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Expanded access to telehealth services during the COVID-19 pandemic

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In response to the COVID-19 pandemic, the U.S. Congress, the Centers for Medicare and Medicaid Services (CMS), many state legislatures and state Medicaid programs, and private payers have implemented significant changes to restrictions on the provision and coverage of telehealth services. These changes are intended to make it easier for individuals to receive treatment remotely during the emergency in order to mitigate risk of exposure for both patients and health care workers, and reduce pressure on an increasingly strained health care infrastructure. The changes are analyzed in detail below.

The federal changes include provisions in the Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSA); last week's Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which we have previously summarized here; the Interim Final Rule (IFR) issued by CMS on March 30 and published on March 31, 2020, and numerous guidance documents posted by CMS. Many of these federal regulatory changes expand the scope of Medicare Part A and Part B benefits available for the duration of the emergency period and, accordingly, impact both Medicare fee-for-service and Medicare Advantage organizations. In addition, earlier this week, CMS announced blanket waivers of certain federal laws and regulations for health care providers. Most of the changes discussed herein are temporary measures that apply only for the duration of the emergency period, which began on January 27, 2020 and will terminate when the Secretary of Health and Human Services (HHS) declares the end of the public health emergency related to COVID-19. The regulatory changes finalized in the IFR, which was effective March 31, are retroactive to March 1, 2020. Comments on the IFR are due June 1, 2020.

I. Changes to Medicare coverage and reimbursement for telehealth

Medicare beneficiaries can receive telehealth services without location or site restrictions

The CPRSA granted HHS the authority to temporarily waive Medicare telehealth restrictions that limit Medicare payment for telehealth services based on where the beneficiaries live and where they receive care. CMS implemented this telehealth waiver authority on March 17, effective as of March 6, 2020. Now, during the period of emergency, beneficiaries can receive telehealth services anywhere in the country, including in their own homes. And effective March 1, CMS's blanket waivers also allow physicians and certain other practitioners to render telehealth services from their homes without having to report their home address on their Medicare enrollment. Further implementation guidance is provided in the IFR and various guidance documents posted on the CMS website.

Medicare will reimburse physicians and other practitioners for telehealth services as if the services were provided in person

Previously, under the Medicare telehealth benefit, the "originating site" where the beneficiary presented for services typically received a small facility fee, while the physician or other practitioner at the "distant site" billed the physician fee schedule rate for his/her services. CPRSA expands the locations where beneficiaries can receive telehealth services, but provides that sites not previously permitted as "originating sites" under the law (e.g., beneficiaries' homes) are not eligible to receive a facility fee. In the IFR, CMS exercised its waiver authority to instruct physicians and other practitioners to bill for telehealth services using a place of service (POS) code as if the services were provided in person, and to use a new Current Procedural Terminology (CPT®)[1] telehealth modifier 95 to identify services furnished via telehealth.

CMS expanded the list of services that Medicare will cover when provided by telehealth, and removed certain frequency restrictions

In the IFR, CMS added, on an interim basis, over 80 CPT codes that are now eligible for reimbursement under Medicare when provided via telehealth. The addition of these codes will expand the ability of health care professionals to screen potential COVID-19 patients via telehealth instead of in person, and will permit the remote assessment and treatment of other patients to

reduce or eliminate the need for those patients to leave their homes or to visit hospitals or physician offices. In addition, on an interim basis, CMS removed frequency restrictions for certain codes.

Relaxation of requirements for telehealth technology

In the IFR, CMS clarified that, for the duration of the emergency period, Medicare will cover telehealth services when provided via technology that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and the distant site physician or practitioner. As noted below, the Office for Civil Rights (OCR), which enforces compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), also announced that it is exercising its enforcement discretion and will not impose penalties on covered health care providers in connection with the good faith provision of telehealth using common audio or video communication products that may not be fully HIPAA compliant.

In the IFR, CMS also finalized, on an interim basis, separate payment for certain CPT codes that generally describe audio-only communication between a practitioner and patient. CMS also announced that it will not enforce the requirement that certain of these codes be used only for established patients.

Medicare beneficiaries are not required to have a pre-existing relationship with the physician or other practitioner providing telehealth or related services in order to receive reimbursement

Section 3703 of the CARES Act further amended the telehealth emergency authority provision enacted in the CPRSA to remove a requirement that the physician or practitioner providing the telehealth service must have treated the beneficiary in the prior three years or be in the same practice as a physician or practitioner who treated the beneficiary in the same time period.

