Telehealth Policy Update

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CENTER FOR CONNECTED HEALTH POLICY (CCHP)

is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.

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- Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.
- Always consult with legal counsel.
- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.

ABOUT CCHP

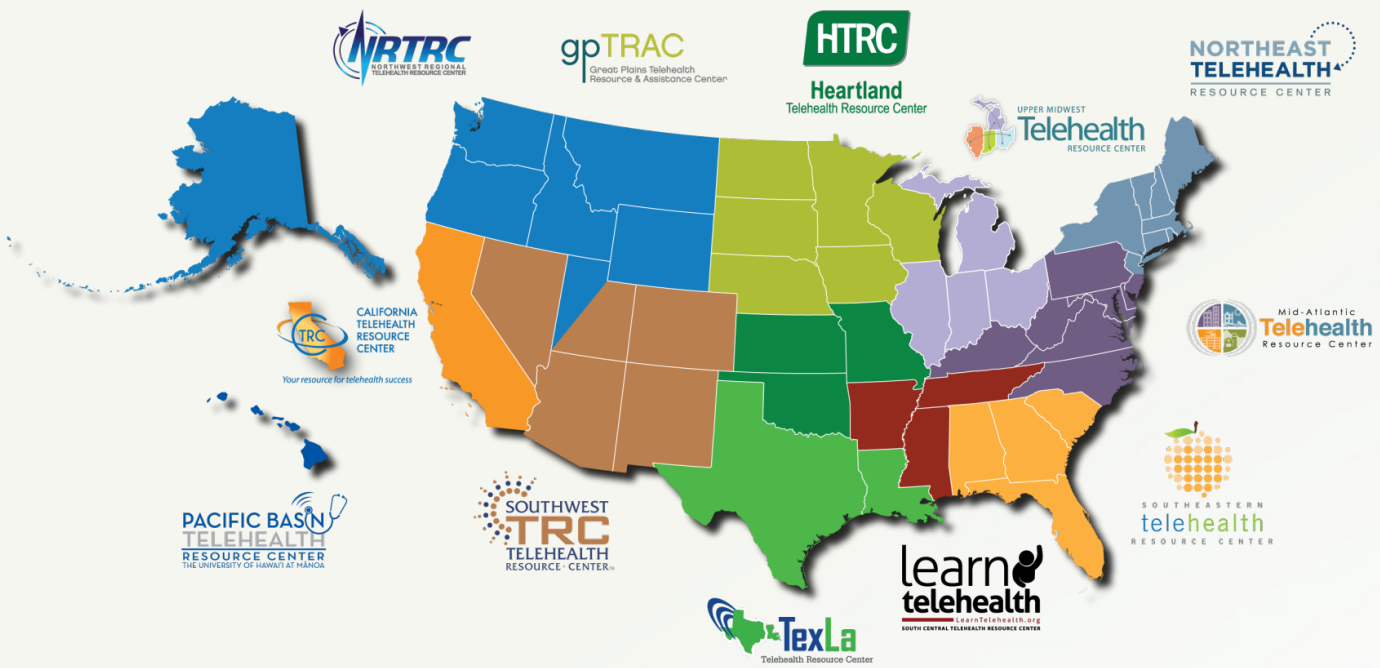
- Established in 2009 as a program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition

California Telehealth Policy Coalition

TRC TELEHEALTH RESOURCE CENTERS

NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org



TTAC TelehealthTechnology.org

Center for Connected Health Policy

2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

TRC

TELEHEALTH RESOURCE CENTERS

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The National Telehealth Policy Resource Center

TELEHEALTH POLICY CHANGES IN COVID-19

FEDERAL

MEDICARE ISSUE	CHANGE
Geographic Limit	Waived
Site limitation	Waived
Provider List	Expanded
Services Eligible	Added additional 80 codes
Visit limits	Waived certain limits
Modality	Live Video, Phone, some srvs
Supervision requirements	Relaxed some
Licensing	Relaxed requirements
Tech-Enabled/Comm-Based (not considered telehealth, but uses telehealth technology)	More codes eligible for phone & allowed PTs/OTs/SLPs & other use

