

CMS Telehealth Factsheet

Q1. What special telehealth flexibility applies to Accountable Care Organizations (ACOs)?

The Bipartisan Budget Act of 2018 (BBA) added section 1899(l) to the Social Security Act, which provides certain ACOs the ability to expand the use of telehealth. There is now special coverage for telehealth services furnished on or after January 1, 2020, to prospectively assigned beneficiaries, by physicians and other practitioners participating in a Medicare Shared Savings Program (Shared Savings Program) ACO that is under two-sided risk and that has selected prospective assignment. Specifically, these new policies:

- Remove the geographic limitations imposed under normal fee-for-service (FFS) rules AND
- Allow a beneficiary to receive many telehealth services from their home

Q2. Who can provide these services?

All physicians and practitioners who furnish and get payment for covered telehealth services (subject to State law) and who bill through the TIN of an ACO participant in an applicable ACO can provide and get payment for covered telehealth services under this new flexibility. Starting January 1, 2020, applicable ACOs are those with prospective assignment for a performance year in the ENHANCED track (including existing Track 3 ACOs), BASIC track levels C, D, or E, or in the Track 1+ Model.

Risk-based ACOs that participate under the preliminary prospective assignment with retrospective reconciliation method do not meet the definition of an applicable ACO, because final assignment is not performed until after the end of the performance year. Clinicians in these ACOs and those in non-risk based ACOs may provide telehealth services subject to the usual Medicare FFS rules.

Q3. When and how can ACOs begin providing telehealth under the expanded flexibilities?

CMS allows clinicians in applicable ACOs to begin providing and receiving payment for covered telehealth services to prospectively assigned beneficiaries without geographic restriction, including, for many services, where the originating site is the and in beneficiary's home, beginning on January 1, 2020. There is no special application or approval process for applicable ACOs or their ACO participants or ACO providers/suppliers. Clinicians in applicable ACOs can provide these covered telehealth services and bill Medicare according to existing telehealth billing rules, starting January 1, 2020.

Q4. Where do I find out if a Medicare Fee-For-Service beneficiary is prospectively assigned?

ACOs under the prospective assignment methodology receive a prospective assignment list near the start of each performance year in the Assignment List Report (ALR). ACOs will receive updated ALRs on a quarterly basis that indicate which beneficiaries have been removed from the assignment list as a result of meeting select assignment exclusion criteria (i.e., beneficiary had a date of death prior to the start of the performance year; beneficiary had at least one month of Part A-only or Part B-only coverage; beneficiary had at least one month in a Medicare Health Plan, including Medicare Advantage plans, cost plans under section 1876 of the Social Security Act, and Program of All-Inclusive Care for the Elderly (PACE) programs; or the beneficiary does not reside in the United States).

Q5. What if a beneficiary is not prospectively assigned?

If a beneficiary was prospectively assigned and appeared on an applicable ACO's prospective assignment list report, but is no longer prospectively assigned to the ACO, a practitioner may still receive payment for covered telehealth services without regard to the otherwise applicable geographic (including originating site) requirements during a 90-day grace period, pursuant to 42 CFR 425.612(f). Practitioners participating in an applicable ACO are prohibited under 42 CFR 425.613(b) from charging beneficiaries for telehealth services when CMS does not pay for them solely because the beneficiary was never prospectively assigned to the ACO or is not within the grace period.

Q6. Does my ACO have to report provision of telehealth services under these new flexibilities?

Yes. ACOs that provide telehealth services using the flexibilities under 42 CFR 425.613 described in this fact sheet, are required to publicly report it, pursuant to 42 CFR §425.308(b)(6).

Q7. Which telehealth services are included?

The approved list of telehealth services is maintained on the CMS website and is subject to annual updates (<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html>). However, as provided in section 1899(l)(3)(B) of the Act, in the case where the beneficiary's home is the originating site, Medicare will not pay for telehealth services that are inappropriate to be furnished in the home (such as HCPCS codes G0406, G0407, G0408, G0425, G0426, and G0427, which are inpatient services), even if the services are on the approved list of telehealth services.

Q8. Does billing telehealth services under the new flexibilities require a CCN?

The flexibilities provided under section 1899(l) of the Act and 42 CFR 425.613 do not change how covered telehealth services are billed to Medicare. Medicare will not pay for distant site claims from institutional facilities (except for CAHs billing under method II).

Q9. What happens if an applicable ACO's Shared Savings Program participation agreement is terminated?

If CMS terminates an ACO's participation agreement, then the ability of physicians and other practitioners billing through an ACO participant TIN to furnish and be paid for telehealth services under these flexibilities would end on the date specified in the notice of termination of the ACO's participation agreement. To protect beneficiaries from potential exposure to significant financial responsibility, an ACO in this situation must include, as a part of its notice of termination to ACO participants required under 42 CFR 425.221(a)(1)(i), a statement that physicians and other practitioners who billed through an ACO participant TIN that is no longer an ACO participant can no longer furnish and be paid for telehealth services in accordance with section 1899(l) after the ACO's date of termination.

Q10. What happens if a clinician in an applicable ACO leaves the ACO?

In order to furnish and receive payment for telehealth services provided to a prospectively assigned beneficiary without regard to the otherwise applicable geographic requirements (including where the originating site is the beneficiary's home), the physician or other practitioner who furnishes the telehealth service must bill for the service under the TIN of an ACO participant that is included on the ACO's certified ACO participant list applicable for the date on which the service is rendered.

Q11. Does Medicare pay a facility fee when the originating site is the beneficiary's home?

No, when telehealth services are received by a beneficiary in his or her home, Medicare will not pay a facility fee as it would if services were received in another permissible originating site, as provided in 42 CFR 425.613(a)(2)(v).

Q12. Could CMS audit my ACO's use of these Telehealth provisions?

Yes. As provided in 42 CFR 425.613(d), CMS monitors and audits the use of telehealth services by ACOs and their ACO participants and reserves the right to take compliance action, up to and including termination of the participation agreement, as specified in §§ 425.216 and 425.218, with respect to an applicable ACO for non-compliance with program requirements, including inappropriate use of telehealth services.

Q13. Where can I find more information on Medicare coverage and payment for Telehealth?

Please see the “Telehealth Services” booklet for more information on the following topics:

- What telehealth services are covered by Medicare;
- How telehealth services are provided;
- How to bill for telehealth services; and
- Which practitioners can bill for telehealth.

Link: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf>.

Q14. Is there language our ACO can use to communicate to our beneficiaries about these Telehealth opportunities?

Yes, there is information in the Marketing toolkit on the ACO Portal that applicable ACOs and their participating health care providers can use to communicate with their prospectively assigned beneficiaries.