June, 2021

Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19 – June, 2021

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.

New Federal Developments

New Item	Activity
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

New State-Level Developments

State	Activity
Connecticut	• Passed House Bill No. 6470, which requires the CT medical assistance program to provide coverage for audio-only telehealth and requires the Commissioner to provide Medicaid reimbursement for services delivered via telehealth at parity.

Hawaii	• Passed Senate Bill No. 970, which authorizes the establishment of a physician-patient relationships via a telehealth interaction if the physician is licensed to practice in the state.
Nevada	• Passed Senate Bill No. 5, which includes the delivery of telehealth services through audio-only interactions; allows providers to establish a patient relationship through telehealth; requires the state to establish a data dashboard that allows analysis of data relating to access to telehealth ; and requires a third-party payer who is not an industrial insurer to cover services provided through telehealth, except for services provided through audio-only interaction.
Texas	• Passed Senate Bill No. 40, which allows health professionals to provide telehealth services and allows licensed dyslexia therapists to provide telehealth services in educational centers.
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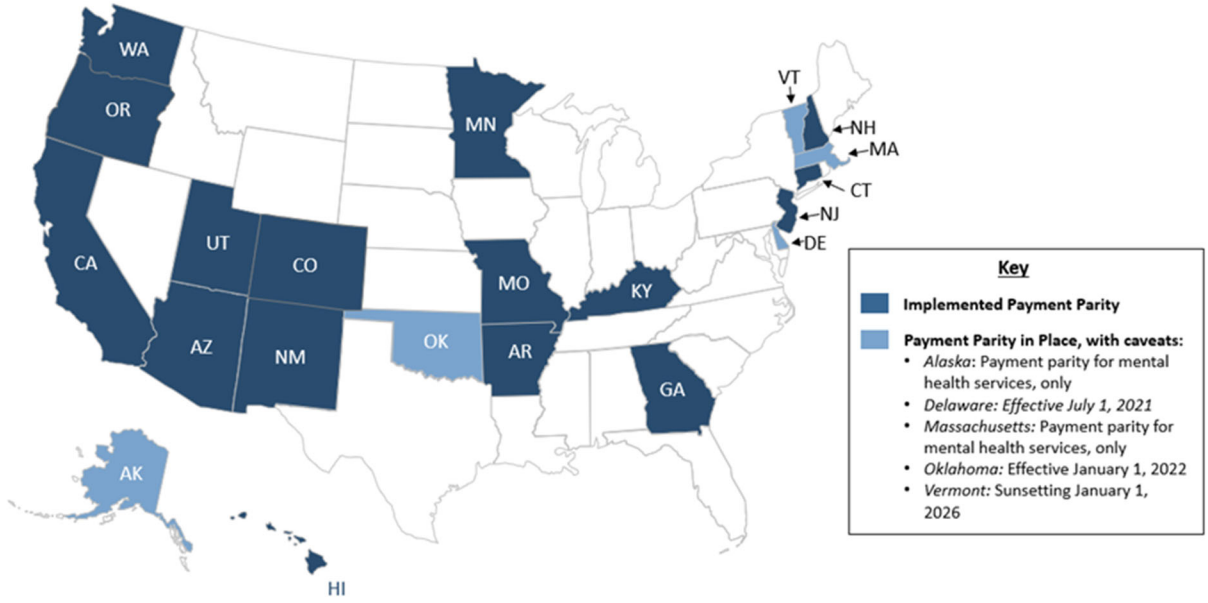
Payment Parity Permanent State Laws and Statutes

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 2021, 16 states have implemented policies requiring payment parity, 5 states have payment parity in place with caveats, and 29 states have no payment parity.

Figure 1. Map of States that Laws Requiring Insurers to Implement Payment Parity (as of June 2021)



Federal Developments More than Two Weeks Old

Executive Branch Activity

Policy	**Details**
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 Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.	• Appropriated by the American Rescue Plan, the $40 million in emergency 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.
On May 6th, the Centers for Medicare & Medicaid Services (CMS) updated the Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs.	• 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-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 Flexibilities and Considerations for their Continuation.	• The report includes preliminary observations from ongoing work related to telehealth in the 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 U.S. Department of Health & Human Services (HHS) announced the renewal of the Public Health Emergency (PHE).	The COVID-19 PHE will be renewed for another 90 days, beginning on April 21 (the date the PHE was previously scheduled to expire) and extending through July 21, 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. *For more information regarding PHE renewal, please see our Manatt Insights summary.*
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	HHS's newly finalized regulations remove historical barriers to

framework that governs fraud and abuse in Medicare and Medicaid programs.	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 telecommunications technology or audio-only services.	Services provided to patients must be included in the plan of care and not substituted for or 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 telehealth during the COVID-19 nationwide public health emergency."	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 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	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.

Delivery of Virtual Care to discuss the future of telehealth in Medicare.	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 telehealth in fee-for-service Medicare.	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 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	
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. 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. 660 *Introduced March 10, 2021* *Bill text not yet available at the time of publication.*	• 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. 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. 2741: Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019	• Remove 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 health centers (FQHCs) and rural health clinics (RHCs)
S. 4103: 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 provider has already conducted an in-person or telehealth evaluation
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 *Reintroduced Jan. 28, 2021*	• Allows HHS Telehealth Resource Center to allocate $50 million to expand Medicare and Medicaid coverage of telehealth services in nursing facilities • 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	• 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	• Amends title XI of the Social Security Act to integrate telehealth models in maternity care services, and for other purposes
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 *Bill text not yet available at the time of publication. Introduced Mar. 23, 2021*	• 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.

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. 2268: 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
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 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.

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.