In the IFR, CMS stated that certain communication technology-based services (CBTS), such as virtual check-ins and remote monitoring, can be furnished to both new and established patients. CMS also specified that patient consent for such services can be obtained at the same time the service is rendered, and may be collected by auxiliary staff under general supervision rather than direct supervision.

Physicians and other practitioners are not required to hold licenses in the state in which they provide telehealth services for purposes of reimbursement under federal health care programs

Physicians and other practitioners are required to be licensed in the states in which they provide services for purposes of reimbursement under federal health care programs, and, in the case of telehealth services, that typically means they must be licensed where the patients they are treating are located at the time of treatment. On March 13, 2020, HHS waived the requirement that physicians or other health care professionals hold licenses in the state in which they provide services, if they have an equivalent and unrestricted license from another state, for such purposes. However, physicians and other practitioners must remain mindful of state licensure requirements that otherwise remain in effect, subject to state law waivers or orders as discussed below.

Physicians and non-physician practitioners may provide direct supervision using real-time interactive audio and video technology

In the IFR, CMS revised the definition of direct supervision to allow, for the duration of the emergency period, direct supervision to be provided using real-time interactive audio and video technology. Prior to the IFR, direct supervision has meant that the physician must be present in the office suite and immediately available to furnish assistance during the procedure. However, for the duration of the emergency period, physicians can meet the direct supervision requirement by virtual presence using audio/video real-time communications that allows the physician to be immediately available to furnish assistance.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) can serve as distant sites for telehealth services under Medicare

Section 3704 of the CARES Act allows FQHCs and RHCs to serve as telehealth distant sites and receive reimbursement for services provided to eligible beneficiaries during the emergency period. Section 3704 further specifies that FQHCs and RHCs will be reimbursed for such telehealth services at payment rates similar to the PFS.

Use of telehealth in the home health setting

In the IFR, CMS amended regulations to allow, for the duration of the emergency period, home health agencies to use technology in conjunction with the provision of in-person visits provided the telehealth visits meet certain requirements.

Telehealth in skilled nursing facilities

CMS is waiving the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents and will allow visits to be conducted, as appropriate, via telehealth options.

Telehealth for hospice patients

To determine continued eligibility for hospice care, CMS requires periodic face-to-face visits between a hospice patient and a hospice physician or nurse practitioner. Section 3706 of the CARES Act permits these visits to be conducted by telehealth during the emergency period.

CMS also amended the hospice regulations, on an interim basis, to specify that routine home care visits provided to hospice patients may be done via telehealth if feasible and appropriate. The use of the technology must be included in the plan of care and tied to the patient-specific needs.

Telehealth in the Inpatient Rehabilitation Facility (IRF)

In the IFR, CMS encouraged rehabilitation physicians to continue in-person assessments as long as necessary precautions are taken; however, during the emergency period, CMS is temporarily allowing certain required face-to-face visits to be conducted via telehealth. Moreover, CMS is removing the post-admission physician evaluation requirement for all IRFs during the emergency period.

II. Changes to Medicaid coverage and reimbursement of telehealth services

CMS issued guidance to state Medicaid programs that included, among other things, a reminder that states have broad flexibility to cover telehealth through their Medicaid programs, including through various methods of communication (such as telephonic, video technology commonly available on smart phones and other devices). Although no 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, a state plan amendment (SPA) would be necessary to accommodate any revisions to payment methodologies for telehealth costs if the state wants to receive federal matching funds for increases in payments under its state plan delivery system.

CMS also encouraged states to amend Medicaid Managed Care (MMC) contracts, as needed, to extend the same telehealth flexibilities authorized under their state plan, waiver, or demonstration for services covered under the contract. Absent coverage under the state plan or otherwise through a Medicaid waiver or demonstration, CMS noted that MMC plans may rely on offering telehealth services as value-added services or as alternatives to other services, subject to ongoing compliance with certain regulatory requirements.

III. Changes to other federal laws related to the provision of telehealth services

Certain HIPAA requirements waived for telehealth services during emergency period

HHS OCR announced that it is exercising its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with HIPAA and its implementing regulations in connection with the good faith provision of telehealth services using common, non-public facing audio or video communication products such as FaceTime, Google Hangouts, or Skype during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, not just related to the diagnosis and treatment of health conditions related to COVID-19.

