Understanding COVID-19 and Public Health Emergency-linked Telehealth Policies

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Agenda

- A Recent History of Medicare Telehealth Policy
- Current Telehealth Policy for RHCs
- Telehealth Policy of the Future and Lingering Questions

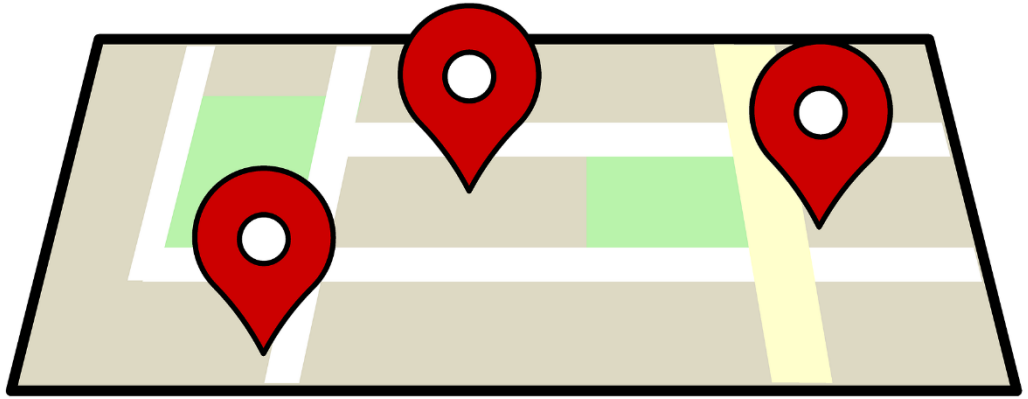
What is Telehealth?

Encounters – intended to replace or add normal, in-person visits

Other Services – intended to supplement encounters; ex. Virtual Care Communications

Originating and Distant Sites

- **Originating Site:** Location of the patient
- **Distant Site:** Location of the provider



Pre-COVID Medicare Telehealth Visit Policy

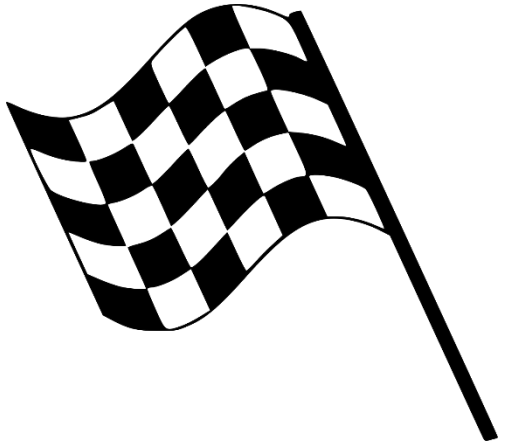
- Limited to:
  - Rural Medicare Beneficiaries Only
  - Specified Originating Sites
  - Specific/Secure/HIPAA Compliant Telehealth Audio/Visual Software
  - RHCs could not serve as “distant sites” because our definition of an encounter required a “face-to-face visit”
- Efforts to expand Medicare coverage of telehealth visits were largely stuck due to cost concerns

The "Silver Lining" of COVID – Telehealth Adoption

- Trump Administration was given authority to waive barriers to telehealth in the early part of the pandemic.
- They used this authority to waive:
  - Originating site requirements
  - HIPAA requirements for audio/video platforms
  - Geographic requirements

- However, HHS claimed that they did not have the authority to allow RHCs/FQHCs to be distant site providers.

