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COMMENTARY

Telehealth Policies Impacting Federally Qualified Health Centers in Face of COVID-19

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Rural Federally Qualified Health Centers in frontier northern California are getting impacted in taking steps in fighting and mitigating against COVID-19. One of the bolder steps being transition of medical and mental health services from in-person visits to telephone encounters, along with heavy reliability and shift to telehealth to prevent and mitigate COVID-19. The current state and federal policies surrounding telehealth in relation to coronavirus cases and fiscal reimbursement have their pros and cons.

As more cases of COVID-19 emerge throughout the United States, the Centers for Disease Control (CDC) is encouraging communities, including first responders, healthcare providers, and health systems to take advantage of the benefits offered by telehealth tools to direct patients to the right level of care. One of the most obvious benefits telehealth offers the healthcare delivery system in dealing with this pandemic includes keeping patients with less severe cases at home with access to their provider through live video, telephone, or asynchronous secure messages. This reduces the risk of the patient further spreading the disease to others. However, there are a number of barriers that prevent the widespread use of telehealth generally, which become exceedingly apparent during an emergency situation. This includes barriers to reimbursement when the patient is located in their home, limitations in the modality (live video, store-and-forward, remote patient monitoring) that can be used, and state licensing laws that require providers be licensed in the state in which the patient is physically located.

California in 2019 passed a bill that removed barriers to Medicaid reimbursement for community health clinics (CHCs/FQHCs) during states of emergency for telephonic services, and when services are provided in the beneficiary's home. In the midst of Covid-19, Congress brought forward and the President signed HR 6074, the "Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020." Among the bill's provisions is the section titled Telehealth Services During Certain Emergency Periods, which would give the Secretary authority to waive or modify the application of some of Medicare's telehealth restrictions in any emergency area.

Pros and Cons: Coronavirus and Telehealth – The New Federal Law & the Policy Hurdles

On March 6, 2020, the President signed HB 6074, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. In addition to the $8 billion appropriated to address coronavirus, HB 6074 grants certain powers to the Secretary of Health and Human Services to waive some of the telehealth limitations in Medicare. As many have noted in recent days, telehealth can be an effective tool in helping to address the current health crisis, especially in rural clinics. However, existing policy barriers limit when, where and how it can be used. By providing the Secretary with the ability to waive some of those limitations, it does allow telehealth to be used more widely. But HB 6074 only addresses the barriers in Medicare. Millions of Americans do not receive their health care through the Medicare program and restrictions on the use of telehealth still exist for them.

What Does HB 6074 Say?

Currently in Medicare, telehealth-delivered services need to take place in specifically designated geographical areas, at a specific type of site, be provided by a certain type of

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provider, using essentially only live video, and only certain services are reimbursed. HB 6074 allows the Secretary to only waive the geographic and site restrictions. While definitely a major change, especially the site limitation that would make the home an eligible site—very important as many people are in self-quarantine—there still remain limits on who the provider can be and what service can be provided via telehealth. Certain providers who could be utilizing telehealth to treat patients exposed to or having coronavirus would still not qualify, such as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). FQHCs and RHCs under Medicare can only act as originating sites; they cannot act as a distant site provider and HB 6074 does not change that.

HB 6074 notes that the provider must be a "qualified provider" which is a physician or practitioner as defined under the telehealth section for Medicare who:

> *furnished to such individual an item or service for which payment was made under title XVIII during the 3-year period ending on the date such telehealth service was furnished; or*
>
> *is in the same practice (as determined by tax identification number) of a physician or practitioner (as so defined) who furnished such an item or service to such individual during such period.*

In Medicare, these additional requirements for a "qualified provider" do not currently exist in telehealth policy. These additional requirements appear to only apply to services related to treatment for coronavirus.

Another change HB 6074 makes from what is seen in the typical telehealth policies for Medicare is that it will lift the limitation on phone use if, "such telephone has audio and video capabilities that are used for two-way, real-time interactive communications," which essentially means a smartphone can be used to engage with a provider. The waivers in HB 6074 appear to apply to all eligible services delivered via telehealth and not only the ones related to coronavirus. However, it is not clear if that is the intent. We will have to wait to see how the Centers for Medicare & Medicaid Services (CMS) implements this new policy.

