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The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020: Telehealth Implications for Health Centers

March 20, 2020

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WHAT WE WILL COVER TODAY

• Emergency declarations and health center funding
• HRSA and telehealth
  – Guidance on telehealth expansion to combat COVID-19
  – Telehealth Program Assistance Letter (PAL)
• Medicare and telehealth
  – Recently implemented Section 1135 waiver relating to Medicare telehealth requirements
  – Use of virtual communication services
• Medicaid and telehealth
  – State flexibility
  – State emergency Medicaid regulations / guidance and 1135 waiver applications
• Other relevant emergency-related waivers
Emergency Declarations and HRSA Health Center Funding
• On January 31, 2020, HHS issued a declaration of a national public health emergency regarding the novel coronavirus (COVID-19)
• On March 6, 2020, a new law, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, P.L. 116-123 (the Act) was enacted
• On March 13, 2020, President Trump declared a national emergency under the National Emergencies Act and made an emergency determination under the Stafford Act
• Waivers under Social Security Act § 1135 of otherwise-applicable Medicare, Medicaid and CHIP requirements are available during “emergency periods,” defined as any period when there is in effect both a declaration of a public health emergency, and a declaration of a national emergency

CORONAVIRUS PREPAREDNESS AND RESPONSE
SUPPLEMENTAL APPROPRIATIONS ACT, 2020

The $8.3 billion Coronavirus Supplemental provides a robust response to this public health emergency.

- $2.2 billion in public health funding for prevention, preparedness, and response, including:
- $950 million to support state & local health agencies
- Allows an estimated
- $7 billion in low-interest loans to affected small businesses
- More than
- $3 billion for research and development of vaccines, therapeutics, and diagnostics
- Nearly
- $1 billion for medical supplies, health care preparedness, and medical surge capacity
- More than
- $1.25 billion to ensure access to affordable vaccines
- More than
- $300 million to secure Americans' health by addressing the coronavirus overseas

Passed by the House Appropriations Committee
Chairwoman Nita M. Lowey
FUNDING FOR HEALTH CENTERS UNDER THE ACT

• $100 million of funding to the Health Resources and Services Administration (HRSA) for grants under the Health Center Program to “prevent, prepare for, and respond to coronavirus.”

• According to HRSA’s Novel Coronavirus (COVID-19) Frequently Asked Questions, HRSA is expediting the award process and anticipates awarding COVID funding in March.
  – Pre-award costs will be supported by this funding and may date back to January 20, 2020, for costs incurred related to preventing, preparing for, and/or responding to COVID-19. HRSA will provide official guidance on the terms of the award.
  – Check the HRSA website and the FAQs for updated information.
HRSA – Telehealth and the Coronavirus Response
HRSA PROGRAM ASSISTANCE LETTER: 
TELEHEALTH AND HEALTH CENTER SCOPE OF PROJECT (1/27/2020)

• Telehealth is not a service or a service delivery method requiring specific HRSA approval
  — *Telehealth is a mechanism or means for delivering a health service(s) to health center patients using telecommunications technology or equipment*

NOTE: Whether a telehealth arrangement is “in scope” from a HRSA perspective is unrelated to whether the services are billable and/or otherwise provided in a manner consistent with state law.
TELEHEALTH AND HRSA SCOPE OF PROJECT

- **Services**: Is the underlying service being provided via telehealth included in the health center’s Form 5A, and is the correct delivery method (i.e., directly, by contract, or by referral) selected?
  - “Primary care” includes screenings or triage, including initial consultations to health center patients or to individuals who may become a patient of the health center
  - If you don’t know whether the underlying service falls in scope, see the [Form 5A Service Descriptors](#) for more information
• **Sites**: Where is the patient located and where is the provider located? See the chart in the Telehealth PAL.
  – The chart contemplates that the patient and/or the provider may be at a location other than a Form 5B service site.
  – See Footnote 11: “The absence of a particular scenario from the table does not preclude that activity from potentially being part of the health center’s scope of project.”
• Health centers may set up "temporary sites (that) are within the health center's service area or neighboring counties, parishes, or other political subdivisions adjacent to the health center's service area" (for in-scope services) with notification made to BPHC within 15 days.
  – See PAL 2014-05 for full details and requirements “to ensure that the emergency response at temporary locations is considered part of the center's scope of project.”
  – Contemplates temporary sites within and outside of the service area.
  – For purposes of FTCA coverage, patients served by covered individuals at temporary locations included in the covered entity's scope of project are considered the covered entity's patients. As such, the covered entity and its providers are covered by FTCA for services provided during the emergency at temporary locations.
Key Takeaways:

1. I suggest that health centers review their scope of project documentation in the EHB to ensure that Forms 5A, 5B and Form 5C are accurate.

2. A health center provider (an employee or a contractor) may provide services via telehealth even if the provider is at a non-service site (e.g., his/her home, a private medical practice). Such location is not recorded in Form 5B or Form 5C.

3. Screenings or triage, including initial consultations to health center patients or to individuals who may become a patient of the health center, may be conducted by health center providers either in person or by telehealth.
TELEHEALTH AND HRSA SCOPE OF PROJECT

• **Key Takeaways:**

  4. Health center providers may deliver in-scope services via telehealth to individuals who have not previously presented for care at a health center site and who are not current patients of the health center.

  5. Telehealth visits are within the scope of project if:
      – The individual receives an in-scope required or additional health service;
      – The provider documents the service in a patient medical record; and
      – The provider is physically located at a health center service site or at some other location on behalf of the health center (e.g., provider’s home, emergency operations center).
TELEHEALTH AND HRSA SCOPE OF PROJECT

• Key Takeaways:

6. If the patient is at their home receiving screening or triage (or any other in-scope services) via telehealth, confirm that “Home Visits” is listed on Form 5C: Other Activities. I suggest that health centers include a reference to “telehealth” in the Form 5C description.

7. If the screenings and consultations are conducted outside of health center sites (for example, in a parking lot or on the street) then include “Portable Clinical Care” on Form 5C.
   – “Mobile team”
   – Indicate the types of locations as appropriate (e.g., street, temporary shelters, schools, soup kitchens) and the frequency as appropriate (e.g., on an as needed basis)
Key Takeaways:

8. Service Area:

- Health centers should focus services provided by telehealth on serving individuals located inside their service area or within areas adjacent to the health center’s service area.

- BUT... it is recognized that patients outside these areas may seek health center screenings and triage by telehealth. Health centers that continue to maintain services for target populations in their service area and provide occasional in-scope services via telehealth to individuals outside these areas would be providing services within the Health Center Program scope of project for all such activities.
• See the summary of “Virtual Visits” which begins on page 53.
• Are virtual/telemedicine visits only permitted after a face-to-face visit at the health center?
  – No, although most telemedicine visits will occur from a referral from a face-to-face visit. If the first or only visit is a reportable virtual visit, health centers must register the patients and collect and report all relevant demographic, service, clinical, and financial data on the UDS tables.
• If a patient’s telemedicine visit is the first or only visit for the patient during the reporting period, the patient should be counted on the UDS? (HRSA webinar summarizing the 2019 UDS instructions)
  – Answer: Yes (but consider that the individual must be registered as a patient and the health center must get the requisite information for UDS reporting, e.g., income and family size).
COVID-19 DATA REPORTING

• HRSA is asking health centers to begin filling out a twice-weekly survey to help track the number of patients who have undergone COVID-19 testing at each health center, along with other critical information about health center operations during the pandemic.

