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Executive Summary - Tracking Telehealth Changes State-by-State in Response to COVID-19 - June 2022

MTELEHEALTH

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As the COVID-19 pandemic continues across the United States, states, payers, and providers are looking for ways to expand access to telehealth services. Telehealth is an essential tool in ensuring patients are able to access the healthcare services they need in as safe a manner as possible. In order to provide our clients with quick and actionable guidance on the evolving telehealth landscape, Manatt Health has developed a federal and comprehensive 50-state tracker for policy, regulatory and legal changes related to telehealth during the COVID-19 pandemic. Below is the executive summary, which outlines federal developments from the past two weeks, new state-level developments, and older federal developments. The full tracker with details for each state is available through *Manatt on Health*, Manatt Health's premium subscription service.

New Federal Developments

New Item	Activity
H.R. 7878: Kidney Health Connect Act of 2022 *Introduced May 24, 2022*	• This bill would allow for renal dialysis facilities to serve as originating sites for telehealth services under the Medicare program.
H.R.7876: Connecting Rural Telehealth to the Future Act *Introduced May 24, 2022*	• This bill would extend Medicare telehealth flexibilities implemented during the COVID-19 Public Health Emergency and would: ○ Extend all temporary telehealth provisions included in the

	FY2022 omnibus through December 31, 2024 ◦ Permanently allow the use of audio-only telehealth flexibilities for two years • Permanently allow audio-only technologies when providers are evaluating or managing patient health or providing behavioral health services

New State-Level Developments

Note: As indicated in the table below, several states have recently taken action to update, continue, or renew their state of emergencies for COVID-19 in response to the rise of new cases linked with the Omicron variant. These updates are highlighted below because in many states, temporary telehealth flexibilities are tied to the status of state of emergency declarations.

State	Activity
Illinois	• Illinois passed House Bill No. 4797, which allows appropriately licensed non-residents to provide social services via telehealth to another non-resident of the state for up to 5 days in one month and 15 days in one year. These limits to not apply when providing social services via telehealth to the recipient of telehealth social services is currently attending an in-state university or college.

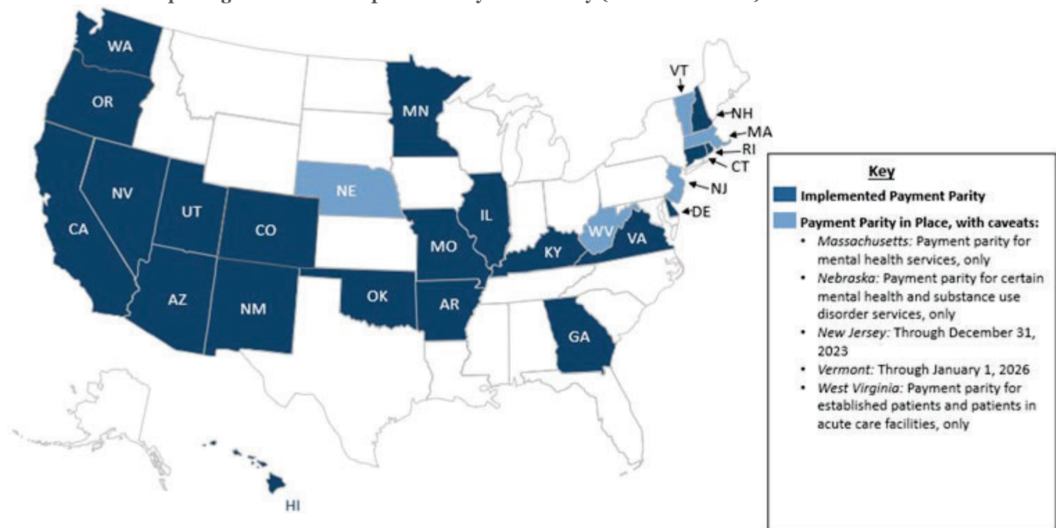
	• Illinois passed Executive Order 22-13, extending various Executive Orders, including ones related to telehealth, through June 25, 2022.
Louisiana	• Louisiana passed House Bill No. 826, which adds licensed, certified, or registered addiction counselors, licensed, certified, or registered prevention professionals, and certified compulsive gambling counselors to the definition of a "healthcare provider" in the Louisiana Telehealth Access Act. • Louisiana passed House Bill No. 304, which requires health plans to cover physical therapy services delivered via telehealth in the same manner that in-person services are covered.

New Hampshire	• New Hampshire passed Senate Bill No. 320, which:
	  ◦ Requires providers delivering telehealth services to be licensed, certified, or registered in New Hampshire if the patient is located in the state at the time of service.
	  ◦ Requires the Office of Professional Licensure and Certification to seek reciprocity agreements with states that have similar licensing requirements as New Hampshire, and to approve telehealth licenses for providers with a license in good standing in another state that participates in such agreements.

Payment Parity Permanent State Laws and Statutes

Payment Parity requires that health care providers are reimbursed the same amount for telehealth visits as in-person visits. During the COVID-19 pandemic, many states implemented temporary payment parity through the end of the public health emergency. Now, many states are implementing payment parity on a permanent basis. As portrayed in Figure 1, as of June 2022, 21 states have implemented policies requiring payment parity, 5 states have payment parity in place with caveats, and 24 states have no payment parity.

Figure 1. Map of States With Laws Requiring Insurers to Implement Payment Parity (as of June 2022)



Federal Developments More than Two Weeks Old

Executive Branch Activity

Policy	Details
HHS Announces $16.3 Million to Expand Telehealth Care in the Title X Family Planning Program *Announced May 10, 2022*	• On May 10, 2022, the United States Department of Health and Human Services announced that the Department will leverage American Rescue Plan Act

	funding to award $16.3 million in grants to support 31 Title X family planning grantees in efforts to expand telehealth infrastructure and capacity. Funds will be available for a 12-month project period, starting on May 15, 2022.
•	
Omnibus FY 2022 Spending Bill	• Temporarily extends the following Medicare telehealth flexibilities, which are central to enabling Medicare beneficiaries to access a broad range of services via telehealth from any location, for 151 days beginning on the first day after the end of the public health emergency (PHE) period: ◦ Any site in the United States, including a patient's home, will be considered an eligible originating

	site for the delivery of telehealth services. - Facility fees will not be paid to newly covered originating sites (e.g., patient's home). - Eligible telehealth practitioners will continue to include qualified occupational therapists, physical therapists, speech-language therapists, and audiologists. - Federally qualified health centers and rural health clinics may serve as originating or distant sites for the delivery of telehealth services. - Providers will not be required to meet in-person visit requirements in order to deliver mental health services via video or audio-only visit. This applies to

	all sites of care, including Federally Qualified Health Centers and Rural Health Clinics (except in the case of hospice patients). ◦ Coverage of telehealth services delivered via audio-only format will continue for specific service codes identified by Medicare as being eligible for delivery via audio only. ◦ Practitioners will be able to use telehealth to conduct face-to-face encounters prior to recertification of eligibility for hospice care. • Allows health savings account-eligible plans to provide pre-deductible coverage for telehealth services through the end of 2022.

	• Establishes telehealth reporting requirements for the Medicare Payment Advisory Commission (MedPAC) and the HHS related to telehealth utilization under the Medicare program.
In January 2022, CMS released "CARES Act Telehealth Expansion: Trends in Post-Discharge Follow-Up and Association with 30-Day Readmissions for Hospital Readmissions	• This report assessed the impact of telehealth on post-discharge follow-up and hospital readmission rates among Medicare beneficiaries based on claims data from April 1, 2019 – September 30, 2020. • The report found that: ○ Telehealth utilization varied based on beneficiaries' socioeconomic characteristics, with higher utilization for post-discharge telehealth visits among dually eligible beneficiaries or those living in areas with

	greater social deprivation. • Use of telehealth for post-discharge follow-up contributed to lower 30-day readmissions when compared to beneficiaries who had no post-discharge follow-up visit, but slightly higher readmission rates relative to those who had an in-person follow-up visit.
In January 2022, CMS released “Changes in Access to Medication Treatment during COVID-19 Telehealth Expansion and Disparities in Telehealth Use for Medicare Beneficiaries with Opioid Use Disorder”	• This data highlight provided information on access to medication treatment for Medicare beneficiaries with opioid use disorder (OUD) as a result of COVID-19 telehealth expansions. • Data suggests that telehealth expansions improved access to medication treatment and contributed to lower use of inpatient and/or emergency department visits among beneficiaries with OUD.