RHC Community Rallies and CARES Act Passes

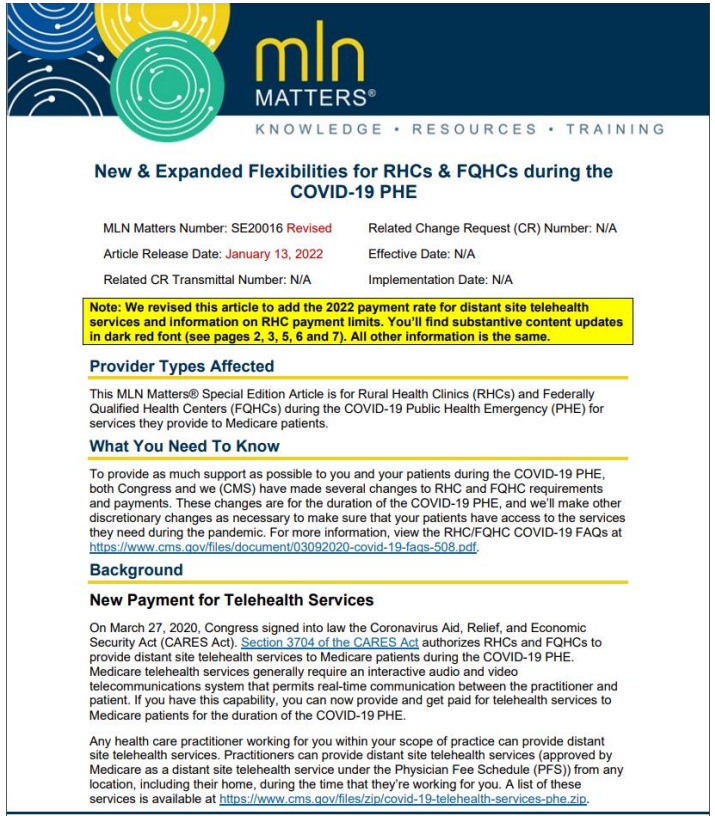


- Allows RHCs to be distant site providers, BUT
- Creates a **"Special Payment Rule"** for RHCs and FQHCs:

  "The Secretary shall develop and implement payment methods that apply under this subsection to a Federally qualified health center or rural health clinic that serves as a distant site that furnishes a telehealth service to an eligible telehealth individual during such emergency period. Such payment methods shall be based on payment rates that are similar to the national average payment rates for comparable telehealth services under the physician fee schedule under section 1848."

G2025 Policy Established – April 17

- MLN Matters SE 20016
- Special Payment Rule is interpreted by CMS to be one payment rate and code **for all telehealth services**
- RHCs to bill G2025 for any of 200+ CPT codes that FFS providers can bill as a telehealth visit listed here
- Costs and encounters associated with telehealth visits must be carved out of the cost report



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New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

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

Article Release Date: January 13, 2022 | Effective Date: N/A

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

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

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 they provide to Medicare patients.

What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and we (CMS) have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view 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, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare patients 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 patient. If you have this capability, you can now provide and get paid for telehealth services to Medicare patients for the duration of the COVID-19 PHE.

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule (PFS)) from any location, including their home, during the time that they're working for you. A list of these services is available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.

Concerns with G2025 System

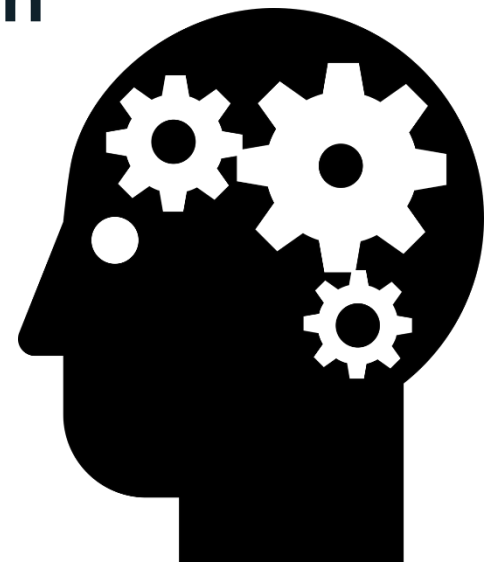
- Payment of $97.24 is less than AIR for vast majority of RHCs
  - May disincentive RHCs from providing telehealth as a replacement for in-person encounters
- Carve-out process presents administrative challenges
- Disguises the actual service provided causing a number of downstream problems such as:
  - Hard (Impossible?) to identify AWV done via telehealth
  - G2025 is not eligible for risk adjustment for ACOs or Medicare Advantage
  - Without descriptions of the services provided, there are challenges in gathering good data

Mental Health via Telehealth Added in 2022 PFS Final Rule

- In December of 2020, Congress made *permanent* Medicare coverage of telehealth for mental health services but made no mention of how this might extend to safety net providers.
- CMS finalized a regulatory change to the definition of an RHC (and FQHC) mental health encounter to include telehealth encounters:
  - (3) Visit - Mental health. A mental health visit is a face-to-face encounter **or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology** for the purposes of diagnosis, evaluation or treatment of a mental health disorder between an RHC or FQHC patient and one of the following…
- NARHC welcomed this policy change by CMS allowing RHCs to use normal coding, normal reimbursement, and normal cost reporting rules for mental health telehealth visits.

Mental Health via Telehealth In-Person Requirements

- In-person requirements are waived during PHE *and for 151 days after PHE ends*
- **Must have an in-person visit within 6 months of furnishing mental health via telehealth service and an in-person service must be provided at least every 12 months thereafter.**
  - Some exceptions may be made based on patient need
  - Some of the details are unclear –
    - Does the telehealth provider need to be the provider that sees the patient for their in-person visit?



