Health Policy and Legislation

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Telehealth: Here Now, Gone Tomorrow?

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Introduction

Since 2020, the COVID-19 public health emergency (PHE) has driven a surge in telehealth utilization due to necessity, consumer and provider willingness to use telehealth, and regulatory waivers facilitating greater access to and reimbursement for these services. According to a recent report from the Department of Health and Human Services (HHS) Office of the Inspector General (OIG), "more than 28 million Medicare beneficiaries—about two in five—utilized telehealth services" during the first year of the pandemic, which was 88 times higher than the prior year.[1] Although utilization rates have decreased in the past year, popularity of the service among patients has remained high despite a corresponding increase in in-person patient visits.

Our previous Alert, "Life After Omicron," highlighted telehealth as a critical policy area to watch in 2022. With many believing that the federal PHE is likely to end in early 2023, telehealth and patient advocacy groups have asked whether the regulatory and oversight flexibilities that encouraged telehealth utilization during the pandemic are likely to soon end as well. For its part, Congress passed the Consolidated Appropriations Act, 2022, which extended many of the Medicare telehealth flexibilities for 151 days after the end of the PHE. Absent additional legislative action, however, the previous statutory restrictions on geographic sites, originating sites, and types of eligible providers and services will resume at the end of the PHE. While several bills circulating through Congress would extend telehealth benefits more permanently, the House and Senate have yet to reach a consensus agreement about moving forward.

In this Alert, we review the current telehealth flexibilities in place during the PHE, outline the advocacy and policy considerations presently swirling around this service, and explore the various bills in Congress and the likelihood of their being signed into law.

CMS' Notable Telehealth Expansion

In its Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS), the Centers for Medicare & Medicaid Services' (CMS) increased beneficiary access to telehealth services during the pandemic in a number of significant ways, including the following:

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- Extending coverage for services through CY 2023 where some benefit may exist, but insufficient evidence exists for permanent coverage.
- Expanding coverage of tele-behavioral health services to Medicare enrollees when the originating site is the patient's home and provided via audio-only telehealth modalities.
- Allowing mental health services to be provided virtually by rural health clinics and federally qualified health centers.
- Adopting coverage for some remote therapeutic monitoring services that monitor non-physiologic patient data within the respiratory and musculoskeletal systems, therapy adherence and therapy response.

Although these coverage expansions have been critical for the provision of needed services during the PHE, it is notable that the CY 2022 PFS did not also extend the temporary flexibilities regarding "direct supervision" requirements that allowed "incident to" services to be billed by non-physician providers as long as the supervising physician was available virtually. As a result, that important flexibility will end with the termination of the PHE barring additional legislative action.

The Case for Telehealth in Brief

Telehealth advocates have been pressing Congress to not only maintain, but broaden these services after the PHE. The multipronged arguments for why this is so important to the United States health care delivery system includes the following key tenets:

1. Expanded access to care—recent reporting by the HHS OIG indicate significantly expanded access to and use of telehealth services by urban, Hispanic, female and dual eligible beneficiaries often by audio-only modalities.

2. Reduced costs—citing decreased out of pocket costs to patients and improved coordination of chronic care management, advocates note that the decreased reliance on brick and mortar facilities allows providers to deliver better care with lower overhead costs.

3. Drives innovation—leveraging the widespread availability of wearable remote monitoring technologies and improved communication between patients, providers, insurers and other members of the care team, supporters argue that telehealth spurs innovation and new models of care delivery that deviate from the way patient care is increasingly delivered today.

4. Efficient access to care in rural areas—a recent study reported in *The Journal of the American Medical Association* (JAMA) Health Forum found that Medicare beneficiaries in rural area disproportionately relied on out-of-state telehealth providers for primary and mental health services.

5. Convenience and satisfaction—patients and providers have both recorded significant improvements in convenience and satisfaction scores with the majorities in both groups reporting that they plan to continue using telehealth services.

6. Mental health and addiction services—as the forgotten epidemic of the COVID-19 crisis, telehealth platforms have provided critical lifelines for many patients unable to access behavioral health and addiction specialists in real-time or at reasonable cost.

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Taken together, these positive results frame a health care delivery model that is easier to access, increasingly innovative, and more economical than current care delivery models. Yet, despite these compelling and supported results, there still remain concerns and unanswered questions about whether patients and providers will be able to rely on the availability of telehealth services for much longer.

Concerning Policy Considerations

An area of ongoing discussion includes concerns about potential overutilization of services, the provision of unnecessary services, waste and, ultimately, billing fraud. The removal of in-person requirements is often cited as an exploitable loophole that would allow billing providers and agents the opportunity to code improperly or provide and bill for unnecessary services. Without adequate safeguards, the expansion of telehealth could drive an unintended increase in the costs of care over time from, among other things, upcharging, overutilization and billing for care not actually provided.

