CCGP-NCTRC
Telehealth Policy Update
Thursday, January 20, 2022
2:00-3:00pm
ARIA: Hello, I'm Aria Javidan, the program coordinator for national consortium of tell health.
Welcome to telehealth policy update.
Today's webinar is hosted by Center for Connected Health Policy.
These webinars are designed to provide support and guiding development of telehealth development.
They are presented the third Thursday of each month.
Next slide please.
To provide background, funded through agreement of office of advancement of telehealth.
There are 12 regions and two national.
One focused on policy and the other on technology, serving for the effective advance of telehealth and in rural and underserved communities.
Next slide please.
A few tips.
Your audio has been muted.
Use the Q&A function of zoom to ask questions.
Questions will be answered at the end of the presentation.
Closed captioning is available for today's webinar at the bottom of your screen.
And you can access today and past webinars on the YouTube channel.
With that, I'll pass it on to our presenter today, Mei Wa Kwong.
MEI: Thank you everyone for joining us here today.
As Aria mentioned, my name is Mei Wa Kwong, the national

telehealth resource center, Center for Connected Health Policy.
We're going to talk about Medicare 2022 changes and updates on federal issues and state issues as well.
Disclaimers before getting started.
Any information provided in today's talk is not to be legal advice, it is for informational purposes.
If you're interested in a formal legal opinion, please seek out legal counsel.
If I happen to mention a company or show a picture of our product or something, neither I nor CCHP has affiliation or relationship with such an organization.
A bit of background about CCHP, we were established in 2009 as a program underneath the public health institute to be a California telehealth organization but an opportunity to become the federal resource center was available in 2012.
CCHP applied for the grant and received it and we have been serving in the capacity ever since.
And we work with a variety of other funders and partners on the state and federal level on other connected health projects.
CCHP acts for a group in California called the California telehealth policy coalition, including over 160 state wide and national organizations interested in advancing telehealth policy in the state.
Right now, as most of you know, we are in the second year of our pandemic.
When the pandemic first began, there were a flurry of telehealth policy changes on the

federal and state levels.
They were for the most part temporary changes.
But as you can see from sort of this 100,000 foot level overview here, there were a lot of common issue areas that the federal and state policy changes touched upon.
Such as location of the patient, types of services allowed to be provided via telehealth reimbursed by Medicare or Medicaid.
Then there were certain issues that were more on the federal side to handle and more on the state side to handle.
For example, on the state side, they kept control over licensing issues but on the federal side, they had control over prescribing controlled substances.
There's still a lot of commonality on the areas they focused on and these are the areas with the temporary policy changes and areas that a lot of people are wondering, what is going to happen once the pandemic is over.
What we do know now, in some jurisdictions and states, they have made some permanent changes but really the landscape on the federal level, a lot is still unknown because we're still under the public health emergency.
We're going to tackle the federal level first.
This is the bulk of the presentation just because I can't cover all 50 states, so I'm doing more of a general overview of what is going on in the states.
This is focused mainly on what is going on with Medicare.

When you talk about federal telehealth policy, a lot of that is really centered around Medicare.
Yes, there are other areas that federal policy touches upon telehealth but the bulk of the specific policy is in the Medicare program.
To understand the Medicare policy around telehealth or related to technology delivering services, you have to understand that Medicare has two different approaches to the services.
There's the telehealth and then the communications technology base services approach.
What is the difference?
When you talk about telehealth policy under Medicare, that is the policy that probably a lot of people are familiar with, it is embedded in federal law.
It is the policy that says it needs to take place in a certain location, it needs to be taking place in a certain type of facility such as a doctor's office or hospital or clinic.
You can only really use live video for the most part unless you're in a demonstration program in Alaska and Hawaii.
That is the telehealth policy in Medicare's eyes.
A lot of it is embedded in federal law and restrictive.
Communications technology based services policy under Medicare, it utilizes telehealth technologies.
It is not considered telehealth in CMS's eyes.
Telehealth is one to one replacement for service.
I go in and see my primary care provider.
I can do that in person or telehealth.

