TELEHEALTH POLICY UPDATE

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TOPICS

- Refresher on PHE authority
- What does the data show
- PHE flexibilities – what remains and what has ended
- CMS and Congressional action

REFRESHER ON PHE AUTHORITIES

HISTORY OF THE COVID-19 PHE

- The COVID-19 public health emergency (PHE) was originally declared on January 27, 2020, by former Secretary of HHS Alex Azar
  - By law, it is limited to 90-day increments and needs to be renewed
- The COVID-19 PHE ended on May 11, 2023.

WHAT DOES A PHE DO

- Invoking a PHE allows the Secretary to, among other things:
  - Access and shift Federal funding
  - Waive or modify certain requirements under Federal health programs (Medicare, Medicaid, CHIP, HIPAA), including conditions of participation and licensing requirements
  - Make temporary appointments
  - Waive certain DEA requirements around telemedicine
  - Limit certain medical professional liability laws
  - Provide low or no cost coverage for testing, treatment, and vaccines
- It does not allow the Secretary to waive most telehealth requirements

TELEHEALTH AND THE COVID-19 PHE

- Congress recognized the limitation of existing telehealth law and the need to leverage telehealth services during the PHE
- In addition to the PHE declaration, Congress stepped in via legislation to provide the Secretary additional authority to waive certain requirements around telehealth
  - The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (the first stimulus bill) gave the Secretary authority to waive two specific requirements for telehealth services under 1834(m): the “originating site” requirements and restrictions on the type of telecommunication used for providing telehealth services.
  - The CARES Act subsequently expanded the telehealth waiver authority to include all provisions in 1834(m).

TELEHEALTH AND THE COVID-19 PHE

- The combination of the authority under the PHE and the authority provided via the CARES Act led to a dramatic increase in access and utilization of telehealth and virtual care
- Hundreds of waivers and flexibilities were issued
- Innovations in virtual care – app-based; at-home; remote patient monitoring, etc.
- Renewed effort in Congress to reform existing telehealth laws
- Point of no return on telehealth

WHICH PHE FLEXIBILITIES REMAINED IN PLACE POST-PHE AND FOR HOW LONG

TELEHEALTH AND THE END COVID-19 PHE

- Congress recognized the end of the PHE was imminent and provided extension of certain telehealth flexibilities through December 31, 2024, via the Consolidation Appropriations Act, 2023 (CAA)
- CMS has made temporary regulatory changes through the annual Medicare Physician Fee Schedule (MPFS)
- CMS has made temporary payment and coding changes through subregulatory guidance and notification

TELEHEALTH FLEXIBILITIES ADDRESSED IN CONSOLIDATED APPROPRIATIONS ACT, 2023 (CAA)

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: QUALIFYING PROVIDERS

Pre-PHE Policy

Medicare limits the types of healthcare providers eligible to provide telehealth services from a distant site to the following:

- Physicians; Nurse practitioners; Physician assistants; Nurse-midwives; Clinical nurse specialists; Certified registered nurse anesthetists; Clinical psychologists (CPs) and clinical social workers (CSWs); Registered dietitians and nutrition professionals.

Policy During the PHE

CMS expanded the types of healthcare professionals that can furnish distant site telehealth services to include all providers that are eligible to bill Medicare for their professional services. The expanded list of healthcare providers includes the following (in addition to the providers listed in the left column):

- Physical therapists; Occupational therapists; Speech language pathologists.

CAA 2023 Provision

Section 4113(b) of the 2023 CAA extends the expanded list of qualifying telehealth providers through December 31, 2024.

[Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or be reimbursed for CPT codes 90792, 90833, 90836 and 90838.]

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: ORIGINATING SITE AND GEOGRAPHIC LOCATION

Pre-PHE Policy

Medicare requires that a beneficiary receive telehealth services at a designated healthcare facility or rural site (originating site) in certain geographic locations.

Policy During the PHE

The originating site requirement is waived. Patients can be anywhere, including their home.

CAA 2023 Provision

Section 4113(a) of the 2023 CAA extends the waiver of the originating site and geographic location requirements through December 31, 2024.

