



July 10, 2020

The Honorable Elizabeth Warren
U.S. Senate
Washington, DC 20510

Dear Senator Warren:

On behalf of healthcare providers, human service providers, patient advocacy organizations, telehealth technology companies, and telecommunications representatives, we would like to take this opportunity to express our gratitude for the flexibilities and enhancements that have been granted during the COVID-19 state of emergency that have accelerated the utilization of telehealth across the United States. These policy changes ensure that our residents have access to critical healthcare services while taking necessary precautions to limit exposure to COVID-19, reduce the stress and burden of traveling to appointments (including the cost of tolls and parking), allow continued social distancing, and preserve personal protective equipment for our healthcare workforce. Telehealth has been a powerful tool – a modality change -- to increase equitable access to care for all residents of the Commonwealth and promote the principles of health equity and health justice. The purpose of this letter is to further expand on the benefits that have been realized and to address critical gaps that remain and must be addressed as we move forward.

Telehealth utilization has grown immensely during the pandemic. According to Blue Cross Blue Shield of Massachusetts, the number of telehealth visits they covered during the first six weeks of the pandemic increased exponentially from 5,000 visits in the six weeks prior to the pandemic to 500,000 visits in the first six weeks of the pandemic, with almost half of those visits for behavioral health services. Previously, telehealth had enjoyed limited insurer coverage and many programs still rely upon grant funding and other philanthropic efforts for payment. Data from the MassINC polling group indicate that nearly one-fifth of respondents had utilized telehealth since the COVID-19 outbreak began, with the highest utilization coming from those deemed to be at the highest risk for the virus (ages 60+). For just one provider, their utilization rate for telehealth during the pandemic has been 83% which is only 5% lower than in-clinic appointments over the same time during the previous year. Telehealth appointments have also helped improve patient compliance with appointments. Show rates have been 89% during this period via telehealth versus the show rate of 80% for in-clinic-only visits during the previous year. Additionally, another large health system has indicated that when surveying their patients after their telehealth visits during the pandemic, 98% of patients report being very satisfied or satisfied with their virtual visits. Telehealth has become an integral part of ongoing treatment and care plans in Massachusetts that must be preserved.

As the Commonwealth moves forward with a phased reopening, the tMED Coalition urges you to preserve these critical policies that have been adopted by providers and utilized by patients across the state, in addition to addressing some gaps in coverage that had not been previously recognized. Already, the Massachusetts Board of Registration in Medicine has adopted permanent policies on telemedicine, clarifying that a face-to-face encounter between the physician and the patient is not required prior to health care delivery via telemedicine and defining the standard of care applicable to the physician is the same whether the patient is seen in-person or through telemedicine. There is significant anxiety among providers and patients alike that there will be a retrenchment of the federal policies, creating clinical, operational and financial challenges for the healthcare landscape that will prevent providers from continuing to use telehealth as a much needed modality for service delivery. This is in addition to the needs of healthcare providers to

continue to limit exposure to COVID-19, promote continued social distancing, prepare for the upcoming flu season, and preserve personal protective equipment for our healthcare workforce for the foreseeable future. To support the continued utilization of telemedicine once the Public Health Emergency (PHE) expires, the tMED Coalition would strongly urge you to pursue the following legislative actions. This letter also outlines critical regulatory actions the administration must take and for which we would request your support.

Legislation

Geographic and originating site requirements. Providers have been permitted to deliver telehealth services to patients in their homes and other locations and in any area of the country through the waiver of the geographic and originating site requirements. Section 1834(m) of the Social Security Act restricts the delivery of telehealth services to certain rural areas of the country through geographic site restrictions and certain physical locations such as hospitals and physicians' offices through originating site restrictions. Section 3703 of the CARES Act (H.R. 748) gave the Secretary of Health and Human Services the authority to waive this and all other requirements of Sec. 1834 (m) during the PHE. Legislation is required to permanently remove these restrictions from statute.

