Perspective on the future of telehealth

CVS Health® supports efforts to make telemedicine an integrated component of the health care delivery system

The demand for telehealth soared in the wake of COVID-19, as patients sought new ways to access providers. Recognizing Medicare beneficiaries' desire to minimize COVID-19 transmission risks, the federal government took unprecedented action using authority **granted** under the Public Health Emergency (PHE) to expand the use of telehealth in the Medicare program.[1] As a result, the Centers for Medicare & Medicaid Services (CMS) temporarily:

- waived the Medicare geographic and originating site requirements;
- dramatically expanded the number of Current Procedural Terminology (CPT) codes eligible for reimbursement and allowed more types of clinicians to bill;
- used its authority to expand access to virtual services such as e-visits, virtual check-ins and remote patient monitoring;
- allowed physician supervision remotely and suspended certain prior patient/ clinician relationship requirements; and
- allowed Medicare clinicians to provide virtual care from their home, which has expanded access to patients and helped reduce clinician burnout so they can have better work-life balance.

Separate from Medicare, based on the CARES Act, high deductible health plans (HDHPs) with health savings accounts (HSA) were allowed to cover telehealth services prior to patients reaching the deductible through the end of 2021. We support legislation to make this change permanent.

Because of the collective actions that CMS took, nearly half (43.5%) of primary care visits for enrollees in the Medicare Fee-For-Service program were provided via telehealth in April 2020, compared with less than one percent before the PHE in February 2019 (0.1%).[2] Even as in-person visits started to resume from mid-April through May, the use of telehealth in primary care declined somewhat but appears to have leveled off at a persistent and significant level (30%) by the beginning of June 2021. Most of CMS' expanded telehealth flexibilities are set to expire at the end of the PHE.

As policymakers evaluate the role of telemedicine post-COVID-19, we support efforts that would make telemedicine an integrated component of the health care delivery system. In that spirit, we support efforts to break down barriers that inhibit Americans' ability to conveniently use telehealth, where and when clinically appropriate.

Specific policy proposals

1. Patient care should be permitted from a patient's home, when clinically appropriate. Barriers to patient and provider location during a telehealth visit should be removed.
2. Remove barriers so patients can access qualified telehealth providers.
3. For Medicare Advantage, CMS should permanently allow telehealth-obtained diagnoses to count toward risk adjustment.

[1] Specifically, the HHS Secretary Azar declared a public health emergency in January. The U.S. Congress passed three laws with specific Medicare telehealth provisions to facilitate its use during the PHE. Lastly, President Trump declared a national emergency, using Stafford Act authority, which dramatically increased the scope of powers available to Secretary Azar to address the PHE.
[2] Bosworth A, Ruhter J, Samson LW, Sheingold S, Taplin C, Tarazi W, and Zuckerman R, Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of COVID-19 Pandemic. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. July 28, 2020.

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Specific policy proposals – Technical details

1. **Patient care should be permitted from a patient's home, when clinically appropriate. Barriers to patient and provider location during a telehealth visit should be removed.**
   - In Medicare, telehealth coverage is generally limited to rural areas and beneficiaries must receive medical services through a telecommunications system in a specific location outside the home referred to as an "originating site."
   - These "originating sites" are typically provider offices, hospitals, rural health clinics or another clinical location like a skilled nursing facility.
   - These outdated requirements contradict the clinical and patient-access benefits of using telehealth. Patients should not be required to leave their homes and "travel" to receive telehealth services and this service should not only be available to Medicare beneficiaries in rural areas. Congress should remove the "originating site" requirement from statute or modify the list and add "home and other locations."
   - CMS should continue allowing clinicians to provide virtual care from their homes. This helps expands patient access to care and helps providers maintain a better work-life balance.

2. **Remove barriers so patients can access qualified telehealth providers.**
   A. Patients should not be required to have a pre-existing treatment relationship with a provider or an in-person exam to establish a treatment relationship.
      - Establishing an in-person relationship is important, but the requirement for one prevents telehealth services from expanding access to those who may have barriers to care such as transportation or provider shortages. This capability has proven necessary for America's seniors during the ongoing PHE.

   B. Congress and CMS should consider telehealth expansions through a transparent process. Specifically, in the Medicare program, CMS should engage the provider and payer community through the annual rule making process in assessing:
      - which CPT codes are eligible for reimbursement;
      - which types of clinicians can bill for telemedicine, including whether certain behavioral health providers (such as drug and alcohol counselors and licensed professional counselors) should be permitted to treat Medicare patients; and
      - the therapeutic and economic differences between services when delivered on-site versus through telehealth (including audio-visual/telephone only modalities).

   C. To help control the costs of telehealth utilization in the commercial market, insurers should have the ability to maintain discretion over determining what clinically appropriate services (and corresponding codes) are eligible for coverage.

   D. Alleviate state licensure barriers that prohibit providers from furnishing telehealth services to patients across state lines by facilitating licensure recognition or reciprocity.
      - Each state's medical board regulates licensure required for healthcare professionals such as physicians and nurse practitioners within its state.
      - Physicians and nurse practitioners must be licensed in each state where they practice medicine, including telehealth. Licensure requirements should be changed to allow providers to deliver telehealth services to patients who need them, even if they reside in different states.

3. **For Medicare Advantage, CMS should permanently allow telehealth-obtained diagnoses to count toward risk adjustment.**
   - CMS should treat telehealth visits the same as in-person visits, providing flexibility to providers and members to do what is best for specific situations.
   - CMS should allow diagnoses from "telephone only" visits to count toward risk adjustment for services provided by licensed healthcare providers during the PHE.