

NASMHPD Children Youth and Families Conference

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Stuart Yael Gordon, J.D., Senior Director of Policy and Communications

COVID-19 Brings Telehealth Flexibility

- ▶ [Commonwealth Fund study](#) reported October 15 that outpatient care for all clinical specialties fell nearly 60 percent in April, at the beginning of the COVID-19 pandemic lockdowns.
- ▶ Both Medicaid and Medicare rushed to fill the gaps in access through telehealth, authorizing flexibilities made possible under the [March 13 declaration of a nationwide Stafford Act Public Health Emergency](#) by President Trump and [a concurrent January 31 § 1135 waiver declaration](#) (retroactive to January 27) by the Secretary of Health and Human Services, Alex Azar.
- ▶ Since then outpatient visits have rebounded, returning in the past month to pre-pandemic levels for many specialties, but remaining 14 percent below March volume for behavioral health providers.
- ▶ While telehealth filled the gap initially, it hit a peak in April, and—Commonwealth Fund says—has slowly declined in the ensuing months.
- ▶ Nevertheless, the use of telehealth continues to be well above pre-pandemic levels.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ Over the two Medicare benefit years prior to 2020, the Centers for Medicare & Medicaid Services (CMS) had expanded the ability for clinicians to bill Medicare for “virtual check-ins” with patients through phone, video chat, and online patient portals. Medicare beneficiaries were able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screening
- ▶ Beginning on March 6, 2020, CMS announced it would temporarily pay all clinicians to provide telehealth services for beneficiaries, regardless of originating site. Clinicians were able to bill immediately for dates of services, at the same amount as for in-person services under the Medicare Physician Pay Schedule.
- ▶ Additionally, the HHS Office of Inspector General (OIG) provided flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by Federal healthcare programs.
- ▶ On March 13, President Trump issued an emergency declaration under the Stafford Act and the National Emergencies Act. Consistent with that emergency declaration, CMS was able to loosen existing restrictions under Medicare.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ A range of healthcare providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, were able to offer telehealth to Medicare beneficiaries in any healthcare facility including a physician's office, hospital, nursing home, or rural health clinic, as well as from their homes.
- ▶ In March 31 COVID-19 interim final regulations, CMS also permitted payment for audio-only telephone evaluation and management (E/M) services.
- ▶ At that time, CMS stated that, given its understanding that audio-only services were being furnished as substitutes for office/outpatient E/M services, it felt that they should be considered as telehealth services, and added them to the Medicare telehealth services list for the duration of the PHE.
- ▶ CMS also issued guidance calling for all insurance companies to expand and clarify their policies around telehealth.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ In its May 2020 interim final regulations in which CMS officially approved the use of telehealth during the PHE, CMS modified the process for adding or deleting services from the Medicare telehealth services list to allow for expedited consideration of additional telehealth services during the PHE, outside of the regular rulemaking process.
- ▶ CMS has added over 144 services to the Medicare telehealth services list, adding 11 new services to the Medicare telehealth services list on and effective October 14 and for the duration of the Public Health Emergency (PHE), presently scheduled to end on January 23, 2021.
 - The newly covered services include neuro-stimulator analysis.
- ▶ On August 3, , the Medicare program issued its [annual Physician Fee Schedule and Quality Payment Program regulations](#) for the coming benefit year, proposing to permanently add 9 HCPCS codes for reimbursement for telehealth services which it felt matched the flexibilities provided in during the Public Health Emergency and temporarily add other HCPCS codes for telehealth services through the end of the PHE while comments are collected on clinical benefit and harm to patients.
- ▶ It would not propose adoption under either category for audio-only telehealth services, insisting the agency lacks the legal authority to do so without a Congressional change to the law.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ Meanwhile, under the Medicaid program, on April 2, the head of Medicaid and CHIP Services issued an [Information Bulletin](#) to State Medicaid Agencies to discuss ways that telehealth services could be implemented.
