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Telehealth Compliance During the COVID-19 Pandemic

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Agenda

- Telehealth Reimbursement: Medicare, Medicaid and FCC Funding Opportunities
- Licensing and Privacy
- Telehealth Compliance: Best Practices
- Conclusion

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Telehealth has increasingly become a critical element of our health systems' responses to COVID-19 as we balance social distancing with the need to continue delivering care.

Growth in Telehealth Utilization

NYU: 5,500 virtual visits per day up from 50 pre-COVID.

Mass General: 10 – 20x increase over pre-COVID.

Medicare: 11K member visits per week to 650K per week.

Teladoc: 50% increase in daily volume from pre-COVID.

Zipnosis: 3,600% increase in utilization through March.

MDLIVE: 50% increase in behavioral health visits from Feb to Mar. Another 75% increase from Mar to Apr.

Examples Telehealth Programs

TeleICU – remote observation/monitoring of ICU patients to reduce COVID exposure risk and extend provider capacity.

Hospital at Home – deliver low acuity inpatient services to patients at home to preserve hospital bed capacity and reduce COVID exposure risk.

Virtual Visits – deliver routine non-urgent medical or behavioral health services to patients remotely.

Remote patient monitoring – remotely monitor physiologic information to proactively monitor health status.

Sources: *Wall Street Journal (4/14/2020); Healthcare IT News (4/3/2020); Becker Hospital Review: NYU Language Adds 1,3000 Provider to Telemedicine Platform (3/27/2020)*

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Telehealth Reimbursement: Medicare, Medicaid and FCC Funding Opportunities

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Medicare Telehealth Prior to the COVID-19 Pandemic

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Historically, Medicare coverage of telehealth has been limited, focusing on providing access to beneficiaries in rural areas.

- Telehealth: Services that normally would occur in-person but instead are conducted via telecommunications technology; paid at full rate.
  - Typically was only available to beneficiaries in rural areas.
  - In most cases, beneficiary could not be at home.
  - Phones could not be used to deliver services.
  - Practitioner generally could provide only E/M or mental health services.
- Virtual Check-Ins: Not services that would normally occur in person; brief communications paid at a lower rate.
  - Could be offered to established patients only.
  - As with telehealth, could only be offered by practitioners who could bill E/M codes.

COVID-19 Changed the Medicare Telehealth Landscape

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Through its 1135 waiver authority and regulatory reform, CMS has rapidly expanded the coverage of telehealth and virtual check-ins.

- Telehealth:
  - No longer limited to rural areas.
  - Beneficiaries can receive services at home.
  - Phones can be used to provide services; audio-only calls now covered.
  - Significant increase in covered services.
  - Expanded list of practitioners that may provide services.
- Virtual Check-Ins: May be offered to new patients. Expanded list of practitioners who can bill for these services. (But Medicare will continue to non-pay if originates from a related E/M service provided in previous 7 days by same practitioner or leads to an E/M service with same practitioner.)

CMS has added over 80 new services that can be delivered via telehealth, in addition to services previously allowable via telehealth.

Summary of New Telehealth Services

Inpatient and ED

- Initial Hospital Care and Hospital Discharge Day Management
- Initial and Subsequent Observation and Observation Discharge Day Management
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent
- ED visits, Levels 1-5
- Critical Care Services
- Initial and Continuing Intensive Care Services

Long-Term Care

- Initial Nursing Facility Visits, All levels (Low, Moderate, and High Complexity) and Nursing Facility Discharge Day Management
- Home Visits

Behavioral Health

- Psychological and Neurological testing
- Group Psychotherapy
- Licensed Clinical Social Work
- Clinical Psychology

Other

- Radiation Treatment Management Services
- ESRD Kidney Failure Services
- Therapy Services – Physical and Occupational Therapy, Speech Language Pathology
- Domiciliary, rest home or custodial care services
- Care planning for patients with cognitive impairment

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Medicare Telehealth: Before and After COVID-19

Issue	Traditional Rule	New Rule During the COVID-19 Pandemic
Beneficiary location (originating site)	Generally must be in a practitioner's office of facility located in a rural area. May be at home only for SUD or ESRD services.	Patient may be located anywhere.
Telehealth technology	Must be an interactive telecommunications system; cannot be a phone.	Must be a two-way, real-time interactive communication; phones permitted.
Services eligible for telehealth	Generally E&M and psychotherapy.	Expanded list includes observation care, critical care, group psychotherapy.
Eligible Practitioners	Only those who provide E&M services.	Physical/ occupational therapists, others included.
Audio-only services	Not considered telehealth and not reimbursable.	Considered telehealth and reimbursable.
Payment rate	Practitioner paid at lower, facility-based rate.	May be paid non-facility rate if located outside a facility.