Current Medicare Telehealth Billing Policies

Name of Telehealth Service	Brief Description	How to Bill	Amount (2022)
Virtual Check-In or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.88
Chronic Care Management	99484, 99487, 99490, 99491, 99424, and 99426 = G0511 99492, 99493 = G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $79.25 G0512 - $151.23
Digital e-visits	Online digital evaluation and management 99421-99423	G0071 No modifier Rev Code 052X	$23.88
Telehealth Visits	One to one substitutes for in-person services/visits List of allowable services maintained by CMS	G2025 Modifier 95 optional Modifier CS (for services where cost sharing is waived) Rev Code 052X Costs and encounters carved out of cost report	$97.24
Mental Health Telehealth Visits	CPT Codes that can be billed with 0900 revenue code	Rev Code 0900 Use proper mental health CPT code Modifier CG always Modifier 95 if audio-video Modifier FQ if audio-only Count costs and encounters on cost report	All-Inclusive Rate

These codes are not new but fall within the telehealth umbrella!

March 11th "Omnibus" bill

- De-links telehealth waivers from PHE
- Telehealth waivers (coverage) extended for 151 days (5-months) post PHE
  - Mental health via telehealth is permanently covered; in-person requirements waived for PHE + 151 days
  - Administration has committed to providing a 60-day notice before ending the PHE

H.R. 4040

- Passed the House in July
- Extends G2025 and other telehealth payment policies through 2024
- NARHC and NRHA got letters entered into the record by Rep. Adrian Smith thanking Congress for continuing telehealth policies but expressing disappointment with the continuation of the special payment rule

NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

July 26, 2022

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Republican Leader
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi and Leader McCarthy:

The National Association of Rural Health Clinics (NARHC) is grateful that the House of Representatives is considering extending Medicare coverage of telehealth through 2024 but we are concerned that the current language in H.R. 4040 will perpetuate inequitable payment policies for safety-net providers.

Presently, our peers in traditional office settings are able to bill for telehealth services as if the service was provided physically in the office. In other words, they have coding and reimbursement parity between telehealth services and in-person services.

On the other hand, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) do not use their normal coding and reimbursement rules for telehealth. RHCs and FQHCs instead have a "special payment rule" that requires them to bill a single code, G2025, for all telehealth services which is then reimbursed at a single nationwide rate (currently $97.24).

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth severely hindering their ability to properly participate in ACOs and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that it should work this way for all services, not just mental health services.

NARHC strongly believes that the best way to encourage telehealth usage in underserved communities is to create parity between in-person and telehealth policies. We strongly encourage Congress to amend H.R. 4040 to include the payment policy enumerated in Section 9 of H.R. 7876, the Connecting Rural Telehealth to the Future Act introduced by Representative Adrian Smith and Representative Terri Sewell.

Please feel free to contact me if you would like to discuss this issue further.

Sincerely,

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What does Medicare telehealth coverage look like in the future?

- It is evident that telehealth is here to stay, but the details remain undecided
  - What telehealth waivers will be rescinded, modified, and kept?
    - Ex. Will HIPAA compliant platforms be required again?
    - Ex. Will providers need to be in specified distant site locations?
    - Ex. Will Medicare pay parity with in-person visits?
    - Ex. Will audio-only telehealth be allowed? What services can be done audio-only?
    - Ex. Will there be in-person requirements for all telehealth?

MedPAC Study Due June 2023

- Consolidated Appropriations Act of 2022 (March 11th bill) directed MedPAC to analyze telehealth policy
- The legislation mandates that the study analyzes:
  - "The utilization of telehealth services under the Medicare program…
  - Medicare program expenditures…
  - Medicare payment policy for telehealth services and alternative approaches to such payment policy, including for federally qualified health centers and rural health clinics."
- There is speculation that Congress will extend telehealth waivers until they get more information, particularly from this study

The Big Questions

- Does telehealth save Medicare money or does telehealth cost Medicare money?
- Does a telehealth visit replace an in-person visit or does it increase volume?

- The MedPAC study and others will provide data to begin answering these questions, but ultimately the analysis from the Congressional Budget Office (CBO) will have the greatest impact…

Moving Forward

- Likely to be a series of temporary extensions of Medicare telehealth policy as questions are answered
- Each extension provides Congress with an opportunity to tweak aspects of the telehealth policy (reminiscent of the doc fix bills…)

- **There is bipartisan agreement and industry wide expectations that Medicare telehealth policy will not revert to the very limited pre-COVID rules.**

Telehealth Implications

- Short term – telehealth policy expires *151 days after PHE*, what does Congress do?
- Medium term – what aspects of telehealth policy are made permanent? Do private payers opt to cover telehealth visits fully? How is audio-only handled?
- **Long term – does telehealth fundamentally alter what it means to have "access" to healthcare?** Will RHCs be able to compete with offices in the city with sophisticated telehealth services?

Q&A

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