TODAY’S PRESENTERS

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THIS PRESENTATION WILL COVER:

- Telehealth crash course
- Medicare and Federal Updates
- DEA Updates and Telehealth
- Medicaid 1135 Waivers
- HIPAA and Technology Selection
- Telehealth program implementation
- Q/A
Telehealth— the new normal?
KEY TERMS:
+ Originating Site: Patient
+ Distant Site: Provider
+ Store and Forward
+ Qualified Provider

UNDERSTANDING SERVICE TYPES:
+ Virtual Health Visit (Provider ↔ Patient)
+ Virtual Check-in (Provider ↔ Patient)
+ E-visit (Provider ↔ Patient)
+ E-Consult (Provider ↔ Provider)
+ Remote physiological monitoring
+ Remote evaluation of prerecorded patient information...

OTHER CONSIDERATIONS:
+ Consent and documentation
Medicare Insights: Medicare Telehealth Expansion
Zach Gaumer
Medicare telehealth coverage expansion for the COVID-19 national emergency
  - Regulatory changes made March 17th
  - Legislative changes made March 27th (Stimulus package)
  - CMS Interim Final Rule published March 30th

CMS is also encouraging the use of other forms of telehealth services and coverage, which they expanded in recent years

Telehealth use under Medicare has been low historically

Use is likely to increase significantly in the months and years ahead
TYPES OF MEDICARE VIRTUAL VISITS

- Medicare Telehealth visits
- E-visits
- Remote Patient Monitoring (RPM)
- E-consults
- Virtual Check-ins
- Telephone-based evaluations (audio-only)
### CMS and Congress temporarily expanded the scope of coverage of Medicare telehealth visits:

- **Urban areas** permitted as originating sites
- **Patients’ residences** permitted as originating sites
- FQHCs and rural clinics permitted as distant sites
- Hospice agencies recertification visits
- HIPAA penalties waived
- “New” patients (as opposed to just “Established” patients) permitted to receive telehealth
- Providers permitted to waive patient cost-sharing

### Additional changes made to Medicare telehealth visits on March 30th:

- 80 new services added to list of permissible services (e.g., ED visits, physical/occupational/speech therapy, inpatient and observation care, ESRD, neuro assessments, home visits)
- Telephone-based evaluation codes created to enable audio-only telephone calls for evaluation and management service
- Home Health: Telehealth visits if conform to the patient’s plan of care, COVID-19 patients can qualify as home bound to initiate the home health benefit
- Hospice: Routine home care visits
- Inpatient rehab facilities can serve patients at home
- Therapy visits (PT, OT, SP, LCSW, psychologists)
- Removal of frequency limits on inpatient and nursing follow-up care and critical care consults
**MEDICARE VIRTUAL SERVICES AND COVERAGE ENCOURAGED**

CMS encourages the use of other types of telehealth services that have no geographic limitations:

- **Virtual check-ins**: Short telephone (or audio/video) calls
- **E-visits**: Communications through an online portal
- **E-consults**: Interprofessional consultations via telephone or email
- **Remote Physiological Monitoring (RPM)**: Clinicians monitoring patient conditions through electronic devices

CMS promotes recent telehealth coverage expansions that eliminated geographic limitations for specific disease populations and Medicare programs:

- **End-Stage Renal Disease (2019)**
- **Stroke care or “telestroke” (2019)**
- **Opioid Use Disorder (2020)**
- **Medicare Advantage Plans** may cover any telehealth service from anywhere (2020)
# Medicare Telehealth Visits Expanded, Current Coverage Details

<table>
<thead>
<tr>
<th>Services reimbursable under Medicare</th>
<th>Description (technology)</th>
<th>Types of services</th>
<th>Technology</th>
<th>Originating sites (location of patient)</th>
<th>Distant site practitioners and providers</th>
<th>Payment and cost-sharing</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare telehealth visits</td>
<td>Physician Fee Schedule (PFS) office visits conducted via telehealth technology for established patients. Visits are considered the same as in-person office visits.</td>
<td>171 services codes:</td>
<td>Two-way audio &amp; video technology permitting real-time communication (e.g., smartphones, online video-chat).</td>
<td>Urban or rural, including the patient’s residence</td>
<td>Physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists certified registered nurse anesthetists, clinical psychologists, social workers, registered dietitians and nutrition professionals</td>
<td>Standard PFS payment amounts for each covered code</td>
<td>March 1, 2020 through end of the emergency</td>
</tr>
</tbody>
</table>

