Telehealth Payments in the Response to the COVID-19 Pandemic

Overview

The Centers for Medicare and Medicaid Services (CMS) recently announced changes to key telehealth provisions to expand access for Medicare recipients during the pandemic, but several challenges remain.

Federal Response

Congressional Medicare activity. The *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* (Public Law No: 116-123) included a provision related to telehealth for the Medicare population. Section 6010 of the *Family First Coronavirus First Response Act* (H.R. 6201) made a technical change to the Medicare telehealth provision of the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* (P.L. 116-123) to ensure that new Medicare beneficiaries are able to access telehealth services under the emergency authority granted to the Secretary. Section 3703 of the *Coronavirus Aid, Relief, and Economic Security Act (CARES)* (H.R. 748) dramatically modified the provision to address outstanding provider concerns.

Related Medicare Administrative activity. On March 17, CMS provided new information regarding the implementation of this new waiver authority, including a press release, fact sheet and updated FAQ. This waiver authority is separate and distinct from the section 1135 waiver authority. The key takeaways from the announcement are as follows:

> *Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.*
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> *These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.*
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> *Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.*
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> *While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.*
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> *The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.*
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> *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.*

In addition, the Office of Inspector General (OIG) published its opinion that during the emergency period "[a] physician or other practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with the then-applicable coverage and payment rules." The opinion further states that this does "not require physicians or other practitioners to reduce or waive any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services." For more information, visit the OIG fact sheet here.

Previously, on March 13, Secretary Azar waived certain requirements, retroactive nationwide as of March 6, related to HIPAA privacy. Specifically, the announcement states the following:

> *Pursuant to Section 1135(b)(7) of the Act, I hereby waive sanctions and penalties arising from noncompliance with the following provisions of the HIPAA privacy regulations: (a) the requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory (as set forth in 45 C.F.R. § 164.510); (b) the requirement to distribute a notice of privacy practices (as set forth in 45 C.F.R. § 164.520); and (c) the patient's right to request privacy restrictions or confidential communications (as set forth in 45 C.F.R. § 164.522); but in each case, only with respect to hospitals in the designated geographic area that have hospital disaster protocols in operation during the time the waiver is in effect.*

On March 17, the Office of Civil Rights (OCR) announced enforcement discretion for certain widely used communications. Specifically, the OCR press release states "effective immediately, that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19." For more information, see the statement, fact sheet, and Bulletin.

On March 20, OCR further announced enforcement discretion regarding HIPAA security, privacy, and breach requirements, while clarifying that this discretion does not apply to the confidentiality of substance use disorder records, given the Substance Abuse and Mental Health Services Administration (SAMHSA) has announced separate enforcement discretion regarding those rules. OCR continues to discourage the use of certain "public facing" platforms such as Facebook Live, Twitch, and TikTok. For additional OCR FAQs, visit here.

In response to the Medicare changes, the American Medical Association (AMA) shared the Quick Guide to Telemedicine in Practice, a new resource to help mobilize remote care with implementation tips, as well as a reference to Current Procedural Terminology (CPT®) codes for reporting telemedicine and remote care services. The AMA also offers an education module in the AMA's STEPS Forward™ that can help physicians use telemedicine in practice, and the Digital Health Implementation Playbook with a 12-steps process for adopting remote monitoring of patients outside the traditional clinical environment.

Application to hospice care. Section 3703 and section 3707 of CARES directly addresses key hospice concerns. Section 3703 rewrites the key provision (as outlined below) to afford greater flexibility in its application, while section 3707 amends the section 1135 face-to-face encounter to allow it to be performed via telehealth as part of the pandemic response. In light of these changes, CMS will likely revise its previous FAQs on the topic. Previously, the National Hospice and Palliative Care Organization (NHPCO) has requested that CMS waive the face-to-face encounter requirement.

VA and Telehealth

To bypass state licensure, the Veterans Administration (VA) issued a final rule *"that ensures that VA health care providers can offer the same level of care to all beneficiaries, irrespective of the State or location in a State of the VA health care provider or the beneficiary"* and *"achieves important Federal interests by increasing the availability of mental health, specialty, and general clinical care for all beneficiaries."*

FDA Guidance

On March 20, the Food and Drug Administration (FDA) issued a final guidance document that allows manufacturers of certain FDA-cleared non-invasive, vital sign-measuring devices to expand their use so that health care providers can use them to monitor patients remotely. The devices include those that measure body temperature, respiratory rate, heart rate and blood pressure.

HDHP Statutory Changes

Section 3701 of the CARES Act clarified that high deductible health plans (HDHPs) could opt to waive deductibles for telehealth services and still be considered a HDHP (i.e., be within a safe harbor).