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Medicare Virtual Check-Ins: Before and After COVID-19

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Issue	Traditional Rule	New Rule During the COVID-19 Pandemic
Patients eligible for virtual check-ins	Established-patients only.	New and established patients.
Practitioners eligible to provide virtual check-ins	Practitioners who can bill E/M codes.	Practitioners who do not bill E/M codes also may provide virtual check-ins, such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists.
Beneficiary consent	Must be documented in patient's record.	May be obtained at the time the service is delivered.

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Most states have expanded existing telehealth policies to enable better access to remote care delivery in light of social distancing measures.

New Policy Flexibilities

- Payment parity
- Out-of-state licensure
- Flexibility in modality (video, phone, secure message, remote monitoring, etc.)
- Originating site flexibilities
- Distant site flexibilities
- Suspension of prior authorization requirements
- Etc.

New Covered Services

- Telephone-based services
- Specialized therapy (physical therapy, occupational therapy, speech language pathology, etc.)
- Tele-dentistry
- Substance use disorder treatment
- Preventive services (e.g. well child visits)
- Inpatient telehealth
- Etc.

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Sources: *Manatt Health 50-State Telehealth Tracker (link).*

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Tracking Medicaid Telehealth Policy Changes

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- 47 states + D.C. issued guidance related to the expansion or reimbursement of telehealth services
- 38 states + D.C., have include audio-only telehealth services
- 30 states + D.C., offer occupational therapy, physical therapy, and speech therapy services through telehealth
- 14 states have issued guidance to providers to allow for telehealth or remote care delivery for early childhood intervention services
- 8 states have issued telehealth guidance for Child Well-care and EPSDT visits

Sources: *Manatt Health 50-State Telehealth Tracker (link).*

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Temporary Telehealth Coverage and Reimbursement Flexibilities in Medicaid

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NYS Medicaid Fee-for-Service Telehealth Flexibilities

Enables all Medicaid providers in all situations to use a variety of communication methods (audio-visual technology, telephone, remote patient monitoring, store and forward) to deliver services remotely during the State of Emergency.	**Allows all services within a provider's scope to be provided through telemedicine/telephonically, as appropriate.**	**Allows originating site to be anywhere the member is located at the time services are delivered.** **Allows distant site to be any location within the United States.**
Adds broad coverage for telephonic services when it is appropriate for the member to receive the services by telephone.	**Reinforces payment parity for telehealth services delivered via two-way audio-visual communication and in-person services.**	**Requires Medicaid Managed Care Plans (MMCPs) to cover at a minimum what is covered in Medicaid fee-for-service.**

Sources: *New York State DOH COVID-19 Guidance for Medicaid Providers (link).*

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Guidance Specific to NYS Medicaid Managed Care Plans

- Plans must cover telehealth/telephonic delivery of all Benefit Package services that are appropriate to delivery through telehealth/telephonic means to properly care for the member.
- Plans may not limit members access to telehealth/telephonic services to solely MMCP's telehealth vendors.
- Plans may have separate detailed billing guidance for Medicaid FFS.
- Plans must establish payment pathways for telephonic encounters, which may mirror the six payment pathways as outlined in the Medicaid Update.
- Plans may use, but are not required to use, the telephonic encounter codes or payment pathways used by Medicaid FFS.
- Absent negotiated rates for telehealth/telephonic services, the MMCP must reimburse network providers at the same rate that would be reimbursed for face-to-face encounters.

