HEALTH MANAGEMENT ASSOCIATES

Webinar: Coverage of Virtual Care Services and Future Policy

September 20, 2022

Today's Agenda

- Context
- Federal policy developments: Medicare and Medicaid
- State-level coverage: Medicaid and Commercial payers
- Interstate licensure
- Health equity and telehealth
- Clinical perspective
- Future developments in virtual care policy

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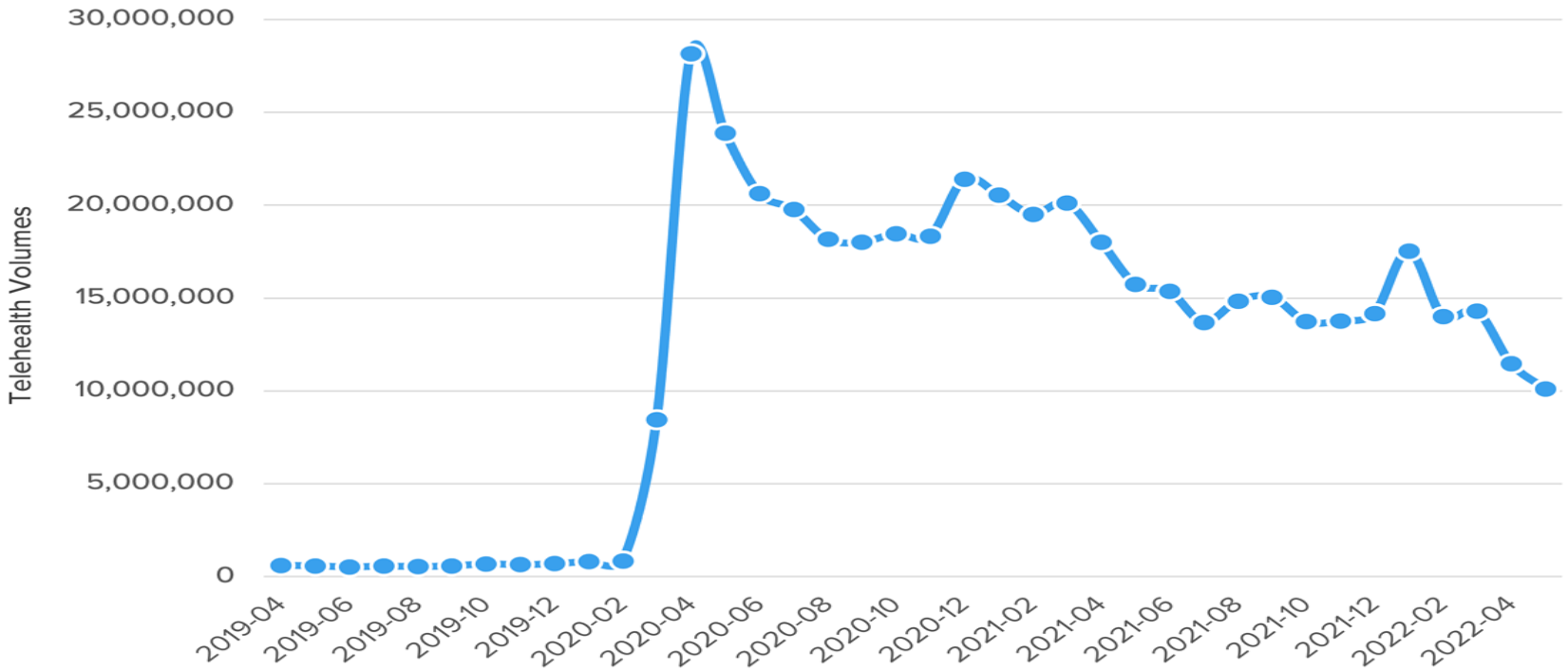
Context

Zach Gaumer, Principal

Telehealth use exploded with the onset of the COVID-19 pandemic, use remains much higher than before the pandemic

- Pre-COVID-19: Telehealth volumes extremely low, less than 1% of patients ever used these services
- April 2020: Use of telehealth reached a peak, across all payers
- April 2022: Use has come down 59 percent from the peak, but use remains much higher than pre-2020