Maintain and Enhance HHS Authority to Determine Appropriate Providers and Services for Telehealth. Congress should provide the Secretary with the flexibility to expand the list of eligible practitioners who may furnish clinically appropriate telehealth services. Similarly, HHS and CMS should maintain the authority to add or remove eligible telehealth services – as supported by data and demonstrated to be safe, effective, and clinically appropriate – through a predictable regulatory process that gives patients and providers transparency and clarity.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). RHCs and FQHCs have been allowed to serve as distant sites for the provision of telehealth services. This flexibility was established in Section 3704 of the CARES Act, which added a paragraph to Section 1834(m) instructing the HHS Secretary to pay for telehealth services that are furnished via a telecommunications system by an FQHC or an RHC, subject to certain requirements. Legislation is required to permanently retain the ability of RHCs and FQHCs to serve as distant sites for the provision of telehealth services.

Make Permanent HHS Temporary Waiver Authority. The Secretary of HHS has authority to grant public health emergency-based waivers under Section 1135 of the Social Security Act when the Secretary declares a public health emergency (PHE) and the President declares a national emergency under the National Emergencies Act (NEA) or the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Currently, both of these declarations are active for the COVID-19 pandemic. Should the PHE or national emergency end, these waivers would terminate. In addition, Congress granted specific telehealth waiver authority under the CARES Act and the Coronavirus Preparedness and Response Supplemental Appropriations Act. Congress should ensure that HHS and CMS can act quickly during future pandemics and natural disasters by making these waiver authorities permanent and allowing HHS and CMS to have broad authority to temporarily waive or modify Social Security Act requirements.

Audio-only communication. Healthcare providers have been allowed to deliver certain Medicare telehealth services via audio-only communication. CMS has interpreted the Section 1834(m) description of telehealth services as “services that are furnished via a telecommunications system” to indicate that Medicare telehealth services must be furnished using video technology. CMS used its authority during the COVID-19 pandemic to waive this requirement for a subset of Medicare telehealth services including some of those that were newly added during the pandemic. However, permanently allowing those and any other services to be delivered via audio-only connection requires legislation, either to codify in statute that telecommunications services can, in certain instances, include audio-only communication or to give the HHS Secretary authority to allow certain services to be delivered via audio-only connection.

Giving healthcare providers the capability to provide services to patients via telehealth and telephone is essential to preventing the spread of COVID-19 to the public, vulnerable patients, healthcare providers, and their staff. However,

many elderly and low-income patients either do not have access to adequate technology or experience difficulty navigating virtual visits with both audio and video capabilities. Therefore, it is essential that telephone visits also be covered and paid for at in-person rates by all payers. Recognizing that it is vital for the elderly to be in contact with their physicians and receive timely care, the Centers for Medicare and Medicaid Services (CMS) approved audio-only visits for the Medicare fee-for-service program but have not provided payment for it under the risk-adjusted Medicare Advantage program payments. It is important that both telehealth video and audio-only services are covered in all federally regulated programs and plans to ensure access for more vulnerable low-income patients and older adults.

Additional practitioners. All healthcare professionals who are eligible to bill Medicare for their professional services, including respiratory therapists, physical therapists, occupational therapists, speech language pathologists, and others have been permitted to deliver and bill for services provided via telehealth. Section 1834(m)(4)(E) limits payment for telehealth services to physicians and a limited set of non-physician practitioners under the Medicare physician fee schedule. In its general waiver document, CMS used its authority under the CARES Act to waive this limitation so as to expand the types of health care professionals that can furnish distant site telehealth services. A change in legislation would be necessary to permanently allow this expanded list of providers to deliver and bill for telehealth services or to give the Secretary the authority to determine which practitioners may deliver and bill for different telehealth services.

