PROGRAM MATERIALS
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October 8, 2020

Telehealth Updates: The Future of Healthcare or Just "Dialing It In?"

(hint: it's the future of healthcare)

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TELEHEALTH UPDATES: THE FUTURE OF HEALTHCARE OR JUST "DIALING IT IN"?

(HINT: IT'S THE FUTURE OF HEALTHCARE)

PRESENTED BY

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OCTOBER 8, 2020

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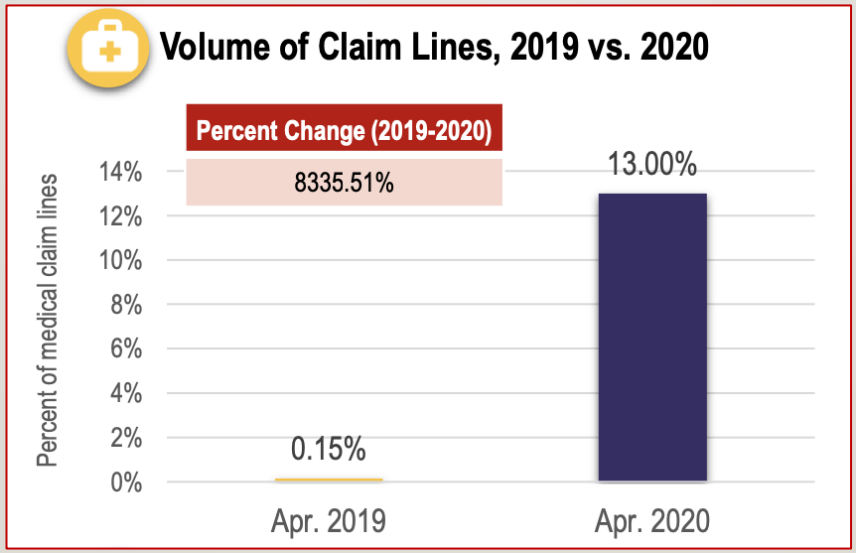
TELEHEALTH - BACKGROUND

- COVID-19 has changed the healthcare delivery landscape across the US
- Since the March 13, 2020 public health emergency ("PHE") declaration[1] and subsequent "loosening" of restrictions governing care delivery, primary means of non-emergent care delivery have pivoted from "in person" to telehealth modalities
- The volume of telehealth claims lines has increased by more than **8,335%** between April last year and April of this year, according to FAIR Health's Monthly Telehealth Regional Tracker[2].



(Source: FAIR Health, https://www.fairhealth.org/states-by-the-numbers/telehealth)

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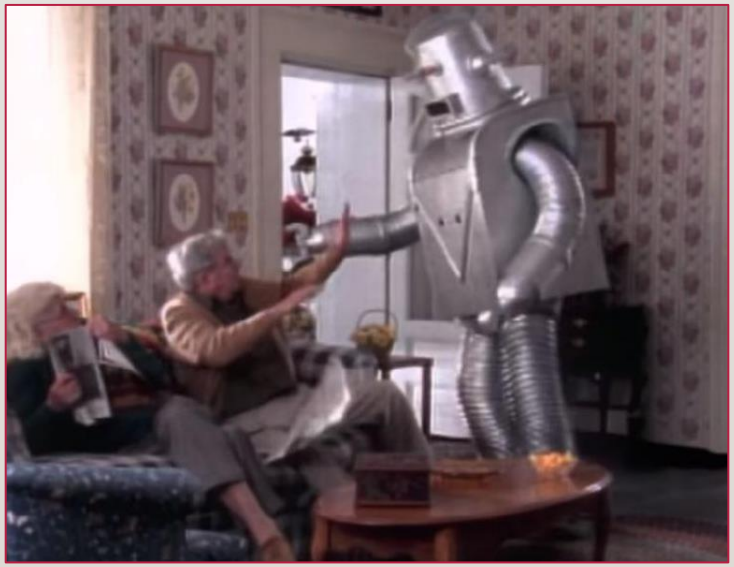
TELEHEALTH – BACKGROUND (CON'T)

- Telehealth has *long* been suggested as a viable technological solution for improving access to care.

- But for multiple reasons (which we will detail today) providers and institutions have been slow to adopt:



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TELEHEALTH – BACKGROUND (CON'T)

- COVID-19 pandemic shifted the paradigm
- Usage has become widespread out of necessity in the wake of COVID:
  - Mitigate transmission of COVID while still delivering patient care services
  - Decreasing emergency department and hospital volume
  - Saving $$ and precious resources such as PPE
- COVID-19 crisis has been like a big pilot program for accelerated adoption of telehealth and digital care modalities outside of rural contexts
- By most measures a remarkable success
- Remote care can of course never fully replace in-person care – clear that telehealth is not just a passing fad, should be more permanent part of US healthcare system
- So yes, telehealth is part of the "future" of healthcare (sorry to spoil the surprise so early on in the presentation)

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TELEHEALTH – BACKGROUND (CON'T)

- Telehealth is here to stay (in some form, anyway)
- Significant legal/regulatory, financial, technological, and practical barriers still in place preventing telehealth from becoming a more permanent feature of healthcare delivery in USA
- In today's presentation we will provide:
  - Overview and history of telehealth
  - Overview of the major barriers to telehealth adoption in US
  - Discuss the "waivers" and rule "relaxations" that have permitted expanded telehealth usage during the COVID-19 crisis
  - Describe the permanent changes that are needed for telehealth to become a permanent part of US healthcare landscape

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WHAT IS TELEHEALTH?

(AND WHY ARE THERE SOME MANY DIFFERENT TERMS USED TO DESCRIBE IT?)

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TELEHEALTH

- **Not a distinct type of service, rather a method/mode of care delivery that involves leveraging broad range of technologies to expand access to care via remote means**

- **Different definitions from state-to-state**

- **Telehealth Advancement Act of 2011 (CA) –** defines telehealth as the "**mode** of delivering healthcare services . . . utilizing information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

- **NY Public Health Law** – defines telehealth as "the use of **electronic information and communication technologies** by providers to deliver healthcare services, which shall include the assessment, diagnosis, consultation, treatment, education, care management, and/or self management of a patient (NY Public Health Law Article 29-G, Section 2999-cc)

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TELE*MEDICINE* AND TELE*PRACTICE*

- Telemedicine = subset of telehealth that refers solely to provision of synchronous (a/k/a live) clinical services to patients through electronic communications without an in-person visit
    - Seeks to "improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. *See, e.g.* 42 C.F.R. 410.78[3]
- Telepractice = the provision of professional service over geographical distances by means of modern telecommunications technology[4]

Telepractice > Telehealth > Telemedicine

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FOUR TYPES OF TELEHEALTH

- Live videoconferencing (synchronous) (Telemedicine)
- Store-and-forward (asynchronous)
- Remote Patient Monitoring ("RPM")
- Mobile Health ("mHealth")

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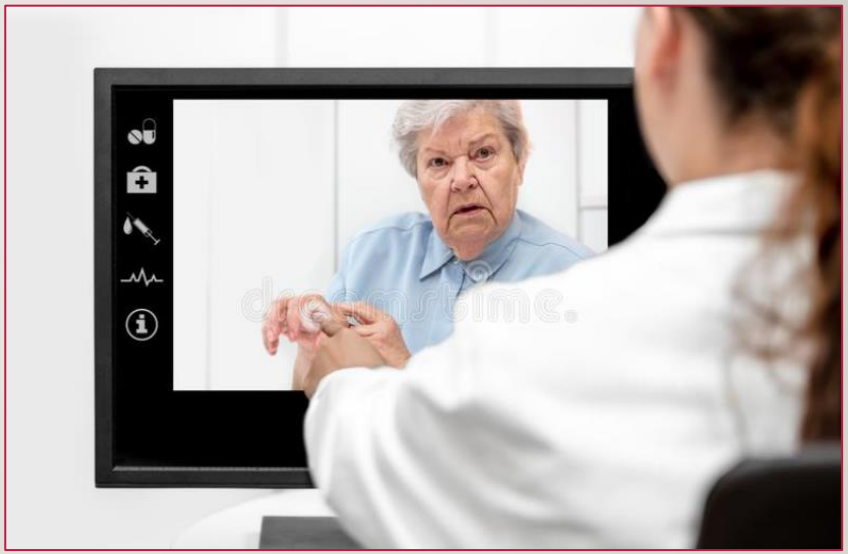
LIVE VIDEOCONFERENCING (SYNCHRONOUS)

- Live, two-way interaction (aka "synchronous) between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology



- In NY excludes audio only telephone communicate, fax, electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telehealth modalities ((NY Public Health Law Article 29-G, Section 2999-cc)

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STORE AND FORWARD (ASYNCHRONOUS)

- Transmission of **digital data** through a secure electronic communication system
  - Digital Data = x-rays, scans, images, videos, etc.
- Data recorded or captured at patient's site of care and then sent to provider elsewhere for further study or opinion
- Provider accesses data after collection = "asynchronous" telehealth

