Memorandum

August 2, 2022

Overview of Recent Telehealth Developments – August 2022 Update

Attention continues to mount on telehealth expansion at the federal level. In Congress, lawmakers remain interested in determining what the longer-term fate of Medicare telehealth coverage will be beyond the COVID-19 public health emergency (PHE). While brief post-PHE expansion of Medicare telehealth coverage was already enacted earlier this year, legislation recently passed by the House would extend several telehealth flexibilities for a longer period of time, regardless of when the PHE ends. Congress also continues to contemplate additional telehealth-related changes as part of its work on behavioral health reform. Such reforms may be likely candidates for inclusion in a forthcoming year-end spending package.

On the regulatory front, the Centers for Medicare & Medicaid Services (CMS) recently proposed a new wave of changes that would further expand Medicare coverage of certain telehealth services. Like what is being contemplated in Congress, these intended changes would give CMS additional time to study the effects of expanded telehealth coverage on quality, cost, outcomes, and patient safety.

At the state level, states continue to contemplate how to ensure access to telehealth services for residents, especially against obstacles such as licensure requirements. New model legislation may serve to alleviate some of those concerns.

Last, continued research on telehealth utilization patterns has shed new light on which subpopulations are utilizing telehealth services. Overall, these analyses suggest that it will be important to ensure all communities can access telehealth meaningfully, which means a continued focus on broadband access, cultural competence, access to audio-only services, and other issues will remain important. New evidence also suggests that broad telehealth access does not lead to duplicative services.
Additional details are below.

Federal Legislative Landscape

Broad Telehealth Flexibilities

The House recently passed the **Advancing Telehealth Beyond COVID-19 Act of 2021 (H.R. 4040)**, introduced by Reps. Liz Cheney (R-WY) and Debbie Dingell (D-MI), that would further extend several temporary Medicare telehealth flexibilities through December 31, 2024. The bill passed with overwhelming support (416-12). The legislation would enact the following flexibilities:

- Eliminating the statutory geographic and originating site requirements for all telehealth services;
- Expanding the list of practitioners eligible to furnish telehealth services;
- Extending telehealth services for federally qualified health centers and rural health clinics;
- Delaying the in-person requirements under Medicare for mental health services furnished through telehealth;

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- Allowing the furnishing of audio-only telehealth services; and
- Allowing a hospice physician or nurse practitioner to continue conducting face-to-face encounters required for recertification,

In the FY 2022 omnibus appropriations package (P.L. 117-103) enacted in March, Congress permitted these flexibilities to continue for a 151-day period following the end of the COVID PHE. The PHE was recently extended through October 13, 2022. Because the Administration previously committed to providing a 60-day notice before allowing the PHE to expire, we would know by August 14 whether the PHE will expire on October 13, 2022. It is currently unclear whether the Administration will extend the PHE declaration at least one more time, though major groups such as the American Hospital Association have urged the Administration to extend the PHE beyond October. Some contend that it would be unhelpful for the Biden Administration to allow the PHE to expire only weeks before the Midterm Elections.

If the PHE does end on October 13, 2022, that means the COVID-19 telehealth flexibilities would end 152 days later on March 14, 2023. See a breakdown in the table below.

PHE Continuation Notification Date	Current PHE End Date	Telehealth Flexibilities End Date if PHE Ends in October
August 14, 2022	October 13, 2022	March 14, 2023

As noted above, however, the modified Cheney-Dingell bill would establish a concrete, two-year extension of these flexibilities that is not contingent on the end date of the PHE. Of note, the original version of the Cheney-Dingell legislation would have made these flexibilities permanent.

Given its broad support, it is possible this bill will be incorporated into a year-end spending package before the current Congressional session ends. The two-year extension included in this legislation would provide policymakers additional time to study the effects of expanded Medicare coverage of telehealth on access, quality, outcomes, costs, patient safety, and fraud. Notably, this two-year extension aligns with recommendations advanced by the Medicare Payment Access Commission (MedPAC) last year (details).

