NPHI Policy Brief

Recent proposed telehealth changes + Policy Proposals

Overview

Recent legislative and regulatory actions indicate that Congress and CMS alike are beginning to recognize the evolution and advancement of care practices and technological tools since the existing telehealth regulations were first promulgated. There have been recent actions and proposals expanding certain existing telehealth flexibilities and adding new potential technology-enabled services to be utilized in the provision of health care services. While hospice-specific issues are not explicitly reflected in these new policies, the actions in this space reflect an interest in telehealth modernization that is likely to impact non-profit hospice and palliative care providers in the future.

Legislative Changes

The Bipartisan Budget Act (BBA) of 2018 incorporated a number of substantial telehealth-related provisions, including:

- Allowing Medicare patients with end-stage renal disease (ESRD) on home dialysis to receive their monthly clinical assessments at home using telehealth, rather than in-person, beginning January 1, 2019.
- Allowing patients arriving at a hospital with acute stroke symptoms to receive a telehealth consultation to determine the best course of treatment, without regard to their geographic location, beginning January 1, 2019.
- Allowing Medicare Advantage (MA) plans to offer additional, clinically appropriate telehealth benefits in their annual bid amount beyond the services that receive payment under traditional Medicare, beginning plan year 2020.
- Enabling Accountable Care Organizations (ACOs) to expand the use of telehealth by allowing other types of ACOs to take advantage of the existing Next Generation ACO telehealth waiver, which waives the geographic location criteria, allows the patient's home to serve as the originating site, and allows for the use of teledermatology and teleophthalmology.

Regulatory Policy Changes

Additionally, this past summer, CMS released the Medicare Physician Fee Schedule (MPFS) proposed rule which proposed policies enacting the ESRD and acute stroke telehealth BBA provisions outlined above. The proposed rule also included policies proposing the creation of new payment codes for two new virtual services:

- *Brief virtual check-ins*: Telephonic or other telecommunications touch-bases with established patients to decide whether an office visit or other service is needed.
- *Remote evaluation of images or video submitted by a patient*: Provider review of patient-submitted audio/video to assess the necessity of an office visit.

Brief Virtual Check-Ins

Under the existing codes, when a patient-to-physician check-in is furnished via communication technology prior to an office visit, the check-in is considered to be bundled into the payment for the resulting visit (e.g., through the billed evaluation and management (E/M) visit code). However, if a pre-office-visit check-in is furnished but no subsequent office visit actually occurs, there is no reimbursement for this service.

Beginning January 1, 2019, CMS is proposing to reimburse, with certain limitations, this virtual check-in when a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit.

Remote Evaluation of Images or Video Submitted by a Patient

CMS is proposing to create a new code that would reimburse physicians when recorded video and/or images captured by a patient are used in order to evaluate a patient's condition. CMS notes these services are intended to determine whether or not an office visit or other service is warranted and is proposing that this service to be a stand-alone service, with certain limitations. This service is distinct from the brief virtual check-in service in that this service involves the evaluation of a patient-generated still or video image, and the subsequent communication of the resulting response to the patient, while the brief virtual check-in describes a service that occurs in real time and does not involve the transmission of any recorded image or video.

Implications for Non-Profit Hospice and Palliative Care Providers

NPHI is hopeful that these changes will bolster the non-profit hospice and palliative care community's capacity to expand access to their high-quality services.

Importantly, CMS' proposal to create separate standalone billing codes for these new virtual encounters demonstrates the potential inclusion of telehealth services in new and existing alternative payment models (APMs). By carving out a unique payment code, CMS seems to indicate the value in these kinds of services and may also consider including their values as part of the equation for payment considerations under new and existing APMs, including new models focused on advanced illness populations. Additionally, given telehealth's cost-saving potential and its significance to the financial success of advanced illness APMs, CMS' shift towards greater telehealth flexibility is encouraging and should help support the creation and refinement of new models of advanced illness care. However, the potential inability to access telehealth in a home setting remains a barrier for hospice use of telehealth at home.

Looking Forward

In addition to the current changes, NPHI has been looking at two ways to expand telehealth flexibility around the face-to-face recertification in hospice.

First, NPHI is advocating for the hospice provisions of t*he Medicare Telehealth Parity Act of 2017* (HR 2550). The bill would modernize the way Medicare reimburses telehealth services by expanding the number of qualifying geographic locations and expanding coverage of telehealth services in a series of three phases. Of most interest to NPHI is Phase 2, which would expand qualifying originating sites to include home telehealth sites including hospice, home health, and home dialysis. The inclusion of patients' homes as qualifying originating sites would expand access to care and ease the burden on individuals with advanced illness, their families, and the providers who care for them.

Second, in addition to the key language in HR. 2550, NPHI is working with various Hill offices and with Committee staff on a proposal to evaluate the effectiveness of performing the hospice face-to-face recertification via telehealth.