	• The study found that the majority of Medicare beneficiaries with OUD who used outpatient telehealth services were <65 years old and disabled, non-Hispanic White, dually-eligible for Medicare and Medicaid, and lived in urban areas.
CY2022 Telehealth Update Medicare Physician Fee Schedule *Released on Jan. 14, 2022*	• This update to the Medicare Physician Fee Schedule primarily covers recent expansions to mental health treatment via telehealth, which will activate at the end of the federal public health emergency (PHE) when temporary PHE waivers expire.
On December 6, CMS released updates to the State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version.	• Funding will support clinical effectiveness research (CER) studies that explore the effectiveness of telehealth for a wide range of conditions and situations, such as: the effectiveness of mHealth technology in smoking cessation, managing

	chronic pain through online classes, and treating depression through remote yoga classes
On December 3, the Patient-Centered Outcomes Research Institute (PCORI) Board of Governors approved $23.5 million to focus on telehealth and mobile health strategies.	• Funding will support clinical effectiveness research (CER) studies that explore the effectiveness of telehealth for a wide range of conditions and situations, such as: the effectiveness of mHealth technology in smoking cessation, managing chronic pain through online classes, and treating depression through remote yoga classes
On November 23, HHS announced $35 million in funding for telehealth in the Title X Family Planning Program.	• $35 million of American Rescue Plan funding will be used to enhance and expand the telehealth infrastructure and capacity of Title X family planning providers • HHS will award 60 one-time grants to active Title X grantees

On November 12, CMS released a Preliminary Medicaid & CHIP Data Snapshot.	• Includes information on services delivered from the beginning of the PHE through May 31, 2021, including a snapshot of services delivered via telehealth among Medicaid and CHIP beneficiaries.
On November 11, CMS finalized the Physician Fee Schedule Rule.	• The Medicare Physician Fee Schedule (MPFS) finalizes the extension of coverage of certain Medicare telehealth services through calendar year (CY) 2023, permanently extends coverage of tele-behavioral health services delivered to patients in their homes and via audio-only technology, and finalizes changes that would allow for rural health centers (RHCs) and federally qualified health centers (FQHCs) to deliver mental health visits virtually. • *For more information regarding the Final CY2023 Physician Fee*

	Schedule, please see our Manatt Insights summary.
On November 9, the FCC approved 75 new projects funded under the COVID-19 Telehealth Program.	• FCC approved 75 projects totaling $42.1 million for Round 2 of the COVID-19 Telehealth Program. The funding will be used to provide reimbursement for telecommunication services, information services, and connected devices necessary to enable telehealth.
On October 15, HHS announced the renewal of the Public Health Emergency (PHE).	• The COVID-19 PHE will be renewed for another 90 days. It is now extended, through January 15, 2022. • This update enumerates the key regulatory flexibilities and funding sources that are linked to the PHE, as well as key emergency measures with independent timelines that are not directly affected by the PHE renewal.

On August 26th, the FCC approved 62 new projects funded under the COVID-19 Telehealth Program.	The projects total $41.98 million for Round 2 of the COVID-19 Telehealth Program. The funding will be used to provide reimbursement for telecommunication services, information services, and connected devices necessary to enable telehealth.
On August 18, the Biden Administration invested over $19M to expand telehealth for rural and underserved communities.	The Biden Administration announced a series of key investments -- totaling $19 million -- that will strengthen telehealth services in rural and underserved communities and expand telehealth innovation and quality nationwide. The Health Resources and Services Administration (HRSA) will invest in the following programs: • Telehealth Technology-Enabled Learning Program (TTELP): ~$4.28M will be awarded to 9 organizations to develop sustainable tele-mentoring programs and networks in rural and medically underserved communities. This program will utilize to help academic

	medical centers train and support providers in rural areas treat patients with complex conditions. • Telehealth Resource Centers (TRCs): $4.55M will be awarded to 12 regional and 2 national telehealth resource centers that provide information, assistance and education on telehealth to providers seeking to deliver care via telehealth. • Evidence-Based Direct to Consumer Telehealth Network Program (EB TNP): ~$3.85M will be awarded to 11 organizations to help health networks improve access to telehealth services and assess its effectiveness. Telehealth Centers of Excellence (COE) Program: $6.5M will be awarded to 2 organizations to evaluate telehealth strategies and services to improve care for rural medically underserved

	communities with high rates of chronic disease and poverty.
On July 23rd, the Centers for Medicare and Medicaid Services (CMS) released the proposed CY 2022 Physician Fee Schedule proposing to extend telehealth benefits.	CMS is proposing to: • Extend coverage of certain Medicare telehealth services through calendar year (CY) 2023, • Permanently extend coverage of tele-behavioral services delivered to patients in their homes and via audio-only technology, and • Make changes that would allow for rural health centers (RHCs) and federally qualified health centers (FQHCs) to deliver mental health visits virtually. *For more information regarding the Final CY2022 Physician Fee Schedule, please see our Manatt Insights summary.*

On July 19th, HHS announced the renewal of the Public Health Emergency (PHE).	The COVID-19 PHE will be renewed for another 90 days, beginning on July 20 (the date the PHE was previously scheduled to expire) and extending through October 18, 2021. This update enumerates the key regulatory flexibilities and funding sources that are linked to the PHE, as well as key emergency measures with independent timelines that are not directly affected by the PHE renewal.
On June 17th, the Federal Communications Commission (FCC) Commission issued updated guidance on the Connected Care Pilot Program.	• The FCC released further guidance on eligible services, competitive bidding, invoicing, and data reporting for selected participants, which will enable applicants selected for the Pilot Program to begin their projects. • The $100 million program will support Connect Care Services focusing on low-income and veteran

	patients over a three-year period. • The FCC approved 36 additional pilot projects for a total of over $31 million in funding.
On May 26th, the Department of Justice (DOJ) announced several criminal charges for fraudulently using COVID-19 flexibilities, including those related to telehealth.	• The charges are against 14 defendants for their alleged participation in various health care fraud schemes that exploited the COVID-19 pandemic and resulted in $143 million in false billings. • The Center for Program Integrity, Centers for Medicare & Medicaid Services (CPI/CMS) separately announced it took adverse administrative action against over 50 medical providers for their involvement in health care fraud schemes relating to COVID-19.
On May 11th, the U.S. Department of Health & Human Services (HHS) awarded funding to the	• Appropriated by the American Rescue Plan, the $40 million in emergency

<table>
<tr><td>Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.</td><td>home visiting funds awarded to states and territories will support the delivery of evidence-based home visiting services to children and families living in communities at risk for poor maternal and child health outcomes.
• Families unable to access home visiting services will be provided technology to participate in virtual home visiting.
• Funds will also be used to train home visitors on how to safely conduct virtual intimate partner violence screenings.</td></tr>
<tr><td>On May 6th, the Centers for Medicare & Medicaid Services (CMS) updated the Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs.</td><td>• The updated FAQs clarify which telehealth services and telephone services are valid for data submissions for the HHS-operated risk adjustment program.
• HHS also clarifies which telehealth service codes will be valid for inclusion for the 2021 benefit year HHS-</td></tr>
</table>

	operated risk adjustment program.
On May 20th, the U.S. Department of Health & Human Services (HHS) announced the expansion of Pediatric Mental Health Care Access Programs.	• Appropriated by the American Rescue Plan, the $14.2 million will expand pediatric mental health access by integrating telehealth services into pediatric primary care. • The funds will expand the projects into new states and tribal areas to provide teleconsultations, training, technical assistance, and care coordination for pediatric primary care providers to treat and refer children and youth with mental health conditions and substance use disorder. • Applications are due by July 6, 2021.
On May 19th the Government Accountability Office (GAO) released Medicare and Medicaid COVID-19 Program	• The report includes preliminary observations from ongoing work related to telehealth in the

Flexibilities and Considerations for their Continuation.	Medicaid and Medicare program. • The GAO's preliminary analysis indicated Medicare fee-for-service telehealth waivers increased utilization and access, but full effects of the waivers are not yet known. • Temporary state Medicaid flexibilities effects are not yet fully known.
On April 15th the Federal Communications Commission (FCC) announced the second round of the COVID-19 Telehealth funding will open April 29th.	Appropriated by the Consolidated Appropriations Act, the $250 million reimbursement program will support projects aimed at boosting access to connected health services through better broadband resources. In an effort to promote transparency on how the funds are distributed, the FCC is seeking comment on changes to the Program, including the metrics used to evaluate applications for funding, and how to treat applications filed in Round 1 of the program.

