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ADDITIONAL TELEHEALTH BENEFITS COMING TO MEDICARE ADVANTAGE IN 2020

Thanks to a final rule issued by the Centers for Medicare & Medicaid Services ("CMS") this spring, Medicare Advantage ("MA") plans will now be able to offer additional telehealth benefits to enrollees starting in 2020. Historically, MA plans have been able to offer more telehealth services compared to Original Medicare as part of their supplemental benefits. The final rule, which allows MA plans to provide "additional telehealth benefits" to enrollees and treat them as basic benefits, is expected to provide MA enrollees with greater access to telehealth services and create additional opportunities for providers.

BACKGROUND

MA plans are currently required to provide certain telehealth services to enrollees as basic benefits paid through the capitation rate. Telehealth services required to be provided as basic benefits are generally limited to services covered by Medicare Part B that are furnished by a physician or other specified practitioner[1] to a Medicare beneficiary via an interactive telecommunications system. The form of telecommunications system must permit a two-way, real-time interactive communication and excludes store-and-forward technologies other than for services provided as part of a federal telemedicine demonstration program.[2] In addition, the beneficiary must be located at an eligible originating site, which is limited both to specific geographic locations and type of care settings.[3] Currently, MA plans have the option to provide other telehealth services as supplemental benefits funded through the use of rebate dollars or supplemental premiums paid by enrollees.

SUMMARY OF CHANGES

Beginning in plan year 2020, MA plans may now elect to offer certain additional telehealth benefits as basic benefits rather than as supplemental benefits. Specifically, MA plans will be able to treat as basic benefits those benefits that are available under Medicare Part B that 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 in the same location as the enrollee ("additional telehealth benefits"). Changing the form of funding to be part of the capitation rate, rather than through rebate dollars or supplemental premiums, makes it more likely that MA plans will offer, and MA enrollees will have access to, additional telehealth benefits. The ability to offer additional telehealth benefits is optional, as MA plans will not be required to offer additional telehealth benefits to their enrollees.

Additional Telehealth Benefits Defined

To qualify as an additional telehealth benefit, the benefit must be available under Medicare Part B and identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic information and telecommunications technology. CMS explained in the final rule that MA plans are in the best position to identify telehealth benefits that are clinically appropriate to furnish through electronic exchange but that an MA plan's determination will require the MA plan to consult with its contracted network providers as part of the MA plan's medical policy.[4]

Forms of Electronic Exchange

Additional telehealth benefits must be provided through electronic exchange, which is defined as electronic information and telecommunications technology. CMS provided examples of electronic information and telecommunications technology in the final rule to include secure messaging, store and forward technologies, telephone, videoconferencing, other internet-enabled technologies and other evolving technologies as appropriate for non-face-to-face communication. However, CMS made it clear that the list of examples is not intended to be a comprehensive list of permitted technologies but rather is intended to allow for flexibility needed based on the service being offered and to allow for technological advances that may develop in the future.

Requirements to Cover Additional Telehealth Benefits as Basic Benefits

MA plans may treat additional telehealth benefits as basic benefits if the following requirements are met:

1. *In-Person Services upon Request*. The MA plan must provide in-person access to the specified Part B service upon the request of the enrollee.

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2. *Use of Contract Providers*. The MA plan must provide additional telehealth benefits through contracted providers. Preferred provider organizations, which are otherwise required to furnish all services both in-network and out-of-network, will not be exempt from this requirement and will be required to use contracted providers to provide additional telehealth benefits.

3. *Disclosure of the Availability of In-Person Services*. The MA plan must advise an enrollee that he or she may receive the specified Part B service through an in-person visit or through electronic exchange.

4. *Provider Selection and Credentialing*. The MA plan must comply with the provider selection and credentialing requirements at 42 C.F.R. § 422.204. The MA plan must also, through its contract with the provider, ensure that the provider meet and comply with applicable state licensing requirements and other applicable state law in which the enrollee is located and is receiving the service. This is no small task. Many states have yet to comprehensively address the requirements attendant to the practice of telemedicine, giving rise to a lack of clarity regarding permissible practices. There also continues to be significant variation among the states, particularly with respect to the permissible uses/modalities of telemedicine, prescription of controlled and non-controlled substances, practitioner/patient relationships, consent requirements and other related practice considerations.