•DEA – PHE prescribing exception/allowed phone for suboxone for OUD
•HIPAA – OCR will not fine during this time

STATE (Most Common Changes)

MEDICAID ISSUE	CHANGE
Modality	Allowing phone
Location	Allowing home
Consent	Relaxed consent requirements
Services	Expanded types of services eligible
Providers	Allowed other providers such as allied health pros
Licensing	Waived some requirements

- Private payer orders range from encouragement to cover telehealth to more explicit mandates
- Relaxed some health information protections

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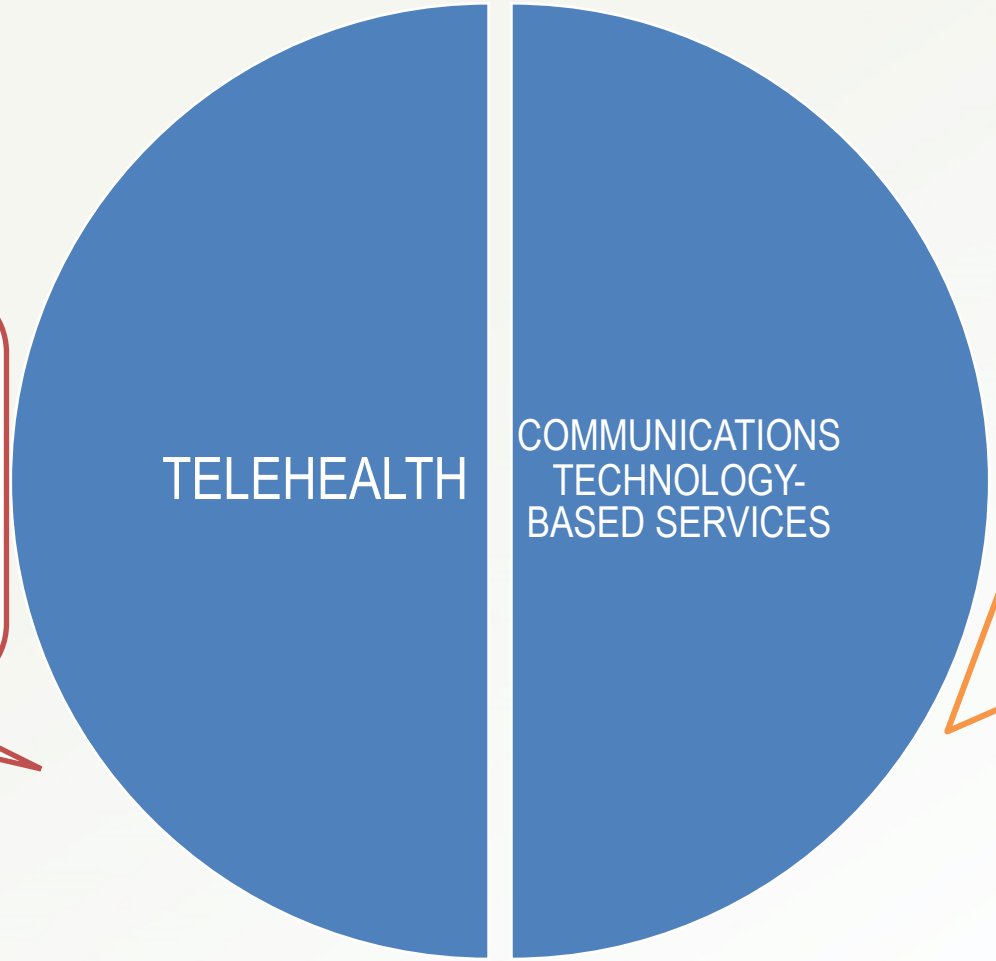
FEDERAL POLICIES