On April 12th the FDA lifted restrictions on telehealth abortions during the PHE.	Healthcare providers will be allowed to prescribe abortion-inducing medication via telehealth, without the usual required in-person examination until the end of the PHE.
On April 12th, HHS announced the Rural Maternity and Obstetrics Management Strategies (RMOMS) program.	The $12 million program will fund three projects over four years to allow awardees to test models to address unmet needs for underserved populations in rural America. One of the focus areas for the program includes telehealth and specialty care.
On April 5th, the U.S. Department of Agriculture (USDA) began accepting applications for the USDA Distance Learning & Telemedicine Grant Program (DLT).	The program makes $44.5 million available to helps rural communities acquire the technology and training needed to connect medical professionals with patients in rural areas. Awards can range from $50,000 to $1 million. Applications must be received by June 4, 2021.

On March 30th, the Centers for Medicare & Medicaid Services (CMS) expanded Medicare coverage for certain services delivered via telehealth.	CMS added several audiology and speech-language pathology related services to the list of authorized telehealth services to Medicare Part B beneficiaries during the PHE. The PHE is expected to last through at least the end of 2021.
On February 26th, HHS Office of the Inspector General (OIG) released a statement clarifying "telefraud" schemes and telehealth fraud.	OIG clarified in a letter the difference between 'telefraud' and 'telehealth fraud'. Nothing that much of its focus has been in the former which generally combine sham phone calls to fraudulently prescribe durable medical equipment or high-cost diagnostic tests. OIG noted that it is continuing work to ensure telehealth delivers quality, convenient care for patients and is not compromised by fraud.
On February 25th, the USDA announced it is investing $42.3 million in distance learning and telemedicine infrastructure.	USDA announced an investment of $42.3 million ($24 million provided through the CARES Act) to help rural residents gain access to health care. The funding is expected to benefit five million rural residents.

On February 25th, the FCC approved the Emergency Broadband Benefit.	The FCC approved a new program which will provide discounts of up to $50 per month towards broadband service for low-income households, and up to $75 per month for households on Tribal lands. There will also be a one-time discount of up to $100 on a computer, laptop, or tablet. The start date for the program has not yet been established.
On January 19th, HHS' OIG released an updated list of its Active Work Plan Items.	HHS OIG announced it is conducting the Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency and the Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency.
On January 15th, the FCC announced the first round of grants for the Connected Care Pilot Program.	The FCC has awarded a total of $26.6 million to 15 pilot projects with over 150 treatment sites in 11 states. The Pilot aims to award $100 million over three years to improve broadband connectivity in underserved parts of the country where access is limited.

On January 15th, CMS released a Preliminary Medicaid & CHIP Data Snapshot.	It includes information on services delivered from the beginning of the PHE through July 31, 2020, including a snapshot of services delivered via telehealth among Medicaid and CHIP beneficiaries.
On January 12th, HHS invested $8 million in a new Telehealth Broadband Pilot Program.	$6.5 million was awarded to the National Telehealth Technology Assessment Resource Center and $1.5 million was awarded to the Telehealth-Focused Rural Health Research Center. The program is aimed at expanding broadband connectivity in rural parts of Alaska, Michigan, Texas, and West Virginia where lack of resources is a major barrier to telehealth adoption.
On December 29th, the Department of Labor's Wage and Hour Division issued guidance for Telemedicine and Serious Health Conditions under the Family and Medical Leave Act (FMLA).	Employees can permanently use telehealth to establish a serious health condition that would qualify them for taking time off from work under the FMLA.

	The Wage and Hour Division (WHD) will consider telemedicine an "in-person" visit.
On December 3rd, HHS issued an amendment to the Public Readiness and Preparedness (PREP) Act.	• The fourth amendment makes two important changes, the first of which implements another nationwide change regarding licensure: any licensed healthcare provider who is permitted to order and administer a Covered Countermeasure in any one state may now order and administer that Covered Countermeasure in any other state via telehealth, even if the provider is not licensed in the other state (subject to compliance with any rules established by the practitioner's state of licensure). A provider may now provide qualifying COVID-19-related telehealth services to patients in multiple states without needing to confirm each state's laws regarding practice across state lines

	(some of which may require out-of-state practitioners to register or otherwise seek authorization from the state). Second, the fourth amendment broadens the scope of protection afforded to all “covered persons” who manufacture, test, develop, distribute, administer, or use Covered Countermeasures (including those who provide telehealth services).
On December 1st, CMS finalized the Physician Fee Schedule Rule (previously proposed on August 4th) which make certain Medicare telehealth flexibilities permanent and extend others for the remainder of the year in which the public health emergency (PHE) ends. Note: On January 19th, CMS published clarifications to its 2021 Physician fee schedule.	**Initial Rule**: CMS finalized several changes to the Medicare telehealth covered services list. First, CMS is adding permanent coverage for a range of services, including group psychotherapy, low-intensity home visits, and psychological and neuropsychological testing, among others. Second, CMS has finalized temporary coverage for certain services through the end of the calendar year in which the COVID-19 PHE ends, including high-intensity home visits,

	emergency department visits, specialized therapy visits, and nursing facility discharge day management, among others. Finally, CMS is indicating which services that have been covered on a temporary basis during the PHE it will not to cover on a permanent basis once the PHE ends. This includes services such as telephonic evaluation and management services, initial nursing facility visits, radiation treatment management services, and new patient home visits, among others. Notably, after significant public comment supporting the addition of more services to the list of services covered through the calendar year in which the PHE ends, CMS included extended coverage for several additional services that it had proposed ending coverage for at the end of the PHE. Prior to the PHE, given statutory restrictions that telehealth services must be delivered via a “telecommunications system,” which CMS has long-interpreted to preclude audio-only

	technology, CMS only covered certain audio-only services defined as communication technology-based services (CTBS), which are not considered Medicare telehealth services. During the PHE, recognizing that in-person visits posed a high risk of infection exposure and that not all providers and patients had access to video technology, CMS established temporary coverage for audio-only telephone (E/M) visits (CPT codes 99441-3). CMS is finalizing that at the end of the PHE, coverage for these audio-only telephone (E/M) visits will end given the statutory restrictions on "telecommunications systems." However, recognizing that audio-only visits could still be beneficial, for CY 2021, CMS is establishing on an interim basis a HCPCS code, G2252, for CTBS audio-only services of 11-20 minutes of medical discussion. This code supplements existing code G2012 which is a CTBS audio-only service of 5-10 minutes of medical discussion.

	In addition to the changes to the telehealth covered services list, CMS is finalizing that the 30-day frequency limit for subsequent nursing facility visits provided via telehealth be revised to a 14-day frequency limit. CMS is also finalizing that additional types of providers—including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists—be permitted to bill for brief online assessment and management services, virtual check-ins, and remote evaluations and has added new codes for these services. On a temporary basis, CMS finalized a policy to allow for virtual supervision using "interactive audio/visual real-time communications technology" (i.e. two-way live video), by revising the definition of "direct supervision" to include virtual presence. This will allow "incident to" services to be provided if furnished under the supervision of a virtually present physician or nonphysician

	practitioner in order to reduce infection exposure risk. CMS will continue allowing virtual supervision through the later of the end of the calendar year in which the PHE ends or December 31, 2021. CMS finalized as proposed several changes to coverage of **remote physiologic monitoring (RPM) services**. CMS finalized that at the conclusion of the PHE, it will once again require that practitioners have an established patient relationship in order to initiate RPM services and that 16 days of data for each 30 days must be collected in order to meet the requirements of CPT codes 99453 and 99454. CMS also finalized that practitioners may furnish RPM services to beneficiaries with acute conditions—previously coverage had been limited to beneficiaries with chronic conditions. In addition, CMS finalized that consent may be obtained at the time the RPM service is furnished; that auxiliary personnel (including contracted

	employees) may furnish certain RPM device setup and supply services; that data from the RPM device must be automatically collected and transmitted rather than self-reported; and that for the purposes of discussing RPM results, "interactive communication" includes real-time synchronous, two-way interaction such as video or telephone. In addition, Medicare Diabetes and Prevention Program (MDPP) providers who use telehealth will continue to be reimbursed through Medicare during the remainder of the COVID-19 PHE and any future applicable 1135 waiver event when in-person care delivery is disrupted. Coverage for virtual-only DPPs will not continue after the PHE. **January 2021 Update**: Clarifies that the 20-minutes of intra-service work associated with CPT codes 99457 and 99458 includes a practitioner's time engaged in "interactive communication" and time engaged in non-face-to-face care

