Crowell

CLIENT ALERT

CMS Seeks Comment on Proposed Rule to Expand Telehealth Access and Coverage in the Medicare Advantage Program

November 7, 2018

The Centers for Medicare & Medicaid Services (CMS) continues to develop policy to expand telehealth coverage. On October 26th, CMS released a proposed rule that would implement policy and technical changes to the Medicare Advantage (MA), Medicare Prescription Drug Benefit (Part D), Program of All-inclusive Care for the Elderly (PACE), Medicare fee-for-service (FFS) and Medicaid Managed Care programs. CMS issues policy and technical changes on an annual basis to these programs, but this year, MA plans should pay special attention to the proposals to implement changes in the treatment of telehealth benefits originally set forth in the Bipartisan Budget Act of 2018 (the BBA). As part of their bid submissions for MA plan offerings starting in 2020, MA plans will be able to include additional telehealth benefits that provide enrollees, for instance, the ability to receive telehealth services from their homes, which is not currently reimbursable under the Physician Fee Schedule (PFS) under original Medicare FFS. MA plans seeking to provide input to CMS on key aspects of how to define the scope of additional telehealth benefits, among other related issues, must submit their comments by **November 30, 2018**.

Current Telehealth Conditions of Payment Are Tied to FFS Medicare

Payments for telehealth benefits under Medicare FFS are primarily governed by section 1834(m) of the Social Security Act. Section 1834(m) limits reimbursement for telehealth services to specific services listed in the PFS[1][1] provided "using an interactive audio and video telecommunications system that permits real-time communication between a Medicare beneficiary and a physician or certain other practitioner"[2][2] and that are delivered at "eligible originating sites" defined by the geography and patient setting where the beneficiary is located. The HHS Office of the Inspector General has focused on compliance issues related to these telehealth conditions of payment (see previous alert). Currently, MA plans may only offer telehealth benefits for services not covered by Medicare FFS as "supplemental benefits" that are funded by the use of rebate dollars and/or supplemental premiums paid by enrollees in Medicare Advantage plans.

CMS's "Additional Telehealth Benefits" Proposal for MA Plans

Section 50323 of the BBA created a new section 1852(m) within the Act expanding MA plans' ability to offer telehealth services and include them for bid submission purposes for plan years beginning in 2020. To implement section 1852(m) of the Act, CMS's proposed rule would allow MA plans to offer "additional telehealth benefits" as part of the government-funded "basic benefits" covered under Medicare Part C. The "additional telehealth benefits" offered under the rule are limited to services for which benefits are available under Part B, but can include telehealth services that are not currently listed in the PFS of the Act so long as they have been identified as clinically appropriate to furnish using electronic information and telecommunications technology as defined under section 1852(m)(2)(A)(i) of the Act. The rule would empower MA plans (not CMS) to determine what is clinically appropriate, as well as the conditions and limitations, premiums, and cost-sharing requirements for additional

telehealth benefits, through the annual Evidence of Coverage issuance process to beneficiaries, and adopts a broad definition of electronic exchange in order to accommodate advances in technology.

Other notable features of the proposed regulations that would govern additional telehealth benefits include that MA plans:

- Would not be able to deliver additional telehealth benefits through non-contracted providers.
- Would have to maintain written policies and procedures for the selection and evaluation of providers for the delivery of additional telehealth benefits.
- Would be allowed to maintain different cost-sharing for additional telehealth benefits compared to the same services delivered in person.
- Would not be able to include capital and infrastructure costs and investments incurred by plan sponsors or by third-party providers (*e.g.*, internet installation and communication platforms or software) relating to such additional telehealth benefits for purposes of plan bid submissions to CMS.
- Would be able to continue offering telehealth benefits outside of those allowed by section 1834(m) and 1852(m) of the Act as "supplemental benefits" (*e.g.*, for telehealth benefits delivered by non-contracted providers).