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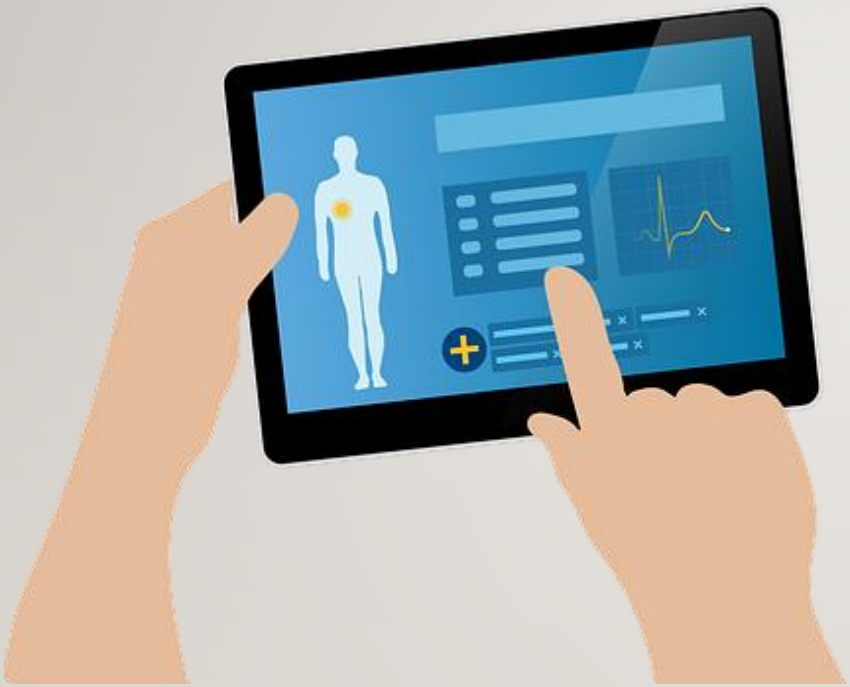
REMOTE PATIENT MONITORING (RPM)



- Equipment transmits patient data to healthcare providers for monitoring
- Often used in management of chronic illness (diabetes, cardiac health, chronic care management)
- Examples include:
  - Glucose monitoring devices
  - Blood microsampling devices
  - Cardiac monitoring devices (heart rate, blood pressure monitor, pulse oximeter)
  - ECG monitoring via remote patch

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MOBILE HEALTH (MHEALTH)

- Utilizes mobile devices to receive a health service or education/information (usually through an app)
- FDA issued guidance in 2013, updated in 2015 and 2019 (reflects changes in accordance with 21st Century Cures Act)[5]
- Same risk-based approach to device software as medical devices:
  - Software functions that are not medical devices not regulated (medical dictionaries, e-textbooks)
  - Software that may meet the definition of medical devices but are low risk, FDA exercises enforcement discretion (functions that use checklists of common signs and symptoms to provide list of possible medical conditions, software that sends alerts to first responders)
  - Software that are medical devices and are the focus of FDA oversight (ex. software that uses sensors or leads connected to mobile platform to measure and display physiological parameters)

HISTORY

- Telehealth has actually been around in one form or another for a long time . . .
- Some believe it was invented on the Jetsons back in the 1960's
- Not actually true . . .

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HISTORY (CON'T)

It's actually been around *much* longer than that…

- **1948:** First Radiological Images Sent Via Telephone
- **1959:** University of Nebraska Uses Telemedicine to Transmit Neurological Examinations -- first case of health professionals using the telephone to send and receive medical documents across long distances.
- **1960s:** Nebraska Psychiatry Institute Uses Closed-Circuit TV for Psychiatric Consultations – with live broadcasts, psychiatrists could interact with their patients from different rooms
- **September 1962**: the Jetsons first aired on TV

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BARRIERS TO ADOPTION

- Although its been around in one form or another for years, prior to COVID it has never been fully embraced for many reasons:
  - Financial barriers (reimbursement, cost)
  - Legal and Regulatory barriers
  - Privacy and Security/Technology concerns
  - Practical and Functional Limitations
- *Many of these issues still exist -- without permanent regulatory reform/change, will continue to impede telehealth utilization*

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FINANCIAL BARRIERS

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FOLLOW THE $$$$$

Like with so many things, its all about the $$$$$.

- **Cost**
  - How much does the technology cost to implement and use?
  - How much does it cost to properly train users?
  - Can it be profitably scaled?
- **Reimbursement:**
  - What services will be reimbursed?
  - By whom? Government payors? Commercial payors? Private pay?
  - How much?

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TELEHEALTH COSTS

- Major reason providers have been slow to embrace telehealth is **cost**:
  - Investment in telehealth equipment, software, infrastructure historically expensive, prohibitively so both for small practices and for huge NFP institutions
  - Equipment and systems quickly become obsolete as technology quickly advances and better options become available.
  - Significant costs also associated with setup, training, implementation and adoption
- In recent year SaaS solutions have emerged that don't require significant up-front investment, clunky equipment/tech, long-term subscriptions
- Still significant costs that are associated with telehealth, including:
  - Securing platforms
  - Licensing
  - Equipment
  - IT support
  - Scheduling
  - Patient education
  - Staff training

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LIMITED REIMBURSEMENT

- Medicare is biggest payor in USA, leads the "reimbursement landscape"
  - States and commercial payors follow Medicare's lead
- Pre-COVID, Medicare was slow to embrace telehealth
- Pre-COVID (and post if no waivers) generally had to meet five (5) conditions of payment to qualify for Medicare reimbursement of a telehealth service . . .

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5 CONDITIONS OF PAYMENT FOR TELEHEALTH

1. Patient is in a "qualifying rural area"
   - Outside of Metropolitan Statistical Area or in a Health Professional Shortage Area in a rural census tract

2. Patient is at one of 8 types of qualifying "originating sites"
   - Physician Office, Hospital, Critical Access Hospital, Rural Health Clinic, FQHC, Hospital-base or CAH-based Renal Dialysis Center, SNF, Community Mental Health Center

3. Services provided by one of ten categories of eligible "distant site practitioners"
   - MD, NP, PA, Nurse-midwife, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Clinical Psychologist, Clinical Social Worker, Registered Dietitian or Nutrition Professional

4. Patient and practitioner must communicate via an interactive audio and video telecommunications system that permits real-time communication (i.e. synchronous telemedicine)

5. The CPT/HCPCS code for the services provided are included in list of covered Medicare telehealth services
   - Significantly expanded for the COVID pandemic, see https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

MEDICAID – CONDITIONS OF PAYMENT FOR TELEHEALTH (PRE-COVID)

- State by state determination whether to cover telehealth, including:
  - What types of services to cover
  - How services are provided and covered
  - Where services are provided and covered
  - What providers can render what services
  - Reimbursement levels (so long as < federal limits)
- All states and DC now reimburse for some level of telemedicine services, rules vary significantly from state to state
  - 15 states provide reimbursement for store-and-forward
  - 23 provide reimbursement for RPM
  - 10 states (Alaska, Arizona, Maryland, Minnesota, Missouri, New York, Oregon, Texas, Virginia, and Washington) reimburse for all modalities
  - 6 states have some form of rural or geographic restriction

MEDICAID REIMBURSEMENT FOR TELEHEALTH (PRE-COVID)

- ***New York:***
  - Provider must enroll in NY Medicaid
  - Eligible "originating" sites limited to Article 28 (hospitals) and 40 (hospices), mental care facilities, physician offices, schools and child day cares, adult care facilities, and patients homes in NYS
  - Services provided must be compliant with HIPAA, BAA with supporting vendor
  - Stringent patient consent requirements

- ***California:***
  - No geographic or facility conditions for MEDI-CAL telehealth reimbursement
  - Providers have flexibility to determine if a particular services or benefit is clinically appropriate for telehealth
  - No RPM reimbursement

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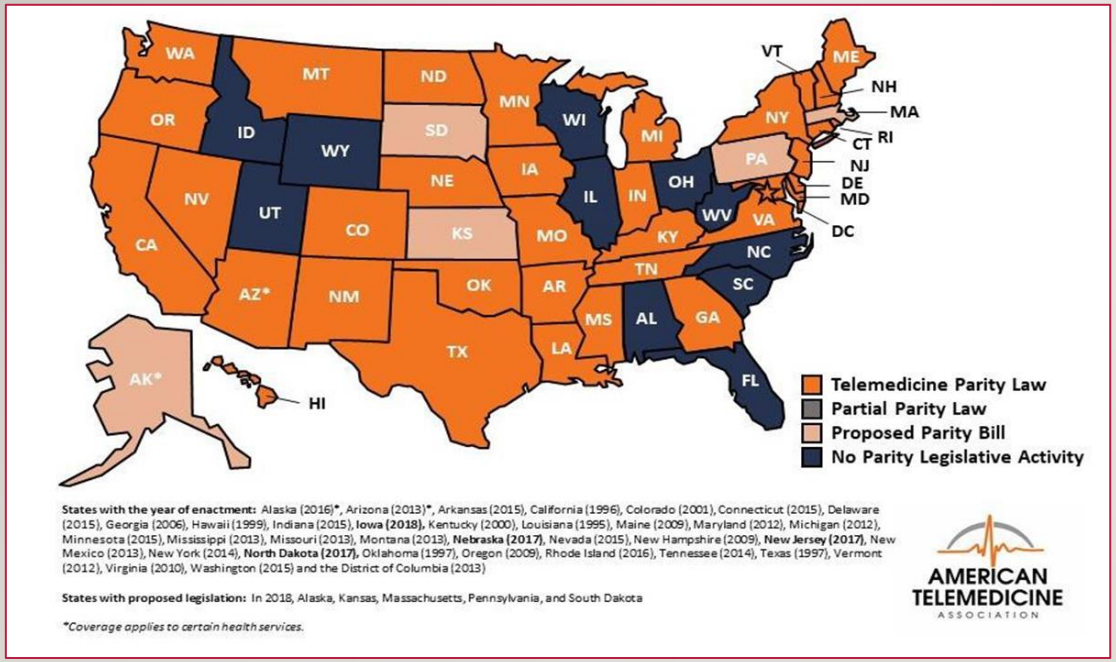
COMMERCIAL/PRIVATE REIMBURSEMENT FOR TELEHEALTH (PRE-COVID)



- Also varies from state-to-state and from payor to payor
- Where there is no commercial coverage often paid directly by patients:
  - Ex. Teledoc and Doctors on Demand (per visit or subscription pricing)
- Coverage determinations largely driven by state telemedicine insurance parity laws prohibiting payors from denying telemedicine reimbursement if they reimburse for in-person services
  - 40 states and DC have parity laws for telemedicine, 2 states pending (MA, UT)[4]

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COMMERCIAL/PRIVATE REIMBURSEMENT FOR TELEHEALTH (PRE-COVID)

- Example of Telehealth Parity Law -- New York Ins. Law 3217-h (2016)
  - Authorizes coverage for telehealth service by private payors and Medicaid
  - Prohibits plans from excluding coverage if services would be covered in person
  - Does not mandate coverage for store and forward and RPM (though some is now covered by NY Medicaid)
  - $ obligations and cost-sharing same as in-person
- All of the biggest commercial payors (Aetna, Cigna, BCBS, Humana, United) cover some telemedicine
- Rates and covered services vary based on applicable laws, payor allowances, negotiated rates, etc.