However, some stakeholders have continued to urge caution on broad telehealth expansions. Based on a recent Congressional Budget Office (CBO) scoring of the 151-day telehealth extension, stakeholders warn that a 10-year extension of Medicare telehealth flexibilities would cost $25 billion.

Telemental Health

The Senate Finance Committee continues to work on developing a comprehensive mental health package, which is expected to include provisions that would enhance telemental health care. The Committee is also crafting provisions related to youth mental health, parity, workforce, and integrating physical and behavioral health care. To date, Senate Finance has released discussion drafts on telemental health and youth mental health. The remaining three discussion drafts are expected in the coming weeks. Once the complete bill is finalized, it is also expected the Senate will attempt to incorporate it in a year-end spending package.

The telemental health package would:

- Remove the statutory limitation that currently requires Medicare beneficiaries to see a provider six months prior to an initial telehealth visit and then once more each year thereafter;
- Permanently allow for audio-only coverage of telemental health services;
- Increase public awareness of telemental health coverage under Medicare through new websites, publications, and public awareness campaigns;
- Establish program integrity measures to monitor providers whose telemental health claims far exceed the average; and
- Create guidance for furnishing telehealth services to people with limited English proficiency.

What's Missing?

Additional telehealth proposals could surface in the coming months with hopes for inclusion in an end-of-year package. For example, stakeholders have been urging Congress to permanently extend the currently pandemic-driven flexibilities that allow telemedicine-based prescribing of controlled substances, which certain mental health therapies. In addition, Congress has until January 2023 to decide whether it will continue to allow high-deductible health plans to continue providing pre-deductible coverage telehealth services, which has been especially impactful for those seeking mental health care.

Federal Regulatory Landscape

CMS continues to implement changes to its telehealth coverage policies under Medicare as part of its evolving response to the COVID-19 pandemic. Most recently, in the calendar year (CY) 2023 Medicare Physician Fee Schedule, CMS included several proposals that would build on previous years' changes which expanded Medicare coverage of certain telehealth services.

- **Additional Services Added on a Temporary Category 3 Basis**: CMS proposed to temporarily add additional services on a category 3 basis. This means that the new services added will be reimbursable by Medicare through the end of CY 2023 – a change CMS made in the wake of the COVID-19 pandemic. These include certain services across the following domains:
    - Therapy services;
    - Audiology testing services;
    - Neurostimulator pulse generator/transmitter services (specifically CPT codes 95970, 95983, and 95984);
    - Emotional/behavioral assessment, psychological, or neuropsychological testing and evaluation services;
    - Psychophysiological therapy;
    - Ophthalmological services;
    - Speech, language, voice, communication, and/or auditory processing disorder services;
    - Home ventilator management;
    - Developmental screening;

- Health behavior intervention;
- Interventions that focus on cognitive function; and
- Self-measured blood pressure, among others.

- **Additional Services Added on a Permanent Category 1 Basis**: CMS also proposed to add three services permanently to the Medicare telehealth list on a category 1 basis. These services involve prolonged services by a physician or other qualified health professional in an inpatient/observation, nursing facility, or home-based setting.

- **Services Proposed for Removal from the Medicare Telehealth List after 151 Days Following the End of the PHE:** Pursuant to recent changes effected by the Consolidated Appropriations Act of 2022 (CAA of 2022), CMS is able to extend certain PHE telehealth flexibilities 151 days following the end of the PHE. This includes maintaining the list of temporary Medicare telehealth services, which were added via PHE-waiver authority. However, once that 151-day period ends, CMS will no longer have the ability to maintain the list of services added to the Medicare telehealth list solely under waiver authority (i.e., services not added to the list via regular rulemaking via the Medicare Physician Fee Schedule updates). CMS enumerated these services in Table 10 on p. 104 of the proposed rule. The agency reiterated that these services will remain available to all beneficiaries regardless of their geographic location or site of care for the first 151 days following the end of the PHE. However, on the 152nd day following the end of the PHE, CMS confirmed that these services will no longer be available to beneficiaries via telehealth.