More Patient Choice, But Still Limited by MA Compliance Requirements and State Laws

The statute and proposed rule both stress that enrollee choice is a priority with respect to these benefit expansions — if an MA plan covers a Part B service as an "additional telehealth benefit" through contracted providers then the plan must also cover that service through an in-person visit, and the beneficiary must have the discretion to choose whether to receive the services in-person or through telehealth means. Beneficiaries would receive information about which contracted MA providers offer services as either in-person visits, as additional telehealth benefits, or both through MA plan provider directory listings. However, CMS explicitly states that MA plans may not provide enrollees with items other than those directly related to their care and treatment under the Part B benefit, such as internet service or the permanent installation of telecommunication systems in an enrollee's home to enable the delivery of additional telehealth benefits.

In offering additional telehealth benefits, MA plans would be required to comply with existing MA rules, as well as with other federal nondiscrimination laws, such as Title VI of the Civil Rights Act, section 504 of the Rehabilitation Act, and section 1557 of the Affordable Care Act. And of course, the preambles to the proposed rule explicitly state that MA plans, "when providing additional telehealth benefits, must ensure through its contract with the provider that the provider meet and comply with applicable state licensing requirements and other applicable laws for the state in which the enrollee is located and receiving the service." Therefore, it is possible that state law may still restrict an MA plan's ability to offer additional telehealth services in certain markets, such as by imposing an initial face-to-face visit requirement, by restricting the types of health care professionals who may deliver telehealth services, or by imposing other requirements related to network adequacy based on whether adequacy is dependent on the distribution of in-person services in a geographical area.

Areas For Comment

Comments on the implementation of requirements related to the scope of additional telehealth benefit requirements in proposed 42 C.F.R. §§ 422.100, 422.135, 422.252, 422.254, and 422.264 are **due November 30, 2018**. CMS is specifically seeking input on the following issues:

- What types of items and services should be considered "additional telehealth benefits."
- Which Part B items and services should MA plans be permitted to offer as additional telehealth benefits (for example, primary care visits, routine and/or specialty consultations, dermatological examinations, behavioral health counseling, etc.).
- Whether additional telehealth services that are clinically appropriate to be provided through electronic exchange should be limited to the list of Medicare telehealth services payable by original Medicare under section 1834(m) of the Act, albeit without the location requirements and other limitations imposed by that section.
- What impact, if any, should additional telehealth benefits have on MA network adequacy policies and how assessing network adequacy relative to additional telehealth benefits may impact rural MA plans, providers, and/or enrollees.
- What additional qualifications, if any, should CMS impose on providers of additional telehealth benefits.
- What types of capital and infrastructure costs and investments should be excluded from the bid and how should CMS operationalize this statutory requirement in the annual bid process.
- Whether CMS should revise other regulations to address the application of additional telehealth benefits.

Our Health Care Group, comprised of experienced Medicare Advantage and Digital Health practitioners, is ready to provide insight and expertise on the potential impact of offering additional telehealth benefits and can assist entities with preparing comments to CMS.

---

[1] Examples of these services include Annual Wellness Visits under HCPCS G0438, office or other outpatient visits under CPT codes 99210-99215, individual and group kidney disease education services under HCPCS codes G0420 and G0421, individual and group health and behavior assessments and interventions under CPT codes 96150-96154, advance care planning under CPT code 99497-99498. A comprehensive list of telehealth services covered under Medicare Part B as of February 2018 is provided here.. The CY 2019 PFS has added more telehealth services, which will be published in the Federal Register this month.

[2] These "other practitioners" may include nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals, so long as State law also permits these professionals to deliver telehealth services.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Jodi G. Daniel
Partner & CHS Managing Director – Washington, D.C.
Phone: +1.202.624.2908
Email: jdaniel@crowell.com

Christopher Pinto
Counsel – Washington, D.C.

Phone: +1.202.624.2708
Email: cpinto@crowell.com