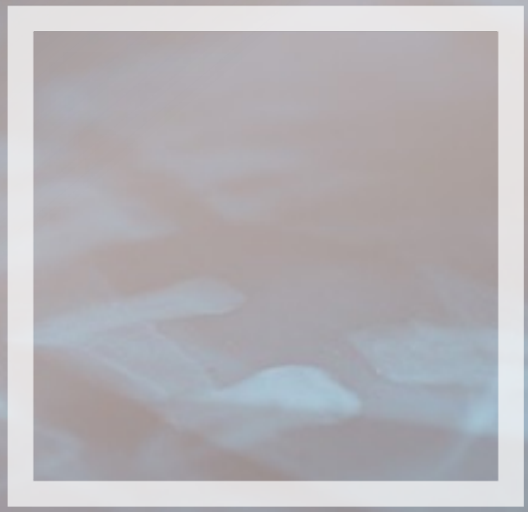
Telehealth 2022 Update: How COVID-19 Has Changed Telemedicine

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AGENDA

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- Historical Telehealth Landscape
- Actions Enabling Telehealth
- The Changing Telehealth Landscape
- Telehealth Now
- Future of Digital Health Policy
- Q & A



Source: South Central Telehealth Resource Center



Historical Telehealth Landscape

Telehealth and Medicare – Before the COVID-19 PHE

- **Geographic -** Patient had to be located in a qualifying rural area
- **Location -** Patient at one of eight qualifying facilities ("originating site"), (i.e., the offices of physicians or practitioners; Hospitals; Critical Access Hospitals; Rural Health Clinics; Federally Qualified Health Centers; Hospital-based or CAH-based Renal Dialysis Centers (including satellites); Skilled Nursing Facilities; and Community Mental Health Centers);
- **Provider -** Service provided by one of ten eligible professionals eligible to furnish and receive Medicare payments for telehealth services ("distant site practitioner")

Social Security Act of 1835(m) or 42 USC 1395m

Telehealth and Medicare – Before the COVID-19 PHE

- **Modality -** The beneficiary and distant site practitioner communicate via an interactive audio and video telecommunications system that permits real-time communication between them (store and forward is covered in Alaska and Hawaii under demonstration programs);
- **Service -** The service is among the list of CPT/HCPCS codes covered by Medicare

Social Security Act of 1835(m) or 42 USC 1395m

Telehealth and Medicare – Before the COVID-19 PHE

In order to bill Medicare for telehealth services, the distant site practitioner must fully comply with each of these requirements.

If the service does not meet each requirement, the Medicare program will not pay for the service.



Actions the Enabled Telehealth to Blossom

Public Health Emergency

- U.S. Department of Health and Human Services (HHS) Secretary Alex Azar declared a public health emergency (PHE) on January 27, 2020.
- On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency.

Public Health Emergency

When the President of the United States declares a major disaster under the Stafford Act or an emergency under the National Emergencies Act and the HHS Secretary declares a PHE under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his or her regular authorities under section 1135 of the Social Security Act (SSA).

1135 Waivers

Under section 1135 of the SSA, the Secretary may waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in SSA programs.