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: MENTAL TELEHEALTH SERVICES: IN-PERSON REQUIREMENT

Pre-PHE Policy

Before the PHE, telehealth treatment for substance abuse disorders (and co-occurring mental health disorders) was already exempted from the Medicare originating site and geographic restrictions.

Telemental health treatment for other conditions, such as anxiety and depression, were not exempt from these restrictions.

Policy During the PHE

In the Consolidated Appropriations Act, 2021 (2021 CAA), Congress removed geographic restrictions and added a Medicare beneficiary's home as a permissible originating site for the diagnosis, evaluation and treatment of a mental health disorder. Medicare beneficiaries can access telemental services from home for mental health needs in addition to substance use (and co-occurring mental health) disorders.

However, Congress also imposed an in-person requirement for these flexibilities: the beneficiary must have an in-person visit with her healthcare provider within the six months prior to the telemental treatment. Congress and CMS have stepped in to delay these requirements throughout the PHE.

CAA 2023 Provision

Section 4113(d) of the 2023 CAA delays implementation of the in-person visit requirement through December 31, 2024, meaning that beneficiaries can continue to access telemental services from home until January 1, 2025, without needing to have an in-person visit with their provider before beginning treatment.

In the CY 2024 PFS final rule, CMS aligned the delay of its additional in-person requirements with the 2023 CAA provisions.

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: AUDIO-ONLY TELEHEALTH SERVICES

Pre-PHE Policy

Medicare typically does not cover certain services provided via telephone (audio-only).

Policy During the PHE

CMS allows reimbursement for certain audio-only evaluation and management (E/M) telephone codes for new and established Medicare patients.

Opioid treatment programs may also conduct therapy and counseling sessions through audio-only telephone calls.

CMS also added these telephone E/M codes to the list of Medicare telehealth services. Because services on that list must be furnished using both audio and video, CMS waived requirements that these telephone E/M codes be provided using video.

CAA 2023 Provision

Section 4113(e) of the 2023 CAA permits the provision of telehealth services through audio-only telecommunications through December 31, 2024.

Note: In the CY 2022 PFS Final Rule, CMS amended the regulatory definition of “interactive telecommunications system” for purposes of Medicare telehealth services to include audio-only communication technology under certain circumstances for mental health services furnished to established patients in their homes. These services are subject to the same in-person visit requirements set forth by the 2021 CAA that apply to mental health services delivered via other types of telehealth when the patient is located in the home (see the Mental Telehealth Services - In-Person Requirement section for additional detail regarding these requirements and delays of implementation).

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Pre-PHE Policy

FQHCs and RHCs are prohibited from serving as distant site telehealth providers and therefore cannot qualify for the distant site payment. Reimbursable codes are limited in scope.

Policy During the PHE

FQHCs and RHCs can be distant sites and can be reimbursed at an amount comparable to the PFS amount.

CMS also expanded telehealth codes that FQHCs and RHCs may use for reimbursement and allows these to be applied to new and established patients.

CAA 2023 Provision

Section 4113(c) of the 2023 CAA permits FQHCs and RHCs to continue providing telehealth services through December 31, 2024.

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: ACUTE HOSPITAL CARE AT HOME

Pre-PHE Policy

The Medicare hospital Conditions of Participation require hospitals to provide 24/7 nursing services to patients, and require a registered nurse be immediately available for patient care, onsite at the hospital.

Policy During the PHE

As part of the broader initiative to allow hospitals to provide care outside their walls and still receive hospital reimbursement rates for that care, CMS created the Acute Hospital Care at Home (AHCAH) program, which enables participating hospitals to provide inpatient-level care for certain specified conditions to patients in their homes. The AHCAH program allows hospitals to treat more than 60 different acute conditions, such as asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease, appropriately and safely in patients' homes with proper monitoring and treatment protocols.

CAA 2023 Provision

Section 4140 of the 2023 CAA extends the current AHCAH program through December 31, 2024.