MEDICARE POLICY

The Medicare policy on the use of technology to provide services is in two buckets

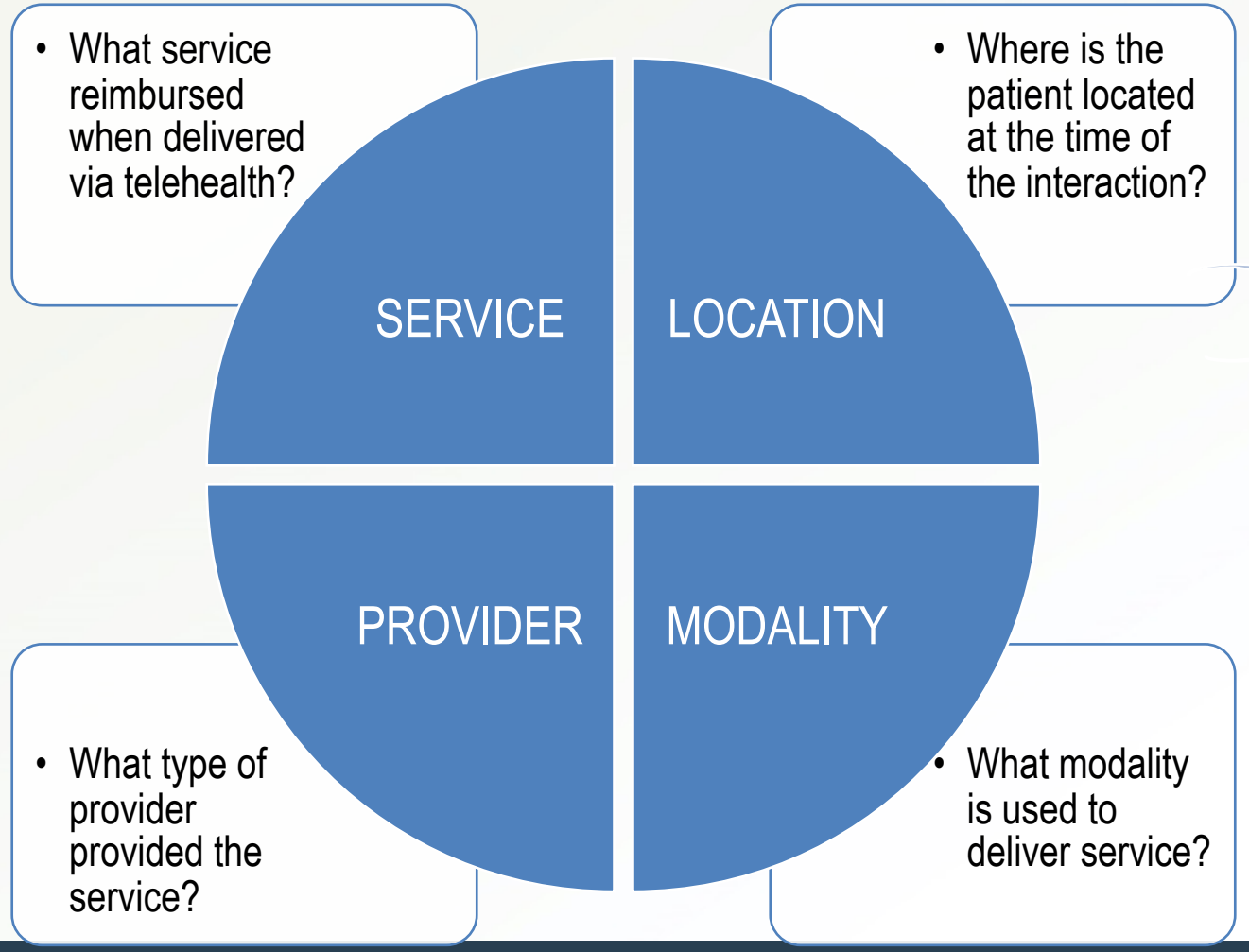
- In Federal Statute
- Only Live Video unless in a demonstration project in AK or HI
- Limited list of providers
- Limited list of eligible services
- Geographic and site limitations