- ▶ The Bulletin clarified:
 - States have broad flexibility in designing the parameters of telehealth delivery methods to furnish services so long as the underlying services are consistent with the overarching provisions in § 1905(a) of the Social Security Act and the state's plan and policy framework as a Medicaid benefit.
 - States that use Medicaid managed care plans to deliver services also can include telehealth delivery methods within their managed care contracts .
 - Generally, a State Plan Amendment (SPA) is not necessary to incorporate telehealth delivery methods if there are no changes to the § 1905(a) benefit descriptions, limitations, or payment methodologies.
 - However, a SPA is necessary when states add specific distinctions for coverage or use different reimbursement methodologies for services furnished through telehealth delivery methods.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ A CMS Fall 2019 review of laws and Medicaid policies in all 50 states and the District of Columbia had found that all Medicaid agencies in the states and the District had some form of reimbursement for services delivered by telehealth.
- ▶ The predominant form of telehealth reimbursed in all 50 states was live video, while 14 states reimbursed for store-and-forward.
- ▶ Additionally, 22 state Medicaid programs had some form of reimbursement for remote patient monitoring.
- ▶ 19 state Medicaid programs explicitly allowed the home and schools to serve as originating sites, although there were often additional geographic or specialty restrictions. The Informational Bulletin offered state examples:
 - **Idaho:** Idaho's Medicaid program had covered live video telehealth for mental health services since 2003, specifically pharmacological management counseling, psychiatric diagnostic interviews, psychiatric crisis interventions, and psychotherapy services. In addition, Idaho allowed for behavioral health services to be delivered via telehealth under a managed care contract. Effective 2008, Idaho had allowed for mental health services provided via telehealth to be provided by physicians in mental health clinics, as well as to other sites. Crisis intervention services were added as covered telehealth services in 2011.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ **Kentucky** : Kentucky Medicaid covered several classes of services provided via telehealth using live video: mental health evaluation and management services; individual psychotherapy; pharmacological management counseling; psychiatric, psychological, and mental health diagnostic interview examinations; and neurobehavioral status examination. Kentucky required that the Department of Health requirements for coverage and reimbursement of services be equivalent for in-person services and services delivered via telehealth, unless the telehealth provider and the Medicaid program agreed to a lower reimbursement rate for telehealth services, or the Kentucky Department of Health established a different reimbursement rate.
- ▶ **Georgia**: Georgia Medicaid covered office visits, pharmacological management, limited office psychiatric services, and a limited number of other physician fee schedule services delivered via live video conference. Georgia Medicaid also reimbursed for mental health services for residents in nursing homes via telehealth for dually eligible Medicaid and Medicare beneficiaries.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ At the request of the Substance Abuse and Mental Health Services Administration (SAMHSA), NASMHPD and the National Association of State Drug Alcohol and Drug Abuse Directors (NASADAD) asked State Agency Directors in June to provide feedback on the use of telehealth.
- ▶ State agencies in turn, solicited feedback from their providers. That feedback made the following points:
 - The use of telehealth and the use of audio-only phone calls to provider mental health and substance use services has proved overwhelmingly beneficial.
 - The use of telehealth and audio-only phone calls in providing services has proved particularly beneficial for:
 - Clients with transportation needs generally, and those fearful of the dangers of COVID-19 infection in traveling on public transportation;
 - Clients in rural areas lacking nearby providers who must normally travel significant distances for a face-to-face session;
 - Individuals with severe anxiety disorders or agoraphobia for whom travel in a vehicle or being in public places is extremely difficult;
 - Individuals who feel more comfortable sharing their feelings and thoughts via telehealth or telephone than in person. Said one respondent, “It is almost as they feel being on a screen protects them and makes them feel safer when discussing deeper rooted thoughts and experiences”;