• Each health center will receive an electronic survey twice a week on Monday and Thursday afternoons via email from BPHCanswers@hrsa.gov.
CHECK YOUR STATE LAW

• Check your state law!
  – Licensing (particularly if provider is out of state)
  – Informed consent
  – Patient privacy
  – Prescribing of controlled substances
  – Medicaid (see Susannah’s slides)
POLICY AND PROCEDURE

• Refer to the Telehealth PAL and Develop A Telehealth Policy and Procedure
  – The in-scope services furnished via telehealth shall be furnished within the health center’s scope of project.
  – Individuals served will be registered as health center patients.
  – The health center will maintain medical records applicable to its provision of in-scope services via telehealth.
  – Patients who receive in-scope services via telehealth will have reasonable access to the health center’s full scope of services (e.g., will be provided with information about the health center’s scope of services and sites).
  – Health center will obtain the patient’s informed consent, in accordance with state law.
  – Health center will bill patients in accordance with its fee schedule and its schedule of discounts.
  – Identify staff who will oversee the provision of services via telehealth
Medicare/Medicaid Telehealth and the Coronavirus Response
MEDICARE/MEDICAID/CHIP EMERGENCY WAIVER PROVISION
SOCIAL SECURITY ACT § 1135

• Purpose of waivers under Section 1135 of the Social Security Act is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period,
  1. sufficient health care items and services are available to meet the needs of Medicare, Medicaid and CHIP enrollees; and
  2. health care providers that “furnish such items or services in good faith, but are unable to comply with one or more requirements [of types listed in the law] may be reimbursed for such items and requirements and exempted from sanctions for such noncompliance”

• HHS may issue such waivers in an area, and during a period, in which
  1. an emergency or disaster has been declared by the President pursuant to the National Emergencies Act or the Stafford Disaster Relief and Emergency Assistance Act; and
  2. a public health emergency has been declared by the Secretary pursuant to section 319 of the Public Health Service Act

• Waivers typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published

• Waivers may be issued on a “blanket” or individual (provider-by-provider) basis, and States may request blanket 1135 waivers relating to Medicare or Medicaid requirements
Medicare/Medicaid/CHIP federal requirements that may be waived under a Section 1135 waiver

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions (to allow for redirection of patients to receive screenings in alternative locations)
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment to permit Medicare enrollees to use out of network providers in an emergency situation
- Certain HIPAA privacy-related sanctions and penalties
- Certain telehealth-related Medicare requirements (added in last week’s legislation) – discussed later

Social Security Act § 1135(b); HHS, 1135 Waivers
HOW DOES THE ACT EASE TELEHEALTH REQUIREMENTS IN MEDICARE & MEDICAID FOR FQHCs? WHAT OTHER FLEXIBILITIES CAN BE USED?

• **Medicare:**
  • Under the Act and the Centers for Medicare & Medicaid Services’ (CMS’) Section 1135 Medicare waiver, telehealth “originating site” requirements and some restrictions on telehealth technology are waived during the emergency period
  • **Medicare “distant site provider” barrier for FQHCs/RHCs remains**
  • Since CY2019, Medicare has paid FQHCs for “virtual communication services,” which may be an important tool for screening and assisting patients during coronavirus crisis

• **Medicaid**
  • States have significant flexibility in choosing whether and how to pay for telehealth services; in general, they may facilitate telehealth coverage without needing CMS approval
  • Many states have issued emergency coronavirus Medicaid regulations that address telehealth
  • Some states have sought Section 1135 waivers to loosen federal requirements (e.g., relating to provider enrollment) that may be relevant to telehealth services
Existing Law - FQHCs and Medicare Remote/Technology-Based Services
AN FQHC “VISIT” MAY NOT BE FURNISHED VIA TELEHEALTH TECHNOLOGY

- Per CMS regulation, an FQHC “visit” must be “face-to-face” (42 C.F.R. § 405.2463)
- CMS has interpreted the term “face-to-face” in the regulation to mean that the FQHC visit must occur in person (not via telehealth)

“[F]or RHCs and FQHCs to be reimbursed under the all-inclusive rate, there must be a face to face encounter between the RHC or FQHC practitioner and the patient, and . . . this requirement would need to be modified in order for RHCs and FQHCs to be able to bill for a telehealth visit.”