- Utilizes telehealth technology but is called "Communications Technology-Based Services" (CTBS)
- Is not limited by federal law telehealth restrictions
- Other restrictions in place such as informed consent requirements
- All modalities found here

FEDERAL POLICY CHANGES DURING COVID-19

- **Most established telehealth policies are on reimbursement**
  - 4 typical elements make up reimbursement policy
  - Most limitations are around these 4 elements
- **Medicare made changes to all of these elements in response to COVID**
- **Permanent federal changes made so far have centered on eligible services and a narrow expansion of originating site**



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FEDERAL TELEHEALTH POLICY CHANGES

Pre-COVID-19

- Limits on originating site
- Type of Eligible Provider
- Specific list of Eligible Services
- Live Video/S&F if AK/HI

- HIPAA
- Stark/Anti-Kickback
- Limitations on prescribing controlled substances
- Limited funding for broadband

Changes Made for COVID-19

- Removed geographic & site limits
- Allowed all eligible providers in Medicare to be allowed to use telehealth
- Expanded list of eligible services
- Allowed the use of audio-only phone for some services

- Eased HIPAA Requirements
- Eased Stark/Anti-Kickback
- PHE exception kicked in for prescribing controlled substances
- Increased funding for broadband/connectivity

Permanent Changes So Far

- Added some services to permanent telehealth list
- Created 3rd Category that temporarily allows for services to be eligible
- Added rural emergency hospitals to originating stie
- Conditioned expansion of mental health

- Reformed Stark/Anti-Kickback
- Additional funding for broadband/connectivity

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PERMANENT FEDERAL TELEHEALTH POLICY CHANGES

ADMINISTRATIVE

- *Physician Fee Schedule Changes*
  - Added some services from the temporary list to the permanent list
  - Created a "Category 3" for approval of services. Temporarily allows some services to continue to be reimbursed through the end of the year the PHE is declared over to determine if they should be permanent

LEGISLATIVE

- *HR 133*
  - Added rural emergency to originating site
  - Expansion of mental health services to be without geographic restriction and allows the home, but limits
  - Additional funding for broadband and FCC Telehealth COVID-19 Program

CY 2021 PHYSICIAN FEE SCHEDULE

- Some of the temporary Medicare telehealth changes permanent
  - Included some of the services allowed during COVID-19 to be on permanent list:
    - G2211 – Visit Complexity with certain office/outpatient evaluation and management services
    - G2212 – Prolonged office or other outpatient evaluation and management service(s)
    - 90853 - Group Psychotherapy
    - 96121 - Psychological and Neuropsychological Testing
    - 99483 – Care Planning for Patients with Cognitive Impairment
    - 99334 - Domiciliary, Rest Home, or Custodial Care services
    - 99335 - Domiciliary, Rest Home, or Custodial Care services
    - 99347 & 99348 – Home Visits (currently only for SUD & co-occurring mental health disorders)

CY 2021 PHYSICIAN FEE SCHEDULE

- Some of the services to remain around temporarily until the end of the year the PHE is over under new category (Category 3) where they will be evaluated to see if they fit into Category 1 or 2
  - End-Stage Renal Disease Monthly Capitation Payment - 90952, 90953, 90959, 90962
  - Domiciliary, Rest Home, or Custodial Care services, Established patients - 99336 & 99337
  - Home Visits, Established Patients - 99349, 99350 (NOTE: CMS stated that these home visits will only be available for the treatment of substance use disorder or co-occurring mental health disorder.)
  - Emergency department Visits - 99281, 99282, 99283, 99284, 99285
  - Nursing Facility discharge day management - 99315, 99316
  - Psychological and Neuropsychological Testing - 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139
  - Therapy Services, Physical, and Occupational Therapy – 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521, 92522, 92523, 92524, 92507 (NOTE: PTs & OTs are not eligible providers)
  - Subsequent Observation and Observation Discharge Day Management – 99217, 99224, 99225, 99226, 99221, 99222, 99223, 99238, 99239
  - Critical Care Services – 99291, 99292
  - Inpatient Neonatal and Pediatric Critical Care, Subsequent - 99469, 99472, 99476
  - Continuing Neonatal Intensive Care Services – 99478, 99479, 99480