Qualifying Technologies to permit the use of Smartphones. CMS-IFC-11744 includes an exception to clarify telehealth technology requirements to allow the use of smartphones in Medicare telehealth. Prior to the public health emergency, the current requirements on the books state that telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications systems for purposes of Medicare telehealth services. However, CMS interpreted this regulation as not applying to mobile computing devices that include audio and video real-time interactive capabilities, even though such devices are now referred to colloquially as “phones” since they can also be used for audio-only telecommunications. CMS rightly recognized that such language might prohibit the use of any smartphone device that could otherwise meet interactive requirements for Medicare telehealth and, for the time of the public health emergency, is defining an interactive telecommunications system to mean any equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site physician or practitioner. A change in legislation is necessary in order to make such a definition permanent.

Hospital outpatient billing for telehealth. Hospitals, including critical access hospitals (CAH), are allowed to bill the outpatient prospective payment system (OPPS) or otherwise applicable payment system for therapy, education, and training services furnished remotely by hospital clinical staff to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital. Examples of such services include counseling, psychotherapy, group therapy, and partial hospitalization program services. Section 1834(m)(1) limits payment for telehealth services to physicians and a limited set of non-physician practitioners under the Medicare physician fee schedule. In CMS-5531-IFC, published in the Federal Register on May 8, CMS used its waiver authority to overcome this limitation by enabling hospital clinical staff to meet through telehealth the requirements of delivering certain outpatient services, subject to certain restrictions. This change allows hospital outpatient departments (HOPDs) to bill for services as if they were delivered in person. However, to permanently allow HOPDs to bill the OPPS or CAHs to use Method I billing for telehealth services, a change in legislation would be necessary, either to codify this in statute or to give the HHS Secretary the authority to determine which providers may deliver and bill for different telehealth services.

Hospice and home health face-to-face requirements and delivery of care. Hospice and home health visits have been permitted to be performed via telehealth in lieu of: (1) the face-to-face visit for the purpose of recertification of Medicare hospice services; and (2) the home health face-to-face encounter. The flexibility for hospice face-to-face requirements to be met via telehealth is found in Section 3706 of the CARES Act (H.R. 748). The corresponding flexibility for home health services is found in CMS’s FAQ document. A statutory change is needed to remove the Affordable Care Act mandate requiring a face-to-face encounter by a physician to certify a patients’ need for home health services.

[Sections 1814(a)(2)(C) and 1835(a) (2)(A) of the Social Security Act; 42 CFR § 424.22(a)(1).] Additionally, healthcare professionals are allowed to provide home health and hospice services -including nurses and therapists - via telehealth and bill accordingly. CMS established this flexibility in CMS-1744-IFC, the interim final rule published April 6, 2020 in the Federal Register. However, new statutory authority is needed to extend this flexibility beyond the PHE to use telehealth under the home health benefit.

Part B Facility Fee. Flexibilities during the public health emergency have allowed hospitals to bill the originating site facility fee for telehealth services paid under the Medicare physician fee schedule and furnished by hospital-based providers to Medicare patients registered as hospital outpatients, including when the patient is located at home. Section 1834(m) (2) (B) (ii) prohibits the payment of a facility fee if the originating site is a patient’s home. In CMS-5531-IFC, CMS used its waiver authority and a complex process to allow hospitals to bill the originating site facility fee for services furnished to patients at home; however, a permanent change to this policy is required to either remove this prohibition from statute or authorize the HHS Secretary to waive it as appropriate.

State Licensure. Flexibilities introduced in March delineate that healthcare practitioners do not need to be licensed in the state where they furnish services, provided that they hold a valid license in another state where they are enrolled in Medicare, are contributing to relief efforts, and are not affirmatively excluded in any state. Practitioners must still be authorized to provide services pursuant to state requirements, though most state licensing boards have waived/relaxed licensure requirements, which are being tracked by the Federation of State Medical Boards. The coalition recommends that licensure flexibilities need to be addressed after the public health emergency since these flexibilities will impact the long-term utilization of telehealth.

COVID-19 Telehealth Program. The Federal Communications’ Commission (FCC) provides funds to eligible healthcare providers to support connected care services provided to patients at their homes or mobile locations. The program funds approved applications for telecom services, information services and devices needed to provide telehealth to COVID-19 and non-COVID-19 patients. The FCC expects the \$200 million fund to be fully committed by mid-July. Legislation is required to extend the program through additional funding and should direct the FCC to expand the program to all hospitals, including for-profit facilities.