## Exceptions provided by the Secretary of Health and Human Services (HHS) for the COVID-19 National Emergency

- HHS will not audit for “existing relationship” between patient and clinician
- Providers may reduce or waive patient cost-sharing
- HHS will waive penalties for HIPAA violations by health care providers

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# Telephone-Based Evaluation Codes Newly Implemented

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<tr>
<td>Telephone-based evaluations</td>
<td>Telephone assessment and management service provided by a qualified clinician to an established or new patient, parent, or guardian not originating from a related assessment and management service</td>
<td>Evaluation and management services for established and new patients</td>
<td>Telephone (audio-only)</td>
<td>Urban, rural, or from the patient’s residence</td>
<td>Physician and other qualified practitioner who can report evaluation and management services, as well as other clinicians, such as physical therapists, occupational therapists, and speech pathologists, social workers, and clinical psychologists.</td>
<td>Provider payment: $10 to $27 (code = 98966-98968, 99441-99443) Patient out-of-pocket costs = 20%</td>
<td>March 1, 2020 to end of the Public Health Emergency</td>
</tr>
</tbody>
</table>
# USE OF VIRTUAL CHECK-INS ENCOURAGED, EXPANDED TO NEW PATIENTS, CURRENT COVERAGE DETAILS

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<th>Effective</th>
</tr>
</thead>
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<tr>
<td><strong>Virtual check-ins</strong></td>
<td>Brief (5-10 minute) visits between a practitioner and their existing and new patients. The service must be agreed to by the patient.</td>
<td>A unique service intended to assess a patient’s condition, symptoms, or needs, and avoid unnecessary trips to the doctor’s office.</td>
<td>Telephone, two-way real-time audio-video, text, email or patient portal.</td>
<td>Anywhere the patient is located, such as urban or rural locations, the patients’ residence, nursing homes, or assisted living facilities</td>
<td>Physician and other qualified practitioner who can report evaluation and management services as well as other clinicians, such as physical therapists, occupational therapists, and speech pathologists, social workers, and clinical psychologists.</td>
<td>Provider payment: $17 (code = G2012)</td>
<td>2019</td>
</tr>
</tbody>
</table>

**Exceptions provided by the Secretary of Health and Human Services (HHS) for the COVID-19 National Emergency**

- HHS will waive penalties for HIPAA violations by health care providers
E-VISITS ENCOURAGED, FOR EXISTING PATIENTS ONLY, CURRENT COVERAGE DETAILS

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<th>Services reimbursable under Medicare</th>
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<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Visits</td>
<td>Non face-to-face patient-initiated communications between a clinician and their existing patient. The service must be generated by the patient and communication can occur over a 7-day period.</td>
<td>A unique evaluation and management service intended to assess a patient’s condition, symptoms, or needs, and avoid unnecessary trips to the doctor’s office.</td>
<td>Online patient portal</td>
<td>Anywhere the patient is located, such as urban or rural locations, the patients’ residence, nursing homes, or assisted living facilities</td>
<td>Physician and other qualified practitioner who can report evaluation and management services, as well as other clinicians, such as physical therapists, occupational therapists, and speech pathologists, social workers, and clinical psychologists.</td>
<td>Provider payment: $15 - $50 (code = 99421-99423, G2061-G2063)</td>
<td>2020</td>
</tr>
</tbody>
</table>

Exceptions provided by the Secretary of Health and Human Services (HHS) for the COVID-19 National Emergency