CY 2021 PHYSICIAN FEE SCHEDULE

- **CTBS** - Clinical social workers, clinical psychologist, physical therapists, occupational therapists and speech language pathologists may furnish brief online assessments and management services, virtual check-ins and remote evaluations. G2250, G2251
- Remote Physiologic Monitoring Services Clarifications
  - After the PHE, an established patient-physician relationship will be required for RPM services.
  - Consent can be obtained at the time RPM services are furnished permanently.
  - Auxiliary personnel are allowed to furnish 99453 and 99454 under a physician's supervision, which would include contracted employees.
  - CMS clarifies that a medical device that is part of 99454 must meet the definition of a medical device of the Federal Food, Drug and Cosmetic Act, and data must be collected and transmitted rather than self-reported to the provider.
  - After the PHE, there will be a requirement for at least 16 days of data collection within each 30-day period for codes 99453 and 99454.
  - Only physicians and practitioners eligible to furnish evaluation and management services may bill for RPM services.
  - Acute as well as chronic conditions qualify for RPM services.
  - The definition of 'interactive communication' in CPT Codes 99457 and 99458 is real-time and includes synchronous two-way interaction that can be enhanced with video or other kinds of data, as described in CPT code G2012.
  - Independent Diagnostic Testing Facilities are not allowed to bill for RPM services.

CY 2021 PHYSICIAN FEE SCHEDULE

- Made on a permanent basis certain allowances for residency training sites located outside of an MSA
- Allowed direct supervision to be provided via live video through the later of the end of the calendar year PHE is declared over or December 31, 2021
- Clarified that if the provider is in the same location as the beneficiary and technology is used to perhaps minimize exposure, should be billed as if it was done in-person and telehealth limitations do not apply.
- SNF frequency limits on telehealth changed from one very 30 days to one every 14 days
- Allow FQHCs and RHCs to bill for principal care management G2064 & G2065 which would be incorporated into G0511 (general care management code used by FQHCs and RHCs)

CCHP Fact Sheet - https://www.cchpca.org/sites/default/files/2020-12/CY%202021%20Medicare%20Physician%20Fee%20Schedule.pdf

CONSOLIDATED APPROPRIATIONS ACT (HR 133)

- Passed in December 2020
- Telehealth provisions
  - Eligible originating site – CAHs or other rural facilities with <50 beds (Rural Emergency Hospital (REH))
  - Mental health services for diagnosis, treatment or evaluation maybe provided via telehealth without geographic restrictions and allow the home to be eligible originating site BUT there must be one in-person visit with telehealth provider within 6-month period prior to telehealth encounter
  - $250 million for COVID-19 Telehealth Program (FCC)
  - Tribal broadband funds
  - Additional broadband funding

CCHP Fact Sheet - https://www.cchpca.org/sites/default/files/2021-01/Appropriations%20Act%20HR%20133%20Fact%20Sheet%20FINAL.pdf

PREP Act Declaration

- Allows for providers to order or administer ‘covered countermeasures’ in a state they are not licensed in as long as its within their scope of practice in the state they are licensed in.
- Covered countermeasures means:
  - A qualified pandemic or epidemic product
  - A security countermeasure
  - A drug, biologic product or device that is authorized under emergency use; or
  - A respiratory protected device that is approved by the National Institute for Occupational Safety and Health

