Telehealth in a Post-PHE World

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This webinar is being presented as a precursor to our **Leading Transformation Track:**

Supporting and equipping attendees with resources, tools and skills to:

**Manage, Lead and Accelerate Digital Transformation**
Telehealth Flexibilities: Timeline, Impact, and Preparation

Public Health Emergency (PHE) End Planning, 151 Day Extension, and the Omnibus Bill
Key Questions

• What is the PHE and how did/does it impact virtual care?

• What has Congress done to make these telehealth flexibilities permanent?

• How long will the telehealth flexibilities last?

• What do we need to get ready for or be thinking about?
Anticipated Timeline

Key Dates:
- 2022 Dec – Omnibus extends some flexibilities 2 years
- 2023 Feb – Notice of PHE End
- 2023 May – Anticipated PHE End 5.11.23
- 2023 Sept – 151 Day Extension End, narrow impact
- 2024 Jan – CMS CY24 Telehealth Codes Begin
- 2024 Dec – Omnibus Flexibilities and CMS CY24 End
- 2025 Jan – CMS CY25 Telehealth Codes Begin

Note: Congress is expected to act within the Omnibus extension to allow Medicare video visits in the home permanently.

151 Day = Consolidated Appropriations Act of 2022
Omnibus = Consolidated Appropriations Act of 2023
What do YOU think is changing or going away?

• Do your homework
• The following are some resources to help inform you
• Nothing in this presentation is intended as legal advice or interpretation of laws, regulations, and policies
• Pull in your legal, billing, and compliance teams to help

Note: Things change everyday. The following screenshots may no longer be relevant.
<table>
<thead>
<tr>
<th>Telehealth and the PHE</th>
<th>Pre-Pandemic</th>
<th>Public Health Emergency</th>
<th>151 Day Transition</th>
<th>Omnibus Bill</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Telehealth just emerging, covered by commercial payors broadly but limited by Medicare/Medicaid</td>
<td>PHE was declared for Covid-19 and within it were waivers for Medicare telehealth that were matched by Maryland Medicaid and HSCRC</td>
<td>Telehealth waivers extended by 151 days post PHE Expiration, matched by Maryland Medicaid and HSCRC</td>
<td>Telehealth Flexibilities extended until Dec. 31, 2024. Note: Preserve Telehealth Act, Maryland Medicaid, expected to extend into CY2025</td>
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<td>Patient Location</td>
<td>Medicare/Medicaid only covered video if rural or in another medical facility</td>
<td>Medicare/Medicaid covered video visits no matter where the patient was located</td>
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<tr>
<td></td>
<td>Home not allowed</td>
<td>Home Allowed</td>
<td></td>
<td></td>
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<tr>
<td>Audio Only</td>
<td>Audio only reimbursed lower</td>
<td>Medicare/Medicaid Audio only covered at parity</td>
<td>Medicare/Medicaid Audio only Allowed. Payment parity varies by State Medicaid.</td>
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<td>Supervision</td>
<td>No Virtual Supervision, Direct Supervision required for RPM</td>
<td>Virtual Supervision allowed, General Supervision allowed for RPM/RTM Through Dec. 31, 2023</td>
<td>Not Addressed</td>
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<td>Inpatient</td>
<td>Limited inpatient codes</td>
<td>Expanded Inpatient Codes Through Dec. 31, 2023</td>
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<td>Platforms</td>
<td>HIPAA compliant platforms only, BAA required</td>
<td>HIPAA compliance non-enforced, BAA required</td>
<td>HIPAA compliant platforms only, BAA required</td>
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</table>
1. Temporary Medicare Changes through December 31, 2024

The Consolidated Appropriations Act (CAA) of 2023 extended the following telehealth flexibilities authorized during the COVID-19 PHE through December 31, 2024:

Health care providers eligible to bill Medicare can bill for telehealth services regardless of where the patient or provider is located (i.e., the patient can be at home).

Audio-only telehealth visits will continue to be reimbursable.

