Medicare Advantage Final Rule – Telehealth Expansion

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On Friday, April 5, 2019, the Centers for Medicare & Medicaid Services ("CMS") finalized its fall 2018 proposal to expand coverage of telehealth benefits for Medicare Advantage beneficiaries, creating a new category of benefits entitled "additional telehealth benefits." This brief alert highlights what this development means for healthcare providers, before reviewing the various ways in which Congress and CMS have expanded the telehealth benefits available to Medicare beneficiaries throughout 2018 and 2019.

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Background: Telehealth Coverage by Medicare and Medicare Advantage

Medicare Coverage of Telehealth. Historically, Medicare has only covered telehealth services delivered to Medicare fee-for-service ("FFS") beneficiaries when the services at issue satisfy the requirements for "Medicare telehealth services" set forth in § 1834(m) of the Social Security Act, and codified at 42 U.S.C. § 1395m(m). In order to be eligible for payment, such services must satisfy five requirements: the services must be rendered to a patient in a rural health professional shortage area ("HPSA") or in a county which is not included in a metropolitan statistical area ("MSA") (unless an exception applies); the patient must be located at an approved "originating site;" the services must be delivered through an approved telecommunications system; the service must be rendered by an approved type of provider; and the service provided must be included on CMS' list of approved "Medicare telehealth services," which it updates annually. In the past few years, Congress and CMS have broadened the authority to offer telehealth based services both in Medicare FFS and in Medicare Advantage.

Medicare Advantage Coverage of Telehealth. Medicare Advantage plans have long been able to cover telehealth services beyond the list of "Medicare telehealth services" referenced above. However, such benefits have been covered as "supplemental," not "basic," benefits. "Basic" benefits are covered under Medicare Part A or Part B, as well as Medicare Advantage plans, who are required to cover such benefits. In contrast, "supplemental" benefits are optional benefits that MA plans *may* cover, with CMS's approval, in addition to "basic" benefits.

"Basic" and "supplemental" benefits are also financed differently. "Basic" benefits are included in the list of services that are covered by traditional Medicare; because all Medicare Advantage plans must cover these services, their cost is factored into the development of annual capitated payments that CMS pays to Medicare Advantage plans. "Supplemental" benefits, meanwhile, are other benefits that an MA plan can offer, but which must be paid for either with rebate dollars and/or quality bonus payment dollars, or with supplemental premiums

paid by patients. Because charging or increasing premiums typically results in lower enrollment, plans are often selective offering supplemental benefits that require an additional premium.

What changed? Medicare Advantage plans can now cover telehealth services as "basic" benefits, though they are not *required* to do so. Pursuant to Section 50323 of the Balanced Budget Act of 2018, CMS has created a new category of telehealth services called "additional telehealth benefits." 42 C.F.R. § 422.135. In the rule, which was published in the Federal Register on April 16, 2019 (the "Final Rule"), "additional telehealth benefits" are defined as services "(1) [f]or which benefits are available under Medicare Part B but not payable [as Medicare telehealth services under 42 U.S.C. 1395m(m)] and (2) [t]hat have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange when the physician … or practitioner … providing the service is not at the same location as the enrollee." In other words, "additional telehealth benefits" are services that Medicare covers as "basic benefits," but in the FFS context would not be covered when delivered via telehealth because they do not satisfy the restrictions for coverage of "Medicare telehealth services" listed above. CMS is also requiring MA plans to confirm that a service can be provided via "electronic exchange" for it to be approved as an "additional telehealth benefit." "Electronic exchange" is broadly defined to mean "electronic information and telecommunications technology."

The Final Rule also states that Medicare Advantage plans will continue to be eligible to provide supplemental telehealth benefits, which it names "MA supplemental telehealth benefits," via remote access technologies and/or telemonitoring for services that are not normally covered by Medicare, and are therefore not "additional telehealth benefits." Medicare Advantage plans that choose to offer services via telehealth as "additional telehealth benefits" must ensure that the same services are also available to Medicare Advantage beneficiaries as "in-person" services, and that "additional telehealth benefits" can only be rendered by appropriately credentialed clinicians. Finally, clinicians who provide "additional telehealth benefits" must be contracted (*i.e.*, "in-network") Medicare Advantage providers.

Analysis: Why this Matters for Providers

Typical Medicare reimbursement standards for "Medicare telehealth services" at 42 U.S.C. § 1395m(m) do not apply to "additional telehealth benefits" provided to Medicare Advantage beneficiaries. Thus, "additional telehealth benefits" can be provided to Medicare Advantage enrollees located anywhere geographically (not just rural areas), and in any originating site, including the home. This is a significant departure from traditional Medicare coverage of telehealth benefits, and one that could result in substantially higher utilization of telehealth services by Medicare beneficiaries. However, because they would now be provided as "basic benefits" to Medicare Advantage beneficiaries, all Medicare Advantage requirements, such as provider credentialling and coverage appeals, will apply. As a result, even providers with deep experience in obtaining reimbursement from Medicare for telehealth services may face new requirements in obtaining coverage for "additional telehealth services" provided to Medicare Advantage beneficiaries.

