Telehealth Policy and Regulation

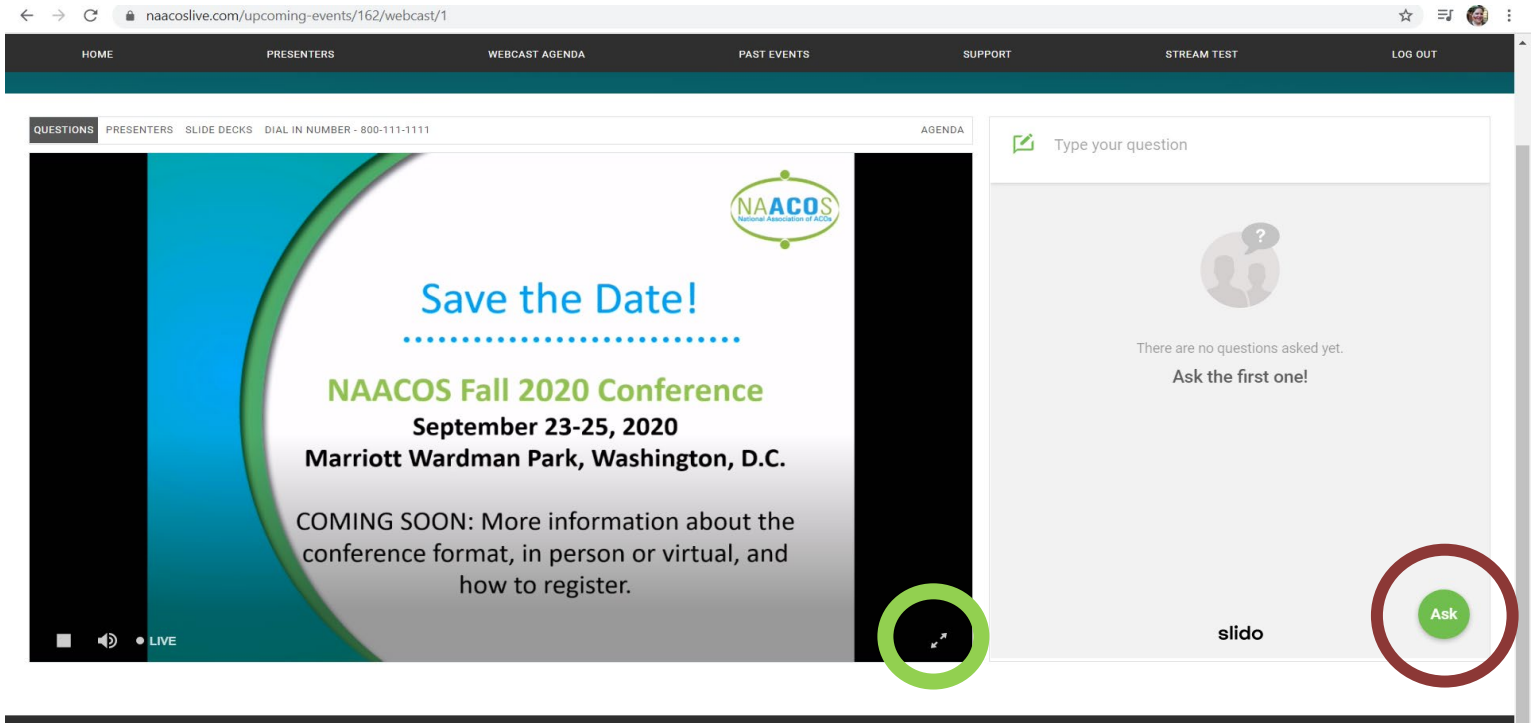
June 2020

Agenda

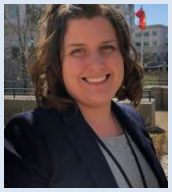
1. Housekeeping
2. Presentation:
   - Policy Updates
   - CMS Presentation
   - Audience Q&A
   - ACO Perspective
   - Audience Q&A

Housekeeping

1. If you would like to make the presentation full screen on your device, hover over the presentation and hit the double arrow button circled in the screen shot below in green.
2. To ask a question, click on the green “ask” button in the bottom right of the questions box. Please see the red circle in the screen shot below.
   - You can type in a question at any time during the presentation.



Speakers

	**David Pittman** Health Policy and Communications Advisor NAACOS
	**Emily Yoder** Analyst Centers for Medicare & Medicaid Services (CMS)
	**Mark Foulke** Executive vice president of transformation value-based care Privia Health
	**Shishir Khetan** Physician/Partner – Internist Privia Health
	**Ron Tamler** Director of digital health implementation Mount Sinai Health System

NAACOS Advocacy and Resources

- NAACOS supported the CONNECT for Health Act of 2019
  - Most recently asked CMS count diagnoses obtained from audio-only telehealth services for risk adjustment purposes
  - Joined letter on the definition of "qualified provider"
  - Another letter supported allowing FQHCs and RHCs access to the emergency declaration waiver
- ACOs benefited from changes included in the CONNECT for Health Act of 2017, which NAACOS also supported
- NAACOS was supportive of wider use of remote patient monitoring in the 2019 Medicare Physician Fee Schedule
- NAACOS asked the FCC to expand eligibility of the COVID-19 Telehealth Program

NAACOS Advocacy and Resources

- BUT WE'RE NOT DONE!
  - NAACOS is seeking clarification on a number of other key topics as it relates to the emergency declaration
- NAACOS would love to see ACOs have wider access to telehealth in non-emergent situations
- A number of COVID-related resources are available on the NAACOS website
  - Developed a telehealth resource to assist ACOs using telehealth services during the COVID-19 crisis
  - Hosted a March 26th webinar on implementing telehealth