The list of providers eligible to deliver telehealth services remains expanded to include physical therapists, occupational therapists, speech language pathologists, and audiologists.

The acute hospital care at home program can continue to be utilized to provide hospital services to patients in their homes, including through telehealth.

Telehealth can be used to conduct recertification of eligibility for hospice care.

Patients with High Deductible Health Plans coupled with Health Savings Accounts can utilize first dollar coverage for telehealth services without first having to meet their minimum deductible.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can provide telehealth services to Medicare beneficiaries (i.e., can be distant site providers), rather than being limited to being an originating site provider for telehealth (i.e., where the beneficiary is located).

The CAA also delayed the imposition of the pre-requisite in-person requirement for mental health services furnished through telehealth until after December 31, 2024.

2. Medicare Payment Parity

During the pandemic the Centers for Medicare & Medicaid Services (CMS) initiated higher reimbursement for telehealth services at non-facilities, such as a patient’s home. In other words, Medicare has been paying for telehealth services as if they were provided in-person, meaning the telehealth visits are being paid by Medicare at the same rate as regular, in-person visits. These higher reimbursement rates are scheduled to end this year. After that, rates could return to lower pre-pandemic levels unless lawmakers choose to extend the policy.
3. Telemedicine Controlled Substances and Ryan Haight Act

During the PHE, the Drug Enforcement Agency (DEA) acted swiftly to waive the Ryan Haight Act’s in-person exam requirement for the prescribing of controlled substances, thereby ensuring millions of both established and new patients were able to receive medically necessary prescriptions via telemedicine.

Thus, when the PHE expires on May 11, without further action on the part of the DEA, the in-person requirement is set to revert, without any special registration rule or other process established to ensure continuity of care. Therefore, continued prescribing of controlled substances for patients never seen in-person, and only through virtual means during the PHE, will be prohibited and these patients would either need to be seen in-person or have their care transitioned to a local provider.

4. End of Telehealth & RPM Copayment Waivers

During the PHE the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a policy statement and FAQ notifying health care providers that they will not be subject to administrative sanctions under the federal Anti-Kickback Statute or the Civil Monetary Penalty and exclusion laws for reducing or waiving cost-sharing amounts (like copayments and deductibles) for telehealth services or remote patient monitoring (RPM) services furnished to Medicare beneficiaries during the PHE.

The guidance documents expressly tie this waiver to the duration of the PHE. Thus, unless the OIG issues additional guidance or an extension, after May 11, health care providers offering telehealth or RPM services to Medicare beneficiaries may no longer reduce or waive any cost-sharing obligations that patients may owe for such services. Digital health companies without payment and collection mechanisms for these payments will need to act swiftly to operationalize new process to ensure these amounts are charged and collected.

5. RPM Services Again Limited to “established patients”

In 2021, CMS reiterated that outside of the PHE, RPM services are limited to “established patients.” However, for the duration of the PHE, CMS waived the “established patient” requirement and allowed practitioners to bill for RPM for new patients. When the PHE ends, CMS will require that RPM services be furnished only to established patients. CMS’ statements suggests after the PHE the physician must first conduct a new patient evaluation and management service before rendering RPM to such patient.
6. Virtual Direct Supervision Scheduled to End This Year
Among the PHE waivers, CMS temporarily changed the direct supervision rules to allow the supervising professional to be remote and use real-time, interactive audio-video technology. That change did not require the professional’s real-time presence at, or live observation of, the service via interactive audio-video technology throughout the performance of the procedure.
In the 2023 physician fee schedule, CMS declined to extend this temporary policy beyond the end of the calendar year in which the PHE ends. Therefore, virtual direct supervision will expire at the end of this year unless CMS revises its policy in future rulemaking.

