OVERVIEW OF FEDERAL TELEHEALTH POLICY AND REIMBURSEMENT

I. EXECUTIVE SUMMARY

This primer provides an overview of federal telehealth policy and reimbursement beginning with Medicare fee-for-service (FFS) telehealth coverage and payment policies, including recent key developments (section I). In section IV, the primer outlines other technology-based, non-face-to-face services that are related to but distinct from Medicare "telehealth services" – such as chronic care management (CCM), remote patient monitoring (RPM) and virtual care services.

Next, the primer outlines new telehealth flexibilities in Medicare Advantage (MA) (section V), as well as current delivery system reform initiatives, including the flexibilities leveraged by the Centers for Medicare and Medicaid Services' (CMS) Innovation Center via demonstration authority (section VI). We then turn to Medicaid telehealth coverage issues and provide a broader perspective of the state landscape to that end (section VII). Following that discussion is a section detailing the efforts of non-Department of Health and Human Services (HHS) telehealth initiatives that may be of interest, such as those undertaken by the US Department of Agriculture (USDA) (section VIII).

Finally, we offer some concluding remarks about potential next steps on the federal telehealth front, including forthcoming reports to Congress delineating telehealth recommendations (due this fall) and prospects of telehealth provisions being included in upcoming "opioids 2.0," rural health or other moving legislative vehicles later this year (section IX).

II. INTRODUCTION

Recent strides have been made to enhance Medicare FFS beneficiaries' access to telehealth services – including through annual updates to the list of Medicare-covered Part B telehealth services, as well as through broader statutory reforms outlined in the primer.

However, due to Medicare's statutory telehealth coverage restrictions (originating site, geographic limitations), only a small proportion of Medicare FFS beneficiaries – about one-quarter of a percent (0.25 percent) – utilized telehealth services in 2016. However, CMS notes that this figure only accounts for "services reported and paid as telehealth services" but does not take into consideration "certain other technology-based services that are not considered telehealth services under the law (e.g., remote cardiac monitoring), and services that are not separately billable (e.g., provider-to-provider consults)."[1]

[1] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf

Additionally, the MA program provides an avenue to offer telehealth services via supplemental benefits, with recent legislation enabling MA plans to provide "additional telehealth benefits" as part of its annual bid, beginning in 2020. Meanwhile, CMS' Innovation Center continues to flex its section 1115A authority, pursuant to the Affordable Care Act (ACA), to test new delivery reforms, including those that enhance access to telehealth benefits.[2]

Finally, in Medicaid, states have considerable flexibility "to determine how telehealth is paid and to determine the laws, rules, regulations, and policies governing telehealth." As a result, nearly all states have opted to reimburse for some type of telehealth or technological-enabled, non-face-to-face (e.g., RPM) services.[3]

III. MEDICARE FEE-FOR-SERVICE

A. Overview

Medicare FFS covers telehealth services furnished via a telecommunications system for certain services – such as professional consultations, office visits, and office psychiatry services – provided specified conditions are met.

Telehealth services must be delivered via an interactive audio and video telecommunications system that permits real-time (synchronous) communication between the physician[4] or qualified practitioner[5], the distant site, and the beneficiary, at an authorized originating site[6] (detailed below). CMS clarifies that "[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system."[7] In general, with limited exceptions (e.g., existing federal telemedicine demonstrations in Alaska and Hawaii, Medicare FFS does not reimburse for 'asynchronous' or 'store and forward' technology – i.e., where a patient's information is transmitted and viewed/read later by the distant site practitioner.[8]

In addition to the technological stipulations, Medicare coverage for telehealth services is broadly hampered by geographic and 'originating site' statutory requirements that limit telehealth reimbursement to

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[2] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf
[3] Ibid.
[4] Defined at section 1861(r)): https://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-r
[5] Defined at section 1842(b)(18)(C): https://www.ssa.gov/OP_Home/ssact/title18/1842.htm#act-1842-b-18-c. Qualified distant site practitioners (subject to applicable state law) include, in addition to physicians, nurse practitioners (NPs) physician assistants (PAs); nurse-midwives; clinical nurse specialists (CNSs); certified registered nurse anesthetists (CRNAs); clinical psychologists (CPs) and clinical social workers (CSWs) (with some billing limitations re: psychiatric diagnostic interview examinations); and registered dietitians or nutrition professionals. See: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf.
[6] Defined at section 1834(m)(4)(C)(ii): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[7] Defined at 42 CFR §410.78: https://gov.ecfr.io/cgi-bin/text-idx?SID=8f5058c7546f10c9874b9afd0f5cecac&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_178
[8] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

beneficiaries located in rural areas – e.g., a county outside of a Metropolitan Statistical Area (MSA); or a rural Health Professional Shortage Area (HPSA) located in a rural census tract.[9]