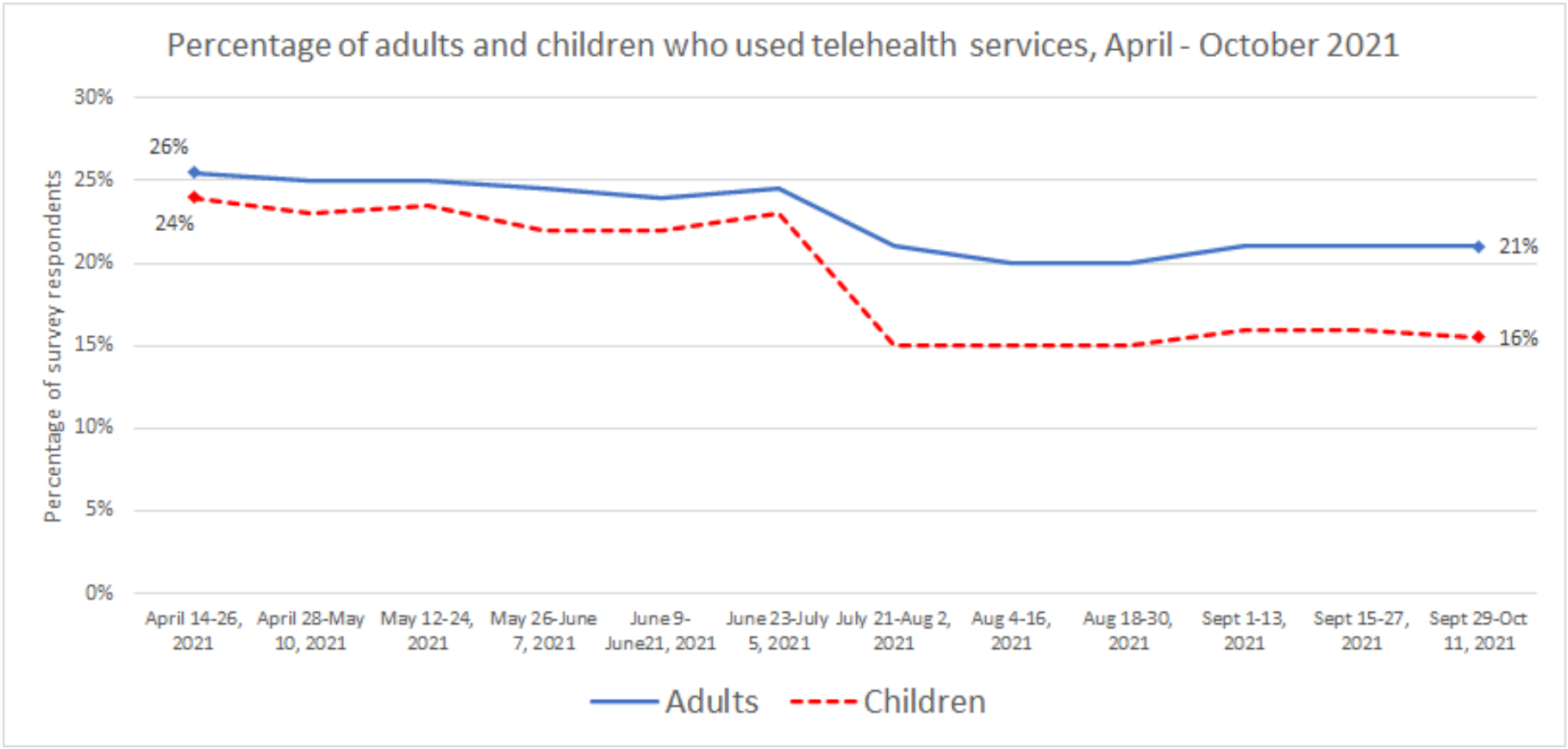
FIGURE 1. U.S. TELEHEALTH VISIT VOLUMES, APRIL 2019- MAY 2022



Source: Trilliant Health national all-payer claims database. • PNG

trilliant health

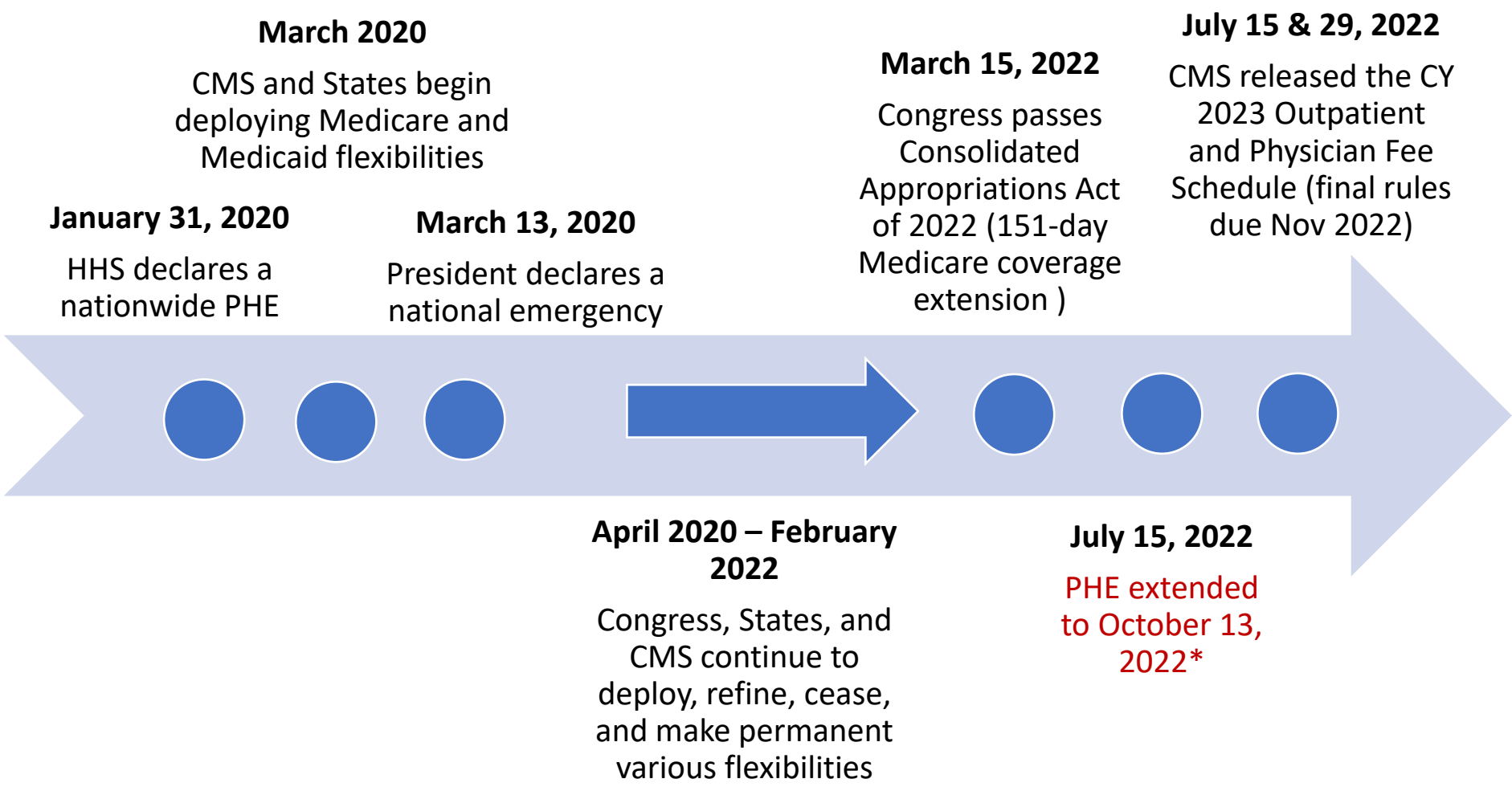
HHS survey: Approximately 21 percent of adults and 16 percent of children reported in the Fall of 2021 using a telehealth service in the prior 4 weeks



Source: Assistant Secretary of Planning and Evaluation (ASPE), US Dept of Health and Human Services, 2022

Prior to the COVID-19 pandemic less than 1 percent of patients used telehealth services. (ASPE 2022)

Coverage of virtual care services has changed dramatically in 2+ years the Public Health Emergency (PHE) has been active, and change will continue



***Biden Administration will provide 60-day notice before expiration**

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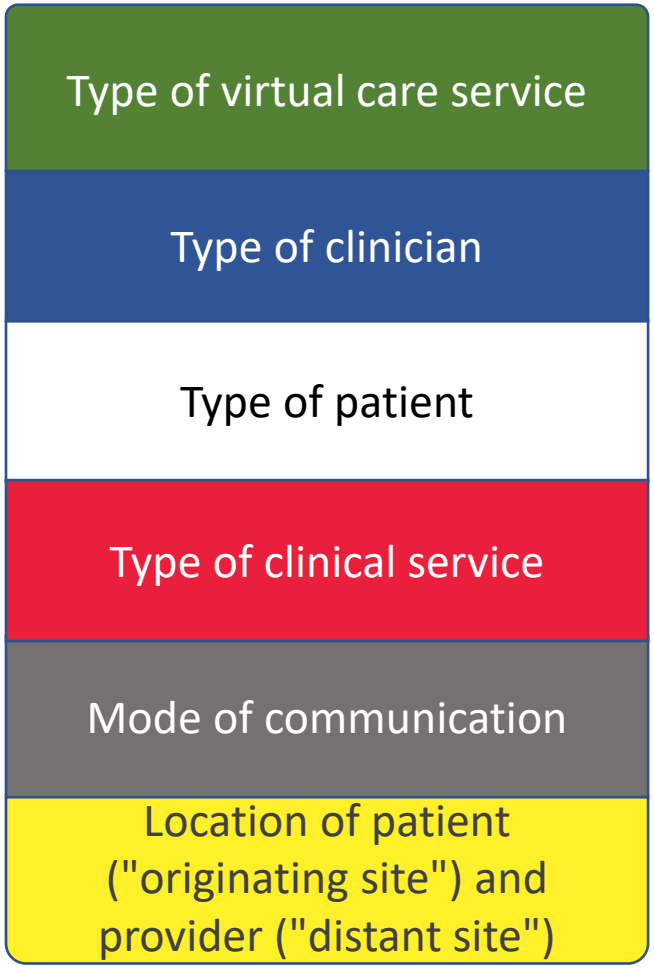
Payers form their virtual care coverage policy by modifying six different components. Components are used to control utilization and access to care

Definition: A method of delivering health care services using information and communication technologies while the patient and the health care provider are in different locations.