State Response

State Licensing and Interstate "Compacts"

Given challenges with clinicians providing care across state lines, the Federation of State Medical Board (FSMB) established the Interstate Medical License Compact Commission (IMLCC). According to IMLCC, *"[t]he Interstate Medical Licensure Compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states."* At this time, 29 states, the District of Columbia and the Territory of Guam, have agreed to the compact. Additional information about FSMB and telemedicine policy is available here.

According to the Center for Connected Health Policy of the National Telehealth Policy Resource Center report, State Telehealth Laws & Reimbursement Policies, issued in late 2019, *"[n]ine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state)."*

In addition to the IMLC, there are additional compacts for nurses, physical therapists and psychologists.

- The Nurses Licensure Compact (34 state members)
- The Physical Therapy Compact (26 members)
- The Psychology Interjurisdictional Compact (12 members)

Emergency Management Assistance Compact. Some have suggested that the use of the Emergency Management Assistance Compact, an agreement among the states and U.S. territories allowing sharing of resources during emergencies, would be a good tool to eliminate telehealth licensure barriers. The EMAC includes a provision for someone licensed in one state to be licensed in another facing an emergency when the compact is invoked. According to Bloomberg, Trina Sheets, executive director of the National Emergency Management Association, which administers the compact, said the compact has not been used in the past to provide telehealth services but would make a good vehicle for that purpose.

State Flexibility. The President declared an emergency under the Stafford Act on March 13. As a result of that declaration and the prior public health emergency declaration, CMS has additional waiver authority under section

1812(f) and section 1135. States can gain new authority to use their Medicaid programs to respond to the coronavirus pandemic under the national emergency President Donald Trump declared Friday. For instance, States may be able to expand the use of telehealth services in their Medicaid programs to combat the coronavirus outbreak. On March 17, CMS issued additional Medicaid telehealth guidance and while also highlighting their main website for telehealth in Medicaid. Per the FAQs, "[n]o federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services."

State activity. On March 15, the State of Washington submitted a section 1135 waiver, which was approved on March 19, and responds to the specific requests. While the CMS approval does not specifically address telehealth, per the previous FAQ, if the intent is to reimburse providers for telehealth in the same manner or in the same rate that the states pay for face-to-face services, those are considered automatically approved.

Washington requested the following items with respect to telehealth:

> *Telehealth 42 C.F.R. §410.78(b):*
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> *7.1 Consistent with the authority granted the Secretary under the Coronavirus Preparedness and Response Supplemental Appropriations Act, eliminate Medicare restrictions on licensing for telehealth and geographic restrictions on originating sites. Allow billing using CPT codes 99444 and 98969 for both new and established patients. Ask the HHS OIG to confirm that telemedicine screenings without co-pays and deductibles do not violate the CMP law or anti-kickback statute.*
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> *7.2 Eliminate the requirement that in order to bill for a telehealth service a provider must have billed that Medicaid or Medicare enrollee for a service within the previous three years.*
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> *7.3 Allow E&M codes to be billed via telehealth or telephonic services even for first time patients.*
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> *7.4 These steps will allow providers to screen and treat significantly more patients, reduce risk to front line health care providers, and assist in resolving the shortage of providers.*
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> *7.5 Allow for reimbursement for telephone visits at the same rate as telehealth video visits. For many cases the video aspect does not add value to the patient interaction – it's the information relayed to the patient that matters. See CPT codes 99441, 99442, 99443; HCPCS G2012, G0071. The state believes we have authority to do this for telehealth and telephonic services under the Medicaid program, but this provision must be clarified for Medicare. In addition, consistent with our request above for the codes to be opened for new patients in addition to the established patients, which these codes currently only apply.*
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> *7.6 Allow capacity funding for providers, which may include grants or other funding Medicaid financing or other dollars available to be used for purchase of equipment as necessary for providers and patients (e.g. laptops, additional cell-phones or additional cell-phone plan minutes for clients so they are free to use the phone for services).*
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> *7.7 Provide indemnify/hold harmless for emergency telehealth services.*

Key Limitations & Additional Considerations

Key Limitations. Despite these recent activities, key gaps remain.

Medicaid. As noted above, CMS has provided flexibility for automatic approval for certain State telehealth waivers. For a list of approved waivers, which do not necessarily include all of the telehealth waivers, visit here.

Private payers (especially ERISA covered plans). While CMS Administrator Seem Verma has made it clear that the Administration is urging private payers to make similar modifications, so far, there has not been a broad announcement to that effect. While some states are moving forward to address the topic at the state level, state activities cannot address ERISA-covered plans.

Coding concerns. Given that this is the first time in which widespread telehealth services would be available, there have been some concerns that the current telehealth codes (for both Medicare and other payers) are not quite comprehensive enough to address all of the needed situations.

