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Medicare Telehealth Coverage and Reimbursement After the Public Health Emergency

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Over the past five months, Congress and the Centers for Medicare & Medicaid Services (CMS) have dramatically, but temporarily, expanded coverage and reimbursement for telehealth services in response to the COVID-19 pandemic. The changes are in effect for the duration of the Health and Human Services (HHS) Public Health Emergency (PHE). As there are significant statutory restrictions on how telehealth services can be delivered and paid for in Medicare, to enact these flexibilities, CMS relied on its 1135 waiver authority, which allows HHS to waive or modify certain Medicare requirements during a federally declared emergency. Principal changes include:

- Lifting the geographic restriction that beneficiaries must be located in a rural area;
- Permitting beneficiaries to receive telehealth services from their homes;
- Allowing a broader range of providers to deliver telehealth services (e.g., physical therapists, occupational therapists, speech language pathologists);
- Adding coverage and payment for audio-only forms of telehealth;
- Enabling federally qualified health centers (FQHCs) and rural health centers (RHCs) to serve as eligible distant sites (i.e., where the provider is located); and
- Expanding Medicare telehealth coverage to more than 100 additional services.

Currently, the HHS PHE is set to expire on October 22, though it has been renewed twice to date and could be extended again. While CMS has taken swift and bold action to expand telehealth coverage and reimbursement, once the HHS PHE expires, so too do most of the flexibilities HHS has enabled.

This week, the Administration took steps to make some of these flexibilities permanent and to extend others through 2021. However, through the flurry of executive and regulatory activity over the past few days, it has become clear that despite the Administration's and CMS's desire to extend telehealth flexibilities in Medicare beyond the PHE, Congress will ultimately need to legislate in order to enact meaningful change.

Executive Order on Telehealth

On August 3, the President issued an executive order (EO) requiring that within 60 days, the Secretary of HHS shall propose regulations to extend temporary telehealth flexibilities put in place during the PHE. The practical impact of this EO is limited given that CMS is already in the process of proposing telehealth coverage and payment changes through its typical policymaking process (such as the

proposed physician fee schedule summarized below) and because most of the temporary telehealth flexibilities would require statutory change to extend beyond the period of the PHE.

Medicare CY 2021 Proposed Physician Fee Schedule

Also on August 3, CMS issued the CY 2021 physician fee schedule (PFS) proposed rule, which proposes several changes to Medicare Part B telehealth payment policy. The rule proposes adding coverage on a permanent basis for a narrow set of telehealth services and extending temporary coverage for an additional narrow set of services, and clarifies which additional temporarily covered services will no longer be covered once the PHE ends. The rule also proposes some changes to coverage of remote physiologic monitoring services and proposes extending the temporary flexibilities around virtual supervision through the end of 2021. Comments on the proposed rule are due October 5.

Proposed Changes to Medicare Telehealth Services

For CY 2021, CMS is proposing several changes to the Medicare telehealth covered services list.

First, CMS is proposing to add permanent coverage for a range of telehealth services, including group psychotherapy, low-intensity home visits, and psychological and neuropsychological testing, among others.

Second, CMS is proposing to add extended temporary coverage for certain services through the end of the calendar year in which the COVID-19 HHS PHE ends, including high-intensity home visits, low-intensity emergency department visits and nursing facility discharge day management, among others.

Finally, CMS is indicating which services that have been covered on a temporary basis during the PHE it does not propose to cover on a permanent basis once the PHE ends. This list includes a wide range of more than 70 services, including telephonic E/M services, nursing facility visits, specialized therapy services, critical care services, end-stage renal disease (ESRD)-related services and radiation management services, among others. In some cases, CMS is barred from making permanent changes in these areas because of statutory restrictions on eligible providers and the use of interactive audio and video equipment. In other cases, CMS has determined that these services are not likely to confer a clinical benefit outside of a public health emergency. The changes are specified in more detail in the table below.

