

**TELEHEALTH EXTENSION AND EVALUATION ACT**

*Sen. Cortez Masto (NV), Sen. Young (IN)*

**Sec. 1: Short Title, Table of Contents**

**Sec. 2: Basic Extension – *Extension of Telehealth Services*** Prior to the pandemic, coverage of Medicare Part B services delivered via telehealth (outside of a risk sharing arrangement) was generally limited a subset of codes for patients in rural areas who were required to receive services at a health facility.<sup>1</sup>

In the Coronavirus Preparedness and Response Supplemental Appropriations Act, Congress expanded HHS’ authority under Section 1135 of the Social Security Act, which confers waiver authorities to the secretary during public health emergencies (PHE), to include waiver authority for certain Medicare telehealth restrictions during the COVID-19 PHE.<sup>2</sup> In early March 2020, CMS used this authority to enable Medicare payment for telehealth services, including office, hospital outpatient department, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient’s place of residence.

In addition, CMS added, on an interim basis, services to the list of eligible Medicare telehealth services, eliminated frequency limitations and other requirements associated with particular services furnished via telehealth, and clarified several payment rules that apply to other services furnished using telecommunications technologies.<sup>3</sup> In the most recent physician fee schedule, CMS proposed to allow some of the services added to the Medicare telehealth list to remain on the list until the end of December 31, 2023 to give the agency time to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 PHE.<sup>4</sup>

This section would extend the telehealth expansions implemented under the 1135 waiver authority for an additional two years after the end of the PHE.

**Sec. 3: DME/Lab Test Guard Rails – *Requirement for provision of high-cost durable medical equipment and laboratory tests*** In its March 2021 Report to Congress, MedPAC recommended that CMS apply certain additional guardrails to a temporary extension of pandemic telehealth flexibilities in order to protect against wasteful spending, fraud and abuse<sup>5</sup>. In addition to applying scrutiny to outlier claims, they suggest that clinicians should be required to provide a face-to-face, in-person visit with a beneficiary before they order high-cost durable medical equipment (DME) or a high-cost lab test for that beneficiary. MedPAC cites the involvement of telehealth companies in large fraud cases where clinicians received illegal kickbacks from these companies for high volumes of prescriptions of both DME<sup>6</sup> and expensive genetic tests.<sup>7</sup>

CMS currently requires a face-to-face visit (not in-person) for some DME products like hospital beds; there is no such requirement for lab tests.

This section would satisfy MedPAC’s recommendation by requiring that a clinician see the patient for an in-person visit no earlier than 12 months prior to the prescription of high-cost lab tests and high-cost DME products. “High-cost” is defined as products and tests in the most expensive quartile of all products and tests. Outlier physicians prescribing high volumes of these treatments relative to their peers will be subject to audit. These requirements would sunset two years after the end of the PHE.

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<sup>1</sup> [MedPAC](#)

<sup>2</sup> [House Appropriations Committee](#)

<sup>3</sup> [CMS](#)

<sup>4</sup> [CMS](#)

<sup>5</sup> [MedPAC](#)

<sup>6</sup> [DOJ](#)

<sup>7</sup> [DOJ](#)

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**Sec. 4: NPI – Requirement to submit NPI number for telehealth billing** In order to bill Medicare directly, clinicians must register for a national provider identifier (NPI). Providers able to bill Medicare include advanced practice registered nurses (APRNs), physician assistants (PAs), physical therapists, occupational therapists, licensed clinical social workers, registered dietitians, nutrition professionals, speech–language pathologists, and clinical psychologists.

Under certain conditions, Medicare pays for services that are billed by physicians and certain other clinicians but performed by non-physician staff such as PAs, APRNs, registered nurses (RNs), medical assistants, technicians, and physical therapists. These are called “incident to” services. These services usually require the direct supervision of a clinician, which means that the billing clinician must be present in the office and immediately available to furnish assistance and direction throughout the performance of the service.

As recommended by MedPAC,<sup>8</sup> this section would require telehealth providers to obtain an NPI in order to bill Medicare. Doing so would provide CMS with more specific information on the types of clinicians delivering services via telehealth, and better monitor for overuse. These requirements would sunset two years after the end of the PHE.

**Sec. 5: RHC/FQHC – Rural Health Centers and Federally Qualified Health Centers** – Prior to the pandemic, RHCs and FQHCs were limited to serving as an originating site (the location of the patient) for telehealth services.<sup>9,10</sup> Section 3704 of the CARES Act allowed both types of facilities to serve as distant sites (the location of the provider) for the duration of the COVID-19 PHE.<sup>11</sup> Under regulations put forth by CMS pursuant to the CARES Act, telehealth services can be provided by any practitioner working for the FQHC or RHC within their scope of service and there are no restrictions on where the service is provided, meaning physicians or practitioners may provide the service from their homes.

