NATIONAL ASSOCIATION OF Community Health Centers

MEMORANDUM

To: **Primary Care Associations and Health Center Controlled Networks**
From: **NACHC State Affairs Team**
Date: **October 27, 2020**
RE: **Resource Guide on Telehealth Coverage in Medicaid**

During the pandemic, health centers have relied on telehealth to deliver essential primary and preventive care. Many health centers had some telehealth technologies in place prior to the pandemic, but most had to boost their operations to go "fully virtual" during the pandemic. Looking ahead, it is critical that state and federal policy protect the ability of health centers to provide, and be reimbursed for, telehealth services.

This Resource Guide provides important understanding on how states may improve Medicaid coverage of telehealth, sample state plan language, and model state legislation. Please do not hesitate to reach out to us at state@nachc.org with any questions.

Medicaid Coverage of Telehealth at Health Centers During the Pandemic

The Centers for Medicare and Medicaid Services (CMS) gives each state significant flexibility in how it decides to cover telehealth (or not) and how it decides to pay for services delivered via telehealth in its Medicaid program. This flexibility existed prior to the COVID-19 pandemic.

In March 2020, CMS encouraged states to expand use of telehealth due to the COVID-19 pandemic, noting that it would work with states to expedite any needed policy changes. To date, **all 50 states plus the District of Columbia and Puerto Rico** have expanded their telehealth policies, the majority of which include FQHCs and are effective through the duration of the Public Health Emergency (PHE). Many are reimbursing health centers at the PPS/APM level or as they would be paid for in-person visits. This policy is not consistent across the states, with wide variation in coverage and reimbursement rates. As health centers and PCAs advocate to make these policies permanent, Primary Care Associations (PCAs) should work with their State Medicaid agencies via State Plan Amendment (SPA), and with their state legislatures to ensure telehealth visits are covered and reimbursed at the Medicaid PPS/APM rate.

State Flexibility in Telehealth

Coverage of Telehealth

As noted, states have considerable flexibility in how they choose to cover telehealth services in their Medicaid program. States have the option to determine whether (or not) to utilize telehealth; what types of services to cover and where in the state it can be utilized; how it is implemented; what types of practitioners or providers may deliver services via telehealth, provided such practitioners or providers are "recognized" and qualified according to Medicaid federal and state statute and regulation; and reimbursement rates. States have full discretion to select from a variety of HCPCS codes and modifiers to identify, track, and reimburse for these services.

In late October 2020, CMS published its *State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth COVID-19 Version: Supplement #1*. Specifically, it "helps states think through how they will explain and clarify which policies are temporary or permanent, when flexibilities will expire, which

services can be accessed through telehealth, which providers may deliver those services, the modality they may use to deliver telehealth services, and the circumstances under which telehealth can be reimbursed."

NACHC recommends PCAs and FQHCs use Supplement #1 to help structure any request for coverage of FQHC services through telehealth both during the PHE and after it ends. It includes key information related to the range of available telehealth modalities, treating substance use disorder via telehealth, coverage templates and links to HRSA and Center for Connected Health Policy resources.

State Plan Amendments

States are not required to submit a SPA to pay for services delivered via telehealth **if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting**. CMS has accepted FQHC telehealth visits as equivalent to face-to-face visits, though a state may wish to submit a SPA to clarify that telehealth visits are treated as fully billable visits. **In the absence of a SPA, NACHC encourages PCAs to request formal confirmation of their billing policy for telehealth visits.**

States may submit a coverage SPA to describe services delivered via telehealth. A state would need an approved state plan payment methodology – and thus may need to submit a SPA – to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face encounter. **NACHC emphasizes that the statutory requirement to pay at least PPS for billable encounters continues to apply to services delivered through telehealth. The state may not differentiate its payment methodology, either PPS or APM, for telehealth.**

States may pay a qualified physician, or other licensed practitioner, at the distant site (the billing provider), and the state's payment methodology may include costs associated with the time and resources spent facilitating care where the beneficiary is located, such as a medical facility or the beneficiary's home. CMS has strongly encouraged states to include costs associated with providing services via telehealth within Medicaid payment methodologies and ensure that rates are adequate to facilitate telehealth services. **NACHC encourages PCAs and their members to work with their states to assure adequacy of payments to health centers.**

Medicaid guidelines require all providers to practice within the scope of their "state practice act." States should follow their state plan regarding payment to qualified Medicaid providers for telehealth services. FQHCs would still to be required to adhere to existing provider qualifications for services delivered through telehealth.