TELEHEALTH FLEXIBILITIES ADDRESSED IN CAA: HEALTH SAVINGS ACCOUNT (HSA)-ELIGIBLE HIGH DEDUCTIBLE HEALTH PLAN (HDHP) COVERAGE OF TELEHEALTH SERVICES

Pre-PHE Policy

Prior to the PHE, enrollees in HSA-eligible HDHPs typically had to meet their deductible before certain telehealth services would be covered.

Policy During the PHE

The CARES Act created a safe harbor allowing HSA-eligible HDHP enrollees to have telehealth services covered on a first-dollar basis. In other words, enrollees did not need to meet their deductible before telehealth services would be covered. The statutory safe harbor was not tied to the PHE and expired on December 31, 2021.

Section 307 of the 2022 CAA reinstated the safe harbor from April 1, 2022, through December 31, 2022.

CAA 2023 Provision

Section 4151 of the 2023 CAA extends the safe harbor period through December 31, 2024. This extension will allow HDHPs with plan years beginning after December 31, 2022, and before January 1, 2025, to rely on the safe harbor and continue coverage of telehealth services.

The Telehealth Expansion Act of 2023 (H.R. 1843/S. 1001) would make this change permanent.

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CONSOLIDATED APPROPRIATIONS ACT, 2023 (CAA)

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CAA: LICENSURE

Telehealth flexibility

During the PHE, CMS waived Medicare and Medicaid requirements that physicians and non-physician practitioners be licensed in the state where they are providing services when the following four conditions are met:

- The provider is enrolled as such in the Medicare program; the provider possesses a valid license to practice in the state that relates to the provider's Medicare enrollment; the provider furnishes services—whether in person or via telehealth—in a state in which the PHE is occurring in order to contribute to relief efforts in a professional capacity; the provider is not affirmatively excluded from practice in the state or in any other state that is part of the 1135 emergency area.
- Note: Practitioners must continue to comply with state licensure requirements.

Further action required

42 USC 1395m(m)(1) permits the Secretary to pay for telehealth services that are furnished by a "physician" or a "practitioner" as those terms are defined in 42 USC § 1395x(r) and 42 USC § 1395u(b)(18)(C), respectively. In turn, those statutory provisions require the provider to be "legally authorized" to practice the profession under state law, which would require compliance with state licensure requirements.

Because the underlying requirement is set forth in statute and the authority to waive the requirement is similarly statutorily limited to periods of emergency, CMS would not be permitted to waive these licensing requirements more broadly without congressional action.

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CAA: HOSPITAL WITHOUT WALLS INITIATIVE

Telehealth flexibility

During the PHE, CMS launched the Hospitals Without Walls Initiative, a broad range of waivers and flexibilities to allow hospitals to treat patients in alternate care settings outside the hospital, including the patient's home. CMS's waivers allow any non-hospital space to be used for patient care as long as the site is approved by the state and is consistent with the state's emergency preparedness or pandemic plan, to ensure patient and provider safety. CMS also issued broad waivers of Medicare coverage rules for services provided via telemedicine to enhance access to necessary care for hospital patients.

These waivers have allowed services that would typically be provided in a hospital outpatient setting, such as cardiopulmonary rehabilitation services, to be provided via telemedicine while the patient is located in his home.

Further action required

Because the Hospitals Without Walls Initiative flexibilities are regulatory waivers currently tied to the PHE and expire when the PHE does, congressional action could extend or make these flexibilities permanent.

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CAA: ENFORCEMENT DISCRETION FOR TELECOMMUNICATIONS MODALITIES

Telehealth flexibility

During the PHE, the HHS Office for Civil Rights (OCR) has maintained a policy of enforcement discretion for telehealth providers, allowing telehealth providers to use a broader range of remote communications products even if those products do not fully comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

OCR clarified via an FAQs document that this enforcement discretion will remain in effect until the HHS Secretary declares that the PHE no longer exists or upon the expiration date of the declared PHE, whichever event occurs first. OCR will issue advance notice to the public before modifying its enforcement discretion policy.

Further action required

On April 11, 2023, OCR issued guidance that extended the enforcement discretion for 90-days after the end of the PHE (through August 9, 2023). OCR indicated it gave extra transition time for covered health care providers to come into compliance with HIPAA Rules when using telehealth services.