- **Implementation of Telehealth Provisions of CAA of 2022:** CMS proposed to implement the provisions in the CAA of 2022 that extend certain Medicare telehealth flexibilities adopted during the PHE for 151 days after the end of the PHE. As a reminder, these changes include:

  - Removing the statutory geographic and originating site restrictions, meaning that beneficiaries will still be able to access telehealth from any location and in any setting of care for the 151-day period following the end of the PHE;
  - Payment of an originating site fee to an originating site with respect to telehealth services furnished during the temporary 151-day period (i.e., payment parity);
  - Expanding the definition of eligible telehealth practitioners to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists;
  - Continuing telehealth payment for FQHCs and RHCs;
  - Delaying the requirement for an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, and again at subsequent intervals as the HHS Secretary determines appropriate; and
  - Requiring CMS to continue covering the services temporarily added to the Medicare telehealth list through PHE waiver authority.

  CMS added that, because the end date of the PHE is not yet known and could occur before the rulemaking process for the CY 2023 PFS is complete, and because the changes made by these provisions are very

specific and concise, it is committing to issue program instructions or other sub-regulatory guidance to effectuate the changes described above.

- **Medicare Telehealth Service Modifiers:** CMS proposed the use of new point of service (POS) indicators to signify in what setting the telehealth service was furnished to a beneficiary (i.e., in the beneficiary's home or not) for use on the 152nd day after the PHE ends.

- **Other Non-Face-to-face Services Involving Communications Technology under the PFS:** During the PHE, CMS loosened the direct supervision requirements for providing telehealth services to no longer require the physical presence of the supervising professional and instead to only require the supervising professional be immediately available through virtual presence. CMS sought feedback on whether these flexibilities should continue beyond the PHE.

- **Telehealth Originating Site Facility Fee Update:** CMS notes that for CY 2023, the proposed payment amount for the telehealth originating site fee is $28.61, but that the final fee will be revised for the final rule based on the historical data through the second quarter 2022 and the most recently available total factor productivity data.

State-Level Developments

The Uniform Law Commission recently approved model legislation to expand access to telehealth at the state level. The legislation would do so by 1) allowing practitioners authorized to provide health care in a state in which a patient is located to also furnish care via telehealth; and 2) establishing a registration system for out-of-state practitioners to make it easier for practitioners to provide care across state lines.

While this model legislation was developed through a consensus-based approach, it is more likely that states will adopt this legislation if they have not already enacted telehealth reforms of their own. A comprehensive tracker of state-level telehealth legislation is available here.

As for its impact on the federal level, we do not anticipate federal legislative efforts on telehealth to incorporate much of this discussion. To date, federal deliberations on telehealth have remained primarily focused on Medicare telehealth coverage. States have modified their own telehealth rules as separate initiatives beyond the federal discussions. Congress included a proposal in the recently passed Bipartisan Safer Communities Act, however, that requires the U.S. Department of Health and Human Services (HHS) to provide technical assistance and issue guidance to states on improving access to telehealth for services covered under Medicaid and CHIP.

Recent Analysis

Telehealth and Health Equity

In May 2022, Health Affairs published a new study which found that Medicare beneficiaries in disadvantaged neighborhoods increased their use of telehealth during the COVID-19 pandemic. However, a February 2022 analysis from the Assistant Secretary for Planning and Evaluation (ASPE) – which examined telehealth utilization

across insurance markets – found that there were significant disparities among subgroups in terms of audio versus video telehealth use. Specifically, ASPE found that video-enabled telehealth rates were lowest among those without a high school diploma, adult ages 65 and older, and Latino, Asian, and Black individuals. By contrast, video-enabled telehealth utilization was highest among high-earners and those with private health insurance coverage.

These analyses further add to the conversation around the equity implications of telehealth coverage. They emphasize both the importance of ensuring telehealth coverage for minority communities as well as ensuring access to broadband services and culturally competent technologies. See our fuller brief exploring these issues here.

Utilization

A recent analysis conducted by Michigan's Institute for Healthcare Policy found that Medicare telehealth utilization remained steady in 2021 and that telehealth was used commonly as a substitute for rather than in addition to in-person care. Analyses like these could serve to curb concerns that broad access to Medicare would drive up costs (as suggested by the recent CBO analysis).