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Sources: *New York State DOH COVID-19 Guidance for Medicaid Providers (link).*

Funding – FCC COVID-19 Telehealth Program

Federal Communications Commission (FCC) - COVID-19 Telehealth Program			
Purpose/ Eligible Use	**Eligible Recipients**	**Funding**	**Application Details**
Purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services	Nonprofit and public : – Hospitals – Medical schools – Community health centers – Community mental health centers – Skilled nursing facilities	$200M Anticipated $1M funding limit per provider	Online application portal opened on April 13, 2020 Rolling basis until funding is exhausted; no deadline but funding is going quickly

Other Notable Funding Opportunities

- Provider Relief Fund - $175B in direct funding to offset provider expenses and lost revenue related to COVID
- Health Center Supplemental Awards - $1.4B supplemental award for health centers

NOTE: As of May 6, FCC has approved 56 applications totaling $25M, including the following in NYS:

- Hudson River HealthCare - $753K
- Mount Sinai - $312K + $863K
- NYU Langone - $984K
- NYU Grossman SoM - $773K
- White Plains Hospital - $166K
- Institute for Family Health - $729K
- New York Psychotherapy and Counseling Center - $127K
- Parker Jewish Institute - $98K
- Service Program for Older People – $26K

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Sources: *FCC COVID-19 Telehealth Program.*

Licensure and Privacy

Out of State Licensure

Out of State Licensure

- All states have issued some flexibility related to cross-state licensure but true 50-state licensure for physicians does not exist as each state has its own licensure requirements and rules.
- Governor Cuomo issued an Executive Order that **enables physicians licensed and in current good standing in <u>any state in the United States</u> to practice medicine (including via telehealth) in New York State** without civil or criminal penalty related to lack of licensure. There are similar waivers in place for physician assistants, nurse practitioners, registered nurses, respiratory therapists (and technicians), midwives, and social workers.
- Out-of-state providers must be enrolled in the NYS Medicaid program in order to bill for telehealth services delivered to a Medicaid member; NYS is offering Provisional Temporary Enrollment to expedite licensure for out-of-state providers.

Sources: *Gov Cuomo Executive Order 202.5, HHS Notification of Enforcement Discretion for Telehealth Remote Communications (3/30/2020); SAMHSA COVID-19 Guidance (3/19/2020) ; e-MedNY COVID-19 Response*

HIPAA Flexibilities Aim to Promote Use of Telehealth

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The HHS Office of Civil Rights (OCR) issued a notice of enforcement discretion that substantially waives federal enforcement of HIPAA in regards to telehealth.

- OCR not to impose penalties for good faith violations of HIPAA privacy, security and breach notification rules by telehealth providers.
- Provides flexibility in key areas:
  - Providers may use unencrypted platforms to communicate with patients.
  - No need for presenting notice of privacy practices.
- Enforcement discretion is premised on "good faith." Provider acts in bad faith if:
  - Engages in a criminal act, such as fraud or identity theft.
  - Sells data or uses data for marketing without authorization.
  - Violates state licensing laws or professional ethical standards.
  - Uses public-facing remote communication products (e.g. Facebook Live).

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States	SAMHSA (42 CFR Part 2)
California: On April 3, Governor Newsom signed an executive order waiving certain state privacy laws related to the good faith provision of telehealth. Waived laws include: (1) the requirement to obtain written or verbal consent before the use of telehealth: (2) penalties under the Confidentiality of Medical Information Act; and (3) the state's breach notification law. **New York**: The Department of Health has waived requirement for telehealth providers seeking to access electronic records through the state's health information exchange network (SHIN-NY) to obtain written consent; verbal consent is now sufficient.	No waiver of federal substance use disorder (SUD) confidentiality regulations. But SAMHSA telehealth guidance notes that some telehealth services may qualify for emergency treatment consent exception, and providers have discretion as to when there is an emergency. CARES Act permits re-disclosures of Part 2 data if doing so complies with HIPAA, but new regulations interpreting that new flexibility may not be issued until 2021.

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Telehealth Compliance: Best Practices

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False Claims Regarding Telehealth May Be Scrutinized

- Criminal conduct stemming from the pandemic is a priority of the Department of Justice, March 16, 2020 memo from Attorney General Barr:

> investigating, and prosecuting wrongdoing related to the crisis. In particular, there have been reports of individuals and businesses selling fake cures for COVID-19 online and engaging in other forms of fraud, reports of phishing emails from entities posing as the World Health Organization or the Centers for Disease Control and Prevention, and reports of malware being inserted onto mobile apps designed to track the spread of the virus. The pandemic is dangerous enough without wrongdoers seeking to profit from public panic and this sort of conduct cannot be tolerated. Every U.S. Attorney's Office is thus hereby directed to prioritize the detection, investigation, and prosecution of all criminal conduct related to the current pandemic.

