



Telehealth Payments in the Response to the COVID-19 Pandemic

Overview

The Centers for Medicare and Medicaid Services (CMS) recently announced changes to key telehealth provisions to expand access for Medicare recipients during the pandemic, but several challenges remain.

Federal Response

Congressional Medicare activity. The [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#) (Public Law No: 116-123) included a provision related to telehealth for the Medicare population. Section 6010 of the [Family First Coronavirus First Response Act](#) (H.R. 6201) made a technical change to the Medicare telehealth provision of the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* (P.L. 116-123) to ensure that new Medicare beneficiaries are able to access telehealth services under the emergency authority granted to the Secretary.

Related Medicare Administrative activity. On March 17, CMS provided new information regarding the implementation of this new waiver authority, including a [press release](#), [fact sheet](#) and updated [FAQ](#). This waiver authority is separate and distinct from the section 1135 waiver authority. The key takeaways from the announcement are as follows:

Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.

These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.

While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.

The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

In addition, the Office of Inspector General ([OIG](#)) published its opinion that during the emergency period “[a] physician or other practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with the then-applicable coverage and payment rules.” The opinion further states that this does “not require physicians or other practitioners to reduce or waive any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services.” For more information, visit the OIG fact sheet [here](#).

Previously, on March 13, Secretary Azar [waived](#) certain requirements, retroactive nationwide as of March 6, related to HIPAA privacy. Specifically, the announcement states the following:

Pursuant to Section 1135(b)(7) of the Act, I hereby waive sanctions and penalties arising from noncompliance with the following provisions of the HIPAA privacy regulations: (a) the requirements to obtain a patient’s agreement to speak with family members or friends or to honor a patient’s request to opt out of the facility directory (as set forth in 45 C.F.R. § 164.510); (b) the requirement to distribute a notice of privacy practices (as set forth in 45 C.F.R. § 164.520); and (c) the patient’s right to request privacy restrictions or confidential communications (as set forth in 45 C.F.R. § 164.522); but in each case, only with respect to hospitals in the designated geographic area that have hospital disaster protocols in operation during the time the waiver is in effect.

On March 17, the Office of Civil Rights ([OCR](#)) announced enforcement discretion for certain widely used communications. Specifically, the OCR press release states “effective immediately, that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.” For more information, see the [statement](#), [fact sheet](#), and [Bulletin](#).

In response to the Medicare changes, the American Medical Association (AMA) shared the [Quick Guide to Telemedicine in Practice](#), a new resource to help mobilize remote care with implementation tips, as well as a reference to Current Procedural Terminology (CPT®) codes for reporting telemedicine and remote care services. The AMA also offers an education module in the AMA’s [STEPS Forward™](#) that can help physicians [use telemedicine in practice](#), and the [Digital Health Implementation Playbook](#) with a 12-steps process for adopting remote monitoring of patients outside the traditional clinical environment.

Application to hospice care. One key concern is whether certain activities (e.g., required face-to-face encounters) could be administered via telehealth under a section 1135 waiver. CMS recently issued a [FAQ](#) directly to that point (copied below).

Question: Are the hospice requirements for a face-to-face encounter waived under Section 1135 of the Act?

*Answer: No. The required timeframe for the occurrence of a hospice face-to-face encounter is typically flexible enough to allow hospices to meet this requirement, even in emergency situations. A face-to-face encounter can occur up to 30 days prior to the start of the third benefit period and 30 days prior to any subsequent benefit periods thereafter (see section 20.1 in chapter 9 of the Medicare Benefit Policy Manual (Pub. 100- 02)). **However, if conditions related to the emergency cause a provider to expect to be unable***

to meet these timeframes, that provider should contact the CMS RO to allow for tracking and completion of this encounter as soon as conditions allow. (emphasis added)

Given that the new telehealth waiver authority is separate and distinct from the section 1135 waiver, to understand the full impact under that authority, it is necessary to review the new FAQs. Unfortunately, the recent announcement regarding telehealth expansion is limited to certain providers, not tied to facilities. The relevant [FAQ](#) (copied below) does not mention hospice providers.

Q: Who are the Qualified Providers who are permitted to furnish these telehealth services under the new law?

A: Qualified providers who are permitted to furnish Medicare telehealth services during the Public Health Emergency include physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services within their scope of practice and consistent with Medicare benefit rules that apply to all services. This is not changed by the waiver.

Recently, the National Hospice and Palliative Care Organization ([NHPCO](#)) has requested that CMS waive the face-to-face encounter requirement.

VA and Telehealth

To bypass state licensure, the Veterans Administration (VA) issued a [final rule](#) “that ensures that VA health care providers can offer the same level of care to all beneficiaries, irrespective of the State or location in a State of the VA health care provider or the beneficiary” and “achieves important Federal interests by increasing the availability of mental health, specialty, and general clinical care for all beneficiaries.”

