MEDICARE TELEHEALTH QUESTIONS 4.27.2020

- **Question: CCMS/Medicare is not paying facility fees for E&M claims. Some hospitals had assumed that Medicare would pay the same as they do for in person visits since they were promoting social distancing at the outset of the pandemic. E.g. a hospital outpatient cancer center in-person visit for an immunosuppressed cancer patient would entail billing and payment for a hospital professional and a technical charge. Hospital staff are virtually supporting the clinician with scheduling, technology education, billing, etc. so there continue to be hospital expenses involved. The hospitals believed that they were taking the appropriate steps to move these visits to virtual settings. Shouldn't the reimbursement fully reflect the costs of providing this care during the public health emergency?**

  The facility fee applies to the originating site, and although CMS has removed geographic limitation which allow the home to serve as an eligible originating site during COVID-19, they unfortunately did not make changes to the existing policies on facility fees when they did so, nor have they done so in any of their recent updates. CMS confirmed this in one of their recent open calls that no facility fees are available at this time. It is our understanding that AHA will continue to advocate in support of this issue, as they are asking for hospitals to be able to bill directly for telehealth visits and, short of that capability, they will be pursuing the ability to receive facility fees for these services.

- **CMS/ Medicare Cost-sharing Waiver – appears to only apply to those patients who were actually tested for COVID. Patients who were not tested due to the restrictive testing requirements or because they were presumptive positive or due to a lack of testing kits do not appear be eligible for cost sharing waiver even when claim submitted with a COVID diagnosis and COVID**

symptoms. Concern that many patients will receive unexpected bills for their COVID-related treatment as a result.

The Families First Coronavirus Response Act only waived cost-sharing for COVID testing and related services. For Medicare beneficiaries, the law lays out a number of those services. However, the law does not extend the waiver of cost-sharing to treatment. So, while many plans have waived that cost-sharing, we expect that some patients will still have cost-sharing obligations. AHA will continue to work with Congress on extending the waiver of cost-sharing to treatment in addition to testing. This issue was hotly-argued on a recent CMS open call and our attorneys anticipate that it will result in an FAQ document or more guidance. It might also be helpful to seek a specific request of clarification with CMS directly. MHA's outreach to CMS' partnership email will serve that purpose.

- ***Under Medicare, patients in partial hospitalization settings who receive virtual services such as group therapy – these go to Medicare Part A and thus are not being reimbursed. Hospitals were taking the appropriate steps to stay in contact with behavioral health patients during a crisis period. The hospitals are seeking clarification as to whether the virtual therapy visits can be billed as outpatient telehealth services so that they can be reimbursed.***

  CMS has indicated that it is trying to determine whether or not it will allow these types of services to be billed in the institutional setting on a UB and how it can use its waiver authority to address this concern. To date, we are not aware of a resolution, but CMS has signaled it is considering flexibility to address this issue. AHA has indicated that they have repeatedly asked for outpatient group therapy – and behavioral health therapy more broadly – to be billable by hospital outpatient departments when provided via telehealth. Again, CMS has indicated that it is working on this. It could potentially be included in the next

round of telehealth flexibilities that CMS executes based on its CARES Act authority, according to AHA.

- **Telephone visits are being reimbursed at around $44 by Medicare regardless of length, intensity, or provider utilized. Since it is not uncommon for Medicare patients to need to use telephone instead of face to face technology, shouldn't these visits be reimbursed on par with video calls as the commercial payers are doing? Why is there reduced reimbursement for these services?**

  This is an issue that has been reiterated to CMS staff and they have continued to emphasize that they are considering how they will use their waiver authority to address this further. However, as of now, CMS has not released additional waivers and rulemaking in this regard, although it is possible this will be coming. If a modification to CMS's modality requirements does occur, it is unclear whether these services will need to be rebilled, or if CMS will institute an edit. As we understand it, this is a reduced reimbursement rate because pre-COVID, audio-only services were not reimbursable by CMS at all. So CMS saw this as an initial improvement.

  It is also important to note that EOHHS filed a third 1135 waiver on Friday which includes a request "to ensure that enrollees without smartphones and similar technologies maintain access to vital Medicare-covered services during the COVID-19 public health emergency, EOHHS requests that Medicare reimburse for all telehealth-eligible Medicare-covered services (as that list may be updated from time-to-time), including evaluation and management services, regardless of whether those services are delivered via audio-only or video telehealth, when the provider determines the services and telehealth format are clinically appropriate and medically necessary."