COMMITTEE ON
ENERGY & COMMERCE
CHAIRMAN FRANK PALLONE, JR.

MEMORANDUM

February 26, 2021

To: Subcommittee on Health Members and Staff

Fr: Committee on Energy and Commerce Staff

Re: Hearing on "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

On **Tuesday, March 2, 2021, at 10:30 a.m. (EDT), via Cisco Webex online video conferencing,** the Subcommittee on Health will hold a hearing entitled, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care."

I. BACKGROUND

Prior to the current coronavirus disease of 2019 (COVID-19) public health emergency (PHE) exemptions, Medicare reimbursement for telehealth services was limited and subject to a number of restrictions. First, Medicare generally only reimburses for telehealth services delivered to a beneficiary in a rural area and at an eligible originating site (such as a hospital or physician's office).[1] An originating site is the place where a beneficiary is located at the time the telehealth service is provided. A beneficiary's home was not considered an eligible originating site prior to the PHE, except in certain narrow circumstances.

Second, Medicare reimburses only for telehealth visits that have both audio and visual capabilities (i.e. two-way audio-visual).[2] Medicare does cover other remote services such as virtual check-ins, which are brief communications with established patients that may be conducted without a visual component,[3] as well as certain forms of remote patient monitoring.[4] Medicare did not reimburse for other forms of audio-only services prior to the PHE.

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[1] Centers for Medicare and Medicaid Services, *Telehealth Services* (Mar. 2020) (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf); Section 1834(m)(4) of the Social Security Act.

[2] Section 1834(m)(1) of the Social Security Act.

[3] Centers for Medicare and Medicaid Services, *MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET* (Mar. 17, 2020) (www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet).

[4] Centers for Medicare and Medicaid Services, *Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021* (Dec. 1,

Third, Medicare reimburses for telehealth services provided by a specified set of practitioners, which includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals.[5]

Fourth, Medicare only reimburses certain covered eligible telehealth services.[6] Each year the Centers for Medicare and Medicaid Services (CMS) considers new services to be added to the telehealth coverage list through annual rulemaking. The criteria for adding new telehealth services involves a two-step regulatory process under which services are evaluated to establish whether the service is similar to services currently included on the telehealth coverage list; and if not, whether the use of technology to deliver the service produces a demonstrable clinical benefit to the patient.[7]

Over the years, Congress has authorized exceptions to Medicare's statutory requirements for telehealth services based on evidence of clinical benefit. For example, Congress permanently waived rural and originating site requirements for mental health services delivered via telehealth.[8] Congress also permanently waived rural and originating site requirements for end-stage renal disease (ESRD) services and treatment of acute stroke and opioid use disorders.[9] Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans may waive telehealth requirements for their beneficiaries. However, the Medicare Payment Advisory Commission (MedPAC) has suggested that these entities warrant such additional telehealth flexibility, because these models assume that providers bear financial risk of overutilization of healthcare services. By contrast, MedPAC has stated, Medicare does not have the same ability to protect against overutilization in the current fee for service (FFS) environment.[10]

2020) (www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1).

[5] Section 1834(m)(1) of the Social Security Act.

[6] Centers for Medicare and Medicaid Services, List of Telehealth Services (www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes) (accessed Feb. 25, 2021); Section 1834(m)(4)(F) of the Social Security Act.

[7] Centers for Medicare and Medicaid Services, CMS Criteria for Submitted Requests (www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria) (accessed Feb. 25, 2021).

[8] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260.

[9] Centers for Medicare and Medicaid Services, *Telehealth Services* (Mar. 2020) (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf).

[10] MedPAC, *Report to Congress: Medicare Payment Policy, Chapter 16, Mandated report: Telehealth services and the Medicare program* (Mar. 2018) (www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0).

II. TEMPORARY TELEHEALTH FLEXIBILITIES DURING THE PUBLIC HEALTH EMERGENCY

A. Medicare

The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 temporarily authorized the Secretary of Health and Human Services (HHS) to waive statutory requirements with respect to telehealth services under Medicare for the duration of the COVID-19 PHE.[11] This waiver authority allowed for Medicare beneficiaries in all areas of the country to receive telehealth services in any location, including their homes (waiving the rural and originating site requirements). In a letter to governors, HHS indicated that the PHE will be in place for the entirety of 2021 and that states would receive 60 days' notice prior to termination of the PHE.[12]

During the PHE, Medicare will cover some audio-only services and will reimburse for both telehealth services and audio-only services as if they were provided in person. In the 2021 Physician Fee Schedule (PFS) rule, CMS indicated that it will not continue the same coverage of audio-only services after the pandemic. However, CMS did finalize in the PFS rule a new permanent code describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit which can be conducted via audio-only technology similar to a virtual check-in.

HHS also temporarily expanded the categories of practitioners eligible to bill Medicare for telehealth services to include physical therapists, occupational therapists, and speech language pathologists.[13] In addition, section 3704 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) authorized Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to bill Medicare for telehealth services during the PHE, expanding access to telehealth services at these sites.[14]

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[11] Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123.

[12] Letter from Norris W. Cochran, Acting Secretary of Health and Human Services, to Governors (Jan. 22, 2021) (ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf).

[13] Centers for Medicare and Medicaid Services, *Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19* (Jan. 28, 2021) (www.cms.gov/files/document/covid-19-physicians-and-clinicians.pdf).

[14] Centers for Medicare and Medicaid Services, *New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE* (Feb. 23, 2021) (www.cms.gov/files/document/se20016.pdf).

Since the beginning of the PHE, Medicare has added 144 new covered telehealth services and about 60 of those services will continue to be covered even after the end of the PHE.[15] The final 2021 PFS rule outlined a third category of telehealth services which describes services that will remain covered only for the duration of the PHE.[16] CMS determined that these telehealth services, while likely to provide some benefit, currently lack sufficient evidence of clinical benefit to be covered permanently.

B. Cost Sharing

Medicare beneficiaries are generally responsible for 20 percent coinsurance for telehealth services, similar to most other outpatient services. The HHS Office of the Inspector General (HHS OIG) announced that it will provide flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by Federal health care programs (including Medicare) during the PHE.[17] As a result, providers may offer telehealth services at no cost to beneficiaries.

C. Privacy and Security

Prior to the PHE, a health care provider generally would have to enter into a business associate agreement with a telehealth vendor supplying a HIPAA-compliant telehealth platform. Such agreement would ensure that the provider and vendor have controls in place to prevent unauthorized access to protected health information (PHI) and a responsibility to notify patients of any breaches of PHI.[18]

The HHS Office for Civil Rights (OCR) announced it will exercise enforcement discretion and not impose penalties for non-compliance with HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the PHE.[19] This enforcement discretion has allowed for providers to temporarily use applications such as Apple FaceTime, Facebook Messenger, or Google Hangouts to provide telehealth services.[20]

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[15] Centers for Medicare and Medicaid Services, *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients* (Dec. 1, 2020) (press release).

[16] *See* note 4.

[17] U.S. Department of Health and Human Services Office of the Inspector General, *HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth Services During the COVID-19 Outbreak* (Mar. 2020).

[18] Congressional Research Service, *HIPAA, Telehealth, and COVID-19* (June 5, 2020).

[19] 45 C.F.R. §§ 160, 164 (2020). *See* www.govinfo.gov/content/pkg/FR-2020-04-21/pdf/2020-08416.pdf (accessed Feb. 23, 2021).

[20] U.S. Department of Health and Human Services, Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency (www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html) (accessed Feb. 25, 2021).

OCR still expects that providers conduct telehealth visits in a private setting or take reasonable precautions to limit incidental uses or disclosures of PHI.[21] A bad faith provision of telehealth may include the use of public-facing communications products (e.g. Facebook Live, public chat rooms), fraud, violations of state licensing laws, or further uses or disclosures of patient data that are prohibited by the HIPAA Privacy Rule.[22]

D. State Licensure

CMS has temporarily waived Medicare and Medicaid's requirements that physicians and non-physician practitioners be licensed in the state where they are providing services.[23] However, this waiver remains subject to state licensing laws. To qualify for this waiver a provider must be enrolled in Medicare, have a valid license to practice in the state related to their Medicare enrollment, be furnishing services in a state where the emergency is ongoing, and they are contributing to relief efforts, and not be excluded from practice in any state.

The majority of states have moved to waive or streamline licensure requirements or enter compacts with neighboring states to allow for providers licensed in other states to deliver care.[24] States have discretion to waive licensure requirements and some have done so broadly, for example by allowing for medical professionals in good standing in any other state to provide telehealth or in person medical services to residents during the PHE.[25] Additionally, 29 states, the District of Columbia and Guam currently participate in the Interstate Medical Licensure Compact.[26] Through this compact eligible physicians can submit a single application to practice in multiple states. The Health Resources and Services Administration (HRSA) also provides support to state licensing boards through its Licensure Portability Grant Program with the goal of reducing statutory and regulatory barriers to telehealth.

E. Controlled Substances

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[21] U.S. Department of Health and Human Services Office of Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency* (www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf) (accessed Feb. 25, 2021).

[22] *Id*.

[23] *See* note 13.

[24] Federation of State Medical Boards, *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19* (www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf) (updated Feb. 19, 2021).

[25] *Id*.

[26] Interstate Medical Licensing Compact, A Faster Pathway to Physician Licensure (www.imlcc.org/a-faster-pathway-to-physician-licensure/) (accessed Feb. 25, 2021).

The COVID-19 PHE has also allowed for greater telehealth flexibility under the Controlled Substances Act.[27] For example, the Drug Enforcement Administration (DEA) worked with HHS to allow DEA-registered practitioners to use telemedicine to issue prescriptions for controlled substances to patients outside of a hospital or clinical setting.[28] Additionally, qualifying practitioners can prescribe buprenorphine to new patients with opioid use disorder via telehealth without an in-person or telemedicine evaluation.[29] These policies are in place through the COVID-19 PHE.

F. Private Insurance

In March 2020, CMS issued guidance allowing insurers in the individual and group market to amend plan benefits during the 2020 plan year to expand coverage for telehealth services.[30] Insurers are generally not allowed to modify coverage mid-year, but CMS guidance stated that the agency would not take enforcement action against insurers that make changes in order to provide greater coverage for telehealth services or to reduce or eliminate cost-sharing for telehealth services. Most insurers have since reduced or eliminated cost-sharing altogether for telehealth for all services or for services related to COVID-19 for a limited period of time.[31] Some insurers are also broadening coverage of telehealth benefits by allowing coverage of more services and expanding in-network telehealth providers.[32] As a result, the use of telehealth services has increased substantially.[33]

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[27] Drug Enforcement Administration, *DEA's response to COVID-19* (Mar. 20, 2020) (press release).

[28] Drug Enforcement Administration Diversion Control Division, COVID-19 FAQ (www.deadiversion.usdoj.gov/faq/coronavirus_faq.htm#ADMINISTERING_FAQ) (accessed Feb. 25, 2021).

[29] Letter from Thomas Prevoznik, Deputy Assistant Administrator, Drug Enforcement Administration Diversion Control Division, to Registrant (Mar. 31, 2020)(www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf).

[30] Centers for Medicare and Medicaid Services Center for Consumer Information and Insurance Oversight, *FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19)* (Mar. 24, 2020) (www.cms.gov/files/document/faqs-telehealth-covid-19.pdf).

[31] Kaiser Family Foundation, *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond* (May 11, 2020) (https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/).

[32] *Id*.

[33] Peterson-KFF Health System Tracker, *How Private Insurers Are Using Telehealth to Respond to the Pandemic* (Aug. 6, 2020) (www.healthsystemtracker.org/brief/how-private-insurers-are-using-telehealth-to-respond-to-the-pandemic/).

G. Medicaid

Unlike Medicare, Medicaid contains few statutory restrictions on the use of telehealth.[34] State Medicaid programs can choose which services to cover through telehealth, which providers may use and be reimbursed for telehealth, and other flexibilities.[35] In October 2020, CMS released a toolkit for states that highlights considerations for determining the scope of their telehealth coverage, as well as a checklist of questions states may want to answer as they expand their telehealth coverage.[36]

During the COVID-19 PHE, many states have made telehealth services more widely available in both Medicaid FFS programs and through Medicaid managed care plans. Most states are allowing both FFS and managed care Medicaid beneficiaries to access services from their home, and most are allowing for reimbursement for some telephone evaluations. Additionally, many states are allowing new providers to offer telehealth services, expanding coverage or access to telehealth during this crisis, and providing payment parity for at least some telehealth services.[37]

III. RECENT TRENDS IN TELEHEALTH

A. Utilization

As a result of the pandemic and the flexibilities in place, patients are increasingly using telehealth to access health care services. Before the PHE, approximately 13,000 beneficiaries in Medicare FFS received telehealth services in a week compared to an estimated 1.7 million receiving telehealth services in a week in April 2020. According to CMS data, over 9 million Medicare FFS beneficiaries received a telehealth service or other virtual service between mid-March through mid-June in 2020.[38] One third of such visits were audio-only visits. Evaluation and management (E/M) services and mental health services were some of the most common services delivered via telehealth.