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SOME EFFORTS TO INCREASE TELEHEALTH COVERAGE PRE-COVID

2018 Bipartisan Budget Act of 2018 – Medicare telehealth provisions (effective 1/1/2019):

- Added 2 conditions where telehealth covered/reimbursed by Medicare outside of the "5" CoPs:
  - **End stage renal disease (ESRD)**:
    - ESRD patients on home dialysis may now receive their monthly clinical assessments at home using telehealth
    - Geographic coverage requirements eliminated for ESRD, freestanding dialysis facilities and the patient's home can serve as originating site
    - Face-to-face visits required only for the first three months of home dialysis and once every three months thereafter.
    - Providers allowed to furnish equipment at no charge to help facilitate telehealth to patients receiving home dialysis (if certain requirements are met)
  - **Acute stroke treatment**:
    - Patients arriving at a hospital with acute stroke symptoms may receive a telehealth consul to determine the best course of treatment, w/o regard to geography
    - Distant site providers eligible for reimbursement.
    - Originating sites will not receive telemedicine reimbursement unless site meets originating site requirements.

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SOME EFFORTS TO INCREASE TELEHEALTH COVERAGE PRE-COVID

2018 Bipartisan Budget Act of 2018 – Medicare telehealth provisions (effective 1/1/2019):

- Telehealth coverage increased for Medicare Part C
  - MA plans can cover additional, clinically appropriate telehealth benefits effective 2020 as part of gov't funded "basic benefits"
  - MA plans required to provide access to services offered via telehealth through in-person visits as well
  - Scope of services covered set forth in regulations promulgated in April 2019 (https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-06822.pdf)
- Telehealth coverage expanded for MSSP Accountable Care Organization (ACO)
  - MSSP ACOs permitted effective 1/1/2020 to expand use of telehealth services through existing Next Generation ACO telehealth waiver, which waives the geographic location criteria, allows the patient's home to serve as the originating site, and allows for the use of teledermatology and teleophthalmology.
  - Waiver can be used in MSSP Track II, MSSP Track III, and certain two-sided risk models.

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TELEHEALTH RULES "RELAXED" FOR COVID -

- Not until COVID-19 and PHE that "originating site" and other restrictions were lifted/waived (temporarily) . . .

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TELEHEALTH RULES "RELAXED" FOR COVID - MEDICARE

- **Medicare** rules re: provision / reimbursement of Telehealth "relaxed" to promote Telehealth (including telemedicine) during crisis
  - 3/16/2020 - CMS "blanket" waiver allowing Medicare payment for visits provided via telemedicine not otherwise covered pre-COVID
  - A larger range of providers now able to offer and be reimbursed by Medicare for 3 categories of "virtual services":
    - **Medicare "telehealth visits"** (which will be considered the same as in-person visits and will be paid at the same rates as regular, in-person visits);
    - **Virtual Check-ins** (Brief, patient-initiated communications via telephone call or information exchange via text, email, or patient portal, with practices they have an existing relationship with);
    - **E-visits** (patient-initiated communications with their doctors via online patient portals).

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TELEHEALTH RULES "RELAXED" FOR COVID – MEDICAID AND COMMERCIAL

- **Medicaid** telehealth coverage expanded (state by state) – in NY:
  - Services covered under a comprehensive health insurance policy or contract cannot be excluded when the service is delivered via telehealth.
  - 3/13/20 - NYS Medicare will reimburse providers for telephonic E&M services for established patients where face-to-face visits are not recommended and it is medically appropriate for telephonic treatment.
- **Commercial Payors** following suit – adopting similar measures to expand coverage and reimbursement for telehealth in alignment with CARES Act and/or state requirements
  - Cost-sharing waivers for telehealth visits with in-network providers
  - Virtual exams, hotlines for dealing with mental/behavioral health issues
  - Advance refills
  - Payor by payor determinations

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WHAT WILL HAPPEN WHEN PHE ENDS?

- PHE ends on 10/23/2020 -- unless extended again, waivers will expire
- What happens then?
- Lots of talk but no action so far (more on this later) – if nothing happens . . .

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REGULATORY/LEGAL BARRIERS

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REGULATORY AND LEGAL BARRIERS TO TELEHEALTH ADOPTION

- Regulation of healthcare delivery in US *largely* falls to the states
- Laws and rules applicable to telehealth/telemedicine vary from state to state
- No uniform approach, states take widely divergent approaches to regulation and policy
- "Patchwork" of laws, approaches -- regulatory inconsistency from jurisdiction to jurisdiction

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REGULATORY AND LEGAL BARRIERS TO TELEHEALTH ADOPTION

- Major legal/regulatory issues and barriers to telehealth include:
  - Licensing issues
  - Establishment of provider-patient relationship
  - Credentialing/privileging
  - Prescribing limitations
  - Corporate Practice of Medicine ("CPOM") restrictions
  - Standard of care and malpractice
  - Fraud and Abuse considerations

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LICENSURE ISSUES

- Historically physicians provided in-person care to patients in the state (or two) where they practiced – no need to be concerned about practicing across state lines
- Telehealth can be practiced across state lines – licensure still a state by state issue
- Location of patient is considered "place of service" or "originating site" – providers must comply with the laws of the state where the patient sites

LICENSURE ISSUES

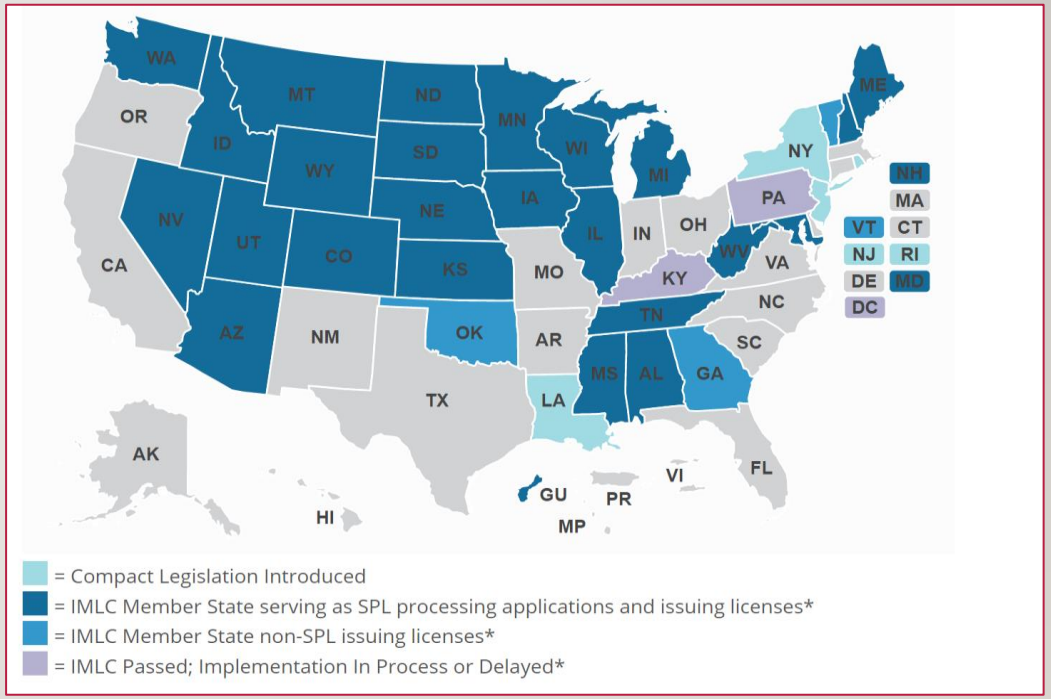
- During COVID PHE, many states have eased or waived licensure requirements and permit providers not licensed in state to provide care via telehealth modalities (to increase access to care)
- Absent waivers, no uniform approach, state-by-state analysis required for physicians seeking to practice across state lines
- A few basic buckets:

1. States that subject out-of-state physicians to full licensure requirements (ex. AK, CO, CT, DE)
2. States that permit physicians to practice across state lines using a "special purpose" license (OR, NE, MI, MO, NM, TE*, TE, AL, OH)
3. Licensure via reciprocity or endorsement (for physicians licensed in other states)
4. States that permit physician-to-physician consults – most states permit it but scope of the exception varies from state to state (i.e. "unqualified" general consults (NY, MA, FL), and "qualified" consults (MI, NJ)
5. States whose licensure statutes and regulations do not address telehealth (AL, AZ, CA, NY)

* No longer offers new licenses, will renew existing licenses

PHYSICIAN INTERSTATE MEDICAL LICENSURE COMPACT

- Agreement among states to allow qualified physicians to achieve licensure across member states in expedited manner
- Intended to increase access to health care for patients in underserved or rural areas via telehealth
- Physicians must meet certain experience requirements and practice standards to join
- Became operational in April 2017, currently includes 29 states, DC, and Guam



Source: IMLC (www.imlcc.org)