	management services during a calendar month. Additionally, only one practitioner can bill CPT codes 99453 and 99454 during a 30-day period and only when at least 16 days of data have been collected on at least one medical device. *For more information regarding the Final CY2021 Physician Fee Schedule, please see our Manatt Insights summary.*
On November 20th, HHS published two rules that finalize reforms to the regulatory framework that governs fraud and abuse in Medicare and Medicaid programs.	HHS's newly finalized regulations remove historical barriers to collaboration between providers and health tech companies on digital health initiatives, including those that promote care coordination and drive value-based efficiencies. Specifically, the regulations include several new and modified "safe harbor" arrangements that would allow providers and health IT companies to collaborate on initiatives that would previously have created risks under the Anti-Kickback Statute. Critically, these safe harbors allow parties to

	exchange health IT technology and other in-kind benefits at less than fair market value, as long as certain requirements are met. Depending on the circumstances, the recipient may be able to receive the benefit for free, or may be required to contribute at least 15% of the total cost. If a given arrangement meets all the criteria for a safe harbor, then the parties are shielded from liability even if they are exchanging "remuneration" within the meaning of the Anti-Kickback Statute. Because violations of the Anti-Kickback Statute can result in substantial civil and criminal penalties, providers often avoid arrangements that do not fit squarely within a safe harbor. *For more information regarding the Anti-Kickback and Stark Reforms, please see our Manatt Insights summary.*
In early November, CMS published a new final rule that enables health home agencies (HHAs) to use	Services provided to patients must be included in the plan of care and not substituted for or

telecommunications technology or audio-only services.	considered a home visit for eligibility or payment purposes.
On October 14, CMS expanded the list of telehealth services Medicare Fee-For-Service will pay for during the PHE.	CMS added 11 new services to the Medicare telehealth service list, adding to the over 80 additional eligible telehealth services outlined in the May 1 COVID-19 IFC. The new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services.
On October 14, CMS released a Preliminary Medicaid and CHIP Data Snapshot to provide information on telehealth utilization during the PHE.	This data shows more than 34.5 million services were delivered to Medicaid and CHIP beneficiaries via telehealth between March and June of this year—an increase of 2,600% when compared to the same period in 2019. Additionally, CMS updated its State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version to help providers and other stakeholders understand which policies are temporary or permanent, and to

	communicate telehealth access and utilization strategies to providers.
On August 4th, CMS released a proposed Physician Fee Schedule Rule which would make certain Medicare telehealth flexibilities permanent and extend others for the remainder of the year in which the public health emergency (PHE) ends.	For CY 2021, CMS is proposing several changes to the Medicare telehealth covered services list. First, CMS is proposing to add permanent coverage for a range of services, including group psychotherapy, low-intensity home visits, and psychological and neuropsychological testing, among others. Second, CMS is proposing to add extended temporary coverage for certain services through the end of the calendar year in which the COVID-19 PHE ends, including high intensity home visits, low-intensity emergency department visits, and nursing facility discharge day management, among others. Finally, CMS is indicating which services that have been covered on a temporary basis during the PHE it does not propose to cover on a permanent basis once the PHE ends. This includes a wide range of more than 70 services such as telephonic evaluation and

	management services, nursing facility visits, specialized therapy services, critical care services, end stage renal disease dialysis-related services, and radiation management services, among others. *For a summary of the proposed Physician Fee schedule Rule, please see the August 7 Manatt Insights summary.*
On May 1, CMS released a second IFR with comment period (IFC), “Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program,” outlining further flexibilities in Medicare, Medicaid, and health insurance markets as a result of COVID-19.	• **Section D.** Opioid Treatment Programs (OTPs) – Furnishing Periodic Assessments via Communication Technology (42 CFR 410.67(b)(3) and (4)): Temporary change to allow periodic assessments of individuals treated at OTPs to occur during the PHE by two-way interactive audio-video or audio-only communication • **Section N.** Payment for Audio-Only Telephone Evaluation and Management Services: Temporary increase in the

	reimbursement rates for telephonic care • **Section AA.** Updating the Medicare Telehealth List (42 CFR 410.78(f)): Temporary change to remove Medicare regulations that require amendments to the list of covered telehealth services be made through the physician fee schedule (PFS) rulemaking process and allow changes to be made to the list of covered telehealth services through subregulatory guidance only *For a summary of the second IFR, please see the May 5 Manatt Insights summary.*
On April 17, CMS released Frequently Asked Questions (FAQs) on Medicare Fee-for-Service Billing and highlighted several changes to RHC and FQHC requirements and payments.	New Payment for Telehealth Services (real-time, audio visual): • Section 3704 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act authorizes RHCs and FQHCs to provide distant site

	telehealth services to Medicare beneficiaries. Services can be provided by any health practitioner working for the RHC or the FQHC as long as the service is within their scope; there is no restriction on locations where the provider may be to furnish telehealth services. • FQHCs and RHCs are paid a flat fee of $92 when they serve as the distant site provider for a telehealth visit. • CMS will pay for all reasonable costs for any service related to COVID-19 testing, including relevant telehealth services. RHCs and FQHCs must waive the collection of co-insurance for COVID-19 testing-related services. Expansion of Virtual Communication Services (telephone, online patient communication):

	• Virtual communication services now include online digital evaluation and management services. CPT codes 99421–23 have been added for non-face-to-face, patient-initiated, digital communications using a secure patient portal. *For more information on Expanded Telehealth Reimbursement for FQHCs and RHCs, see our June 9 Manatt newsletter.*
On April 2, CMS issued an informational bulletin regarding Medicaid coverage of telehealth services to treat substance use disorders (SUDs)—one of many guidance documents required by the October 2018-enacted Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.	This guidance provides states options for federal reimbursement for "services and treatment for SUD under Medicaid delivered via telehealth, including assessment, medication-assisted treatment, counseling, medication management, and medication adherence with prescribed medication regimes." *For a summary of this bulletin, please see the April 6 Manatt Insights summary.*

On March 30, CMS released an interim final rule (IFR) outlining new flexibilities to preexisting Medicare and Medicaid payment policies in the midst of the COVID-19 public health emergency (also, PHE).	These provisions include adding over 80 additional eligible telehealth services, giving providers flexibility in waiving copays, expanding the list of eligible types of providers who can deliver telehealth services, introducing new coverage for remote patient monitoring services, reducing frequency limitations on telehealth utilization, and allowing telephonic and secure messaging services to be delivered to both new and established patients. The provisions listed in this rule are effective March 31, with applicability beginning on March 1. *For more information on the IFR, see our April 9 Manatt newsletter.*
On March 18, the HHS and the Office for Civil Rights (OCR) issued a public notice stating that OCR will not impose penalties for noncompliance with regulatory requirements under the HIPAA rules "against covered health care providers in connection with the good faith provision of	This will allow providers to communicate with patients through telehealth services and remote communications technologies during the COVID-19 national emergency. Providers may use any non-public-facing remote communication product

telehealth during the COVID-19 nationwide public health emergency.”	that is available to communicate to patients; these applications can include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, and Skype. *For more information on our HIPAA summary, see our April 23 Manatt newsletter.*
On March 10, CMS introduced significant new flexibilities for Medicare Advantage (MA) and Part D plans to waive cost-sharing for testing and treatment of COVID-19, including emergency room and telehealth visits during the crisis.	MA plans are required to: • Cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at noncontracted facilities; this means that facilities that furnish covered A/B benefits must have participation agreements with Medicare. • Waive, in full, requirements for gatekeeper referrals where applicable. • Provide the same cost-sharing for the enrollee as if the service or benefit had

	been furnished at a plan-contracted facility. • Make changes that benefit the enrollee effective immediately without the 30-day notification requirement at 42 § 422.111(d)(3). Such changes could include reductions in cost-sharing and waiving of prior authorizations. *For more information on Medicare changes, see our March 17 Manatt newsletter.*

Legislative Activity

Bill/Activity	**Key Proposed Actions**
Activity	
In March 2021, MedPAC issued a report entitled "Medicare Payment Policy."	The report included a chapter that proposes how Medicare may cover telehealth services for a limited duration of time after the end of the COVID-19 PHE; the commission noted that more time and data are needed prior to recommending permanent coverage and reimbursement changes. Specifically, MedPAC proposes temporarily continuing the

	following flexibilities for a limited duration of time after the end of the PHE: • Providing reimbursement for specific telehealth services to all beneficiaries, regardless of their location; • Covering certain telehealth services (in addition to those covered prior to the PHS), if there is potential clinical benefit; and, • Covering certain telehealth services delivered via audio-only modalities if there is potential clinical benefit. After the PHE ends, MedPAC proposes: 1) returning to the fee schedule's facility rate for telehealth services and collecting data on the cost to deliver telehealth services; and, 2) reintroducing cost sharing for telehealth services. In addition, MedPAC suggests implementing the following safeguards to prevent unnecessary spending and fraud: • Requiring clinicians to have an in-person visits with a patient prior to ordering high-cost durable medical equipment or laboratory tests; • Monitoring outlier clinicians who bill more telehealth services per beneficiary relative to other clinicians; and,