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CAA: CONTROLLED SUBSTANCES TELEHEALTH PRESCRIBING

Telehealth flexibility

During the PHE, providers have been able to prescribe controlled substances via telehealth without first conducting an in-person examination. This flexibility will expire when the PHE ends, requiring providers to adhere to stricter pre-PHE prescribing rules.

In most cases, patients would again need to be located in a physician's office or a hospital registered with the US Drug Enforcement Administration (DEA) to be prescribed a controlled substance via telehealth.

Further action required

On May 10, 2023, the US Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a temporary rule extending telemedicine flexibilities adopted during the COVID-19 PHE. The temporary rule will allow telemedicine providers to continue prescribing controlled substances through December 31, 2024. The temporary rule went into effect on May 11, 2023.

Note: On February 24, 2023, the DEA issued two proposed rules (the Telemedicine Controlled Substance Proposed Rule and the Telemedicine Buprenorphine Proposed Rule) that would have established additional potential pathways for the prescription of certain controlled substances in limited quantities via telehealth without an initial in-person medical examination. The proposed rules would have expanded the use of telemedicine for prescribing controlled substances compared with pre-PHE requirements while simultaneously re-establishing certain barriers many patients face in accessing in-person care and the barriers that telehealth providers without physical practice locations face in providing care by requiring at least one in-person visit. While the temporary rule is in place, the DEA indicated that, in light of the 38,000 comments it has received, it will be further evaluating its recently proposed rules for post-PHE telemedicine prescription of controlled substances.

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CAA: COVERAGE OF MEDICARE TELEHEALTH SERVICES

Telehealth flexibility

Permanent v Temporary: During the PHE, Medicare primarily utilized Categories 1, 2, and 3 for telehealth services. Category 3 provided the most flexibility and CMS utilized this to temporarily add codes during the PHE that would be eligible for reimbursement.

Further action required

Permanent v Temporary: Via rulemaking, CMS made a change to the reimbursement lists. In the final MPFS CY2024 rule, CMS moved from Categories 1, 2 and 3 to “permanent” and “provisional” lists.

As of January 1, 2024, CMS moved all codes currently in Categories 1 and 2 to the “permanent” list. Any codes added on a “temporary Category 2” or a Category 3 basis were placed on the “provisional” list.

But, no codes were added to the permanent list.

TELEHEALTH FLEXIBILITIES **NOT** ADDRESSED IN CAA: CODING OF MEDICARE TELEHEALTH SERVICES

Telehealth flexibility

Place of Service (POS): During the PHE, CMS provided temporary policies that allowed physicians and practitioners who billed for Medicare telehealth services to report the POS code that they would have reported had the service been furnished in-person. This allowed telehealth services to be paid at the PFS non-facility rate.

- POS 02, Telehealth Provided Other than in Patient's Home
- POS 10, Telehealth Provided in Patient's Home

Further action required

POS: In the CY2024 MFPS final rule, CMS finalized the policy that beginning in CY 2024, claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the **lower** PFS facility rate. Claims billed with POS 10 (Telehealth Provided in Patient's Home) will be paid at the **higher** PFS non-facility rate.

WHAT DOES THE DATA SHOW

LEVEL SET

- Telehealth utilization prior to January 2020
- First established as a Medicare service in 2002; limited to very small number of beneficiaries (rural and inside a hospital)
- What has happened in the last 22 years?

Takeaway:

- Medicare telehealth policies need to be updated (even prior to the PHE)
- The PHE catapulted us to a point of no return

