

Medicare's telehealth coverage expansion during the COVID-19 pandemic

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Schools around the country are being closed. Major League Baseball has postponed its season. Broadway shows are closed. The Kentucky Derby has been rescheduled.

These measures are part of “social distancing,” the new norm in the wake of the coronavirus pandemic. On a nationwide basis, we are being encouraged to limit our social interactions to slow the spread of the virus, slow the rate of those who will fall ill to COVID-19, and avoid overtaxing our healthcare system over a short period of time.¹

What does social distancing mean for those who require healthcare during this time? Could they be helped by telehealth, which has the potential to replace some in-person services and better triage care based on needs?

While much is still unknown about the virus that causes COVID-19, at this point, everyone is encouraged to practice social distancing over the course of the next few months. Besides steering clear of large gatherings, schools, and other group situations, this includes avoidance of physician offices and hospitals, if possible, to prevent exposure and spread of coronavirus. This is especially true for the elderly, a population considered at risk for falling seriously ill to COVID-19.²

Medicare is the federal health insurance program for those over the age of 65, the disabled, and those with end stage renal disease (ESRD). Medicare has specific definitions for telehealth services—it is covered by Part B³ and is limited to live audio/video services furnished by specified practitioners at a distant site to a beneficiary in an originating site. Restrictions under the Medicare program regarding beneficiary location, provider type, and geography have limited the adoption of telehealth services provided to Medicare beneficiaries.⁴ These include geographic restrictions to rural areas and originating site restrictions⁵ requiring the beneficiary to be at a qualifying location, such as a doctor’s office or clinic. The beneficiary’s home is not considered an originating site under Original

Medicare’s telehealth coverage rules.⁶ Medicare Advantage plans and providers participating in accountable care organizations (ACOs) have more flexibility, and, in certain cases can waive these geographic and originating site restrictions.

The *Telehealth Services During Certain Emergency Periods Act of 2020* (the TSDCEPA),⁷ which is part of the *Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020*, has removed many of these restrictions temporarily. Specifically, the TSDCEPA does the following:

- Applies to an emergency area or a portion of such an area. Given that President Trump issued a *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* on March 13, 2020,⁸ the provisions would appear to apply nationally and for the Medicare program, which is federally administered. In addition, the Department of Health and Human Services (HHS) declared a national public health emergency related to coronavirus, effective January 27, 2020.⁹
- Originating site restrictions are temporarily waived. This means the beneficiary’s home may be considered a qualifying originating site.
- The provider types who are eligible for payment for telehealth services under Medicare have not changed and still include the same set of “distant site practitioners” such as, physicians, nurse practitioners, physician assistants, clinical psychologists, and social workers. However, the distant provider must have furnished “... an item or service during the 3-year period ending on the date such telehealth service was furnished.”¹⁰ This implies that only the beneficiary’s existing provider (or one who has provided services to the beneficiary in the last three years) is permitted to provide telehealth services under this waiver. As a result of this provision, newly eligible Medicare beneficiaries may not be able to receive telehealth services. In addition, this provision may create barriers for telehealth vendors or providers looking to enter the Medicare market but have not provided services to Medicare beneficiaries in the last three years. Finally, there are operational challenges to ensure provider reimbursement—for example, examining claims over a three-year look-back period at a tax ID number (TIN) level.¹¹ However, as of March 17, 2020, CMS’s FAQs on TSDCEPA explicitly states that CMS will not be enforcing this requirement.

Q: Will CMS enforce an established relationship requirement?

A: No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other healthcare 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.

- The TSDCEPA does not alter state laws governing telehealth, such as licensure. However, on March 13, 2020, CMS issued guidance on new flexibilities available under 1135 Waivers.¹² The fact sheet states that the following waiver is available, "Provider Locations: Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid." It is probable that this flexibility would apply to Medicare-covered telehealth services, but is unclear at this time.
- Smartphones with audio and video capabilities can be used to provide telehealth services. This clarifies that telehealth services can be provided via phone if they are capable of providing not just audio but also live video.
- Effective dates are being clarified. According to a FAQ released on March 17, "patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020."¹³ It is also unclear when the provisions of the TSDCEPA might sunset or how long the waiver is in effect.

Telehealth has had the potential to replace an office visit or an emergency department visit. Under this new law and related flexibility telehealth has the potential to significantly expand the capacity of the U.S. healthcare system, freeing up clinical resources for patients with acute care needs. According to Milliman's analysis of Medicare Part B services, Medicare covers approximately 277 million office visits annually.¹⁴ Shifting a small portion of these visits to telehealth visits may have a beneficial impact on a strained health system at risk of being overwhelmed by demand for services. For example, if 3% of these visits shift to

telehealth visits over a three-month period, there would be 2.1 million fewer office visits. While this does not take into account that some of the telehealth visits could lead to an additional in-person visit, telehealth visits may prove instrumental for triaging health care needs such that in-person visits are provided to those needing in-person services—such as physical examination or specific screenings or tests provided at the doctor's office.