7. End of HIPAA-related Enforcement Discretion
For the duration of the PHE, the HHS Office for Civil Rights (OCR) exercised enforcement discretion allowing providers to use telehealth in good faith even if their platforms or software did not follow Health Insurance Portability and Accountability Act (HIPAA) rules. However, this enforcement discretion only remains in effect until the end of the PHE.
Thus, after May 11, the OCR will resume enforcement of penalties on providers for noncompliance with HIPAA rules for technology use. Ahead of the end of the PHE, OCR has provided clarification on how and the circumstances under which the HIPAA rules apply to telehealth.
Key PHE-related Provisions Ending May 11, 2023

- Use of temporary expansion sites (such as convention centers, vacant stores, tents or others allowed under the Hospital Without Walls program) and spaces within the hospital that do not conform to the conditions of participation requirements for patient rooms, such as conference rooms and surgical suites.
- Use of provider-based departments that were relocated to settings outside the hospital, including patients’ homes, after receipt of an extraordinary circumstances waiver and that provide education and therapy services to hospital outpatients.
- Skilled nursing facility (SNF) beds available for patients not meeting SNF requirements.
- EMTALA waiver allowing hospitals to redirect patients from their emergency departments to screening tents for COVID-19 testing.
- Flexibility on limit of 25 beds for Critical Access Hospitals (CAHs) and the 96-hour rule for average length of stay.
- Reduced information requirements for post-acute care discharge to a SNF, rehabilitation center, long-term care hospital or home health agency.
- Flexibility to not have a separate nursing plan of care for each patient.
- Permission from the Drug Enforcement Agency to prescribe controlled substances without an in-person visit.
- Medicare’s 20% add on payments for patients diagnosed with COVID-19 to offset the cost of complex COVID-19 patient care.
- Free COVID-19 at-home tests and no cost sharing for testing services and therapeutics for Medicare beneficiaries (including those in Medicare Advantage plans) and those enrolled in private coverage. After the PHE ends, patient cost sharing will be required except for Medicaid beneficiaries who have at least an additional year of tests and therapeutics access at no cost. Additionally, Medicare will continue to pay $40 for COVID-19 vaccines administered in outpatient settings through Dec. 31, 2023.
- State option to provide Medicaid eligibility for certain uninsured individuals to cover COVID-19 testing, testing-related services, vaccination and treatment coverage at 100% federal match. 12. Health plan requirements to reimburse out-of-network providers for COVID-19 vaccines and testing.
Key PHE-related Provisions Ending Dec. 31, 2023
1. Enhanced federal funding to state Medicaid programs of 6.2% (See note below for additional details on Medicaid coverage).
2. Reimbursement for cardiac, intensive cardiac and pulmonary rehabilitation services provided via telehealth under the physician fee schedule.
3. Reimbursement parity for services performed via telehealth that typically would have been performed in person.
4. Permission for physicians and non-physician practitioners to directly supervise diagnostic services virtually through audio/video real-time communications technology (excluding audio-only).

Key PHE-related Provisions Ending at a Future Date
1. Liability immunity for use of countermeasures for COVID-19 will end Oct. 1, 2024, which is the end of the Public Readiness and Emergency Preparations (PREP) Act declaration.
2. Certain telehealth flexibilities that congress extended through Dec. 31, 2024:
   1. Waiver of geographic and location requirements
   2. Reimbursement for telehealth services furnished by physical therapists, occupational therapists, speech language pathologists and audiologists reimbursement for audio-only services
   3. Reimbursement for telehealth services furnished by federally qualified health centers and rural health clinics
   4. Use of telehealth to recertify eligibility for hospice
   5. Implementation of the in-person visit requirement for initiation of tele-behavioral health services is delayed until the end of 2024.
   6. Acute Care Hospital at Home program, which congress extended through Dec. 31, 2024.
   7. Food and Drug Administration (FDA) emergency use authorizations (EUAs) for drugs and devices do not have a specified ending.
3. Hospital COVID-19 data reporting requirements that were instituted in 2020. CMS revised the CoP to require hospitals to continue reporting COVID-19-related data after the conclusion of the PHE through Apr. 30, 2024, unless the Health and Human Services Secretary establishes an earlier end date.
## External Resources