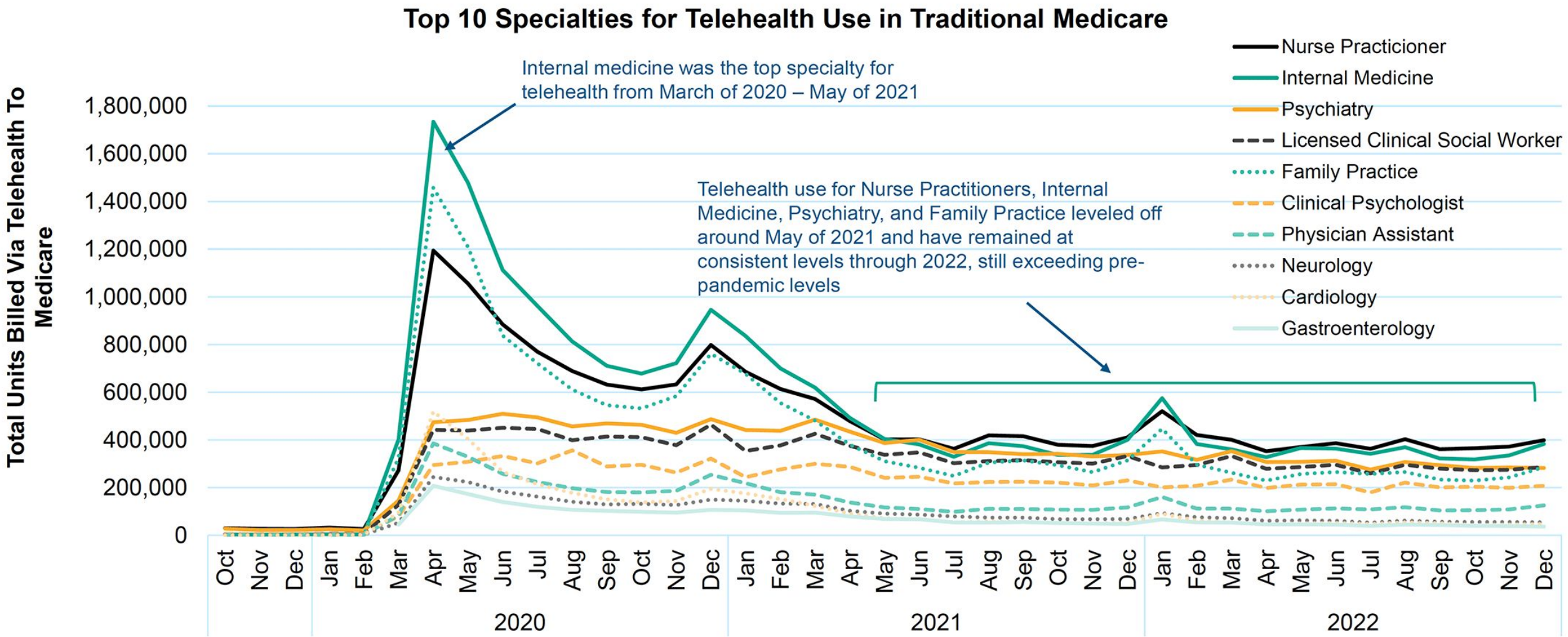
MEDICARE TELEHEALTH UTILIZATION DATA

Year	Telehealth Eligible Users	Telehealth Users	Percentage of Medicare Users with a Telehealth Service
2020	30,946,785	14,826,919	48%
2021	29,967,346	10,249,756	34%
2022	28,885,208	8,503,157	29%

Key Points:

- Medicare telehealth utilization Q1 2020 was 7%
- 2023 Q1-Q3 showing about 15%

Telehealth Use Remained at Consistent Levels in 2022, with Nurse Practitioners Becoming the Top Specialty in Medicare