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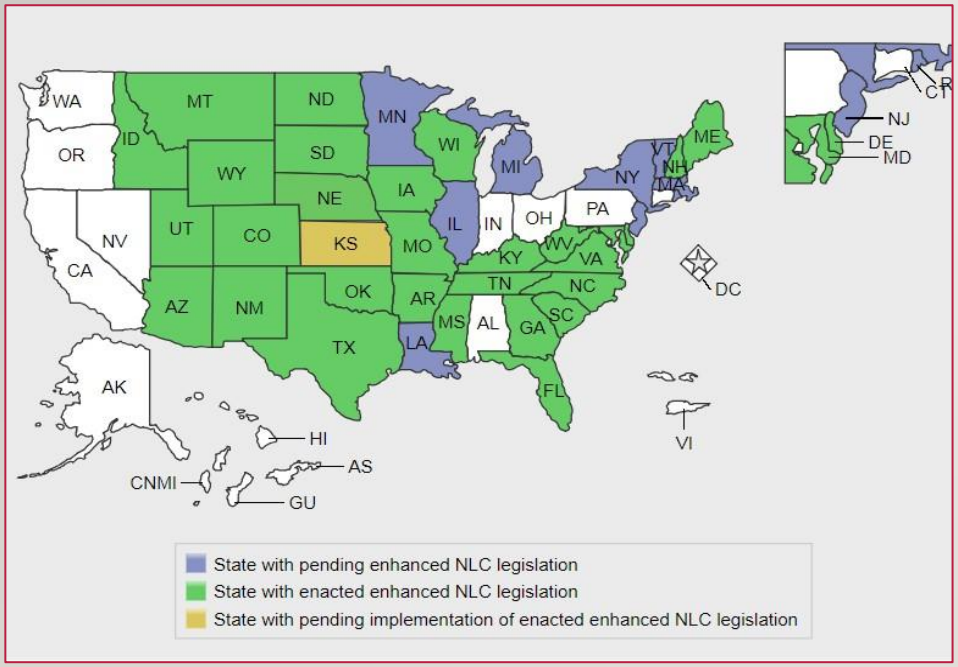
NURSING SCOPE OF TELEHEALTH PRACTICE



- Also varies state-to-state
- Interstate Nurse Licensure Compact –
  - Allows nurses licensed in any state to practice without additional licensure in any other participating state
  - Introduced in 1999, updated 1/19/18
  - More than ½ of states now participate
- All states allow licensure by endorsement so long as licensure requirements in applicant state are as stringent as endorsing state
  - Some state require additional educational and other requirements for licensure by endorsement (e.g. FL)

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ESTABLISHMENT OF PHYSICIAN-PATIENT RELATIONSHIP

- Currently no states that explicitly prohibit the establishment of a provider-patient relationship via telehealth
  - Texas was the last holdout but changed its laws in 2017 following dispute where Texas Medical Board threatened disciplinary action against Teladoc physicians who prescribed without a face to face visit
- Some states have statutory provisions that make it difficult to establish provider-patient relationship via telehealth
  - Georgia (Ga. Comp. R. & Regs. R. 360-3-.07)
  - New Jersey (N.J. Admin. Code 13:35-7.1.A) – initial in-person exam required for prescription of Schedule II meds and in-person every three (3) months
- Others expressly permit establishment of provider-patient relationship via telehealth:
  - Maine – telemedicine practice guidelines clear that patient relationship can be established via telemedicine, but that static internet questionnaire not enough to create relationship (02-373-6 Me. Code R. 3 (2016)
  - Maryland – relationship can be created via evaluations conducted via real-time audio or audio and video communication (Md. Code Regs 10.32.05.05)
- Some states' rules depend on specialty at issue:
  - West Virginia – relationship can be established via store and forward tech for pathology and radiology only (W. Va Code 30-14-12d (2016))
  - Ohio – social workers must conduct initial in-person evaluation to create relationship (Ohio Admin Code 4757-5-13)

ESTABLISHMENT OF PHYSICIAN-PATIENT RELATIONSHIP (CON'T)

- All state laws require that:
  - Patient consent to telehealth encounter and documenting the consent in the record
  - Telehealth encounters meet current standards of care
  - Technologies used are sufficient to allow for accurate treatment and diagnosis
- Many states with stricter establishment provisions have exceptions for intermittent consultations or emergent situations:
  - Delaware – telemedicine may be provided without pre-existing physician-patient relationship in certain situations, including informal and infrequent consultations, emergencies where the physician does not charge for the services, episodic consultations (Del. Code Ann. Tit. 24, 1769(D))
- Ultimately the rule vary by state, require state by state assessment to determine what is required/prohibited

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PRESCRIBING RULES AND REGULATIONS

- Also vary by state
- Often requires "established" patient relationship before prescription can be written
- Some require a physical examination before prescribing
  - At least 20 states allow physical exams/evaluations to be performed via telehealth
- Many states ordinarily prohibit prescribing based solely on internet questionnaires, consults, calls, or emails
  - e.g. Utah -- requires healthcare providers to satisfy a list of requirements before prescribing medication through a telemedicine visit, prohibits providers from writing prescriptions based only on an internet questionnaire
- EVERY state prohibits "unprofessional conduct" in prescribing
- Controlled substances regulated federally – Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (Pub. L. No. 110-425):
  - Prohibits online pharmacies from dispensing controlled substances without a valid prescription from a physician who has examined the purchaser in person
  - Exceptions for treatment in a hospital or clinic, treatment in practitioner physical presence, Indian Health Services or tribal organization, public health emergencies declared by HHS

STANDARD OF CARE

- Physicians ordinarily do not owe a duty to a patient unless/until physician-patient relationship established
  - Traditionally the foundation of the relationship was the in-person encounter
  - Existence more questionable in telehealth, in particular asynchronous telehealth where the patient and physician never meet and physician merely interprets based on remotely collected information
- Assuming relationship *is* established, what is the standard of care?
  - At very least, same for telehealth as for in-person care – *see* NJ ST 45:1-62(d)(2):
  - *"Any health care provider providing health care services using telemedicine or telehealth shall be subject to the same standard of care or practice standards as are applicable to in-person settings."*
  - If standard of care requires in-person exam/evaluation, should not be provided via telehealth
  - Some states have created additional telehealth specific standards

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MALPRACTICE CONCERNS

- Lawsuits in telehealth not common. Most common: failure to diagnose properly (radiology, dermatology)
- As telehealth proliferates likely uptick in lawsuits for improper use of/lack of training on telehealth modalities
- Can physicians be held liable for *not* utilizing available telemedicine technologies?
  - If/when they become part of the standard of care, probably
- Malpractice coverage concerns -- must ensure that malpractice insurer covers telehealth
  - Carriers may require submission of info re: location, frequency, type of services provided via telehealth
  - May be surcharge on malpractice premium for telehealth depending on risk factors, geography, etc.
  - Geographical limits on where services are covered

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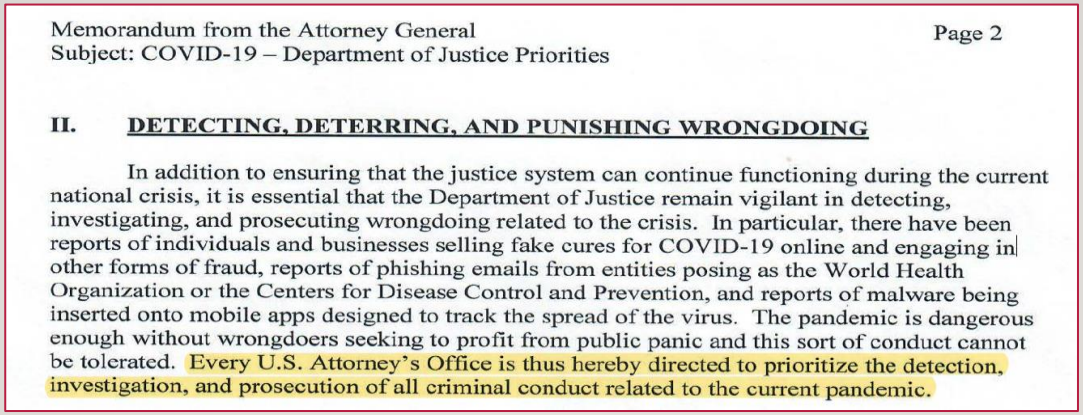
TELEHEALTH ENFORCEMENT

- Telehealth and remote services are ripe for fraud, waste, and abuse:
  - Patchwork regulation and guidance across jurisdictions and payors
  - Easy to bill for fictitious services and phantom visits
  - Overbilling opportunities abound amidst coding confusion
  - Confusion about what is covered and what is not
  - Limits safeguards and inconsistent enforcement
- Pre-COVID was already becoming "hot target" for civil and criminal enforcement
  - ***2012 – US ex. rel Cohen v. Anton Fry and CPC Associates*,** early civil enforcement case alleging that psychiatrist billed Medicare for services provided via phone (and thus that did not qualify as telehealth) (settled in 2012)
  - **April 2019 -** DOJ "crackdown" resulted in charges against 24 telehealth and DME company executives and physicians for alleged fraud totaling $1.2B from kickbacks and bribes related to prescribing unnecessary equipment
  - **September 2019 -** DOJ charged 35 individuals in $2.1B Medicare billing fraud scheme involving kickbacks paid to telehealth providers to order genetic testing

TELEHEALTH ENFORCEMENT

- DOJ committed early on to "aggressive" enforcement of COVID-19 related fraud.



Memorandum from the Attorney General
Subject: COVID-19 – Department of Justice Priorities

Page 2

II. DETECTING, DETERRING, AND PUNISHING WRONGDOING

In addition to ensuring that the justice system can continue functioning during the current national crisis, it is essential that the Department of Justice remain vigilant in detecting, 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.

