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Expansion of Telehealth During the COVID-19 Emergency *(as of 4/4/20))*

Overview:

Congress and the Department of Health & Human Services (HHS) have instituted several flexibilities that waive many of the generally applicable rules governing Medicare telehealth services in response to the COVID-19 public health crisis. These flexibilities have been implemented incrementally. These steps should increase both supply and demand for telehealth during the public health emergency.

COVID-19 Telehealth Timeline:

- On March 6, Congress passed the *Coronavirus Supplemental Appropriations Act (*H.R. 6074*),* which included a $500 million authorization to enhance telehealth services. The legislation gives the U.S. Department of Health and Human Services (HHS) Secretary the authority to waive or modify certain telehealth Medicare requirements when the President has declared a National Emergency, or the HHS Secretary has declared a Public Health Emergency.

- On March 17, the Centers for Medicare and Medicaid Services (CMS) and other agencies released FAQs and further guidance on the use of telehealth during the coronavirus (COVID-19) national emergency.

- On March 27, Congress passed the third stimulus bill, the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act/ H.R. 748), that further expanded access to telehealth. The CARES Act also reauthorized and provided $29 million per year for four years for two Health Resource Service Administration (HRSA) HRSA grant programs -- Telehealth Network and Telehealth Resource Centers and the Telehealth Network Grant Program. The CARES Act also provides $200 million for the Federal Communications Commission (FCC) to advance telehealth. The CARES Act also changes the language of previous legislation to require "evidence-based" projects to assess the impact of telehealth on access to care. If recent changes drive broader patient and provider adoption of telehealth, evidence-based demonstrations could be a valuable source of information on telehealth's efficacy, quality, and outcomes policymakers.

- On March 31, CMS announced dozens of new temporary waivers and an interim final rule to grant healthcare providers, facilities, and laboratories additional flexibilities, including regarding telehealth.

- On April 2, the FCC approved a COVID-19 Telehealth Program, which will make the $200 million advanced from the CARES Act (as mentioned above) available to help healthcare providers that purchase telecommunications services, broadband connectivity, and devices necessary for providing telehealth services in response to COVID-10. See more information on the program in the attached FCC memo.

Medicare Telehealth Waivers:

The following requirements for billing telehealth services through Medicare have been waived during the emergency period.

Qualified Providers

To deliver telehealth services, a clinician must still be a Medicare "qualified provider." The initial waiver did not expand the list of eligible providers to provide services and be reimbursed. However, the CARES Act allows flexibility to open the waiver to additional providers. Accordingly, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are added to the list of eligible providers for this emergency period only.

Other eligible providers include:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists (CP)
- Clinical social workers (CSWs) (NOTE: C.P.s and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838).
- Registered dietitians or nutrition professional
- FQHCs and RHCs (during the emergency period only)

Modality Restrictions: Telehealth services may now be furnished via telephone or other qualifying devices so long as the device has both audio and video capabilities. CMS is continuing to require that devices/telephones have audio and video capabilities for the list of Medicare-covered telehealth codes; however, the Agency is permitting audio-only communications for CPT codes 99441-99443 and 98966-98968, which are telephone E/M visits. Medicare did not previously cover these codes.

Established Patient: The established relationship requirement codified in H.R. 6074 will not be enforced and was removed in the CARES Act. H.R. 6074 implemented an "established patient" requirement for telehealth services furnished pursuant to any new waivers. This would have required that patients be seen by the provider furnishing telehealth services, or provider in the same group practice, within three years and had services billed under Medicare. CMS guidance clarified that it would not enforce this requirement, meaning that patients need not been billed under Medicare in the past three years by the provider or practice. Notably, the CARES Act removed the COVID-19 telehealth waiver requirement that

a provider must have seen the patient within the last three years (which CMS has already stated they would not enforce).

Geographic Restrictions: Geographic restrictions are waived, permitting qualified professionals to furnish services to patients located in any geographic area (e.g., both non-rural and non-health professional shortage area (HPSAs)

Qualifying Originating Sites: Originating site restrictions are waived, qualified professionals are permitted to furnish services to patients that are in their homes or other locations.

Qualifying Distant Sites: Qualified healthcare professionals may furnish telehealth services from their own homes (i.e., they are not required to be at their office when furnishing telehealth to patients). Specifically, CMS states that: "The practitioner is not required to update their Medicare enrollment with the home location. The practitioner should list the home address on the claim to identify where the services were rendered. The discrepancy between the practice location in the Medicare enrollment (clinic/group practice) and the practice location identified on the claim (provider's home location) will not be an issue for claims payment."

Covered Telehealth Codes: Reimbursement is allowed for any telehealth code, even if unrelated to COVID-19 diagnosis, screening, or treatment. CMS expanded the list of ordinarily covered codes to now include more than 80 additional codes during the public health emergency. The full list of codes eligible for telehealth is listed here.