CMS, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for CY 2014 (Dec. 10, 2013)
MEDICARE “TELEHEALTH” AND VIRTUAL COMMUNICATION SERVICES

We will focus today on two types of services furnished under Medicare Part B:

1. **Telehealth services** – services rendered via synchronous telecommunications that are considered a substitute for an in-person visit (Social Security Act (SSA) §1834(m); 42 C.F.R. § 410.78)

2. **Virtual communication services** – brief discussions via remote technology with a practitioner to determine if a visit is necessary (Medicare Physician Fee Schedule (PFS) Calendar Year (CY) 2019 Final Rule)
“Telehealth services” is a discrete Medicare Part B benefit (SSA § 1834(m)), added to the Medicare benefit in 2000.

“Hub-and-spoke” model: Physician or practitioner located at “distant site” (“hub”) furnishes care to a patient located at an “originating site” (“spoke”).

Distant site key requirements
- “Physician or practitioner” – must be a physician or practitioner who bills for services under the Physician Fee Schedule
- “Distant site” – where physician or practitioner is located
- “Covered telehealth services”
  - Must correspond to a CPT/HCPCS code included on a CMS list of covered telehealth services
  - SSA § 1834(m)(4)(F); the Secretary of HHS is required to identify changes to the list of covered telehealth services annually ([https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html))

Distant site fee corresponds to Physician Fee Schedule rate for in-person service.
• **Distant site key requirements, cont.**
  
  – Communications system

  • With limited exceptions, “interactive telecommunications system” required – “audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site physician or practitioner”

  • By regulation, “telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system”

42 C.F.R. § 410.78(a)(3)
MEDICARE TELEHEALTH SERVICES – FQHC MAY NOT BILL AS DISTANT SITE

• **Under current law, FQHC may not bill as distant site provider**

• CMS’ reasoning:
  – FQHCs are facilities, and are not “physicians or practitioners” allowed to bill as distant site under SSA § 1834(m)
  – Medicare telehealth services are considered a “non FQHC/RHC service”
  – FQHC may not bill for distant site telehealth service, and associated costs may not be included as FQHC service costs on the cost report
  – This prohibition applies equally to telehealth services furnished by FQHC employees and to services furnished by contractors

• **Note:** Medicare Advantage plans are not required to follow this restriction, and many do pay FQHCs for telehealth services

CMS, [Medicare Benefit Policy Manual](https://www.cms.gov), Chapter 13, Section 200
MEDICARE TELEHEALTH SERVICES – FQHC MAY BILL AS ORIGINATING SITE

• **Originating site key requirements**
  – “Originating site” – site at which eligible telehealth individual is located
  – With various exceptions, originating site must be a facility listed in the statute and regulations; FQHCs are included
  – Geographic location requirements must be met [SSA § 1834(m)(4)(C)(i); 42 C.F.R. § 410.78(b)(4)]
    • Located in a health professional shortage area (Public Health Service Act § 332(a)(1)(A)) that is either outside a Metropolitan Statistical Area (MSA) or within a rural census tract of an MSA
    • Located in a county that is not located in an MSA (as defined in SSA § 1886(d)(2))
    • An entity participating in a federal telemedicine demonstration program approved by the Secretary of HHS as of December 31, 2000 [SSA § 1834(m)(4)(C)(i); 42 C.F.R. § 410.78(b)(4)]

• **FQHC may bill Medicare for telehealth originating site fee, provided geographical requirements are met**
MEDICARE TELEHEALTH SERVICES –
FQHC MAY BILL AS ORIGINATING SITE

• Originating site geographic location must be met (see HRSA Telehealth Payment Analyzer to determine if a site qualifies)
• Telehealth is a non-FQHC service, but FQHCs are instructed to bill for the originating site fee on an FQHC claim
• The Medicare Part B deductible must be applied to the originating site fee
• Medicare’s payment to FQHC is 80% of the lesser of the fee ($26.65 in CY2020) or the provider’s charge
NEW STATUTORY MEDICARE TELEHEALTH FLEXIBILITY UNDER SECTION 1135 WAIVER

• The Act modified Section 1135 to add a new area of flexibility, specific to Medicare telehealth.
• Requirements waived, with respect to telehealth services furnished by a “qualified provider”:
  – The originating site requirements described in Section 1834(m)(4)(C) (both facility requirements and geography requirements), “except that a facility fee under paragraph (2)(B)(i) of such section may only be paid to an originating site that is [one of the listed originating sites in the law]”
  – The restriction on use of a telephone for telehealth services, except that the telephone must have “audio and video capabilities that are used for two-way, real-time interactive communication”

Social Security Act § 1135(b)(8) (as amended by Coronavirus Preparedness and Response Supplemental Appropriations Act § 102); March 17, 2020 Medicare Section 1135 Waiver
CMS 1135 WAIVER – “QUALIFIED PROVIDER” DEFINITION

• “Qualified provider” is defined as (with respect to a telehealth service, as defined in Social Security Act § 1834(m)), a physician or practitioner who—
  (A) “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 [Medicare] 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.”

Social Security Act § 1135(g)(3) (as added by Coronavirus Preparedness and Response Supplemental Appropriations Act, Div. B, § 102, and as amended by the Families First Coronavirus Response Act, Div. F, § 6010); March 17, 2020 Medicare Section 1135 Waiver
CMS SECTION 1135 WAIVER RELATING TO THE MEDICARE PROGRAM – CMS GUIDANCE

• The waiver is effective for services rendered on or after March 6, 2020
• Services under the waiver are not limited to patients with COVID-19
• The waiver does not expand the range of services/codes that qualify as “telehealth services” under Section 1834(m)(4)(F) (codes listed here)
• The waiver does not relax the “distant site provider” requirements; in fact, it imposes a more strenuous criterion (the 3-year requirement); HOWEVER, HHS does not intend to enforce the 3-year requirement

“To the extent the waiver . . . requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.”

CMS, Medicare Telehealth Frequently Asked Questions (Mar. 17, 2020)
CMS reiterates that even under the waiver, health care facilities may not bill Medicare for distant site telehealth services.

CMS has provided “DR” unique condition codes for Medicare facility claims that are authorized under the 1135 waiver.

CMS, Medicare Telehealth Frequently Asked Questions (Mar. 17, 2020)

Medicare Fee-for-Service Response to the Public Health Emergency on the Coronavirus (COVID-19) (Mar. 18, 2020)
TAKEAWAYS

• Unless the Medicare waiver is modified or expanded, it will only ease health center patients’ access to telehealth services delivered by non-FQHC providers (for example, on a referral basis)

• **This Medicare waiver has no direct bearing on State Medicaid programs’ rules**; however, if a State has chosen to follow the Medicare rules in defining Medicaid telehealth originating sites or qualifying communications technology, then the Medicare waiver will also facilitate access to telehealth via Medicaid

• Medicare Advantage plans often have more liberal telehealth policies than original Medicare, and FQHCs should take advantage of virtual communication services
Medicare Virtual Communication Services
“VIRTUAL COMMUNICATION SERVICES” AND CORONAVIRUS RESPONSE

• CMS has encouraged providers to use virtual communication services during the COVID-19 emergency
• There is no waiver required for FQHCs to provide these services
• CMS in Medicare Physician Fee Schedule (PFS) Calendar Year (CY) 2019 Final Rule recognized two new types of “virtual communication services”
  – Communication technology-based services (“virtual check-ins”)
  – Remote evaluation services
• Services “not a substitute for a visit, but are instead brief discussions with the RHC or FQHC practitioner to determine if a visit is necessary”
VIRTUAL CHECK-INS AND REMOTE EVALUATION SERVICES

- Medicare pays for a “brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit”
  - CMS, CY2019 Medicare Physician Fee Schedule Final Rule
- Two types of service (differentiated chiefly by mode of communication)
  - Virtual check-ins (HCPCS code G2012): real-time discussion between practitioner and patient
  - Remote evaluation services (HCPCS code G2010): practitioner evaluates patient-transmitted pre-recorded information (e.g. still or video images, information from heart rate monitors); practitioner interprets the information and follows up within 24 hours
- Payment methodology
  - Physicians/practitioners: Physician Fee Schedule (PFS)
  - FQHCs: fee based on national average non-facility PFS rate
VIRTUAL CHECK-INS AND REMOTE EVALUATION SERVICES