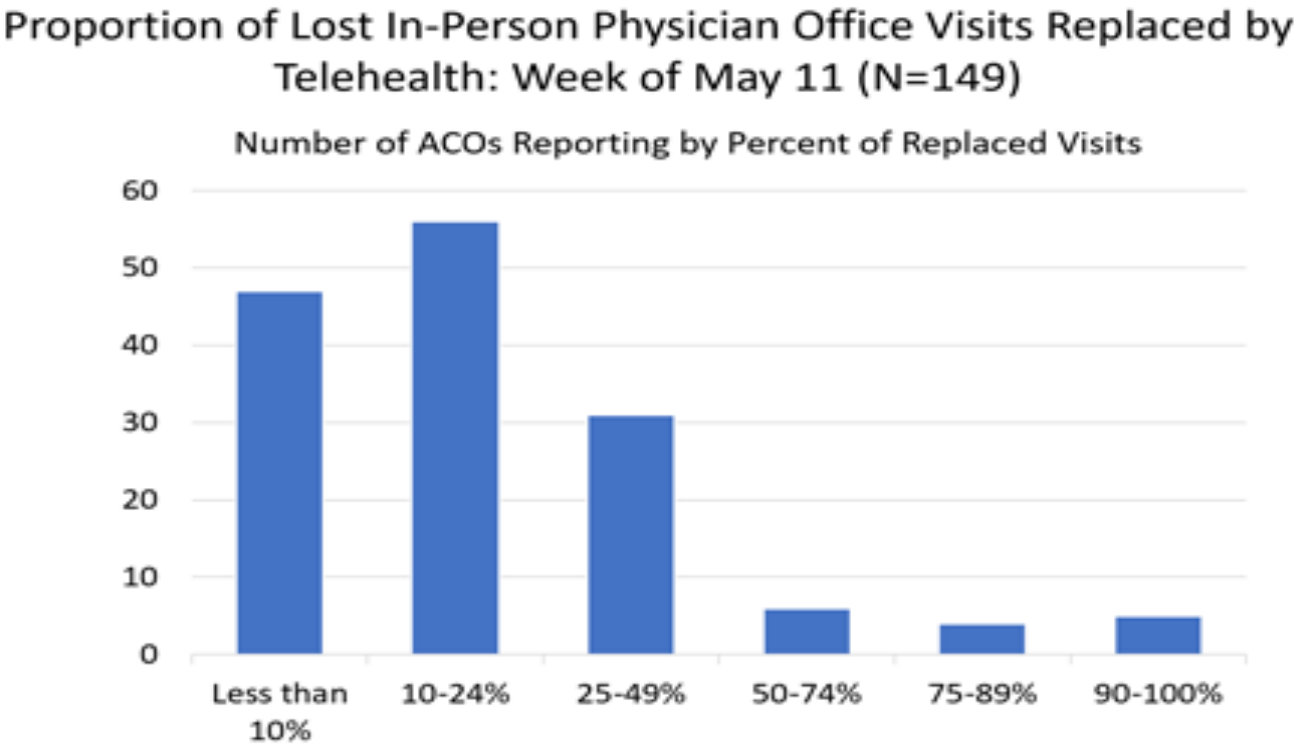
Please email advocacy@naacos.com with questions or feedback

Telehealth

- Congress has given CMS broad authority to waive federal law around telehealth during public health emergencies
  - Significant changes in laws enacted on March 6 and 27
  - CMS released guidance on March 17 and interim final rules released on March 30 and April 30
  - The HHS Inspector General is allowing smartphones and other consumer-grade technology and eliminating cost sharing for telehealth and remote monitoring
  - Medicaid has released guidance
  - State medical and licensing boards have modified requirements
  - FCC has stood up a $200 million program to help adopt telehealth
  - Telehealth.HHS.gov is a great catch-all place for updates!

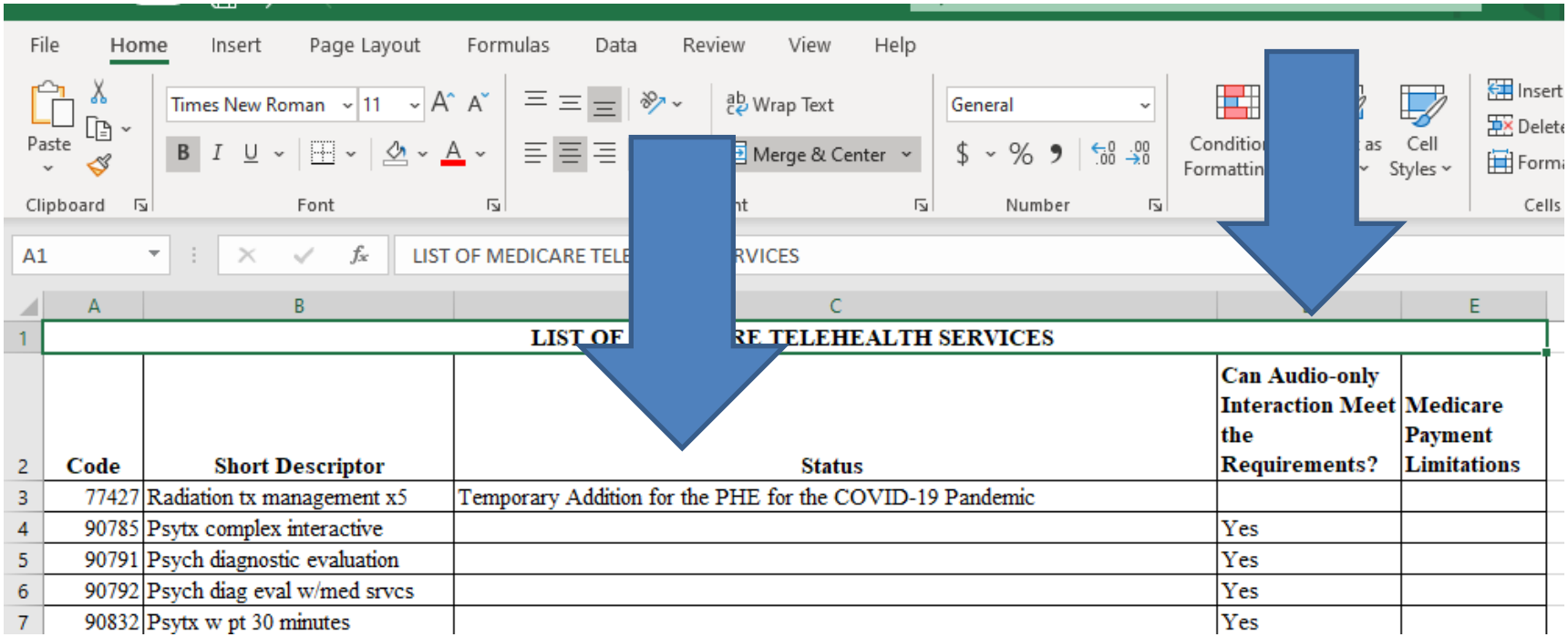
Telehealth

- Results of NAACOS's weekly poll on in-person visits
  - More than half of ACOs replaced 10-24% of lost in-person visits with telehealth
  - About 10% of ACOs replaced at least half of lost in-person visits with telehealth



Telehealth – Audio-only Services

- CMS said it would waive its video requirement for certain telehealth services, allowing them to be delivered through audio-only telephone calls.
  - Telehealth-eligible services are listed at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes



	A	B	C	D	E
1	LIST OF RE TELEHEALTH SERVICES				
2	**Code**	**Short Descriptor**	**Status**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
3	77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic		
4	90785	Psytx complex interactive		Yes	
5	90791	Psych diagnostic evaluation		Yes	
6	90792	Psych diag eval w/med srvcs		Yes	
7	90832	Psytx w pt 30 minutes		Yes	

