



TELEHEALTH REIMBURSEMENT

Telehealth is a well-established means of increasing access to care and health education for underserved and rural communities, and its capabilities have greatly expanded with recent technological advancements. Telehealth is the use of virtual and digital technology to provide health care, education and other health related services from a distance. Telehealth encompasses such service delivery modalities as live video teleconferencing, asynchronous secure transmission (store and forward) and remote patient monitoring. Rather than a separate clinical service, telehealth is a tool to strengthen care delivery, medical practice support, and educational and preventative measures to patient care.

Telehealth continues to grow as more services and policies are being implemented on the state and federal level. However, reimbursement gaps remain. These gaps impede expansion of telehealth services within the health care field. Medicare, Medicaid, and private payers offer varying degrees of telehealth reimbursement, with their reimbursement policies differing greatly in terms of services covered, and other requirements and restrictions. Overall there is a lack of cohesiveness of policies both within and between public and private payers. The telehealth reimbursement policies of the aforementioned three major insurance players are examined below.

MEDICARE

Medicare first began to reimburse for telehealth services with passage of the Balanced Budget Act of 1997. Reimbursement conditions in Medicare were expanded in the Benefits Improvement and Protection Act of 2000, but very few changes have occurred since then. As of September 2016, Medicare only reimburses for live-video conferencing telehealth services under very specific circumstances. Store-and-forward, or asynchronous services, is not permitted for reimbursement (except for Federal telemedicine demonstration programs in Alaska or Hawaii, as stated in CMS' telehealth services fact sheet). Additionally, current law places specific restrictions on the originating site (i.e. the physical location of the patient), practitioner at the distant site (i.e. the physical location of the practitioner) and types of services that can be delivered.

GEOGRAPHIC AND ORIGINATING SITE RESTRICTIONS

In order to be reimbursed for live-video telehealth, the patient must be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HSPA), except in the case of treating an acute stroke or end stage renal disease (ESRD) related visits (beginning Jan. 1, 2019). The Health Resources Services Administration (HRSA) maintains a Medicare telehealth payment eligibility search tool to determine if the specific location of an originating site qualifies.

Additionally, Medicare limits the originating sites eligible to receive services through telehealth to the following facilities:

- Provider offices
- Hospitals
- Critical access hospitals
- Rural health clinics
- Federally qualified health centers
- Skilled nursing facilities
- Community mental health centers
- Hospital-based or critical access hospital-based renal dialysis centers

If these sites meet Medicare's rural/geographic requirements, these sites are also eligible for a facility fee from Medicare to compensate for the use of their facility.

The following sites are also eligible originating sites and exempt from the rural geographic requirement beginning Jan. 1, 2019 under Medicare in specific situations, but are not eligible to receive the facility fee:

- Renal dialysis facility for ESRD-related visits **ONLY**
- Home for ESRD-related visits **ONLY**
- Mobile Stroke Unit for treatment of acute stroke **ONLY**
- Any site determined appropriate by the Secretary for treatment of acute stroke **ONLY**

PROVIDER RESTRICTION

Only the following list of distant site providers qualify to deliver services via telehealth through Medicare:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Clinical nurse specialists
- Clinical psychologists and clinical social workers
- Registered dietitians or nutrition professionals

SERVICE RESTRICTION

Medicare maintains a list of specific services/CPT codes they will reimburse for via telehealth. Each year, the US Department of Health and Human Services considers submissions for new telehealth-delivered services to be approved. Therefore, the list changes every year. Some examples of services currently reimbursed by CMS include:

- Emergency department consultations;
- Outpatient visits;
- Nutrition therapy;
- Smoking cessation services
- Psychotherapy; and
- Brief (15 minutes) behavioral counseling for obesity, alcohol misuse, or depression screening.

CHRONIC CARE MANAGEMENT AND REMOTE MONITORING

In January 2015, CMS created a new chronic care management (CCM) code, which provides for non-face-to-face consultation. This has opened up the possibility of receiving reimbursement for virtual asynchronous remote monitoring of chronic conditions. Since then, CMS has released several instructional documents on billing the CCM codes and added reimbursement for complex CCM as well as two add-on codes. Additionally, in the final calendar year 2018 Physician Fee Schedule, CMS unbundled code **99091** allowing providers to get reimbursed separately for time spent on collection and interpretation of health data generated remotely. By not defining these codes as a “telehealth” service, these services are not subject to the restrictions other telehealth services currently face, such as geographic and location limitations and prohibitions on the use of asynchronous technology in most cases. For more information, see CMS’ CY 2018 Physician Fee Schedule , FAQs on CCM, and factsheet on the new codes.

MEDICARE ADVANTAGE

Medicare advantage plans will start being able to provide coverage for additional telehealth benefits (beyond those already covered under Medicare Part B) beginning in plan year 2020. Those benefits would include services available under part B, but ineligible for payment due to the restrictions around telehealth currently in Medicare and those that are identified as clinically appropriate. The Secretary is required to solicit comments on the types of telehealth services that should be considered additional telehealth benefits by Nov. 30, 2018, and once implemented enrollees will have discretion as to whether or not to receive those services through an in-person visit or telehealth.