There's a replacement for it taking place in person that can be done telehealth now.
Communication technology based services are services that technology enabled us to be able to do for the patient but didn't necessarily take place in person.
So for example, your remote patient monitoring a patient with hyper tension and you want to have their blood pressure readings for a week.
I'm not going into like my primary care doctor's office three times a day to have my blood pressure reading done.
Now technology allows me to do that through a device at home and send the information electronically to my primary care provider.
Those types of things not one to one replacement, CMS considers that communication technology services.
They don't necessarily have something as equivalent to in person.
We're not going to consider it telehealth.
It is this other category.
Why I'm spending so much time on this, during the pandemic, I think it got a little confused for some folks.
They were wondering why some of their reimbursement rates were different.
It was because they were billing something that was communication technology rather than telehealth service.
This is a CMS policy that I'm spending time on and talking about.
Once you start going to the state level, it gets confusing.
Some states treated some of the

services as underneath telehealth policies.
Others kept it separate and others kind of didn't really reimburse for them.
It is different on the state level but where Medicare is concerned, it is these buckets out here, telehealth and communication technology based services.
They're not considered telehealth services in CMS's eyes, they don't have the restrictions like it has to take place in a certain area and only in these types of locations.
They have their own limitations and policies but they don't necessarily face the limitations that telehealth sees in statute.
Now, also to understand telehealth policy in general and Medicare, there is usually four issue areas or elements that the telehealth policy touches upon.
It touches upon service, location, provider and modality.
You may have something that says it will reimburse for mental health programs when the patient is located in a doctor or clinic setting, the location and patient.
When it is being provided via live video, the modality used and provided by a psychiatrist who is allowed to provide the service and get reimbursed.
Those are the four basic areas that they touched upon.
That's where you will see where the changes impact the service provider and modality.
When you talk about Medicare and CMS, three of these areas, CMS doesn't have a lot of control over as far as setting the policy.
It is embedded in federal law.

They are limited in what they can do.
Service is really the only area they have a lot of control over.
Location, the type of provider who can be reimbursed and modality used, they have their hands more tied in that.
That is embedded in federal law.
Although the modality one, we'll talk about that in a second, they did find a creative way to address that, a little bit without having a congressional change done.
So what happened in 2021 that is going to impact 2022.
For those not familiar with it, what CMS does every year for the Medicare program, they have a physician fee schedule that lays out new policies they want to propose and institute for the following year.
For 2022 they introduce in the summer, sometime around July†2021 and give you a 60 day period the public can comment on it and finalize sometimes in November, sometimes December.
Saying this is going to be the final policy, this is going to go into effect unless otherwise stated January†1st the following year.
That's what happened in 2021 for the policies that are going to take place in 2022.
They came out in July and it was finalized in November and those are the links to see all of that.
But basically I'm going to cover all of the things related to the telehealth.
So what was the first thing that happened?
The first thing that we're going to cover are basically the services that are covered.

So this is as I said earlier, the one area where CMS has a lot of control over what they will say.
They don't have to wait for Congress to be allowed to act.
Every year CMS allows the public an opportunity of suggesting services, codes to be put on the permanent telehealth list and then they judge those, whether to approve it or not based on two tests.
You can pass one or two tests the get on the permanent telehealth eligible list.
Category†1 or Category†2 test.
Category†1 is saying it is a service proposed to put on the permanent list is similar to a service already on the list, it passes the test.
The Category†2 test, if you provide us with enough evidence to support that this can be done effectively over telehealth with good benefits, we'll move it on to the permanent list.
Category†2 test is really hard to pass.
So usually what you see, like services getting put on the permanent list, they have passed Category†1, similar to stuff they are reimbursing for.
The previous year in 2020, CMS created a Category†3 list.
What Category†3 is, a temporary holding bucket.
When the pandemic started, CMS added a bunch of services temporarily to the list and said these services during the pandemic, you can provide via telehealth and we'll pay for it but it is not on the permanent list.
Since that time they have added a couple of services to the permanent list, but what they

