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Policy Update

COVID-19 Telehealth: Where Things Stand on May 5, 2020

Summary

Health and Human Services Secretary Alex Azar declared a public health emergency (PHE) on January 27, 2020. Subsequently, Congress passed and the president signed three bills that provide varying degrees of regulatory and financial relief for healthcare providers during the Coronavirus (COVID-19) PHE. These bills have triggered a cascade of actions from the Centers for Medicare and Medicaid Services (CMS) designed to increase access to and use of telehealth services, and provide flexibilities for providers to complete certain administrative requirements virtually. Greater reliance on virtual care and administration may limit patient travel and exposure to COVID-19 and reduce the spread of the virus, in adherence to other federal guidelines. At the same time, telehealth gives providers an opportunity to provide some healthcare services to their patients without a face-to-face encounter, preserving revenue during the crisis.

This +Insight has been updated to reflect additional changes from the CMS Interim Final Rule of April 30, 2020. These changes are highlighted in the chart.

Key Takeaways:

- Congress and the Administration have substantially loosened Medicare restrictions on, and expanded the use of, telehealth services, but only for the duration of the COVID-19 PHE.
- CMS has allowed additional flexibility for the use of audio-only communications to provide telehealth services.
- CMS has expanded the types of clinical practitioners that can furnish Medicare telehealth services.
- CMS will add new telehealth services on a sub-regulatory basis during the PHE.

Telehealth Changes Broadly Applicable Across Provider Types

Telehealth		
Pre-Emergency Policy	**Policy During Emergency**	**Sources**
Medicare limits the type of healthcare providers eligible to provide telehealth services.	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. As a result, a broader range of practitioners, such as physical therapists, occupational therapists and speech language pathologists can use telehealth to provide many Medicare services.	CMS Interim Final Rule (2)
Certain facilities qualify for a telehealth originating (patient) site fee.	CMS will pay a telehealth originating (patient) site fee for patients receiving telehealth services in their home or other temporary expansion site, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner.	CMS Interim Final Rule (2)
Medicare requires that a beneficiary receive telehealth services at a designated healthcare facility or rural site (originating site).	The originating site requirement is waived. The patient can be anywhere, including his/her home.	FAQ Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Sec. 102)
Medicare provides a list of services payable under the PFS, which is updated annually.	CMS temporarily expanded the list of telehealth codes eligible for reimbursement.[1]	List of Telehealth Services
For services that have different rates in non-facility and facility services, Medicare uses the facility (lower)	CMS clarified that the telehealth payment to the furnishing physician or practitioner will be the same as payment for in-person services. CMS will assign the payment rate that ordinarily would have been paid under the PFS if the	CMS Interim Final Rule

[1] The additions include certain emergency department visits; initial and subsequent observation; initial hospital care and hospital discharge day management; initial nursing facility visits and nursing facility discharge day management; critical care; domiciliary, rest home or custodial care; home visits; inpatient neonatal and pediatric critical care; initial and continuing intensive care; care planning for patients with cognitive impairment; croup psychotherapy; End Stage Renal Disease (ESRD); psychological and neuropsychological testing; radiation treatment management; and therapy services (including licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services and speech language pathology services).

payment rate when services are furnished via telehealth.	services were furnished in-person. This means that physicians who normally would have seen the patient in the office would receive the facility (higher) rate.	
Medicare requires the use of an interactive audio and video telecommunications system that permits real-time communication between the patient at the originating site and the provider at the distant site. Telephones are excluded from the definition of audio and video telecommunications system.	Providers are allowed to use audio-visual functionality on mobile phones. The HHS Office for Civil Rights (OCR) will exercise enforcement discretion allowing the good faith use of popular video-chat applications, including FaceTime, Zoom and Skype. Note: CMS's argument for this modification does not rely on PHE-specific concerns, but the change is still limited to the duration of the PHE.	Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Sec. 102) OCR Guidance CMS Interim Final Rule
Medicare requires that providers be licensed in the state in which the patient is located. Medicaid requirements vary by state.	CMS will waive Medicare and Medicaid's requirements that physicians and non-physician practitioners be licensed in the state where they are providing services when the following four conditions are met: 1. The provider is enrolled as such in the Medicare program. 2. The provider possesses a valid license to practice in the state that relates to his Medicare enrollment. 3. The provider furnishes services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in her professional capacity. 4. 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.	1135 Waiver CMS Interim Final Rule
Under the relationship requirement created in the Coronavirus Preparedness and Response Supplemental Appropriations Act, the patient must have seen the doctor (or someone in the practice) before the telehealth visit.	CMS announced that it will not enforce the relationship requirement during the emergency period, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act subsequently codified that policy by revising the changes made by the Coronavirus Preparedness and Response Supplemental Appropriations Act.	1135 Waiver CARES Act (Sec. 3703)
A prescription for a controlled substance issued via the internet	US Drug Enforcement Administration-registered practitioners may issue prescriptions for schedule II-V controlled substances without meeting the relationship requirement, provided that:	DEA Guidance

