and who would therefore benefit more greatly by inclusion of certain telehealth services (e.g., additional telehealth services for managing chronic conditions).

What are the expected outcomes of the policy?

- A more expedited process for adding services to the Medicare telehealth list is expected to allow CMS to offer coverage of new telehealth services in a more agile fashion when there is evidence that coverage is clinically appropriate.
- More agile coverage expansions that facilitate broader access to care could improve health outcomes for beneficiaries, especially beneficiaries for whom access to certain services would meet a disproportionate need among certain subpopulations.
- Equity-focused considerations as part of the criteria for adding Medicare telehealth services may also support broader coverage of services that could benefit communities of color.

What are other options that can achieve a similar outcome?

- CMS could continue adding telehealth services on an annual basis but explicitly include health equity concerns as part of determining whether a proposed telehealth service would provide a clinical benefit.

Can the solution be successfully sustained?

- Yes. A new process may require additional federal personnel to review the necessary data to make coverage decisions, which could require a marginal budgetary increase for HHS.

We reiterate that there are no major legislative proposals that explicitly direct CMS to modify the process for adding telehealth services under Medicare and/or that stipulate that health equity should be a consideration for Medicare coverage. However, a provision in the CONNECT for Health Act of 2021 that would direct HHS to review its current process for adding telehealth services, coupled with the increased emphasis on health equity, could

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result in a new process that both accounts for equity concerns when making coverage decisions and that results in a more expeditious process for adding telehealth services. Such a process could allow HHS to make telehealth coverage decisions that better address the unique needs of communities of color s as policymakers develop their understanding of systemic health disparities.

V. Conclusion

The COVID-19 pandemic has elevated the place of telehealth in the health care delivery system. While many Medicare beneficiaries enjoy access to telehealth under the current PHE-driven waivers, Congress must act if beneficiaries are to retain broad access to telehealth post-pandemic. There are several proposals that would act to ensure access to telehealth post-pandemic, which may see meaningful legislative advancement as early as the end of this year, though more likely not until early next year. The impending expiration of the PHE declaration – set to end in early next year, though likely to be again extended another 90-days – will compel the legislative "deadline" for Congress to act.[61]

Though permanent telehealth expansion may be characterized as generally beneficial for Medicare beneficiaries, such reforms stand to improve or worsen health disparities. As discussed, removing the statutory geographic and originating site restrictions would, theoretically, dramatically enhance access to telehealth for all Medicare beneficiaries. However, due to more foundational systemic issues – such as language barriers, broadband affordability challenges, lack of culturally competent care, etc. – coverage expansion alone will not ensure that communities of color can fully participate in the benefits of telehealth. As such, legislative proposals to establish payment parity between in-person and telehealth services; ensure coverage for audio-only services; and expand access to and affordability of broadband are paramount to a digitized health care system that accounts for health equity in its design.

While the financial sustainability of telehealth remains an open question, we note that the premise of this question rests on the current Medicare FFS payment system. Such questions and concerns may dissolve as Medicare moves more of its care into risk-bearing, capitated payment arrangements, where providers would have built-in incentives to control the cost of patient care and deliver the most cost-effective suite of services to improve health.

[61] https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVDI-15Oct21.aspx