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LOOKING AROUND THE CORNER: MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES AFTER THE PUBLIC HEALTH EMERGENCY

MAY 20, 2020

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As regulators make public statements in support of permanently expanding telemedicine uses, telehealth stakeholders are asking a key question: "What would it take for the recent changes to Medicare telehealth reimbursement to become permanent beyond the public health emergency?"

In response to the Coronavirus (COVID-19) public health emergency (PHE), legislators and regulatory agencies changed the rules related to telehealth services, particularly in the case of telehealth services delivered to Medicare beneficiaries. During the PHE, telehealth providers are able to receive Medicare reimbursement for a greater variety of telehealth services, leverage more types of healthcare providers and treat Medicare patients in more locations than ever before. Telehealth providers are energized by these changes and are voicing resistance to the prospect of losing these new reimbursement opportunities post-PHE.

The pathways to making these and other changes permanent are neither simple nor clear, however. Medicare reimbursement of telehealth services is governed by both statutory and regulatory requirements, and therefore the PHE-driven changes have come via federal legislation and regulatory modifications by the Centers for Medicare and Medicaid Services (CMS). While CMS has the authority to make certain permanent modifications to telehealth reimbursement, other modifications require congressional action. CMS is considering whether and how to make some of these changes permanent, and this paper describes what steps would be necessary to do so.

STATUTORY BARRIERS TO MEDICARE REIMBURSEMENT OF TELEHEALTH SERVICES

Historically, the originating site and geographic requirements have been significant barriers to Medicare reimbursement of telehealth services. Medicare generally reimburses telehealth services provided to beneficiaries only when they are at a qualifying originating site (*e.g.*, practitioner office, hospital, rural health clinic) and are located in a rural area (originating site requirements). Practically, this means that beneficiaries are not permitted to receive telehealth services when they are located in their own home. The originating site requirements are set forth in statute under 42 USC §

1395m(m)(4)(C) and may be modified only through congressional action.[1]

Given the risks posed by in-person medical care during the PHE, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, one of the first acts of legislation passed in response to the pandemic, permitted the waiver of the originating site requirements "in any emergency area . . . during any portion of any emergency period." 42 USC § 1320b-5(b)(8). Subsequently, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) expanded the authority of the Secretary of Health and Human Services to waive the statutory requirements related to Medicare coverage of telehealth services furnished in any emergency area during any portion of the PHE. Accordingly, any waivers issued by the Secretary will be ineffective once the PHE declaration is lifted. As a result, congressional action is the only pathway to permanently revise the originating site requirements and certain other barriers to Medicare reimbursement of telehealth services.

REGULATORY FLEXIBILITY TO MODIFY MEDICARE REIMBURSEMENT OF TELEHEALTH SERVICES

While modifying the originating site requirements requires congressional action, CMS still has significant powers to otherwise modify rules related to Medicare telehealth. For example, 42 USC § 1395m(m)(4) defines the term "telehealth service" to include specified Current Procedural Terminology (CPT) codes (including professional consultations, office visits and office psychiatry services) and "any additional service specified by the Secretary." This existing statutory language gives the Secretary the authority to designate additional CPT codes as qualifying telehealth services. CMS has previously exercised this authority by proposing qualifying telehealth services in the annual Medicare Physician Fee Schedule (PFS) rulemaking process. However, based on its existing criteria for adding new telehealth services, CMS also used this authority to add several qualifying telehealth services for the duration of the PHE.

During the PHE, CMS has promulgated additional regulatory changes to Medicare telehealth rules. As with its expansion of CPT codes, however, CMS justified many of these changes in reference to the circumstances arising during the PHE. For example, a frequent CMS goal in modifying the rules has been to reduce the risk of patient and provider exposure to COVID-19. Although CMS has the power to make these modifications permanent—including the expansion of permissible telehealth services—under its existing authority through its usual rulemaking process, it will have to determine that these changes are appropriate for telehealth under normal, non-PHE circumstances.

The table below outlines the myriad statutory and regulatory changes to Medicare rules during the PHE, and analyzes how these changes could become permanent after the PHE has been lifted.

[1] Medicare does not apply the requirements for "telehealth services" to remote patient monitoring, e-visits or virtual check-ins, because these services may be provided when patients are at home.

TELEHEALTH CHANGES BROADLY APPLICABLE ACROSS PROVIDER TYPES

PRE-PHE POLICY	POLICY DURING THE PHE	POST-PHE REQUIREMENTS TO MAKE CHANGES PERMANENT
Qualifying Providers Medicare limits the type of healthcare providers eligible to provide telehealth services from a distant site to the following: ▪ Physicians ▪ Nurse practitioners (NPs) ▪ Physician assistants (PAs) ▪ Nurse-midwives ▪ Clinical nurse specialists (CNSs) ▪ Certified registered nurse anesthetists ▪ Clinical psychologists (CPs) and clinical social workers (CSWs) [Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for CPT codes 90792, 90833, 90836 and 90838.] ▪ Registered dietitians or nutrition professionals	CMS expanded the types of healthcare professionals that can furnish distant site telehealth services to include all providers that are eligible to bill Medicare for their professional services. The expanded list of healthcare providers now includes (in addition to the providers listed in the left column): ▪ Physical therapists ▪ Occupational therapists ▪ Speech language pathologists Source: COVID-19 Emergency Declaration Blanket Waivers	**Congressional Action** 42 USC § 1395m(m)(1) permits the Secretary to pay for telehealth services that are furnished by a "physician" or a "practitioner," as those terms are defined in 42 USC § 1395x(r) and 42 USC § 1395u(b)(18)(C), respectively. These terms encompass only certain types of providers.[2] Congressional action would be necessary to permanently revise or otherwise expand the list of practitioners permitted to receive Medicare reimbursement for telehealth services.

[2] Specifically, physicians, PAs, NPs, CNSs, certified registered nurse anesthetists, certified nurse-midwives, CSWs, CPs, and registered dietitians or nutrition professionals.