



COMMITTEE ON
WAYS & MEANS
REPUBLICANS

the **WAY FORWARD** *on* HEALTH CARE

EXPANDING TELEHEALTH TO MORE AMERICANS

What's the problem?

Health disparities experienced by some racial and ethnic minority groups in underserved communities are often very similar to health disparities experienced in rural populations [Obesity, hypertension](#), and diabetes are all major contributors to health disparities in these communities. Plus, racial and ethnic minorities in rural communities often experience a compounding effect resulting in the [poorest health outcomes](#).

Barriers to accessing care contribute to these disparities.

Here's how we'd fix it:

One way to improve access to care in these communities is continuing to expand and invest in telehealth. CMS has issued a bevy of temporary flexibilities and financial investments to make telehealth more accessible for patients across the country during the public health emergency. [Congress should build on this progress](#) and take steps to ensure these technologies are breaking through to the communities in dire need, both for the remainder of our COVID-19 response and into the future.

That's why Ways and Means Health Subcommittee Republican Leader Devin Nunes, together with the GOP members of the Committee, [released a discussion draft](#) to chart a new course in the delivery of health care.

Here's what the proposal includes:

Make permanent the removal of originating site and geographic restrictions and add the beneficiary's home as an originating site.

Traditionally, in order to receive a telehealth service in Medicare, a beneficiary must be in a rural area and must travel to a healthcare facility. By removing geographic and originating site restrictions, Medicare beneficiaries across the country will have the option of utilizing telehealth services from the convenience of their home.

Permanently allow reimbursement to FQHCs and RHCs for telehealth services.

Prior to the Public Health Emergency waivers, FQHCs and RHCs were restricted in their ability to provide telehealth services to Medicare beneficiaries. Permanently removing these restrictions is critical to improving access for patients in rural and underserved areas.



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Permanently include physical therapists, occupational therapists, and speech language pathologists as authorized practitioners of telehealth services and give the HHS Secretary authority to waive limitations on other types of clinical practitioners that can furnish Medicare telehealth services.

Before waiver expansions during the Public Health Emergency, the list of providers that were eligible to furnish telehealth was narrow, limiting opportunities for Medicare beneficiaries to access telehealth services. Breaking down these limitations on which practitioners can provide telehealth services in Medicare will provide new opportunities for patients.

Permanently allow for telehealth services to be provided by audio-only telephone, if the patient does not have the ability to use audio-visual technologies and if the patient already has an established relationship with the provider.

Not all Americans have access to Zoom or Facetime. The use of audio-only telehealth – like a landline telephone – during the Public Health Emergency has been critical for reaching many patients that otherwise might not be able to receive care. In rural and underserved areas, a lack of technological infrastructure can limit patients' video-conferencing capabilities. Additionally, digital literacy can also keep patients from accessing telehealth resources via videoconferencing. While more examination is needed to determine how to best incorporate audio-only telehealth, it is clear this option has a role to play moving forward.

Permanently allow coverage for telehealth services under the deductible for high deductible health plans with a health savings account.

Making this policy permanent will give patients easier access to this effective and convenient type of care, potentially lowering health care costs overall.



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Permanently allow the remote authorization of dialysis care through telehealth technologies instead of requiring an in-person visit (so long as patients receive mandatory in-person training for the first three months when starting home dialysis), and give the HHS Secretary the authority to waive other in-person visit requirements as long as the Secretary can certify safety.

The Public Health Emergency has demonstrated the ability to better integrate telehealth into a variety of home health settings. Moving forward, patients should have the choice to continue to use telehealth to receive care such as home dialysis. Additionally, the Secretary of HHS should have the ability to expand similar flexibilities to other cases, where clinically appropriate.

Ensure rigorous stewardship of taxpayer dollars in three ways: require OIG to conduct a survey of telehealth claims to study potential improper payments one year after the end of the Public Health Emergency; increase funding to the HHS Office of Audit Services and Office of Investigations to ensure they have the resources necessary to handle oversight of the increase in telehealth claims since the start of the public health emergency; and require CMS to offer education and training sessions to practitioners on Medicare telehealth requirements and related resources.

These provisions serve as a starting point towards ensuring that increasing patients' opportunity to utilize telehealth does not mean increasing our tolerance for waste, fraud, and abuse. Any steps Congress takes to expand telehealth must also include appropriate program integrity safeguards.

Together, these provisions serve as a way to launch a discussion as to how to best secure patients' access to care through technology and ensure that patients in rural and underserved areas are not left behind.