Health Law Daily Wrap Up, STRATEGIC PERSPECTIVES: As telehealth grows, federal reimbursement needs streamlining, (Feb. 20, 2019)

Health Law Daily Wrap Up

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Providers and patients alike are recognizing the benefits of telehealth outside of the rural areas where it is traditionally available for federal reimbursement, but the limited availability of federal regulation and guidance surrounding telehealth reimbursement creates inconsistency in application.

Telehealth, also called telemedicine, generally involves the use of interactive, two-way telecommunications systems by a doctor or other health care provider and his or her patient. Traditionally, telehealth has been used to treat behavioral health and substance use disorders in rural and underserved areas, where access to specialty providers can be difficult. However, stakeholders are beginning to acknowledge the benefits of telehealth for patients who, while not located in rural or underserved areas, are not able to easily travel for in-person visits with their providers.

With federal restrictions on telehealth loosening and states endeavoring to make telehealth available to their residents, the need for streamlining of oversight and federal reimbursement of telehealth services is becoming apparent. This Strategic Perspective discusses the challenges of providing federal telehealth reimbursement, the application of value-based payment to telehealth services, and the coverage and reimbursement of telehealth services via Medicare and Medicaid.

What is Telehealth

Presenting at the Healthcare Information Management Systems Society (HIMSS) Global Conference & Exhibition in February 2019, Morgan Waller, the director of telemedicine business and operations with Children's Mercy Kansas City, and Pat Huchko, the director of clinical services at InTouch Health, described the types of services falling under the definition of telehealth.

Telehealth is most commonly recognized as simultaneous, two-way communication between the provider and the patient, including virtual visits and consults and continuous remote monitoring. Telehealth can also be asynchronous (not live or in real-time), which can include store-and-forward technology, email and electronic communication, or web-based health data management. Services received via telehealth may be facilitated, in which a health care professional other than the physician or practitioner facilitates the communication with the patient. Alternatively, the communication can be non-facilitated or direct-to-consumer, which relies on the patient or a family member and the provider alone to ensure that the communication and assessment are effective.

Medicare and Medicaid Coverage of Telehealth

Medicare does not cover all forms of telehealth services. Social Security Act §1834(m) provides for payment under Medicare for telehealth services furnished through a telecommunications system by a physician or practitioner to an eligible individual when the physician or practitioner providing the telehealth services is not at the same location as the beneficiary. In Alaska or Hawaii, the term "telecommunications system" includes store-and-forward technologies providing asynchronous transmission of health care information in single or multimedia formats. The provider of telehealth services to an eligible individual is paid an amount equal to what Medicare would have paid if the service had been furnished without the use of a telecommunications system. Medicare also pays a facility fee to the originating site. Remote monitoring is not telehealth subject to the restrictions of sec. 1834(m).

Originating sites. The originating site of telehealth services for the purpose of Medicare reimbursement is the location of the eligible individual at the time the service is furnished via a telecommunications system, only if the

site is located in an area designated as a rural health professional shortage area, in a county not included in a Metropolitan Statistical Area, or from an entity that participates in a federal telemedicine demonstration project that has been approved by or receives funding from HHS as of December 31, 2000. The site may be the office of a physician or practitioner, a critical access hospital, a rural health clinic, a federally qualified health center (FQHC), a hospital, a hospital-based or critical access hospital-based renal dialysis center, a skilled nursing facility, or a community mental health center. A recent final rule, discussed later in this Strategic Perspective, expanded possible originating sites for the treatment of individuals diagnosed with substance use disorder or a co-occurring mental health disorder.

Licensure to provide services via telehealth. Health care providers must be licensed in the state in which they practice medicine, and, where furnishing telemedicine services constitutes the practice of medicine, several state statutes require a license for the practice of medicine across state lines (see *Telemedicine services focus: licensure, reimbursement rules, corporate practice prohibitions*, May 10, 2018). Exceptions exist in some states where consultations with local physicians are involved, there is a special or temporary telemedicine license, the provider receives licensure by endorsement, or under the Interstate Medical Licensure Compact (IMLC). As of April 2017 22 states had entered into the IMLC, which allows qualified physicians who meet experience and practice standards to receive expedited licensure across member states.

Need for expanded coverage of telehealth services. A report by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) conducted in 2017 and released in December 2018 noted that one of the key challenges of using telehealth is the financing of services by Medicare, Medicaid, and private payers (see *ASPE evaluates telehealth benefits and challenges to help rural substance use epidemic*, December 17, 2018). In discussing the limitations of Medicare reimbursement for telehealth services with the ASPE, providers noted the limitations of providing reimbursement only in certain rural settings. According to the report, the providers stressed the need for behavioral health services in nursing homes for patients not located in rural areas whose mobility outside of the home is limited, as well as for individuals with psychiatric-related disabilities who might not be able to leave their homes for treatment. In such cases, telehealth presents an option for providing care from within the home.

While Medicare coverage of telehealth may be described as limited but consistent, the ASPE characterized coverage of telehealth services under Medicaid as highly variable and ever-changing by state. Medicare generally restricted telehealth services to patients in rural areas, in 24 states and the District of Columbia, but Medicaid places no restrictions on the location and setting in which the patients receive telehealth services, and 15 of those states do not restrict the type of provider delivering the telehealth services. All 48 states that provide coverage under Medicaid for telehealth services include some form of coverage and reimbursement for behavioral health services provided through videoconferencing.