What About the States?

Changes in the telehealth policy for Medicare will only cover some of the American population. States and state Medicaid programs have their own limitations on how telehealth can be used. Depending on the state and who is covering the health service, telehealth may be limited in how it can be used. For example, many state Medicaid programs do not allow the home to be an eligible originating site. For treating those who are quarantined at home during this crisis, telehealth would not be an option if they are covered by one of those Medicaid programs that do not allow the home to be an originating site. There are some state Medicaid programs that also limit the types of specialties for which telehealth can be used. For example, Pennsylvania Medicaid limits the use of telehealth to only mental and behavioral health services.

One would think that if a state of emergency is declared in a state, then surely these currently existing telehealth limitations could be waived. However, very few states have in statute utilization of telehealth when a state of emergency is declared. California is one of the few states with actual law having recently passed, AB 1494, which removed barriers to Medicaid reimbursement for community health clinics (CHCs)/FQHCs during states of emergency for telephonic services, and when services are provided in the beneficiary's home. Depending on how broad the policies are, other states may have to pass legislation in order to allow telehealth to be used more extensively.

Private payer policies can be even more limiting on the use of telehealth. Some states do not have requirements on what health plans are required to cover if a service is delivered via telehealth. So, there is a possibility that if a person has coverage through their employer, a service via telehealth may not be covered. All of the aforementioned issues relate to telehealth reimbursement. For the most part, there is nothing that prohibits a person from receiving services via telehealth (provided all other laws such as licensing, privacy, etc., are met). However, if insurance covers it or an individual will have to pay for it out-of-pocket is another story. As the situation and landscape constantly change with each new piece of information, we should ensure our health care providers have access to every tool available to care for patients safely and effectively.

Insurers Expand Telehealth Coverage in Wake of Coronavirus

On Friday, March 6, 2020, CVS announced that it is providing coronavirus diagnostic testing and telemedicine visits with no out-of-pocket costs or cost sharing for Aetna members. This means no co-pays for telemedicine visits for 90 days. They will also waive copays for the testing kit for patients who meet the CDC's guidelines for testing. Additionally, Aetna is extending its Medicare advantage virtual evaluation and monitoring visit benefit to all Aetna Commercial members as a fully covered benefit. Other insurers have taken similar measures, with

Blue Cross Blue Shield announcing that it will allow for enhanced telehealth and other clinical support, and encourage the use of virtual care. The company may be implementing some impactful telehealth policy expansions.

After a meeting with the CEOs of health insurance companies including UnitedHealth Group, Anthem, Cigna, Humana, Aetna, and the Blue Cross Blue Shield Association on March 10, Vice President Mike Pence said the insurers had "agreed to cover telemedicine to allow people to speak to their doctors remotely about the coronavirus."

Rural clinics and FQHCs in the United States provide primary health care to the most vulnerable people of society. Patients constitute those 65 years and above, young children, adults, and women. Most of them lack basic resources, may not have jobs, are low income, on Medicaid with high income inequity and high health care disparity. It is vital for federal and state government via CMS to address policy implementation issues on widening the scope of telehealth when the nation faces an emergency situation like COVID-19. Though the government is making policy changes, the type of services, locations, and conditions on how such telehealth services can be reimbursed in an emergency situation like COVID-19 in rural locations with lack of resources will impact spread, outcome, diagnosis, testing, treatment, and complications. Certain waivers in HB 6074 are helpful, but it will be crucial to see how CMS implements the new policy. Like some telehealth options, telemedicine reimbursement is limited depending on the state that is covering the services and how they are performed. It can get difficult in many states to treat patients who are quarantined at their homes. It is recommended that states fully lift barriers for Medicaid reimbursement in national emergencies like COVID-19. California lifted the barrier and this will positively impact the treatment, outcome, and response to COVID-19 for patients and providers. Removing such barriers will allow more patients to be treated quickly, especially in rural, underserved areas. Telehealth should therefore be extensively used in an emergency situation like this to reach more people in less time with higher safety outcomes.

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