COVID-19 Brings Telehealth Flexibility (cont'd)

- The use of telehealth and audio-only phone calls in providing services has also proved particularly beneficial for:
 - Individuals fearing COVID-19 infection during face-to-face encounters;
 - Individuals fearing stigma from seeking treatment for mental illness and substance use, who are now able to obtain that treatment in the privacy of their own homes;
 - Clients with disabling co-occurring conditions such as cardio-pulmonary disease that may otherwise negatively impact their ability to travel to treatment;
 - Children who, previous to the pandemic, received counseling in no-longer-available school-based counseling sessions but were able to continue their therapy at home through telehealth;
 - Clients in crisis, afraid to leave the home to seek help, fearing involvement with law enforcement; and
 - Individuals who contracted COVID-19 and were in quarantine.
- ▶ Missed (“no-show”) appointments and cancelled appointments dropped by a statistically significant percentage (estimated by respondents as 10 percent or more) after the telehealth flexibilities were enabled.
- ▶ In at least one state where winter weather continues into early spring and often forces cancelations of therapy sessions, the number of sessions canceled due to weather dropped.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ There had been an upward trend in the number of client sessions, due—at least in part—to increased clinician capacity/availability as a result of the elimination of client and provider transportation time.
 - One provider responded, “[t]he ability to work via telehealth has been positive. I have been able to save on my expenses due to not driving five days per week to the office (lunches out, drinks bought, etc. which tends to happen when you are out). The travel time in the morning and evenings have given me more time with my son which impacts my own mental well-being, as well as his. During this difficult time, I was able to find positives in the situation, including being able to complete tasks that had been on my to do list for a while. I hope that the continued use of telehealth services will have the ability to increase services provided and give people the ability to have more options when it comes to mental health and/or substance use services.”
- ▶ The number of family therapy sessions and family wraparound meetings increased due to the flexibility of telehealth (overcomes issues of transportation, getting everyone in a family together at one time, etc.).
- ▶ Individuals in socially isolating residential treatment were able to maintain contact with family members during the pandemic.
- ▶ For those clients remaining in the workforce during the pandemic, telehealth helped circumvent scheduling conflicts created by work schedules and childcare demands.
- ▶ Enhanced use of telehealth made forensic evaluation more efficient, by eliminating the travel time to evaluation sites. As a result, states were able to shorten the wait for evaluations.



COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ Telehealth reduced the rates of readmission to psychiatric hospitals because of the ready availability of treatment, keeping people from decompensating and landing in the emergency room, particularly in the midst of a pandemic likely to engender anxiety and depression.
- ▶ For providers of children's services, telehealth provides an opportunity to view and engage the client in his or her own environment, and in interactions with family members that might not otherwise be visible in a more public environment.
- ▶ Providers reported that therapy with elementary school children via telehealth proved to be more effective than the provider thought it would be, with clients able to make great strides in those sessions. Said one respondent, "The children were very happy to see their staff person face-to-face [after months of audio-only sessions by telephone]. It is very difficult to engage younger service users without technology. The smiles on their faces told the story. 'I am so happy to finally get to see you.'"
- ▶ Group therapy sessions have been facilitated, and have been better attended, due to the ability of therapists to hold telehealth group sessions during evening hours not previously convenient to the provider or the clients.
- ▶ Other services provided in a home environment, made possible by telehealth during the pandemic, included medication management, psychosocial assessment, and diagnostic evaluation.

COVID-19 Brings Telehealth Flexibility (cont'd)

- ▶ Telehealth allowed for more continuity of care. An inpatient- or outpatient-treating physician was more likely to follow their clients via telehealth given the flexible scheduling options.
- ▶ Telehealth facilitated patient privacy and built patient autonomy and self-confidence.
- ▶ While some respondents said that older clients found the telehealth technology challenging, not everyone found that to be so. One respondent stated that “The older population learning new technology to be able to participate in telehealth empowers them and gives them more motivation and confidence for continued change in all areas of their lives.”
- ▶ Telehealth helped to alleviate the impact of provider shortages and resulting wait times.
- ▶ In at least one state with a Medicaid wait list for specified types of behavioral health services, telehealth made it possible to serve those individuals on the wait list.
- ▶ Effective evidence-based tools have been used with telehealth with very positive outcomes. This includes an increase in the use of Assertive Community Treatment (ACT) in at least two states; one state reported a 50 percent increase in the use of ACT.

COVID-19 Brings Telehealth Flexibility (cont'd)

Audio-Phone Based Services

- ▶ Phone-based services proved critical as an alternative for clients that either did not have access to video technology or may be wary of video and simply prefer phone (e.g., clients with body-image concerns, clients who feel video is more risky from a privacy perspective, etc.) or find it easier to open up via phone than in a face-to-face session.
 - Said one provider respondent: “While I appreciate the value of seeing a client in session, I cannot dismiss the importance of being able to provide phone sessions to consumers that have poor internet quality or limited data.”
- ▶ Phone-based services also have been instrumental in engaging an older population that may not use the internet/video technology.
 - One State Commissioner phrased it, “The ability to provide telephonic services or audio-only telehealth is the cherry on top.”

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule (cont'd)

- ▶ The August 3 Physician Pay Schedule proposed regulations suggested adding the following behavioral health-related services as delivered by telehealth, on a permanent basis:
 - **GPCIX:** Visit complexity inherent to evaluation and management (E/M) associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)
 - **90853:** Group psychotherapy (other than of a multiple-family group)
 - **96121:** Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
 - **99XXX:** Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)
 - **99334 & 99335:** Domiciliary or rest home E/M visits, 15 & 25 minutes respectively.
 - **99347 & 99348:** E/M home visits, , 15 & 25 minutes respectively.

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule (cont'd)

- ▶ The proposed Physician Payment regulations also suggested adding the following behavioral health-related services as delivered by telehealth, on a permanent basis:
 - **99483:** Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule (cont'd)

- ▶ The proposed regulations proposed allowing the following services to be provided by telehealth temporarily, until the end of the PHE, while comments are collected on potential clinical benefit and harm to patients would include:
 - **96130:** Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
 - **96131:** Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).
 - **96132:** Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
 - **96133:** Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule (cont'd)

- ▶ During the Public Health Emergency, CMS implemented several policies on an interim final basis related to payment for the services of teaching physicians involving residents. Under the proposed regulations, CMS is considering whether these policies should be extended on a temporary basis (that is, until January 23, 2021, to allow for a transition period before reverting to status quo) or be made permanent, and is soliciting public comments on whether these policies should continue once the PHE ends.
 - In general, under 42 CFR § 415.170, payment is made under the PFS for services furnished in a teaching hospital setting if the services are personally furnished by a physician who is not a resident, or the services are furnished by a resident in the presence of a teaching physician, with specified exceptions. Under § 415.172, if a resident participates in a service furnished in a teaching setting, PFS payment is made only if the teaching physician is present during the key portion of any service or procedure for which payment is sought.
 - Under § 415.184, PFS payment is made for psychiatric services furnished under an approved graduate medical education (GME) program if the requirements of §§ 415.170 and 415.172 are met, except that the requirement for the presence of the teaching physician during psychiatric services in which a resident is involved may be met by observation of the service by use of a one-way mirror, video equipment, or similar device.
 - Under § 415.184, the requirement for the presence of the teaching physician during the psychiatric service in which a resident is involved may be met by the teaching physician's direct supervision using audio/video real-time communications technology.
 - If extended or made permanent, audio only supervision would still not be reimbursed.

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule (cont'd)

- ▶ CMS also released on October 14 a new supplement to its [State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version](#), providing new examples learned from states that have implemented telehealth changes. CMS says the [updated supplemental information](#) is intended to help states think through how to explain and clarify to providers and other stakeholders which policies are temporary or permanent.
- ▶ The toolkit is intended to help states identify services that can be accessed through telehealth, which providers may deliver those services, the ways providers may use in order to deliver services through telehealth, as well when telehealth can be reimbursed once the PHE expires includes approaches and tools states can use to communicate with providers on utilizing telehealth for patient care. It updates and consolidates in one place the Frequently Asked Questions (FAQs) and resources for states to consider as they begin planning beyond the temporary flexibilities provided in response to the pandemic.

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule (cont'd)

- ▶ CMS also noted in its October 14 announcement that it had previously released a preliminary [Medicaid and CHIP data snapshot](#) on telehealth utilization during the PHE.
 - The snapshot reveals that there were more than 34.5 million services delivered via telehealth to Medicaid and CHIP beneficiaries between March and June 2020, representing an increase of more than 2,600 percent over the same period from the prior year.
 - The data also shows that adults ages 19 to 64 received the most services delivered via telehealth, although there was substantial variance across both age groups and states.
 - Between mid-March and mid-August 2020, over 12.1 million Medicare beneficiaries – over 36 percent – of people with Medicare Fee-For-Service have received a telemedicine service.
- ▶ **NOTE:** Commonwealth Fund report issued October 14 says that telehealth services hit their peak in April but gradually declined in the months following.

Telehealth Flexibility Regulations in Medicare Physician Fee Schedule: Audio Only Telehealth Remains in the Air

- ▶ CMS recognizes that the need for audio-only interaction could remain as beneficiaries continue to try to avoid sources of potential infection, such as a doctor's office and, in that circumstance, a longer phone conversation may be needed to determine if an in-person visit is necessary.
- ▶ In its proposed Physician Fee Schedule regulations, CMS is not proposing to continue to recognize those codes for payment for audio only visits after conclusion of the PHE because, outside of the circumstances of the PHE, it says it is not able to waive the statutory requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology.
- ▶ But does the law require a legislative fix by Congress?

Audio Only Telehealth Remains in the Air (cont'd)

- Here's the statutory definition of telehealth Services under 42 USC 1395m(m)(4)(F):
 - (F) Telehealth service.—
 - (i) In general.—The term “telehealth service” means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.
 - (ii) Yearly update.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).
- Because the codes were initially frozen in time, it could be arguably necessary to amend the statute to eliminate the date on which they are frozen and substitute new codes effective either January 1, 2020 or on the effective date of any legislation. On the other hand, the Secretary has the authority to modify or delete codes, which implies the regulatory authority to make a change that may not otherwise have been allowed in the year 2000.

Audio Only Telehealth Remains in the Air (cont'd)

- ▶ The second sentence of 42 USC 1395m(m)(1) provides:
 - For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term “telecommunications system” includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.
 - CMS is interpreting this as an exception to the general rule, implying that any other service outside a Hawaii or Alaska demonstration program must be synchronous, involving both video and audio signals.
 - However, general canons of statutory construction would not bear this interpretation absent explicit statutory language.
- ▶ Both the Mental Health Liaison Group and NASMHPD filed comments recommending that audio-only telehealth be permanently adopted.

Audio Only Telehealth Remains in the Air (cont'd)

▶ NASMHPD' s letter stated:

- NASMHPD and its members very much appreciate the telehealth flexibilities authorized by the Centers for Medicare and Medicaid Services (CMS) during the COVID-19-related public health emergency, all of which, including the audio-only flexibilities, have proven highly successful in ensuring continued access to mental health and substance use disorder treatment services during the pandemic . We therefore applaud CMS proposing to authorize, in the proposed regulations, adoption of a number of those flexibilities, either permanently, or on a temporary basis with opportunity for public comment on the potential benefit and potential harm of permanent adoption. ...
- Audio-only telehealth was reported by survey participants to be particularly critical as an alternative for clients that either did not have access to video technology or may have been wary of video and simply preferred phone (e.g., clients with body-image concerns, clients who felt video is more risky from a privacy perspective, etc.) or found it easier to “open up” in audio-only sessions than in face-to-face sessions. Phone-based audio-only services proved particularly instrumental in engaging seniors who may not have been using or felt themselves as ready to use with comfort internet/video technology.
- It is for that reason that we are particularly disappointed to hear that CMS does not feel it has the statutory authority to permanently authorize the use of audio-only telehealth. We understand that the agency believes that the language of 42 U.S.C § 1395m(m)(1) has the effect of occupying the field for asynchronous (audio only) communications, thereby precluding other jurisdictions from being granted similar authority in the absence of similar statutory language.

Audio Only Telehealth Remains in the Air (cont'd)

▶ NASMHPD' s letter went on to state:

- We do not agree with the CMS interpretation. There is no reason to assume that Congress, in granting specific authority to those two jurisdictions to undertake a particular type of telehealth communications, intended to exclude by implication the granting of the same or even similar authority to all other jurisdictions. Congress may have simply chosen at the time not to grant authority to other jurisdictions because the issue was not before them, i.e. no other jurisdiction requested audio-only telehealth authority at that particular time. If one recognizes that the language in question is clearly an affirmative grant of authority to two specific jurisdictions, rather than inferring from language not present that Congress intended the language to be treated as an exception or exemption to a general rule, then the canon of statutory authority recognized by the Supreme Court in *Chicago v. Environmental Defense Fund*, 511 U.S. 328114 S. Ct. 1588 (1994), would apply: There is a presumption against creating exemptions in a statute that otherwise has none.
- In addition, we would note that the definition of “telehealth” in subparagraph (m)(4)(F) of the same section states “The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1)” —a clear grant of authority to the Secretary of Health and Human Services to expand the definition of “telehealth services” without the need for Congressional action when he or she deems it appropriate each year.
- Given the broadly recognized public good that would result from permanent authorization for audio-only telehealth services under Medicare and the lack of any reported recognizable harm that could conceivably result from its use, NASMHPD urges CMS to adopt by regulation permanent authority to use audio-only telehealth within the Medicare program