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Executive Order Expands Telemedicine and Eases Burden on Rural Providers

On August 3, 2020, President Donald Trump signed an executive order aimed at expanding access to care through two avenues: telemedicine and eased financial burdens on rural providers.[1] This *Health Capital Topics* article will discuss the executive rule and the subsequent agency actions on these fronts.

The August 3rd executive order builds on President Trump's original expansion of coverage for telemedicine services in early March 2020, an order which was praised by the *American Telehealth Association* (ATA) and *American Medical Association* (AMA) for swiftly responding to the growing healthcare crisis.[2] The new order allows some of the 135 services that were originally waived on a temporary basis to be permanently delivered via telemedicine technology going forward.[3]

For both patients and providers, the stakes of continuing to provide, and have access to, telemedicine care are high, and the permanent expansion of reimbursement for such services has been long sought by groups such as the *American College of Physicians* (ACP), which has been lobbying the *Centers for Medicare & Medicaid Services* (CMS) since June 2020 to allow certain measures to remain in place after the COVID-19 *public health emergency* (PHE) is over.[4] ACP's request focused on the importance of continuing facility fee payments, maintaining flexibility in physician direct supervision, lifting restrictions based on geographical site, allowing physicians to practice telemedicine across state lines, continuing pay parity between telemedicine and in-person *evaluation and management* (E/M) and other visits, expanding *remote patient monitoring* (RPM) codes, and allowing physicians to reduce or waive cost-sharing for telemedicine.[5]

Telemedicine has quickly become routine for Medicare beneficiaries since the start of the PHE. Only 14,000 Medicare beneficiaries used telemedicine per week at the start of 2020, but from March to early July, the number of beneficiaries who have received care through telemedicine has soared to over 10 million.[6] As relates to primary care, only 0.1% of Medicare primary care visits were conducted via telemedicine prior to February 2020, compared with 43.5% in April 2020.[7] There is evidence that both primary and specialty care physicians have experienced increases in the number of telemedicine visits, and even the state with the lowest rate of telemedicine use, Nebraska, saw increases in telemedicine primary care visits, up to 22% of all primary care visits.[8] The *Department of Health and Human Services* (HHS), as well as CMS, have touted this technology for its greater efficiency of care and as a way to stay safe and avoid unnecessary exposures.[9] HHS is largely responsible for this rapid expansion of telemedicine, due to its emergency declaration allowing beneficiaries to receive care wherever they were located – even across state lines – and its decision to not impose *Health Insurance Portability and Accountability Act* (HIPAA) penalties for providers who committed a privacy violation by using unencrypted video programs such has Skype or FaceTime to conduct telemedicine visits (but who had acted in good faith).[10] Telemedicine's growing importance, as well as input from healthcare stakeholders such as the AMA and the ACP, seem to have impacted CMS's decision-making process in its 2021 updates to the *Medicare Physician Fee Schedule* (MPFS) and *Quality Payment Program* (QPP). These rules are discussed in this month's Health Capital Topics article entitled, "2021 Physician Fee Schedule & Quality Payment Program Proposed Rules Released."

Rural providers have often not been able to take advantage of the opportunities provided by telemedicine to the same extent as those in urban areas,[11] but President Trump's executive order also directly addresses these rural providers, signaling for dramatic functional and reimbursement changes for them and the 57 million Americans they serve.[12] The order highlights opportunities in technological infrastructure investment for rural areas.[13] As telemedicine becomes a greater part of the healthcare delivery system, access will be an important issue for patients in rural areas who may not have the requisite Internet technology or bandwidth in place to support telemedicine. The order also calls on HHS to develop a new payment model with increased flexibility, more predictable payments, and incentives for quality of care for rural hospitals.[14] Some healthcare executives believe that such a payment model would greatly aid and incentivize rural systems that are prepared to transition to value-based care.[15] COVID-19 has hit rural hospitals especially hard, with a dozen closing in the first half of 2020[16] and nearly a quarter in danger of bankruptcy.[17] This new executive order may provide some much-needed relief for struggling rural providers

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and increase quality and access to care for Americans living in these rural areas.