5. *Information Provided to CMS upon Request*. The MA plan must make information about coverage of additional telehealth benefits available to CMS upon request, including statistics on use or cost, the manner or method of electronic exchange, evaluations of effectiveness and demonstration of compliance with the requirements of providing additional telehealth benefits.

6. *Differential Cost Sharing*. The regulations permit an MA plan offering additional telehealth benefits to maintain different cost sharing for services furnished through an in-person visit and through electronic exchange. CMS made it clear that the primary purpose of any differential in cost sharing must parallel the actual cost of administering the service and not steer enrollees or inhibit access.

OPEN ISSUES

CMS did not address a number of issues in the final rule, indicating that future sub-regulatory guidance would be provided. These issues include the following:

1. *Advising Enrollees of Availability of In-Person Services*. An MA plan enrollee must have the choice to receive a service offered as an additional telehealth benefit service through an in-person visit or as an additional telehealth benefit. The final rule requires that MA plans advise enrollees of the right to choose the specified Part B service through an in-person visit or electronic exchange. CMS intends to issue sub-regulatory guidance regarding this requirement.

2. *Provider Directories*. An MA plan must maintain an accurate provider directory of active, contracted providers. CMS proposed, but did not finalize, a requirement that an MA plan ensure its provider directory identify those providers who offer services for additional telehealth benefits and in-person visits or offer services exclusively for additional telehealth benefits. Rather, CMS intends to address any provider directory requirements in sub-regulatory guidance, including model language for the directory.

3. *Evidence of Coverage*. An MA plan is required to disclose the benefits offered under the plan annually through the MA plan's Evidence of Coverage ("EOC"). CMS proposed, but did not finalize, a requirement that an MA plan advise enrollees through the EOC that the specified Part B service(s) can be received through an in-person visit or through electronic exchange. CMS intends to issue guidance as to how an MA plan is to address additional telehealth benefits in the EOC and the Annual Notice of Change, including model language for the EOC.

4. *MA Network Adequacy Policies*. An MA plan is required to meet network adequacy criteria to show that the plan maintains a network of appropriate providers sufficient to provide adequate access to covered services to meet the needs of the population served. The final rule did not address the potential impact that MA additional telehealth benefits will have on network adequacy policies, if any. CMS intends to update sub-regulatory guidance to reflect any changes in policy.

PRACTICAL TAKEAWAYS

Expanding access to telehealth services for MA beneficiaries is another example of CMS's efforts to modernize the MA and Part D programs and improve quality among MA plans. As payment for the delivery of telehealth services continues to evolve, additional opportunities for providers and health plans will be created. To capitalize on these opportunities, providers should familiarize themselves with applicable federal and state laws to ensure they know the extent of covered services and are appropriately paid for these services. These new opportunities also create additional flexibility and incentives for health plans to explore new relationships with telehealth providers.

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We will continue to monitor developments in this area. In the meantime, if you have any questions or would like additional information about this topic, please contact:

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[1] Specified practitioners include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists and registered dietitians and nutrition professionals. 42 U.S.C. § 1395m(m)(1); 42 U.S.C. § 1395u(b)(18)(C).

[2] An interactive communications system requires, at a minimum, equipment that permits two-way, real-time interactive communication between the beneficiary and the practitioner and excludes telephones, fax machines and e-mail. 42 C.F.R. § 410.78(a)(3). The statute does provide an exception for federal telemedicine demonstration programs conducted in Alaska or Hawaii, in which case providing for the asynchronous transmission of health care information is permitted.

[3] Eligible originating sites are limited to: (i) the office of a physician or practitioner, (ii) a critical access hospital, (iii) a rural health clinic, (iv) a Federally Qualified Health Center, (v) a hospital, (vi) a hospital-based or critical access hospital-based rental dialysis center, (vii) a skilled nursing facility or (viii) a community mental health center; provided that the site must be located (a) in an area designated as a rural health professional shortage area, (b) in a county that is not included in a Metropolitan Statistical Area or (c) from an entity that participates in a federal telemedicine demonstration project approved by the Secretary of Health and Human Services as of December 31, 2000. A notable exclusion from an eligible originating site is a beneficiary's home. 42 U.S.C. § 1395m(m)(4)(C).

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