- HHS will waive penalties for HIPAA violations by health care providers

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## CMS ENCOURAGING TELEHEALTH WITHIN THE MEDICARE ADVANTAGE PROGRAM

<table>
<thead>
<tr>
<th>Program component</th>
<th>Description (technology)</th>
<th>Types of services</th>
<th>Technology</th>
<th>Originating sites (location of patient)</th>
<th>Distant site practitioners</th>
<th>Payment and cost-sharing</th>
<th>Effective</th>
<th>Remaining concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>Plans may include the costs of the telehealth services they cover in the pricing of their basic plan benefits and in their annual bid amounts. MA plan offerings for telehealth may now exceed the scope of Fee-For-Service telehealth coverage</td>
<td>Any</td>
<td>Any</td>
<td>Any</td>
<td>Any</td>
<td>Payments: Negotiated rates</td>
<td>2020</td>
<td>1) CMS policy creates a disincentive for plans to use telehealth by excluding telehealth encounters from the risk adjustment process that establishes plans’ patient case mix used to set payment rates 2) Will CMS require plans to cover all telehealth services expanded under FFS during the emergency?</td>
</tr>
</tbody>
</table>

CMS’s 2021 Medicare Advantage Proposed Rule proposes to enhance MA coverage of telehealth services by:
- Allowing plans operating in rural areas to use telehealth services to fulfill some network adequacy standards
- Permitting plans to cover telehealth services through a non-contracted provider as a basic benefit
OVERALL:
Recent changes to Medicare telehealth policy will generate significant increases in telehealth use

Rapid growth:
+ Primary care practices will use Medicare telehealth visits, e-visits, and check-ins
+ Medicare Advantage plans will cover more telehealth services
+ Behavioral health services
+ Nursing homes and assisted living use
+ Treatment of Opioid Use Disorder
+ Home Health and hospice visits
+ Therapy visits (PT, OT, SP, clinical psych, social worker)

Slower growth:
+ Remote patient monitoring (RPM) of patients in their homes
+ ESRD patients
+ Tele-stroke care in emergency departments
+ E-consults as physicians gain comfort with the service
+ Rural areas will continue their use

Providers most likely to increase their use:
+ Primary care physicians
+ Behavioral health clinicians
+ Therapists (PT, OT, SP, LCSW, psychologists)
+ Health care systems

TELEHEALTH USE IS ABOUT TO INCREASE SIGNIFICANTLY

Recent changes to Medicare telehealth policy will generate significant increases in telehealth use.
### Characteristics of users

<table>
<thead>
<tr>
<th>Characteristics of users</th>
<th>Percent of users/state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dually eligible for Medicare and Medicaid</td>
<td>60 percent of users</td>
</tr>
<tr>
<td>Disabled and younger than 65 years</td>
<td>60 percent of users</td>
</tr>
<tr>
<td>Any chronic condition</td>
<td>92 percent of users</td>
</tr>
<tr>
<td>Diabetes diagnosis</td>
<td>37 percent of users</td>
</tr>
<tr>
<td>Depression diagnosis</td>
<td>24 percent of users</td>
</tr>
<tr>
<td>States with highest telehealth use per capita</td>
<td>Iowa, South Dakota, Missouri, Minnesota, Texas</td>
</tr>
</tbody>
</table>

### Telehealth visits by type of service

- Physician office visits: 58%
- Psycholotherapy/psychiatric exams: 23%
- Inpatient follow-up: 6%
- Emergency department or outpatient consult: 4%
- Subsequent nursing care: 4%
- Other: 1%
TELEHEALTH GROWTH MOST LIKELY IN COUNTIES WITH HIGH LEVELS OF MEDICARE ADVANTAGE ENROLLMENT

% of Medicare Beneficiaries Enrolled in Medicare Advantage

- No data
- Less than 10%
- 10% to 19%
- 20% to 29%
- 30% to 39%
- 40% or greater

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**OVERALL:**
Which of the temporarily expanded telehealth services will Medicare continue to cover after the Public Health emergency?

- Urban and at-home Medicare telehealth visits?
- ‘New’ patients gaining access to various services?
- Home Health and Hospice visits?
- Therapy visits?
- ED visits?
- Telephone-based evaluation visits?
Medicaid 1135 Waivers
And Examples of State actions
David Bergman
HIPAA ENFORCEMENT RELAXATION

Health Insurance Portability and Accountability Act (HIPAA):
Effective immediately, the HHS Office for Civil Right (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.

THIS DOES NOT IMPACT ENFORCEMENT OF STATE PRIVACY LAWS/REGULATIONS WHICH MAY REMAIN IN PLACE
1135 Medicaid Waivers

1135 Waivers allow reimbursement during an emergency or disaster even if providers can’t comply with certain Federal requirements that would under normal circumstances bar Medicare, Medicaid or CHIP payment.