Physicians and other practitioners may reduce or waive cost-sharing amounts owed by federal health care program beneficiaries for telehealth services

On March 17 and March 24, 2020, the HHS Office of Inspector General (OIG) released policy statements indicating that during the emergency period it will not seek administrative sanctions against physicians and other practitioners who reduce or waive any cost-sharing amounts owed by federal health care program beneficiaries for telehealth services and other non-face-to-face services such as virtual check-ins, remote care management and remote patient monitoring. In addition, on March 30, the OIG announced it would exercise enforcement discretion to offer flexibility for health care providers to provide goods and services necessary to respond to the pandemic without fear that their conduct will be subject to enforcement under the rules that would ordinarily apply, including with respect to telehealth services, which we previously summarized here.

Practitioners registered with the Drug Enforcement Agency (DEA) may issue prescriptions for controlled substances to patients via telehealth

On March 16, 2020, the Acting DEA Administrator activated the public health emergency exception in the Controlled Substances Act to allow DEA-registered practitioners to prescribe controlled substances via telehealth rather than an in-person evaluation if (1) the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; (2) the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and (3) the practitioner is acting in accordance with applicable federal and state laws.

IV. Certain changes to state licensure and other state laws to facilitate telehealth

In addition to the many federal program changes related to telehealth services, state legislatures, medical boards and other state agencies have taken steps to encourage or facilitate the use of telehealth within their states. These state actions include: waiving requirements for physicians and certain other health care practitioners to be licensed in the state in order to provide telehealth services to a patient in the state, provided they hold a valid license in another state; granting temporary licenses to physicians and other health care practitioners already licensed in another state; and waiving licensure fees, continuing education and background check requirements. On March 24, 2020, HHS sent a letter to state governors asking them to modify regulatory and legal requirements around licensure, standard of care, scope of practice, supervision requirements, licensure and certification requirements, student practice and malpractice insurance in an attempt to free up resources. Some states have temporarily revised their statutes and regulations to expand the types of services that can be provided by telehealth or waive certain restrictions, such as requirements for having first established an in-person patient relationship. Some states have even waived requirements that telehealth services be provided through equipment allowing real-time audio and video interaction, and have allowed audio-only (telephone) communications to qualify as telehealth in some circumstances.

Note that even with CMS's waiver of the Medicare requirement that telehealth providers must be licensed in the state in which the patient is located, providers still must ensure they are in compliance with applicable state licensure requirements.

V. Certain changes to private payer coverage of telehealth

While private payer policies regarding coverage and reimbursement of telehealth services have always varied a great deal, many insurers have announced policy changes to make telehealth services more widely available and affordable. Many insurers have expanded the list of services that they will cover when provided by telehealth, and many have made telehealth services available without any cost sharing to their insureds for a limited period of time, or for certain services, such as screening and assessment related to COVID-19.

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Federal and state actions regarding the use of telehealth to provide services during the COVID-19 pandemic are ongoing, and laws and implementation guidance are expected to continue to evolve. Should you have questions about the changes to the restrictions on the provision and coverage of telehealth services, please do not hesitate to contact the Hogan Lovells attorney with whom you regularly work or any attorney listed on this alert.

Authored by Brooke Bumpers, Sheree Kanner, Ken Choe, Stuart Langbein, Melissa Bianchi, Beth Roberts, Thomas Beimers, Craig Smith, Beth Halpern, Margaux Hall, and Laura Hunter

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Contacts

Brooke Bumpers
Counsel
Washington D.C.
brooke.bumpers@hoganlovells.com

Sheree Kanner
Partner
Washington D.C.
sheree.kanner@hoganlovells.com

Ken Choe
Partner
Washington D.C.
ken.choe@hoganlovells.com

Stuart Langbein
Partner
Washington D.C.
stuart.langbein@hoganlovells.com

Melissa Bianchi
Partner
Washington D.C.
melissa.bianchi@hoganlovells.com

Beth Roberts
Partner
Washington D.C.
beth.roberts@hoganlovells.com

Thomas Beimers
Partner
Washington D.C.
thomas.beimers@hoganlovells.com

Craig Smith
Partner
Miami
craig.smith@hoganlovells.com

Beth Halpern
Partner
Washington D.C.
elizabeth.halpern@hoganlovells.com

Margaux Hall
Partner
Washington D.C.
margaux.hall@hoganlovells.com

Laura Hunter
Associate
Washington D.C.
laura.hunter@hoganlovells.com

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