• **Program requirements** for virtual check-ins/remote evaluation:
  – FQHC provides at least 5 minutes of medical discussion conducted remotely
  – Recipient must be established patient of FQHC (had at least one billable visit in prior year)
  – Rendering clinician must be FQHC practitioner (not nurse, health educator, etc.)
  – Service **must be initiated by patient**
  – Discussion must be for a condition not related to an FQHC service provided in prior 7 days, and it does not lead to an FQHC service within next 24 hours (or soonest available appointment)

• **Communication technology**
  – Virtual check-ins: audio-only telephone interactions; “two-way audio interactions that are enhanced with video or other kinds of data transmission”
  – Remote evaluation services: practitioner follow-up may take place “via phone call, audio/video communication, secure text messaging, or patient portal communication”

• **Note**: no patient location requirements; no limitations on frequency
VIRTUAL CHECK-INS AND REMOTE EVALUATION SERVICES

• **Relationship to FQHC/RHC services**
  – CMS considers virtual communication services to be included within “FQHC services”; nonetheless, the costs of the service are **not** included within the PPS rate but instead are paid for under a separate fee-based methodology
  – FQHCs should list costs associated with virtual communication services in the “other than RHC/FQHC services” portion of Medicare cost report

• **Billing requirements and payment**
  – FQHC bills for the services on FQHC (institutional) claim
  – Services may be billed either on their own or on a claim with other FQHC services
  – One G code (G0071) is used to pay for both virtual check-ins and remote evaluation services
  – Payment rate for G0071 set at national average of the non-facility PFS payment amounts for G2012 and G2010 (in CY2020, **$13.53**).
  – There is no bar on an FQHC billing Medicare for virtual communication services in the same month as it bills Medicare for care management services for the same patient.
VIRTUAL COMMUNICATION SERVICES:
BENEFICIARY COINSURANCE AND CONSENT

• **FQHCs must impose coinsurance for virtual communication services**
  – Coinsurance is equal to 20% of the lesser of the fee schedule amount or the health center’s designated charge
  – Collection of coinsurance may be more challenging given that the service does not involve a face-to-face visit
  – **Note,** however, that coinsurance is subject to the FQHC’s sliding fee discount policy; and HHS OIG has issued guidance concerning waiver of coinsurance during COVID-19 emergency period (discussed later)

• **FQHC must obtain beneficiary consent before virtual communication services are furnished**
  – Consent must be obtained in advance of furnishing service
  – Consent may be verbal or written
  – Must be documented by treating practitioner in patient’s medical record

*Medicare Benefit Policy Manual Ch. 13, Sec. 240; Virtual Communication Services in RHCs and FQHCs, Frequently Asked Questions* (Dec. 2018)
Medicaid Telehealth and Coronavirus Response
TELEHEALTH IN MEDICAID

• Federal Medicaid law and regulations do not describe or define “telehealth” or “telemedicine”
• This contrasts with the Medicare program, where “telehealth” is defined as a discrete service

States have **broad discretion** in choosing whether and how to cover services furnished via telehealth under Medicaid, including:

- what types or modalities of telehealth are covered
- which providers may furnish telehealth services
- how telehealth services are paid for
- in which parts of the State telehealth is available

Per informal Centers for Medicare & Medicaid Services (CMS) guidance, if State Medicaid program does choose to cover services furnished via telehealth, State Medicaid agencies must:

- Adhere to any state law restrictions regarding licensure or scope of practice
- Comply with Social Security Act § 1902(a)(30)(A) (payments consistent with efficiency, economy, and quality of care)

TELEHEALTH IN MEDICAID

• Per federal law, the scope of coverage of each discrete category of “medical assistance” (services), as well as the payment methodology for each service, must be described in the Medicaid State plan.

• **States are not required to submit a separate State Plan Amendment (SPA) for coverage or reimbursement of telehealth**, if they decide to pay for such services the same way/amount that they pay for face-to-face services.

• States must submit a separate state plan amendment (Section 4.19-B of State plan) only **if they want to pay providers for telemedicine services in a distinct manner**.

• State Medicaid programs are not required to use the Medicare “hub-and-spoke” (“distant site”/”originating site”) framework to pay for telehealth.

• Medicaid MCOs have significant discretion in covering services furnished via telehealth (even if similar telehealth services are not covered fee-for-service under the State plan).

The FQHC PPS: where does telehealth fit in?
The Medicaid FQHC PPS is a bundled, cost-related payment methodology where the “visit”—which can be defined at the State’s discretion, but has traditionally been defined by States as a “face-to-face” encounter—is the unit of payment. How can States adapt the methodology to meaningfully recognize role of remote / technology-based services furnished by FQHCs in Medicaid?

In many instances, State Medicaid policies with respect to the intersection of FQHC payment and telehealth are unclear. Many state’s telehealth rules/regulations do not even specify whether or how the rules apply to FQHCs. A few common areas of ambiguity:

- Which types of telehealth services/activities are considered to be encompassed within the State’s Medicaid FQHC benefit for purposes of FQHC cost reporting?
- Does the State’s FQHC “visit” definition encompass synchronous telehealth visits?
- Are FQHCs eligible to bill Medicaid for telehealth services based on a fee schedule (just the way a physician group would)? If so, is an FQHC cost report “carve-out” expected?
MEDICAID TELEHEALTH AND THE CORONAVIRUS RESPONSE

In describing the policies available to States to address the coronavirus, CMS reiterated states’ telehealth flexibility in a Medicaid COVID-19 FAQ (last updated March 18, 2020), stating

• “States have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephonic, video technology commonly available on smart phones and other devices) to use”

• “Telehealth is important not just for people who are unable to go to the doctor, but also for when it is not advisable to go in person”

CMS reiterated that no SPA is necessary to pay providers for telehealth services in the same manner that they already pay for face-to-face services.
WHAT STATE MEDICAID TELEHEALTH FLEXIBILITY MEANS FOR FQHCs IN THE CORONAVIRUS RESPONSE

FQHCs and PCAs should advocate before their State for broader telehealth coverage/payment, because in most cases, no federal approval is required.

• Generally, a State can (on either a permanent or temporary basis) lift a telehealth-related restriction (for example, a rule that bars FQHCs from serving as “distant sites”) without a State Plan Amendment

• A State could also amend its FQHC “visit” definition, as stated in State guidance or regulations, to include telehealth visits, without a State Plan Amendment--provided that the PPS or APM payment methodology applies to such a telehealth visit in the same manner as an in-person visit
  – May be a different case if the “visit” definition is included in the State plan
STATE GUIDANCE EXAMPLE: ARIZONA

• “13. Question: Can Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) offer services via telehealth?
  Answer: On March 18, 2020, CMS issued guidance for Medicaid programs confirming that FQHCs and RHCs can offer services via telehealth, including services via telephone. For more information on the services that can be offered via telehealth/telephone, please see other telehealth questions/answers in this FAQ document.”

• “14. (added 3/19/20) Question: What rate will AHCCCS pay an FQHC/RHC for services delivered via telehealth?
  Answer: In accordance with the March 18, 2020 guidance from CMS, for services offered via telehealth within the scope of the FQHC/RHC benefit, health plans and AHCCCS FFS programs will pay the established PPS rate. For services offered via telehealth that are not covered as part of the FQHC/RHC benefit, health plans will reimburse FQHCs/RHCs at contracted rates and AHCCCS FFS programs will reimburse FQHCs/RHCs consistent with the AHCCCS fee schedule.”

[Nothing in the document suggests the policy changes are temporary or confined to the emergency period.]