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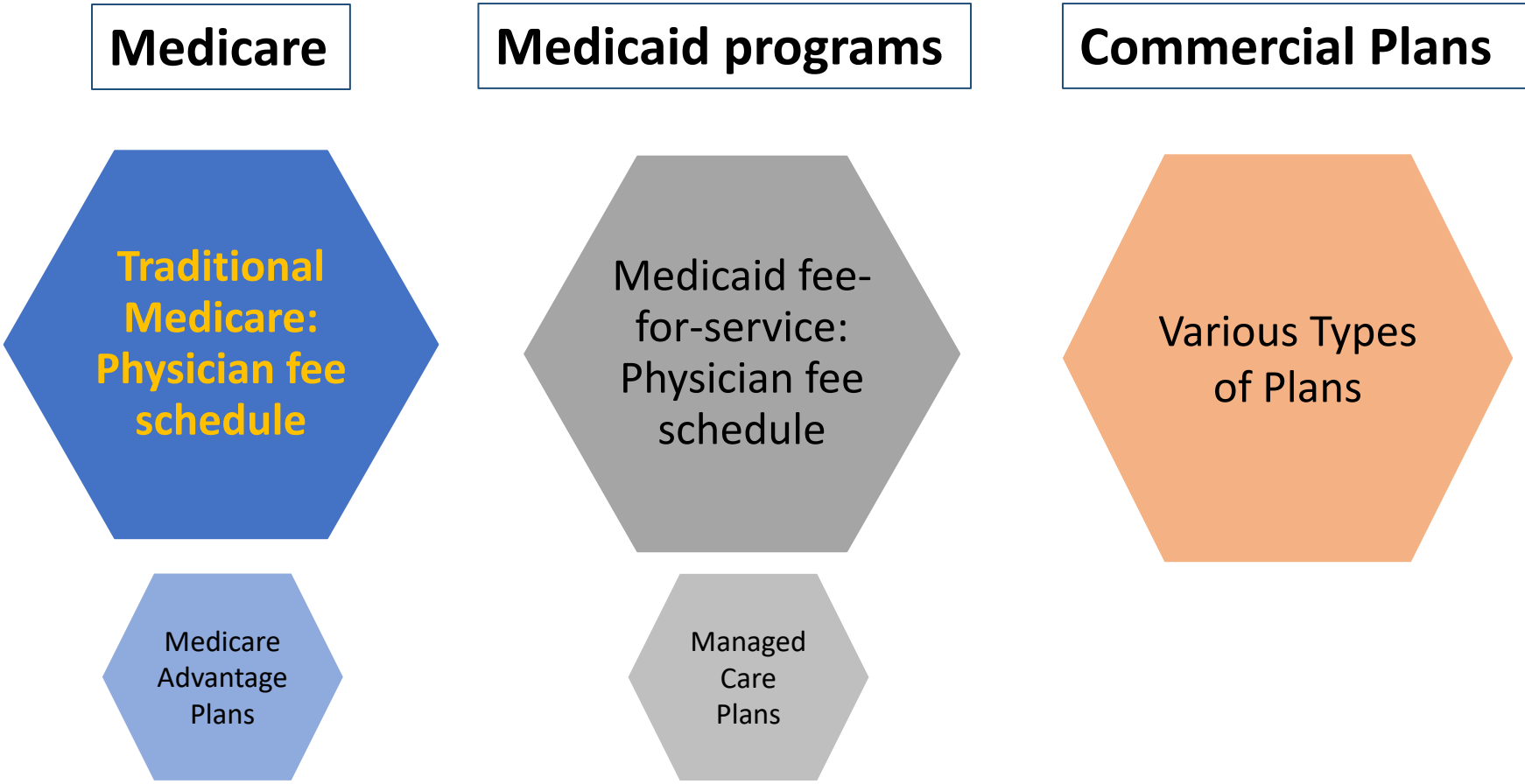
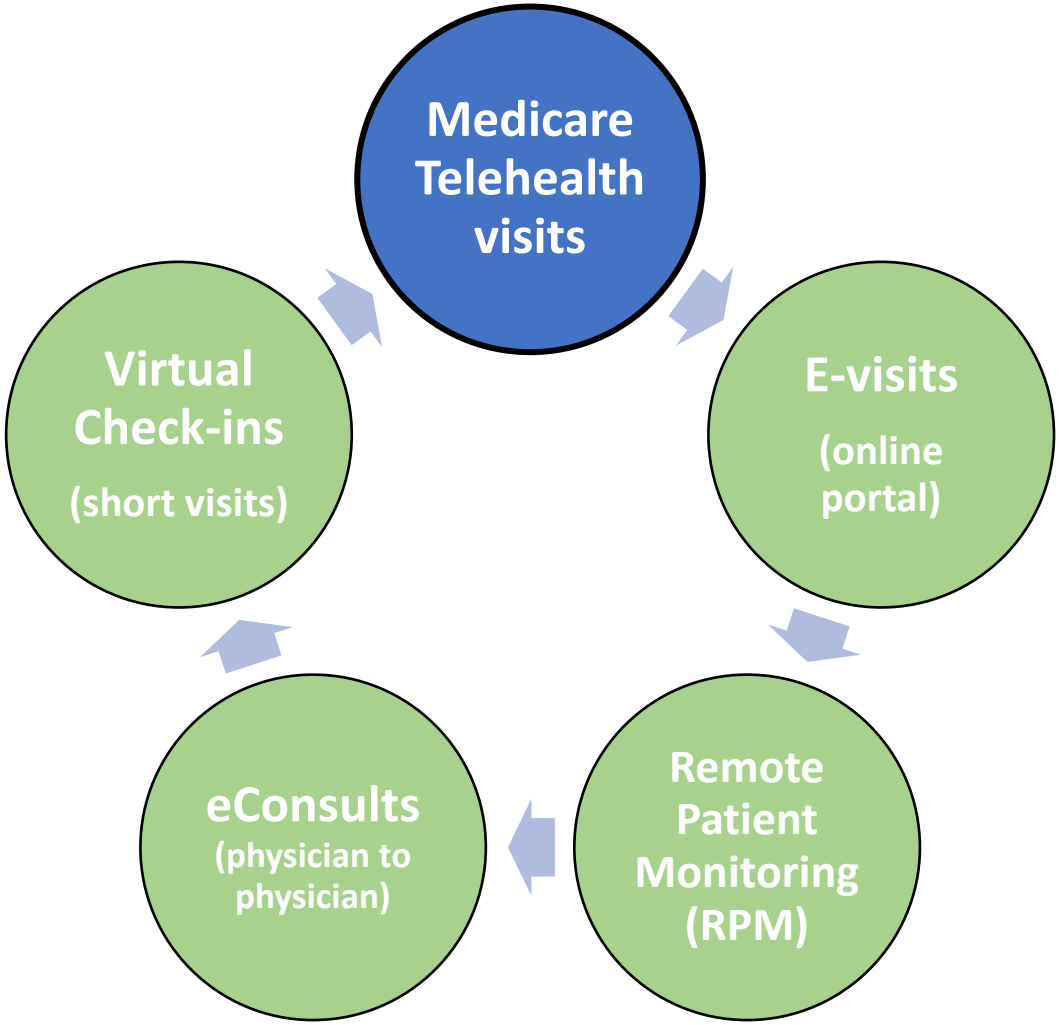
Medicare program has become the model for most payers. Virtual care services are covered primarily through the Physician Fee Schedule, Plans negotiate their own rates



Most payers also follow the Medicare structure of defining types of virtual care – Medicare defines five types, each have different coverage rules



Green bubbles = Communication Technology-Based Services (CTBS)

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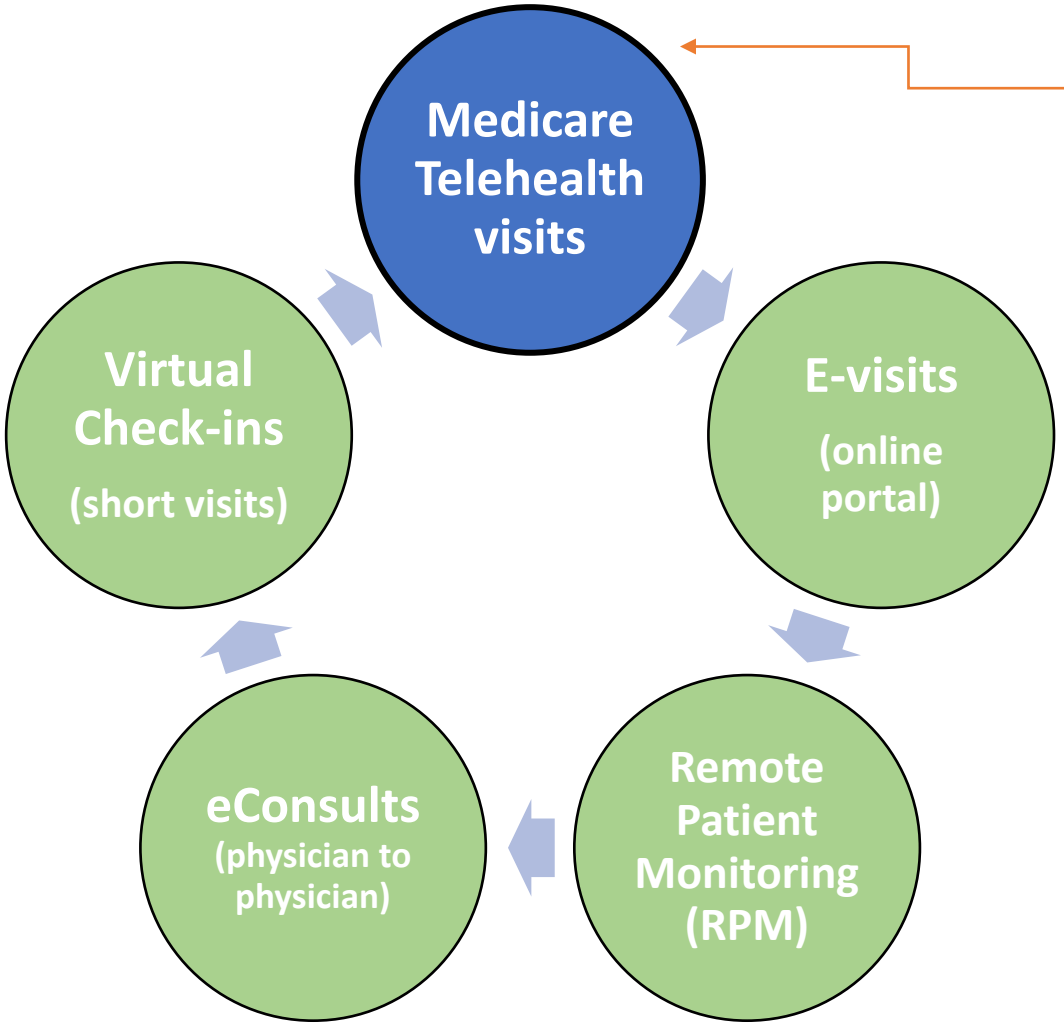
Federal Policy: Medicare, Medicaid, and the Public Health Emergency

Zach Gaumer, Principal

Medicare covers 5 types of virtual care to varying degrees. Permanent law limits the use of telehealth visits to rural originating sites (not urban and homes), this limit does not apply to CTBSs



Subject to statutory geographic originating site limitations

Communication Technology-Based Services (CTBS): Not subject to statutory geographic originating site limitations

