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Congress's COVID-19 Funding Legislation Expands Access to Telehealth Services for Medicare Beneficiaries

Article By:

Helaine I. Fingold

Amy F. Lerman

Matthew Sprankle

While the world continues to respond to the growing COVID-19 pandemic, the United States Congress recently passed legislation that provides for more than $8 billion in emergency funding to combat COVID-19. Part of this supplemental funding package, signed into law on March 6, 2020, includes the Telehealth Services During Certain Emergency Periods Act of 2020 (the "Act"),[1] which authorizes the Administration to loosen restrictions on telehealth in order to expand access to COVID-19 related telehealth services for Medicare beneficiaries—many of whom are especially vulnerable to this virus and in the event of future emergencies. On March 17, 2020, the Administration announced the implementation of this waiver with a retroactive effective date of March 6, 2020.

Medicare's historically limited telehealth coverage

Beginning in late 2001, Congress amended the Social Security Act to provide for limited coverage of telehealth services, largely to benefit those beneficiaries living in rural areas. Coverage of telehealth services was to include: (1) live, synchronous, "two-way" modalities, where the patient and provider are linked by real-time, audiovisual technology (excluding telephone communications)[2]; (2) that were provided to rural-based patients; (3) who received the care at specific types of locations ("originating sites").[3]

Since 2001, Medicare has gradually broadened its coverage of telehealth services in several limited ways. First, the program lifted some of its restrictions on originating sites, for example,[4] allowing the patient's home to be a valid originating site in certain circumstances (e.g., patients with end-stage renal disease, co-occurring substance use and mental health disorders, etc.).[5] Since January 2019, providers may also be reimbursed for brief "virtual check-ins" with established patients, including by audio-only real-time telephone interactions, where the communication is not related to a medical visit within the previous seven days and does not lead to a medical visit in the succeeding twenty-four hours.[6] Also beginning in January 2019, Medicare allows for coverage of telehealth services provided via non-synchronous modalities, including through the use of asynchronous, "store-and-

forward" technologies (e.g., sending MRI results from a patient's home to a provider's office)."[7] Yet, despite these recent expansions, broad use of these services by Medicare beneficiaries is still limited by the narrow geographic and location restrictions that have long existed.

The Secretary's authority to broaden Medicare coverage of telehealth services under the Act

The Act lessens some of Medicare's restrictions on coverage of telehealth services as in connection with the COVID-19 Public Health Emergency Declaration (the "COVID-19 Emergency Declaration"). Specifically, the Act grants the Secretary of the U.S. Department of Health & Human Services authorization to "waive or modify the application of" Medicare statutory and applicable regulatory provisions for telehealth services delivered by a qualified provider in an emergency area during an emergency period, including any telehealth service that is already reimbursable under applicable HCPCS codes—not just services for the treatment of COVID-19.

In addition, the Act allows for the waiver of current restrictions that prohibit the use of a telephone to conduct the telehealth visit,[8] enabling provision of telehealth services beyond a virtual check-in through audio-only telephone.[9] Through this waiver-based expansion, Medicare will now cover telehealth services provided via telephone as long as the telephone has "audio and video capabilities that are used for two-way, real-time interactive communication."[10] Finally, the Act enables Medicare to cover telehealth services to beneficiaries regardless of where they live and where they seek to receive care for the period of the emergency. Medicare has exercised its authority to grant this waiver, effective March 6, 2020, and has posted a related Frequently Asked Questions document to its website.

A sign of progress for expanding telehealth coverage and reimbursement?

While the Act will likely have a positive effect on the provision of services related to the COVID-19 pandemic, it should also increase the delivery of telehealth services unrelated to COVID-19. This outcome will hopefully open the door for more permanent Medicare reform to loosen current restrictions, expanding access to telehealth for the Medicare population generally across all geographic areas.

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[1] H.R.6074, Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020.

[2] 42 C.F.R. § 410.78(a)(3), (b).

[3] Sec. 223(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L.106-554).

[4] For more information about this change, see a recent blog post covering the SUPPORT for Patients and Communities Act (known as the "SUPPORT Act"), which sought to address originating site restrictions by granting Medicare coverage of telehealth services to eligible beneficiaries in their homes.

[5] *See* Sec. 50302 of the Bipartisan Budget Act of 2018 and Sec. 2001 of the SUPPORT Act.

[6] For more information about these virtual check-ins and expanded telehealth access, see a recent EBG Client Alert discussing the 2019 Physician Fee Schedule.

[7] 2019 Physician Fee Schedule, 83 Fed. Reg. 59452 (Nov. 23, 2018).

[8] Pursuant to the Act, to be codified as 42 U.S.C. § 1320b-5(b)(8).

[9] As discussed above, the virtual check-in limits coverage of telehealth interactions to those with established patients where the communication is not related to a medical visit within the previous seven days and does not lead to a medical visit in the succeeding twenty-four hours. Telehealth interactions that fall out of this duration scope are “bundled” with the other medical visit(s) and the virtual check-in is not coverage as a separately identifiable service.

[10] Pursuant to the Act, to be codified as 42 U.S.C. § 1320b-5(g)(3).

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