Telehealth – Annual Wellness Visits

- CMS added AWVs to the list of telehealth-eligible services in 2015 when telehealth patients were largely seen in rural hospitals and health clinics
  - At the time, CMS didn't imagine so many services to be conducted in patients' homes
- CMS says patient-reported vital signs are acceptable for AWVs furnished via telehealth
  - **This was something NAACOS had asked CMS to clarify!**
- CMS is still considering how to address visits when the patient cannot self-report
- More information from CMS in this transcript and FAQs document

Telehealth – Risk Adjustment

- Before the COVID-19 pandemic, CMS didn't acknowledge coding associated with risk adjusting patient populations from telehealth or non-face-to-face services
  - Meant ACOs were harmed from an inability to accurately code patient visits
- In an April 10 memo, CMS instructed Medicare Advantage (MA) organizations and other organizations "to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility."
- **This was something NAACOS had asked CMS to do!**
- Risk scores can only be submitted for video services
  - We're asking this to be expanded to audio-only too

Telehealth – Codes Used in Assignment

- CMS will count certain services delivered through telehealth, virtual check-ins, e-visits, or telephone, toward MSSP assignment effective for the 2020 PY and any other PY that starts during the COVID-19 PHE
  - Will use remote evaluation of patient video/images (G2010), virtual check-ins (G2012), e-visits (99421-99423), and newly covered telephone E/M services (99441-99443) for ACO patient attribution
  - Will count codes newly added to the telehealth list during the PHE toward attribution
  - Starts for services delivered through telehealth beginning March 1
- CMS uses more than 60 CPT and HCPCS codes for MSSP assignment and lists them in §425.400(c)(1)(iv). Of these, 51 appear on CMS's list of services eligible to be delivered through telehealth
- We've sought clarification from CMS on what happens to the other 30 telehealth services previously on Medicare's list of telehealth-eligible services but unmentioned in the April 30 IFC

Telehealth – Hospitals Without Walls

- CMS's Hospital Without Walls initiative enabled hospitals to stand up temporary locations, including patients' home, hotels, and other community facilities
  - CMS is allowing hospitals to screen patients at off-site locations and furnish inpatient and outpatient services at temporary expansion sites
  - More information from CMS

Other Changes:

- Lots of relaxing of supervision requirements and easing of enrollment in Medicare
- Numerous "Patients Over Paperwork" waivers, including those around "Stark" Laws
  - More information from CMS here and here

Telehealth – Other Changes

- Will pay for services at “non-facility” rate
  - Report the POS code as if the service been in-person. CMS finalized CPT telehealth modifier, modifier 95. Claims should not include the POS code “02-Telehealth.”
- Allowed to deliver remote patient monitoring and virtual check-ins to new patients, as well as established patients.
- Will allow face-to-face requirements to be filled via telehealth for hospice and inpatient rehab
- Under the CARES Act that was signed into law on March 27, Congress allowed FQHCs and RHCs the same freedoms to use telehealth in Public Health Emergencies. This includes serving as distant site providers.

Telehealth – Other Changes

- In the March 30 interim final rule, CMS activated six E/M CPT codes that are "telephone-only" (99441-99443)
  - CMS increased payment for these E/M services by cross-walking those codes with analogous office/outpatient (E/M) codes (99212-99214)
  - This increases payments from a range of about $14-$41 to about $46-$110
- CMS is expanding the types of practitioners that may bill for telehealth services, adding physical therapists, occupational therapists, and speech language pathologists.
- CMS will pay for remote patient monitoring for as short as two days.
  - Previously, Medicare would only pay for these services if data is collected for at least 16 days out of a 30-day period. This change is limited to patients who have a suspected or confirmed diagnosis of COVID-19.
- CMS's COVID-19 FAQs on Medicare FFS Billing

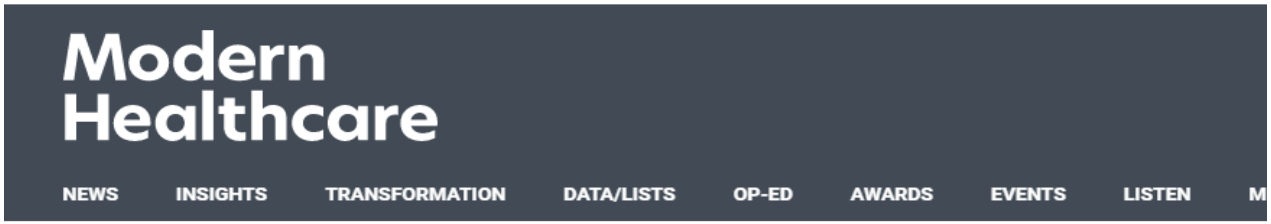
Telehealth – More NAACOS Advocacy

- **Use a 24-month beneficiary assignment window**
  - This will adjust for new telehealth flexibilities and provide a more stable patient population for ACOs
- **Payment for Audio-Only Telephone E/M Services**
  - Continue to add codes to this audio-only list as it is made aware of additional services that can be safely delivered through the telephone and wishes CMS would start with two transitional care management codes (99495-99496)
- **Risk adjusting for audio-only telehealth**
  - We urge CMS to count diagnoses obtained from audio-only telehealth services for risk adjustment purposes
- **Clarification on Codes used in Beneficiary Assignment**
  - Count all codes used for ACO assignment listed in §425.400(c)(1)(iv) even when delivered via telehealth

Please send additional advocacy suggestions to us at:

advocacy@naacos.com

Telehealth – What's Next?



Home › Policy

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No 'simple switch' for telemedicine expansion, HHS senior adviser says

JESSICA KIM COHEN

TWEET SHARE SHARE EMAIL

Telehealth – What's Next?

What happens after COVID-19 ends?

- Most of what CMS is allowing with telehealth goes away when the public health emergency as declared by the HHS secretary ends
  - Can't pay for audio-only services
  - Limitations on where the patient is located and whether they're an established patient or not
- Federal law narrowly defines telehealth as a live video interaction, mostly limited to rural areas
- Two-sided risk ACOs who use prospective assignment *do retain* flexibilities around telehealth regarding where the patient is located
  - This is less than 20% of all MSSP ACOs
- NAACOS is reviewing current waivers and flexibilities, what would be useful to expand, and what needs Congressional action and not

Telehealth – What's Next?