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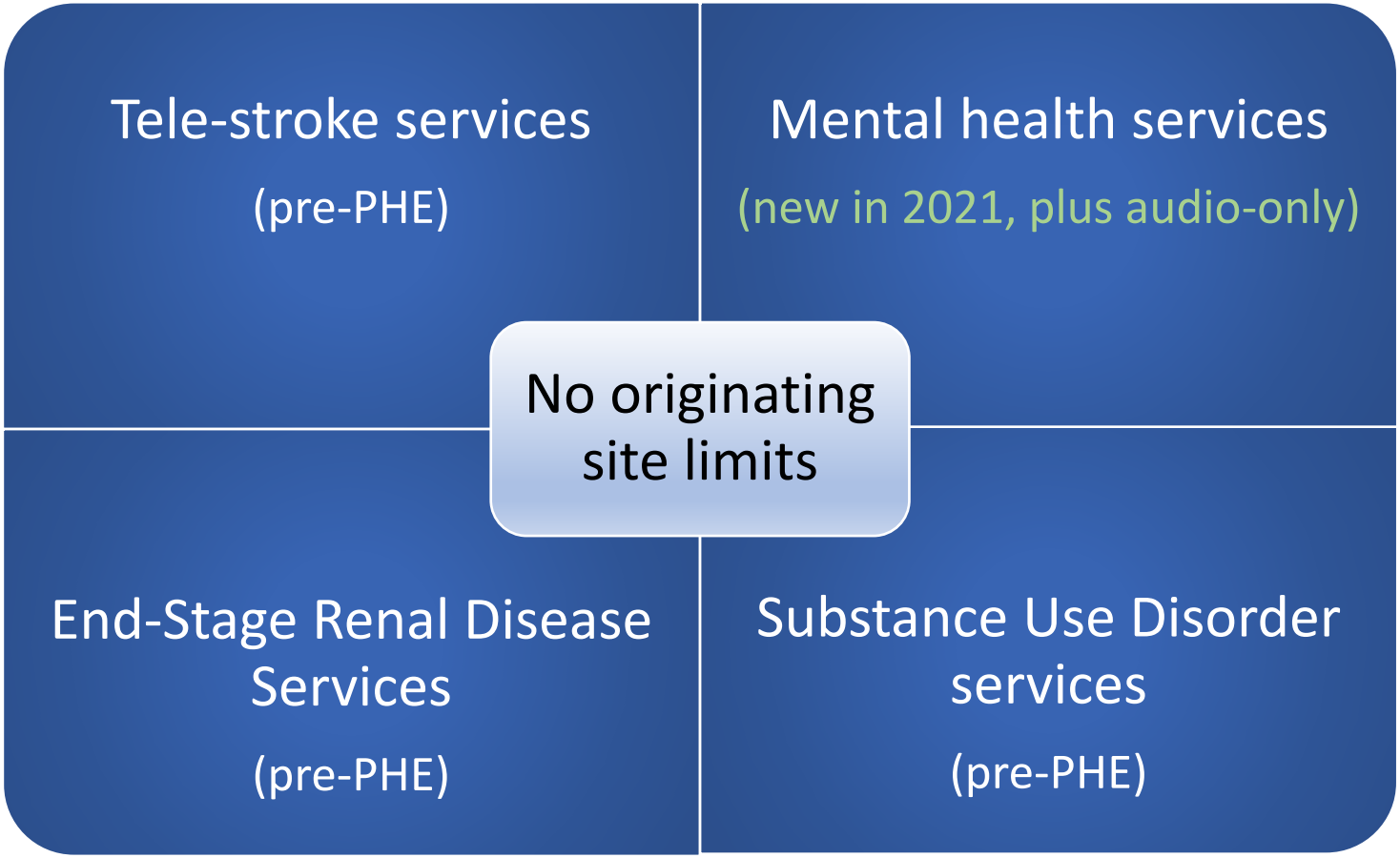
Four disease groups are exempted from Medicare's geographic originating site limits, urban and home originating sites are permitted



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Medicare expanded coverage of virtual care services substantially during the Public Health Emergency (PHE), much of the coverage remains temporary

Pre-PHE (permanent)	During PHE (temporary)
• Originating sites: Rural only, healthcare settings	→ Originating sites: Urban, patients' home
• Distant sites: Clinicians in certain types of healthcare facilities	→ Distant sites: FQHCs, RHCs, hospitals, clinicians' residences
• Established patients only	→ New patients and established patients
• Cost sharing: 20 percent	→ Cost sharing: Providers can waive or reduce
• HIPAA: Several requirements	→ HIPAA penalties waived

• Telehealth visits:
  • 100 service codes total (mostly E&M and behavioral health)
  • Two-way audio/video only
	→ Telehealth Services:
	  • More than 200 service codes added (e.g., ED, PT/OT therapy, speech, home visits)
	  • Audio-only
	  • Hospice home visits and recertifications
	  • Home Health visits
	  • Removal of frequency limits on inpatient and nursing follow-up care

• Communication Technology Based Services (CTBS)
  • RPM (2018)
  • Virtual Check-ins (2019)
  • E-consults (2019)
  • E-visits (2020)
	→ CTBSs: Expanded to new patients

Current (2022) Medicare policy for 200+ telehealth codes: Complex coverage rules, three groups of services with separate coverage expiration dates

Medicare telehealth service group	Volume of services	Examples	Coverage expiration date	Coverage change occurring when the PHE expires
Group A: Permanently covered	109 services (39% of services)	• E&M services • Group Psychotherapy • Psychological and Neuropsychological Testing • Domiciliary, Rest Home, or Custodial Care services • Home Visits, Established Patient • Cognitive Assessment and Care Planning Services • Visit Complexity Inherent to Certain Office/Outpatient (E/M)	None	No home and urban visits. Audio-only not permitted.
Group B: Temporarily covered	64 services (23% of services)	• Therapy Services, Physical and Occupational Therapy, All levels • Home Visits, Established Patient • Emergency Department Visits, Levels 1-5 • Psychological and Neuropsychological Testing • Hospital discharge day management • Inpatient Neonatal and Pediatric Critical Care, Subsequent • Critical Care Services	12/31/23 (or later if PHE extends into 2023)	No home and urban visits. Audio-only not permitted.
Group C: PHE covered	105 services (38% of services)	• Home Visits, New Patient • Audio-only visit • Eye exam • Initial hospital care	End of PHE plus 151 days	Not covered

Medicare's PHE telehealth coverage flexibilities may be extended further before the end of the year, many payers will follow Medicare's lead

What coverage expires with PHE's end?

- Audio-only (except for mental health)
- Originating site (home/urban) for all codes
- One-third of all covered codes
- Distant site flexibilities (FQHCs)
- CTBSs for new patients
- Physical therapists may not conduct telehealth

What coverage remains at PHE's end?

- Originating site (home/urban) mental health, substance use, ESRD, stroke
- Rural telehealth visits
- Audio+video telehealth visits
- CTBS services for existing patients
- Audio-only for mental health
- Medicare Advantage plans cover any telehealth services they prefer

Public Health Emergency (federal)

- Current expiration: October 15, 2022
- Anticipated conclusion: PHE will likely be extended for another 90 days, into January 2023, due to mid-term elections
- Congressional Budget Office building into their modeling PHE expiration in June 2023

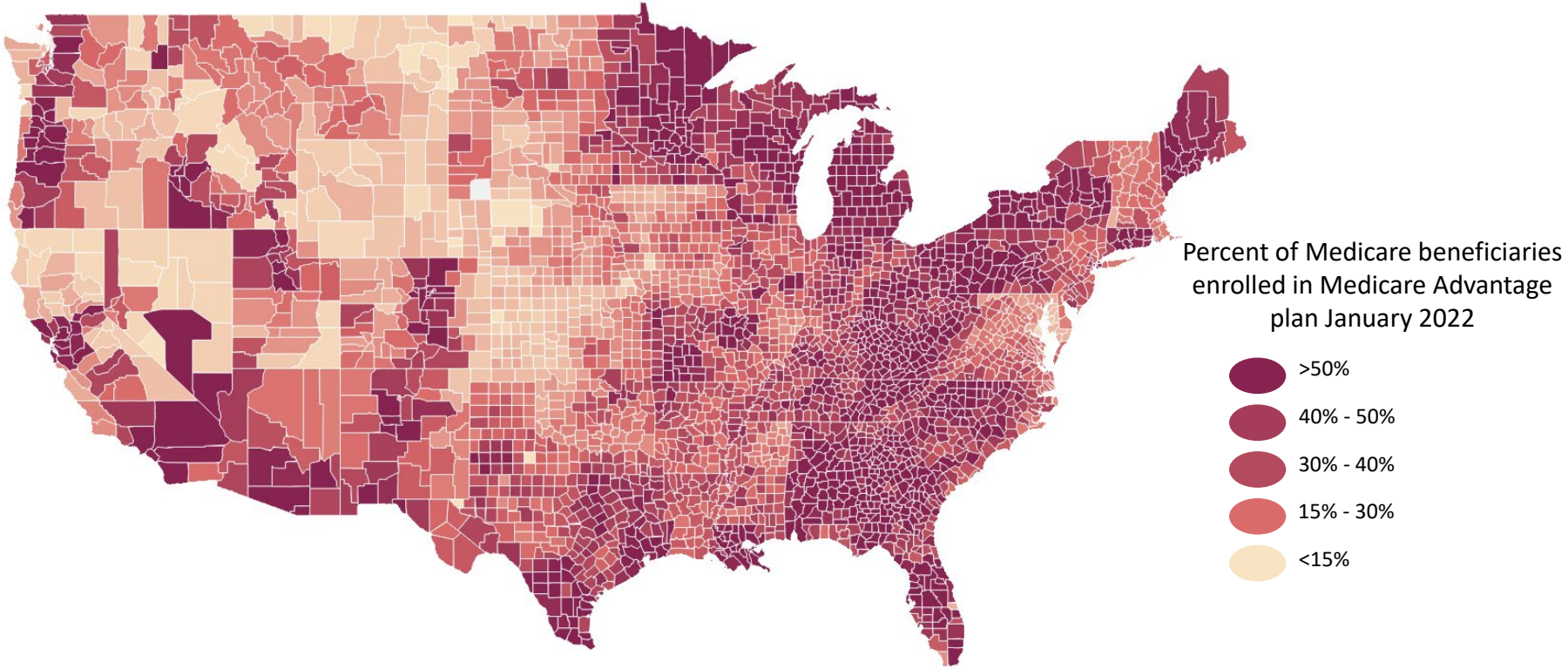
2023 Medicare Physician Fee Schedule Proposed Rule offers minor enhancements, Final Regulations due in November 2022