OTHER FEDERAL ACTIONS

- Biden Administration
  - Likely to see more scrutiny now of telehealth as policymakers decide what to keep around
  - Increasing calls for data
- PHE appears to be extended through the rest of the year
  - https://www.cchpca.org/sites/default/files/2021-01/Public-Health-Emergency-Message-to-Governors.pdf

STATE POLICIES

MEDICAID REIMBURSEMENT BY SERVICE MODALITY (Fee-for-Service)

Live Video

50 states and DC

Store and Forward

Only in 18 states

Remote Patient Monitoring

21 states

As of October 2020

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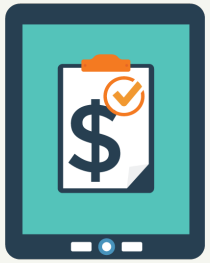
REIMBURSEMENT REQUIREMENTS FOR PRIVATE PAYERS



43 states and DC

have telehealth **private payer** laws

Some go into effect at a later date.

Parity is difficult to determine:

Parity in services covered vs. parity in payment

Many states make their telehealth private payer laws *"subject to the terms and conditions of the contract"*

As of October 2020

2021 LEGISLATIVE TRENDS

- Federal Level
  - Re-introduction of bills to make some of the temporary changes permanent
- State Level
  - Payment parity for private payers
  - Telephone in Medicaid (usually just for mental/behavioral health)
  - Licensing for out of state providers
  - Requirements for regulatory boards to create regulations around telehealth

CCHP

- CCHP Website – cchpca.org
  - Telehealth Federal Policies - https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies
  - State Emergency Waivers/Guidance - https://www.cchpca.org/resources/covid-19-related-state-actions
- Subscribe to the CCHP newsletter at cchpca.org/contact/subscribe

Thank You!

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APPENDIX

CMS TELEHEALTH POLICY - NOW

SUBJECT AREA	POLICY DURING COVID-19	POLICY FQHC/RHC
Geographic/Site location for patient	No geographic restrictions, patient allowed to be in home during telehealth interaction	No geographic restrictions, patient allowed to be in home during telehealth interaction
Location of provider	Provider able to provide services when at home, need not put home address on claim	Provider able to provide services when at home
Modality	Live Video. Phone will be allowed for codes audio-only telephone E/M services and behavioral health counseling and educational services. Other modalities allowed for **Communications Based Services**	Live Video. Phone will be allowed for codes that are audio-only telephone E/M services and behavioral health counseling and educational services. Other modalities allowed for **Communications Based Services**
Type of provider	All health care professionals to bill Medicare for their professional services.	Temporarily added to list of eligible providers by CARES Act

CMS TELEHEALTH POLICY - NOW

SUBJECT AREA	POLICY DURING COVID-19	POLICY FQHC/RHC
Services	Approximately 240 different codes available for reimbursement if provided via telehealth. List available HERE.	Can only provide the services on THIS list via telehealth and be reimbursed by Medicare.
Amount of reimbursement	Same as would received if it had been provided in-person (Fee-for-service rate). Some rates for telephone visits have been increased.	$92.03
Modifiers	Per the final interim rule, providers are allowed to report POS code that would have been reported had the service been furnished in person so that providers can receive the appropriate facility or non-facility rate and use the modifier "95" to indicate the service took place through telehealth. If providers wish to continue to use POS code 02, they may and it pays the facility rate	For services delivered January 27, 2020 – June 30, 2020 **RHCs**: Use G2025 with CG modifier. 95 modifier can be appended, but is not required. **FQHCs**: Must report 3 HCPCS/CPT codes: (1) the PPS specific payment code; (2) the HCPCS/CPT code that describes the service with the 95 modifier; (3) G2025 with modifier 95 **Beginning July 1, 2020** FQHCs/RHCs: Only submit G2025. RHCs should no longer use CG modifier.

CMS TELEHEALTH POLICY - NOW

OTHER ISSUES	POLICY DURING COVID-19
Dialysis Patients	Secretary has power to waive requirements that home dialysis patients receiving services via telehealth must have a monthly face-to-face, non-telehealth encounter in the first three months of home dialysis and at least once every three consecutive months.
Hospice	During an emergency period, the Secretary may allow telehealth to be used to meet the requirement that a hospice physician or nurse practitioner must conduct a face-to-face encounter to determine continued eligibility for hospice care.
Providers needing to put their home addresses	Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.
Hospitals & Originating Site Fee	Hospitals can bill an originating site fee when the patient is at home. Guidance.
Hospital-Only Remote Outpatient Therapy & Education Services	Hospitals may provide through telecommunication technology behavioral health and education services furnished by hospital-employed counselors or other health professionals who cannot bill Medicare directly. Includes partial hospitalization services and can be furnished when the beneficiary is the home. Guidance.

CMS TELEHEALTH POLICY - NOW

OTHER ISSUES	CMS
Removal of frequency limits	Subsequent inpatient visit limit of once every three days (CPT codes 99231-99233); Subsequent SNF visit limit of once every 30 days (CPT codes 99307-99310) • Critical care consult of once per day (CPT codes G0508-G0509).
Stark Laws	Some waivers allowed for Stark including hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians; health care providers can support each other financially to ensure continuity of health care operations
Supervision/Practice Top of Licensure	Some supervision changes including allowing live video for physician supervision.

CMS Telehealth Manual: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

CMS FAQ - https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

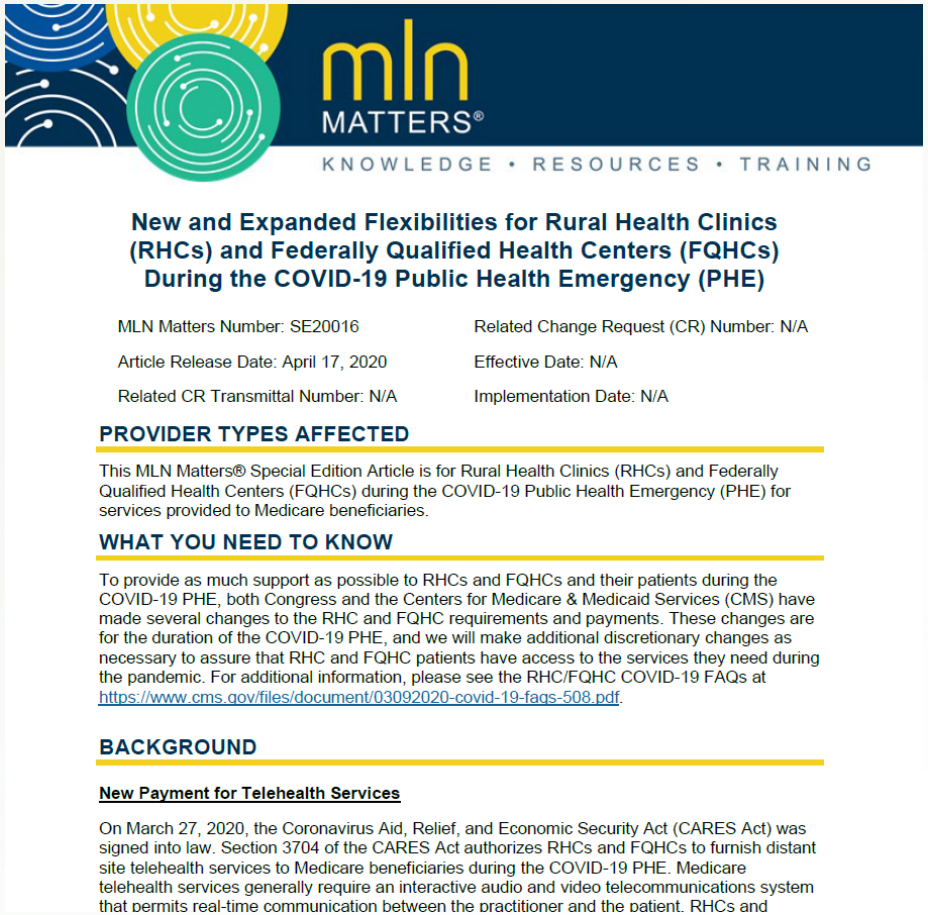
CMS Emergency Declarations - https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