STATE GUIDANCE EXAMPLE: COLORADO

• “Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services - For the duration of the COVID-19 state of emergency, Health First Colorado is allowing telemedicine visits to qualify as billable encounters for Federally Qualified Health Centers (FQHCs), Rural Health Clinic (RHCs), and Indian Health Services (IHS). Services allowed under telemedicine may be provided via telephone, live chat, or interactive audiovisual modality for these provider types”

• Under existing policy, telehealth encounters do not count as billable visits in Colorado, but the costs associated with telehealth are included in the cost report for purposes of the State’s cost-based FQHC APM

• The new telehealth policies are in effect only during the COVID-19 state of emergency

STATES’ MEDICAID 1135 WAIVER APPLICATIONS

• Numerous States have requested emergency waivers under Section 1135 to address the COVID-19 epidemic; applications by Washington and Florida have been approved
• Section 1135 waivers are necessary only to the extent a State wants to take emergency measures to ensure access to care and those measures would otherwise violate federal requirements (e.g., State seeks to pay for services furnished by clinicians who are not enrolled in the program or are licensed in a different state)
• Washington State requested in its Medicaid 1135 waiver application to “permit distant site (provider) services to be rendered in a rural health clinic (RHC),” citing Medicare distant site restrictions
  – CMS approved the waiver on 3/19/2020, but without the telehealth term
  – No waiver of federal law was necessary for Washington to abandon the distant site RHC restriction
  – Inclusion of the RHC distant site change in the application reflected the (common) incorrect assumption that federal Medicare requirements control State Medicaid programs’ telehealth policies
Other Waivers / Emergency Policies Relevant to Telehealth
HHS OFFICE OF INSPECTOR GENERAL (OIG) POLICY STATEMENT CONCERNING WAIVER OF COINSURANCE FOR TELEHEALTH SERVICES

• “Ordinarily, routine reductions or waivers of costs owed by Federal health care program beneficiaries, including cost-sharing amounts such as coinsurance and deductibles, potentially implicate the Federal antikickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries.”

• In an effort to reduce legal barriers to health care providers’ ability to respond to COVID-19 concerns, OIG “not subject physicians and other practitioners to OIG administrative sanctions for arrangements that satisfy both of the following conditions:
  1. 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.
  2. The telehealth services are furnished during the time period subject to the COVID-19 Declaration.”

• It is unclear whether this policy statement would apply to services billed to federal programs by FQHCs as facilities (since it refers to “physicians or practitioners).

HHS OIG, Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak (Mar. 17, 2020)
NON-APPLICATION OF CERTAIN TELEHEALTH PRESCRIBING RESTRICTIONS UNDER THE CONTROLLED SUBSTANCES ACT

- The Controlled Substances Act (as amended by the Ryan Haight Online Pharmacy Consumer Protection Act of 2008) provides that no controlled substance may be delivered, distributed or dispensed by means of the internet without a “valid prescription.”
- A “valid prescription” is defined in part as one that is issued for a legitimate medical purpose in the usual course of practice by “a practitioner who has conducted at least 1 in-person medical evaluation of the patient.” 21 U.S.C. 829(e)(2)(A).
- There are various exceptions to this requirement, including for services “being conducted during a public health emergency declared by the Secretary [of HHS]”
- Per DEA directive, the exception extends only to schedule II-V controlled substances, and the following conditions must be met:
  - the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
  - the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
  - the practitioner is acting in accordance with applicable Federal and State laws.

U.S. Department of Justice, Drug Enforcement Agency, COVID-19 Information Page
# OTHER UPCOMING TRAINING EVENTS

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<td>Post-Acute Care Series - Part III: Residents’ Privacy &amp; Access to Medical Records</td>
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<tr>
<td>Starts March 25th</td>
<td>De-Mystifying the Compliance Manual (6-parts)</td>
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<td>March 26th</td>
<td>Navigating Telehealth Legal Risks</td>
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All webinars start @ 1 pm ET unless otherwise noted.

For more information and to register:
Email learning@ftlf.com or go to https://learning.ftlf.com

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