Although a just-released HHS OIG report concluded that telehealth fraud remained rare during the pandemic, it noted approximately $127.7 million was billed to Medicare by more than 1,700 providers with concerning billing practices that posed a high risk to Medicare. The report concluded that a decision to continue telehealth at current scale would require "strong, targeted oversight . . . to protect against fraud, waste, and abuse."[2]

The provider community has also raised concerns about the time that it takes to utilize some telehealth platforms and the fact that providers may not be compensated for time answering patient messages or interacting on telehealth platforms outside of normal hours. Whereas inquiries or patient requests were previously delegated to the on-call provider or managed during open office hours, the increased use of these platforms has expanded contact outside of working hours while pressure remains to address information in real-time.

Lastly, there are legitimate concerns about abuse and violations of the Controlled Substances Act through telehealth. The proliferation of mental health and tele-psychiatry platforms, which allow some providers to prescribe certain controlled substances without in-person visits, has come under recent scrutiny by the Drug Enforcement Agency (DEA) and state agencies with oversight over patient safety. Citing concerns that these platforms put some patients at increased risk for harm, opponents argue that the wider availability of these controlled substances could also pose a risk to the greater public through diversion, theft or illicit manufacturing without appropriate safeguards.

Congress Gets into the Act

In the 117th Congress, members of Congress in both chambers have introduced telehealth legislation, many with significant bipartisan support, demonstrating the popularity of telehealth both in Congress and among the electorate. In July 2022, the House passed H.R. 4040, the Advancing Telehealth Beyond COVID-19 Act. This bill would extend the Medicare flexibilities allowed under the PHE until the end of 2024.

H.R. 4040 is only one example of the telehealth-related legislation proposed in the 117th Congress. The following bills are examples of such legislation:

- H.R. 1332 – Telehealth Modernization Act – 128 bipartisan cosponsors.
- H.R. 366 – Protecting Access to Post-COVID-19 Telehealth Act – 62 bipartisan cosponsors.
- H.R. 6202 – Telehealth Expansion Act – 79 bipartisan cosponsors.
- S. 368 – Telehealth Modernization Act – 18 bipartisan cosponsors.
- S. 3594 – Telehealth Extension and Evaluation Act – four bipartisan cosponsors.

While many of these telehealth bills are new efforts for the 117th Congress, others have been introduced in various forms over the years. For instance, since 2016, Sen. Brian Schatz (D-HI), alongside a bevy of bipartisan cosponsors, has introduced the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act. The bill has evolved since it was first introduced, but the current version would generally expand Medicare coverage of telehealth services by allowing CMS to waive many current restrictions on telehealth services and permanently eliminating other restrictions, such as the requirement that telehealth must occur only at an approved "originating site."

Ultimately, despite telehealth's increasing popularity on Capitol Hill, Congress has declined to send legislation to the President's desk that would constitute a large-scale permanent expansion of telehealth. This is due in large part to cost estimates from the Congressional Budget Office (CBO). These estimates are based in the CBO's assumption that telehealth flexibilities would incentivize increased use, leading to higher costs for federal programs. For example, the CBO estimates that H.R. 4040's two-year extension of PHE flexibilities would cost the federal government nearly $2.5 billion.[2] In March 2022, the CBO estimated that five months' worth of extended telehealth flexibilities would cost $663 million, meaning—all else being equal—telehealth expansion would cost almost $25 billion over 10 years.[3]

What's Next?

Although telehealth use accelerated significantly during the pandemic, the dynamics around continuing the PHE-related flexibilities remain very fluid. Despite significant bipartisan interest in codifying ongoing access, support from patient-users across the country, and a strong cadre of advocacy groups, outstanding concerns about the costs of, and program integrity implications for, extending telehealth flexibilities broadly beyond the PHE continue to challenge the congressional path forward to enacting large-scale reforms.

Like other areas of technological advancement in health care delivery, telehealth expansion relies in significant part on both public and private-sector investments. Likewise, commercial and governmental payers' policies will continue to play a major role going forward in ensuring patients' access to timely, high-quality care.

While conventional wisdom would argue that election year dynamics should favor telehealth expansion, the concurrent wind-down of the public health emergency adds a significant degree of uncertainty into the debate. Stakeholders across the patient, provider and business communities with interests in telehealth are likely to find a sustained bipartisan focus in this space as Congress and executive branch agencies look beyond COVID-19 and continue to shape the future of telehealth in the months ahead.

[1] https://oig.hhs.gov/oei/reports/OEI-02-20-00720.asp.

[2] https://www.cbo.gov/system/files/2022-07/hr4040.pdf.

[3] https://www.crfb.org/papers/fiscal-considerations-future-telehealth.

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