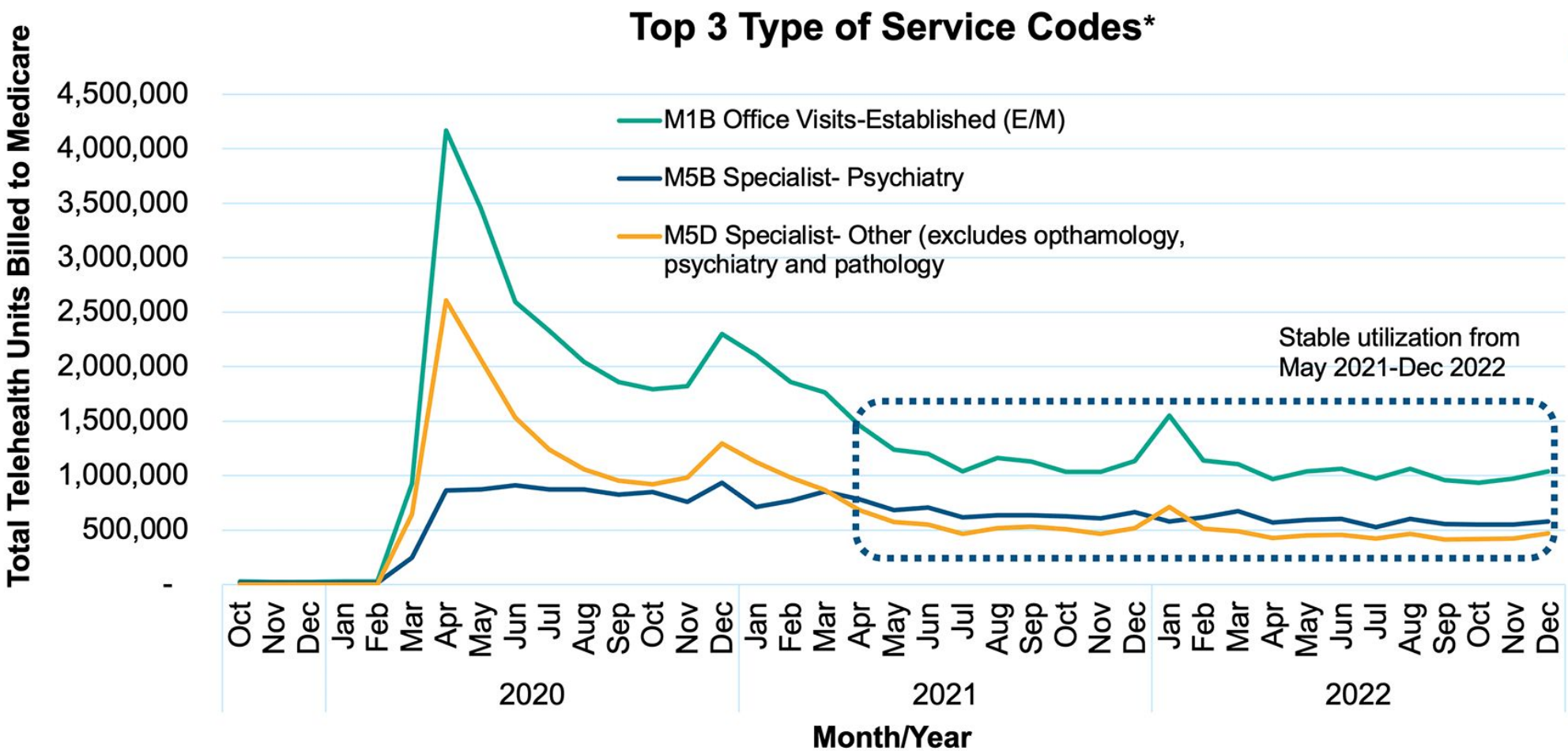


Partnership to Advance Virtual Care

Methodology: M+ estimated the total number of units where a Medicare fee-for-service beneficiary received telehealth services using the 5% carrier and outpatient standard analytic files limited data sets for 2019 - 2022. Claims defined as provided via telehealth if they expand beneficiary access via phone, video, or the internet or if they contained a place of service code for telehealth or included a modifier for telehealth (95, G0, GT, GQ, FR, FQ). Results are extrapolated for the full Medicare fee-for-service population.

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Most Telehealth Is For Evaluation and Management (E/M) Services for Established Patients



- Aside from a spike in January of 2022, E/M visits via telehealth for established patients held steady from May 2021 through 2022
- The volume for psychiatry visits remained virtually consistent during the PHE, demonstrating the continued importance of telehealth for behavioral health