Further, only eight types of health care settings (originating sites) are authorized to receive Medicare reimbursement for services on the list of Medicare telehealth services.[10] Authorized originating sites include: (1) the offices of physicians or practitioners; (2) hospitals; (3) critical access hospitals (CAHs); (4) rural health clinics (RHCs); (5) federally qualified health centers (FQHCs); (6) hospital-based or CAH-based renal dialysis centers (including satellites); (7) skilled nursing facilities (SNFs); and (8) community mental health centers (CMHCs).[11] Therefore, unless the originating site requirements are waived or modified, (e.g., via statutory changes or existing demonstration authority), a beneficiary's home does not typically qualify as an originating site.

B. Covered Telehealth Services

Additions or modifications to the list of Medicare-covered telehealth services are vetted by CMS and finalized during the annual Medicare Physician Fee Schedule (Medicare PFS) rulemaking process. Pursuant to a change codified in the Calendar Year (CY) 2019 MPFS final rule[12], CMS now accepts requests for additions to the list of Medicare telehealth services by February 10 of each year (as opposed to the previous deadline of December 31). Therefore, for telehealth services to be considered during the PFS rulemaking for CY 2021, requests must be submitted to CMS by February 10, 2020.[13] CMS made this change to align with the agency's receipt of code valuation recommendations from the American Medical Association's (AMA) Relative Value Scale (RVS) Update Committee (RUC).[14]

Appendix A lists the Medicare-covered telehealth services for CY 2019.

C. Recent Key Developments

CMS recently issued regulations codifying robust Medicare FFS telehealth coverage expansions for certain services – home dialysis, acute stroke, and substance abuse/mental health – pursuant to the Bipartisan Budget Act of 2018 (BBA)[15] and the opioid legislative package last fall, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (or SUPPORT for Patients and Communities Act).[16]

Further, CMS continues to leverage its existing administrative authority to expand telehealth access via annual updates to the list of Medicare-covered telehealth services (which are subject to 'originating site,'

[9] Refer to section 1834(m): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[10] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
[11] Defined at section 1834(m)(4)(C)(ii): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[12] https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf
[13] Additional details about the submission process are available at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Submitting.html
[14] https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf
[15] https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf
[16] https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf

geographic and other restrictions); increased coverage of RPM and other virtual care services (technology-based services that are related to but distinct from telehealth); as well as ongoing delivery reforms incorporating telehealth services.

1. Home Dialysis and Tele-stroke

In the CY 2019 Medicare PFS final rule,[17] CMS effectuated BBA-authorized provisions that expanded Medicare FFS telehealth coverage for beneficiaries with end-stage renal disease (ESRD) and acute stroke. These provisions took effect on Jan. 1, 2019. Specifically, CMS added ESRD beneficiaries' homes and free-standing renal dialysis facilities to the list of originating sites and waived the application of Medicare's telehealth geographic requirements (including for hospital-based or CAH-based renal dialysis centers) for purpose of the home dialysis monthly ESRD-related clinical assessments.

Additionally, CMS finalized provisions adding mobile stroke units to the permissible list of originating sites for the diagnosis, evaluation, or treatment of symptoms of an acute stroke. As with home dialysis monthly ESRD-related clinical assessments, CMS waived the application of Medicare's geographic coverage restrictions, thereby expanding telehealth coverage for ESRD and acute stroke beneficiaries.

2. Substance Use Disorder and Behavioral Health

In addition to ESRD and acute stroke telehealth provisions, CMS incorporated in its CY 2019 Medicare PFS final rule an interim final rule with comment period to implement a provision in the opioid legislative package last fall, the SUPPORT for Patients and Communities Act.[18] Pursuant to the new law, CMS finalized the addition of the individual's home as a permissible originating site for telehealth services furnished on or after July 1, 2019 for purposes of treatment of a substance use disorder (SUD) or a co-occurring mental health disorder.