- Telehealth coding practices:
  - Modifier codes: Temporarily requires use of modifier code '95' and either provider of service code '02' (not in home) or '10' (home) for all telehealth services.
  - Permanently requires use of modifier '93' for all audio-only services.
- Proposed 2023 payment rates 4 percent lower than 2022 across most services, lower for specialists
- Enhances coverage of behavioral health services by loosening clinician scope of practice rules
- General focus on Health Equity and Access
- Proposed to - add several new telehealth service codes, including: Covering patient-measured blood pressure with an approved device through the end of 2023
- Requested feedback on whether CGM should be tied to a required periodic in-person visit
- Proposed to - not to cover audio-only services (other than for mental health) beyond the PHE

***Medicare is also expanding coverage of telehealth for hospital outpatient departments/clinics – focus on Mental Health**

Medicare Advantage (MA) plans will soon account for 50% of Medicare beneficiaries, Plans negotiate their own rates with providers

- Medicare Advantage (MA) plans required to cover all benefits covered under Traditional Medicare, but can cover more.
- MA plans can negotiate their own rates with providers.
- Medicaid managed care plans function similarly.
- MA plans account for 45 percent of beneficiaries now, projected to exceed 50 percent by 2030.
- MA plan penetration rates vary by state and county.



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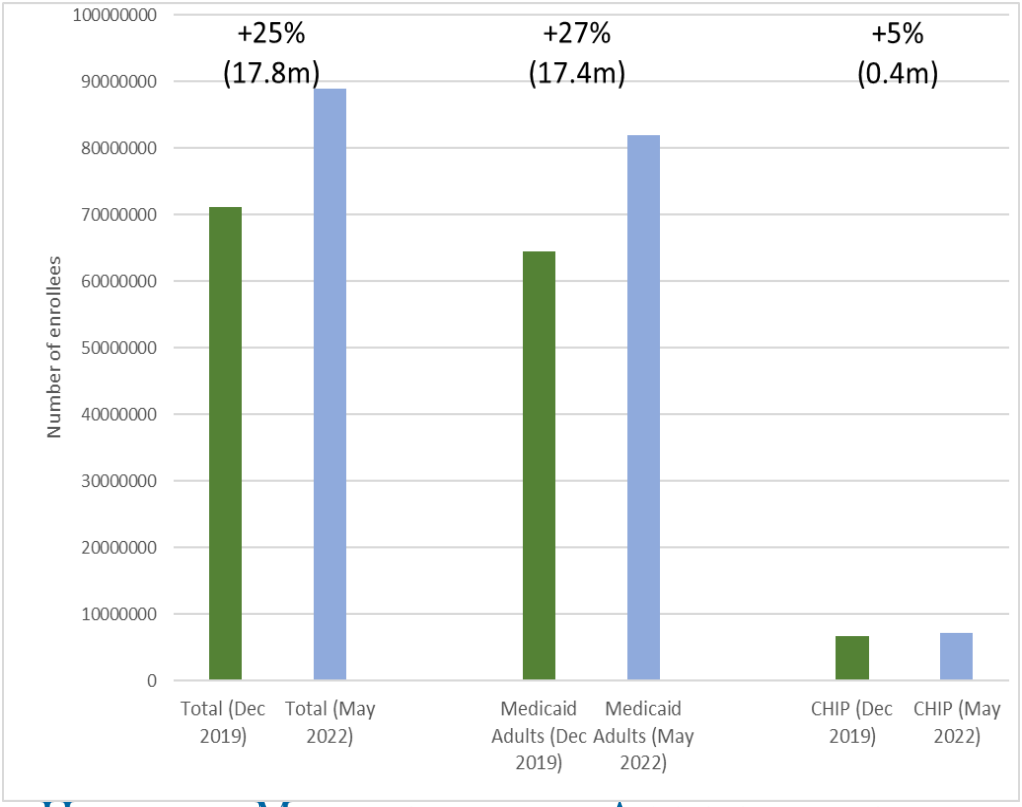
Medicaid: At end of PHE many Medicaid patients will lose coverage

- Medicaid enrollment increased 25 percent during the PHE due to additional federal funding
- When PHE ends, states will be required to determine if all their enrollees remain eligible for Medicaid
- Kaiser Family Foundation estimates 5.3 - 14.2 million Medicaid enrollees could be disenrolled after the PHE
- These patients will become uninsured



Rank	State	Change # of child enrollees (12/2019 to 5/2022)
1	Georgia	84,000
2	Pennsylvania	74,000
3	Illinois	58,000
4	Louisiana	57,000
5	Michigan	51,000
6	Oregon	45,000
7	Arizona	42,000
8	Ohio	30,000
9	Kentucky	27,000
10	Virginia	26,000
*	US total	400,000

Federal Wrap-up: The end of the PHE could bring coverage chaos, but Congress appears poised to take action

- **March 15, 2022:** Medicare coverage impacted by PHE expiration was extended 151 days beyond the end of the PHE.

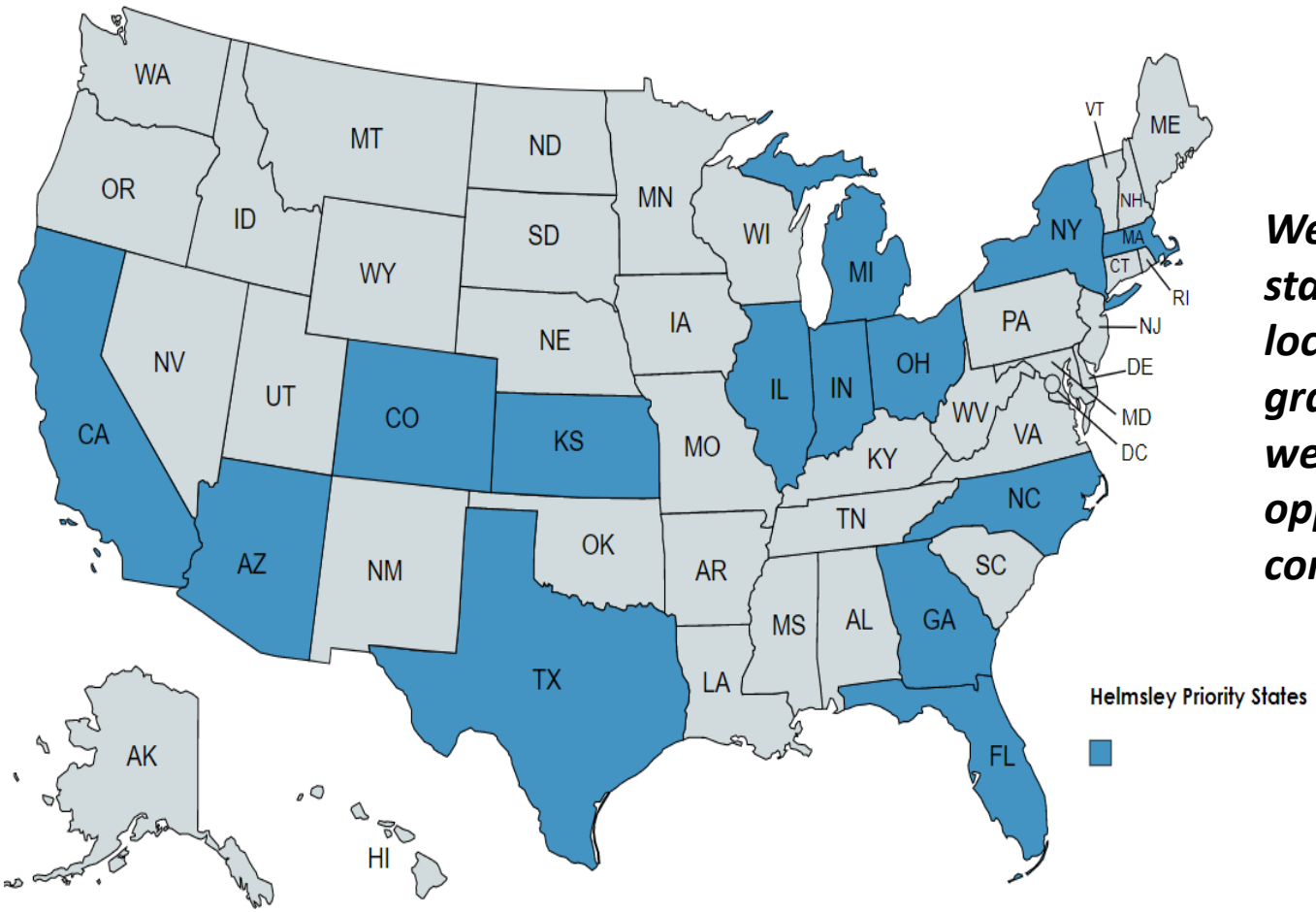
- **July 27, 2022**, US House passed the *Advancing Telehealth Beyond COVID-19 Act of 2022* (H.R. 4040) which would extend the following Medicare telehealth flexibilities to the end of 2024**:**
  - Removes geographic originating site requirements
  - Expands list of telehealth-eligible providers
  - Delays in-person visit requirements for mental health services
  - Audio-only as a covered telehealth modality

- **Fall - Winter 2022:** the ball is in the court of the US Senate to consider the House's bill

State-level virtual care coverage: Medicaid and Commercial plans

Yamini Narayan, Consultant

State Review



We identified a sample of states that reflect the locations of existing HCT grantees and projects, as well as states where new opportunities are being considered.