must generally be predicated on an in-person medical evaluation.	1. The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his professional practice. 2. The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system. 3. The practitioner is acting in accordance with applicable federal and state laws. Note: Practitioners must continue to comply with state laws and regulations, many of which have also changed during the emergency.	
Provider enrollment is a formal process, including criminal background checks, application fees and site visits.	CMS will waive certain screening requirements, including the provision of a home address if services are provided at home, and will set up toll-free hotlines at each of the Medicare Administrative Contractors to initiate temporary Medicare billing privileges. Note: Practitioners are not required to update their enrollment with their home address.	FAQ
The frequency of telehealth services is limited for certain Medicare services.	Certain services no longer have limitations on the number of times they can be provided by Medicare telehealth: 1. A subsequent inpatient visit can be furnished via Medicare telehealth, with no frequency limits. 2. A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, with no frequency limits. 3. Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once-per-day limitation.	CMS Interim Final Rule
Medicare does not cover certain services provided via telephone (audio-only).	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. CMS will increase payments for certain telephone evaluation and management services (99441-99443) to match payments for similar office/outpatient visits (99212-99214). This change will increase payments for these services from a range of about $14-$41 to about $46-$110. The increased payments are retroactive to March 1, 2020.	CMS Interim Final Rule CMS Interim Final Rule (2)

	CMS also added these telephone E/M codes to the list of Medicare telehealth services. Because services on the Medicare telehealth list are required to be furnished using both audio and video, CMS waived requirements that these telephone E/M codes be provided using video.	
Co-payments are generally applicable for telehealth services.	The HHS Office of Inspector General announced flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.	Policy Statement Guidance
Medicare Advantage plans and coverage vary.	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.	March 10, 2020 HPMS Memo
Coverage of telehealth services under Medicaid varies by state.	CMS issued an FAQ encouraging Medicaid programs to use existing flexibilities to increase access to telehealth.	Medicaid FAQ

Other Telemedicine Guidance: Regulatory Changes Providing Increased Flexibility to Use Telemedicine in Place of In-Person Requirements

Other Telemedicine Guidance		
Pre-Emergency Policy	**Policy During Emergency**	**Sources**
Direct supervision requires that a physician be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician does not have to be present in the room when the procedure is performed.	CMS modified the definition of direct supervision to state that necessary physician presence for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or healthcare provider. This interim change has broad application across a variety of settings. Note: CMS is seeking information from commentators on whether CMS should develop guardrails.	CMS Interim Final Rule
With some exceptions, 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.	The requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology. This includes both in-person and telehealth visits.	CMS Interim Final Rule
Review and interpretation of diagnostic testing is limited to established patients and specific providers.	Although some of the code descriptors refer to "established patient," CMS will relax enforcement of this aspect of the code descriptors. Specifically, CMS will not conduct review to consider whether those services were furnished to established patients. CMS also expanded the list of providers that may use these specific codes to include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech-language pathologists.	CMS Interim Final Rule
Remote Patient Monitoring (RPM) is limited to established patients who have more than one disease.	RPM can be provided to new *and* established patients, patients with both acute and chronic conditions, and patients with only one disease.	CMS Interim Final Rule
CMS relies on local coverage determinations (LCDs) and national coverage determinations (NCDs) to	To the extent that an NCD or LCD would otherwise require a face-to-face visit for evaluations and assessments, clinicians do not have to meet those requirements during the PHE.	CMS Interim Final Rule

set requirements for face-to-face visits around evaluation and assessments.		

Guidance by Provider Type: Specific Policy Changes for Certain Medicare Providers

Guidance by Provider Type		
Pre-Emergency Policy	**Policy During Emergency**	**Sources**
Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) are prohibited from serving as distant site telehealth providers and therefore cannot qualify for the distant site payment. Reimbursable codes are limited in scope.	RHCs and FQHCs can be a distant site and can be reimbursed at an amount comparable to the PFS amount. CMS also expanded telehealth codes that RHCs and FQHCs may use for reimbursement, and will allow these to be applied to new *and* established patients.	CARES Act (Sec. 3704) CMS Interim Final Rule
CMS requires a variety of in-person visits and limits the frequency of telehealth services for Medicare patients with certain conditions that need specific follow-up visits.	CMS removed the frequency restrictions for certain codes related subsequent inpatient visits, subsequent nursing facility visits and critical care consultation services. CMS will allow a telehealth service to substitute for the face-to-face requirement for the clinical examination of the vascular access site for End State Renal Disease.	CMS Interim Final Rule
Home dialysis requires face-to-face visits.	The CARES Act waives the face-to-face requirement.	CARES Act (Sec. 3705)
Hospice physicians and nurse practitioners cannot conduct recertification encounters using telehealth.	The CARES Act allows qualified providers to use telehealth technologies to fulfill the hospice face-to-face recertification requirement. CMS further clarified this in its Interim Final Rule.	CARES Act (Sec. 3706) CMS Interim Final Rule
Hospice services are generally required to be in-person for the purposes of reimbursement.	When a patient is receiving routine home care, hospices may provide services via a telecommunications system, if it is feasible and appropriate to do so, to ensure that Medicare patients continue receiving reasonable and necessary services for the palliation and management of terminal illness and related conditions without jeopardizing the patients' health or the health of those providing such services.	CMS Interim Final Rule
Physician and non-physician practitioners are required to perform in-person visits for nursing home residents.	CMS will waive this in-person requirement and allow visits to be conducted, as appropriate, via telehealth options.	CMS Interim Final Rule