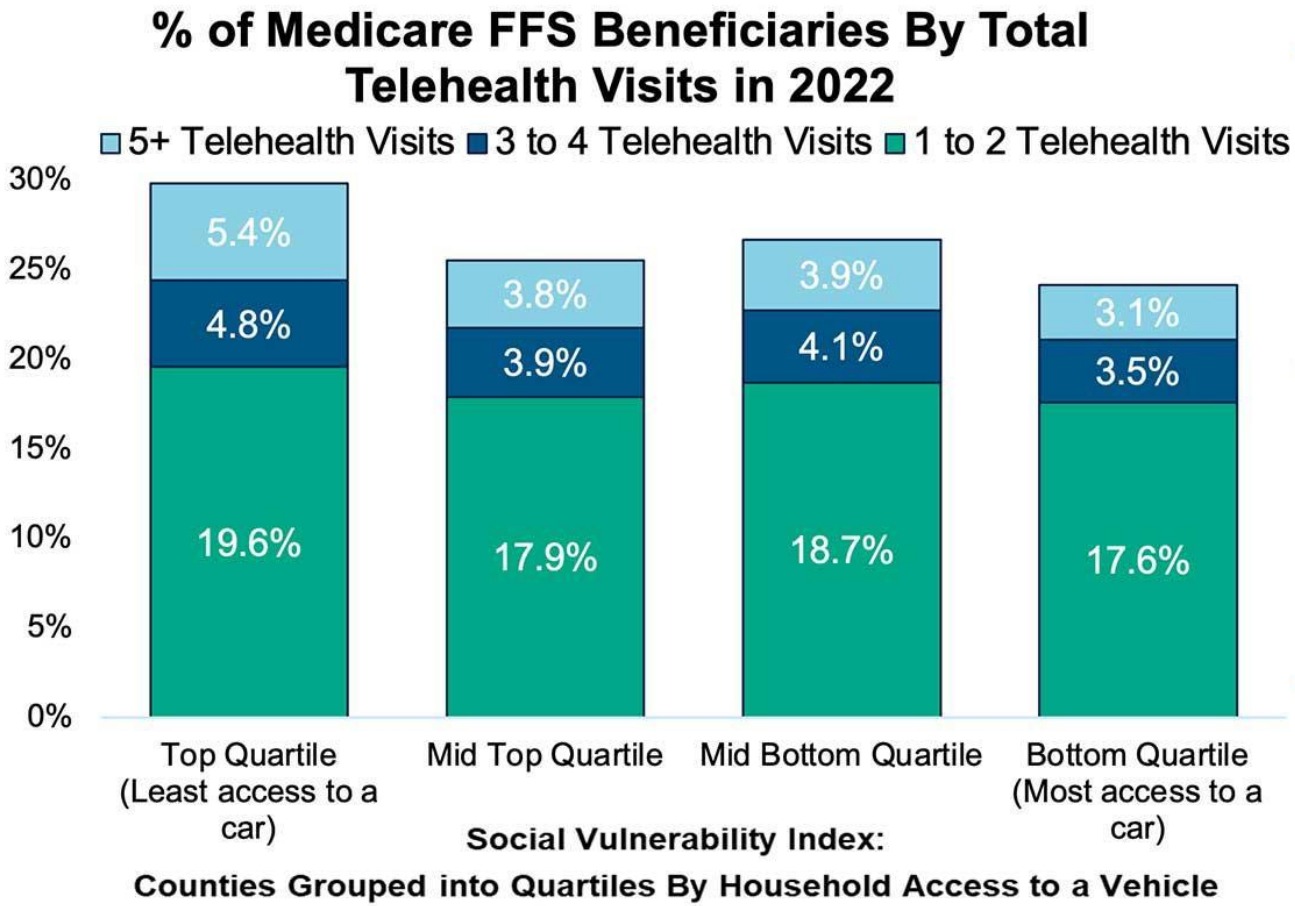
*Berenson-Eggers Type of Service (BETOS) codes assign HCPCS to clinically meaningful categories, refer to: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/downloads/BETOSDescCodes.pdf

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Medicare Telehealth Use Is Highest In Counties Where Households Are Least Likely To Own a Vehicle



- The Centers for Disease Control and Prevention (CDC) Social Vulnerability Index* (SVI) ranks counties by their vulnerability across multiple core areas, including household access to a car.
- Using Medicare fee-for-service claims data, these same counties where households are least likely to own a personal vehicle also had the highest rates of Medicare telehealth use in 2022.
- This correlation demonstrates the importance of continued access to telehealth services in communities where it may be difficult for families to access care.