On August 11, 2020, approximately one week after the publication of President Trump's executive order, CMS released a new payment model for rural providers – the *Community Health Access and Rural Transformation* (CHART) model.[18] Citing disproportionate health burdens faced by rural populations in the U.S., this model aims to reduce costs to rural providers while improving access to quality healthcare through:

(1) Making up-front investments and capitated payments based on quality and patient outcomes;

(2) Lessening regulatory burdens to give rural providers greater flexibility; and,

(3) Ensuring financial stability for providers, in order to allow them to offer services that address social determinants of health.[19]

The CHART model will achieve these ends through two value-based reimbursement "*tracks*": (1) the *Community Transformation Track* and (2) the *Accountable Care Organizations (ACO) Transformation Track*.[20] The *Community Transformation Track* will consist of 15 "Lead Organizations," e.g., state Medicaid agencies, local public health departments, and academic medical centers, which organizations will represent a rural community (defined as one or multiple continuous counties or census tracts) and work with community partners to facilitate value-based payment and viability.[21] Lead Organizations will receive upfront funding of $2 million upon acceptance into the program and an additional $3 million throughout the five-year program to coordinate community efforts.[22] CMS will also set an annual *capitated payment amount* (CPA), so that participating rural hospitals will receive stable revenue.[23] CMS will also decrease some regulatory burdens, by allowing participating hospitals to waive cost sharing, provide transportation for Medicare beneficiaries, and offer incentives for Chronic Disease Management Programs.[24] CMS will offer other benefits as well, including continuing telemedicine expansion post-COVID-19 and waiving the required 3-day inpatient stay prior to a skilled nursing facility (SNF) admission.[25] The 15 Lead Organizations will be chosen in Spring 2021 with the performance period set to begin July 2022.[26]

Similarly, the *ACO Transformation Track* will consist of up to 20 ACOs with a majority of providers or suppliers in rural areas, which ACOs will be required to join the *Medicare Shared Savings Program* (MSSP).[27] For a five-year period, the selected ACOs would each receive: (1) a minimum, one-time payment of $200,000 plus $36 per beneficiary served; and, (2) prospective payments of at least $8 per Medicare beneficiary per month for up to two years.[28] ACOs will also be enrolled in the *Beneficiary Incentive Program*, enjoy telemedicine coverage expansion beyond COVID-19, and be waived from the three-day inpatient stay requirement prior to a SNF admission.[29] Applications for this track will open in Spring 2021 with selection of participating ACOs in Fall 2021; the performance period would begin in January 2022.[30]

Since March 2020, the Trump Administration has released numerous executive orders and other mandates to expand healthcare services and support providers in the midst of the COVID-19 pandemic. President Trump's August 3rd executive order, together with CMS's 2021 *Physician Fee Schedule* and *Quality Payment Program* proposed rules highlight the administration's belief that telemedicine will continue to play a permanent, significant role through the end of the COVID-19 crisis and into the future. As CMS Administrator Seema Verma said in a statement following the release of the proposed rules: "*Telehealth can never fully replace in-person care, but it can complement and enhance in-person care by…[increasing] access and choices for America's seniors*."[31] Further, this executive order, and CMS's proposed CHART model, may serve to expand healthcare access and protect providers in struggling rural areas. The Trump Administration hopes that these two measures will lead to better health outcomes for patients in rural areas and future sustainability for rural providers.[32]

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20 *Ibid.*
21 *Ibid.*
22 *Ibid.*
23 In order to participate, hospitals must be acute care hospitals, Critical Access Hospitals, or special rural designation hospitals and must commit to implement the CHART model and sign a Participation Agreement with CMS; Centers for Medicare and Medicaid Services, August 11, 2020.
24 *Ibid.*
25 *Ibid.*
26 *Ibid.*
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