States may also pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for the delivery of telehealth services. Ancillary costs associated with the site where the beneficiary is located may be incorporated into the fee-for-service rates, or separately reimbursed as an administrative cost by the state when a Medicaid service is delivered. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth, and properly allocated to the Medicaid program. CMS states that such payment does not need to be at the level of the PPS rate.

NACHC emphasizes that states must continue to pay the PPS rate or under the APM for services delivered through telehealth. This is affirmed by CMS in FAQ #15 (see below), which conveys current policy and does not represent a novel interpretation of the statutory requirement to pay at least PPS.

> Q15. Can states pay FQHCs and RHCs an amount less than the PPS rate on a FFS basis with an approved SPA or waiver? Additionally, if a service is provided telephonically, can the state pay the provider an

amount lower than Prospective Payment System (PPS) rate for the telephonic service delivered via telehealth?

A15. If a service is covered within the scope of the FQHC/RHC benefit, section 1902(bb) of the Act requires a state to pay a provider using the state plan prospective payment system (PPS) rate or an alternative payment methodology (APM) that pays at least the PPS rate. For services that are not covered as part of the FQHC/RHC benefit, a state may pay providers using the state plan fee- for-service payment methodology established for that service. Rates for those services may be lower than the PPS or an APM paid for FQHC/RHC services, provided the rate is consistent with all other applicable requirements, including section 1902(a)(30)(A) of the Act. This policy applies whether a service is delivered face-to-face or telephonically.

Sample SPA Language

Here are two examples of SPA language approved by CMS. Notably, language that adds payment for the additional cost of services delivered through telehealth will generally not appear in the FQHC section of the Medicaid state plan, unless the state elects to pay under an APM that consolidates payment for the encounter, plus the additional costs associated with telehealth.

A state may specify in the Medicaid state plan which types of services qualify for payment when delivered through telehealth but is not required to do so. **To ensure full payment (PPS plus the additional fee) of services provided through telehealth, NACHC recommends advocating that the state specifies, in its state plan, coverage of all FQHC services without limitation unless the service, by definition, must be delivered face-to-face.**

It is important to note that a state may not pay less than the PPS rate for FQHC services, as the statute does not contemplate differentiating payment based on the mode of delivery at FQHCs. **While there is no need to specify in the state plan that payment of PPS still applies to services delivered through telehealth, you may wish to ask the state to memorialize this point in the state plan as a protection to the health centers.**

The first example specifies that the distant provider will receive a separate add-on facility fee in addition to the direct service rate already approved in the state plan. This means distant site FQHCs could **potentially** receive PPS plus an additional payment.

> **Example 1:** For services provided via telehealth, the billing provider will code the service using modifier (x). The provider will receive an add-on fee of $x, which is effective for services on or after xx/xx/xxxx; all rates are published at [state's website]. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers. The distant site provider will also be reimbursed in accordance with the standard Medicaid reimbursement methodology for the allowable Medicaid services performed.

In the second example, "qualifying patient sites" (of a distant provider) may receive a facility fee that is pegged to the Medicare rate. The distant site providers would continue to also receive the state plan rate, which for FQHCs is PPS.

Example 2: Qualifying patient sites are reimbursed a facility fee. The fee is set at x% of Medicare and is effective for services on or after xx/xx/xxxx; all rates are published at [state's website]. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers. Distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology.