	• Prohibiting “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly. Notably, the path forward proposed by MedPAC in this report does not ensure long-term permanent coverage for telehealth for all Medicare members regardless of where they are located (e.g., patients in non-rural areas, patients located in their home), or for telehealth services delivered via audio-only modalities.
On March 5th, the House Energy & Commerce Health Subcommittee held a hearing, The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care to discuss the future of telehealth in Medicare.	Members of the sub-committee were not aligned on a timeline for adopting permanent telehealth reimbursement policies in Medicare, but generally voiced support for continuing many of the flexibilities that have been implemented during the public health emergency. While acknowledging the value that telehealth has demonstrated during the pandemic, many members continue to express long-standing concerns about the potential for increased fraud and abuse of telehealth services.
On January 14th, MedPAC hosted a meeting to discuss whether and how to permanently expand	The Commissioners largely supported the policy options outlined by MedPAC staff to maintain on a permanent basis some of the temporary policy changes made during the PHE. Several commissioners noted that given the pace of change with respect to telehealth

telehealth in fee-for-service Medicare.	adoption during the COVID-19 pandemic and the lack of concrete evidence to support permanent expansion of certain policies, they would be more comfortable supporting expansion on a more time-limited basis (e.g. 1-2 years) than permanently. In addition, the Commissioners identified several areas that will require continued discussion in order to balance access, cost and quality imperatives. The policy options will be incorporated into MedPAC's upcoming report to Congress expected in March 2021. *For more information regarding the MedPAC meeting, please see our Manatt Insights Newsletter.*
On November 9, MedPac issued a report on the expansion of telehealth in Medicare.	The presentation highlights permanent (post-PHE) policy options that CMS may consider when expanding Medicare telehealth coverage. *For more information, please see our Manatt Newsletter.*
Introduced Legislation	
H.R. 7666: Restoring Hope for Mental Health and Well-Being Act of 2022	• This bill would provide grant support to schools and emergency departments to establish or expand existing pediatric

Introduced May 6, 2022	mental health care telehealth access programs.

H.R. 7573: Telehealth Extension and Evaluation Act
 	
Introduced April 26, 2022
	• This bill aims to extend certain telehealth flexibilities enabled by Medicare for two years following the COVID-19 pandemic. It would allow:
	  ◦ Limitation on payment for high-cost medical equipment via telehealth
	  ◦ Limitation on payment for high-cost laboratory tests via telehealth
	  ◦ A telehealth service provided by a Federally Qualified Health Center or Rural Clinic to be reimbursed as an outpatient service
	  ◦ Telehealth flexibilities at critical access hospitals, including payment for telehealth services that are furnished via a telecommunications system
	  ◦ The use of telehealth for the dispensing of controlled substances by means of the internet
	• This act would also fund a study on the effects of changes to telehealth under

	the Medicare and Medicaid programs during the COVID–19 emergency.
S. 4132: Women's Health Protection Act of 2022 *Introduced May 4, 2022* *(Note: Failed to pass the Senate on May 11, 2022)*	• This bill would protect a provider's ability to perform and a patients ability to receive abortion services, including via telehealth.
•	
H.R. 7097: Telehealth Treatment and Technology Act of 2022 *Introduced on March 16, 2022*	• This bill would enable appropriately licensed health care professionals to practice within the scope of their license, certification, or authorization via telehealth in any State, the District of Columbia, or any territory or possession of the United States regardless of where they obtained their license or where they are located. • Under this bill, health care professionals would: ○ Be able to deliver telehealth services to any patient regardless of whether they have a prior treatment relationship with the patient, as long as a new relationship may be established only via a written

	acknowledgment or synchronous technology. ◦ Be required to complete the following steps before initiating services via telehealth: ▪ Verify the patient's identity; ▪ Obtain oral or written acknowledgement from the patient (or patient's legal representative to perform telehealth services; and, • Obtain or confirm an alternative method of connecting with the patient if the telehealth technology connection fails.
2021 CONG US S 3593 *Introduced Feb. 8 2022*	• This bill would extend certain telehealth services covered by Medicare for an additional two years after the last day of the public health emergency period, and initiate a study to evaluate the impact of telehealth services on Medicare beneficiaries.
Telehealth Extension and Evaluation Act *Introduced on Feb. 7, 2022*	• This bill would allow Centers for Medicare and Medicaid Services (CMS) to extend Medicare payments for a variety of telehealth services, and

	commission a study on the impact of the pandemic telehealth flexibilities.
S. 150: Ensuring Parity in MA for Audio-Only Telehealth Act of 2021 *Reintroduced Feb. 2, 2021*	• Requires Medicare to factor certain qualifying diagnosis obtained through telehealth during the PHE when setting risk adjustment payments in Medicare Advantage plans in future years • Requires any payment made for a telehealth service during the PHE under the new risk adjust to be the same as the in-person rate
S. 155: Equal Access to Care Act *Reintroduced Feb. 2, 2021*	• Allows licensed health care providers to provide health care services in a secondary state under the rules and regulations that govern them in their primary state • If passed, the bill would remain in effect for up to 180 days after the PHE ends
S. 340: Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act	• Extends ability to prescribe Medication Assisted Therapies (MAT) and other necessary drugs without needing a prior in-person visit • Enables Medicare to cover audio-only telehealth services for substance use disorder services in a case where a

Reintroduced Feb. 22, 2021	provider has already conducted an in-person or telehealth evaluation
S. 368: Telehealth Modernization Act *Reintroduced Feb. 23, 2021*	• Remove geographic barriers for originating site • Require telehealth services to be covered by Medicare at FQHCs and RHCs • Direct HHS to permanently expand the telehealth services covered by Medicare during the PHE • Require Medicare to cover additional telehealth services for hospice and home dialysis care
S. 445: Mainstreaming Addiction Treatment Act of 2021 *Reintroduced Feb. 25, 2021*	• Allows community health practitioners to dispense narcotic drugs in schedule III, IV, or V, to an individual for maintenance treatment or detoxification through the practice of telemedicine
S. 620: KEEP Telehealth Options Act of 2021 *Reintroduced Mar. 9, 2021*	• Directs the HHS Secretary and the Comptroller General of the United States to conduct studies and report to Congress on actions taken to expand access to telehealth services under the Medicare, Medicaid, and Children's

	Health Insurance programs during the COVID-19 emergency
S. 660: Tele-Mental Health Improvement Act *Introduced March 10, 2021*	• A bill to require parity in the coverage of mental health and substance use disorder services provided to enrollees in private insurance plans, whether such services are provided in-person or through telehealth.
S. 801: Connected MOM Act *Introduced Mar. 17, 2021*	• Requires Health and Human Services to identify and address barriers to coverage of remote physiologic devices under State Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women
S. 1309: Home Health Emergency Access to Telehealth (HEAT) Act *Introduced Apr. 28, 2021*	• Gives the Centers for Medicare & Medicaid Services (CMS) the authority to issues waivers to allow payments for home health services furnished via visual or audio telecommunication systems during an emergency period
S. 1704/H.R.5981: Telehealth Expansion Act *S. 1704 introduced May 19, 2021*	• Permanently allows first-dollar coverage of virtual care under high-deductible health plans (HDHPs)

H.R. 5981 introduced November 15, 2021	• Allows access to a wider variety of telehealth services without first meeting a deductible
S. 2061: Telemental Healthcare Access Act of 2021 *Introduced June 15, 2021*	• Expands access to telemental health services by removing statutory requirement that Medicare beneficiaries be seen in-person within six months of being treated for mental health services through telehealth
S. 2097: Telehealth Health Savings Account (HSA) Act *Introduced June 17, 2021*	• Allow employers to offer high-deductible health plans that include telehealth services without limiting employees' ability to use health savings accounts.
S. 2110: Increasing Rural Telehealth Access Act of 2021 *Introduced June 17, 2021*	• Expands access to health care by improving remote patient monitoring technology for individuals in rural areas
S. 2111: Audio-Only Telehealth for Emergencies Act *Introduced June 17, 2021*	• Allow physicians delivering care during a public health emergency or a major disaster declaration to receive the same compensation for audio-only telehealth visits as they would receive for in-person appointments

S. 2173: Promoting Responsible and Effective Virtual Experiences through Novel Technology to Deliver Improved Access and Better Engagement with Tested and Evidence-based Strategies (PREVENT DIABETES) Act *Reintroduced June 22, 2021*	• Enables Medicare coverage of connected health services in the MDPP (Medicare Diabetes Prevention Program)
S. 2197: Rural and Fronteir Telehealth Expansion Act *Introduced June 23, 2021*	• Amends title XIX of the Social Security Act to increase the Federal medical assistance percentage for States that provide Medicaid coverage for telehealth services.
H.R. 318: Safe Testing at Residence Telehealth Act of 2021 *Reintroduced Jan. 13, 2021*	• Provides Medicare payment of telehealth assessments provided in relation to COVID-19 • Requires Medicare payment of COVID-19 blood tests ordered via telehealth during the PHE • Requires practitioners to report demographic data with respects to tests and services ordered via telehealth

H.R. 341: Ensuring Telehealth Expansion Act of 2021 *Reintroduced Jan. 15, 2021*	• Extend telehealth provisions in the CARES Act through December 31, 2025 • Require payment parity for telehealth services furnished at FQHCs and RHCs • Allows the use of telehealth to conduct a face-to-face encounters for recertification of eligibility for hospice care
H.R. 366: Protecting Access to Post-COVID-19 Telehealth Act of 2021 *Reintroduced Jan. 19, 2021*	• Eliminate most geographic and originating site restrictions in Medicare and establish the patient's home as an eligible distant site • Authorize CMS to continue reimbursement for telehealth for 90 days beyond the end of the PHE • Allow HHS to expand telehealth in Medicare during all future emergencies • Require a study on the use of telehealth during COVID-19
H.R. 596: The Advancing Connectivity During the Coronavirus to Ensure Support for Seniors (ACCESS) Act	• Allows HHS Telehealth Resource Center to allocate $50 million to expand Medicare and Medicaid coverage of telehealth services in nursing facilities

Reintroduced Jan. 28, 2021	• Creates a grant for nursing homes to offer virtual visits
H.R. 708: Temporary Reciprocity to Ensure Access to Treatment Act (TREAT) *Reintroduced Jan. 19, 2021*	• Note: H.R. 708 is nearly identical in scope to the Equal Access to Care Act (see S.155 above), with the exception that H.R. 708 would grant HHS authority to unilaterally create similar temporary licensure regulations in the event of future public health or other emergencies
H.R. 726: COVID–19 Testing, Reaching, And Contacting Everyone (TRACE) Act *Introduced Feb. 2, 2021*	• Authorizes the Secretary of Health and Human Services to award grants to eligible entities to conduct diagnostic testing for COVID-19, and related activities
H.R. 937: Tech To Save Moms Act *Introduced Feb. 8, 2021*	• Amends title XI of the Social Security Act to integrate telehealth models in maternity care services, and for other purposes
H.R. 1149: Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021 *Reintroduced for fourth*	• Permanently removes the Medicare geographic restrictions and allow the home to be an originating site for mental telehealth services • Remove the geographic and distant site restrictions for federally qualified

time on Apr. 29, 2021 with overwhelming support (sponsored by 50 bi-partisan senators)	health centers (FQHCs) and rural health clinics (RHCs) • Allows the HHS secretary to waive telehealth restrictions • Encourages CMS Innovation Center to test more payment models that include telehealth
H.R. 1406: COVID-19 Emergency Telehealth Impact Reporting Act *Reintroduced Feb. 26, 2021*	• Require HHS to study telehealth use during the pandemic and impact on care delivery
H.R. 1397: Telehealth Improvement for Kids' Essential Services (TIKES) Act *Reintroduced Feb. 26, 2021*	• Provide states with guidance and strategies to increase telehealth access for Medicaid and Children's Health Insurance Program (CHIP) populations. Guidance and strategies will include: ○ Delivery of covered telehealth services ○ Recommended voluntary billing codes, modifiers, and place-of-service designations

	◦ Simplifications or alignment of provider licensing, credentialing, and enrollment ◦ Existing strategies States can use to integrate telehealth into value-based health care models ◦ Examples of States that have used waivers under the Medicaid program to test expanded access to telehealth • Require a Medicaid and CHIP Payment and Access Commission (MACPAC) study examining data and information on the impact of telehealth on the Medicaid population • Require a Government Accountability Office (GAO) study reviewing coordination among federal agency telehealth policies and examine opportunities for better collaboration, as well as opportunities for telehealth expansion into early care and education settings
H.R. 2166: Ensuring Parity in MA and PACE for Audio-Only Telehealth Act	• Requires the inclusion of certain audio-only diagnoses in the determination of risk adjustment for Medicare Advantage plans and PACE programs, and for other purposes.

Bill text not yet available at the time of publication. Introduced Mar. 23, 2021	
H.R. 2168: Expanded Telehealth Access Act *Bill text not yet available at the time of publication. Introduced Mar. 23, 2021*	• Allows on a permanent basis the HHS Secretary to expand the list of healthcare providers who would be able to use the connected health program including: physical and occupational therapists, audiologists, and speech and language pathologists
H.R. 2228: Rural Behavioral Health Access Act *Bill text not yet available at the time of publication. Introduced Mar. 26, 2021*	• Allows for payment of outpatient critical access hospital services furnished through telehealth under the Medicare program, including behavioral health services such as psychotherapy
H.R. 2903: CONNECT for Health Act *Introduced Apr. 28, 2021*	• Amends title XVIII of the Social Security Act to expand access to telehealth services
H.R. 3371: Home Health Emergency Access to Telehealth (HEAT) Act *Reintroduced May 20, 2021*	• Gives the Centers for Medicare & Medicaid Services (CMS) the authority to issues waivers to allow payments for home health services furnished via visual or audio telecommunication systems during an emergency period

H.R. 3447: Permanency for Audio-Only Telehealth Act *Introduced May 20, 2021*	• Allows Medicare coverage of audio-only telehealth services after the COVID-19 public health emergency
H.R. 3755: Women's Health Protection Act of 2021 *Reintroduced June 8, 2021*	• Allows health care providers to provide abortion services via telemedicine
H.R. 4012: Expanding Access to Mental Health Services Act *Introduced June 17, 2021* *Bill text not yet available at the time of publication.*	• Permanently broadens mental health options, including intake examinations and therapy, via telehealth for Medicare members.
H.R. 4040: Advancing Telehealth Beyond COVID-19 Act of 2021 *Reintroduced June 22, 2021*	• Permanently removes the originating site and geographical limitations within Medicare. • Makes permanent the telehealth coverage at Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) • Removes restrictions that limit health care providers' ability to provide access to smart devices and innovative digital technology to their patients.

H.R. 4036/S.2112: Enhance Access to Support Essential Behavioral Health Services (EASE) Act *S. 2112 introduced June 17, 2021* *H.R. 4036 Introduced June 22, 2021*	• Permanently allows Medicare and Medicaid to reimburse for all behavioral health services for children, seniors and those on disability.
H.R. 4058 S.2061: Telemental Health Care Access Act of 2021 *S. 2061 introduced June 15, 2021* *H.R. 4058 introduced June 22, 2021*	• Expands access to telemental health services by removing statutory requirement that Medicare members be seen in-person within six months of being treated for mental health services through telehealth.
H.R. 4437: HEALTH Act of 2021 *Introduced July 16, 2021*	• Amends title XVIII of the Social Security Act to permanently provide reimbursement to Federally qualified health centers (FQHCs) and rural health clinics (RHCs) under the Medicare program for services delivered via telehealth.
H.R. 4480 *Introduced July 16, 2021*	• Requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide coverage for services furnished

	via telehealth if such services would be covered if furnished in-person.
H.R. 4670: Advanced Safe Testing at Residence Telehealth Act (A-START) *Introduced July 22, 2021*	• Enables individuals who receive care through Medicare Advantage, Medicaid, and the Veterans Affairs to receive FDA-approved at-home tests at home in conjunction with an assistive telehealth consultations
H.R. 4770: Evaluating Disparities and Outcomes of Telehealth (EDOT) During the COVID-19 Emergency Act of 2021 *Introduced July 28, 2021*	Requires the Secretary of HHS to conduct a study evaluating the effects of changes to telehealth under Medicare and Medicaid during the COVID-19 emergency.
H.R. 4918: Rural Telehealth Expansion Act *Introduced Aug. 3, 2021*	Amends the Social Security Act to include store-and- forward technologies as telecommunications systems through which telehealth services may be furnished for payment under the Medicare program.
H.R. 5248: Temporary Responders for Immediate Aid in Grave Emergencies Act of 2021 *Introduced Sept. 14, 2021*	Authorizes the HRSA Provider Bridge Program to: • Streamline the process for mobilizing health care professionals during the COVID-19 pandemic and future public health emergencies, including by

	utilization communications pathways and new technologies; and, • Connect health care professionals with state agencies and health care entities to quickly increase access to care for patients via telehealth.
H.R. 5425: Protecting Rural Telehealth Access Act *Introduced Sept. 29, 2021*	• Amends title XVIII of the Social Security Act to protect access to telehealth services under the Medicare program • Eliminates geographic requirements for originating sites • Requires reimbursement for telehealth services provided in a critical access hospital • Requires a telehealth payment rate for telehealth services furnished by a FQHC or RHC Allows the use of audio-only technology for certain telehealth services including: E/M services, behavioral health counseling and education services, and other services determined appropriate by the secretary.
Passed Legislation	