State Response

State Licensure and Interstate “Compacts”

Given challenges with clinicians providing care across state lines, the Federation of State Medical Board (FSMB) established the [Interstate Medical License Compact Commission \(IMLCC\)](#). According to IMLCC, “[t]he Interstate Medical Licensure Compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states.” At this time, 29 states, the District of Columbia and the Territory of Guam, have agreed to the compact. Additional information about FSMB and telemedicine policy is available [here](#).

According to the Center for Connected Health Policy of the National Telehealth Policy Resource Center report, [State Telehealth Laws & Reimbursement Policies](#), issued in late 2019, “[n]ine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state).”

In addition to the IMLC, there are additional compacts for nurses, physical therapists and psychologists.

- The [Nurses Licensure Compact](#) (34 state members)
- The [Physical Therapy Compact](#) (26 members)
- The [Psychology Interjurisdictional Compact](#) (12 members)

Emergency Management Assistance Compact. Some have suggested that the use of the Emergency Management Assistance Compact, an agreement among the states and U.S. territories allowing sharing of resources during emergencies, would be a good tool to eliminate telehealth licensure barriers. The EMAC includes a provision for someone licensed in one state to be licensed in another facing an emergency when the compact is invoked. According to Bloomberg, Trina Sheets, executive director of the National Emergency Management Association, which administers the compact, said the compact has not been used in the past to provide telehealth services but would make a good vehicle for that purpose.

State Flexibility. The President [declared](#) an emergency under the [Stafford Act](#) on March 13. As a result of that declaration and the prior public health emergency declaration, CMS has additional waiver authority under section [1812\(f\)](#) and [section 1135](#). States can gain new authority to use their Medicaid programs to respond to the coronavirus pandemic under the national emergency President Donald Trump declared Friday. For instance, States may be able to expand the use of telehealth services in their Medicaid programs to combat the coronavirus outbreak. On March 17, CMS issued additional Medicaid telehealth [guidance](#) and while also highlighting their main [website](#) for telehealth in Medicaid. Per the [FAQs](#), “[n]o federal approval is needed 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.”

State activity. On March 15, the State of Washington submitted a section 1135 [waiver](#), which was [approved](#) on March 19, and responds to the specific requests. While the CMS approval does not specifically address telehealth, per the previous FAQ, if the intent is to reimburse providers for telehealth in the same manner or in the same rate that the states pay for face-to-face services, those are considered automatically approved.

Washington requested the following items with respect to telehealth:

Telehealth 42 C.F.R. §410.78(b):

7.1 Consistent with the authority granted the Secretary under the Coronavirus Preparedness and Response Supplemental Appropriations Act, eliminate Medicare restrictions on licensing for telehealth and geographic restrictions on originating sites. Allow billing using CPT codes 99444 and 98969 for both new and established patients. Ask the HHS OIG to confirm that telemedicine screenings without co-pays and deductibles do not violate the CMP law or anti-kickback statute.

7.2 Eliminate the requirement that in order to bill for a telehealth service a provider must have billed that Medicaid or Medicare enrollee for a service within the previous three years.

7.3 Allow E&M codes to be billed via telehealth or telephonic services even for first time patients.

7.4 These steps will allow providers to screen and treat significantly more patients, reduce risk to front line health care providers, and assist in resolving the shortage of providers.

7.5 Allow for reimbursement for telephone visits at the same rate as telehealth video visits. For many cases the video aspect does not add value to the patient interaction – it’s the information relayed to the patient that matters. See CPT codes 99441, 99442, 99443; HCPCS G2012, G0071. The state believes we have authority to do this for telehealth and telephonic services under the Medicaid program, but this provision must be clarified for Medicare. In addition, consistent with our request above for the codes to be opened for new patients in addition to the established patients, which these codes currently only apply.

7.6 Allow capacity funding for providers, which may include grants or other funding Medicaid financing or other dollars available to be used for purchase of equipment as necessary for providers and patients (e.g. laptops, additional cell-phones or additional cell-phone plan minutes for clients so they are free to use the phone for services).

7.7 Provide indemnify/hold harmless for emergency telehealth services.

Key Limitations & Additional Considerations

Key Limitations. Despite these recent activities, key gaps remain, including Medicaid coverage, private payer coverage, and Medicare coverage limited to certain clinicians (not facilities).

Medicaid. As noted above, CMS has provided flexibility for automatic approval for certain State telehealth waivers. For a list of approved waivers, which do not necessarily include all of the telehealth waivers, visit [here](#).

Private payers (especially ERISA covered plans). While CMS Administrator Seem Verma has made it clear that the Administration is urging private payers to make similar modifications, so far, there has not been a broad announcement to that effect. While some states are moving forward to address the topic at the state level, state activities cannot address ERISA-covered plans.

Medicare facilities. Despite the new authority providing much-needed relief for Medicare providers, the waiver is limited to certain providers. As such, there is not a separate way for the facility to bill for services.