Medicaid Fee-For-Service coverage of virtual care services in Helmsley's 14 priority states: Broad adoption of key telehealth services

State	Audio-only visits	RPM	Home as an allowable originating site	Prescribing through telehealth	Out-of-state licensure
14 states	9 out of 14	10 out of 14	All states	8 out of 14	10 out of 14
AZ	Y	Y	Y	Y	Y
CA	Y	Y	Y	Y (MAT)	Y
CO	Y	Y	Y	Y (regulations apply)	Y (depends on profession)
FL	N	N	Y	Y (excluding controlled substances)	Y
GA	N	N	Y	N	Y
IL	Y	Y	Y	Y	N
IN	Y	Y	Y	N	Y (ends with federal PHE)
KS	N	NI	Y	N	N
MA	Y	N	Y	Y	Y
MI	Y	Y	Y	Y	Y
NC	Y	Y	Y	N	Y
NY	N	Y	Y	Y (through 9/27/22)	N
OH	Y	Y	Y	Y	Y
TX	N	Y	Y	N	N

In many states, coverage expansion is temporary until determined otherwise.

Commercial coverage of virtual care services in Helmsley priority states: Broad adoption of key telehealth services in certain plans

Plan with the greatest market share	Audio-only visits	RPM	Home as an allowable originating site	Prescribing through telehealth
Totals	11 out of 14	9 out of 14	13 out of 14	5 out of 14
AZ (Cigna)	Y	Y	Y	Y
CA (Cigna)	Y	Y	Y	Y
CO (Anthem BCBS)	Y	Y	Y	NI
FL (FL Blue)	N	Y	Y	Y (Teladoc)
GA (Aetna)	Y	Y	Y	Y
IL (BCBS)	Y	NI	Y	NI
IN (Anthem)	Y	Y	Y	NI
KS (BCBS)	Y	NI	Y	NI
MA (BlueCross)	N	Y	NI	Y
MI (BCBS)	Y	NI	Y	NI
NC (BCBS)	Y	NI	Y	NI
NY (United Healthcare Choice)	N	Y	Y	NI
OH (Anthem BCBS)	Y	Y	Y	NI
TX (BCBS)	Y	NI	Y	NI

Commercial plan policies vary by state and may offer greater or more restrictive coverage compared to the state FFS plan.

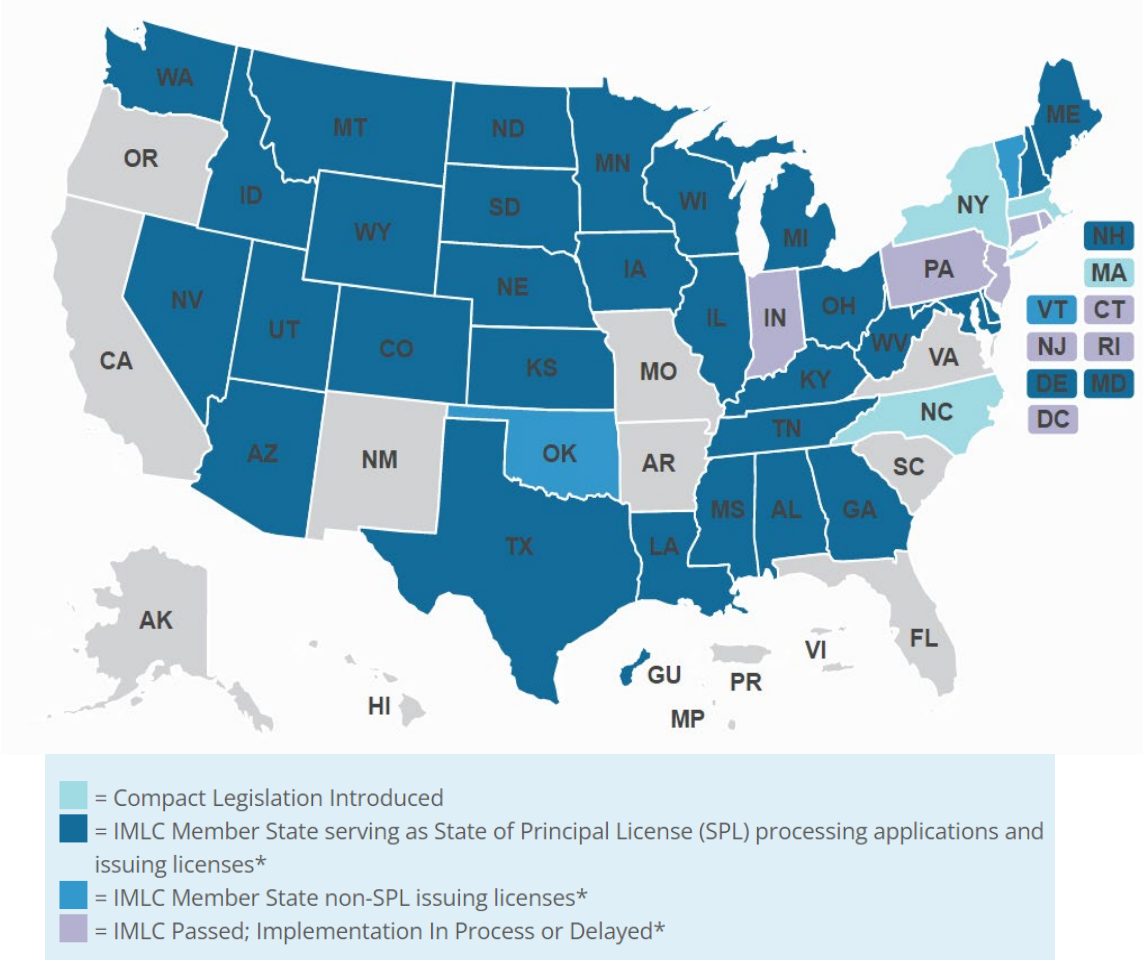
Interstate Licensure Update

Yamini Narayan, Consultant

Cross-state Licensure: Physicians

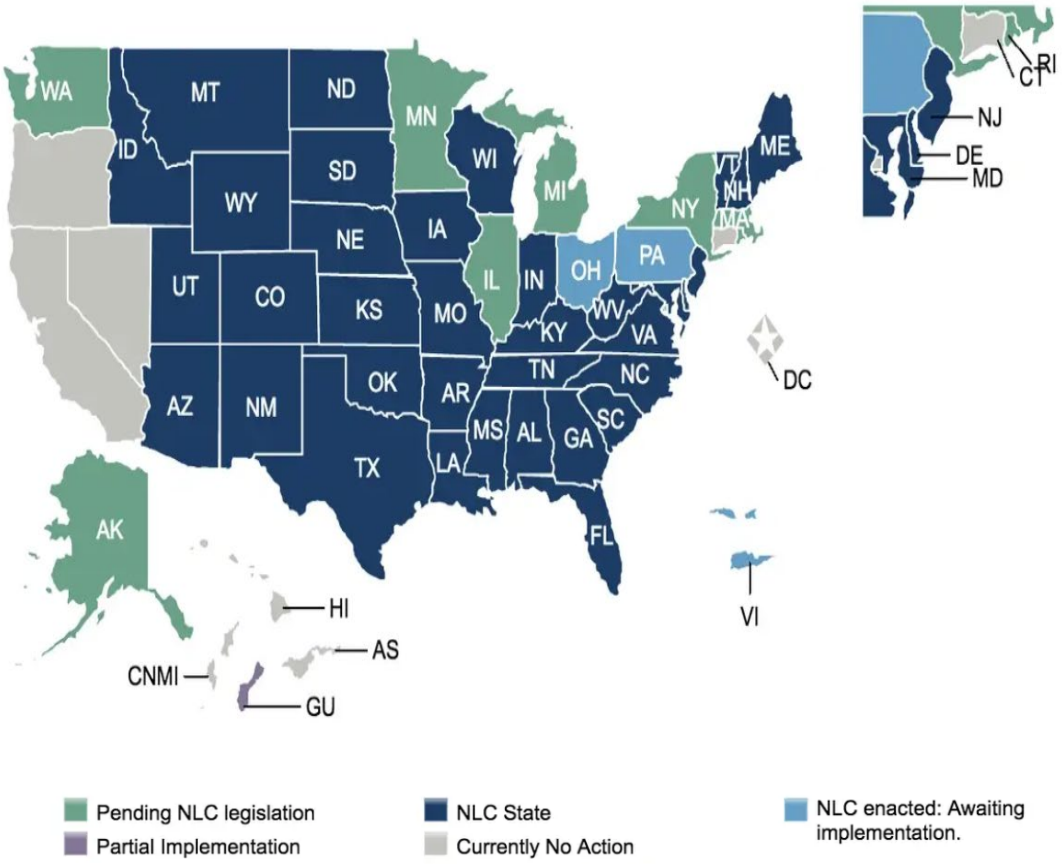
- The Interstate Medical Licensure Compact (IMLC) Committee streamlines the licensing process for physicians who want to practice in multiple states. Its goal is to improve access to health care, particularly for patients in underserved or rural areas
- IMLC currently includes 34 states (previously 29), the District of Columbia, and the Territory of Guam
  - New states: Texas, Georgia, Ohio, Louisiana
  - Legislation did not pass in Oregon and Missouri
- IMLC issued 2,766 licenses in August 2022