Coverage as "basic" instead of "supplemental" benefits will encourage Medicare Advantage plans to expand telehealth coverage. Allowing Medicare Advantage plans to cover "additional telehealth benefits" as "basic benefits," rather than "supplemental benefits," means that MA plans will be paid for providing these services as part of their capitated payments from CMS. This change gives MA plans greater flexibility in their overall benefit design, particularly if an MA plan determines that its telehealth offerings will reduce its overall costs. Utilization of telehealth services among Medicare beneficiaries is historically quite low – CMS reported that just 90,000 Medicare FFS beneficiaries, or one quarter of one percent of eligible individuals, received services via telehealth in 2016 [1] – a problem that could be remedied in part by this change, particularly as the share of Medicare beneficiaries in MA—now a third–continues to grow. .

Medicare Advantage plans can provide more than "Medicare telehealth services" as "additional telehealth benefits." Historically, the only basic services eligible for Medicare payment when provided via telehealth were those set forth on the list of "Medicare telehealth services" maintained on the CMS website and updated on an annual basis. Under the Final Rule, however, Medicare Advantage plans are authorized to use telehealth to provide *any* service that Medicare typically covers, as long as the plan determines that it is clinically appropriate for the service to be provided via electronic exchange.

The Bigger Picture: Medicare Coverage of Telehealth

It is important to note that the changes introduced in the Final Rule in Medicare Advantage do not alter the status quo regarding Medicare FFS reimbursement of telehealth; conversely, the restrictions on Medicare reimbursement of "Medicare telehealth services" set forth at 42 U.S.C. § 1395m(m) (and summarized above) remain in effect for all services *except* those provided to Medicare Advantage enrollees. However, in the last few years, CMS has taken steps to embrace telehealth outside of the Medicare Advantage context, sometimes using creative solutions to expand coverage in spite of the limitations on Medicare telehealth services set forth in 42 U.S.C. § 1395m(m).

In the 2019 Physician Fee Schedule, CMS created a new set of services called "communication technology based services." By defining them as something other than "Medicare telehealth services," CMS ensured that these benefits are *not* subject to the requirements set forth at 42 U.S.C. § 1395m(m). As a result, all Medicare beneficiaries – both FFS and Medicare Advantage patients – can receive "virtual check-ins," "store-and-forward services," and "inter-professional consults" that do not satisfy the requirements for "Medicare telehealth services" at 42 U.S.C. § 1395m(m). In other words, these services can be provided to patients whether or not they are located in a rural area, and from any originating site, including the home.

Congress has also expanded Medicare beneficiaries' access to telehealth in 2018 and 2019. The Bipartisan Budget Act of 2018 added the home as an approved originating site for certain monthly services that patients with end stage renal disease require, added mobile stroke units as an approved originating site for telestroke services, and established a telehealth waiver eliminating the restrictions on "Medicare telehealth services" for patients enrolled in two-sided accountable care organizations ("ACOs") for agreement periods commencing on or after July 1, 2019. Congress also took action through the SUPPORT for Patients and Communities Act, adding the home as an approved originating site for Medicare patients receiving substance use disorder ("SUD") treatment, and requiring the DEA to establish a telemedicine registration process by October 2019 which will enable providers to prescribe controlled substances via telehealth without first examining a patient in-person (This change will also expand telehealth access for non-Medicare patients).

Together with the forthcoming changes to Medicare Advantage coverage of telehealth set forth above, these changes suggest that CMS and Congress are both getting more comfortable with Medicare beneficiaries receiving telehealth services, and are chipping away at the restrictions set forth in 42 U.S.C. § 1395m(m) where appropriate. At the same time, as payment for telehealth to providers and plans grows, so will attention to program integrity and payment safeguards. In 2018 and 2019, Medicare, state Medicaid programs, and the Department of Justice have all demonstrated that they are applying greater scrutiny to telehealth programs. Therefore, legal and regulatory compliance is critically important in this rapidly developing space.

[1] Centers for Medicare & Medicaid Services, "Information on Medicare Telehealth," Nov. 15, 2018.

Hooper, Lundy & Bookman will continue monitoring the developing changes to Medicare's telehealth landscape. For further information, please contact Jeremy Sherer in Boston, Marty Corry in Washington, D.C., or Stephanie Gross in San Francisco.

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