Telephone only. Several of the current Medicare codes require audio and visual capabilities. Given that many elderly individuals may not have access to such resources, providers are requesting the ability to perform certain tasks via telephone only.

Additional Considerations. As providers take steps to implement new telehealth provisions, legal experts suggest that providers should take into account key issues with respect to security (including specific platforms), medical credentials, and recording of those visits. Changes in health care as the coronavirus pandemic progresses may force regulators to adjust barriers around telehealth.

Medical licensing, credentials, and out of network issues. While Secretary Azar was able to waive certain licensure requirements to allow for Medicare and Medicaid payments to providers who do not have a license within that State, the waiver does not extend to non-Federal programs. As such, some states require physicians to have a medical license in the same state that their patient is located in order to provide virtual healthcare. And, especially with respect to controlled substances, States may have additional requirements for e-prescribing those products. Further, even if the State opts to waive the licensure requirements, it may still have additional requirements regarding credentialing. Finally, even if an out-of-state provider is able to address the licensure and credentialing issues, the provider will likely be considered out-of-network by private payers.

Adequate notes. To ensure proper compliance in the event of an audit, clinicians should ensure that provider notes are adequate and consider the use of audiovisual recording to provide the necessary data to support coding and billing.

Legislative Text. As described above, the text of Public Law No: 116-123, showing changes made by sec. 6010 of H.R. 6201 and section 3703 of H.R. 748, follows:

SEC. 101. SHORT TITLE.

This division may be cited as the ``Telehealth Services During Certain Emergency Periods Act of 2020''.

SEC. 102. SECRETARIAL AUTHORITY TO TEMPORARILY WAIVE OR MODIFY APPLICATION OF CERTAIN MEDICARE REQUIREMENTS WITH RESPECT TO TELEHEALTH SERVICES FURNISHED DURING CERTAIN EMERGENCY PERIODS.

(a) In General.--

(1) Waiver authority.--The first sentence of section 1135(b) of the Social Security Act (42 U.S.C. 1320b-5(b)) is amended--

(A) in paragraph (6), by striking ``and'' at the end;

(B) in paragraph (7), by striking the period at the end and inserting ``; and''; and

(C) by inserting after paragraph (7) the following new paragraph:

``(8) in the case of a telehealth service (as defined in paragraph (4)(F) of section 1834(m)) furnished in any emergency area (or portion of such an area) during any portion of any emergency period**, the requirements of section 1834(m).** ~~to an individual by a qualified provider (as defined in subsection (g)(3)) -~~

~~``(A) the requirements of paragraph (4)(C) of such section, except that a facility fee under paragraph (2)(B)(i) of such section may only be paid to an originating site that is a site described in any of subclauses (I) through (IX) of paragraph (4)(C)(ii) of such section; and~~

~~``(B) the restriction on use of a telephone described in the second sentence of section 410.78(a)(3) of title 42, Code of Federal Regulations (or a successor regulation), but only if such telephone has audio and video capabilities that are used for two-way, real-time interactive communication.''.~~

(2) Definition of qualified provider.--Section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)) is amended by adding at the end the following new paragraph:

~~``(3) Qualified provider.--The term `qualified provider' means, with respect a telehealth service (as defined in paragraph (4)(F) of section 1834(m)) furnished to an individual, a physician or practitioner (as defined in paragraph (4)(D) or (4)(E), respectively, of such section) who--~~

~~``(A) 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~~ **furnished to such individual, during the 3-year period ending on the date such telehealth service was furnished, an item or service that would be considered covered under title XVIII if furnished to an individual entitled to benefits or enrolled under such title; or**~~'~~

~~``(B) 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.''.~~

(3) Implementation.--The Secretary of Health and Human Services may implement the amendments made by this subsection by program instruction or otherwise.

(b) Clarification of Definitions of Emergency Area and Emergency Period.--Paragraph (1) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)) is amended to read as follows:

``(1) Emergency area; emergency period.--

``(A) In general.--Subject to subparagraph (B), an `emergency area' is a geographical area in which, and an `emergency period' is the period during which, there exists--

``(i) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

``(ii) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

``(B) Exception.--For purposes of subsection (b)(8), an `emergency area' is a geographical area in which, and an `emergency period' is the period during which, there exists--`

`(i) the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act on January 31, 2020, entitled `Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus'; and

``(ii) any renewal of such declaration pursuant to such section 319.''.

1834(m) reads as follows:

(m) PAYMENT FOR TELEHEALTH SERVICES.—

(1) IN GENERAL.—The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term ‘‘telecommunications system’’ includes store-and-for- ward technologies that provide for the asynchronous trans- mission of health care information in single or multimedia for- mats.