Bills

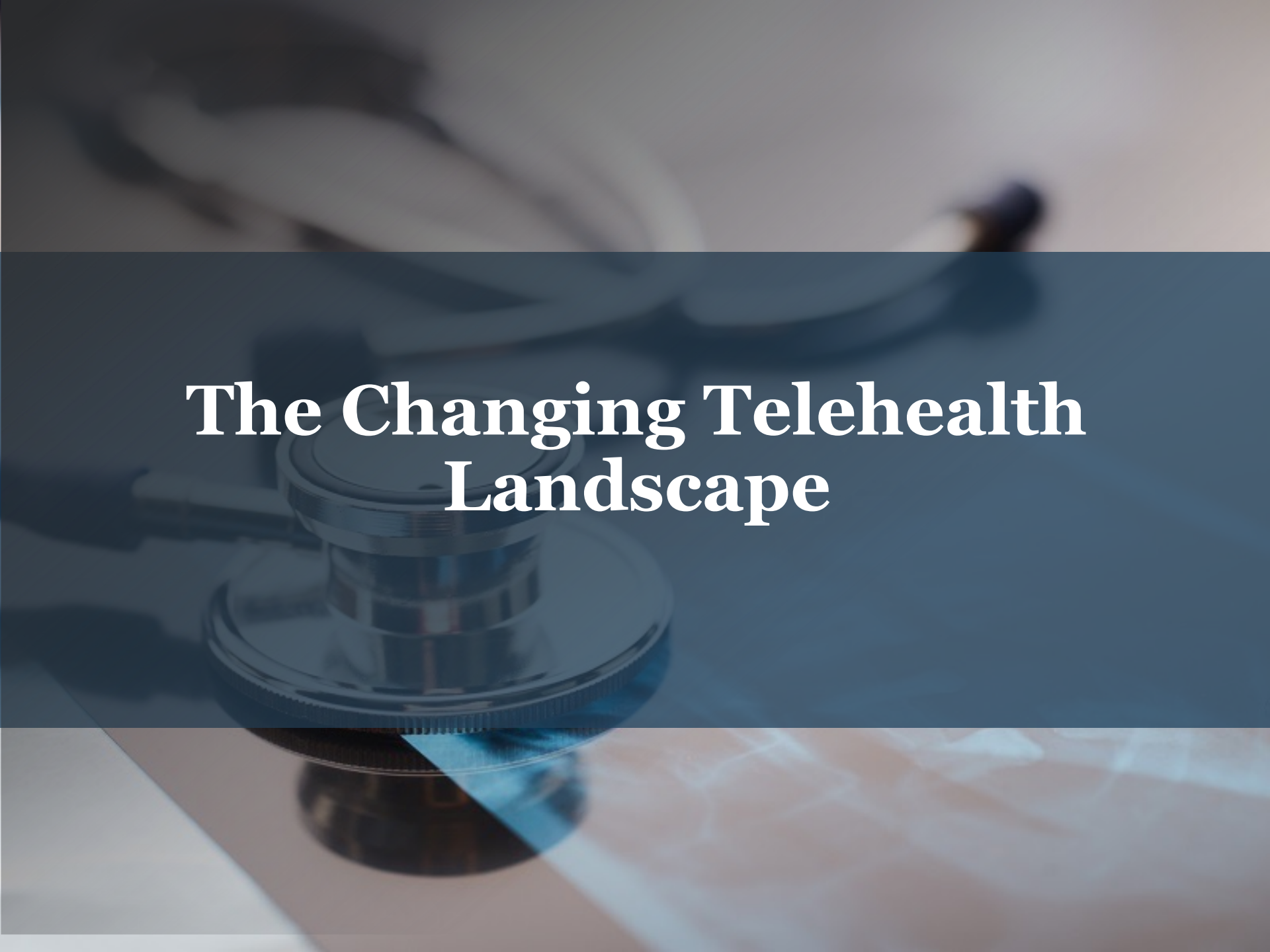
- In addition to the 1135 waivers, Congress passed and the president signed several bills that provide varying degrees of regulatory and financial relief for healthcare providers during the COVID-19 PHE.
- These bills have triggered a cascade of actions from CMS designed to increase flexibilities for providers and ***increase access to and use of telehealth services***.

COVID-19 Telehealth Coverage Expansion

- **Section 1135 Waiver**
  - Coronavirus Preparedness and Response Supplemental Appropriations Act expanded Secretary's authority to waive *geographic* and *location restrictions* for duration of COVID-19 PHE
- **CMS Interim Final Rules**
  - Suspended certain service restrictions for duration of COVID-19 PHE
    - Expanded list of covered services. Medicare added over one hundred CPT and HCPCS codes to the telehealth services list.
    - Eliminated frequency requirements
    - Permitted use of telehealth for required face-to-face visits, direct supervision for incident-to billing, teaching physician virtual presence
    - Telehealth visits billed to Medicare are paid at the same FFS rate as an in-person visit

COVID-19 Telehealth Coverage Expansion

- **CMS Interim Final Rules Cont.**
  - Suspends certain provider restrictions for duration of COVID-19 PHE
    - Permits therapists and S/L pathologists to provide covered services via telehealth
    - Waives state licensure requirement (although state requirements continue to apply)
  - Authorizes payment for certain audio-only E/M services



The Changing Telehealth Landscape

COVID-19 Telehealth Changes

- **Location:** No geographic restrictions for patients or providers.
- **Eligible providers:** All health care providers who are eligible to bill Medicare can bill for telehealth services, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- **Eligible services:** Over 100+ new codes added to list of Medicare telehealth services.

COVID-19 Telehealth Changes

Licensing: Subject to state licensure rules, providers can furnish services outside their state of enrollment.

Modality: Some telehealth services only require telephone.

Supervision: Direct supervision under 42 C.F.R. § 410.21 can be provided using real-time, interactive audio-video technology.

Teaching: Teaching physician present via telehealth for telehealth services furnished at residency training site outside MSA.

Cost-Sharing

Cost-sharing: Providers can reduce or waive patient cost-sharing (copayments and deductibles) for telehealth visits.

Pre-COVID-19, providers who reduce or waive costs owed by federal healthcare program beneficiaries, including cost-sharing amounts such as coinsurance and deductibles could trigger AKS, CMP and exclusion laws related to kickbacks, and the CMP prohibition on inducements to beneficiaries.

HHS Office of Inspector General announced flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

See HHS OIG Guidance, March 17, 2020.

Frequency Limitations

- **Frequency:** Subsequent SNF visits limited to once every 14 days (down from 30); inpatient and critical care remain once every 3 days.
- Pre-COVID-19, the frequency of telehealth services was limited for certain Medicare services.
- Certain services no longer have limitations on the number of times they can be
- provided by Medicare telehealth:
  - A subsequent inpatient visit can be furnished via Medicare telehealth, with no frequency limits.
  - A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, with no frequency limits.
  - Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once-per-day limitation.

Medicare: Modalities

- Pre-COVID-19, Medicare required use of an interactive audio and video telecommunications system, and telephones were excluded.
- Providers are allowed to use audio-visual functionality on mobile phones. *See* Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; CMS IFR.
- CMS will allow reimbursement for certain audio-only E/M telephone codes to new *and* established Medicare patients.
- Opioid treatment programs may also conduct therapy and counseling sessions through audio-only telephone calls.



OCR will not penalize providers for using potentially non-HIPAA-compliant tools or for good faith use and disclosures of PHI

Pre-COVID-19, telemedicine services had to be provided via HIPAA compliant platform.

The HHS Office for Civil Rights (OCR), the department responsible for enforcing certain regulations issued under HIPAA, will exercise enforcement discretion allowing the good faith use of popular video-chat applications, including FaceTime, Zoom and Skype.

- *See OCR Guidance*, March 17, 2020.

Controlled Substance Prescribing

A prescription for a controlled substance issued via telemedicine required a prior in-person exam. However, under the CSA, DEA has the authority to waive certain requirements during a PHE. 12 U.S.C. 829(e).

US Drug Enforcement Administration-registered practitioners may issue prescriptions for schedule II-V controlled substances to patients for whom they have not conducted an in-person physical examination, provided that:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his professional practice.
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable federal and state laws. 42 U.S.C. 247d.

Note: Practitioners must continue to comply with state laws and regulations, many of which have also changed during the emergency.

Other Federal Agency Waivers

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No administrative sanctions for reducing or waiving cost-sharing obligations for telehealth services

Confirmed PHE exception for telemedicine prescribing of controlled substances

OCR will not penalize providers for using potentially non-HIPAA-compliant tools or for good faith use and disclosures of PHI

Medicare FFS Telehealth Waivers

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Location

- Removal of Geographic & Facility Requirements

Modality

- Smartphones
- Audio-only allowed

Reimbursement

- Will pay facility fee for telehealth services furnished at home at same rate as in person
- Report POS codes that would have been reported in person
- Modifier 95 applied to claims furnished via telehealth