<table>
<thead>
<tr>
<th><strong>PHE Resources</strong></th>
<th><strong>Key Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AAMC – Association of American Medical Colleges</strong></td>
<td>➢ Communities PHE Waivers and Flexibilities</td>
</tr>
<tr>
<td><strong>Foley and Lardner</strong></td>
<td>➢ Public Health Emergency Ends May 11th</td>
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<tr>
<td><strong>AHA – American Hospital Association</strong></td>
<td>➢ Public Health Emergency Flexibility Endings</td>
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</table>
| **ACC - Alliance for Connected Care** | ➢ Count down clocks  
➢ [https://connectwithcare.org/](https://connectwithcare.org/) |
| **DEA – Drug Enforcement Agency** | ➢ Controlled Substance Proposed Rules |
| **CMS – Centers for Medicare and Medicaid Services** | ➢ [Medicare Telehealth FAQs](#)  
➢ [Covid-19 Waivers](#)  
➢ [2.27.23 CMS PHE New Overview Fact Sheet](#) |
| **NCTRC – National Consortium of Telehealth Resource Centers** | ➢ [Preparing for Change: Federal Telehealth Flexibilities](#) |
What do I need to do first?

Assemble the SWAT team and a Virtual Command Center
Monitoring, communicating and facilitating the needed changes prompted by telemedicine flexibilities and optimizing them as they stabilize.

Ongoing communications to providers and patients regarding shifting legislation and requirements around telemedicine.

Planning for the continued and increased use of telemedicine services from budgeting to staffing while communicating ongoing changes.

Guidance regarding licensure, risk, contracts, privacy, expanded services, and the ever evolving requirements around the provisioning of telehealth.

Creation, support, and passage of legislation to facilitate licensure portability, federal payor flexibilities, and telehealth state regulations.
March 2, 2023

**Buckets-o-fun**

**Access**
Direct scheduling and decision tree logic creation to allow for rules around state licensure, role, payor, pt. location etc.

**PB**
Reversing flexibility logic, creation of possible modifier for patient location and BH dx, billing logic for updated standards by CPT code, and training

**MSO**
Licensure and Compact management for both credentialled and noncredentialled providers

**Compliance**
Guidance regarding supervision, inpatient use cases, and new documentation requirements

**HB**
Navigating the evolving requirements of HSCRC and expanding roles performing telemedicine
What do I need to do next?

Make an overarching plan with broad milestones, outputs, responsible parties, and triggers

<table>
<thead>
<tr>
<th>Step #</th>
<th>Action</th>
<th>Trigger (If applicable)</th>
<th>Responsible Group</th>
<th>Responsible person</th>
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<td>Govt Affairs</td>
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</table>

Note: This plan should be flexible enough to use for each change, planned or unplanned.

March 2, 2023

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## Tips: Billing

- Take a code/billing inventory
  - CPT code, RVU’s, reimbursement, if you are using/billing it, where it is billed, who is using it, and how the logic is built in the system
- Assess and prioritize
- Determine billing logic changes
- Tackle and Test

### CPT/HCPCS Description Work RVUs Rate Location CPT Codes POP/P&OP HB/PH/PBHB Currently billing (Yes/No) Program Appendix P/Virtual/Tel Notes Modifier Related Jiras Tied to PHE (Yes/No)

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Work RVUs²</th>
<th>Rate Location</th>
<th>CPT Codes</th>
<th>POP/P&amp;OP</th>
<th>HB/PH/PBHB</th>
<th>Currently billing (Yes/No)</th>
<th>Program</th>
<th>Appendix P/Virtual/Tel</th>
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Tips: In Depth Planning

- Use in depth planning once you know specific changes
- Make it flexible! Dates are changing with legislative updates

- Be ready for change and to start over
- If discouraged - phone a friend – *we are in this together*
**Keynotes and Plenary Sessions**

**Opening Keynote: Audio-Only vs. Audio-Video Telehealth: Policy Considerations for Achieving Sustainable Equitable Outcomes**

During this session attendees will learn about novel research on State Medicaid Director perceptions of audio-only versus Audio-Video telehealth, learn about the new Qual modifier for audio-only telehealth and hear about policy actions that can be taken to move the needle on more sustainable and equitable outcomes for patients.