Medicare requires rehabilitation physicians to conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the inpatient rehabilitations facility.	CMS will allow the face-to-face requirements to be conducted via telehealth.	CMS Interim Final Rule
Provision of home health services via telehealth are limited, depending on the beneficiary's care plan.	The CARES Act requires the Secretary to issue guidance encouraging the use of telecommunications systems, including remote monitoring consistent with the plan of care. CMS provided detailed information on how to adjust a plan of care to include remote patient monitoring or other telemedicine services.	CARES Act (Sec. 3707) CMS Interim Final Rule

Special Note on State Licensing, Prescribing and Standard of Care Regulation

The telehealth waivers provided through CMS and other agencies have given providers and beneficiaries significant flexibilities, but the challenges of existing state licensure and other regulatory requirements remain. While CMS announced that it will waive reimbursement restrictions on practicing across state lines, it has not waived or modified state licensing, prescribing and other practice requirements.

As states experience the strain of COVID-19 on their health systems, governors, health departments and professional boards have eased state licensure and other requirements through state-level actions, such as declarations of emergency. Secretary Azar applauded these actions in a letter to the governors, but he also called on them to do more. Without an enforceable national policy, however, even the most liberalizing state policy changes will perpetuate the existing dynamic of widely varying state-specific laws, regulations and requirements. Accordingly, providers should continue to monitor and comply with relevant state laws, regulations and orders. Stakeholders also have an opportunity to communicate with CMS regarding the complications and barriers that state-based regulation presents for national policy, as demonstrated by the current pandemic.

Funding Opportunities

The CARES Act includes several funding opportunities focused on expanding access to telehealth services.

Health Resource Services Administration (HRSA) Grants: The CARES Act reauthorizes and provides $29 million per year for four years for two HRSA grant programs: Telehealth Network and Telehealth Resource Centers. These support the use of telehealth technologies for services relating to mental health, at-home care, and preventive care in rural and underserved communities.

- Telehealth Network Grant Program: The current funding opportunity aims to promote rural tele-emergency services with an emphasis on tele-stroke, tele-behavioral health and tele-emergency medical services. Eligible applicants include rural or urban nonprofit entities that will provide direct clinical services through a telehealth network. Information on the Telehealth Network Grant Program is available here.

- Telehealth Resource Centers Grant Program: Telehealth Resource Centers (TRCs) provide assistance, education and information to organizations and individuals who actively provide or are interested in providing healthcare at a distance. On April 22, 2020, HRSA announced $11.5 million for the 14 existing TRCs. For more information on the program, visit The National Consortium of Telehealth Resource Centers website.

Federal Communication Commission (FCC) Grants: The CARES Act provides $200 million for the FCC to support healthcare providers addressing COVID-19 by providing telecommunications services, information services and devices necessary to enable the use of telehealth services during the PHE.

On March 30, 2020, the FCC chairman presented his plan for the $200 million. The plan would immediately support healthcare providers responding to the pandemic by allowing them to purchase telecommunications services, information services and devices necessary to enable the provision of telehealth services during this emergency period. The FCC would provide selected applicants with full funding for these eligible telehealth services and devices. In order to receive funding, eligible healthcare providers would submit a streamlined application to the FCC for this program.

On April 13, 2020, the FCC began accepting applications for this program. Application will be accepted on a rolling basis and will select participants until all COVID-19 telehealth program funding has been committed or the current pandemic has ended. As of May 4, 2020, the FCC has approved four sets of applications (first set, second set, third set, fourth set).

The FCC also made several regulatory announcements on existing telehealth support:

- Supporting Telehealth and Remote Learning by Waiving Gift Rules: The FCC waived gift rules in the Rural Health Care and E-Rate Programs to make it easier for broadband providers to support telehealth and remote learning efforts during the pandemic. The waiver will allow healthcare providers, schools and libraries to accept improved capacity, Wi-Fi hotspots, networking gear, or other equipment or services to support doctors and patients, teachers and students, and librarians and patrons during the COVID-19 outbreak. More information is available here.

- Increasing Rural Health Care Funding: The FCC announced that it will fully fund all eligible Rural Health Care Program services for the current funding year with an additional $42.19 million. This action will help ensure that healthcare providers have the resources they need to promote telehealth solutions for patients during this outbreak. In addition, a March 26, 2020, order took several actions to assist program participants, including extending the application window until June 30, 2020, among other administrative deadlines. More information is available here.

Department of Agriculture Rural Development: The CARES Act provides $25 million for the Distance Learning, Telemedicine, and Broadband Program, which supports telemedicine and distant learning services in rural areas. A current funding opportunity is open here.

For more information, contact Rachel Stauffer, Mara McDermott, Dale Van Demark, Lisa Schmitz Mazur, Marshall Jackson, Jr., or Amanda Enyeart.