(2) PAYMENT AMOUNT.—
(A) DISTANT SITE.—The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.
(B) FACILITY FEE FOR ORIGINATING SITE.—
(i) IN GENERAL.—Subject to clause (ii) and paragraph (6)(C), with respect to a telehealth service, subject to section 1833(a)(1)(U), there shall be paid to the originating site a facility fee equal to—
(I) for the period beginning on October 1, 2001, and ending on December 31, 2001, and for 2002, $20; and
(II) for a subsequent year, the facility fee specified in subclause (I) or this subclause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.
(ii) NO FACILITY FEE IF ORIGINATING SITE IS THE HOME.—No facility fee shall be paid under this subparagraph to an originating site described in para- graph (4)(C)(ii)(X).
(C) TELEPRESENTER NOT REQUIRED.—Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).
(3) LIMITATION ON BENEFICIARY CHARGES.—
(A) PHYSICIAN AND PRACTITIONER.—The provisions of section 1848(g) and subparagraphs (A) and (B) of section 1842(b)(18) shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.
(B) ORIGINATING SITE.—The provisions of section 1842(b)(18) shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.
(4) DEFINITIONS.—For purposes of this subsection:
(A) DISTANT SITE.—The term ''distant site'' means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.
(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term ''eligible telehealth individual'' means an individual enrolled under this part who receives a telehealth service furnished at an originating site.
(C) ORIGINATING SITE.—
(i) IN GENERAL.—Except as provided in paragraphs (5), (6), and (7), the term' 'originating site'' means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—
(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));
(II) in a county that is not included in a Metropolitan Statistical Area; or
(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.
(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:
(I) The office of a physician or practitioner. (II) A critical access hospital (as defined in section 1861(mm)(1)).
(III) A rural health clinic (as defined in section 1861(aa)(2)).
(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).
(V) A hospital (as defined in section 1861(e)). (VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).
(VII) A skilled nursing facility (as defined in section 1819(a)).
(VIII) A community mental health center (as defined in section 1861(ff)(3)(B)).
(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).
(X) The home of an individual, but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).
(D) PHYSICIAN.—The term ''physician'' has the meaning given that term in section 1861(r).
(E) PRACTITIONER.—The term ''practitioner'' has the meaning given that term in section 1842(b)(18)(C).
(F) TELEHEALTH SERVICE.—
(i) IN GENERAL.—The term ''telehealth service'' means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804– 90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).
(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1881(b)(3)(B), at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).
(6) TREATMENT OF STROKE TELEHEALTH SERVICES.—
(A) NON-APPLICATION OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute
stroke, as determined by the Secretary.
(B) INCLUSION OF CERTAIN SITES.—With respect to telehealth services described in subparagraph (A), the term ''originating site'' shall include any hospital (as de- fined in section 1861(e)) or critical access hospital (as de- fined in section 1861(mm)(1)), any mobile stroke unit (as defined by the Secretary), or any other site determined ap- propriate by the Secretary, at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system.
(C) NO ORIGINATING SITE FACILITY FEE FOR NEW SITES.—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).
(7) TREATMENT OF SUBSTANCE USE DISORDER SERVICES FURNISHED THROUGH TELEHEALTH.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after July 1, 2019, to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder, as determined by the Secretary, at an originating site described in paragraph (4)(C)(ii) (other than an originating site described in subclause (IX) of such paragraph).

SEC. 3706. USE OF TELEHEALTH TO CONDUCT FACE-TO FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD.
Section 1814(a)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395f(a)(7(D)(i)) is amended—
(1) by striking ''a hospice'' and inserting ''(I) subject to subclause (II), a hospice''; and
(2) by inserting after subclause (I), as added by paragraph (1), the following new subclause:
''(II) during the emergency period described in section 1135(g)(1)(B), a hospice physician or nurse practitioner may conduct a face-to-face encounter required under this clause via telehealth, as determined appropriate by the Secretary; and''.

The amendment would change current law as shown below (proposed new text added in red):

(7) in the case of hospice care provided an individual—
(A)(i) in the first 90-day period—
(I) the individual's attending physician (as defined in section 1395x(dd)(3)(B) of this title) (which for purposes of this subparagraph does not include a nurse practitioner), and
(II) the medical director (or physician member of the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program providing (or arranging for) the care, each certify in writing at the beginning of the period, that the individual is terminally ill (as defined in section 1395x(dd)(3)(A) of this title) based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness, and
(ii) in a subsequent 90- or 60-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill based on such clinical judgment;

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director (and the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program;

(C) such care is being or was provided pursuant to such plan of care; and

(D) on and after January 1, 2011—

(i)(I) subject to subclause (II), a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary);

(II) during the emergency period described in section 1135(g)(1)(B), a hospice physician or nurse practitioner may conduct a face-to-face encounter required under this clause via telehealth, as determined appropriate by the Secretary; and

(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this subchapter, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary);