To: The Honorable Rep. Diana DeGette
Cc: Sheri Lou Santos, Health Policy Director
From: California Telehealth Policy Coalition
Date: June 29, 2020
Topic: DRAFT Recommendations for Federal Statutory Changes to Support Telehealth Beyond COVID-19

Dear Representative DeGette:

The California Telehealth Policy Coalition would like to thank you for the opportunity to provide input on a potential legislative package that would modernize the Medicare program and health care financing, particularly as it pertains to telehealth services. As a group of over 80 organizations dedicated to advancing telehealth policy in California, we appreciate telehealth's role in providing safe, secure and clinically appropriate care to all Americans.

During the current public health emergency, HHS Secretary Azar and CMS Administrator Verma have made meaningful changes to expand telehealth coverage to Medicare beneficiaries to ensure they can get the care they need during this time from their home. These changes have been made using 1135 waiver authority and will not last past the expiration of the public health emergency. Below are several recommendations and specific statutory changes that can be made to support telehealth going forward in the Medicare program.

Recommendation 1: Amend the Social Security Act (SSA) to allow CMS to determine eligible, distant site practitioners.

Under the 1135 waiver, Secretary Azar and Administrator Verma have been able to waive the restrictions on the types of health care practitioners that can deliver telehealth services to a Medicare beneficiary. The Medicare program should not limit eligible health care practitioners to those specified in the Medicare Part B payment provisions (42 U.S.C. § 1842(b)(18)(B)). We recommend the following changes to 42 U.S.C. § 1395m:

> (m)(4)(E) PRACTITIONER.—The term "practitioner" has the meaning given that term in section 1842(b)(18)(C). The term "practitioner" shall have that meaning as prescribed by the Secretary.

Recommendation 2: Amend the SSA to grant CMS the ability to determine appropriate originating sites.

Additionally, under the 1135 waiver, CMS has been able to waive the originating site limitations that normally prevent most health care practitioners from furnishing telehealth services unless the originating site is located in a health professional shortage area, rural area or in a federal telemedicine demonstration project (Hawaii and Alaska). Additionally, the home as an originating site is generally limited to certain behavioral health and ESRD-related services.

To ensure that Medicare beneficiaries in any part of the country are able to continue receiving telehealth services from their home, we recommend the following changes to 42 U.S.C. § 1395m:

(m)(4)(C) ORIGINATING SITE.—

(i) IN GENERAL.—Except as provided in paragraph (5), (6), and (7), the term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system. and only if such site is located—

(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));

(II) in a county that is not included in a Metropolitan Statistical Area; or

(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.

(II) A critical access hospital (as defined in section 1861(mm)(1)).

(III) A rural health clinic (as defined in section 1861(aa)(2)).

(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).

(V) A hospital (as defined in section 1861(e)).

(VI) A hospital-based or critical access hospital- based renal dialysis center (including satellites).

(VII) A skilled nursing facility (as defined in section 1819(a)).

(VIII) A community mental health center (as defined in section 1861(ff)(3)(B))

(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).

(X) The home of an individual, but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

(XI) Any location as designated by the Secretary.

Recommendation 3: Amend the SSA to require CMS to allow for telehealth coverage of all clinically appropriate services.

During the COVID-19 pandemic, CMS has used its 1135 waiver authority to expand the list of services eligible to be furnished by telehealth. Once the PHE expires, CMS may pull back on the list of services eligible to be furnished by telehealth, leaving health care practitioners liable for the significant financial and human resources they have devoted to telehealth start-up during the PHE. We recommend the following changes to 42 U.S.C. § 1395m to ensure CMS covers all clinically appropriate services coming out of the PHE:

> (m)(4)(F) TELEHEALTH SERVICE.—
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> (i) IN GENERAL.—The term "telehealth service" means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary. The Secretary shall interpret "telehealth service" to mean any covered item that can be provided through telehealth in a clinically appropriate manner.
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> (ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).

Recommendation 4: Amend the SSA to allow Medicare health care practitioners outside of Alaska and Hawaii to be able to provide store-and-forward telehealth, and for telephonic communications to be formally considered within the scope of telehealth.

Current law limits the spread of store-and-forward applications of telehealth to demonstration projects in Alaska and Hawaii, limiting the ability of CMS to expand these services to other parts of the country. Additionally, although CMS is currently allowing for coverage of certain services when provided via telephone, stakeholders worry that CMS will end telephone coverage at the end of the PHE, leaving many Medicare beneficiaries without proper internet connectivity in the dark and unable to receive virtual care from their health care providers. We recommend the following changes to 42 U.S.C. § 1395m to ensure beneficiaries can continue to receive their care through telephonic means.