U.S. State Participation in the Compact



Cross-state Licensure: Nurses

Compact Nursing States List 2022



- The Nursing Licensure Compact (NLC) is an agreement between states that allows nurses to practice across state lines
- In 2018, the process was streamlined through the creation of the Enhanced Nursing Licensure Compact (eNLC)
- 39 states currently participate in eNLC

Health Equity and Virtual Care Services

Erica L. Reaves, Senior Consultant

Research Demonstrates Inequities in Access to Virtual Care Services, Further Exacerbating Population Health Disparities

Several researchers have demonstrated that virtual care services delivery models may exacerbate population health disparities.

Access to broadband internet in the home and computer/device use and ownership vary by race and ethnicity in the U.S., exacerbating existing health inequities.

- Device Disparities. 80% of White adults own a desktop or laptop computer, compared with 69% of Black adults and 67% of Hispanic adults. One in four (25%) of Hispanics are "smartphone-only" internet users, whereas 12% of White adults and 17% of Black adults are smartphone dependent.
- Internet Access Disparities. 80% of White adults have broadband internet access at home, compared to 71% of Black and 65% of Hispanic adults who have broadband access at home.

  (Pew, 2021)

Some suggest audio-only visits may offer a solution.

There is insufficient evidence that video visits provide superior care and better outcomes.

However, video visits provide several potential advantages compared with audio-only visits.

- Can see a patient's home environment (and potentially conduct a home safety evaluation)
- Can conduct a visual physical examination
- Can visually review medications with patients
- Can share screens with patients to share laboratory and study results
- Can incorporate more effective verbal cues when using translator services for non–English-speaking patients

Potential Targets for Advancing Equitable Access to Virtual Care Modalities for Improved Health and Social Outcomes

- **Structural and Financial Barriers to Address Digital Redlining**. Removing financial barriers could include waiving copayments for telehealth visits and providing waivers to purchase needed smartphones, data plans, or internet access to support telehealth visits

- **Digital Health Literacy Training.** Enhancing consumer education through digital health navigators, for example, to increase telehealth use in underserved communities or under-resourced health centers

- **Technical Assistance.** Funding telehealth infrastructure; providing technical assistance to support telehealth implementation for providers in rural, low-income, and under-resourced communities and advance inclusive technology deployment for patients and caregivers

- **Person-Centered Design and Testing.** Removing design barriers in patient portals and apps that impact older adults, people with physical, cognitive, or sensory impairments, and people with limited English proficiency; including diverse populations when designing and testing platforms

- **Ongoing Evaluation.** Evaluating the impact of telehealth policies and innovations on the digital divide and health outcome disparities by subpopulations

- **Community Partnerships.** Creating or strengthening partnerships with public institutions (e.g., public libraries, schools); community-based organizations (e.g., senior centers, recreation centers, cultural centers); and associations (e.g., National Digital Inclusion Alliance, American Telemedicine Association) to address critical provisions post-public health emergency

Public Libraries as Key Partners for Advancing Health Equity in Virtual Care

- **The vast majority of the U.S. population lives in a public library service area**
  - More than 171 million registered users, representing over half of the nearly 311 million Americans who lived within a public library service area, visited public libraries over 1.35 billion times (IMLS, 2019)

- **As a digital safety net, public libraries keep communities and marginalized populations connected, ensuring equitable access to information and bridging the digital divide**
  - The nation's approx. 17,000 public libraries offer no-fee broadband internet access, Wi-Fi, and devices (e.g., computers and tablets) (ALA, 2022)
  - Libraries also offer computer skills classes and hands-on assistance with digital activities (ALA, 2022)
  - More than two-thirds (69%) of U.S. libraries provided Wi-Fi service outside the building during the pandemic. Investments in library broadband capacity, Wi-Fi, and related devices and services will support post-pandemic economic recovery (IMLS, 2022)

- **Public libraries are viewed as safe, trustworthy spaces, though concerns about patrons' privacy remain**
  - According to the Pew Research Center, 42% of patrons report using libraries' digital resources to search for health information (CDC, 2018; Pew, 2015)
  - Architecture/interior design of libraries maximizes open spaces for shortage, and, with public computers often placed in communal spaces, there are concerns about the availability of **private spaces** in patrons could conduct a virtual care visit.

- **Public libraries' participation in virtual care is somewhat limited though increasing; public libraries and health professionals need additional supports to advance person-centered, high quality virtual care**
  - Public health and clinical professionals (e.g., community health workers, public health nurses, patient navigators, nurses, physicians) may have the capacity to liaise among local libraries, clinical practices, and health systems, facilitating relationships that can expand access to telemedicine visits.
  - According to DeGuzman and colleagues, "libraries may benefit from systematic guidelines for assessing technological readiness and collaborating with health providers." (DeGuzman et al., 2020)

Schools as Key Partners for Advancing Health Equity in Virtual Care

- School-based virtual care offers a unique opportunity to engage the pediatric and young adult populations in a setting that is familiar to students and parents/guardians
- School-based virtual care may also allow public health and clinical professionals to offer diagnosis-specific services and supports, e.g., patient education on type 1 diabetes, behavioral health counseling
- As with libraries, there are concerns about space and patients' privacy and access to technological assistance to navigate patient portals, virtual care platforms, etc.
- Snapshot of current efforts:
  - **Health Resources & Services Administration (HRSA)** – over $5.4 million awarded in 2021 to 27 school-based health centers across 19 states; aim to expand access to general primary medical care, behavioral health services, oral health, vision, and enabling services such as transportation, outreach, and translation services
  - **University of Virginia Karen S. Rheuban Center for Telehealth** (2016) – four (4) school-based telehealth centers in Bland County and Martinsville, Virginia, funded by a four-year $1.1 million grant from HRSA; aimed to make health education fun and engaging through games, apps, and friendly competition
  - **South Carolina Telehealth Alliance** – three to four schools in every county have a telehealth center and visits are covered by Medicaid
  - **The Utah Education and Telehealth Network and 19Labs** – telehealth kits/kiosks created and branded by 19Labs were delivered to 21 rural school districts; funded by the CARES Act
  - **California School-Based Health Alliance and Anthem Blue Cross** – safety net clinics and a no-cost Virtual Care Kiosk Program; includes mental health care and treatment

Clinical perspective of developments in virtual care policy

Jean Glossa, MD, MBA, FACP
Managing Director

Virtual care may exacerbate health equity issues, measures can be taken by providers to reduce this concern

Disparities in the use of telehealth is not a new concept.

Telehealth does not increase access to everyone equally.

Consider: English language literacy, health literacy, technology limitations and connectivity issues.

Patient reaction to virtual care has been positive, driven by greater access

"I'm Not Feeling Like I'm Part of the Conversation" Patients' Perspectives on Communicating in Clinical Video Telehealth Visits

Howard S. Gordon, MD[1,2,3], Pooja Solanki, MPH[1], Barbara G. Bokhour, PhD[4,5], and Ravi K. Gopal, MD[6,7]

[1]Jesse Brown Veterans Affairs Medical Center and VA Center of Innovation for Complex Chronic Healthcare, Chicago, IL, USA; [2]Section of Academic Internal Medicine, Department of Medicine, University of Illinois at Chicago, Chicago, IL, USA; [3]Institute for Health Research and Policy, University of Illinois at Chicago, Chicago, IL, USA; [4]Center for Healthcare Organization and Implementation Research, Edith Nourse Rogers Memorial Veterans Affairs Medical Center, Bedford, MA, USA; [5]Department of Health Law, Policy & Management, Boston University School of Public Health, Bedford, MA, USA; [6]Center of Innovation for Veteran-Centered & Value-Driven Care, Rocky Mountain Regional Veterans Affairs Medical Center, Aurora, CO, USA; [7]Department of Medicine, University of Colorado School of Medicine, Aurora, CO, USA.