Data from private insurers also demonstrates a surge in telehealth adoption during the pandemic with telehealth claims increasing by 2,938 percent between November 2019 and

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[34] MACPAC, *Report to Congress Chapter 2: Telehealth in Medicaid* (Mar. 2018) (www.macpac.gov/wp-content/uploads/2018/03/Telehealth-in-Medicaid.pdf).

[35] *Id.*

[36] Centers for Medicare and Medicaid Services, *State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth – COVID-19 Version, Supplemental #1* (Oct. 14, 2020) (www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf).

[37] *See* note 31.

[38] *Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19,* Health Affairs (July 15, 2020) (www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/).

November 2020.[39] Similarly, from March through June 2020, the use of telehealth in Medicaid increased significantly. During that same period, over 34 million Medicaid services were provided through telehealth, which was a 2,632 percent increase in the use of telehealth compared to the same period in 2019.[40]

B. Program Integrity

HHS OIG has announced plans to examine the impact of the rapid adoption of telehealth during the pandemic, particularly with respect to Medicare program integrity.[41] Since 2016, HHS OIG has witnessed increases in telehealth related fraud. Recent HHS OIG work has uncovered approximately $4.5 billion in telehealth related fraud.[42] Examples of potential fraud identified include cold calling patients to bill for telehealth services, billing for an impossible number of telehealth visits in a day, billing for services or equipment not rendered, and overseas providers not licensed in the United States providing telehealth services. In addition, the CMS Center for Program Integrity took administrative action in 2020 to revoke the Medicare billing privileges of 256 medical professionals for their involvement in telehealth related fraud schemes.[43]

IV. EVIDENCE OF TELEHEALTH CLINICAL BENEFITS

Research has shown that telehealth has benefits for patients. For example, telehealth may increase access to mental health providers, improve outcomes in integrated care settings, and be

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[39] FAIR Health, *Monthly Telehealth Regional Tracker, Nov. 2020* (s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/nov-2020-national-telehealth.pdf) (accessed Feb. 25, 2021).

[40] Centers for Medicare and Medicaid Services, *Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19: Preliminary Medicaid & CHIP Data Snapshot* (www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf) (accessed Feb. 25, 2021).

[41] U.S. Department of Health and Human Services Office of the Inspector General, Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks (oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000535.asp) (accessed Feb. 25, 2021).

[42] U.S. Department of Health and Human Services Office of the Inspector General, *2020 National Health Care Fund Takedown* (oig.hhs.gov/documents/root/230/2020HealthCareTakedown_FactSheet_9dtIhW4.pdf) (accessed Feb. 25, 2021).

[43] U.S. Department of Justice, *National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More than $6 Billion in Alleged Fraud Losses* (Sept. 30, 2020) (press release).

at least as effective as an in-person visit for several psychiatric services.[44] A review by the Agency for Healthcare Research and Quality (AHRQ), which examined 950 studies of telehealth, indicated telehealth is beneficial for specific uses and patient populations, such as remote home monitoring for patients with chronic conditions, communicating and counseling patients with chronic conditions, and providing psychotherapy.[45] The review indicated the need for additional studies for other services and other populations, where limited evidence exists.[46] A review of direct-to-consumer telehealth services by MedPAC found that expansion of these services may result in increased access and convenience but also significant costs to Medicare, potential for misuse, and unclear impacts on quality.[47]

V. WITNESSES

The following witnesses have been invited to testify:

Megan R. Mahoney, M.D.
Chief of Staff
Stanford Health Care

Ateev Mehrotra, M.D., M.P.H.
Associate Professor of Health Care Policy
Harvard Medical School

Elizabeth Mitchell
President and CEO
Purchaser Business Group on Health

Jack Resneck, Jr., M.D.
Board of Trustees
American Medical Association

Frederic Riccardi
President
Medicare Rights Center

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[44] Donald M. Hilty et al., *The Effectiveness of Telemental Health: A 2013 Review,* Telemedicine Journal and E-Health (June 2013); Akuh Adaji and John Fortney, *Telepsychiatry in Integrated Care Settings,* Psychiatry Online (July 18, 2020).

[45] Totten AM, Womack DM, Eden KB, et al., *Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews* (2016).

[46] *Id.*

[47] *See* note 10.