- **DATA ON EVIDENCE AND OUTCOMES ARE NEEDED!**
  - A lack of demonstrated savings has limited Congress and CMS expanding telehealth to more providers
- Data we could use:
  - Overall numbers demonstrating uptake, outcomes, etc.
  - The extent to which telehealth services replaced existing in-person services vs. were new or additional services
  - Health outcomes of beneficiaries using telehealth vs. those who did not
  - The types of telehealth services most commonly used
  - The rural vs. non-rural breakdown of beneficiaries using telehealth
- Anecdotes help too
  - Individual stories of people who received telehealth during COVID and benefitted from it
- NAACOS is planning on researching this as soon as data are available
- ***We want to successfully advocate for the expansion of telehealth post-COVID but in a way that doesn't disadvantage ACOs***

Emily Yoder, CMS

Emily Yoder
Analyst
CMS

Emily Yoder is an analyst in the Division of Practitioner Services (DPS) in the CMS Center for Medicare. She has worked on Medicare Physician Fee Schedule rate setting and policy development since 2015, including primary care, evaluation and management visits, communication technology based services, and Medicare telehealth. She holds graduate degrees from the University of Chicago and, as a Fulbright Fellow, from the University of Warwick, in the United Kingdom.

If only I had known – Hard-won Lessons in Telehealth

Billing and Regulatory information current as of 6/1/2020

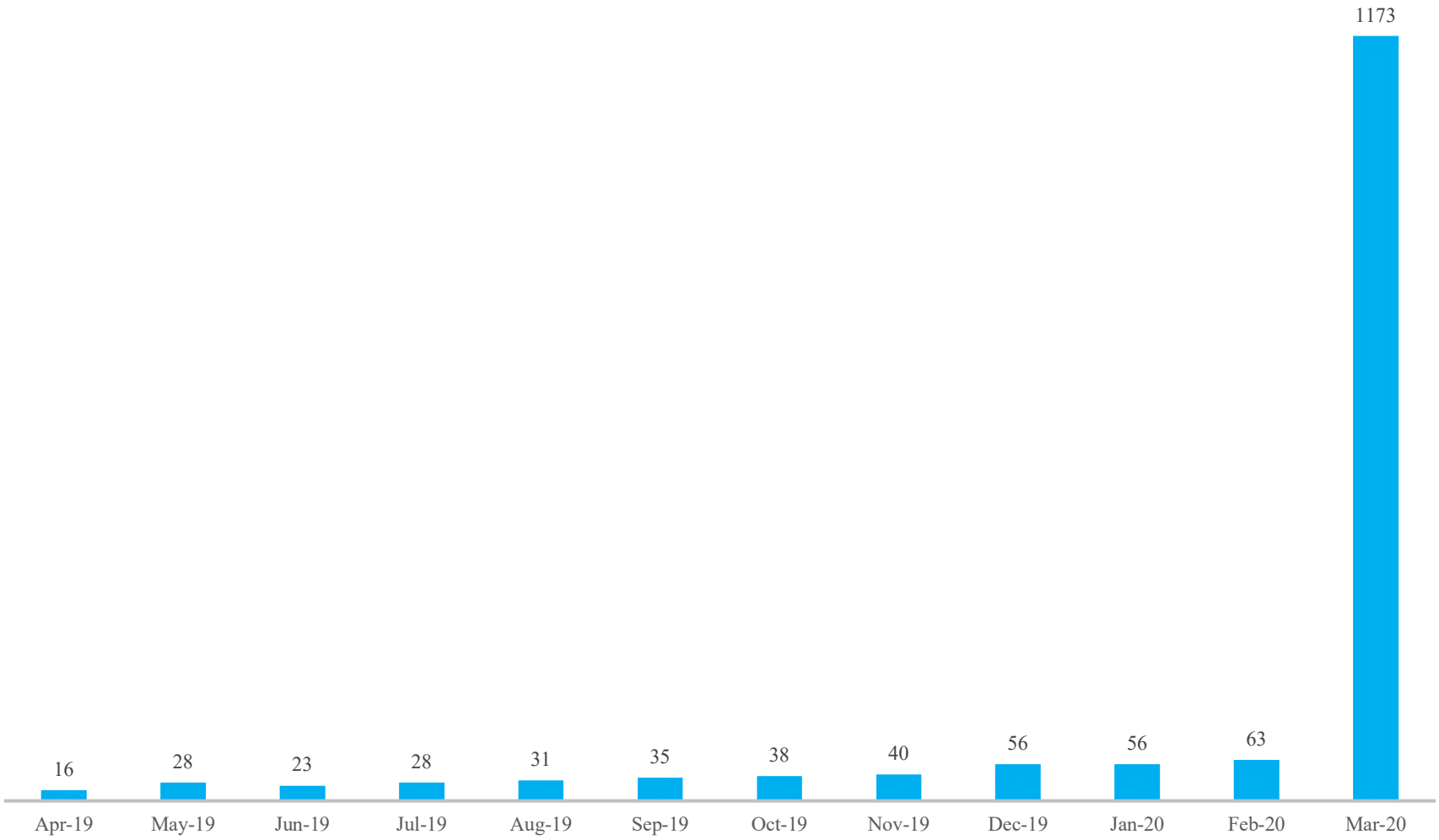
Ronald Tamler, MD, PhD, MBA
Director, Digital Health Implementation
Professor of Medicine,
Icahn School of Medicine at Mount Sinai

Mount Sinai

COVID-19 in NYC – a timeline

- 3/1: first known case in NYC
- 3/2: second case – documented transmission to dozens of people
- 3/8: 11 cases in NYC: NY gov declares state of emergency
- 3/12: Mount Sinai prepares for “war”: Focus on ramping up in-patient and ICU capacity, provider redeployment, Restrictions to in-person ambulatory care
- 3/12-3/23: Over 1,000 Mount Sinai providers have their first video visit ever