*Andrey Ostrovsky MD, FAAP, Managing Partner, Social Innovation Ventures and Former U.S. Medicaid Chief Medical Officer*

**Morning Plenary: Equity through Digital Health Readiness**

Dr. Rising will explore the concept of digital health readiness as an action-oriented approach to facilitate equity through access to healthcare through telehealth. She will introduce the digital health readiness screener recently developed by her team and discuss practical implications for use of this screener in both clinical and community sites. In addition, she will highlight key findings and developments from a PCORI-funded national consensus conference focused on developing a patient-centered research agenda to reduce disparities in telehealth uptake that took place Fall 2022.

*Kristin Rising, MD, MSHP, Director, Center for Connected Care, Professor, Emergency Medicine, Thomas Jefferson University*

**Luncheon Keynote: The Art of Resilience: Make Your Life a Masterpiece**

Prepare to be taken on a journey with her perspective view inside the patient experience. Allison Massart’s riveting and insightful keynote narrates the immense value that healthcare providers have upon a patient when they are failing. This dynamic and poignant program offers real solutions to the struggle of how to keep the patient in the driver’s seat and other practical considerations. By weaving her remarkable journey with patient healing lessons, Allison highlights the integral nature of patient-centered care and forlines audience members, regaining their passion for why they went into healthcare in the first place. She explains, “The power of what you do far beyond the technical part of your job. You are healing the places medicine cannot touch. In fact, YOU are the medicine I talk about as ‘life-changing.’” Allison’s keynote offers a sincere and direct approach to navigating adversity, transforming life obstacles, and always finding a way to be the healer in the room. This content-rich and deeply moving speech also offers applicable tools for managing change, adversity, and the everyday challenges of being human.

*Allison Massart, Keynote Speaker, Executive Coach, Celebrated Artist [www.allisonmassart.com]*

**Closing Keynote: Artificial Intelligence in Health Care: Friend or Foe to Health Equity?**

Mike Capps, CEO of Divereyes, will outline how he believes AI has the true potential to deliver improved health care outcomes, but it’s critical the right technical approach is adopted. Mike will discuss the dangers of ‘black box’ technology and the need to ensure the AI is understandable and transparent in true partnership with healthcare professionals.

*Michael Capps, PhD, Co-founder and Chief Executive Officer, Divereyes and Former President, Epic Games*
Leading Transformation Track

**Pre-Summit Session: Innovate or Die: Yikes, But I Don't Have the Time!**

- Time: 02:00 PM - 03:00 PM
- Date: March 15, 2023
- Location: Leading Transformation

**Building Cultures of Innovation: Leading through Crisis**

- Time: 02:30 PM - 03:30 PM
- Date: March 16, 2023
- Location: Leading Transformation

**YES, AND... Using Improvisation to Transform Team Culture**

- Time: 04:30 PM - 05:30 PM
- Date: March 16, 2023
- Location: Leading Transformation

**Achieving Transformation through Strategy-Driven Execution**

- Time: 08:45 AM - 09:45 AM
- Date: March 17, 2023
- Location: Leading Transformation

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**Telehealth EQUITY:**
Is the “Solution” for Addressing Inequities in Health Quality and Access Now Exacerbating those Same Issues?

**REGISTER NOW**
MARCH 15-17, 2023 / HYBRID EVENT

**LOCATION:**
Hilton Norfolk The Main
100 E. Main Street
Norfolk, VA

**BACK BY POPULAR DEMAND:**
- Telebehavioral Health Track
- Leading Transformation Track

MATRCSummit.org
Leading Transformation Track

Learn & Do Post-Summit Webinar Series

- Deciding What Problem to Solve
- Innovation is Best Practices as a Team Sport
- Iterative Prototyping
- Evidence-Based Storytelling

For more information and to register: http://www.MATRCSummit.org
Thank You For Joining Us Today!

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UVA Center for Telehealth
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