- Telehealth will be the first big wave/target of COVID-related and post-COVID FWA enforcement – has already begun

DOJ's COVID-19 Fraud Enforcement Targets Telehealth Industry

- **Scrutiny and enforcement will trend upwards in wake of COVID** – lack of regulatory clarity/consistency may scare providers aware from fully embracing telehealth modalities

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PRIVACY AND SECURITY ISSUES

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PRIVACY AND SECURITY OF HEALTH INFORMATION

- **Privacy** – protection of consumer rights and information
- **Security** – protection of hardware, physical and electronic data, and operational systems
- *Long* been serious concerns about privacy and security of healthcare data
  - Substantial federal regulation/enforcement across multiple agencies (HHS-OCR, HIS, FDA, OMB, FTC, etc.)
  - State-level privacy and security laws, some of which (such as California Confidentiality of Medical Information Act) are broader and in scope than federal regulations
- Telehealth increases privacy and security concerns because of the nature of data uses and management associated with remote care and novel modalities

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

- Protects the privacy and security of protected health information (PHI), fines up to $1.5mm per year for violations
- Requires the protection and secure handling of PHI by "covered entities" and their "business associates"
  - Covered entities (CE) = health care providers that engage in certain electronic transactions, clearinghouses, and health plans)
  - Business Associates (BA) = agents and subcontracts of covered entities that handle PHI and their agents and subcontracts (sub-Bas)
- HIPAA Privacy Rule – CEs and BAs must develop and follow procedures that protect privacy of PHI
- HIPAA Security Rule – sets standards for securing patient data that is stored or transferred via electronic methods

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COVID-19 INCREASES PRIVACY AND SECURITY RISKS

- Even before COVID telehealth widely seen as posing significant cybersecurity challenges

> **Telehealth is biggest threat to healthcare cybersecurity, says report**
>
> A new study from SecurityScorecard and DarkOwl sees increased risk across application and endpoint security, IP reputation, patching cadence and network security.

(SOURCE: Healthcare IT News[8])

- COVID-19 forced a surge in use of telehealth without associated security protocols
- Loosening of regulatory restrictions to encourage telehealth usage:
  - **March 17, 2020** OCR-HHS "enforcement discretion" and waiver of HIPAA penalties against providers that communicate with patients and provide telehealth services in "good faith" through non-public facing "everyday" communications technologies such as Skype, Google Hangouts, Facebook Messenger, and FaceTime during the PHE
- While these steps were necessary to increase access to care during crisis, make PHI even more vulnerable

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PRIVACY AND SECURITY CONCERNS

- Providers using telehealth may or may not be covered by HIPAA
- HIPAA compliance has become "industry standard" expected by patients who have concerns about privacy and security of their PHI and how it is being used
- Even if users are not technically required to comply w/ HIPAA, advisable that they still do to mitigate regulatory risk and potential civil liability, keep patients happy
- At very least ensure that:
  - Environment where telehealth interaction takes place, both at originating (patient) and distant (provider) site is secure
  - That no PHI is inadvertently exposed or vulnerable to third-party interference
  - End-to-end encryption, other security features, regular audits and updates
- Bad actors still abound, will continue to hack and steal PHI -- which is more profitable to hackers than credit card information[9]– risk will ↑ as TH ↑

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PRACTICAL LIMITATIONS

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FUNCTION AND CAPACITY LIMITATIONS

- Functional issues – telehealth still subject to technological limitations, bugs, inherent capacity limitations (getting better but still challenging for patients and providers)

- Even if all financial barriers are resolved, regulatory issues are ironed out, privacy and security concerns are assuaged, one unassailable fact remains:

> "Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for America's seniors," said CMS Administrator Seema Verma.

(per Seema Verna, CMS Administrator, in August 3, 2020 CMS Press Release[12])

- Some specialties better suited to telehealth provision than others:
  - Mental health services
  - Some primary care
  - Dermatology

- Some services just can't be provided via telehealth (at least not with current technology)
  - Serious interventions (cardiac procedures, brain surgery)
  - Emergency services

WHAT HAPPENS NEXT?

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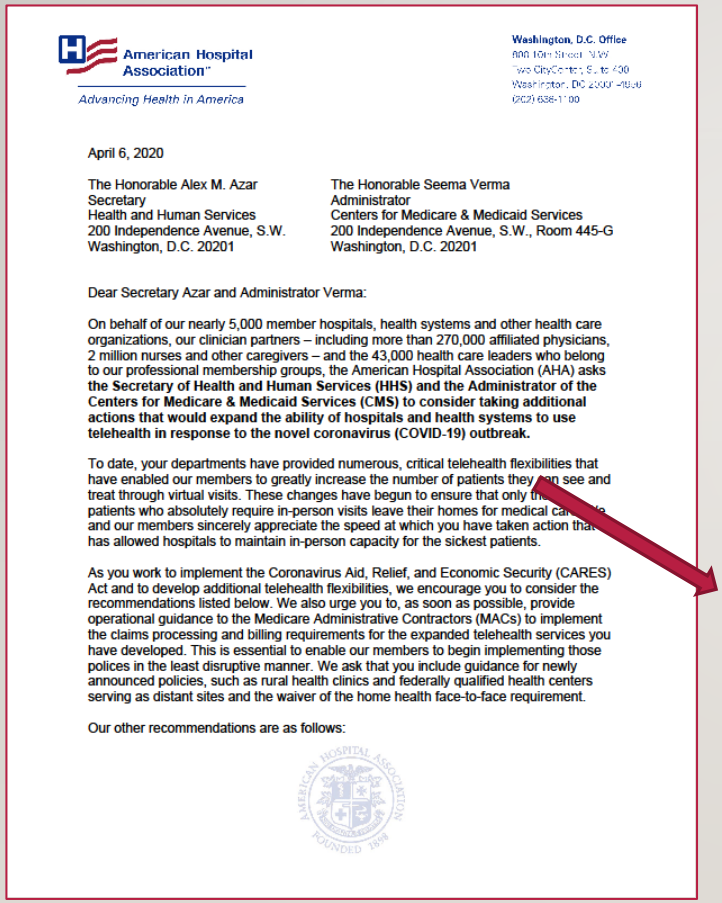
THE FUTURE?



American Hospital Association
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

April 6, 2020

The Honorable Alex M. Azar
Secretary
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Dear Secretary Azar and Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks **the Secretary of Health and Human Services (HHS) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) to consider taking additional actions that would expand the ability of hospitals and health systems to use telehealth in response to the novel coronavirus (COVID-19) outbreak.**

To date, your departments have provided numerous, critical telehealth flexibilities that have enabled our members to greatly increase the number of patients they can see and treat through virtual visits. These changes have begun to ensure that only those patients who absolutely require in-person visits leave their homes for medical care, and our members sincerely appreciate the speed at which you have taken action that has allowed hospitals to maintain in-person capacity for the sickest patients.

As you work to implement the Coronavirus Aid, Relief, and Economic Security (CARES) Act and to develop additional telehealth flexibilities, we encourage you to consider the recommendations listed below. We also urge you to, as soon as possible, provide operational guidance to the Medicare Administrative Contractors (MACs) to implement the claims processing and billing requirements for the expanded telehealth services you have developed. This is essential to enable our members to begin implementing those polices in the least disruptive manner. We ask that you include guidance for newly announced policies, such as rural health clinics and federally qualified health centers serving as distant sites and the waiver of the home health face-to-face requirement.

Our other recommendations are as follows:

Overwhelming consensus that expansion of telehealth during PHE (involuntary pilot program/beta test) successful, critical to ensuring continuity of care during pandemic

To date, your departments have provided numerous, critical telehealth flexibilities that have enabled our members to greatly increase the number of patients they can see and treat through virtual visits. These changes have begun to ensure that only those

(4/6/2020 letter from AHA to HHS/CMS re: expansion of telehealth)

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THE FUTURE?

Widespread agreement between government **<u>and</u>** providers that telehealth should be expanded/made a more permanent fixture in US healthcare

American Hospital Association
Advancing Health in America

Washington, D.C. Office
[illegible]

April 6, 2020

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Our other recommendations are as follows:

The New York Times https://nyti.ms/3bjGxmr

PERSONAL HEALTH

A Pandemic Benefit: The Expansion of Telemedicine

Medical practice over the internet can result in faster diagnoses and treatments, increase the efficiency of care and reduce patient stress.

By Jane E. Brody

May 11, 2020

Even if no other good for health care emerges from the coronavirus crisis, one development — the incorporation of telemedicine into routine medical care — promises to be transformative. Using technology that already exists and devices that most people have in their homes, medical practice over the internet can result in faster diagnoses and treatments, increase the efficiency of care and reduce patient stress.

CMS

Press release

Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas

Aug 03, 2020 Billing & payments, Physicians

The Centers for Medicare & Medicaid Services (CMS) is proposing changes to expand telehealth permanently, consistent with the Executive Order on Improving Rural and Telehealth Access that President Trump signed today. The Executive Order and proposed rule advance our efforts to improve access and convenience of care for Medicare beneficiaries, particularly those living in rural areas. Additionally, the proposed rule implements a multi-year effort to reduce clinician burden under our Patients Over Paperwork initiative and to ensure appropriate reimbursement for time spent with patients. This proposed rule also takes steps to implement President Trump's Executive Order on Protecting and Improving Medicare for our Nation's Seniors and continues our commitment to ensure that the Medicare program is sustainable for future generations.

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ADMINISTRATIVE ACTIONS

- Recent administrative actions to expand telehealth:
  - July 25, 2020 -- HHS renewed COVID-19 PHE, extended pandemic-related waivers
    - PHE now extended to October 23, 2020 unless renewed again (which seems likely) or if the HHS Secretary terminates it earlier
  - August 3, 2020 – Executive Order to expand rural access to telehealth and make certain telehealth services permanent post covid.[10]
  - August 3, 3020 – CMS issued proposed rule (1353 pages)[11] announcing and soliciting comments on proposed policy changes for Medicare payments under PFS, including:
    - Expanding Medicare beneficiary access through Telehealth for home visits for evaluation and management (E&M) services and some visits for individuals with cognitive impairments
    - Temporarily continuing payment for telehealth services for emergency department visits and other services to give the healthcare community "time to consider whether these services should be delivered permanently through telehealth outside of the" PHE.