New CPT Codes

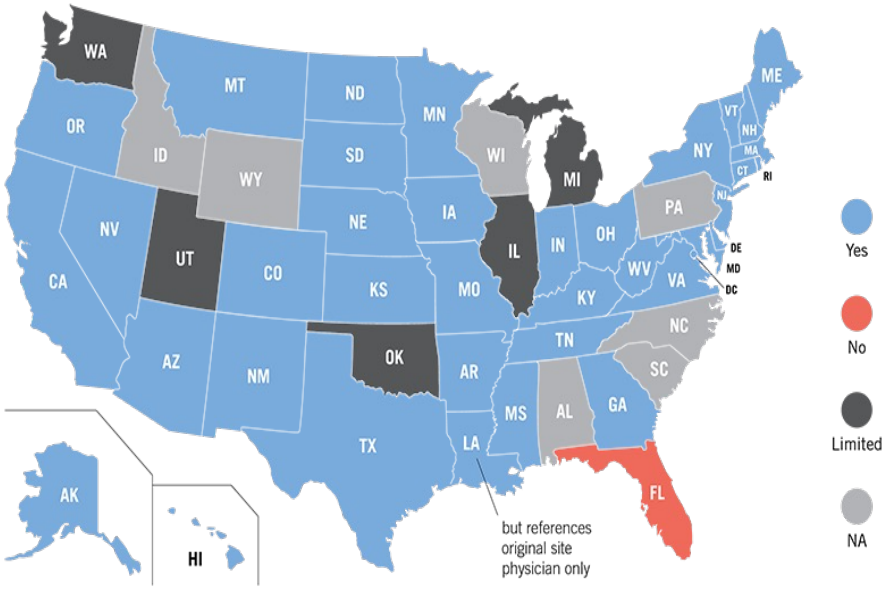
- Added over 100 new CPT and HCPCS codes for telehealth services

Other

- Expanded types of professionals who can provide telehealth services
- Waived in-state licensure requirement (but state requirements still apply)
- Direct Supervision can be provided through real-time audio-video

Commercial Health Insurance

- Many commercial health plans broadened coverage for telehealth services in response to COVID-19, either voluntarily or per state law/executive order.
- As of 2021, **43 states** and D.C. maintain some sort of state telehealth commercial payer law. (These are permanent laws, not COVID temporary laws)
- As of 2021**, 22 states** maintain laws expressly addressing reimbursement of telehealth services (an increase from 16 states in 2019).
  - Of these, 14 offer true "payment parity" (an increase from 10 in 2019)
  - Arkansas, California, Delaware, Georgia, Hawaii, Kentucky, Minnesota, Missouri, New Mexico, Texas, Utah, Vermont, Virginia, and Washington.



Resource
https://www.foley.com/en/insights/publications/2021/02/50-state-telehealth-commercial-insurance-laws



Telehealth Now

Extension of Telehealth Flexibilities

- On March 15, 2022, the President signed into law the Consolidated Appropriations Act, 2022 (The Act).
- The Act extends certain telehealth flexibilities for Medicare patients for 151 days after the official end of the federal public health emergency (PHE).
- Medicare Payment Advisory Commission (MedPAC) and the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS) must report on how well the telehealth flexibilities are working, and if more guardrails are needed for fraud and abuse. The long-term cost impact of telehealth to the Medicare program must be assessed.
  - Reports due June 2023.

Extension of Telehealth Flexibilities

- How the Act will impact telehealth:
  - Medicare will pay for telehealth provided at home.
  - Continued expansion of telehealth practitioners, i.e., qualified occupational therapists, physical therapists, speech language pathologists, and audiologists.
  - Payment for audio-only telehealth continues
  - Delayed in-person requirement for mental health services
    - In December 2020, Congress created an in-person exam requirement alongside coverage of telemental health services at a patient's home that was intended to go into effect when the PHE ends.
    - The law included a **requirement for an in-person visit** within six months of the first telehealth service and subsequent in-person visits every 12 months thereafter. Now, this in-person requirement for mental health services furnished through telehealth is delayed until the 152nd day after the PHE sunsets.

Extension of Telehealth Flexibilities

- Extension for FQHCs and RHCs flexibilities that allowed these entities to serve as distant sites (location of the practitioner) in addition to being an originating site (the location of the patient).
- Extension of first dollar coverage for telehealth under HDHP/HSA Plans
  - During the COVID-19 PHE, Congress issued **temporary relief for telehealth and High Deductible Health Plans** (HDHP) and health savings accounts (HSA), allowing coverage for telehealth services without plan members incurring costs even before plan members' deductibles are met (i.e., first-dollar coverage).