- Group Psychotherapy (CPT code 90853)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code GPC1X)

- Prolonged Services (CPT code 99XXX)
- Psychological and Neuropsychological Testing (CPT code 96121)

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99336-99337)
- Home Visits, Established Patient (CPT codes 99349-99350)
- Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133)

- Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306)
- Psychological and Neuropsychological Testing (CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Initial hospital care and hospital discharge day management (CPT 99221-99223; CPT 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT 99468-99472; CPT 99475-99476)
- Initial and Continuing Neonatal Intensive Care Services (CPT 99477-99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)
- Radiation Treatment Management Services (CPT 77427)
- Emergency Department Visits, Levels 4-5 (CPT 99284-99285)
- Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324-99328)
- Home Visits, New Patient, all levels (CPT 99341-99345)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT 99217-99220; CPT 99224-99226; CPT 99234-99236)

In addition, CMS is proposing that the current 30-day frequency limit for subsequent nursing facility visits provided via telehealth be revised to a once-every-three-days limit. CMS is also proposing that additional types of providers, including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech-language pathologists, be permitted to bill for brief online assessment and management services, virtual check-ins, and remote evaluations; CMS will add new codes for these services.

While the proposed PFS does include an expansion of certain telehealth services, the rule also illustrates the limitations that CMS has in broadly expanding coverage and reimbursement given statutory restrictions.

Proposed Changes to Remote Physiologic Monitoring Services

For CY 2021, CMS provides clarity regarding coverage of remote physiologic monitoring (RPM) services and introduces new flexibilities for services that were added to the PFS in CY 2019. CMS proposes that at the conclusion of the PHE, CMS will return to the pre-PHE requirements that practitioners have an established patient relationship in order to initiate RPM services and that 16 days of data for each 30 days must be collected in order to meet the requirements of CPT codes 99453 and 99454. CMS also proposes that practitioners may furnish RPM services to beneficiaries with acute conditions; previously, coverage had been limited to beneficiaries with chronic conditions only. In addition, CMS proposes that consent may be obtained at the time the RPM service is furnished; that auxiliary personnel may furnish certain RPM device setup and supply services and that data from the RPM device must be automatically collected and transmitted rather than self-reported; and that for the purposes of discussing RPM results, "interactive communication" includes real-time synchronous, two-way interaction such as video or telephone. These changes will make it easier to initiate and deliver RPM services.

Proposed Changes to Enable Direct Supervision by Interactive Telecommunications Technology

During the PHE, CMS adopted a policy that allowed for virtual supervision using interactive audiovisual real-time communications technology by revising the definition of "direct supervision" to include virtual presence. This policy has allowed "incident to" services to be provided if furnished under the supervision of a virtually present physician or nonphysician practitioner. In the PFS proposed rule, CMS is proposing to continue allowing virtual supervision through December 31, 2021, and is seeking comment as to whether there should be additional guardrails in place during that time to address concerns regarding patient safety, clinical appropriateness, fraud, waste and abuse.

Congressional Action

Because of the statutory nature of most of the Medicare telehealth restrictions program, extending these key flexibilities beyond the PHE ultimately will require congressional action. Congressional negotiations on the next COVID-19 response bill appear to have reached an impasse, threatening immediate action on telehealth despite bipartisan support for this topic. As part of negotiations in the next round of COVID-19 response legislation, Senate Republicans introduced the Health, Economic Assistance, Liability Protection and Schools (HEALS) Act, which proposes several changes to telehealth in Medicare. First, the bill would allow (but not require) the Secretary of HHS to extend the temporary telehealth flexibilities made available during the PHE until December 31, 2021, or until the end of the PHE, whichever is later. The bill would require the Medicare Payment Advisory Commission (MedPAC) to provide a report on the impact of telehealth flexibilities on access, quality and cost by July 1, 2021. Similarly, the bill would require HHS to post data on use of telehealth throughout the pandemic and to provide a report including legislative recommendations to Congress no later than 15

months after the bill is enacted. Finally, the bill would extend for five years beyond the end of the PHE a provision of the CARES Act that permits FQHCs and RHCs to serve as distant sites for the purposes of delivering telehealth. There are several other bills that have been introduced in the House and the Senate, though it seems unlikely that they will be taken up unless as part of the next stimulus package (for more information, see the Manatt Insights tracker). While the temporary changes that the PFS rule proposes would, if finalized, extend some important telehealth changes through 2021, congressional action will be necessary to relax most telehealth restrictions on a permanent basis.