The **Social Vulnerability Index (SVI) is based on 16 U.S. census variables focusing on four core areas: Socioeconomic status, Household Characteristics, Racial and Ethnic Minority status, and Housing Type & Transportation which includes household access to a vehicle. The SVI ranks U.S. counties in 2020 from 0 to 1, with higher values indicating greater vulnerability. The chart to the left groups counties into quartiles based on the percentage of households that have access to a vehicle: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html*

Partnership to Advance Virtual Care

Methodology: M+ estimated the total number of unique Medicare fee-for-service beneficiaries by county with at least one telehealth visit using the 5% carrier and outpatient standard analytic files limited data sets for 2022. Claims defined as provided via telehealth if they expand beneficiary access via phone, video, or the internet or if they contained a place of service code for telehealth or included a modifier for telehealth (95, G0, GT, GQ, FR, FQ). Results are extrapolated for the full Medicare fee-for-service population.

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WHAT WILL CMS OR CONGRESS DO

ADMINISTRATION ACTION

- Prescription of Controlled Substance via Telemedicine: DEA final rule (revisiting by December 31, 2024)

- Coverage/Payment and Telemental health in-person requirement: addressed in Medicare Physician Fee Schedule (proposed in July/finalized on November 1)

CONGRESSIONAL ACTION NEEDED

- Extension/permanency of HSA-eligible HDHP telehealth safe harbor (through December 31, 2024)
  - Will Congress act? *Maybe*
- Medicare telehealth flexibilities (through December 31, 2024)
  - Will Congress act? *Highly Likely*
- Acute Hospital Care at Home (through December 31, 2024)
  - Will Congress act? *Highly Likely*

WAYS AND MEANS COMMITTEE

- On May 8, 2024, the Committee considered a bill that would extend the all the current Medicare telehealth flexibilities for two year (or through December 31, 2026). This includes:
  - Waivers to the geographic and originating site restrictions
  - Expansions to the list of eligible practitioners
  - Eligibilities for federally qualified health centers (FQHCs) and rural health clinics (RHCs)
  - Allowing telehealth to be provided through audio-only telecommunications
  - Allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care
    - Note: the bill does at some limitations on this flexibility including if the beneficiary is located in area where the Secretary of HHS has put a moratorium on enrollment due to waste, fraud and abuse issues
  - Delaying the in-person visit requirement before a patient receives tele-mental health services.
  - A five-year extension of the Acute Hospital Care at Home waiver program, along with an additional report from CMS

ENERGY AND COMMERCE COMMITTEE

- On May 16, 2024, the Committee considered a new version of the Telehealth Modernization Act which includes:
  - A two-year extension of the following Medicare telehealth flexibilities, through December 31, 2026:
    - Removing originating site and geographic restrictions
    - Expanding the list of eligible practitioners
    - Delaying in-person requirements for mental health services provided through telehealth
    - Continuing audio-only services
    - Telehealth services for FQHCs and RHCs
      - Changes to reimbursement starting January 1, 2025 (this is a change from the Ways and Means bill)
  - A new modifier for telehealth services for claims for telehealth services that are provided through a telehealth virtual platform and claims for telehealth services that are billed incident to a physician's or practitioner's professional service
  - A five-year extension of the Acute Hospital Care at Home waiver program, along with an additional report from CMS

SENATE FINANCE COMMITTEE

- On May 17, 2024, the Committee released a white paper on outlining policy concepts related to reforming the way physicians are paid by Medicare and meeting the needs of those with chronic illness.
- While this is not telehealth specific, the report does mention ensuring access to telehealth and intention to address the expiring provisions
- Chairman also mentioned his intentions on permanency during a May 16 hearing on rural healthcare

CONSIDERATIONS FOR ACTION

CONSIDERATIONS

Timing:

- Medicare Physician Fee Schedule
  - Proposed rule: June/July 2024
  - Final rule: November 1, 2024
- Congressional deadline
  - Flexibilities end: December 31, 2024

Cost:

- Estimates for a two-year extension are around $3.6B

Election year:

- Not a lot of floor time
- Becomes political as we get closer

THANK YOU & QUESTIONS