

## MEMORANDUM

TO: PCAs  
FROM: Public Policy and Research Division  
DATE: March 19, 2020  
RE: **NACHC FAQs on COVID-19, Medicare, Medicaid and Telehealth**

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**Q. Did President Trump’s recent announcement on Medicare and telehealth allow FQHCs to provide telehealth services as “distant providers?” What about the first supplemental funding bill passed by Congress?**

Unfortunately, neither the first supplemental bill signed on March 9 nor Trump’s announcement on March 17, 2020 allows FQHCs to provide and be reimbursed for telehealth services as distant providers in Medicare (meaning when the provider is at the health center and the patient is at home). This is a long-standing issue that CMS believes it does not have the authority to address. At this point, any movement on this issue will have to come from Congress. **You can read more on NACHC’s recent blog post [here](#).**

**Q. How are health centers reimbursed by Medicaid for telephone services?**

On March 18, 2020 CMS issued a [FAQ document for State Medicaid and CHIP Agencies on COVID-19 related issues](#). Included in that FAQ are several questions on FQHC telehealth and telephone visit issues. Please see page 10 of the FAQ for specifics on the guidance provided to states on these issues.

**Q. What does the most recent CMS guidance on telehealth under Medicaid mean?**

In [the guidance issued on](#) March 17, 2020, CMS states that “States have a great deal of flexibility” with respect to which Medicaid services they provide through telehealth. This means a state may elect to pay for FQHC services provided through telehealth but is not required to do so.

A State is not required to submit a State Plan Amendment (SPA) to implement payment for telehealth services, *unless there is a change in the level of payment from what it would pay for the service if it were “furnished in a face-to-face setting*. Thus, it appears that a state would not have to submit a SPA if it chooses to pay an FQHC for a telehealth service the same PPS or APM rate that it would pay if that service was provided as a face to face visit, but a State would need to file a SPA if it chooses to pay an FQHC other than its PPS rate for the telehealth service.

Providers rendering services through telehealth must be Medicaid qualified practitioners within the scope of their State Practice Act, and CMS provides guidance on payment for ancillary costs, such as technical support.

**Q. Do modifications to state telehealth policy require a State Plan Amendment?**

As noted above, “States are not required to submit a State plan amendment (SPA) to pay for telehealth services 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. “

**Q. What specific steps should an FQHC take to ensure they will receive Medicaid telehealth reimbursement?**

Health centers should work directly with their PCAs on any policy-related changes to telehealth policy. Doing so will ensure that the PCA is able to communicate a uniform and clear message and request to their state Medicaid agencies and policy makers. Allowing the PCAs to serve as the point of contact with the state allows the PCA to also share the message with all health centers in the state on state policies on coverage of telehealth services.

**Q. Is there any template language for states looking to expand telehealth under Medicaid? For example language from states who have applied for telehealth expansion?**

From the CMS guidance, below are examples of language states have used, and CMS has approved, to describe telehealth payment policies within the Medicaid state plan.

- **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.*

- **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 (as the State may have a certain comfort level with them since CMS has approved them), we think it important that PCAs try to get their state to insert **specific FQHC payment language**. For example, in Example 1 above, we recommend adding the following language:

*“Notwithstanding the previous paragraphs, for services provided via telehealth by FQHCs, payment for such services shall be 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”*