ADMINISTRATIVE ACTIONS

- Good start but administrative action and regulatory reform can only go so far:
  - CMS' regulatory authority outside of the PHE is largely limited to what types of services can be provided via telehealth
  - CMS cannot make telehealth reimbursement available permanently or permanently expand the list of providers authorized to provide services via telehealth.
- Per CMS Administrator Verma in 9/15/2020 interview with Modern Healthcare[12], ***real*** change requires congressional action via legislation

> **MH:** What about telehealth expansions? What will be made permanent? (CMS expanded access to and payment for telehealth amid the COVID-19 pandemic, but the expansions were made under temporary waivers.)
>
> **Verma:** So that's something that the president's particularly focused on. He put out an executive order and he wants to make the telehealth benefit more permanent, in terms of the waivers we've been able to do because of COVID. There's like three or four areas there. No. 1 is we've expanded the number of services that can be provided via telehealth. Unfortunately, without Congress' help we can't do that beyond rural areas, and we also can't allow the individual to obtain their telehealth services from their homes. So those are some things we're working on with Congress. But under the president's leadership we've expanded the number of services.

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LEGISLATIVE ACTIONS

- Telehealth expansion bills starting to pile up:
  - HEROES Act (passed by House in May) – includes direct funding and other provisions aimed at increasing telehealth access and infrastructure
  - Telehealth Modernization Act (S.4375) (L. Alexander)
  - Telehealth Expansion Act of 2020 (S.4230)
  - Equal Access to Care Act of 2020 (T. Cruz)
  - COVID-19 Telehealth Program Extension Act (A. Spanberger, D. Johnson)
  - Helping to Ensure Access to Local Telehealth (HEALTH) Act of 2020
- Nothing passed into law yet . . . nothing likely for a while
- PHE expires October 23, 2020 –
  - Likely will be renewed by HHS again
  - Without permanent change, once PHE ends we could go back to the "old days" of limited telehealth

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THE FUTURE?

- What changes are needed to enable expanded and permanent delivery of telehealth services??
  - **Adequate reimbursement for telehealth services to providers**
  - **Reimbursement consideration for telehealth capacity and infrastructure costs (upfront, ongoing costs)**
  - **Pay-parity for services regardless of whether delivered in-person or via telehealth modalities**
  - **Remove geographic and originating site restrictions for provision of telehealth services**
  - **Allow coverage and payment for audio-only communication** (as clinically appropriate)
  - **Give HHS authority to expand eligible practitioners and services that can deliver and bill for telehealth services**
  - **Coordinate licensure requirements across state lines** – national approach to medical licensure to ensure providers residing in one state can deliver telehealth services to patients in other states
  - **Coordinated rules regarding prescribing, types and standards of services provided via telehealth**
  - **Increased access to broadband services to facilitate telehealth in rural and underserved communities**

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IF YOU BUILD IT, THEY WILL COME

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QUESTIONS?

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THANK YOU

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REFERENCES

1. Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, issued on March 13, 2020 (attached)
2. https://www.fairhealth.org/states-by-the-numbers/telehealth
3. https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html#:~:text=For%20purposes%20of%20Medicaid%2C%20telemedicine,practitioner%20at%20the%20distant%20site.&text=This%20definition%20is%20modeled%20on,services%20(42%20CFR%20410.78
4. "What is Telepractice?", State Education Department, Deputy Commissioner for the Professions, Office of Professions, http://www.op.nysed.gov/COVID19_Telepracticeguidance.html
5. Policy for Device Software Functions and Mobile Medical Applications, Guidance for Industry and Food and Drug Administration Staff, September 27, 2019, https://www.fda.gov/media/80958/download
6. "When Telehealth cost-sharing waivers expire for 5 payers," Becker's Hospital Review, Morgan Haefner, September 17, 2020
7. Federation of State Medical Boards, Telemedicine Policies (July 2020)
8. "Telehealth is biggest threat to healthcare cybersecurity, says report," Healthcare IT News, September 10, 2020, https://www.healthcareitnews.com/news/telehealth-biggest-threat-healthcare-cybersecurity-says-report#:~:text=Telehealth%20is%20biggest%20threat%20to%20healthcare%20cybersecurity%2C%20says%20report,-A%20new%20study&text=The%20report%2C%20released%20Thursday%20from,enormous%20increase%20in%20targeted%20attacks
9. "Your medical record is worth more to hackers than your credit card," Caroline Humer and Jim Finkle, Reuters, September 24, 2014, https://www.reuters.com/article/us-cybersecurity-hospitals/your-medical-record-is-worth-more-to-hackers-than-your-credit-card-idUSKCN0HJ21I20140924
10. "President Donald J. Trump Is Expanding Access to Telehealth Services and Ensuring Continued Access to Healthcare for Rural Americans," https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-expanding-access-telehealth-services-ensuring-continued-access-healthcare-rural-americans/
11. CMS August 2020 Proposed PFS Rule, https://www.federalregister.gov/documents/2020/08/17/2020-17127/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part
12. "CMS' Seema Verma on COVID-19 vaccines, provider funds and stark law," https://www.modernhealthcare.com/medicare/cms-seema-verma-covid-19-vaccines-provider-funds-and-stark-law?utm_source=promote-editorial&utm_medium=email&utm_campaign=Exclusive&utm_term=SeemaVerma&utm_content=09202020

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PROCLAMATIONS

Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak

Issued on: **March 13, 2020**

★ ★ ★

In December 2019, a novel (new) coronavirus known as SARS-CoV-2 ("the virus") was first detected in Wuhan, Hubei Province, People's Republic of China, causing outbreaks of the coronavirus disease COVID-19 that has now spread globally. The Secretary of Health and Human Services (HHS) declared a public health emergency on January 31, 2020, under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19. I have taken sweeping action to control the spread of the virus in the United States, including by suspending entry of foreign nationals seeking entry who had been physically present within the prior 14 days in certain jurisdictions where COVID-19 outbreaks have occurred, including the People's Republic of China, the Islamic Republic of Iran, and the Schengen Area of Europe. The Federal Government, along with State and local governments, has taken preventive and proactive measures to slow the spread of the virus and treat those affected, including by instituting Federal quarantines for individuals evacuated from foreign nations, issuing a declaration pursuant to section 319F-3 of the Public Health Service Act (42 U.S.C. 247d-6d), and releasing policies to accelerate the acquisition of personal protective equipment and streamline bringing new diagnostic capabilities to laboratories. On March 11, 2020, the World Health Organization announced that the COVID-19 outbreak can be characterized as a pandemic, as the rates of infection continue to rise in many locations around the world and across the United States.

The spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems. As of March 12, 2020, 1,645 people from 47 States have been infected with the virus that

causes COVID-19. It is incumbent on hospitals and medical facilities throughout the country to assess their preparedness posture and be prepared to surge capacity and capability. Additional measures, however, are needed to successfully contain and combat the virus in the United States.

NOW, THEREFORE, I, DONALD J. TRUMP, President of the United States, by the authority vested in me by the Constitution and the laws of the United States of America, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq*.) and consistent with section 1135 of the Social Security Act (SSA), as amended (42 U.S.C. 1320b-5), do hereby find and proclaim that the COVID-19 outbreak in the United States constitutes a national emergency, beginning March 1, 2020. Pursuant to this declaration, I direct as follows:

Section 1. Emergency Authority. The Secretary of HHS may exercise the authority under section 1135 of the SSA to temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak.

Sec. 2. Certification and Notice. In exercising this authority, the Secretary of HHS shall provide certification and advance written notice to the Congress as required by section 1135(d) of the SSA (42 U.S.C. 1320b-5(d)).

Sec. 3. General Provisions. (a) Nothing in this proclamation shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This proclamation shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This proclamation is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

IN WITNESS WHEREOF, I have hereunto set my hand this thirteenth day of March, in the year of our Lord two thousand twenty, and of the Independence of the United States of America the two hundred and forty-fourth.

DONALD J. TRUMP

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12230

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WHAT IS TELEPRACTICE?

Background and Definition

Telepractice is defined as the provision of professional service over geographical distances by means of modern telecommunications technology. This generic term includes, for example, telehealth, teletherapy, teledentistry, telemedicine, telenursing, etc. Telepractice is used by health providers in a growing number of areas, including radiology, dermatology, dentistry, home health care, emergency medical services and the provision of mental health services by psychologists and social workers. The use of technology in professional practice is also growing in the design and business professions. For example, architectural and engineering design plans and design changes have been shared across state and national borders since electronic computer assisted design (CAD) programs were developed in the 1970s. In the accounting field, the proliferation of national and international firms both require and enable the type of instantaneous interaction that advanced technology is able to provide.

Telepractice Applications

Telepractice can take on many forms, including its use for intra- and inter- disciplinary professional research and training. Given the jurisdiction of the Board of Regents, our primary focus is on the use of telecommunications technology to deliver professional services to a patient or client who is located at a distance from the provider. In this context, telepractice has four basic components: data, expertise, distance, and the electronic transmission of one or both of the first two. It includes the delivery of images, sound, text, and graphical data via telephone, facsimile, Internet and/or video conferencing. The technology is primarily applied in two ways:

- One application is through the expanded use of electronic communication, where information and individual, static images are transmitted to the professional located at a distance for use in consultation, review or diagnosis. For example, radiological images may be transmitted from an associate in a remote location for assessment at a major medical center, or construction details may be e-mailed for faster feedback and reaction from a field project in the Middle East to the headquarters of an architectural firm in Manhattan.

- The other application is more interactive. This approach may include teleconferencing along with a video image that is instantaneously displayed to the professional for consultation, review, and diagnostic purposes. During the transmission, the professional may converse with the client or patient so that multiple tasks can be performed and recorded during the session. These tasks might include taking a medical history and/or reading an X-ray of an injury, much like in a face-to-face session, but without direct physical contact. As a result of the technology, a consultation can involve broad input, be participatory, and can connect those in remote regions with medical, financial or design professional services in centralized urban centers.

WHAT IS THE IMPACT OF NEW YORK STATE LAW ON TELEPRACTICE?

In accordance with New York State statute, full licensure and current registration are required of any professional who practices in New York State, unless specifically suspended or waived pursuant to an Executive Order issued by the New York State Governor during a disaster emergency. All New York State licensed professionals are responsible for adhering to the same laws, rules and regulations and for upholding the same standards and competencies when engaging in telepractice as they are when practicing without the use of technology over a distance. This understanding is essential to ensure public protection and the integrity of the professions.