Regulation

Billing for telehealth as if delivered in-person. CMS is paying for Medicare telehealth services as if they were delivered in person by instructing physicians and practitioners who bill for Medicare telehealth services to report the place-of-service (POS) code that would have been reported had the service been furnished in person. Before the PHE, practitioners billed for telehealth services with POS code 02 to signify telehealth. In CMS-1744IFC, CMS instructed providers to instead use the POS code they use when they provide services in person and append the -95 modifier to services delivered via telehealth. CMS, through its regular rulemaking activities, should retain these modified billing instructions going forward so as to continue paying for telehealth services as if they were delivered in person.

Additional telehealth services. During the PHE, CMS has provided payment for more than 135 additional services when furnished via telehealth and allow additional services to be added on a sub-regulatory basis to the list of Medicare telehealth services. In the calendar year 2002 Medicare physician fee schedule (PFS) final rule, CMS established that PFS annual rulemaking would serve as the process for adding and deleting services from the Medicare telehealth list. However, in CMS-1744-IFC, the agency added more than 80 additional services to that list and in CMS-5531-IFC it changed the process for adding any additional services to a sub-regulatory approach that would not require notice-and comment rulemaking. CMS has continued to add services to the approved Medicare telehealth list of services during the PHE. CMS should use its regulatory authority to permanently retain the expanded list of approved Medicare telehealth services and permanently retain the sub-regulatory process for adding codes to the list of approved Medicare telehealth services.

Providers at home. Providers have been providing telehealth services from their homes and do not need to update their Medicare enrollment to include their home location nor must their clinic or physician group practice do so if the provider has reassigned his/her benefits. Provider enrollment requirements are regulatory, found at 42 CFR 424.516. During the pandemic, sub-regulatory guidance established this waiver by clarifying that providers do not have to update their enrollments. CMS should make this guidance permanent under its regulatory authority.

Direct supervision. The flexibilities during the PHE have allowed direct supervision to be provided using real-time, interactive audio and video technology. The regulations governing supervision requirements appear at 42 CFR § 410.26. In CMS-1744-IFC, CMS revised the definition of direct supervision (410.26(a) (2)) to allow the necessary presence of the physician for direct supervision to include virtual presence through audio/ video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. CMS should permanently retain this flexibility through rulemaking.

Virtual check-ins and e-visits. During the pandemic, virtual check-ins and e-visits have been permitted to be used for new patients in addition to established patients. Virtual check-ins and e-visits were created by CMS in the calendar year 2019 Medicare physician fee schedule final rule. The flexibility for these services to be used for new patients was published in CMS-1744-IFC. CMS should use its regulatory authority to continue to allow virtual check-ins and e-visits to be used for new and established patients.

Remote Patient Monitoring or Remote Physiological Monitoring (RPM). Flexibilities have allowed RPM to be used for new patients in addition to established patients and for acute conditions in addition to chronic conditions. Through annual rulemaking, CMS has finalized payment for several RPM codes, but they were available only to established patients and generally understood to be available only for the monitoring of chronic conditions. CMS-1744-IFC clarified that RPM can be used for acute conditions, including, but not limited to, COVID-19, and extended the use of RPM to new patients. (CMS-5531-IFC made other changes to implement this flexibility.) CMS should use its regulatory authority to continue to allow RPM to be used for both new and established patients and for both acute and chronic conditions.

Physical examinations. CMS has waived the requirement for a history and/or physical examination to bill office outpatient evaluation and management (E/M) visits delivered via telehealth, such that these visits can be provided for any patient via telehealth and such that the office outpatient E/M level selection for these services when furnished via telehealth can be based solely on the level of medical decision-making or time spent by the provider on the day of the visit. Through the calendar year 2020 Medicare physician fee schedule final rule, CMS established a similar policy to this waiver through which E/M level selection can occur based on medical decision-making or time, beginning in calendar year 2021. This waiver was established in the CMS-1744IFC rule and should be included in future CMS annual rulemaking.