ACCOUNTABLE CARE ORGANIZATION, BUNDLED CARE AND TELEHEALTH

Beginning Jan. 1, 2020 all Accountable Care Organizations (ACOs) tested or expanded under the Center for Medicare and Medicaid Innovation with a two-sided model with Medicare fee-for-service beneficiaries will have the ability to expand telehealth services to include the home as an eligible originating site and would not be subject to Medicare’s current telehealth originating site geographic requirements. Some ACOs, designed to reduce fragmentation of care, have already been given additional flexibility in their use of telehealth to treat eligible beneficiaries.

In Medicare specifically, some of the current telehealth requirements in the Social Security Act are waived in both the Next Generation ACO model as well as the Comprehensive Care for Joint Replacement model, which tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements. Although the telehealth restrictions would have also been waived in CMS’ Episode Payment Models program which was supposed to begin in Jan. 2018, that program was cancelled.

MEDICAID

CMS gives states the ability to determine their own policies related to telehealth. The official policy indicates that states may reimburse for telehealth under Medicaid as long as the service satisfies federal requirements of “efficiency, economy, and quality of care”. This policy enables states to have unique standards for what services they deem appropriate for reimbursement, which causes gaps in the system due to a massive lack of uniformity between states and results in differing reimbursement policies. Recently, CMS has further clarified states’ flexibility to define their telehealth policy without filing a State Plan Amendment (SPA), stating that “States are not required to submit a (separate) SPA for coverage or reimbursement of telemedicine services, if they decide to reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations.”

MEDICAID TELEHEALTH REIMBURSEMENT LANDSCAPE

Like Medicare, live-video conferencing is the most common telehealth modality that is reimbursed, with 48 states and DC reimbursing for live video telehealth of some form as of October 2017. However, there are often many restrictions on the type of provider, facility, service or geographic location that can be reimbursed. Reimbursement for other forms of telehealth is less common. Store-and-forward telehealth is only reimbursed in 15 states, however it is often restricted to certain specialties such as dermatology. Remote patient monitoring is reimbursed in 21 states, and also often is confined to specific circumstances, such as it only be reimbursed when delivered by a home health agency, or for specific conditions (such as COPD or diabetes). In addition to reimbursement to the distant site, many state Medicaid programs, like Medicare, provide a facility fee, and in addition, sometimes allow for a transmission fee to cover the cost of connecting the patient to the distant site provider. See CCHP's 50 State Telehealth Laws and Reimbursement Report for additional information on each state's policies.

PRIVATE PAYERS

There is no unique set of standards that pertains to insurance companies throughout the country. As of October 2017, 36 jurisdictions (including DC) have enacted (or will enact at a later date) laws that govern private payer telehealth reimbursement. In most cases, these laws offer coverage parity, requiring insurers to cover the same services delivered through telehealth, as are covered in-person, as long as it meets the same standard of care. For example, as of October, the state of New York's parity law forbids private payers to "exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage ... because the service is delivered via telehealth [...]."

But, it does not state that private payers must reimburse telehealth services equally as in-person services, prompting one insurer in New York to reimburse telehealth delivered services at a 50% reduced rate. Thus, a few states (including New York) have begun to introduce payment parity legislation that requires private payers to cover telehealth services "at the same rate" as when the service is provided in-person. Many states also make their telehealth parity laws "subject to the terms and conditions of the contract." This phrasing may set up certain conditions where an insurer has the flexibility to restrict telehealth reimbursement within their contract. See CCHP's 50 State Telehealth Laws and Reimbursement Report for additional information on each state's policies

CONCLUSION

Typically, in the field of telehealth, policy develops much more slowly than the rapidly advancing technology. Still, incremental changes are taking place to further develop telehealth legislation. In 2017, 210 telehealth related bills were active across thirty states. One of the most common pieces of legislation relate to Medicaid and private payer reimbursement. It is anticipated that these trends will continue over the next few years as telehealth policy strives to keep pace with technology's capabilities.

RESOURCES:

Center for Connected Health Policy: www.cchpca.org

Telehealth Resource Centers: www.telehealthresourcecenter.org

Centers for Medicare and Medicaid: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/>

Prepared by:



Footnotes

1 “Telehealth Services.” Center for Medicaid and Medicare Services. Medicare Learning Network. December 2015.

<<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>>

2 “Medicare Telehealth Payment Eligibility Analyzer” Health Resources Services Administration. Accessed Aug. 3, 2016.

<datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx>

3 “Chronic Care Management Services Frequently Asked Questions.” Center for Medicare and Medicaid Services. MLN Matters # SE1516. Accessed Aug. 3, 2016. <

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1516.pdf>>

4 “Chronic Care Management Services” Center for Medicare and Medicaid Services. Medicare Learning Network. May 2015. <

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>>

5 “Telemedicine” Medicaid.gov. Accessed Aug. 3, 2016. <<https://www.medicaid.gov/medicaid/benefits/telemed/index.html>>

6 NY Insurance Law Article 32, Section 3217-h.

7 “State Laws and Reimbursement Policies.” Center for Connected Health Policy. Fall 2017. <http://www.cchpca.org/state-laws-and-reimbursement-policies>

¹CY 2018 Physician Fee Schedule. CMS. <https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf>