To amend titles XI and XVIII of the Social Security Act to extend certain telehealth services covered by Medicare and to evaluate the impact of telehealth services on Medicare beneficiaries, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Ms. CORTEZ MASTO (for herself and Mr. YOUNG) introduced the following bill; which was read twice and referred to the Committee on

A BILL

To amend titles XI and XVIII of the Social Security Act to extend certain telehealth services covered by Medicare and to evaluate the impact of telehealth services on Medicare beneficiaries, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) In General.—This Act may be cited as the “Telehealth Extension and Evaluation Act”.

(b) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Extension of telehealth services.

Sec. 3. Temporary requirements for provision of high-cost durable medical equipment and laboratory tests.

Sec. 4. Requirement to submit NPI number for telehealth billing.

Sec. 5. Federally qualified health centers and rural health clinics.

Sec. 6. Telehealth flexibilities for critical access hospitals.

Sec. 7. Use of telehealth for the dispensing of controlled substances by means of the internet.

Sec. 8. Study on the effects of changes to telehealth under the Medicare and Medicaid programs during the COVID–19 emergency.

1 SEC. 2. EXTENSION OF TELEHEALTH SERVICES.

Section 1135(e) of the Social Security Act (42 U.S.C. 1320b–5(e)) is amended by adding at the end the following new paragraph:

“(3) TWO-YEAR EXTENSION OF TELEHEALTH SERVICES FOLLOWING THE COVID–19 EMERGENCY PERIOD.—Notwithstanding any other provision of this section, a waiver or modification of requirements pursuant to subsection (b)(8) shall terminate on the date that is 2 years after the last day of the emergency period described in subsection (g)(1)(B).”.

1 SEC. 3. TEMPORARY REQUIREMENTS FOR PROVISION OF HIGH-COST DURABLE MEDICAL EQUIPMENT AND LABORATORY TESTS.

(a) HIGH-COST DURABLE MEDICAL EQUIPMENT.—

Section 1834(a)(1)(E) of the Social Security Act (42 U.S.C. 1395m(a)(1)(E)) is amended by adding at the end the following new clauses:
“(vi) Standards for high-cost durable medical equipment.—

“(I) Limitation on payment for high-cost durable medical equipment.—During the 2-year period beginning on the day after the last day of the emergency period described in section 1135(g)(1)(B), payment may not be made under this subsection for high-cost durable medical equipment ordered by a physician or other practitioner described in clause (ii) via telehealth for an individual, unless such physician or practitioner furnished to such individual a service in person at least once during the 12-month period prior to ordering such high-cost durable medical equipment.

“(II) High-cost durable medical equipment defined.—For purposes of this clause, the term ‘high-cost durable medical equipment’ means, with respect to a year, durable medical equipment for which payment
may be made under paragraphs (2) through (8), the price under the clinical lab fee schedule which for such year is in the highest quartile of national purchase prices of durable medical equipment payable for such year.

“(vii) Audit of providers and practitioners furnishing a high volume of durable medical equipment via telehealth.—

“(I) Identification of providers.—During the 2-year period beginning on the day after the last day of the emergency period described in section 1135(g)(1)(B), Medicare administrative contractors shall conduct reviews, on a schedule determined by the Secretary, of claims for durable medical equipment prescribed by a physician or other practitioner described in clause (ii) during the 12-month period preceding such review to identify physicians or other practitioners with respect to whom at least 90 percent of all durable medical
equipment prescribed by such physician or practitioner during such period was prescribed pursuant to a telehealth visit.

“(II) Audit.—In the case of a physician or practitioner identified under subclause (I), with respect to a 12-month period described in such subclause, the Medicare administrative contractors shall conduct audits of all claims for durable medical equipment prescribed by such physicians or practitioners to determine whether such claims comply with the requirements for coverage under this title.”.

(b) High-cost Laboratory Tests.—Section 1834A(b) of the Social Security Act (42 U.S.C. 1395m–1) is amended by adding at the end the following new paragraphs:

“(6) Requirement for high-cost laboratory tests.—

“(A) Limitation on payment for high-cost laboratory tests.—During the 2-year period beginning on the day after the last day
of the emergency period described in section 1135(g)(1)(B), payment may not be made under this subsection for a high-cost laboratory test ordered by a physician or practitioner via telehealth for an individual, unless such physician or practitioner furnished to such individual a service in person at least once during the 12-month period prior to ordering such high-cost laboratory test.

“(B) High-cost laboratory test defined.—For purposes of this paragraph, the term ‘high-cost laboratory test’ means, with respect to a year, a laboratory test for which payment may be made under this section, and the purchase price of which for such year is in the highest quartile of purchase prices of laboratory tests for such year.

“(7) Audit of laboratory testing ordered pursuant to telehealth visit.—

“(A) Identification of providers.—During the 2-year period beginning on the day after the last day of the emergency period described in section 1135(g)(1)(B), Medicare administrative contractors shall conduct periodic reviews, on a schedule determined by the Sec-
retary, of claims for laboratory tests prescribed by a physician or practitioner during the 12-month period preceding such review to identify physicians or other practitioners with respect to whom at least 90 percent of all laboratory tests prescribed by such physician or practitioner during such period were prescribed pursuant to a telehealth visit.

“(B) AUDIT.—In the case of a physician or practitioner identified under subparagraph (A), with respect to a 12-month period described in such subparagraph, the Medicare administrative contractors shall conduct audits of all claims for laboratory tests prescribed by such physicians or practitioners during such period to determine whether such claims comply with the requirements for coverage under this title.”.

SEC. 4. REQUIREMENT TO SUBMIT NPI NUMBER FOR TELEHEALTH BILLING.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in the first sentence of paragraph (1), by striking “paragraph (8)” and inserting “paragraphs (8) and (9)”; and
(2) by adding at the end the following new paragraph:

“(9) REQUIREMENT TO SUBMIT NPI NUMBER FOR TELEHEALTH BILLING.—During the 2-year period beginning on the day after the last day of the emergency period described in section 1135(g)(1)(B), payment may not be made under this subsection for telehealth services furnished by a physician or practitioner unless such physician or practitioner submits a claim for payment under the national provider identification number assigned to such physician or practitioner.”.

SEC. 5. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

Section 1834(m)(8) of the Social Security Act (42 U.S.C. 1395m(m)(8)) is amended—

(1) in the paragraph heading by inserting “AND THE 2-YEAR PERIOD AFTER SUCH EMERGENCY PERIOD” after “PERIOD”;

(2) in subparagraph (A), in the matter preceding clause (i), by inserting “and the 2-year period immediately following such emergency period” after “1135(g)(1)(B)”; and

(3) by striking subparagraph (B) and inserting the following:
“(B) Payment.—

“(i) In general.—A telehealth service furnished by a Federally qualified health center or a rural health clinic to an individual pursuant to this paragraph on or after the date of the enactment of this subparagraph shall be deemed to be so furnished to such individual as an outpatient of such clinic or facility (as applicable) for purposes of paragraph (1) or (3), respectively, of section 1861(aa) and payable as a Federally qualified health center service or rural health clinic service (as applicable) under the prospective payment system established under section 1834(o) or under section 1833(a)(3), respectively.

“(ii) Treatment of costs for FQHC PPS calculations and RHC AIR calculations.—Costs associated with the delivery of telehealth services by a Federally qualified health center or rural health clinic serving as a distant site pursuant to this paragraph shall be considered allowable costs for purposes of the prospective payment system established under section
1834(o) and any payment methodologies developed under section 1833(a)(3), as applicable.”

SEC. 6. TELEHEALTH FLEXIBILITIES FOR CRITICAL ACCESS HOSPITALS.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by section 4, is amended—

(1) in the first sentence of paragraph (1), by striking “and (9)” and inserting “; (9) and (10)”;

(2) in paragraph (2)(A), by striking “paragraph (8)” and inserting “paragraphs (8) and (10)”;

(3) in paragraph (4)—

(A) in subparagraph (A), by striking “paragraph (8)” and inserting “paragraphs (8) and (10)”;

(B) in subparagraph (F)(i), by striking “paragraph (8)” and inserting “paragraphs (8) and (10)”;

(4) by adding at the end the following new paragraph:

“(10) TELEHEALTH FLEXIBILITIES FOR CRITICAL ACCESS HOSPITALS.—

“(A) IN GENERAL.—During the period beginning on the date of the enactment of this
paragraph and ending on the date that is 2 years after the end of the emergency period described in section 1135(g)(1)(B), the following shall apply:

"(i) The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a critical access hospital, including any practitioner authorized to provide such services within the facility, that is a qualified provider (as defined in subparagraph (B)) to an eligible telehealth individual enrolled under this part notwithstanding that the critical access hospital providing the telehealth service is not at the same location as the beneficiary, if such services complement a plan of care that includes in-person care at some point, as may be appropriate.

"(ii) The amount of payment to a critical access hospital that serves as a distant site for such a telehealth service shall be determined under subparagraph (B).

"(iii) for purposes of this subsection—

"“(I) the term ‘distant site’ includes a critical access hospital that
furnishes a telehealth service to an eligi-
gible telehealth individual;

“(II) the term ‘qualified provider’
means, with respect to a telehealth
service described in clause (i) that is
furnished to an eligible telehealth in-
dividual, a critical access hospital that
has an established patient relationship
with such individual as defined by the
State in which the individual is lo-
cated; and

“(III) the term ‘telehealth serv-
dices’ includes behavioral health serv-
dices and any other outpatient critical
access hospital service that is fur-
nished using telehealth to the extent
that payment codes corresponding to
services identified by the Secretary
under clause (i) or (ii) of paragraph
(4)(F) are listed on the corresponding
claim for such critical access hospital
service.

“(B) PAYMENT.—For purposes of sub-
paragraph (A)(ii), the amount of payment to a
critical access hospital that serves as a distant
site that furnishes a telehealth service to an eligi-
gible telehealth individual under this paragraph
shall be equal to 101 percent of the reasonable
costs of the hospital in providing such services,
unless the hospital makes an election under
paragraph (2) of section 1834(g) to be paid for
such services based on the methodology de-
scribed in such paragraph. Telehealth services
furnished by a critical access hospital shall be
counted for purposes of determining the pro-
vider productivity rate of the critical access hos-
pital for purposes of payment under such sec-
tion.

“(C) IMPLEMENTATION.—Notwithstanding
any other provision of law, the Secretary may
implement this paragraph through program in-
struction, interim final rule, or otherwise.”.

SEC. 7. USE OF TELEHEALTH FOR THE DISPENSING OF
CONTROLLED SUBSTANCES BY MEANS OF
THE INTERNET.

Section 309(e)(2) of the Controlled Substances Act
(21 U.S.C. 829(e)(2)) is amended—

(1) in subparagraph (A)(i)—
(A) by striking “at least 1 in-person medical evaluation” and inserting the following: “at least—

“(I) 1 in-person medical evaluation”; and

(B) by adding at the end the following:

“(II) during the period beginning on the date of the enactment of this subclause and ending on the date that is 2 years after the end of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), for purposes of prescribing a controlled substance in schedules II through V, 1 telehealth evaluation; or”; and

(2) by adding at the end the following:

“(D)(i) The term ‘telehealth evaluation’ means a medical evaluation that is conducted in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient using a telecommunications system referred to
in section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site practitioner.

“(ii) Nothing in clause (i) shall be construed to imply that 1 telehealth evaluation demonstrates that a prescription has been issued for a legitimate medical purpose within the usual course of professional practice.

“(iii) A practitioner who prescribes the drugs or combination of drugs that are covered under section 303(g)(2)(C) using the authority under subparagraph (A)(i)(II) of this paragraph shall adhere to nationally recognized evidence-based guidelines for the treatment of patients with opioid use disorders and a diversion control plan, as those terms are defined in section 8.2 of title 42, Code of Federal Regulations, as in effect on the date of enactment of this subparagraph.”.
SEC. 8. STUDY ON THE EFFECTS OF CHANGES TO TELE-HEALTH UNDER THE MEDICARE AND MED-ICAID PROGRAMS DURING THE COVID–19 EMERGENCY.

(a) In General.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study and submit to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an interim report on any changes made to the provision or availability of telehealth services under part A or B of title XVIII of the Social Security Act (including by reason of the amendments made to the Controlled Substances Act under section 7) since the start of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)). Such report shall include the following:

(1) A summary of utilization of all health care services furnished under such part A or B during such emergency period, including the number of telehealth visits (broken down by service type, the number of such visits furnished via audio-visual technology, the number of such visits furnished via audio-only technology, and the number of such visits
furnished by a Federally qualified health center, rural health clinic, or community health center, respectively, if practicable), in-person outpatient visits, inpatient admissions, and emergency department visits.

(2) A description of any changes in utilization patterns for the care settings described in paragraph (1) over the course of such emergency period compared to such patterns prior to such emergency period.

(3) An analysis of utilization of telehealth services under such part A or B during such emergency period, broken down by race and ethnicity, geographic region, and income level (as measured directly or indirectly, such as by patient’s zip code tabulation area median income as publicly reported by the United States Census Bureau), and of any trends in such utilization during such emergency period, so broken down. Such analysis may not include any personally identifiable information or protected health information.