Consent to treat. Annual consent for telehealth treatment may be obtained at the same time, and not necessarily before the time, that services are furnished during the PHE. In its fact sheet on flexibilities to fight COVID-19 for physicians and other clinicians, CMS clarified that beneficiary consent should not interfere with the provision of non-face-to-face services and that annual consent may be obtained at the same time, and not necessarily before, services are furnished. CMS should retain this approach to consent through its rulemaking authority.

Recording Hierarchal Condition Categories (HCCs). Healthcare providers may capture diagnoses impacting risk adjustment during telehealth visits during the PHE. In response to the PHE, CMS released a risk adjustment FAQ in which it indicated any service provided through telehealth that is reimbursable under applicable state law and otherwise meets applicable risk adjustment data submission standards may be submitted to issuers' External Gathering Data Environments (EDGE) servers for purposes of the HHS-operated risk adjustment program. CMS should use its regulatory authority to retain this policy.

Frequency limitations. Certain subsequent inpatient and nursing facility visits and critical care consultations provided via telehealth will not be subject to previously established frequency limitations. In CMS-1744-IFC, CMS used its regulatory authority to remove frequency limitations from certain visits provided via telehealth. CMS uses its annual rulemaking authority to establish these frequency limitations, as part of its process for adding services to the Medicare telehealth list. CMS should use this same authority to remove frequency limitations.

Patient Cost-Sharing Obligations. The Office of the Inspector General (OIG) announced on March 17, /2020 that it will allow providers to waive patient cost-sharing requirements for telehealth and, per a subsequent FAQ, for other remote, technology-based services, for the duration of the PHE. Telehealth services are usually subject to the same co-payment or deductible requirements as most other services reimbursed by Medicare, and routinely waiving that patient's cost-sharing obligation can normally subject the provider to regulatory scrutiny under the federal Ant-Kickback Statute and beneficiary inducement law.

Continuation of real-time audio & video telehealth E/M Services. The tMED Coalition recommends that CMS continue permit the use of real-time audio & video telehealth E/M services to patients at home who cannot or should not undertake in-person office visits and for whom telehealth services are safer or more feasible including: i) established patients with a health condition or functional limitations that make travel to the physician's office difficult or risky; ii) new patients whose principal complaint involves symptoms of an infectious disease; and iii) new or established patients during infectious disease outbreaks, severe weather, public health emergencies or other situations where social distancing is appropriate.

Prescribing Controlled Substances. The Drug Enforcement Administration (DEA) has adopted policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients. The DEA may want to consider making such provisions permanent.

HIPAA Non-Enforcement. Continue to temporarily waive the restrictions on the type of technology that may be used to provide telehealth by allowing the use of everyday communications technologies, such as FaceTime or Skype.

We look forward to continuing our work with you to advance and expand access to telehealth services in the commonwealth. Should you have any questions or concerns, please contact Adam Delmolino, Director of Virtual Care & Clinical Affairs at the Massachusetts Health & Hospital Association, at (617) 642-4968 or adelmolino@mhalink.org.

Sincerely,

tMED – the Massachusetts Telemedicine Coalition

Massachusetts Health & Hospital Association
Massachusetts Medical Society
Massachusetts League of Community Health Centers
Conference of Boston Teaching Hospitals
Massachusetts Council of Community Hospitals
Hospice & Palliative Care Federation of Massachusetts
Health Care for All
Organization of Nurse Leaders
HealthPoint Plus Foundation
Massachusetts Association of Behavioral Health Systems
Massachusetts Academy of Family Physicians
Seven Hills Foundation & Affiliates
Case Management Society of New England
Massachusetts Occupational Therapy Association

Atrius Health
 New England Cable & Telecommunications Association
 Association for Behavioral Healthcare
 National Association of Social Workers – Massachusetts Chapter
 Massachusetts Psychiatric Society
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