This section would allow FQHCs and RHCs to serve as distant site provider for an additional two years after the expiration of the PHE.

**Sec. 6: Critical Access Hospitals (CAHs) – Telehealth Flexibilities for Critical Access Hospitals** – CAHs serve rural and frontier communities, and are generally paid for inpatient and outpatient services at 101 percent of reasonable costs. Additionally, CAHs can utilize care teams that include state-licensed clinicians who may not be Medicare-eligible providers, such as behavioral health therapists, to deliver services within their scope of practice.

Prior to the pandemic, CAHs could not serve as distant sites where providers deliver services to a remote patient unless the telehealth services were billed by the eligible provider rather than the hospital.<sup>12</sup> As a result, Medicare paid physician fee schedule (PFS) rates for telehealth services delivered by a physician or other practitioner when the CAH functioned as the distant site. Because PFS telehealth reimbursement rates are so far below the cost that a CAH incurs to deliver that service, it was infeasible for hospitals to provide services via telehealth.

In March 2020 CMS announced the Hospitals Without Walls (HWW) program to enhance hospital capacity and keep patients safe during the pandemic.<sup>13</sup> Under the HWW flexibilities, CAHs are able to deliver certain services to patients at home, and bill for those services at 101% of cost as though they were delivered in-person. CAHs were also able to utilize their entire care teams to deliver services, rather than being limited to Medicare-eligible providers. Neither of these flexibilities were achieved under the statutory changes to Sec. 1834(m) of the Social Security Act in the Coronavirus Preparedness and Response Supplemental Appropriations Act (*see **Basic Extension above***) that allowed patients to receive services at home. The HWW program will end with the termination of the COVID-19 PHE.

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<sup>8</sup> [MedPAC](#)

<sup>9</sup> [FPM](#), is a peer-reviewed journal published by the American Academy of Family Physicians

<sup>10</sup> [CMS](#)

<sup>11</sup> [CARES Act Statutory Language](#)

<sup>12</sup> [MedPAC](#)

<sup>13</sup> [CMS](#)

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To ensure that CAHs can continue to offer telehealth services after the expiration of the HWW program, this bill would add CAHs as a distant site provider of telehealth (allowing the facility to bill) and then crosswalk the payment to 1834(g) for two years post PHE.

**Sec. 7: MAT Telehealth –*Telehealth for Substance Use Disorder Treatment*** – The Ryan Haight Act of 2008 prohibited the dispensation of controlled substances via the internet (including telemedicine) without an in-person evaluation of the patient except under certain circumstances. The Drug Enforcement Agency (DEA) confirmed the COVID-19 PHE as an exception to this rule, allowing DEA-registered practitioners in all areas of the United States to issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable Federal and State laws.<sup>14</sup>

Additionally, DEA gave practitioners further flexibility during the PHE to prescribe buprenorphine to new and existing patients with opioid use disorder (OUD) via telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in person or via telemedicine.<sup>15</sup>

Provisional data from the National Center for Health Statistics shows that drug overdoses in 2020 exceeded 93,000 cases, a 30 percent increase over 2019. Experts have suggested that limited access to anti-addiction medications like buprenorphine and methadone during the pandemic contributed to surging overdose figures.<sup>16</sup>

This section would extend the above flexibilities for two years post PHE.

**Sec. 8: Study – *Study on the Effects of Changes to Telehealth under the Medicare and Medicaid Programs During the COVID-19 Emergency*** – In order to better inform Congress' work to make telehealth flexibilities permanent using comprehensive cost and use data, this section would require HHS to study the impact of the pandemic telehealth flexibilities extended in this bill on utilization, cost, fraud, privacy, and equitable access within the Medicare and Medicaid programs over the course of the extension and as much of the pandemic as data availability will allow.<sup>17</sup>

Specifically, the study should include a summary of telehealth utilization data, such as

- the number of telehealth visits (audio-only and video visits) and in-person visits, disaggregated by service type (e.g. mental health, primary care);
- any changes in utilization over the course of the PHE, and compared to prior to the PHE;
- demographic characteristics of beneficiaries who utilized telehealth services; and
- geographic data on both the patients utilizing telehealth services and the corresponding providers offering telehealth service.

It should also include a description of expenditures and savings, recommendations for which flexibilities should be made permanent, and any instances of fraud identified by the HHS Secretary acting through the Office of the Inspector General. HHS would make available to Congress an interim report one year after passage of the bill, and a final report 18 months after the expiration of the PHE.

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<sup>14</sup> [DEA](#)

<sup>15</sup> [DEA](#)

<sup>16</sup> [Washington Post](#)

<sup>17</sup> [Rep. Kelly](#)

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Additionally, this section would make available grant funding to state Medicaid programs to conduct reports on telehealth utilization over the course of the pandemic. Grants would be made beginning in 2023, and states must submit an interim report one year thereafter and a final report three years thereafter.