CMS Guidance - https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

CARES ACT

Pre-COVID-19, FQHCs & RHCs were not allowed to act as distant site providers in the Medicare program. The CARES Act changed that and during a public health emergency, they can provide services as a distant site provider using telehealth. **UPDATED APRIL 30, 2020.**

https://www.cms.gov/files/document/se20016.pdf



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KNOWLEDGE • RESOURCES • TRAINING

New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

MLN Matters Number: SE20016 | Related Change Request (CR) Number: N/A

Article Release Date: April 17, 2020 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

To provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 PHE, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic. For additional information, please see the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

BACKGROUND

New Payment for Telehealth Services

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs and

MEDICARE GUIDANCE TO FQHCS/RHCS

THE QUESTION	CMS INSTRUCTION
What modality may be used?	For telehealth, FQHCs and RHCs may furnish services through an interactive audio and video telecommunications system and certain services via audio-only. Some services not considered "telehealth" but use telehealth technologies also available. See "Virtual Communications Services" below.
What provider in my FQHC/RHC can provide services?	Any health care practitioner working at an FQHC/RHC as long as its within his/her scope of practice.
Can my practitioners furnish services when they are at home?	Yes, the health care practitioner does not need to be located at the FQHC/RHC during the telehealth interaction.
What services can be provided?	Only the services that are approved for coverage when delivered via telehealth. The list of services can be found HERE.

MEDICARE GUIDANCE TO FQHCS/RHCS

THE QUESTION	CMS INSTRUCTION
Will an FQHC get their PPS rate/RHC their AIR rate?	No. The CARES Act required a methodology based upon the fee-for-service rates be used to calculate an amount to be paid for telehealth services provided by FQHC/RHCs. This amount is $92.03.
If the FQHC and RHC don't get their PPS/AIR rate, does the Medicare Advantage (MA) wrap-around payment apply to these services?	No. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.
Co-pays?	For services related to COVID-19 testing including those done through telehealth, RHCs/FQHCs must waive the collection of co-insurance from beneficiaries. Use the "CS" modifier on the service line.

MEDICARE GUIDANCE TO FQHCS/RHCS

THE QUESTION	CMS INSTRUCTION
Will the costs for providing telehealth be used to determine the PPS/AIR?	No, but the cost still must be reported on the appropriate cost form. For RHCs – Form CMS-222-17 on line 79 of Worksheet A in the "Cost Other Than RHC Services." FQHCs use CMS-224-14, on line 66 of Worksheet A, "Other FQHC Services."
Do I need to get informed consent?	Not for telehealth, but you do for Care Management and Virtual Communication Services. The consent can be obtained at the same time the services are being furnished and can be obtained by someone working under the general supervision of the RHC/FQHC practitioner and direct supervision of obtaining the consent is not required.

TECHNOLOGY ENABLED/COMMUNICATIONS-BASED SERVICES

SERVICE	MODALITY
Virtual Check-In Codes G2010, G2012	Live Video, Store-and-Forward or Phone
Interprofessional Telephone/Internet/EHR Consultations (eConsult) 99446, 99447, 99448, 99449, 99451, 99452	Can be over phone, live video or store-and-forward
Remote monitoring services: Chronic Care Management (CCM); Complex Chronic Care Management (Complex CCM); Transitional Care Management (TCM); Remote Physiologic Monitoring (Remote PM); Principle Care Management (PCM)	RPM
Online Digital Evaluation (E-*Visit) – G2061-2063 Online Medical Evaluations – 99421-99423	Online portal

Interim Final Rule - https://www.cms.gov/files/document/covid-final-ifc.pdf No CMS guidance document issued yet