In the practice of medicine and dentistry, Education Law includes specific provisions permitting occasional consultations by physicians and dentists licensed in their home state (Education Law Section 6526(3) for medicine, and Section 6610(5) for dentistry). This consultation exemption statutorily establishes the extent to which these professionals licensed in other jurisdictions may practice in New York State when engaged in consulting arrangements.

This regulatory approach is premised on the prohibition in law against professional practice in New York by anyone who is not licensed in this State. This premise is based on the need to adhere to the requirements for admission to the professions and to the standards for professional practice developed by the Legislature and the Board of Regents to insure maximum public protection.

CONCLUSION

As technology advances, so do the available options for delivery of professional services. It is incumbent upon a licensee engaging in telepractice to ensure that he or she is aware of any and all guidelines, policies, laws, rules and/or regulations governing tele practice as well as ethical and cost-benefit considerations.

Telemedicine Policies
Board by Board Overview

Document summary:

Licensure

- Forty-nine (49) state boards, plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Twelve (12) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- Six (6) state boards require physicians to register if they wish to practice across state lines.

Reimbursement - Medicaid

- All states and the District of Columbia provide reimbursement for some form of live video in Medicaid fee-for-service.
- Fourteen (14) states reimburse for store-and-forward.
- Twenty-two (22) states reimburse for remote patient monitoring.
- Eight (8) states reimburse for all three, with certain limitations.

Reimbursement – Private Payer

- Forty (40) states and the District of Columbia govern private payer telehealth reimbursement policies.
- Six (6) states have private payer parity laws.

Last updated: July 2020

	State License Required	Reimbursement Policies				Other Rules/Regulations (citation only)
		Medicaid			Private Payer Law	
		Live Video	Store-and-Forward	Remote Patient Monitoring		
AL	√*[1]	√		√		Ala. Admin. Code § 540-x-16
AK	√	√	√	√		"Telehealth Statutes, Regulations & Policy" Alaska Dept. of Health and Social Services SB 74 of 2016, Chapter 25 SLA 16 "Board Issued Guidelines: Telemedicine" Alaska State Medical Board, Nov. 2014
AZ-M	√	√	√	√	√	Ariz. Rev. Stat. § 32-1421 "Issue Brief: Telemedicine" Arizona State Senate, Nov. 10, 2014
AZ-O	√	√	√	√	√	Ariz. Rev. Stat. § 32-1821 Ariz. Rev. Stat. § 32-1854 "Issue Brief: Telemedicine" Arizona State Senate, Nov. 10, 2014
AR	√	√			√	AR Code § 17-95-206 AR Stat. 10-3-1702(10) "When Does Telemedicine or Internet- Based Patient Healthcare Violate Regulation 2.8?" AR State Med. Board Newsletter Fall 2012
CA-M	√	√	√		√^[2]	Ca. Business & Prof. Code § 2290.5 Medical Board of California
CA-O	√	√	√		√^	Same as CA-M

[1] √* denotes that a state may issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
[2] √^ denotes that a state has a private payer parity law.

Last updated: July 2020

CO	√	√		√	√	Colo. Rev. Stat. § 12-36-106(1)(g) "40-27: Guidelines for the Appropriate Use of Telehealth Technologies in the Practice of Medicine" Colorado Medical Board, Aug. 2015
CT	√	√	√		√	Public Act 15-88, Effective 10/1/15 CT Gen. Stat. § 17b-245c
DE	√	√			√^	18 Del. C § 3370 24 Del. C § 1702 24 Del. C § 1769D
DC	√	√			√	DC Municipal Regulations § 4618
FL-M	√+[3]	√			√	Fla. Stat. § 456.023 Fla. Admin. Code § 64B8-9.0141
FL-O	√+	√			√	Fla. Admin. Code § 64B15-14.0081
GA	√	√	√		√^	Ga. Code § 360-3.07 O.C.G.A. § 43-34-31 Ga. Comp. R. & Regs. 360-3-.07
GU	#[4]					10 GCA § 12202(b)
HI	√	√			√^	Haw. Rev. Stat. § 453-1.3
ID	√	√				Idaho Code Ann. § 54-5601
IL	√	√		√	√	225 ILCS 60/49.5
IN	√	√		√	√	Ind. Code 25-1-9.5 Ind. Code 25-22.5-14 Ind. Code 12-15-5-11 844 IAC 5-8
IA	√	√			√	IAC 653 – 13.11
KS	√	√		√	√	No unique laws regulating practice of telemedicine.

[3] √+ denotes that a state requires physicians to register if they choose to practice medicine across state lines.
[4] Guam Code, 10 GCA § 12202(b), requires only that physicians are licensed somewhere within the United States.

KY	√	√			√	Ky. Rev. Stat. § 311.550(17) Ky. Rev. Stat. § 311.5975 "Policy: Telemedicine Statement" Kentucky Board of Medical Licensure, Sept.1997 "Board Opinion regarding the use of Telemedicine Technologies in the Practice of Medicine" Kentucky Board of Medical Licensure, June 2014
LA	√*	√		√	√	La. Rev. Stat. § 37.1276.1 La. Rev. Stat. § 37:1271 La. Rev. Stat. § 40:1223.3 La. Admin. Code 46:XLV.408 "Advisory opinion: The use of telemedicine technologies with established patient" LA State Board of Medical Examiners, March 24, 2014
ME-M	√+	√		√	√	32 MRSA § 3300-D "Guidelines: Telemedicine" Maine Board of Licensure in Medicine, Sept. 2014 "Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999 "Advisory Ruling: Telemedicine – Radiology" Maine Board of Licensure in Medicine, May 1994 "Advisory Ruling: Telemedicine – Psychotherapy" Maine Board of Licensure in Medicine, August 1993
ME-O	√	√		√	√	"Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
MD	√	√	√	√	√	Code of Maryland and Rules (COMAR) 10.32.05 "Telemedicine" MD Dept. of Health and Mental Hygiene
MA	√	√			√	243 CMR 2.01(4)

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MI-M	√	√			√	MCL 333.16283 et. seq.
MI-O	√	√			√	See MI-M
MN	√+	√	√	√	√^	Minn. Stat. § 147.032 "Telemedicine Registration" Minnesota Board of Medical Practice "Telemedicine Laws in Minnesota" Minnesota House Research, July 2020
MS	√	√		√	√	MS Code Ann. § 73-25-34 MS Admin Code title 30, part 2635, ch. 5
MO	√	√		√	√	Mo. Rev. Stat. § 191.1145(6) Mo. Rev. Stat. § 191.1146 Mo. Rev. Stat. § 334.010 Mo. Rev. Stat. § 334.108
MT	√	√			√	MT Code Ann. § 37-3-102 MT Code Ann. § 37-3-343 Montana Admin. Code 24:156:8
NE	√	√		√	√	Neb. Rev. Stat. § 71-8501 et seq.
NV-M	√*	√	√		√	NRS 630.261(e)
NV-O	√	√	√		√	NRS 633.165
NH	√	√			√	NH Rev. Stat. § 329:1-d NH Rev. Stat. § 415-J "Guidelines for Physician Internet and Prescribing" New Hampshire Board of Medicine Policy, April 2004 "Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
NJ	√*	√			√	NJ Rev. Stat §§ 45:9-21(b-c)
NM-M	√*	√	√		√^	NM Admin. Code 16.10.2 et seq.
NM-O	√	√	√		√^	No unique laws regulating practice of telemedicine.

Last updated: July 2020

NY	√	√	√	√	√	Telemedicine Statutes of New York "Statements on Telemedicine" NY State Office of Prof. Medical Conduct "Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
NC	√	√				"Position Statement: Telemedicine" North Carolina Medical Board, November 2014
ND	√	√			√	N.D. Cent. Code § 54-52.1-04.13 "Statement on Telemedicine Policy" ND Board of Medical Examiners, March 21, 2014
OH	√*	√			√	OAC § 4731-10-11 OAC § 4731-11-01 OAC § 4731-11-09 ORC § 4731.296 "Position Statement on Telemedicine" State Medical Board of Ohio, May 2012
OK-M	√	√			√	Okla. Stat. § 36-6801 et seq. Oklahoma Admin. Code § 435 Amendments to OAC § 435, May 2016 "Adopted Telemedicine Policy (Mental Health)" Oklahoma Medical Board, Sept. 18, 2008 "Definition of Face to Face Encounter by Telemedicine in Oklahoma" Oklahoma Medical Board, Sept. 25, 2013
OK-O	√*	√			√	"Licensure" Okla. Stat. §59-633 "Guidelines on Telemedicine" Oklahoma State Board of Osteopathic Examiners
OR	√*	√		√	√	Or. Rev. Stat. § 677.139 Or. Rev. Stat. § 743A.058 Or. Admin. Code 410-130-0610 "Statement of Philosophy" Oregon Medical Board, January 2012

PA-M	√*	√				Pa. Code § 17.4
PA-O	√*	√				Pa. Code § 25.243
PR	√					20 LPRA § 6001 et seq.
RI	√	√			√	RI Gen Laws § 5-37-12 "Guidelines for Appropriate Use of Telemedicine and Internet in Medical Practice" Rhode Island Board of Medical Licensure and Discipline
SC	√	√		√		S.C. Code Ann. 40-47-37 "Telemedicine Advisory Opinion" South Carolina Board of Medical Examiners, August 2015 "Establishment of Physician-Patient Relationship as Prerequisite to Prescribing Drugs" South Carolina Board of Medical Examiners, August 2015
SD	√	√			√	SD Codified Laws § 36-4-41 SD Codified Laws § 36-2-9
TN-M	√	√	√		√	Tenn. Code Ann. § 63-1-155 Tenn. Code Ann. § 63-6-201 Tenn Comp. R. & Regs. 0880-02.16 "Policy Statement: Practicing Medicine on patients within Boundaries of Tennessee by Physicians in other states" Tennessee State Board of Medical Examiners, Oct. 1994
TN-O	√*	√	√		√	Tenn. Comp. R. & Regs. 1050-02.17
TX	√*	√	√	√	√	22 Tex Admin. Code § 174 "Out-of-State Telemedicine License" Texas Medical Board
UT-M	√	√		√	√	Utah Code § 58-1-307
UT-O	√	√		√	√	Same as UT-M

VT-M	√	√	√	√	√	"Policy: Medical Practice Across State Lines" Northeast Region State Medical Boards, Sept. 1999
VT-O	√	√	√	√	√	Same as VT-M
VI	√					VI St. T. 27 § 16
VA	√	√	√	√	√	Va. Code § 38.2-3418.16 "Guidance Document 85-21" Virginia Board of Medicine, Feb. 2015
WA-M	√	√	√	√	√	RCW 18.71.030 WAC 182-531-1730 "Guideline: Appropriate Use of Telemedicine" Medical Quality Assurance Commission, Oct. 2014
WA-O	√	√	√	√	√	RCW 18.57.040
WV-M	√	√				W Va. Code § 30-3-13 "Position Statement on Telemedicine" West Virginia Board of Medicine, Nov. 2014
WV-O	√	√				W. Va. Code §30-14-12d "Telemedicine Policy" West Virginia Board of Osteopathic Medicine, Sept. 2015
WI	√	√				Wisconsin Admin. Code Med. §24
WY	√	√				WY Board Rules § 1.4(e)

For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.