❖ The Good News

- Patients liked increased access
- Patients liked not having to travel long distances
- Liked less time in waiting rooms

❖ The Not so Good News

- Concerns about errors in care due to lack of physical exam
- Perception that providers paid less attention to them
  - Felt less involved
- Felt difficult to speak up and asking questions
  - Felt rushed
  - Hard to find opportunities to speak
- Difficult to establish doctor-patient relationship

Gordon et al: Journal of General Internal Medicine, DOI: 10.1007/s11606-020-05673-w, 2020

How clinics and providers should interpret recent policy developments

Lessons learned from telehealth fraud investigations

- Recent OIG report on 7 “high risk” practice patterns; program integrity measures
- Telehealth fraud has been and will continue to be a concern and will stall progress

Payers continue to demonstrate a committed interest in virtual care

- Medicare: Virtual care now fully integrated for mental health, physical therapy and other therapy services. The program continues to drive change across all payers
- Medicaid: Although coverage is variable across states, more states are covering audio-only, tele-mental health services, remote patient monitoring
- Commercial: Payers experimenting with virtual first models of care which reduce the frequency of required in-person visits or eliminate the requirement for new patients to have an in-person visit prior to their first virtual visit

Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks, OEI-02-20-00720 (hhs.gov)

How clinics and providers should interpret recent policy developments

Shifts to Value Based Care will ease telehealth adoption

- Paying for value and outcomes rather than transactional encounters
- VBP shifts across all payers

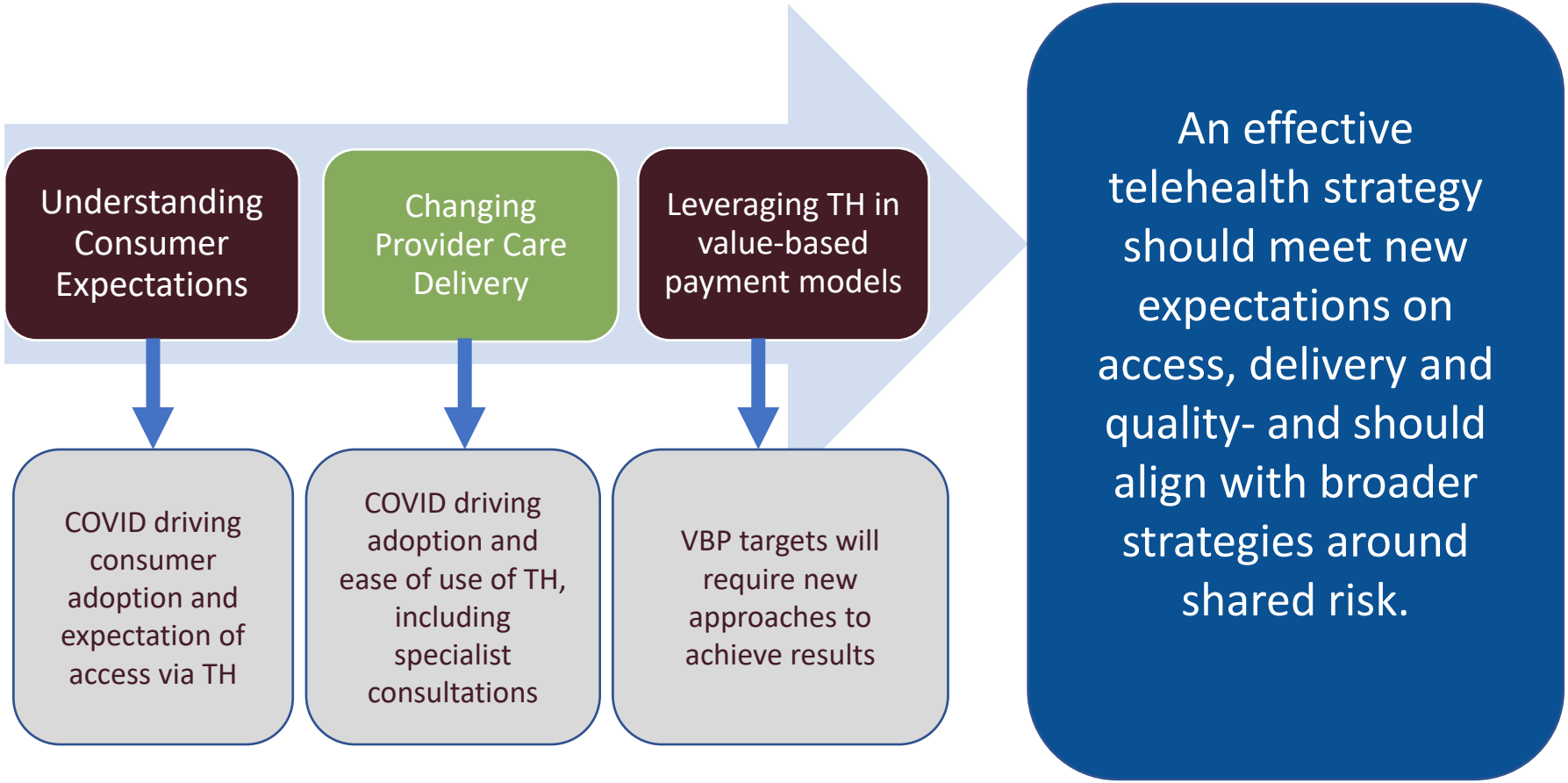
Models of care delivery to integrate into your practice:

- Video/audio visits, Remote Patient Monitoring, CGM, and E-consults
- Seek to utilize entire care team
- Account for health equity and access challenges

The longer the PHE is extended the more entrenched and "normalized" different forms of virtual care will become.

The virtual care landscape will continue to evolve for several years.

STRATEGIC POSITIONING FOR TELEHEALTH GROWTH



Slide Appendix

Payers use a wide variety of policy guardrails to limit spending and control misuse of services

- Originating site: home, facility, office
- Geographic: urban, rural, health professional shortage area
- Cost-sharing: Beneficiary pays for most of the cost of the service
- Tele-presenter w/patient
- Patient characteristics: disease type, new/established
- Clinician type: Physicians, Nurse practitioners, psychologists, social workers
- Service type: Medical vs. mental, primary vs. specialty care, or code by code
- Virtual care type: telehealth visit, virtual check-in, e-visit, etc.
- Modality: Audio-video vs. audio-only vs. asynchronous
- Frequency limits
- Regular in-person visit requirement (Medicare mental health services)

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Remote patient monitoring remains a great opportunity for providers

CMS fee schedule 2019 “remote physiological monitoring”

- Separate from telemedicine/virtual visits*
- Asynchronous/store and forward- not considered “telemedicine” by CMS definition

RPM- Remote Physiologic Monitoring of chronic or acute conditions, for est pts** (99091, 99453/4/7/8)

- Device must record, upload and transmit physiological data
- Heart rate, blood sugar, blood pressure, etc.

RTM-Remote Therapeutic Monitoring/Treatment Management

- For management of patients using medical devices that collect non-physiological data
- Can be self reported or digitally uploaded
- FDA defined medical device, not merely a wellness wearable device
- Pain management, med adherence, therapy response, and potentially CBT in 2023
- Primary billers are expected to be NP, PA, PTs (not an E/M code)

Related codes to consider:

- CGM- Continuous glucose monitoring (95250)
- Self monitoring of B/P (99473/4)
- E-visits-99421-99423; G2061-G2063
- Virtual check ins- G2012/G2010
- Chronic care mgmt.- 99490/1; 99487/89
- Transitional care mgmt.- 99495/6

New in 2022 and still a great new opportunity: Remote Therapeutic Monitoring codes

For monitoring *non-physiologic* data:

- **98975**: RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set up and patient education on use of equipment. $19
- **98976**: RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days; $54
- **98977**: RTM (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days; $54
- **98980**: RTM treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes; $49
- **98981**: RTM treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 min; $40

2023 Medicare Outpatient Proposed Rule offers a minor few enhancements for hospital outpatient departments, Final regulations in November 2022

Mental Health Services Furnished Remotely by Hospital Staff

- Allow hospital clinical staff to conduct remote mental health and substance abuse services and to designate these services as hospital outpatient depart services for purposes of reimbursement.
  - Patients permitted to be in their homes
  - Hospital clinical staff must conduct the service from inside the hospital facility.
  - Three new codes
- Requires in-person service within 6 months prior to the initiation of the remote service and then every 12 months thereafter. Exceptions to the in-person visit requirement based on beneficiary circumstances.
- Audio-only may be used to furnish these services when the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology.

Proposals are suggestive of future CMS policy:

- Allowing hospital outpatient departments to bill for virtual care
- Including a periodic in-person requirement for mental health services
- Audio-only services are viewed as not equivalent to audio+video or in-person