H.R. 6074: Coronavirus Preparedness and Response Supplemental Appropriations Act	• Allows CMS to extend coverage of telehealth services to beneficiaries regardless of where they are located • Allows CMS to extend coverage to telehealth services provided by “telephone” but only those with “audio and video capabilities that are used for two-way, real-time interactive communication” (e.g., smartphones) *For more information on Medicare changes, see our March 17 Manatt newsletter.*
H.R. 748: Coronavirus Aid, Relief, and Economic Security (CARES) Act	• Telehealth Provisions include: ○ Telehealth Network and Telehealth Resource Centers Grant Programs ○ Exemption for Telehealth Services ○ Increasing Medicare Telehealth Flexibilities During Emergency ○ Enhancing Medicare Telehealth Services for Federally Qualified Health Centers and Rural Health Clinics During Emergency Periods ○ Temporary Waiver of Requirement for Face-to-Face

	Visits Between Home Dialysis Patients and Physicians ◦ Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care During Emergency Period ◦ Encouraging Use of Telecommunications Systems for Home Health Services Furnished During Emergency Period *For more information on the CARES Act, see our March 27 Manatt newsletter.*
H.R. 133: Consolidated Appropriations Act, 2021	• Telehealth provisions include: ◦ Expanding Access to Mental Health Services Furnished through Telehealth ◦ Funding for Telehealth and Broadband Programs including: ▪ An additional $250M to the FCC COVID-19 Telehealth Program ▪ $285M for a pilot program to award grants to Historically Black Colleges or Universities, tribal

	colleges and universities, and other minority-serving institutions ▪ $3.2B to establish an Emergency Broadband Benefit program at the FCC ▪ $1B at the NTIA support broadband connectivity on tribal lands to be used for broadband development, telehealth, distance learning, affordability and digital inclusion ▪ $300M for broadband development program targeted towards rural areas to support broadband infrastructure development *For more information on the Consolidated Appropriations Act, see our December 23 Manatt newsletter.*
H.R. 1319: American Rescue Plan Act of 2021	• Includes funding for the following opportunities that would expand access to telehealth, including: ○ Emergency Grants to help Rural Health Care facilities increase telehealth capabilities

	◦ Funding to support information technology infrastructure for telehealth at Indian Health Services Centers ◦ Funding to support behavioral and mental health professionals who utilize telehealth to deliver care via telehealth ◦ Support and training for home care visiting entities that conduct virtual home visits • Assistance for rape crisis centers transitioning to virtual services

Relevant Telehealth Data and Reports

In June 2022, FAIR published an article titled "In March 2022, Telehealth Utilization Fell Nationally for Second Straight Month". Telehealth utilization, as measured by telehealth's share of all medical claim lines, fell nationally for the second straight month, according to FAIR Health's Monthly Telehealth Regional Tracker. Researchers suggest the decline in telehealth use was due to an ongoing reduction in the severity and prominence of COVID-19, encouraging more patients to attend in-person visits. The article also states that despite the decline in overall telehealth usage, mental health conditions remain at the top of the list of telehealth diagnoses.

In May 2022, The National Committee for Quality Assurance (NCQA) released a report titled "The Future of Telehealth Roundtable," which highlights strategies that could help close care gaps as telehealth usage continues to grow. In October 2021, NCQA hosted a roundtable discussion

to facilitate dialogue on the future of telehealth delivery in a post-pandemic world; the three following strategies were identified to promote equitable access in telehealth delivery:

- Creating telehealth services that cater to personal patient preferences and needs, as some individuals may face struggles due to their primary language and socioeconomic status
- Addressing regulatory barriers to access and changing regulations to allow expanded provider eligibility for licensure
- Leveraging Telehealth and Digital Technologies to Promote Equitable Care Delivery

The report suggests that as telehealth becomes the new "normal", it is important to prevent inequitable gaps in telehealth delivery.
In May 2022, JAMA Pediatrics published a research letter titled, "Association of Race and Socioeconomic Disadvantage With Missed Telemedicine Visits for Pediatric Patients During the COVID-19 Pandemic." The letter highlights how pediatric patients are more likely to miss telehealth visits if they are low-income. Specifically, a higher probability of economic disadvantage was associated with a greater likelihood of missing a telehealth visit as compared to an in-person visit across racial groups. Additionally, telehealth visits were associated with lower no-show rates for future clinical appointments, but only for those with lower economic disadvantage.

In May 2022, Health Affairs published a study titled, "Medicare Beneficiaries In Disadvantaged Neighborhoods Increased Telemedicine Use During The COVID-19 Pandemic." The study found that Medicare beneficiaries living in disadvantaged areas had the greatest odds of expanded telehealth utilization as a result of emergency federal telemedicine coverage expansions during the COVID-19 pandemic. However, odds of increased telehealth access dropped as age increased.

In May 2022, Harvard Business Review released an article titled "The Telehealth Era Is Just Beginning," which explored the current landscape and evidence around telehealth, and discussed future trends in telehealth utilization and policy coming out of the COVID-19 pandemic. Using internal data from Kaiser Permanente and Intermountain Healthcare, combined with National Committee for Quality Assurance outcomes data and health plan member satisfaction surveys, the authors outline five opportunities that broader telehealth utilization could provide:

- A reduction in expensive, unnecessary ER visits
- An improvement in timeliness and efficiency of specialty care
- Access to the best doctors
- A reversal of America's chronic-disease crisis
- Mitigation of health care disparities

The report also suggested that further integration among care team members and adoption of capitated payment models may expedite the implementation of telehealth.

RAND Corporation released a report titled "Experiences of Health Centers in Implementing Telehealth Visits for Underserved Patients During the COVID-19 Pandemic", which evaluated the progress of FQHCs that participated in the Connected Care Acceleration (CCA) initiative by investigating changes in telehealth utilization and health center staff experiences with implementation. The study found that although overall visit volumes remained about the same from the pre-pandemic to the pandemic study periods, the share of audio-only and video visits dramatically increased during the pandemic, and audio-only visits were the leading modality for primary and behavioral health. The study recommends continued study of telehealth trends, particularly regarding equitable access to telehealth.

In March 2022, the American Medical Association released their 2021 Telehealth Survey Report, which aimed to gather insights on the experiences of current and expected future use to inform ongoing telehealth research and advocacy, resource development, and continued support for physicians, practices, and health systems. Data was collected from individuals, state and specialty medical organizations, and members of the American Medical Association Telehealth Immersion Program. The survey indicated that 85% of physicians currently use telehealth, and over 80% of patients said that they receive better access to care since using telehealth. In addition, 54.2% of respondents indicated that telehealth has improved the satisfaction of their work, and 44% said that telehealth has lowered costs.

In March 2022, GAO published a report titled "CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care", which examined the use of telehealth among Medicaid beneficiaries before and during the COVID-19 pandemic across six select states: Arizona, California, Maine, Mississippi, Missouri, Tennessee. The report also explored the states' experiences with telehealth during the pandemic, future plans for post-PHE telehealth coverage, and CMS' oversight of quality of care for services delivered via telehealth. GAO found that five of the selected states delivered 32.5 million services via telehealth to approximately 4.9 million beneficiaries between March 2020 and February 2021, up from 2.1 million services delivered to about 455,000 beneficiaries during the same time period in the previous year. Notably, the report highlighted the need for improved data collection and analysis related to the quality of care delivered via telehealth. Based on the results of the study, GAO issued two recommendations to CMS: (1) collect and analyze information about the effect delivering services via telehealth has on the quality of care Medicaid beneficiaries receive, and (2) determine any next steps based on the results of the analysis.