In addition, 1135 Waivers can be implemented retroactively. All currently approved waivers were activated as of March 1, 2020 and will extend through the conclusion of the designated emergency.

36 states have received approval for their 1135 waivers:

+ March 16: Florida;
+ March 19: Washington;
+ March 23: Alabama, Arizona, California, Illinois, Louisiana, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, and Virginia
+ March 24: North Dakota, Oklahoma, South Dakota
+ March 25: Indiana, Iowa, Kansas, Kentucky, Missouri, Oregon, Rhode Island
+ March 26: Colorado, Hawaii, Idaho, Maryland, Massachusetts, New York
+ March 27: Wyoming, Minnesota, Delaware, Pennsylvania, Connecticut
+ March 30: Texas, Montana, Vermont, West Virginia
Examples of Approved Flexibility via 1135 Waivers:

+ Reimburse for otherwise payable claims from out of state providers not otherwise enrolled in Medicaid. Certain conditions apply.
+ Expedited and temporary provider enrollment in Medicaid.
+ Waiver of service prior authorization.
+ Automatic extension of pre-existing prior-authorizations through the end of the public health emergency.
+ Reimbursement for services in non-licensed facilities housing individuals evacuated from licensed facilities.
+ Suspend PASSR Level I and Level II Assessments for 30 days.
+ Suspend State Fair Hearing Requests and Appeal Timelines: >90 days and up to 120 additional days for eligibility determination. Does NOT include adverse benefit determinations.
+ Retractive to March 1, 2020.
OTHER STATE CHANGES IMPACTING TELEHEALTH

+ Audio-only (i.e. telephone) allowable as telehealth
+ Establish patient-provider relationship via telehealth
+ Expand number of CPT codes reimbursable via telehealth
+ Expansion of providers eligible to bill for telehealth
+ Eliminating cost share requirements for telehealth visits
+ Allowing verbal consent to be treated via telehealth
+ Payment parity for telehealth and in-person visits
Accelerating a Telehealth Implementation
Jean Glossa, MD
Components Should include:

+ Organizational – Planning, Engagement, Change Management
+ Experience with Telehealth
+ Technology Capacity
+ Equipment Selection
+ Regulatory or Policy Understanding
+ Financing and Reimbursement
+ Clinical Considerations
+ Relationship with Specialty Care Providers
+ Workforce Development
+ Patient Engagement and Marketing
+ Evaluation and Outcome Measurement
Telehealth Readiness Questionnaire

The Telehealth Readiness Questionnaire is quick, web-based tool that will help your organization better understand your readiness to adopt telehealth such as telemedicine visits, virtual check-ins or e-visits. At the end of the questionnaire, please indicate whether you’d like a brief consultation with an HMA telehealth expert to help interpret your results and identify strategies for your next steps.

To access the Questionnaire, please click the button below.

[TELEHEALTH READINESS QUESTIONNAIRE](https://www.healthmanagement.com/telehealth-readiness-questionnaire/)
CONDUCT A THOROUGH VENDOR SELECTION PROCESS

1. Define business plan
2. Identify functions performed by equipment or service vendor
3. Perform a first market scan to learn and identify choices
4. Define requirements
5. Create vendor information sheet and fill out for select vendors
6. Modify/refine requirements
7. Finalize criteria and scoring / weighting
8. Bid if required, or negotiate
9. Select (or trial/pilot)
ASSESS ORGANIZATIONAL WORKFLOWS RELATED TO TELEHEALTH

+ Understand individual and role accountabilities, handoffs, training requirements etc.

+ Model and develop workflows to drive successful program implementation
THE WAITING ROOM

Updates to the visit workflow:

- Check in/out
- Consent
- Documentation
- Privacy and security
- Interruptions
- Follow up
Treating Addiction in the Setting of COVID-19
Focus on Telemedicine and Regulation Changes for MAT

THURSDAY, APRIL 2 AT 12:00-1:00 ET

PRESENTED BY:
SCOTT HAGA, PA-C
SHANNON ROBINSON, MD
Questions?

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