> (m) PAYMENT FOR TELEHEALTH SERVICES.—
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> (1) IN GENERAL.—The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to

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an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term "telecommunications system" includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats. For the purposes of the preceding sentence, "telecommunications system" includes two-way, real-time audio-video technologies, store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats, remote patient monitoring, and audio-only telephonic communications.

Recommendation 5: Amend the existing Health Care at Home Act to require individual and group health plan coverage of telehealth during and beyond COVID-19.

Under current law, there is no federal requirement for employer-sponsored group health plans and insurers to cover telehealth, and states are preempted from making similar requirements of these plans and insurers under ERISA. Senator Tina Smith has put forward the Health Care at Home Act (S.3741), which would require these health plans and insurers to cover telephonic and live video visits for any benefits that would otherwise be provided in person, during the COVID-19 PHE. We recommend the following changes to the legislation and adoption of the remainder of the language:

(a) IN GENERAL.—During any portion of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), notwithstanding sections 2703 and 2715(d)(4) of the Public Health Service Act (42 U.S.C. 300gg–2, 300gg–15(d)(4)), a A group health plan and a health insurance issuer offering group health insurance coverage, including a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(e)))—

(1) shall—

(A) provide benefits under such plan or such coverage for any eligible service (as defined in subsection (c)), including a mental health and substance use disorder service, furnished via a qualifying telecommunications system (as defined in subsection (c)) by a health care provider to an individual who is a participant, beneficiary, or enrollee under such plan or such coverage, notwithstanding that such provider furnishing such service is not at the same location as the individual;

(B) so provide such benefits for such service under the same terms and with application of the same cost-sharing requirements (including a deductible, copayment, or coinsurance) as would apply if such service were furnished by such provider to such individual in person;

(C) reimburse such provider for such service in an amount equal to the amount of reimbursement for such service had such service been furnished by such provider to such individual in person;

(D) not impose any requirement under such plan or coverage that such provider have a prior relationship with such individual; and

(E) not restrict the ability of any health care provider with a contractual relationship for furnishing an eligible service under such plan or coverage from furnishing such service via a qualifying telecommunications system, and shall not establish incentives or penalties under such plan or coverage for receiving such an eligible service from such a provider via such a system; and

(2) may waive any cost-sharing requirement (including application of a deductible, copayment, or coinsurance) for an item or service furnished for purposes of diagnosing or treating COVID–19, including any such service that is an eligible service furnished via a qualifying telecommunications system.

(b) APPLICATION.—The provisions of this section shall be applied by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury to group health plans and health insurance issuers offering group or individual health insurance coverage as if included in the provisions of part A of title XXVII of the Public Health Service Act, part 7 of the Employee Retirement Income Security Act of 1974, and subchapter B of chapter 100 of the Internal Revenue Code of 1986, as applicable.

(c) DEFINITIONS.—In this section:

(1) ELIGIBLE SERVICE.—The term "eligible service" means, with respect to a group health plan and a health insurance issuer offering group or individual health insurance coverage, a service—

(A) for which benefits are provided under such plan or such coverage when such service is furnished in person;

(B) that is medically necessary (as determined by the health care provider furnishing such service); and

(C) that is able to be safely and effectively furnished via a telecommunications system.

(2) HEALTH INSURANCE TERMS.—The terms “group health plan”, “health insurance issuer”, “group health insurance coverage”, and “individual health insurance coverage” have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code of 1986, as applicable.

(3) QUALIFYING TELECOMMUNICATIONS SYSTEM.—The term “qualifying telecommunications system” means a telecommunications system that includes, at a minimum, audio capabilities permitting two-way, real-time interactive communication between the individual receiving an eligible service via such system and the health care provider furnishing such system, including a telephone, videoconferencing system, internet communications system, streaming media communications system, and such other systems as specified by the Secretary of Health and Human Services.

(d) EFFECTIVE DATE.—This section shall apply with respect to items and services furnished on or after the first day of the emergency period described in subsection (a).

The California Telehealth Policy Coalition is grateful to provide these recommendations and looks forward to working with your office on telehealth issues in the future. Should you have any further questions regarding these recommendations, please feel free to reach out to Robby Franceschini, Director of Policy, BluePath Health at robby.franceschini@bluepathhealth.com or Mei Kwong, Executive Director, Center for Connected Health Policy at meik@cchpca.org.

Sincerely,

The California Telehealth Policy Coalition