Additional Considerations. As providers take steps to implement new telehealth provisions, legal experts suggest that providers should take into account key issues with respect to security (including specific platforms), medical credentials, and recording of those visits. Changes in health care as the coronavirus pandemic progresses may force regulators to adjust barriers around telehealth such as medical licensing, security provisions, and adequate notes of the visits.

Security. While the HIPAA privacy requirements have been waived, the HIPAA security provisions are still in place. The security provision requires covered entities that create, receive, use, or maintain a patient's protected electronic health information to protect it by using secure safeguards. Likely related to those security concerns, while the OCR has provided enhanced access to certain platforms, others have been discouraged (e.g., Facebook Live, Twitch, and TikTok). There are ways to reduce security concerns such as getting patient consent or conducting risk tests that weigh the pressing demand for telehealth against the potential risks.

Medical licensing, credentials, and out of network issues. While Secretary Azar was able to waive certain licensure requirements to allow for Medicare and Medicaid payments to providers who do not have a license within that State, the waiver does not extend to non-Federal programs. As such, some states require physicians to have a medical license in the same state that their patient is located in order to provide virtual healthcare. And, especially with respect to controlled substances, States may have additional requirements for e-prescribing those products. Further, even if the State opts to waive the licensure requirements, it may still have additional requirements regarding credentialing. Finally, even if an out-of-state provider is able to address the licensure and credentialing issues, the provider will likely be considered out-of-network by private payers.

Adequate notes. To ensure proper compliance in the event of an audit, clinicians should ensure that provider notes are adequate and consider the use of audiovisual recording to provide the necessary data to support coding and billing.

Legislative Text. As described above, the text of Public Law No: 116-123, showing changes made by sec. 6010 of H.R. 6201, follows:

SEC. 101. SHORT TITLE.

This division may be cited as the ``Telehealth Services During Certain Emergency Periods Act of 2020''.

SEC. 102. SECRETARIAL AUTHORITY TO TEMPORARILY WAIVE OR MODIFY APPLICATION OF CERTAIN MEDICARE REQUIREMENTS WITH RESPECT TO TELEHEALTH SERVICES FURNISHED DURING CERTAIN EMERGENCY PERIODS.

(a) In General.--

(1) Waiver authority.--The first sentence of section 1135(b) of the Social Security Act (42 U.S.C. 1320b-5(b)) is amended--

(A) in paragraph (6), by striking ``and'' at the end;

(B) in paragraph (7), by striking the period at the end and inserting ``; and''; and

(C) by inserting after paragraph (7) the following new paragraph:

``(8) in the case of a telehealth service (as defined in paragraph (4)(F) of section 1834(m)) furnished in any emergency area (or portion of such an area) during any portion of any emergency period to an individual by a qualified provider (as defined in subsection (g)(3))--

``(A) the requirements of paragraph (4)(C) of such section, except that a facility fee under paragraph (2)(B)(i) of such section may only be paid to an originating site that is a site described in any of subclauses (I) through (IX) of paragraph (4)(C)(ii) of such section; and

``(B) the restriction on use of a telephone described in the second sentence of section 410.78(a)(3) of title 42, Code of Federal Regulations (or a successor regulation), but only if such telephone has audio and video capabilities that are used for two-way, real-time interactive communication.''

(2) Definition of qualified provider.--Section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)) is amended by adding at the end the following new paragraph:

``(3) Qualified provider.--The term `qualified provider' means, with respect a telehealth service (as defined in paragraph (4)(F) of section 1834(m)) furnished to an individual, a physician or practitioner (as defined in paragraph (4)(D) or (4)(E), respectively, of such section) who--

``(A) ~~furnished to such individual an item or service for which payment was made under title XVIII during the 3-year period ending on the date such telehealth service was furnished~~ **furnished to such individual, during the 3-year period ending on the date such telehealth service was furnished, an item or service that would be considered covered under title XVIII if furnished to an individual entitled to benefits or enrolled under such title; or**

``(B) is in the same practice (as determined by tax identification number) of a physician or practitioner (as so defined) who furnished such an item or service to such individual during such period.''

(3) Implementation.--The Secretary of Health and Human Services may implement the amendments made by this subsection by program instruction or otherwise.

(b) Clarification of Definitions of Emergency Area and Emergency Period.--Paragraph (1) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)) is amended to read as follows:

``(1) Emergency area; emergency period.--

``(A) In general.--Subject to subparagraph (B), an `emergency area' is a geographical area in which, and an `emergency period' is the period during which, there exists--

``(i) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

``(ii) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

``(B) Exception.--For purposes of subsection (b)(8), an `emergency area' is a geographical area in which, and an `emergency period' is the period during which, there exists--`

`(i) the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act on January 31, 2020, entitled `Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus'; and

``(ii) any renewal of such declaration pursuant to such section 319.".