(4) A description of expenditures and any savings under such part A or B attributable to use of such telehealth services during such emergency period.
(5) A description of any instances of fraud identified by the Secretary, acting through the Office of the Inspector General or other relevant agencies and departments, with respect to such telehealth services furnished under such part A or B during such emergency period and a comparison of the number of such instances with the number of instances of fraud so identified with respect to in-person services so furnished during such emergency period.

(6) A description of any privacy concerns with respect to the furnishing of such telehealth services (such as cybersecurity or ransomware concerns), including a description of any actions taken by the Secretary, acting through the Health Sector Cybersecurity Coordination Center or other relevant agencies and departments, during such emergency period to assist health care providers secure telecommunications systems.

(7) Identification of common ICD-10 codes billed via telehealth, comparing measures of quality and outcomes between telehealth care and in-person care for the same category of service.
Recommendations regarding the permanency of the waivers and authorities under the provisions of, and amendments made by, this Act.

(b) CONSULTATION.—In conducting the study and submitting the report under subsection (a), the Secretary—

(1) shall consult with—

(A) the Medicaid and CHIP Payment and Access Commission;

(B) the Medicare Payment Advisory Commission;

(C) the Office of Inspector General of the Department of Health and Human Services; and

(D) other stakeholders determined appropriate by the Secretary, such as patients, tribal communities, medical professionals, health facilities, State medical boards, State nursing boards, telehealth providers, health professional liability providers, public and private payers, and State leaders; and

(2) shall endeavor to include as many racially, ethnically, geographically, and professionally diverse perspectives as possible.
(c) Final Report.—Not later than 18 months after the end of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary shall—

(1) update and finalize the interim report under subsection (a); and

(2) submit such updated and finalized report to the committees specified in such subsection.

(d) Grants for Medicaid Reports.—

(1) In general.—Not later than January 1, 2023, the Secretary shall award grants to States with a State plan (or waiver of such plan) in effect under title XIX of the Social Security Act (42 U.S.C. 1396r) that submit an application under this subsection for purposes of enabling such States to study and submit reports to the Secretary on any changes made to the provision or availability of telehealth services under such plans (or such waivers) during such period.

(2) Eligibility.—To be eligible to receive a grant under paragraph (1), a State shall—

(A) provide benefits for telehealth services under the State plan (or waiver of such plan) in effect under title XIX of the Social Security Act (42 U.S.C. 1396r);
(B) be able to differentiate telehealth from in-person visits within claims data submitted under such plan (or such waiver) during such period; and

(C) submit to the Secretary an application at such time, in such manner, and containing such information (including the amount of the grant requested) as the Secretary may require.

(3) USE OF FUNDS.—A State shall use amounts received under a grant under this subsection to conduct a study and report findings regarding the effects of changes to telehealth services offered under the State plan (or waiver of such plan) of such State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during such period in accordance with paragraph (4).

(4) REPORTS.—

(A) INTERIM REPORT.—Not later 1 year after the date a State receives a grant under this subsection, the State shall submit to the Secretary an interim report that—

(i) details any changes made to the provision or availability of telehealth benefits (such as eligibility, coverage, or payment changes) under the State plan (or
waiver of such plan) of the State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during the emergency period described in paragraph (1); and

(ii) contains—

(I) a summary and description of the type described in paragraphs (1) and (2), respectively, of subsection (a); and

(II) to the extent practicable, an analysis of the type described in paragraph (3) of subsection (a),

except that any reference in such subsection to “such part A or B” shall, for purposes of subclauses (I) and (II), be treated as a reference to such State plan (or waiver).

(B) Final report.—Not later than 3 years after the date a State receives a grant under this subsection, the State shall update and finalize the interim report and submit such final report to the Secretary.

(C) Report by Secretary.—Not later than the earlier of the date that is 1 year after the submission of all final reports under sub-
paragraph (B) and December 31, 2027, the Secretary shall submit to Congress a report on the grant program, including a summary of the reports received from States under this paragraph.

(5) MODIFICATION AUTHORITY.—The Secretary may modify any deadline described in paragraph (4) or any information required to be included in a report made under this subsection to provide flexibility for States to modify the scope of the study and timeline for such reports.

(6) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical assistance as may be necessary to a State receiving a grant under this subsection in order to assist such State in conducting studies and submitting reports under this subsection.

(7) STATE.—For purposes of this subsection, the term “State” means each of the several States, the District of Columbia, and each territory of the United States.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) MEDICARE.—For the purpose of carrying out subsections (a) through (e), there are authorized
to be appropriated such sums as may be necessary for each of fiscal years 2022 through 2026.

(2) MEDICAID.—For the purpose of carrying out subsection (d), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2023 through 2027.