States have used the flexibility of their Medicaid programs and new legislation to expand telemedicine where possible without creating conflicts with federal requirements under the Ryan Haight Act (P.L. 110-425). The Act prohibits dispensing a controlled substance via the internet without a valid prescription, which can be issued only for a legitimate medical purpose by a practitioner who has evaluated the patient in person at least one time (see *States fail to fully use telemedicine to fight public health crises*, September 28, 2018).

Benefits of telehealth services. The benefits of telehealth services are apparent both for providers and for patients. For physicians, the opportunity to provide telehealth services helps cut costs and can be more convenient, said Jayme Matchinski, an officer with Greensfelder, Hemker & Gale, P.C. Physicians offering telehealth services may also expand their patient base geographically. For patients, the benefits of telehealth are also cost and convenience, as telehealth services can be less expensive for a patient than an in-office visit, according to Matchinski. "Telehealth services may be more convenient for patients due to scheduling and availability of their physician," Matchinski said. "Billing for telehealth services can also be more streamlined and not require the utilization of a third-party billing company."

Telehealth also permits more streamlined patient appointments and reduced wait times (see *5 ways technology is leading the revolution in patient care*, January 14, 2019). One study found that 15 state hospitals that used a

telemedicine platform to triage 500,000 patients reduced hospital staffing costs by 25 percent while increasing admissions by 20 percent. With a quickly growing market, projected to reach $52.89 billion by the end of 2025, telehealth may very well transform patient care.

New services, changes to geographic requirements. As providers and patients alike are recognizing the benefits associated with telemedicine and technology-based communication services, CMS finalized proposals for several new services under the 2019 physician fee schedule (PFS) final rule (83 FR 59836, November 24, 2018) (see *PFS regs update MIPS scoring and MSSP for 2019, plan E/M changes for 2021*, November 26, 2018). Under the new rule, Medicare beneficiaries gain coverage to virtual check-ins and remote evaluation by a physician of recorded video and images submitted by an established patient, reducing the need for patients to travel to their physicians in order to participate in monitoring. The PFS final rule also added coverage for chronic care remote physiologic monitoring and interprofessional internet consultation.

Additionally, the PFS final rule implemented changes made by section 2001(a) of the SUPPORT for Patients and Communities Act (P.L. 115-271) by removing originating site geographic requirements for telehealth services furnished on or after July 1, 2019, for the purpose of treating individuals diagnosed with substance use disorder or a co-occurring mental health disorder. The regulations make similar modifications to lift geographic restrictions on the originating sites where acute stroke telehealth services can be furnished. The interim final rule also added the home of an individual as a permissible originating site for end-stage renal disease (ESRD) services and stipulated that no facility fee will be paid when the individual's home is used as the originating site.

Challenges of Providing Reimbursement for Telehealth Services

The geographic complexities of providing care via telehealth make federal reimbursement tricky. Matchinski cited the uniformity and consistency of reimbursement for telehealth services across the country as a major challenge for federal health care programs in providing such reimbursement.

According to Matchinski, Medicare administrative contractors (MACs) located throughout the country are responsible for the processing and reimbursement of telehealth claims for services provided to government beneficiaries. Because of local coverage decisions (LCDs) and differing interpretations of Medicare regulations and coverage guidelines, MACs across the country can make inconsistent reimbursement decisions. "Without federal regulations governing the provision and reimbursement of telehealth, including telemedicine, it does not appear that there is uniformity or consistency in reimbursement by [MACs] for federal health care programs which provide health care services to government beneficiaries," Matchinski said. She also noted a lack of quality assurance and outcome measurement standards for the provision of telehealth services.

Payment models. The ASPE report identified challenges to telehealth reimbursement using a fee-for-service model. When reimbursement occurs per service provided, providers have no incentive to focus on the quality rather than the quantity of the services provided. Because of the lack of in-person contact involved in telehealth services, providers may be tempted to move through assessments and services more quickly without focusing on the needs of the patient. According to the ASPE, some providers suggested that the use of value-based purchasing would help address the issue.

FQHCs and other organizations working under value-based purchasing models establish contracts purchasing blocks of time with providers to provide telehealth services for patients. Under these arrangements, a provider is contracted to provide up to a certain number of hours, which can be used to support the patient's needs that week, and the FQHC takes the risk associated with how paying the provider to be available or the block of time factors into the overall payment rate for the facility's patients.

Along the same lines, Matchinski asserts there should not be a frequency limitation on reimbursement for telehealth services. "I think the physician should determine the medical necessity for the provision of telehealth and telemedicine services to patients, which will drive the frequency and necessity of the provision of telehealth and telemedicine services to the specific patient," she said. "I believe that it is difficult to determine the requisite frequency of telehealth services to each individual patient due to the patient's acuity, medical needs, and access and utilization of telehealth and telemedicine services."

Conclusion

Patient advocates and health care providers see the benefits of utilizing telehealth and are championing the broadening of federal reimbursement for such services. While CMS continues to add to its list of covered telehealth services for patients with limited ability to travel to health care facilities, the uniformity and consistency of reimbursement for telehealth services can be improved.

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