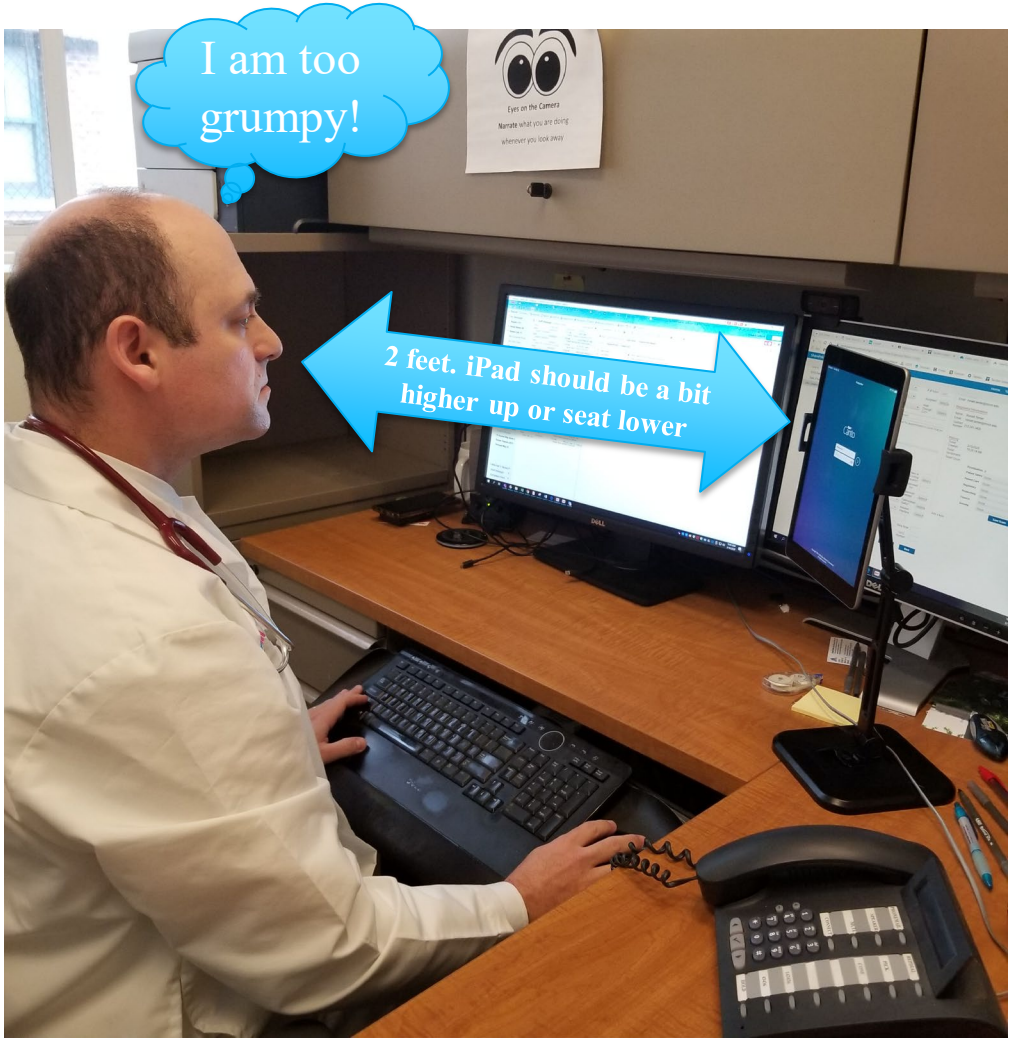
Providers involved with video visits



The Pandemic as Accelerant of Telehealth

- Infection prevention – for patients and providers
- Urgent evaluation and care for acutely ill and recently discharged patients
- Patient engagement for chronic conditions
- Uneven access to specialty care
- Imperative of preventing unnecessary ER visits
- Loosening of regulatory restrictions
  - HIPAA
  - State licensing waivers
  - Reimbursement by CMS for video visits originating from home
  - More generous reimbursements of telephone visits

Set up



- Ensure a clutter-free environment (check behind you). Look professional. **Smile!**
- Ideally, use an attached stand or a freestanding stand (photo).
- Position camera or tablet/phone 2 ft. away at eye-level
- Make sure you have a mirror ready!

For a productive visit: Set yourself up for success

- Your camera device may be *next* to your desktop. This means that whenever you are documenting on your workstation or reviewing data, your patient will feel like you are *looking away* from them
- Acknowledge this by *narrating what you are doing*: “I am looking away from the camera to check your latest labs”
- Translator: Position a phone right next to your camera device and set to speaker. If you are using your phone for video, you will need a second phone.
- Be prepared for video visits to be shorter / more focused than in-person visits, and there is no wait for assessment of vital signs.
- Continuous glucose monitoring transmitted through the cloud can be discussed via telehealth (and billed with modifier 25).
- Send your recommendations (e.g. after visit instructions) to the patient via portal or secure email

For a productive visit: Document exam by inspection

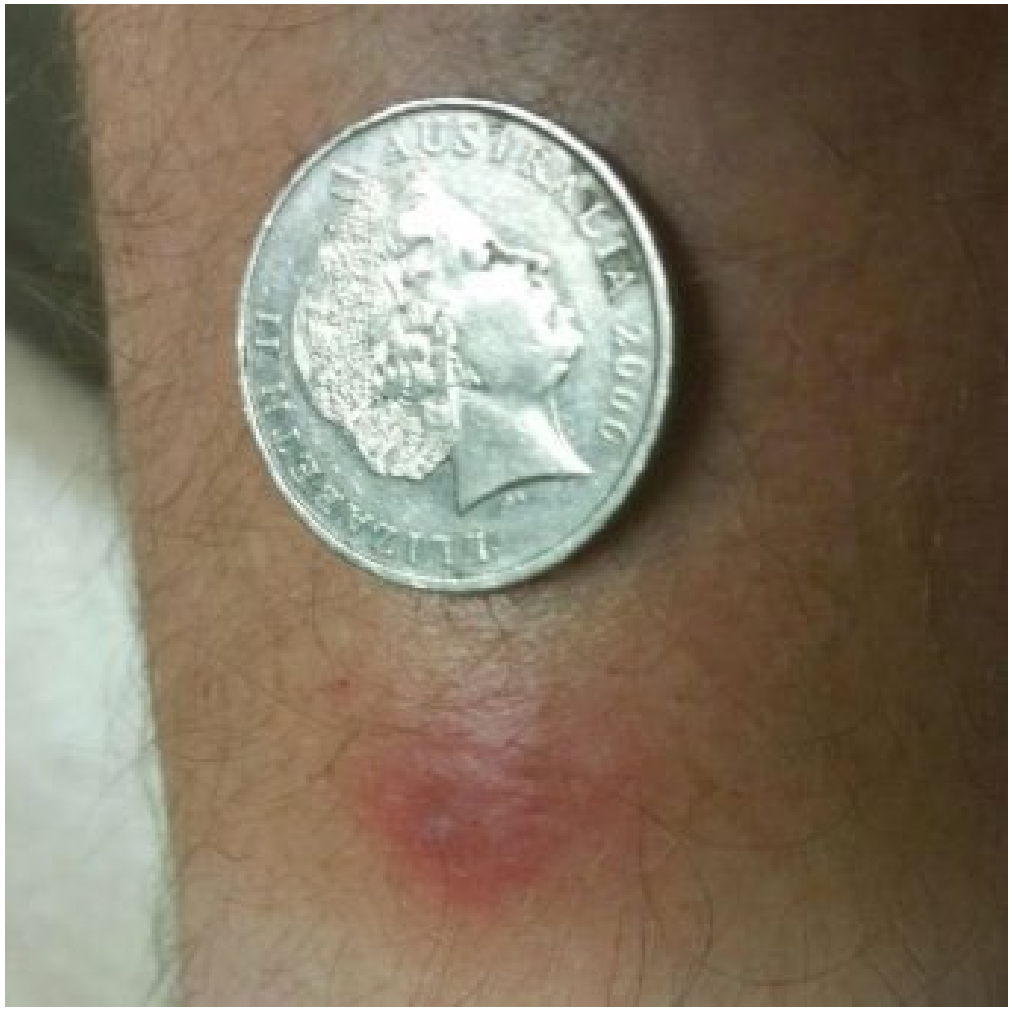
You can document quite a bit by inspection:

- Constitutional: e.g. well-nourished, well-developed, well-appearing, Vitals
- Ears, nose, mouth, throat: e.g. normocephalic, atraumatic, external ears normal by inspection
- Eyes: proptosis, extra-ocular eye movement intact, nl sclerae, conjunctivae not injected
- Neck: visible goiter, range of motion of neck
- Respiratory: comment on increased respiratory effort
- Cardiovascular: patient can palpate PMI
- Chest/Breast: e.g. gynecomastia, symmetry
- Gastrointestinal: e.g. no caput medusae, no tenderness with self-palpation in supine position
- Genitourinary: visual exam of external genitalia
- Musculoskeletal: ROM (active & passive), nails/digits
- Lymphatic: Large lymph nodes can be visible
- Skin: rashes, ulcers, varicose veins
- Psychiatric: anxiety level, affect, memory, tangential conversation
- Neurologic: motor deficits, select cranial nerves (e.g. sticking out tongue). Can the patient hear you? If so, document it!

For a productive visit: Ask the patient to be your assistant

- Have the patient step on their home scale
- Do they have a home bp monitor? Do they know how to obtain their own heart rate? Most patients have their own thermometer
- Patients can depress their own shins to determine extent of edema
- Have the patient position their phone in ways to help you:
  - Foot ulcers: Have the patient put the camera on the floor and show you the bottom of their feet
  - Top of scalp
  - Nape of neck (acanthosis)
  - Close-ups of body areas that trouble them
  - Neurologic and musculoskeletal exams: Have the patients move their extremities for passive and active ROM etc
  - GI: self-palpation under supervision may help document rebound, guarding etc.

When documenting lesions, have the patient place a ruler or a coin nearby



Billing (temporary rules during national emergency)

- You do not need to document a physical exam if you bill by complexity
- Or, you can bill by time spent on the encounter with the patient:
- During this time of national emergency, CMS has temporarily loosened restrictions on time-based billing. You can now also bill by time for services performed for the patient before and after the visit (must be rendered same day as visit!)
- For this kind of billing, *the actual duration of the time spent with the patient is not relevant*. Instead, for **overall care**, document:

Follow-up visits:
≥15 min = level 3 / ≥25 min = level 4 / ≥40 minutes = level 5

New visits (not consults):
≥30 min = level 3 / ≥45 min = level 4 / ≥60 minutes = level 5

- Add CPT **99354** if your visit lasts **≥30 minutes** longer than level 5.
- Add CPT **99354 + 99355** if your visit lasts **≥75 minutes** longer than level 5.

The Pandemic as Accelerant of Unequal Access to Care

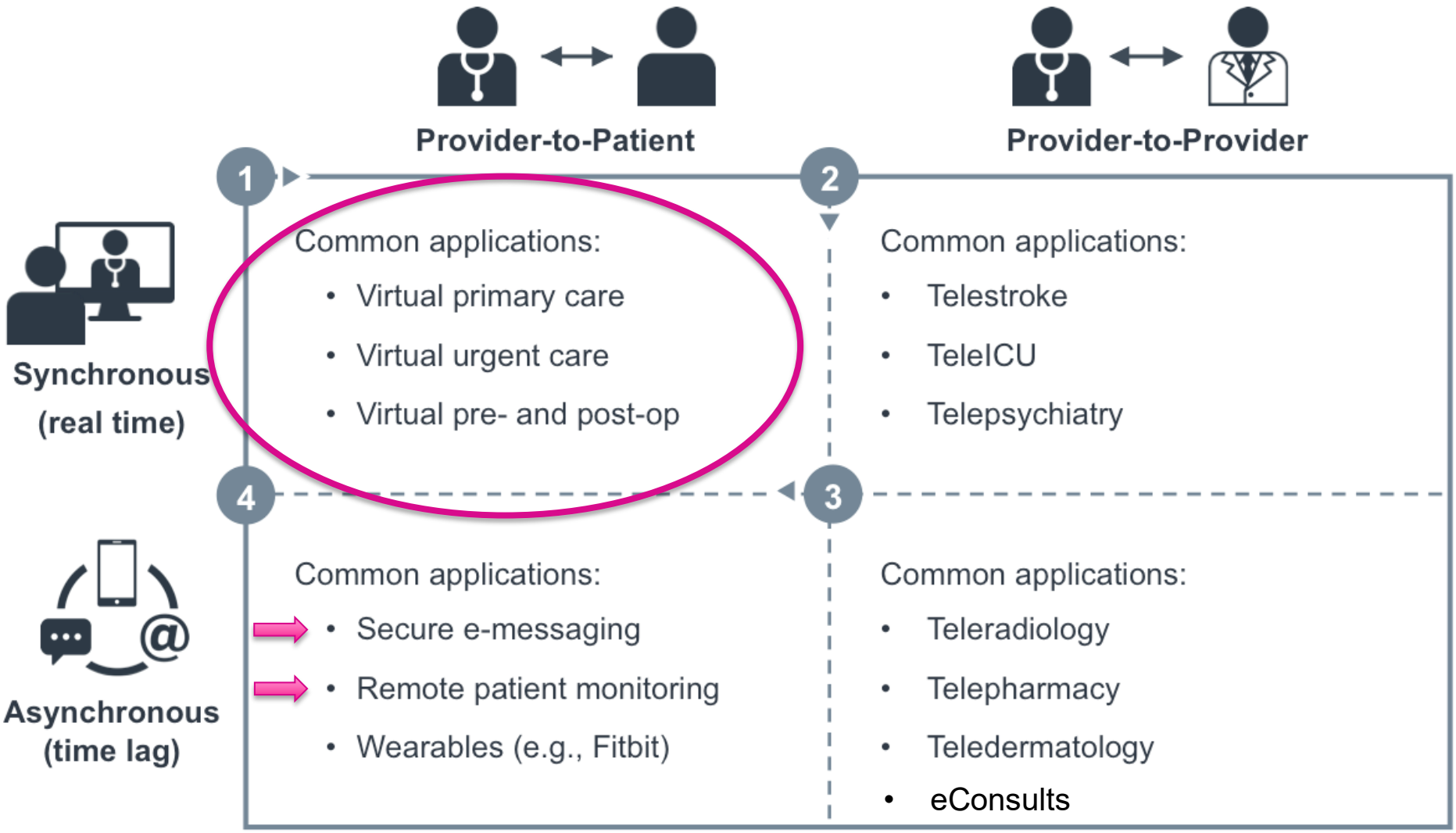
Technological hurdles disenfranchise the most vulnerable patients

- The elderly
- Poor technological literacy
- Poor access to medical care or poor understanding of how to optimize access to care
- No English or poor English
- Socioeconomically disadvantaged: no Wifi, no data plan, no smart phone

⇒ Increased need for “old-fashioned” tools of engagement (e.g. navigators), smart remote patient monitoring, phone visits.