While not technically considered "telehealth services" under Medicare, it is worth noting that beginning in 2019, Medicare had added new "non-face-to-face" services eligible for reimbursement under the Physician Fee Schedule (PFS)—most notably, virtual check-ins.¹⁵ An example of a virtual check is when a patient calls their physician and the physician is able to do an assessment over the phone.¹⁶ A virtual check-in may also be helpful in supporting clinicians to conduct triage and determine whether a video visit or an in-person visit is necessary.

One practical question for evaluating implementation feasibility at the practice level is whether providers are equipped to provide services via HIPAA-compliant telehealth platforms. On March 17, 2020, the Office of Civil Rights (OCR) released guidance stating they will not be enforcing HIPAA provisions for providers who wish to use live video services to patients during the emergency period. OCR states in their guidance, "A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients."¹⁷

Telehealth is not a new concept. However, the current coronavirus crisis provides an opportunity to leverage the availability of telehealth services and deliver care remotely. It is unclear whether Medicare will extend these flexibilities for telehealth services beyond the current COVID-19-related public health emergency. However, if Medicare beneficiary and provider use of this technology leads to value for the healthcare system through desirable healthcare outcomes, reduced risk, and member satisfaction, this could lead to quicker adoption by both payers and beneficiaries. In addition, if telehealth is effective in reducing burden on our healthcare system during this time of emergency, then increased adoption for services that can be effectively delivered remotely may well be worthwhile to continue in the future.

Guidance and directives from the federal government are rapidly evolving. The information in this article is based on statute and guidance in place as of March 18, 2020.

ENDNOTES

- ¹ In this post, we use the naming conventions as outlined by the World Health Organizations, where the coronavirus (technically severe acute respiratory syndrome coronavirus 2 or SARS-CoV-2) is the virus which causes the disease, COVID-19. Retrieved on March 18, 2020, from [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it).
- ² Are You at Higher Risk for Severe Illness? CDC. 2020. Retrieved on March 19, 2020, from: <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>.
- ³ What Part B covers. Medicare.gov. Retrieved on March 18, 2020, from <https://www.medicare.gov/what-medicare-covers/what-part-b-covers>.
- ⁴ Telehealth Services. Medicare Learning Network. Centers for Medicare and Medicaid Services. (January 2019). Retrieved on March 18, 2020, from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctst.pdf>.
- ⁵ Originating site is the location of the Medicare beneficiary, while the distant site is the location of the provider.
- ⁶ Except for beneficiaries with ESRD getting home dialysis. Telehealth Services. Medicare Learning Network. Centers for Medicare and Medicaid Services. (January 2019). Retrieved on March 18, 2020, from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctst.pdf>.
- ⁷ H.R. 6074. United States Congress. (January 3, 2020). Retrieved on March 18, 2020, from <https://www.congress.gov/116/bills/hr6074/BILLS-116hr6074enr.pdf>.
- ⁸ Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. Whitehouse.gov. (March 13, 2020). Retrieved on March 18, 2020, from <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.
- ⁹ Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus. Press release. Department of Health and Human Services. (January 31, 2020). Retrieved on March 18, 2020, from <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>.
- ¹⁰ H.R. 6074. United States Congress. (January 3, 2020). Retrieved on March 18, 2020, from <https://www.congress.gov/116/bills/hr6074/BILLS-116hr6074enr.pdf>.
- ¹¹ Drobac, Krista. The Reality of the New Telehealth Authority in Medicare. Alliance for Connected Care. Retrieved on March 18, 2020, from <http://connectwithcare.org/blog-reality-of-new-telehealth-authority-in-medicare/>.
- ¹² COVID-19 Emergency Declaration- Health Care Providers Fact Sheet. Retrieved on March 18, 2020, from <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>.
- ¹³ Medicare Telehealth Frequently Asked Questions. CMS. (March 17, 2020). Retrieved on March 18, 2020, from <https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>.
- ¹⁴ Milliman *Health Cost Guidelines – Ages 65 and Over*TM.
- ¹⁵ HCPCS code GVC11.
- ¹⁶ Virtual Check-ins. Medicare.gov. Retrieved on March 18, 2020, from <https://www.medicare.gov/coverage/virtual-check-ins>.
- ¹⁷ Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. Office for Civil Rights. 2020. Retrieved on March 18, 2020, from <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>.



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