Rural Telehealth: What is the impact to CAHs and RHCs during the PHE and beyond?

August 12, 2020

TODAY'S WEBINAR

Today's webinar is presented on behalf of the Oregon Office of Rural Health.

Thank you for joining us!

DISCUSSION TOPICS

- Looking at how the provisions of telehealth services has changed during the COVID-19 Public Health Emergency (PHE)
- Discussing the challenges of providing telehealth during the PHE
- Imagining how the PHE may change the telehealth landscape in the future.

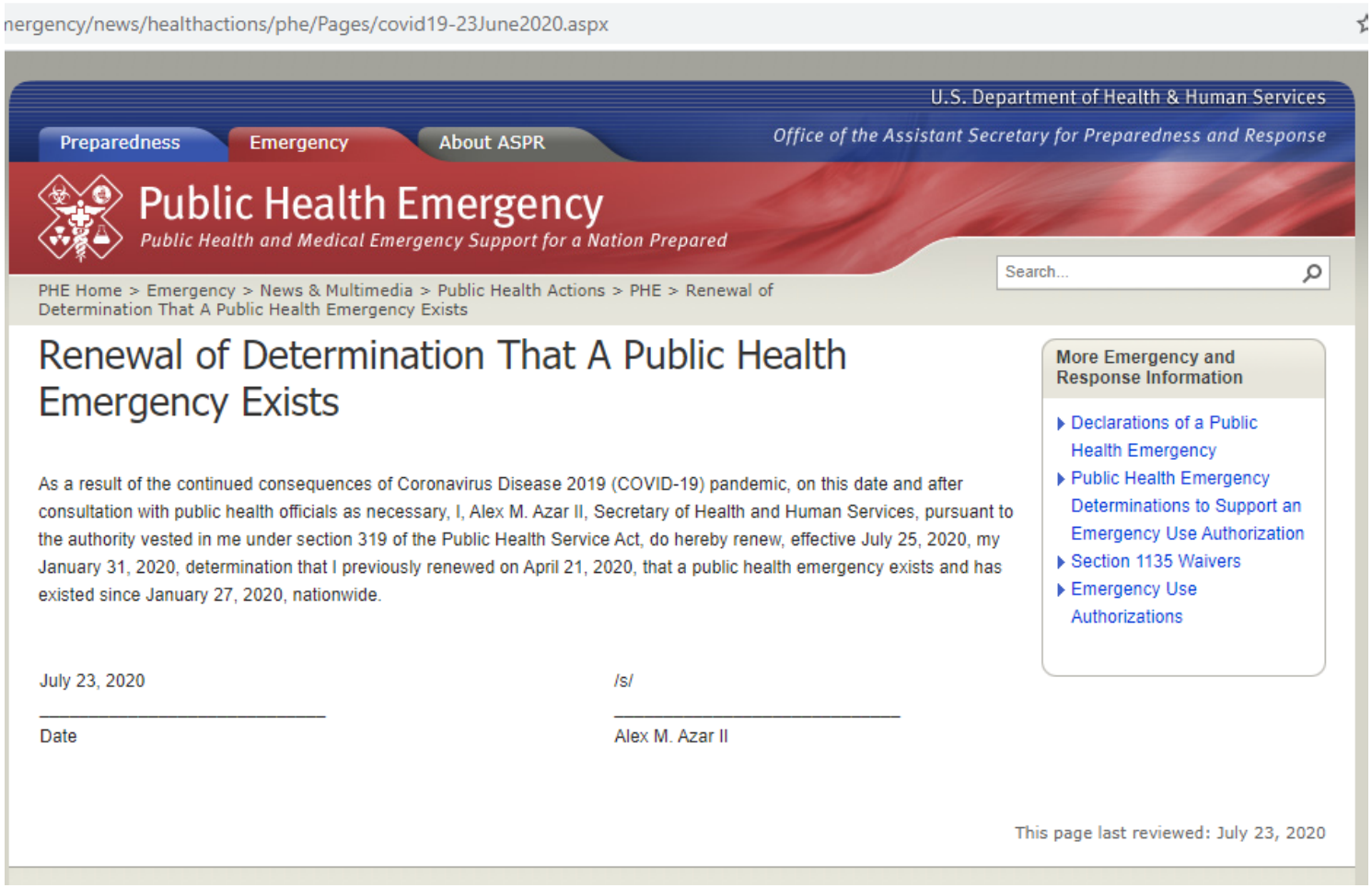
PUBLIC HEALTH EMERGENCY EXTENDED

JULY 25, 2020

"We are empowering medical providers to serve patients wherever they are during this national public health emergency. We are especially concerned about reaching those most at risk, including older persons and persons with disabilities."

– Roger Severino, OCR Director

PUBLIC HEALTH EMERGENCY EXTENDED FOR 90 MORE DAYS



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Office of the Assistant Secretary for Preparedness and Response

Public Health Emergency

Public Health and Medical Emergency Support for a Nation Prepared

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Renewal of Determination That A Public Health Emergency Exists

As a result of the continued consequences of Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective July 25, 2020, my January 31, 2020, determination that I previously renewed on April 21, 2020, that a public health emergency exists and has existed since January 27, 2020, nationwide.

July 23, 2020
_____
Date

/s/
_____
Alex M. Azar II

More Emergency and Response Information

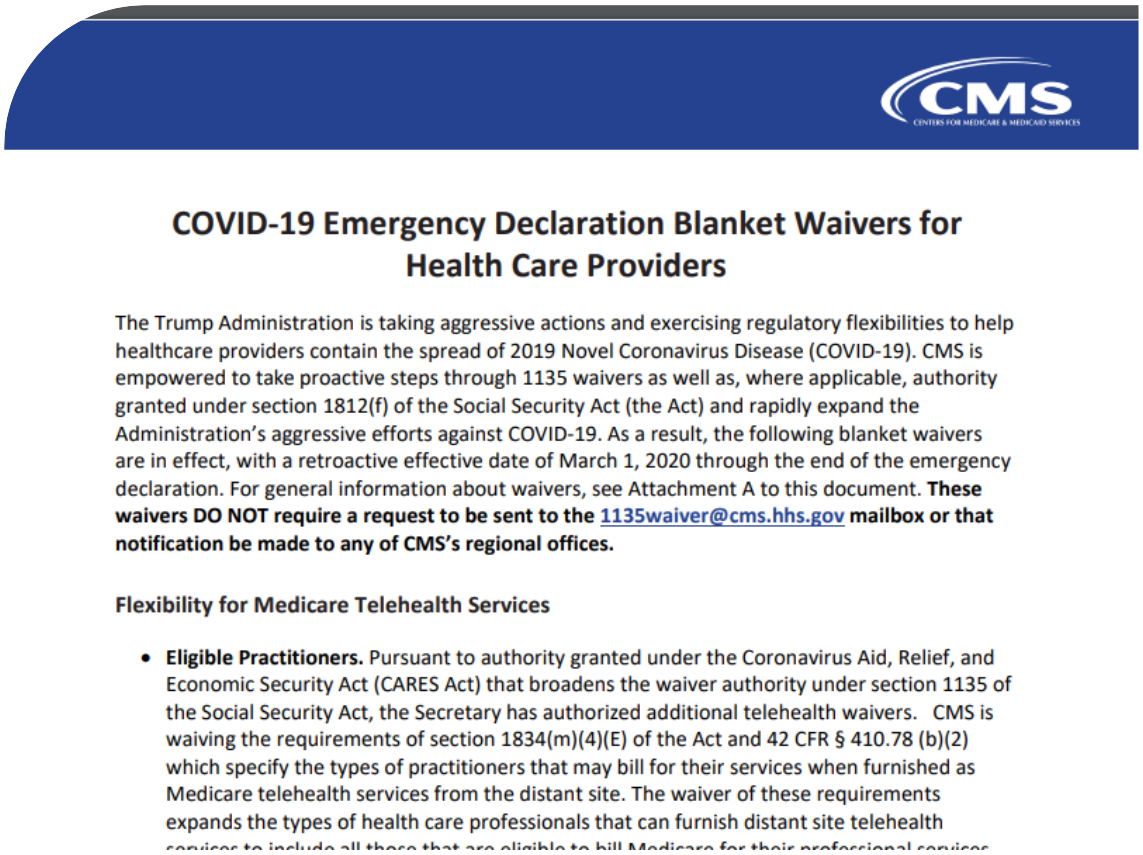
- Declarations of a Public Health Emergency
- Public Health Emergency Determinations to Support an Emergency Use Authorization
- Section 1135 Waivers
- Emergency Use Authorizations

This page last reviewed: July 23, 2020

HOW HAS THE PROVISION OF TELEHEALTH SERVICES CHANGED DURING THE COVID-19 PUBLIC HEALTH EMERGENCY (PHE)?

PHE BLANKET WAIVERS

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf



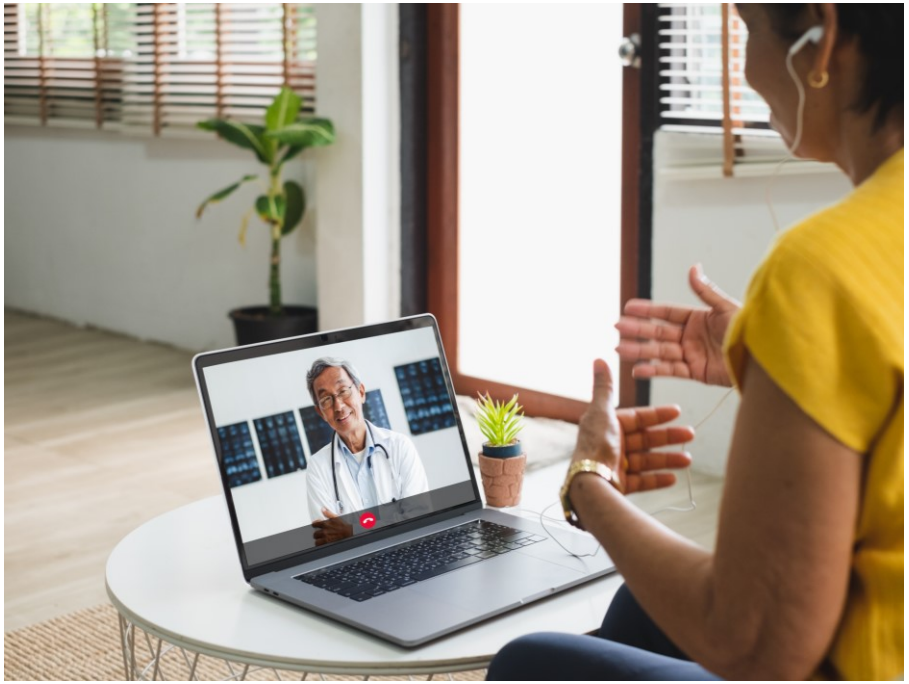
COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. **These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS's regional offices.**

Flexibility for Medicare Telehealth Services

- **Eligible Practitioners.** Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services

Originating Site versus Distant Site



Originating Site: This is the location of the patient who is receiving the telehealth service.

Distant Site: This is the location of the healthcare provider who is rendering the telehealth service.

FACILITY CHARGES VERSUS PROFESSIONAL CHARGES

- Telehealth services are professional services. These services can be billed as Professional Part B services or as CAH Method II services. See RHC note below.
- The facility charge is limited to the originating site fee if the patient is at the hospital.
- The RHC charge can be for the distance site provider only during the PHE. Normally, the RHC can only charge the originating fee as a healthcare facility type. New billing guidance has been given concerning the HCPCS codes and modifiers to be used.
- There is no restriction on the location of the healthcare professional or the patient under the PHE waivers.

WHAT LEEWAY DO THE WAIVERS GIVE US?

- Flexibility with the location of both the originating site and distance site for delivery of telehealth services during COVID-19.
- Flexibility with the services which can be performed as telehealth services.
- Flexibility across provider types which normally would not be reimbursed for telehealth services.
- Increased or additional reimbursement for some provider types and services under the PHE. (RHCs, for example)

WHAT LEEWAY DO THE WAIVERS GIVE US?

- Non-Rural Provider types can use telemedicine.
- No HIPAA enforcement pertaining to non-compliant telemedicine methods of communication.
- Expansion sites allowed during COVID-19.
- Staffing requirements loosened.
- Use of telemedicine for both COVID-19 and non-COVID related patient services.

WHAT SERVICE CAN BE PERFORMED AS TELEHEALTH SERVICES?

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

The list is quite extensive and can be downloaded as a zip file.

It includes Evaluation and Management services, other evaluation and therapeutic services, preventive services and other medical services.

Example of Service Which are Approved by CMS for Telehealth during PHE

99205	Office/outpatient visit new	
99211	Office/outpatient visit est	
99212	Office/outpatient visit est	
99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99217	Observation care discharge	Temporary Addition for the PHE for the COVID-19 Pandemic
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99224	Subsequent observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99225	Subsequent observation care	Temporary Addition for the PHE for the COVID-19 Pandemic

Examples of Selected Preventive Services Which Can be Performed by Telehealth

G0436	Tobacco-use counsel 3-10 min		Yes
G0437	Tobacco-use counsel>10min		Yes
G0438	Ppps, initial visit		Yes
G0439	Ppps, subseq visit		Yes
G0442	Annual alcohol screen 15 min		Yes
G0443	Brief alcohol misuse counsel		Yes
G0444	Depression screen annual		Yes
G0445	High inten beh couns std 30m		Yes
G0446	Intens behave ther cardio dx		Yes
G0447	Behavior counsel obesity 15m		Yes

HIPAA AND PHE TELEMEDICINE

- **The OCR will exercise discretion in enforcement of violations when a provider has acted in good faith to provide telemedicine during the emergency.**
- **A covered health care provide may use audio or video communication technology to provide telehealth to patients during the emergency can use audio/video applications. (Examples: Facetime, Skype, Messenger) that would normally not be compliant as long as they are not public facing**
- **Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers**

- **Applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.**

APPS & CONSENT TO TREAT

- **Health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.**

- **Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.**

- **Some vendors provide HIPAA-compliant video communication products and that will enter into a HIPAA BAA with providers.**

HIPAA COMPLIANT APPLICATIONS

NEED BAA

- Skype for Business / Microsoft Teams
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet
- Cisco Webex Meetings / Webex Teams
- Amazon Chime
- GoToMeeting

THE CHALLENGES OF PROVIDING TELEHEALTH DURING THE PHE

BARRIERS TO TELEMEDICINE FOR RURAL PROVIDERS

- Limited Access to High Speed Internet
- Limited Access to Smartphones
- Credentialing and Licensing
- Reimbursement
- Sustainability
- Malpractice
- Transportation
- Interoperability
- Mistrust of Technology and Healthcare
- Lack of Provider Buy-in or Utilization

Source: https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers

INTERNAL BARRIERS

- ORGANIZATIONS ARE NOT NIMBLE ENOUGH TO CHANGE QUICKLY OR LACK EXPERTISE
- EHR OR SYSTEM LIMITATIONS; NO TELEHEALTH MODULE
- STAFFING CHALLENGES
- TECHNOLOGY LIMITATIONS
- LACK OF COMMUNITY TRUST/LOW VOLUMES
- PATIENTS DO NOT HAVE SMART DEVICES OR COMPUTER ACCESS
- LACK OF PROVIDER BUY-IN
- FINANCIAL RESTRAINTS
- COST REPORTING RAMIFICATIONS

CLINICAL DOCUMENTATION CHALLENGES

- OBTAINING CONSENT TO TREAT
- KNOWING WHAT TO DOCUMENT AND HOW
- STOP AND START TIMES
- LOCATION OF PATIENT AND PROVIDER
- TREATMENT OF A MINOR/PRESENCE OF A GUARDIAN
- HOW TO DOCUMENT HISTORY AND VITALS
- PAPER NOTE OR EHR TEMPLATE
- HOW TO DOCUMENT REFERRALS
- HOW TO OBTAIN COVID TESTING AFTER TELEMED VISIT
- CORRECT ICD-10 CODING FOR REASON FOR THE VISIT

SAMPLE CLINICAL DOCUMENTATION FOR TELEHEALTH

Patient Demographics/Type of Service

TELEMEDICINE/TELEPHONIC NOTE

☐ Claim Date _____
☐ Scanned to EHR by ____

Date: _____ Provider Name: _____ Provider Credential: _____

Pt Name: _____ DOB/Age_____ Start Time: _____ Stop Time: _____
☐ Minor: Parent/Guardian is present.
Account/Med Record #_____ ☐ New Pt ☐ Established Pt
☐HIPAA Acknowledged ☐ Verbal Consent Obtained By _____
Type of Service: ☐ Audio/Visual Live ☐ Audio/Visual Stored ☐ Audio Only ☐ Phone Call
☐ Virtual Communication Service ☐ No Pt Devise/Computer App Used: _____

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PURPOSE OF TELEMEDICINE/TELEHEALTH SERVICE:

☐ Possible Exposure to COVID-19 ☐ Symptoms of COVID-19 ☐ Other Respiratory S/S
☐ Other Acute Condition _____ ☐ Other Chronic Condition _____
☐ Other: _____ ☐ Care Management
Location of Patient: _____ Location of Provider:_____
==========

Status of Chronic Conditions as HPI

HISTORY OF PRESENT ILLNESS or Reason for Telemedicine/Telehealth Visit
Signs and Symptoms: ☐ Cough ☐ Fever _____ ☐ Body Aches ☐ Sinus Congestion
☐ Chest Congestion ☐ Fatigue/Malaise ☐ Nausea ☐ Diarrhea ☐ Headache ☐SOB
☐ Other Acute Signs/Symptoms: _____ ☐ **COVID Exposure**
ONSET/ Exposure Date: _____Family/Friends/Coworkers Sick: ☐ Yes ☐ No
Travel History Self/Family/Others: _____
Status of Chronic Conditions: **1**. _____ ☐ Stable ☐ Worse ☐ Better
2._____ ☐ Stable ☐ Worse ☐ Better **3**. _____☐Stable ☐ Worse ☐ Better
==========
☐ **Problem List Reviewed** ☐ **Medications Reviewed** ☐**Allergies**_____
Review of Systems: Experiencing Any Other Complaints Unrelated to HPI? ☐ Yes ☐ No
If yes, which body system and complaint: _____
==========
Vitals per Pt/Historian: ☐ **Temp**_____☐**Weight**_____☐**Height**_____ ☐**BP**_____
Observation/Visualization:

Assessment and Plan

==========

Assessment: **Plan:**

1._____

2._____

3._____

☐ Lab Ordered:_____ ☐ Send to Hospital:_____

☐ Self-Quarantine ☐ See in clinic _____ ☐ Refer to: _____ ☐ Record Sent

☐ Rx Ordered/Refill: _____

Pharmacy Name/Phone_____ ☐ Electronically ☐ Called In

☐ Patient Education Given _____ ☐ Follow-up _____

Signature: _____ Date/Time:_____

MODIFIERS AND BILLING GUIDANCE

- There is specific guidance for billing both telemedicine services for CAHs and Provider-based Rural Health Clinics.
- There are unique modifiers which should be appended to services on both facility and professional claims which denote COVID-related services. These include the -DR, -CS and -95 modifiers. Be sure that your business office and revenue cycle directors are aware of these modifiers.
- There are new ICD-10-CM diagnosis codes for COVID-related episodes of care, screenings, and lab testing.
- Telehealth visits do not have to be limited to COVID-related concerns or diagnoses.

BE WARE OF SCAMS

- Beware of scams and “pop-up” vendors who are selling quick solutions.
- Be prudent in making purchases. Vet the vendor and make sure what they are reputable and that the product or service is something you can use.
- Examples:
  - Remote Patient Monitoring is not separately reimbursed for Rural Health Clinic.
  - There are just a handful of point of care COVID testing equipment that has been given FDA Authorized Emergency Use status.
  - Inferior PPE or lab supplies
  - Vendors offering 90 days free with a hook in the agreement.

IMAGINING HOW THE PHE MAY CHANGE THE TELEHEALTH LANDSCAPE IN THE FUTURE

"Today's ASPE report shows that Medicare providers and beneficiaries rapidly embraced these new opportunities. The meteoric rise of telehealth during the pandemic has not only helped us combat the virus, but also prompted a new conversation around the future of patient-centered care."

– HHS Secretary Azar

ASPE REPORT, JULY 28, 2020

https://aspe.hhs.gov/pdf-report/medicare-beneficiary-use-telehealth

- The report emphasizes fee-for service primary care increases in telehealth. Rural providers—CAHs and RHCs may have lagged behind their FFS counterparts due to barriers and reimbursement.
- However, the statistics indicate that we may never be able to ignore the significance of telemedicine in both urban and rural settings.

HEALTH, ECONOMIC ASSISTANCE, LIABILITY PROTECTION AND SCHOOLS (HEALS) ACT

NRHA statement on HEALS Act on 7/28/2020:

“The bill included **very modest improvements** for rural health care practitioners:

- Minimal relaxation of Medicare Accelerated and Advance Payment Program offset and payback period (Sec. 302);
- ***Provides the HHS Secretary with the authority to extend Medicare telehealth waivers until Dec. 31st, 2021 (Sec. 303);***
- **Codifies a 5-year extension of RHC and FQHC Medicare telehealth flexibilities once the Public Health Emergency (PHE) ends (Sec. 304)**
- Appropriates an additional $25 billion for the Provider Relief (no rural-specific carve out), $225 million for RHCs, and 7.6 billion for CHCs via the Public Health and Social Services Relief Fund.”

HEALS ACT (GOP PHASE 4 PROPOSED) FOR RHCS

Section 304 – Extending Medicare telehealth flexibilities for Federally qualified health centers and rural health clinics This section specifies that the expansion of telehealth in Medicare for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) provided in the Coronavirus Aid, Relief, and Economic Security (CARES) Act **continues for five years beyond the end of the public health emergency**. It enables beneficiaries to receive telehealth from FQHC and RHCs serving as a distant site regardless of where they are located, including in the safety of their own home. This section ensures a sustained period of telehealth access for the many in rural and underserved areas that rely on FQHCs and RHCs for care.

No movement on this act since it was introduced.

However, the reimbursement is proposed at a Fee-For-Service Amount. NARHC and NRHA are proactively engaged in this discussion.

Now that providers and patients have had a taste, it's difficult to imagine the telehealth genie going back into the bottle."

-- CMS Administrator
Seema Verma (07/28/2020)

TRUMP'S CHART MODEL

- https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet
- The Centers for Medicare & Medicaid Services (CMS) Innovation Center is announcing a new Model, the Community Health Access and Rural Transformation (CHART) Model (or the "Model").
- The Centers for Medicare & Medicaid Services (CMS) Innovation Center is announcing a new Model, the Community Health Access and Rural Transformation (CHART) Model (or the "Model").
- Many believe this is a repackaging of older ACO and capitation models.
- More hospital focused than RHC focused, it appears.

PUBLIC HEALTH POLICY V. REIMBURSEMENT METHODOLOGY FOR RURAL PROVIDERS

- Will Reimbursement Policy for Telehealth catch up to other public health initiatives?
- Advocacy is required to close the gap.
- Technology is available through grants and other funding opportunities, but will professional and facility reimbursement catch up?
- Will all the barriers to telehealth for rural hospitals, RHCs and other providers be resolved?
- Will the needs of rural patients be met?
- How do we collaborate to see these needs met?

QUESTIONS OR COMMENT?

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