Post-COVID Digital Health Policy

Telehealth Extension and Evaluation Act

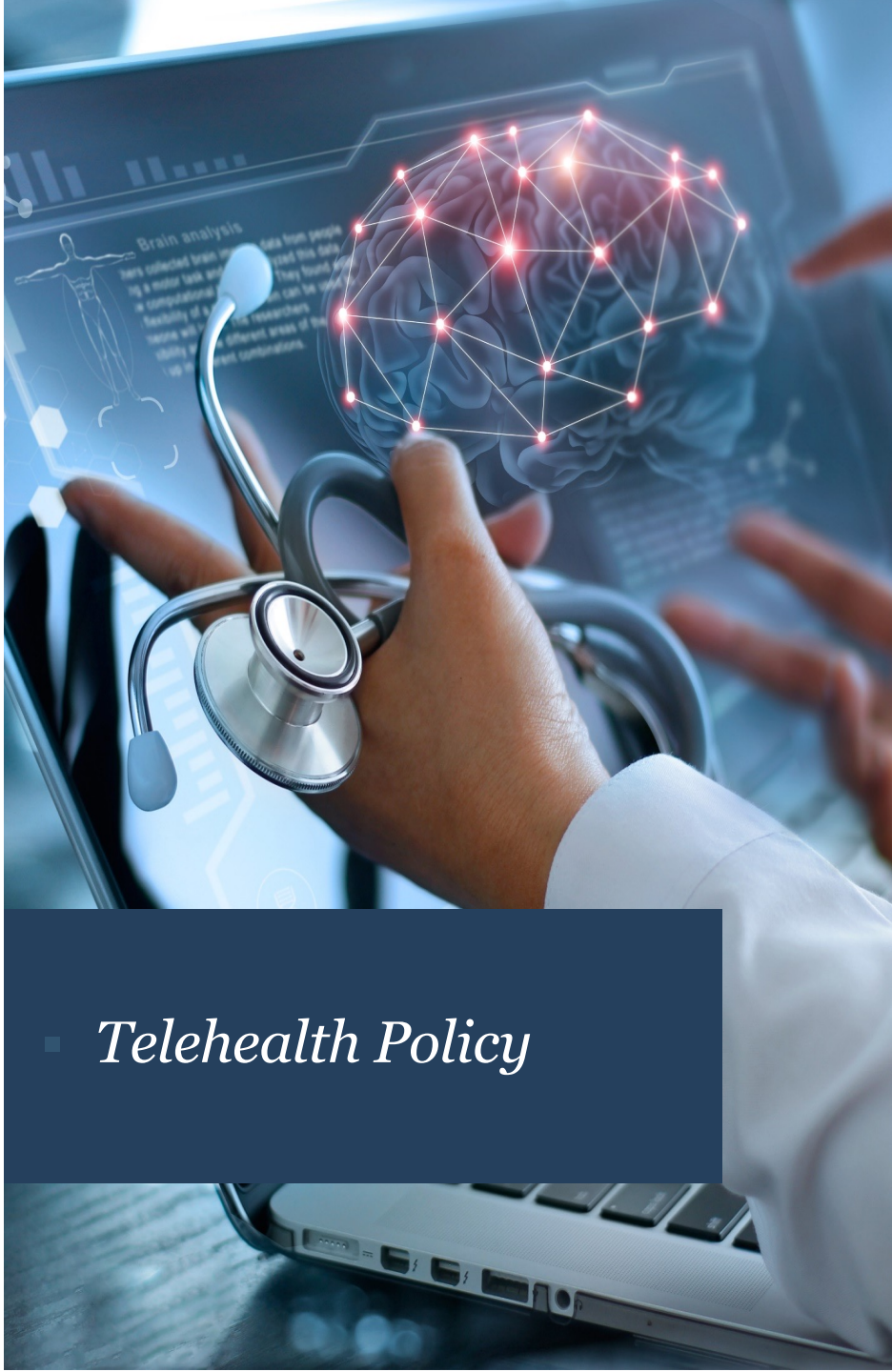
- Introduced on February 7, 2022 and currently under consideration, the Telehealth Extension and Evaluation Act proposes a two-year extension of certain COVID-19 telehealth flexibilities:
- extend the waivers of the geographic and site restrictions and allow Medicare beneficiaries to access telehealth even when at home;
- allow controlled substances to be prescribed via an initial telehealth encounter under the Ryan Haight Act; and . . .

Telehealth Extension and Evaluation Act

- Extends Medicare payment flexibilities for Rural Health Centers (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs).
  - In March 2020, through its "Hospitals without Walls" program, CMS began allowing hospitals to provide services outside their hospital buildings for the duration of the public health emergency.
- To address Medicare program integrity concerns, the bill also introduces in-person restrictions on telehealth orders for certain high-cost durable medical equipment (DME) and laboratory tests.

Expansion of Telehealth

- State Law Changes
- 2023 Proposed Physician Fee Schedule
- Legislative Fixes
- Stake Holder Efforts



- *Telehealth Policy*

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