In addition to these codes, CMS will also cover CPT codes 99441-99443 and 98966-98968, which are telephone evaluation and management (E/M) visits, and may be furnished using audio-only modalities.

Licensing: CMS has temporarily waived the requirement that physicians or other healthcare professionals hold licenses in the State in which they provide services if they have an equivalent license from another state and are enrolled in Medicare. This licensing waiver applies to Medicare and Medicaid billing and does not have the effect of waiving State or local licensure requirements or any other requirement specified by the State or a local government.

Beneficiary Cost-sharing: Still applies, but the HHS Office of the Inspector General (OIG) is providing health care providers flexibility to reduce or waive fees. The OIG issued guidance stating it would not subject physicians and other practitioners to OIG administrative sanctions for arrangements regarding reduced or waived cost-sharing for telehealth or other non-face-to-face services during the COVID-19 public health emergency.

Beneficiary Consent: Annual consent may be obtained at the same time (i.e., not necessarily before) the time that services are furnished.

Removal of Frequency Limitations: The following 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, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233);
- A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310);

- Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

Virtual Check-ins, E-Visits, and Remote Patient Monitoring (RPM): Clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients. Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists can provide e-visits (HCPCS codes G2061-G2063).

Clinicians can provide RPM services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. See more information in the CMS interim final rule here.

End State Renal Disease (ESRD) & Home Dialysis Patients: CMS is exercising enforcement discretion on the requirement that home dialysis patients receiving services via telehealth must have a monthly face-to-face, non-telehealth encounter in the first initial three months of home dialysis and after the first initial three months, at least once every three consecutive months. ESRD clinicians no longer must have one "hands on" visit/month for the current required examination of the vascular access site. Clinicians will not have to meet the National Coverage Determination (NCD) or Local Coverage Determination (LCD) of face-to-face visits for evaluations and assessments during this public health emergency.

Medicare Advantage (MA) Telehealth Policies:

MA plans have some flexibility to expand their coverage of telehealth beyond what they currently do. What is covered will depend on what each plan decides to do. CMS issued a memo to Medicare Advantage plans that clarified the types of flexibilities available during a public health emergency and state-level declarations of emergency.

Medicaid Telehealth Policies:

A Medicaid FAQ was issued stating that state Medicaid programs have broad authority to utilize telehealth within their Medicaid programs, including telehealth or telephonic consultations in place of typical face-to-face requirements when certain conditions are met. As a result, access to and reimbursement of telehealth varies by State. CMS encouraged States to use this flexibility to increase the use of telehealth, and provided further guidance and clarification concerning state coverage:

- ❖ No federal approval is necessary for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.
- ❖ A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

Notably, on March 24, HHS Secretary Azar sent guidance and a letter to all 50 governors urging them to suspend state regulatory barriers to practice that limit patient access to care. The guidance indicates that, at least at present, the secretary does not have the authority to override state law. In the guidance, the secretary notes that while he may waive requirements related to Medicare, Medicaid, and CHIP Program reimbursement, "health care providers must still comply with various state laws and requirements."

For a list of licensure waivers by State from the Federation of State Medical Boards (FSMB), click here.

Additionally, on April 2, CMS released new Medicaid guidance on the various ways to use federal Medicaid funds to expand telehealth treatments of substance use disorders.

Commercial Payors:

Several health plans have announced that they will make telehealth more widely available or offering telehealth services for free for a certain period. Some of the announcements have come from Aetna, Cigna, and BlueShield BlueCross.

Additional Federal Action:

HIPAA Enforcement

The Office of Civil Rights (OCR) issued guidance that loosens restrictions for healthcare professionals-

- OCR will waive potential HIPAA penalties for good faith use of telehealth during the nationwide public health emergency due to COVID-19.
- A covered healthcare professional that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 emergency can use any non-public-facing remote communication product that is available to communicate with patients and provide telehealth in good faith without the risk that OCR might impose penalties for noncompliance with the HIPAA rules. OCR advises that providers should not use modalities that are public-facing, such as Facebook Live or Tik Tok.
- This exercise of discretion applies to telehealth provided for any reason, not only the diagnosis and treatment of COVID-19-related health conditions.

OIG Enforcement

As noted above, the OIG issued guidance that provides flexibility during this national emergency. Specifically, physicians and other practitioners will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations federal healthcare program beneficiaries may owe for telehealth services furnished during the national emergency.

DEA Enforcement

The Drug Enforcement Agency (DEA) released guidance allowing DEA-registered providers to issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a provider acting in the usual course of her professional practice.
- The telehealth communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The provider acts under applicable federal and State law.

The provider may issue a prescription electronically (for schedules II-V) or by calling in an emergency schedule II-V prescription to the pharmacy. Qualified professionals must continue to comply with state laws and regulations, some of which may have changed during the emergency.

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