All Tribes Call – April 6, 2020
Centers for Medicare & Medicaid Services and the National Indian Health Board
Questions & Answers

MEDICAID QUESTIONS:

Q1: TTAG submitted a letter requesting an extension on the four walls limitation. Currently, the guidance states that IHS/Tribal facilities need to be in compliance by 2/21/21. Due to the COVID crisis and its impact in Indian country, it is not feasible that IHS/Tribal facilities can complete the 6 to 9 months of administrative and SPA work that needs to be done in the midst of this public health emergency. Our resources are completely tied up addressing the COVID emergency and it is not possible to meet the 2/21/21 deadline. States will be coming in with similar requests.

A: We've received your letter and are taking this request under consideration.

Q2: What is the status of the California's 1135 Medicaid waiver request to provide telehealth services outside the four walls?

A: California's 1135 waiver request to provide reimbursement for telehealth services outside the four walls is currently under review. CMCS is currently reviewing outstanding requests working through a team that is sorting the questions and reviewing them so they can be answered as quickly as possible.

While CMCS reviews CA's request, we want to remind all states and Tribal programs that in the FAQs issued in January 2017, CMS provided a grace period to January 2021 before CMS will review claims for services furnished by Tribal clinic providers "outside the 4 walls" of the clinic." CMCS does not intend to review whether or not the 4 walls requirement was met until 2021.

Q3: Can we make the 6.2% FMAP increase permanent? Can it extend beyond the public health emergency? How long will it last?

A: On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-192, including any extensions, terminates. A permanent extension or extension beyond the public health emergency is not a CMS decision. As it stands, the FMAP is extended through the quarter in which the public health emergency ends.

Please note that the 6.2% FMAP does not apply to expenditures for services "received through" an IHS facility (including an IHS facility operated by an Indian Tribe or Tribal

organization), as the 100% match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies.

For more information on the 6.2% FMAP, please visit: https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf

MEDICARE QUESTIONS:

Q4: Will there be additional guidance released on the Medicare accelerated advance payments? It might be difficult for Tribes to repay during the COVID-19 crisis.

A: Guidance on accelerated payments was issued and can be found here:. https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

MEDICARE TELEHEALTH:

CMS has recently updated its guidance regarding Medicare Telehealth related to COVID-19. Please see these FAQs for more detail, starting on page 20: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Q5: We are a Tribal Medicare Federal Qualified Health Clinic (FQHC) but we have never been able to bill for telehealth. We do about 50 telehealth visits a day using zoom. How do we bill as a Tribal Medicare FQHC for telehealth visits? Also, regarding the frequency of rulemaking, is it 7 days for a telehealth visit?

A: Section 3704 of the CARES Act authorizes Rural Health Clinics (RHCs) and FQHCs to provide and be paid for telehealth services to Medicare patients for the duration of the COVID-19 Public Health Emergency (PHE). Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. For more information on Medicare telehealth services provided by RHCs and FQHCs, please see the Medicare Learning Network (MLN) article: https://www.cms.gov/files/document/se20016.pdf and FAQs, beginning on page 16: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Q6: For Medicare telehealth, do you have to use phones with audio and visual capabilities? We have a lot of patients without computers or iphones/ipads or without internet connections so we are limited to audio only communication.

A: The Medicare telehealth requirement for real-time two-way audio/video communications remains in place. However, we finalized, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for audio only telephone E/M codes.

Q7: Regarding patient consent to telehealth services and expanding the types of providers that can provide telehealth services. Do providers have to be enrolled with Medicare and bill using their PTAN? How is that addressed if the provider is not registered w PTAN?

A: Yes, providers must be enrolled with Medicare and bill using their PTAN.

Q8: Are we considering an extension of these emergency procedures for Medicare telehealth? If these flexibilities were made permanent, is that a statutory or regulatory change?

A: The duration of these flexibilities is directly tied to the duration of the public health emergency. After the public health emergency is over, these flexibilities would revert to their pre-emergency status. However, through the normal rulemaking process we could consider proposing some of these flexibilities be made permanent. So that would be a regulatory change.

Q9: Just a comment, we also support telephonic only visits be considered telehealth alongside visual telehealth visits. We have the same issues where our patients do not have access to the technology or internet to do visual connections. We only provide telephone only visits when our providers have determined that he or she can provide the same kind of care in a safe manner via phone only.

A: Thank you for that comment. Remember currently telehealth visits have to be audio/visual. There are also additional services payed under the PFS that utilize telecommunications technology but are not Medicare telehealth—these are the virtual check in (which can be done via audio-only or audio/video), the phone visits (audio-only), the eVisits (online patient portal only), and the remote asynchronous services (patient submits image or video).

Q10: We are not an FQHC. We spoke with our MAC and we were under the impression we could bill for a phone only visit without visual communication, is that correct?

A: Yes, there are phone visits that can be billed for under the physician fee schedule but they are not technically considered part of the Medicare telehealth benefit.

Q11: Can you clarify, a Medicare telehealth visit has to be audio *and* visual? And bill an E&M code?

A: Yes, that is correct a Medicare telehealth visit has to be audio and visual.

Q12: What is the different between a virtual check in and a telephone only visit?

A: Telephone only visits are old codes that prior to the COVID public health emergency we had considered non-covered. However, during this public health emergency, we reassessed the coverage status for these codes and activated them for purposes of

COVID. A telephone only visit is like a virtual check in but it has more options for duration beyond 5 to 10 minutes where as a virtual check is a short 5 to 10 minute interaction that is about determining whether an in person visit is needed.

Q13: Do all the other virtual check in rules apply still? Do the calls have to be initiated by the patient? Do cost sharing rules apply?

A: We are offering enforcement discretion. We will not be looking to see if a patient is new or established. We understand that it is important that new patients have access to these services too. Cost sharing is not automatically waived but it is determined on a case by case basis.

Q14: What kind of behavioral health therapists and providers are now able to provide services under this telehealth interim guidance? I would like to request that you consider adding other providers like licensed family therapists who are not currently reimburseable by Medicare under an emergency consult.

A: Other behavioral health providers include licensed clinical social workers and clinical psychologists. Unfortunately, reimbursement for providers whose services are not currently reimbursable under Medicare cannot be waived. That would require a congressional fix and is not in CMS's power to waive, even under an emergency waiver.

Q15: For direct care providers (IHS), to what extent is there a working relationship between Medicare, Medicaid, and IHS to set up telehealth services? We are running into issues with pharmacy because typically, a doctor's visit is required before we can renew a prescription.

A: A telehealth visit would suffice for a visit required prior to renewing a prescription as telehealth visits are meant to be the same, and fulfill the same sets of requirements, as an in-person visit.