While the above paragraphs may be useful to consider in working with your state – since CMS has approved them – **PCAs should work to ensure inclusion of specific FQHC payment language like the** following**:**

"Notwithstanding the previous paragraphs, services provided via telehealth by FQHCs, to the extent that they qualify as services of an FQHC per Section 1905(a)(2)(C) of the Social Security Act, shall be reimbursed at the same per visit amount that the FQHC would receive for such services if they were provided by the FQHC in a face-to-face visit, per section 1902(bb) of the SSA."

Model Legislation

Some PCAs may seek state legislation to ensure that services delivered via telehealth are covered at FQHCs and reimbursed appropriately. While this is not a critical step, it can be an important one to demonstrate your state's commitment to allowing health centers to provide these services. Below is model state legislation that would ensure health centers are allowed to provide services via telehealth and are paid at the PPS or APM rate.

PPS/APM for Telehealth Visits
Services provided by telehealth by Federally Qualified Health Centers (FQHCs), to the extent that they qualify as services of an FQHC per Section 1905(a)(2)(C) of the Social Security Act (SSA), shall be reimbursed at the same per visit amount that the FQHC would receive for such services if they were provided by the FQHC in a face-to-face visit, per section 1902(bb) of the SSA. For telehealth services that are not covered as part of the FQHC benefit, payment to FQHCs shall follow the fee-for-service payment methodology established for that service. This policy applies whether a service is delivered face-to-face or telephonically **[Add reference to applicable state law as appropriate if it exists, that is, if there is state law that establishes FQHC services as a Medicaid-covered service, provision for PPS and/or APM reimbursement, if there is definition of an FQHC service as one that requires a face-to-face visit, etc.]**

Definition of "telehealth" and "telehealth services"
"Telehealth" and "telehealth services" mean a mode of delivery of health care services through HIPPA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store and forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Medicaid recipient's covered person's health care, while that recipient person is located at an originating site and the provider is located at a distant site. Such services also include telephonic services.

Payment for additional telehealth costs
Costs associated with the delivery of telehealth services by a Federally Qualified Health Center (FQHC) serving as a distant site pursuant to this Section may be reimbursed through a separate amount to the distant site or when paid to the distant site provider in addition to the PPS/APM, the payment may be treated as an alternative payment methodology pursuant to section 1902(bb)(6) of the Social Security Act.

Managed Care

The treatment and payment of telehealth visits provided in paragraph __ above shall also apply if, and when, the service is provided by an FQHC to a Medicaid recipient who is enrolled in a Managed Care Organization (MCO) for whom the FQHC has contracted with such MCO to provide Medicaid services. Additional "wrap-around" payments that the state, or MCO, are required to pay to the FQHC per Section 1902(bb)(5) shall be based on calculations that include such telehealth visits as face-to-face visits for which payment is due to the FQHC under the PPS, per 1902(bb) of the SSA.

CMS Medicaid Telehealth Resources

- **3.22.2020** Creation of new Medicaid Disaster State Plan Amendment Template
    - This tool allows states to temporarily expand coverage to add telehealth as a Medicaid benefit in a public health emergency or disaster.
- **4.2.2020** Release of the Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act Informational Bulletin
    - This bulletin identifies opportunities for telehealth delivery methods to increase access to Medicaid services and federal reimbursement for SUD treatment services delivered via telehealth, including in school-based health centers.
- **4.23.2020** Release of the Medicaid and CHIP Telehealth Toolkit
    - This toolkit helps states better understand how to implement telehealth to support Medicaid and Children's Health Insurance Programs (CHIP) during the COVID-19 pandemic.
- **10.14.2020** Release of the State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth, Supplement #1.
    - This supplement provides additional support to state Medicaid and CHIP agencies in their adoption and implementation of telehealth, exploring terminology, communication strategies, telehealth operations and implementation tools, and shared experiences and examples from states and territories across the nation. It includes updates to FAQs and Resources for states to consider as they expand telehealth and begin to plan beyond temporary flexibilities.

For questions, please contact state@nachc.org.