In the same rule, CMS established a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Part B, beginning on or after January 1, 2020. In the rule, CMS sought "information regarding services furnished by OTPs, payments for these services, and additional conditions for Medicare participation for OTPs that stakeholders believe may be useful for CMS to consider for future rulemaking to implement this new Medicare benefit category."[19]

3. Other Newly-Added Telehealth Services

In addition to the broader ESRD, acute stroke and SUD-focused telehealth provisions, CMS has expanded access to Medicare-covered telehealth services via its annual Medicare PFS rulemaking process. For example, in the CY 2018 Medicare PFS final rule, CMS added several codes to the list of telehealth services

[17] https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf
[18] https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf
[19] https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf

including: CPT codes 96160[20] and 96161[21] (Health Risk Assessment); and CPT codes 90839[22] and 90840[23] (Psychotherapy for Crisis), among other codes.[24]

More recently, in its CY 2019 Medicare PFS final rule, CMS added two new G-codes (G0513 – first 30 minutes[25] and G0514 – for each additional 30 minutes[26]) to the list of Medicare-covered telehealth services for prolonged preventive services (effective CY 2019). However, for prolonged preventive services and all other Medicare telehealth services generally (unless specifically exempted), Medicare's broader statutory telehealth requirements regarding originating sites and geographic limitations continue to apply.

IV. TECHNOLOGY-BASED (BUT NON-TELEHEALTH) SERVICES

A. Chronic Care Management

1. Overview

CMS defines CCM as "[c]are coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline." CMS adds that "[t]hese services are typically non-face-to-face and allows eligible practitioners to bill for at least 20 minutes or more of care coordination services per month."[27]

CMS began paying separately for CCM services under the MPFS in CY 2015. Prior to CY 2015, Medicare FFS payment for non-face-to-face care management services was bundled into the payment for face-to-face evaluation and management (E/M) visits.[28] In recognition of the added time that practitioners spend on between-appointment care coordination for chronically-ill beneficiaries, CMS unbundled Current Procedural Terminology (CPT) code 99490[29] to enable a separate monthly reimbursement when at least 20 minutes of non-face-to-face clinical staff time is spent on a Medicare patient with multiple chronic conditions.

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[20] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=96160&M=5
[21] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=96161&M=5
[22] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=90839&M=5
[23] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=90840&M=5
[24] https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-medicare-physician-fee-schedule-calendar-year-2018
[25] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=G0513&M=5
[26] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=G0514&M=5
[27] https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources.html
[28] https://www.federalregister.gov/documents/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory
[29] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99490&M=5

CMS stipulates several requirements of qualifying practitioners[30] to bill for CCM and complex CCM codes, including: documentation in a patient's medical record that written or verbal consent was obtained to furnish CCM services after informing the patient of applicable cost-sharing; that only one practitioner may be paid for their CCM services during a calendar month; and that they have the right to stop CCM services at any time.[31] Additionally, the practitioner must use certified electronic health record technology (CEHRT) to record certain patient data including demographics, medical problems, medications, and medication allergies.[32]

2. Recent Key Federal Developments

In CY 2017, CMS unbundled two additional "complex" CCM codes (CPTs 99487[33] and 99489[34]) to allow for higher rates of reimbursement in cases when 60 minutes or more of nonface-to-face clinical staff time is required for patients presenting a higher degree of complexity. These complex CCM codes cannot be billed for the same patient in the same month that non-complex CCM code 99490 is billed; however, CPT 99487 can be billed instead to attain a higher payment rate where care coordination activities have exceeded 60 minutes of clinical staff time in a calendar month, and CPT 99489 may be billed for each additional 30 minutes after that.

In addition to the complex CCM codes introduced, the CY 2017 Medicare PFS final rule also reduced certain requirements associated with the initiating visit, so that only new patients or those not seen within a year require an in-person visit prior to the commencement of CCM payment.[35] When an initiating visit is necessary to commence CCM, the CY 2017 final rule also introduced Add-On code G0506[36] which may be billed on top of the in-person visit – i.e. an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE] or other face-to-face encounter – when the practitioner personally performs extensive assessment and CCM care planning beyond what is normally described for the visit.

Additional provisions of the CY 2017 MPFS rule reduced administrative burden associated with billing CCM codes by focusing on timely sharing and availability of health information rather than use of specific electronic technology, simplifying patient consent requirements, and reducing documentation rules.[37]

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[30] CCM and complex CCM codes may be billed by physicians, PAs, CNSs, NPs, and certified nurse midwives (CNMs), as well as federally-qualified health centers (FQHCs), rural health clinics (RHCs), and critical access hospitals (CAHs). See: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf.

[31] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

[32] Ibid.

[33] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99487&M=5

[34] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99489&M=5

[35] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf

[36] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=G0506&M=5

[37] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf

Finally, the rule newly allowed for the billing of non-complex CCM under CPT code 99490 by federally qualified health centers (FQHCs) and rural health clinics (RHCs). Complex CCM codes are not payable at these sites, nor is the add-on code for initiating visits.[38]

Finally, CMS effectuated changes in the CY 2018 Medicare PFS final rule to deem RPM "complementary" to billable CCM services[39] and, in the CY 2019 Medicare PFS final rule, added three new CCM codes for remote monitoring of blood pressure, the latter of which are discussed immediately below.

B. REMOTE PATIENT MONITORING AND VIRTUAL CARE

1. Overview

RPM, a distinct modality within a broader range of telehealth-related services, leverages "digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations."[40] RPM may assist in allowing providers to effectively manage patients outside traditional health care settings and in reducing hospitalizations and readmissions.[41]

As detailed below, CMS distinguishes RPM from traditional Medicare-covered telehealth services, the latter of which are subject to statutory coverage restrictions (originating site, geographic limitations and otherwise). Additionally, in the latest round of Medicare PFS rulemaking (CY 2019), CMS began paying for two new communication technology-based services – "virtual check-ins" – that enable practitioners to determine whether an office visit or other service is needed.[42]

2. Recent Key Federal Developments

Through the rulemaking process, CMS has taken steps to more clearly distinguish RPM from telehealth services, as defined under section 1834 of the Social Security Act (SSA), and to create more opportunities for Medicare reimbursements.[43] In each of these rules, CMS emphasized that services furnished remotely using communications technology are not substitutes for an in-person visit and are not considered as among the list of statutorily defined "Medicare telehealth services," and are thus not subject to statutory telehealth coverage restrictions.

In November 2017, CMS finalized a policy allowing for a separate payment for remote monitoring in Medicare via the CY 2018 MPFS final rule.[44] Specifically, the agency unbundled CPT code 99091[45] allowing providers to collect reimbursement separately for time spent (30 minutes or more) on the collection

[38] Ibid.
[39] https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf
[40] https://www.cchpca.org/about/about-telehealth/remote-patient-monitoring-rpm
[41] Ibid.
[42] https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf
[43] https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
[44] https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf
[45] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99091&M=5

and interpretation of patient health data generated remotely from devices such as electrocardiogram (ECG), blood pressure, and glucose monitors.

Most recently, through the CY 2019 MPFS final rule, effective January 1, 2019, CMS added a new family of codes (CPT codes 99453[46], 99454[47], and 99457[48]) titled "Chronic Care Remote Physiologic Monitoring," to better reflect how services are delivered to patients. For example, where code 99091 requires a minimum of 30 minutes per 30-day period, code 99457 would require only 20 minutes per calendar month and may be billed by "clinical staff" (nurses, medical assistants, etc.) in addition to physicians and qualified health care professionals. The additional codes allow reimbursement for time spent setting up remote monitoring equipment and training patients on their use, which may help to incentivize wider adoption.[49]

Considering improvements to communication technology in the health care setting, CMS added a new code (HCPCS code G2012[50]) for separate payment for a "brief communication technology-based service, e.g., virtual check-in," used to determine if an office visit is necessary.[51] Additionally, CMS created a new code (HCPCS code G2010[52]) for separate payment of "remote professional evaluation of patient-transmitted information conducted via 'store and forward' video or image technology."[53] Specifically, still or video images generated by patients or information from medical devices, such as heart monitors, would be transmitted to a physician, who would have 24 business hours to determine if an office visit is necessary. Like RPM, virtual care services may not substitute an in-person office visit and, therefore, are not subject to Medicare's statutory originating site and geographic restrictions for telehealth services. CMS stipulated certain billing requirements pertaining to HCPCS codes G2012 and G2010 to ensure that an authorized practitioner may only bill separately for virtual care if it is a stand-alone service that occurs outside the defined timeframe.

On a separate but related note, as part of the separate CY 2019 home health prospective payment system (HH PPS) final rule, CMS finalized a policy to define RPM under the Medicare home health benefit as ''the collection of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the HHA [home health agency]."[54]

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[46] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99453&M=5
[47] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99454&M=5
[48] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=99457&M=5
[49] https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf
[50] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=G2012&M=5
[51] Ibid.
[52] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=G2010&M=5
[53] Ibid.
[54] https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf

Lastly, as result of the Bipartisan Budget Act of 2018 (BBA)[55], CMS released a proposal to allow Medicare Advantage (MA) plans to offer RPM as a supplemental benefit. Public comments were due Dec. 31, 2018 and a final rule is still pending.[56]

V. MEDICARE ADVANTAGE

A. Overview

MA provides managed care services to enrollees and is financed through a capitated payment arrangement. Recent statutory changes have resulted in greater flexibilities for MA plans to offer telehealth services to enrollees.

B. Recent Key Developments

In the BBA of 2018, Congress authorized MA plans to offer additional telehealth benefits for certain services under Medicare Part B that are "clinically appropriate" to deliver via telehealth.

Recent proposed regulatory changes – if enacted as written – would further codify these statutory authorizations, namely in CMS' CY 2020 MA and Part D proposed rule. Providing further specificity to the provisions included in the BBA, CMS outlined certain flexibilities that would significantly increase MA plan sponsors' abilities to expand telehealth service offerings.[57] Specifically, the proposal would account for "additional telehealth benefits" in the program's capitated payments. CMS proposes to define additional telehealth benefits as services that "(1) are furnished by an MA plan for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act [relating to Medicare payment for telehealth]; and (2) have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange." As noted above, per provisions included in the BBA, these services may include RPM as a supplemental benefit.

Of note, CMS believes MA plans are best-suited to determine which telehealth services are clinically appropriate to furnish electronically, leaving wide discretion for sponsors to determine which services to offer via telehealth. Beyond this, CMS will also offer additional telehealth flexibilities within the MA program involving new, value-based model approaches. Such changes are included below in the Delivery System Reforms section of this document.

VI. DELIVERY SYSTEM REFORMS

While telehealth has a place in current care delivery models, certain delivery reform initiatives are experimenting with expanded use of this innovative service modality. As noted previously, use of telehealth in Medicare FFS is limited due to statutory coverage restrictions (originating site, geographic limitations)

[55] https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf
[56] https://www.federalregister.gov/documents/2018/11/01/2018-23599/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare
[57] https://www.federalregister.gov/documents/2018/11/01/2018-23599/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare

and presumably due to the program's inherent reimbursement construct, which lacks explicit provider incentives to control telehealth-associated costs.[58]

However, in value-based payment arrangements, Medicare rewards providers for delivering high-quality care and generating savings. In some cases, providers are incentivized to do so by receiving a cut of any cost savings they may generate. And in others, providers receive prospectively set payments to manage the care of their patient populations, a payment arrangement known as capitation. Importantly, these rates do not change based on beneficiary care utilization. As such, value-based programs have greater flexibility to leverage telehealth services without concern over inciting higher beneficiary utilization. CMS and policymakers can therefore examine the effect of broader use of telehealth on cost, quality, and health.

A. Updates to the Medicare Shared Savings Program

Consider first the Medicare Shares Savings Program (MSSP).[59] In this program, Accountable Care Organizations (ACOs) establish integrated provider networks that, together, manage the care of attributed beneficiaries. Participating providers are encouraged to find meaningful ways to lower the total cost of care by the prospect of receiving a portion of any savings they generate against Medicare-established spending benchmarks.

Recent changes to the MSSP suggest CMS intends for ACOs to experiment with using telehealth as a cost-savings and quality-improvement strategy.[60] As noted previously, traditional Medicare rules limit providers' abilities to use telehealth unless specific geographic and originating site requirements are met. Beginning in 2020, however, ACOs that take on two-sided risk will be able to provide telehealth services to a much larger portion of the Medicare population (e.g., including beneficiaries in non-rural locations) than they would otherwise be able to under traditional Medicare. Such a change will allow providers to reach beneficiaries in their homes, which may be especially impactful for providers who manage rural populations. The thinking behind this is clear: CMS is allowing ACOs to experiment with broadened use of telehealth within a scheme of two-sided risk, where CMS is not at exceptional risk of financial loss, and where providers stand to gain.

B. Medicare Advantage Value-Based Insurance Design Model

Pursuant to section 1115A authority, the CMS Innovation Center[61] operates a multitude of demonstration programs that seek to test the effects of new care delivery and payment models. One such program, through MA, tests how health plans can encourage higher-value care through different benefit designs and offerings. Called the MA value-based insurance design (MA VBID) model, this demonstration provides plans with flexibilities not available in traditional MA to incent higher-value care.[62]

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[58] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0
[59] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
[60] https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicare-program-medicare-shared-savings-program-accountable-care-organizations-pathways-to-success
[61] https://innovation.cms.gov/
[62] https://innovation.cms.gov/initiatives/VBID

In early 2019, the Innovation Center announced that it will be introducing four new interventions that MA VBID plans may offer in 2020.[63] One such intervention will be to leverage telehealth providers to ensure or improve network adequacy. Plans will be encouraged to submit their strategies for creatively leveraging telehealth to address unmet care needs among their patient populations. Because MA operates under a capitated arrangement, CMS seeks creative proposals on how plan participants in the model will leverage telehealth to cost-effectively improve outcomes and patient access in a payment context that does will not drastically increase Medicare program spending.

C. PTAC Developments

One route by which HHS determines new models for testing is through the Physician-Focused Payment Model Technical Advisory Committee (PTAC).[64] Established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), PTAC reviews submitted alternative payment models (APMs) to assess their viability for implementation. If PTAC finds that a submitted model shows merit, PTAC may recommend it to the Secretary of HHS for implementation. The Secretary may then decide to implement a model, which may come through the form of a demonstration model.