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Fact sheet

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET

Mar 17, 2020 Telehealth

Medicare coverage and payment of virtual services

INTRODUCTION:

Under President Trump's leadership, the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high-risk of complications from the virus that causes the disease COVID-19 – are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this virus.

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. Innovative uses of this kind of technology in the provision of healthcare is increasing. And with the emergence of the virus causing the disease COVID-19, there is an urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.

EXPANSION OF TELEHEALTH WITH 1135 WAIVER: Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-

sharing for telehealth visits paid by federal healthcare programs.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care. In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins**, which are short patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.

Medicare beneficiaries will be able to receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves and others at risk.

TYPES OF VIRTUAL SERVICES:

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries summarized in this fact sheet: Medicare telehealth visits, virtual check-ins and e-visits.

MEDICARE TELEHEALTH VISITS: Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person.

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
- It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health

emergency.

KEY TAKEAWAYS:

- *Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.*
- *These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.*
- *Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.*
- *While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.*
- *The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.*
- *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.*

VIRTUAL CHECK-INS: In all areas (not just rural), established Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation.

Medicare pays for these "virtual check-ins" (or Brief communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. These virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would generally apply to these services.

Doctors and certain practitioners may bill for these virtual check in services furnished

through several communication technology modalities, such as telephone (HCPCS code

G2012). The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. Standard Part B cost sharing applies to both. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPCS code G2010).

KEY TAKEAWAYS:

- *Virtual check-in services can only be reported when the billing practice has an established relationship with the patient.*
- *This is not limited to only rural settings or certain locations.*
- *Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.*
- *HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.*
- *HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.*
- *Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.*

E-VISITS: In all types of locations including the patient's home, and in all areas (not just rural), established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry and communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse

practitioners) can bill the following codes:

- 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

- G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
- G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
- G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

KEY TAKEAWAYS:

- *These services can only be reported when the billing practice has an established relationship with the patient.*
- *This is not limited to only rural settings. There are no geographic or location restrictions for these visits.*
- *Patients communicate with their doctors without going to the doctor's office by using online patient portals.*
- *Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.*
- *The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable.*
- *The Medicare coinsurance and deductible would generally apply to these services.*

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. For more information:

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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Press release

Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas

Aug 03, 2020 Billing & payments, Physicians

The Centers for Medicare & Medicaid Services (CMS) is proposing changes to expand telehealth permanently, consistent with the Executive Order on Improving Rural and Telehealth Access that President Trump signed today. The Executive Order and proposed rule advance our efforts to improve access and convenience of care for Medicare beneficiaries, particularly those living in rural areas. Additionally, the proposed rule implements a multi-year effort to reduce clinician burden under our Patients Over Paperwork initiative and to ensure appropriate reimbursement for time spent with patients. This proposed rule also takes steps to implement President Trump's Executive Order on Protecting and Improving Medicare for our Nation's Seniors and continues our commitment to ensure that the Medicare program is sustainable for future generations.

Expanding Beneficiary Access to Care through Telehealth

Over the last three years, as part of the Fostering Innovation and Rethinking Rural Health strategic initiatives CMS has been working to modernize Medicare by unleashing private sector innovations and improve beneficiary access to services furnished via telecommunications technology. Starting in 2019, Medicare began paying for virtual check-ins, meaning patients across the country can briefly connect with doctors by phone or video chat to see whether they need to come in for a visit. In response to the COVID-19 pandemic, CMS moved swiftly to significantly expand payment for telehealth services and implement other flexibilities so that Medicare beneficiaries living in all areas of the country can get convenient and high-quality care from the comfort of their home while avoiding unnecessary exposure to the virus. Before the public health emergency (PHE), only 14,000 beneficiaries received a Medicare telehealth service in a week while over 10.1 million beneficiaries have received a Medicare telehealth service during the public health emergency from mid-March through early-July. For more information on Medicare's unprecedented increases in telemedicine and its impact on the health care delivery system,

visit the CMS Health Affairs blog here.

As directed by President Trump's Executive Order on Improving Rural and Telehealth Access, through this rule, CMS is taking steps to extend the availability of certain telemedicine services after the PHE ends, giving Medicare beneficiaries more convenient ways to access healthcare particularly in rural areas where access to healthcare providers may otherwise be limited.

"Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for America's seniors," said CMS Administrator Seema Verma. "The Trump Administration's unprecedented expansion of telemedicine during the pandemic represents a revolution in healthcare delivery, one to which the healthcare system has adapted quickly and effectively. Never one merely to tinker around the edges when it comes to patient-centered care, President Trump will not let this opportunity slip through our fingers."

During the public health emergency, CMS added 135 services such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services, that could be paid when delivered by telehealth. CMS is proposing to permanently allow some of those services to be done by telehealth including home visits for the evaluation and management of a patient (in the case where the law allows telehealth services in the patient's home), and certain types of visits for patients with cognitive impairments. CMS is seeking public input on other services to permanently add to the telehealth list beyond the PHE in order to give clinicians and patients time as they get ready to provide in-person care again. CMS is also proposing to temporarily extend payment for other telehealth services such as emergency department visits, for a specific time period, through the calendar year in which the PHE ends. This will also give the community time to consider whether these services should be delivered permanently through telehealth outside of the PHE.

Prioritizing Investment in Preventive Care and Chronic Disease Management

Under our Patients Over Paperwork initiative, the Trump Administration has taken steps to eliminate burdensome billing and coding requirements for Evaluation and Management (E/M) (or office/outpatient visits) that make up 20 percent of the spending under the Physician Fee Schedule. These billing and documentation requirements for E/M codes were established 20 years ago and have been subject to longstanding criticism from clinicians that they do not reflect current care practices and needs. After extensive stakeholder collaboration with the American Medical Association and others, simplified coding and billing requirements for E/M visits will go into effect January 1, 2021, saving clinicians 2.3 million hours per year in burden reduction. As a result of this change, clinicians will be able to make better use of their time and restore the doctor-patient relationship by spending less

time on documenting visits and more time on treating their patients.

Additionally, last year, the Trump Administration finalized historic changes to increase payment rates for office/outpatient E/M visits beginning in 2021. The higher payment for E/M visits takes into account the changes in the practice of medicine, recognizing that additional resources are required of clinicians to take care of the Medicare patients, of which two-thirds have multiple chronic conditions. The prevalence of certain chronic conditions in the Medicare population is growing. For example, as of 2018, 68.9% of beneficiaries have 2 or more chronic conditions. In addition, between 2014 and 2018, the percent of beneficiaries with 6 or more chronic conditions has grown from 14.3% to 17.7%.

In this rule, CMS is proposing to similarly increase the value of many services that are comparable to or include office/outpatient E/M visits such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, physical and occupational therapy evaluation services and others. The proposed adjustments, which implement recommendations from the American Medical Association, help to ensure that CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients, like primary care and complex or chronic disease management.

Bolstering the Healthcare Workforce/Patients Over Paperwork

CMS is also taking steps to ensure that healthcare professionals can practice at the top of their professional training. During the COVID-19 public health emergency, CMS announced several temporary changes to expand workforce capacity and reduce clinician burden so that staffing levels remain high in response to the pandemic. As part of its Patients over Paperwork initiative to reduce regulatory burden for providers, CMS is proposing to make some of these temporary changes permanent following the PHE. Such proposed changes include nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives (instead of only physicians) to supervise others performing diagnostic tests consistent with state law and licensure, providing that they maintain the required relationships with supervising/collaborating physicians as required by state law; clarifying that pharmacists can provide services as part of the professional services of a practitioner who bills Medicare; allowing physical and occupational therapy assistants (instead of only physical and occupational therapists) to provide maintenance therapy in outpatient settings; and allowing physical or occupational therapists, speech-language pathologists and other clinicians who directly bill Medicare to review and verify (sign and date), rather than re-document, information already entered by other members of the clinical team into a patient's medical record.

Public comments on the proposed rules are due by October 5, 2020.

For a fact sheet on the CY 2021 Physician Fee Schedule proposed rule, please visit: https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-4

For a fact sheet on the CY 2021 Quality Payment Program proposed rule, please visit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1100/2021%20QPP%20Proposed%20Rule%20Fact%20Sheet.pdf

For a fact sheet Medicare Diabetes Prevention Program- https://www.cms.gov/newsroom/fact-sheets/proposed-policies-medicare-diabetes-prevention-program-expanded-model-mdpp-calendar-year-2021

To view the CY 2021 Physician Fee Schedule and Quality Payment Program proposed rule, please visit: https://www.federalregister.gov/documents/2020/08/17/2020-17127/medicare-program-cy-2021-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

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