⇒ Despite these challenges, it is possible to provide high-quality care to our most vulnerable patients (see appendix re lab visits and ophthalmology visits)

Telehealth matrix



Phone Check-ins

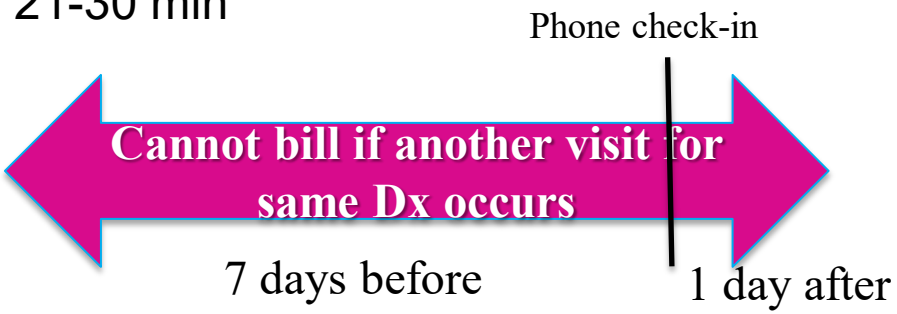
Documentation:

- Patient verbal consent!
- Call can be with established patient, parent or guardian
- Confirmed patient name and DOB
- Call duration: “I spent XX minutes on a telephone call with patient…etc…”
- Document the points of your discussions and any orders or changes to medications or treatment plan
- NEVER for a New Visit

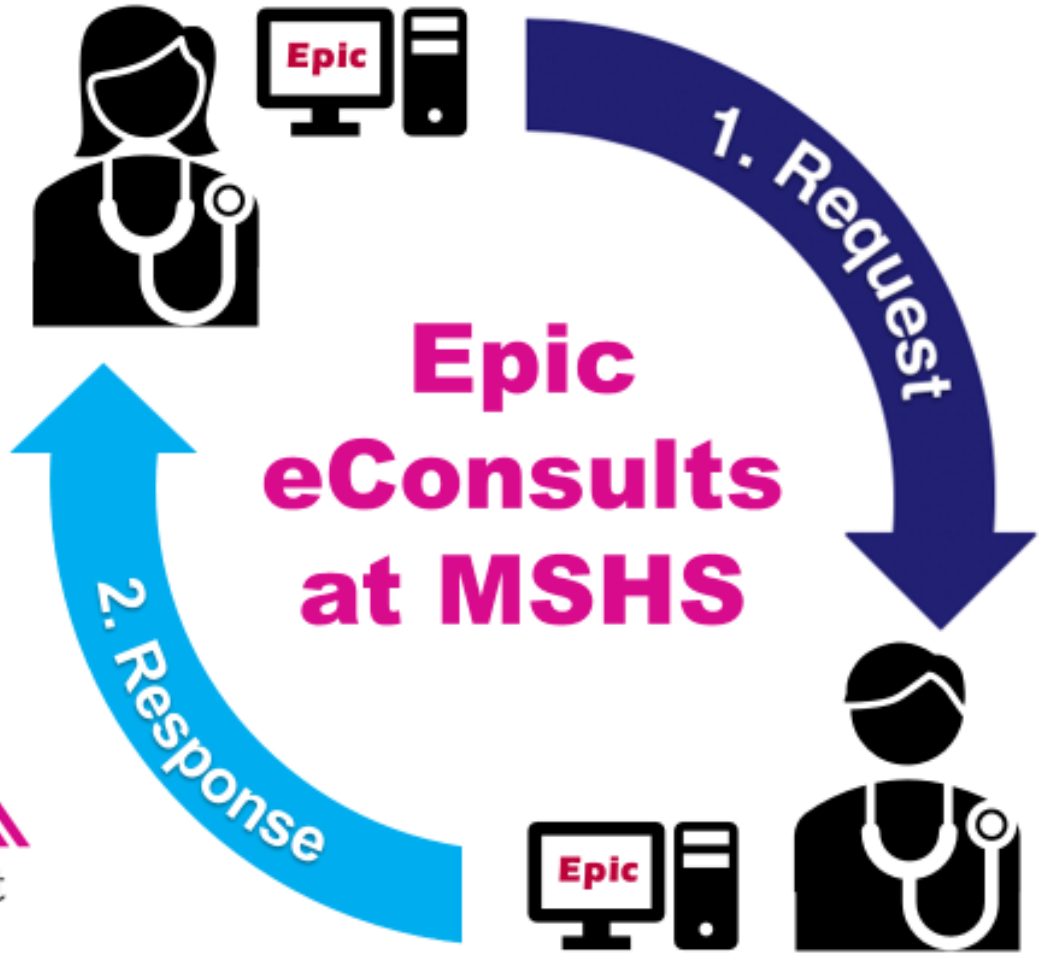
99441: 5-10 min

99442: 11-20 min

99443: 21-30 min



Ambulatory eConsults
(the ultimate in social distancing)



Mount Sinai

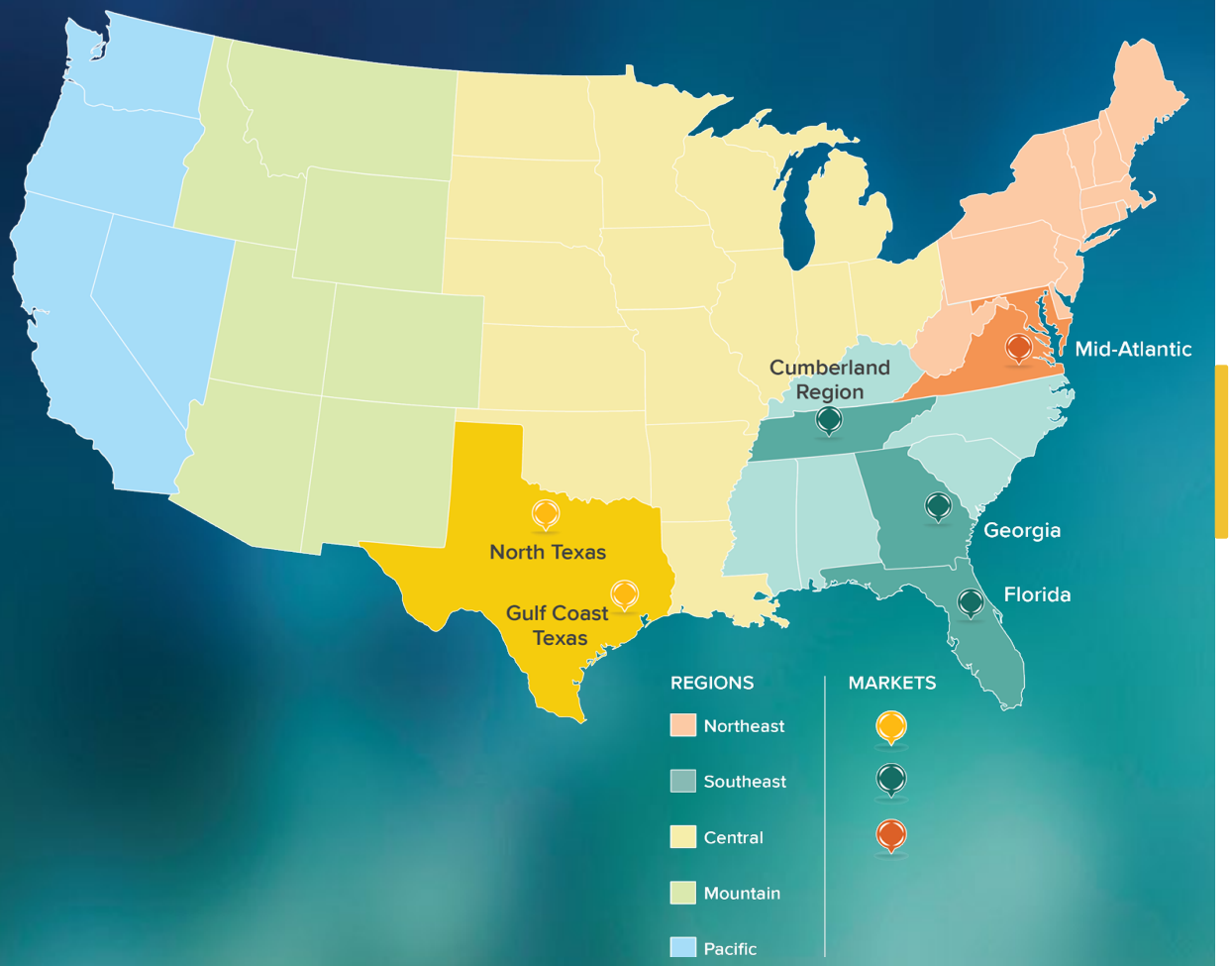
To get started, type "eConsult" in Orders

- 25+ ambulatory specialties available
- Response time < 3 business days
- Receiving specialist may facilitate appointment
- eConsult becomes part of patient's chart
- Eligible non-Epic practices may use ECL
- **Remember**: Document (verbal) patient consent!

Text-2-Chat

Patient engagement via text messages for 3 groups of patients:

- Recently discharged COVID-19 patients (data for 60 days):
  - 31 medical students engaged 1045 New Yorkers in 1228 chats
  - Chatbot engaged 1697 additional people in 2392 chats
- Patients of Mount Sinai Health Partners (value-based care)
- Other patients with chronic disease states (currently live: Oncology, cardiology; in build: Neurology.)
- Patient agrees to receive intermittent text messages. Based on pre-programmed simple algorithms, case is escalated to navigator or stepped up to a video visit with a provider.



PRIVIA HEALTH

2,500+
Providers

658K
Attributed Lives

190K
Medicare Advantage & MSSP Lives

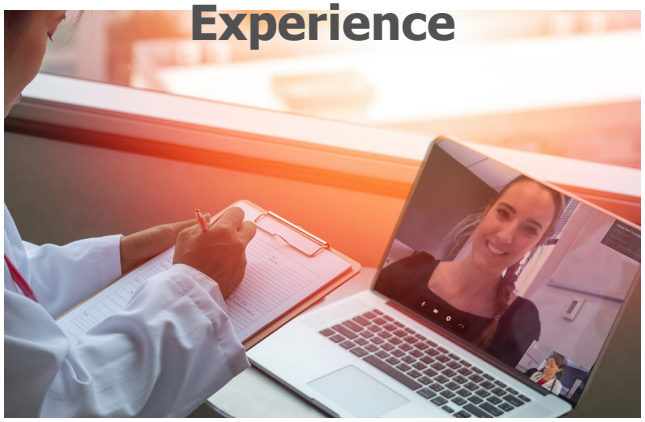
$285M+
Total Savings Generated
(2014 - 2018)

Virtually Integrated Care

Seamless Continuity of Care

Proprietary virtual platform integrated into EHR delivering insight at the point of care

Enhanced Consumer Experience



Meeting our patients when, where and how they want to receive their care with a safe alternative to in-office visits

Maintaining Continuum of Care

Monthly Virtual Visits

140,000

87%
Patients rate as a Great experience

2,000+
Privia providers offering virtual visits

25+
Medical specialties offering virtual visits

Enhancing access by:

- **Engaging specialists for second opinions**
- **Offering remote patient monitoring**
- **Conducting rounding at skilled nursing facilities**
- **Hosting group diabetes education classes**

Healthy at Home Campaign

965,949
Patients Emailed Weekly

31%
Average Email Open Rate
(593,995 Opened)

13%
Email Click Rate
(68,863 Clicks)

376
Patient Outreach Lists Created for Care Centers

10.1%
Increase in Appts During Past Week

9,184
Additional Appts Completed in First 2 Weeks

Future Focus

Reimbursement

Parity Payment w/ In-office visits

Modern face-to-face encounter

Benefit Design

Cost-Sharing to Encourage Use

Medicare Adv. Basic Benefit

Value-Based Contracts

Physician and Patient Engagement

Transactional/Integrated

Questions?

If you do not get a chance to ask your question today, or if you have additional questions in the future, please email advocacy@naacos.com

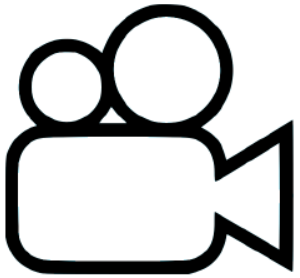
Thank you!

Appendix

Do Not Disturb

Video Visit

In Progress



TURN **OFF** YOUR BLUETOOTH and

Close all other apps!

I will call you on your phone.
Please put me on **speakerphone** when you answer

Lab Tests and Quality Metrics

- You can send a lab slip to the patient or the lab (by snail mail or electronically)
- Many patients are skittish about going in to a lab
  - Most labs do not test COVID PCR, only antibodies (ideally obtained 3 weeks after getting sick)
  - Patient should call ahead and schedule an appointment to ensure social distancing
  - Many labs reserve specific times for vulnerable populations
  - POC testing: CVS® A1c, Labcorp Pixel ® - typically not covered by insurance
- For diabetes patients, consider prescribing:
  - A connected blood glucose meter (Bluetooth or other solution)
  - A continuous glucose monitoring device, e.g. Freestyle® Libre. This is useful for patients on multiple insulin doses per day and
  - A regular blood glucose meter with high-contrast display and low setup requirements , e.g. Contour Next® EZ
- Remarkably, many ophthalmology visits can be virtual