



The Reality of the New Telehealth Authority in Medicare

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On Friday, Congress passed, and the President signed the *Coronavirus Preparedness and Response Supplemental Appropriations Act*. This legislation gave the Secretary of Health and Human Services (HHS) the authority to waive telehealth restrictions in Medicare, thereby creating a new pathway for some seniors to get care during this crisis. However, there are practical and operational challenges that may make the reality for seniors and medical practitioners different from the vision of the legislation.

Given the statutory restrictions that prevent medical practitioners from being paid by Medicare for using telehealth, the bill is a step forward in a time when we need many tools to address the spread of the virus, particularly for seniors. Today, practitioners can only get paid if a senior is physically present in a facility that is located in a rural area. The defined boundaries of a rural area are re-calculated every year, and a patient's home does not count as a facility. That means that seniors must travel to medical institutions for telehealth visits, a situation that public health officials say patients should avoid during the Coronavirus outbreak.

The authority that Congress granted to the Secretary would allow Secretary Azar to lift the Medicare payment restrictions so patients could have telehealth visits with their doctors in their homes during the outbreak as long as a public health emergency has been declared. This is common sense public policy.

Operationally, there are challenges that may limit the number of seniors who can take advantage of the new tool, should the Secretary use his new authority.

1. Definition of "Qualified Provider"

To qualify as a medical provider who can receive payment for a telehealth visit under the new authority, the provider must have a previous relationship with the patient. Specifically, they must have provided a service within the last three years that was paid for by Medicare. If the provider seeing that patient is from some other part of the hospital or physician group, the provider must under the same Tax ID Number (TIN) as the provider who has the established relationship.

While the intent was clearly to leverage existing patient-provider relationships, the provision, as written, makes it incredibly difficult to offer covered telehealth visits in Medicare. First, hospitals and large provider offices often contract with vendors to provide telehealth services under their care umbrella (the ability to bring in outside help will become particularly important if the crisis worsens). Those vendors are not often credentialed into the hospital EMR or claims database, making it difficult to determine if there has been a relationship in the past three years. Second, virtual visits generally start with a doctor or medical practitioner. If the hospital doesn't work through a vendor, under this language, the medical practitioner would have to start a patient visit with a look-back at claims data for the past three years to determine eligibility. That's not the job of a clinician, but if they don't do it and claim Medicare reimbursement, they risk incurring a false claim. Finally, if there has been a covered claim within the hospital or provider group in the past three years, but under a different TIN, Medicare will not cover the telehealth visit. Hospitals can have many TIN numbers. For example, if the patient had a visit in the



radiology department in the past three years, it wouldn't count toward eligibility if the patient is having a telehealth visit with the hospital's primary care medical group.

2. *Newly-eligible Medicare patients not eligible*

Congress drafted the language in a way that makes the previous relationship with the patient a Medicare relationship. The eligibility for coverage of the visit is triggered by the patient having received care through the provider while the patient is on Medicare. So, if you were 64 years old last year with commercial insurance and you saw your doctor, that visit wouldn't count toward the previous relationship requirement because it wasn't covered by Medicare.

3. *Giving telehealth visits away for free to Medicare patients*

If a hospital system finds the hurdles to billing Medicare for telehealth during this public health emergency too high, they cannot simply give the Medicare patient the visit for free. Hospitals around the country are contemplating providing Coronavirus-related care at no cost. However, hospitals cannot simply give the Medicare patient the visit for free. CMS could consider this an inducement under Medicare rules. Unless those rules are waived, the visit could be considered a violation of anti-kickback rules. We should commend the Administration on their work to reduce anti-kickback barriers to value-based care. Perhaps they can waive the rules during this crisis.

In sum, great effort by Congress to cover telehealth during this outbreak, but more needs to be done to ensure that it can practically be implemented.