- The HHS Office of Inspector General (OIG) is exercising enforcement discretion regarding the anti-kickback statute that may impact telehealth:
  - E.g., hospital may provide free access to its telehealth platform to independent physicians on its medical staff if does so to all staff on an equal basis and does not condition on the volume or value of referrals; provider may waive telehealth cost sharing.
  - This discretion would not apply to claims that are medically unnecessary or violate Medicare guidelines.

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Telehealth Billing Compliance: Best Practices

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Existing Best Practices	New Considerations
▪ Only provide telehealth when clinically appropriate to do so. ▪ Keep documentation of start and stop times to support code selection. ▪ Do not bill for telehealth if it is an administrative or non-medical discussion; telehealth is for clinical services. ▪ Only provide telehealth if acting within scope of practice under state law.	▪ Expanded list of telehealth services ≠ invitation to bill for such services. If inpatient services can't be provided effectively via telehealth, they shouldn't be. ▪ Medicare place of service (POS) code: No longer need to use Code 02; instead should use code that would have been used had the service been provided in person. Add CPT modifier 95 to indicate telehealth. ▪ Ensure that only the practitioner provides the telehealth service, despite guidance on "virtual visits." (Virtual visits allow a physician to supervise a non-billing professional providing services in the home via remote communications technology.)

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Telehealth Privacy Compliance: Best Practices

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Despite OCR flexibility, providers still face legal liability from other sources (state attorneys general, patients) that mandate privacy compliance.

- Comply with recommended but not required practices under OCR's HIPAA guidance:
  - Enter into business associate agreements with vendors.
  - Notify patients of privacy and security risks.
  - Avoid communicating from public settings.
- Use most secure platform that is feasible (e.g., higher standard if practitioner is at home/office vs. traveling). Never use public facing platforms (e.g., Facebook Live).
- Provide breach notifications required under state law, if not waived (e.g., in NY, covered entities must notify state attorney general of breaches).
- Maintain procedures for compliance with 42 CFR Part 2 if SUD data is involved (general need for written consent absent emergency).

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Licensure Compliance: Best Practices

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- Do not assume state licensure requirements applicable to out-of-state practitioners are waived during the public health emergency.
  - CMS 1135 blanket waiver regarding out-of-state licensure applies only to Medicare requirements; state laws still must be followed.
  - Rules vary by state.
- Take advantage of licensure compacts where applicable.
- Ensure prescribing practices comply with state and federal law. While the Department of Justice has waived provisions of the Ryan Haight Act to permit the prescribing of controlled substances after a telehealth encounter, there are restrictions:
  - Must evaluate the patient if have not previously examined the patient.
  - May only call in schedule II prescriptions to pharmacies in emergencies.
  - More restrictive state laws still apply.

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Telehealth Compliance: Timing

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- Many Medicare, state law, privacy and OIG telehealth flexibilities are scheduled to conclude at the end of the public health emergency.
- As of today, the public health emergency is scheduled to expire on July 25, although it may be extended by additional 90-day periods.
- While certain flexibilities are likely to continue post-pandemic, we don't yet know what those are.
- Telehealth providers must be prepared to make another quick shift.

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Conclusion

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Looking Ahead To a Post-COVID World

"The genie's out of the bottle on this one."

- Seema Verma, Administrator for CMS

Virtual Doctors Are Here to Stay

Relaxed rules on telemedicine should be the new norm.

Telemedicine Is Here to Stay

Some industry experts say that the rapid shift toward telemedicine in response to COVID-19 safety recommendations will stick long after the pandemic is over.

INDUSTRY NEWS
SOURCE: TALK BUSINESS & POLITICS

Telehealth, telemedicine here to stay, says expert

TECH

Medicine is changing dramatically in this critical period, and Silicon Valley hopes the changes are here to stay

The Doctor Will Zoom You Now

The pandemic lockdown is proof of concept for mass telemedicine.

Analysis

Telehealth's Not Getting Switched Off After COVID-19 Crisis

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About

Jared Augenstein provides strategic advisory services, project management, policy analysis, and startup business planning to healthcare providers, health tech and services companies, states, payers, biotech companies and healthcare associations and foundations.

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