Of note, in February 2019, the University of New Mexico, Health Sciences Center (UNM) submitted a proposed payment model that leverages telemedicine solutions to prevent costly medivac transports from rural hospitals to the state's university hospital.[65] The model focuses on emergent cerebral care, which rural hospitals are typically less-equipped to address. In broad terms, UNM's model – the Access to Critical Cerebral Emergency Support Services (ACCESS) – creates a platform by which university hospital physicians can provide real-time consults to rural emergency room providers, allowing beneficiaries to receive high-quality care without requiring a costly transport. In the proposed ACCESS model, the design team reported substantial Medicare savings primarily through avoided patient transports, given average air transfer costs $30,000. Moreover, patients showed improved outcomes due to more timely receipt of care.

After the three-week public comment period closes on March 24, 2019, a PTAC review team will internally review the proposal and submit their written findings to the full PTAC. There is no established timeframe by which this must occur. PTAC will then hold their final deliberation on this model and determine whether they recommend it for implementation at a subsequent PTAC public meeting, which typically held quarterly.[66] While it is uncertain whether PTAC will recommend this model for full implementation to the Secretary, such a model serves as an example of the kinds of innovative uses of telehealth that HHS is considering as it seeks to identify broader applications for telehealth platforms.

D. Primary Care and Telehealth

Though telehealth can serve as a critical time-saver during emergency care episodes as described above, its use is also being explored as a means for expanding access to primary care services. In another Innovation Center demonstration, the Comprehensive Primary Care Plus (CPC+) model, primary care teams are

[63] https://www.cms.gov/newsroom/fact-sheets/value-based-insurance-design-model-vbid-fact-sheet-cy-2020
[64] https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee
[65] https://aspe.hhs.gov/system/files/pdf/255906/ProposalUNMHSC.pdf
[66] https://aspe.hhs.gov/system/files/pdf/226776/PTACProposalInstructions508.pdf

encouraged to offer services through alternative modalities.[67] One such modality is telehealth, whereby care teams may offer patients more convenient ways for accessing care in non-emergent situations. Primary care practices are able to do so more freely, as they do not operate under a FFS arrangement and instead receive capitated payments for the number of patients attributed to the practice.

In 2017, the first CPC+ program year, CMS reported that approximately 34 percent of practices were now offering telehealth or e-visits as alternate care modalities.[68] As a result, more patients are receiving primary care services they may otherwise not have due to barriers seeing their provider in-person. Though CMS has not conducted evaluations for the model yet, it is plausible that increased access to primary care services will lead to improved outcomes and reduced inpatient or emergency department utilization.

VII. MEDICAID AND STATE LANDSCAPE

A. Overview

While federal Medicaid statute does not explicitly recognize telemedicine as a distinct service, CMS generally views telemedicine as a "cost-effective alternative" to traditional face-to-face consultations or examinations. As such, states have considerable flexibility in covering and reimbursing for these activities, so long as payments do not exceed Federal Upper Limits (FPLs).[69] Further, states do not need to submit a separate State Plan Amendment (SPA) for establishing the coverage of telemedicine services if it reimburses providers the same as a face-to-face service. However, states must obtain approval from CMS if reimbursement differs from the face-to-face service.[70]

CMS estimates that, "[a]s of spring of 2018, 49 states and Washington, DC provide reimbursement for some form of live video in Medicaid [FFS]. Fifteen states provide reimbursement for store-and-forward. In addition, twenty state Medicaid programs provide reimbursement for [RPM]."[71]

B. Recent Key Developments

The SUPPORT for Patients and Communities Act includes a provision requiring CMS to issue, within one year of the bill's enactment (i.e., on or around October 24, 2019) guidance on providing SUD treatment via telehealth to students in school-based health centers and high-risk individuals, such as American Indians, adults under 40, persons with a history of non-fatal overdose, and individuals experiencing both a serious mental illness and a SUD. Specifically, the legislation directs CMS to issue guidance regarding how federal reimbursement can be used for telehealth services including assessment, medication-assisted treatment (MAT), counseling, medication management, and medication adherence.[72]

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[67] https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
[68] https://innovation.cms.gov/Files/reports/CPC+2017-Summary.pdf
[69] https://www.medicaid.gov/medicaid/benefits/telemed/index.html
[70] Ibid.
[71] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf
[72] See sec. 1009: https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf

Additionally, the SUPPORT Act also tasks the Government Accountability Office (GAO) to report on best practices and solutions to barriers in providing telehealth services to children. Similarly, the legislation tasks CMS with issuing similar recommendations in this regard – i.e., on potential options to address Medicaid barriers to telehealth and RPM for children. Both the GAO and CMS reports are also due within one year of the bill's enactment (i.e., on or around October 24, 2019).[73]

C. Physician and Nurse Licensure

Though federal standards govern medical training and testing, each state has its own licensing board and requirements. This dynamic creates administrative and financial burdens for physicians seeking licensure in multiple states, which can be particularly limiting for the provision of telemedicine across state lines.

There has been a national movement toward licensure compacts for nurses and physicians in recent years. The enhanced Nursing Licensure Compact (eNLC), created by the National Council of State Boards of Nursing (NCSBN), has been enacted via state-level model legislation in 29 states, with two additional states (Kansas and Louisiana) set to implement the eNLC by July 1, 2019.[74]

Additionally, the Interstate Medical Licensure Compact (IMLC), launched by the Federation of State Medical Boards (FSMB), seeks to do the same for physicians, but progress has been slower.[75] Differing from the single multi-state license available to nurses through the eNLC, the IMLC model retains each state boards separate licensure authority and fee collection and simply expedites issuance of multiple state licenses. Thirty-seven medical and osteopathic boards in 26 states and 1 territory have entered the agreement. According to the IMLC, pursuant to the IMLC agreement, "licensed physicians can qualify to practice medicine across state lines within the Compact if they meet the agreed upon eligibility requirements," with roughly 80 percent of physicians meeting the IMLC criteria for licensure.[76]

D. Collaborative Practice Agreements

The NCSBN has also published a Consensus Model for advanced practice nurse practitioner (APRN) regulation, licensure, accreditation, certification and education, and advocates for its adoption in each state.[77] This effort seeks to alleviate the challenge that collaborative practice agreements vary from state to state and dictate the scope of practice governing a nurses, including diagnosis, treatment, and prescribing, under a physician's supervision.[78] The parameters of each are set by the respective state law and overseen by state licensing boards, and impact APRNs, nurse practitioners (NPs), and physician assistants (PAs) alike.

VIII. Other (Non-HHS) Federal Funding Streams

[73] Ibid.
[74] https://www.ncsbn.org/nurse-licensure-compact.htm and https://www.ncsbn.org/listofmemberstatesanddates111618.pdf
[75] https://imlcc.org/
[76] Ibid.
[77] https://www.ncsbn.org/aprn-consensus.htm
[78] https://www.rwjf.org/en/library/articles-and-news/2010/04/nurse-practitioner-physician-collaboration-requirements-by-state.html

In addition to the Medicare and Medicaid telehealth policy-focused efforts addressed above – many of which provide new reimbursement opportunities in this arena – there are other, non-HHS federal funding streams of note. At the USDA, these programs include: (1) the Distance Learning and Telemedicine (DLT) Program (for which applications under the traditional DLT Program are due May 15, 2019, while opioid-focused DLT grant applications are due April 15, 2019);[79] and (2) broadband-focused loan and loan guarantee programs[80] and grants.[81] Also of note, the Federal Communications Commission (FCC) operates the Rural Health Care (RHC) Program[82], which includes broadband-focused efforts, and the Health Resources and Services Administration (HRSA) oversees various telehealth programs as well.[83]

IX. OUTLOOK: WHAT'S AHEAD FOR TELEHEALTH POLICY

While recent statutory changes pursuant to the BBA and the SUPPORT Act will undoubtedly enhance Medicare providers' ability to leverage telehealth as a modality for treating certain patients (e.g., home dialysis, acute care, and SUD/behavioral health issues), additional developments lay on the horizon.

Specifically, CMS and GAO's forthcoming Medicaid telehealth-focused reports to Congress (due fall of 2019), addressed in section VII above, will likely play a role in informing potential congressional action on telehealth measures this year or early the following. We anticipate those reports will offer clues to Congress as it considers ways to enhance beneficiary access as part of a broader legislative vehicle – such as an "opioids 2.0," rural or Medicare/Medicaid "extenders" package. As always, WHG will continue to keep you apprised of any key developments in this regard and welcomes any questions in the meantime.

[79] https://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants
[80] https://www.rd.usda.gov/programs-services/rural-broadband-access-loan-and-loan-guarantee and https://www.rd.usda.gov/programs-services/telecommunications-infrastructure-loans-loan-guarantees
[81] [81] https://www.rd.usda.gov/programs-services/community-connect-grants
[82] https://www.fcc.gov/general/rural-health-care-program
[83] https://www.hrsa.gov/rural-health/telehealth/index.html

APPENDIX A: CY 2019 List of Medicare Telehealth Services[84]

Code	Short Descriptor	Code	Short Descriptor
90785	Psytx complex interactive	**97804**	Medical nutrition group
90791	Psych diagnostic evaluation	**99201**	Office/outpatient visit new
90792	Psych diag eval w/med srvcs	**99202**	Office/outpatient visit new
90832	Psytx pt&/family 30 minutes	**99203**	Office/outpatient visit new
90833	Psytx pt&/fam w/e&m 30 min	**99204**	Office/outpatient visit new
90834	Psytx pt&/family 45 minutes	**99205**	Office/outpatient visit new
90836	Psytx pt&/fam w/e&m 45 min	**99211**	Office/outpatient visit est
90837	Psytx pt&/family 60 minutes	**99212**	Office/outpatient visit est
90838	Psytx pt&/fam w/e&m 60 min	**99213**	Office/outpatient visit est
90839	Psytx crisis initial 60 min	**99214**	Office/outpatient visit est
90840	Psytx crisis ea addl 30 min	**99215**	Office/outpatient visit est
90845	Psychoanalysis	**99231**	Subsequent hospital care
90846	Family psytx w/o patient	**99232**	Subsequent hospital care
90847	Family psytx w/patient	**99233**	Subsequent hospital care
90951	Esrd serv 4 visits p mo <2yr	**99307**	Nursing fac care subseq
90952	Esrd serv 2-3 vsts p mo <2yr	**99308**	Nursing fac care subseq
90954	Esrd serv 4 vsts p mo 2-11	**99309**	Nursing fac care subseq
90955	Esrd srv 2-3 vsts p mo 2-11	**99310**	Nursing fac care subseq
90957	Esrd srv 4 vsts p mo 12-19	**99354**	Prolonged service office
90958	Esrd srv 2-3 vsts p mo 12-19	**99355**	Prolonged service office
90960	Esrd srv 4 visits p mo 20+	**99356**	Prolonged service inpatient
90961	Esrd srv 2-3 vsts p mo 20+	**99357**	Prolonged service inpatient
90963	Esrd home pt serv p mo <2yrs	**99406**	Behav chng smoking 3-10 min
90964	Esrd home pt serv p mo 2-11	**99407**	Behav chng smoking > 10 min
90965	Esrd home pt serv p mo 12-19	**99495**	Trans care mgmt 14 day disch
90966	Esrd home pt serv p mo 20+	**99496**	Trans care mgmt 7 day disch
90967	Esrd home pt serv p day <2	**99497**	Advncd care plan 30 min
90968	Esrd home pt serv p day 2-11	**99498**	Advncd are plan addl 30 min
90969	Esrd home pt serv p day 12-19	**G0108**	Diab manage trn per indiv
90970	Esrd home pt serv p day 20+	**G0109**	Diab manage trn ind/group
96116	Neurobehavioral status exam	**G0270**	Mnt subs tx for change dx
96150	Assess hlth/behave init	**G0296**	Visit to determ ldct elig
96151	Assess hlth/behave subseq	**G0396**	Alcohol/subs interv 15-30mn
96152	Intervene hlth/behave indiv	**G0397**	Alcohol/subs interv >30 min
96153	Intervene hlth/behave group	**G0406**	Inpt/tele follow up 15
96154	Interv hlth/behav fam w/pt	**G0407**	Inpt/tele follow up 25
96160	Pt-focused hlth risk assmt	**G0408**	Inpt/tele follow up 35
96161	Caregiver health risk assmt	**G0420**	Ed svc ckd ind per session
97802	Medical nutrition indiv in	**G0421**	Ed svc ckd grp per session

[84] https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes.html

Code	Short Descriptor	Code	Short Descriptor
97803	Med nutrition indiv subseq	**G0425**	Inpt/ed teleconsult30
G0426	Inpt/ed teleconsult50		
G0427	Inpt/ed teleconsult70		
G0436	Tobacco-use counsel 3-10 min		
G0437	Tobacco-use counsel>10min		
G0438	Ppps, initial visit		
G0439	Ppps, subseq visit		
G0442	Annual alcohol screen 15 min		
G0443	Brief alcohol misuse counsel		
G0444	Depression screen annual		
G0445	High inten beh couns std 30m		
G0446	Intens behave ther cardio dx		
G0447	Behavior counsel obesity 15m		
G0459	Telehealth inpt pharm mgmt		
G0506	Comp asses care plan ccm svc		
G0508	Crit care telehea consult 60		
G0509	Crit care telehea consult 50		
G0513	Prolong prev svcs, first 30m		
G0514	Prolong prev svcs, addl 30m		