In March 2022, the HHS-OIG released a data brief titled "Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic," which examined trends in telehealth

utilization among Medicare fee-for-service and Medicare Advantage beneficiaries from March 2020 to February 2021. The data brief indicated that more than 40% of Medicare beneficiaries utilized telehealth during the first year of the pandemic, with use remaining high through early 2021. Beneficiaries used 88 times more telehealth services during the first year of the pandemic as compared to the prior year.

In March 2022, the American Medical Association (AMA) released a physician survey examining experiences with and perceptions of telehealth. Of the 2,232 provider respondents, nearly 85% indicated they currently use telehealth to deliver care to patients, while 70% indicated they plan to continue offering telehealth services. Moreover, 60% of providers surveyed felt telehealth enabled them to provide high quality care, while 80% of respondents indicated patients received better access to care since using telehealth.

In February 2022, the American Medical Association (AMA), in collaboration with Manatt Health, published a report titled "Accelerating and Enhancing Behavioral Health Integration Through Digitally Enabled Care," which used findings from a diverse working group to highlight solutions that industry stakeholders can apply to address gaps hindering the equitable and sustainable adoption of digitally-enabled behavioral health integration (BHI). Solutions included: increasing BHI training for primary care and behavioral health providers through the incorporation of digitally enabled BHI into standard curricula, encouraging the incorporation of telehealth into BHI by implementing payment parity for behavioral health services delivered via video or audio-only modalities, and passing legislation to remove originating site and geographic restrictions for all telehealth services in Medicare that limit access to care.

In February 2022, Doximity, a provider networking and digital health service, published the second edition of its "State of Telemedicine Report," which highlighted findings in patient and provider perceptions of telehealth based on surveys conducted between January 2020 and June 2021. Patients

overall showed growing trust in telehealth as a mechanism for high-quality care, with 55% reporting that they felt telemedicine provided equal or greater quality of care than in-person visits in 2021, compared to 40% in 2020. In addition, approximately two thirds of physicians indicated that using telemedicine allowed them to build or preserve trust with their patients.

In February 2022, The U.S. Government Accountability Office (GAO) released a report titled, "Defense Health Care: DOD Expanded Telehealth for Mental Health Care during the COVID-19 Pandemic," which focused on telehealth use in the military. Among active duty servicemembers, pre-pandemic telehealth visits made up 15% of mental health care visits, compared to 33% in April 2021. Department of Defense (DOD) officials highlighted the value of telehealth and its ability to improve access and continuity of care. In addition, officials suggested that telehealth may reduce the stigma of seeking mental health treatment by allowing servicemembers to receive care more privately without the risk of being seen in military treatment facilities.

In February 2022, the HHS Office of the Assistant Secretary for Planning and Evaluation released an issue brief titled "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services," which compared differences in telehealth access for audio-only and video visits between April and October 2021. While overall telehealth utilization was similar across demographic groups, except among the uninsured, there were significant differences in video telehealth use. Rates of video telehealth use were lowest among Latino, Asian and Black individuals, those without a high school degree and adults ages 65 and older.

In October 2021, the HHS-OIG released a data snapshot report titled "Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship," which evaluated the relationship between providers and Medicare patients utilizing telehealth between March and December 2020. Notably, the data snapshot found that

84% of Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship.

In October 2021, JAMA published an study titled “Changes in Virtual and In-Person Health Care Utilization in a Large Health System During the COVID-19 Pandemic,” which sought to assess the association between the growth of virtual care and health care utilization in an integrated delivery network. The study found that while COVID-19 caused in-person visits to decline and virtual services to increase, there was no significant change in the overall volume of healthcare utilization, suggesting that virtual care was substitutive, rather than additive in the ambulatory care setting.

In September 2021, the HHS-OIG released two telehealth reports “States Reported Multiple Challenges With Using Telehealth To Provide Behavioral Health Services to Medicaid Enrollees” and “Opportunities Exist To Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid” based on surveys conducted in early 2020. The surveys focused around telemental health delivery though managed care organizations.

In July 2021, AAMC in in partnership with Manatt Health published “Sustaining Telehealth Success: Integration Imperatives and Best Practices for Advancing Telehealth in Academic Health Systems”, conducting extensive interviews with many leading telehealth AMCs across the country (Ochsner, VA, Kaiser, MUSC, UMMC, Intermountain, Jefferson, etc.) and synthesizing best practices through this report.

In July 2021, The National Association of Community Health Centers (NACHC) published “Telehealth During COVID-19 Ensured Patients Were Not Left Behind,” which explores how health centers have utilized telehealth and the implications for health center patients should the PHE flexibilities not be extended.

In June 2021, the Lucile Packard foundation published “COVID-19 Policy Flexibilities Affecting
Children and Youth with Special Health Care Needs” to identify key

flexibilities enacted during the PHE related to children and youth with special health care needs (CYSHCN) and summarize stakeholders' perspectives about the impact of policy flexibilities on CYSHCN and their families and providers.

In June 2021, the Commonwealth Fund published "States' Actions to Expand Telemedicine Access During COVID-19 and Future Policy Considerations," which examined state actions to expand individual and group health insurance coverage of telemedicine between March 2020 and March 2021 in order to better understand the changing regulatory approach to telemedicine in response to COVID-19.. Notably, the report found that twenty-two states "changed laws or policies during the pandemic to require more robust insurance coverage of telemedicine." Three policy flexibilities that states focused on included: requiring coverage of audio-only services; requiring payment parity between in-person and telemedicine services; and, waiving cost sharing for telemedicine or requiring cost sharing equal to in-person care.

In June 2021, the Substance Abuse and Mental Health and Services Administration (SAMHSA) released "Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," a guide supporting the implementation of telehealth across diverse mental health and substance use disorder treatment settings. The guide examines the current telehealth landscape and includes guidance and resources for evaluating and implementing best practices that will continue to assist treatment providers and organizations seeking to increase access to mental health services via telehealth.

In May 2021, the National Academy for State Health Policy (NASHP) released "States Expand Medicaid Reimbursement of School-Based Telehealth Services" exploring how states are increasing Medicaid coverage of school-based telehealth services during COVID-19, determining which services can effectively be delivered through telehealth, and supporting equitable access to telehealth services for students.

In May 2021, the Kaiser Family Foundation published "Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future" analyzing Medicare beneficiaries' utilization of telehealth using CMS survey data between summer and fall of 2020.

In May 2021, the American Medical Association in partnership with Manatt Health published "Return on Health: Moving Beyond Dollars and Cents in Realizing the Value of Virtual Care" to articulate the value of digitally enabled care that accounts for ways in which a wide range of virtual care programs can increase the overall health and generate positive impact for patients, clinicians, payors and society.

In March 2021, the Journal of the American Medical Association (JAMA) published "In-Person and Telehealth Ambulatory Contacts and Costs in a Large US Insured Cohort Before and During the COVID-19 Pandemic," highlighting existing disparities related to the digital divide.

FAIR Health publishes a Monthly Telehealth Regional Tracker to track how telehealth is evolving comparing telehealth: volume of claim lines, urban versus rural usage, the top five procedure codes, and the top five diagnoses.

In February 2021, the Commonwealth Fund published "The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases" tracking trends in outpatient visit volume through the end of 2020 hoping to track what the clinical impacts of the pandemic are and how accessible has outpatient care been, if there are new policies encouraging greater use of telemedicine, and what has been the financial impact of the pandemic on health care providers.

In February 2021, the California Health Care Foundation in partnership with Manatt Health published "Technology Innovation in Medicaid:What to Expect in the Next Decade," a survey of 200 health care thought leaders in order to learn where health technology in the safety net is expected to go over the next decade.

In February 2021, Health Affairs published “Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States”, which examined outpatient and telemedicine visits across different patient demographics, specialties, and conditions between January and June 2020. The study found that 30.1% of all visits were provided via telemedicine, and usage was lower in areas with higher rates of poverty.

On December 29, JAMA published an article evaluating whether inequities are present in telemedicine use during the COVID-19 pandemic. The study found that older patients, Asian patients, and non–English-speaking patients had lower rates of telemedicine use, and older patients, female patients, Black, Latinx, and poorer patients had less video use. The authors conclude that there are inequities that exist and the system must be intentionally designed to mitigate inequity.