did in 2020 for 2021, they created a Category†3, saying we're going to take a chunk of the temporary services on the COVID list and put them in Category†3.
What that means is, they're going to hang around a little bit longer after the pandemic is over.
The way they had it phrased previously, in Category†3, the services will stick around until the end of the year that the public health emergency is declared over.
They changed that last year, now they're saying they have given it a more definite deadline saying the temporary services in Category†3 stick around until the end of 2023.
Basically that time they feel will give them sufficient time to examine the evidence if they pass a Category†1 or Category†2 test and then moved to the permanent list.
Let's say for example, the public health emergency is declared over in 2022, the services in Category†3 they put on there will hang around until the end of 2023.
However, if any of those temporary COVID services, any of the services on the list which are not currently on the permanent list or in Category†3, then they will disappear when the public health emergency is declared over.
Just to be clear on that, Category†3 is a temporary holding bucket until the end of 2023 to decide if they're going to move it on the permanent list.
If you're not on already as a service or Category†3 bucket,

then once the public health emergency is declared over and you're on the temporary COVID services list, it goes away.
It is no longer eligible once the public health emergency is declared over.
They also for 2022, they did add some of those temporary COVID codes over to -- I'm sorry, they added more of the Category†3 codes.
They had certain codes they did for 2021 in 2023 and added a couple of temporary codes in Category†3.
You have three buckets.
Permanent telehealth list that stays no matter what is going on.
You have Category†3, codes sticking around until the end of 2023 and then the COVID telehealth list that has some codes that will disappear once the public health emergency is declared over unless a change happens.
All right.
Other changes that they have made.
This one, again, is not by CMS's choice, this is a piece of legislation that passed in 2020.
CMS was implementing what was in statute then.
It expanded the use of telehealth to provide mental health visits.
So, what the consolidated appropriation act said, you can use telehealth without the geographic limitation coming into play and can be provided in the home.
However, and this was not CMS's choice, it was written into the bill, however, there needs to be an in-person visit with the telehealth provider at least six

months before telehealth services are being provided.
So what CMS did, they simply implemented that policy.
To do that, they said the same thing, they were saying that okay, you can use telehealth to provide mental health services in the geographic limitation would not apply and you can do it in the home.
However, you do need the six month visit to take place.
And what they also said was additionally, if the 12 months in, you need to basically have that in person visit renewed every 12 months.
To start your services, you need to have had an in person visit at least six months prior.
And then you need to basically have one more in person visit every 12 months basically just to keep that engagement there.
They also allowed audio-only to provide the mental health visits and redefine when the mental health visit was.
We'll get into more details on each of the bullet points here.
Mental health visit, i said it was consolidated appropriation act.
They said you need to have the six month in person visit before they take place and every 12 months.
They did allow limited exceptions to the 12 month sort of requirement.
Basically they said if it would disrupt services or not benefit the patient, we'll let it slide.
They said the in-person visit means you need to have had some sort of service rendered to the patient in person and need to be paid by Medicare.
Tracking for them, you did have

an in-person visit and you counted as in-person visit. They said it needed to be paid through Medicare to count. If there's somebody under the same subspecialty as somebody as you, they could do the in person visit and that could count. This is where we start to get into vagueness on what does this mean exactly. So far CMS hasn't issued clarifying that I have seen, but basically what they said in the physician fee schedule, for home, they're going to have a wider definition for what the home means. It could include temporary lodging to basically accommodate folks who may be homeless or displaced during a period of time or traveling. And also if you needed to travel a short distance from your home, it would count to be an eligible site, maybe without Wi-Fi in the home and had to travel to get it. As I mentioned earlier, the in-person visit requirement doesn't apply if the provider and patient feel that it is going to interfere with the benefits of receiving services for the patient or patient receiving services or their care. Again, it is very vague, so I don't know how you would capture that in the record to prove that that was going on and that's why the decision was made. Or where the cut-off is. I have been hoping to see if there's more clarifying information to be issued and as of today there hasn't been. This is what it said in the final physician fee schedule.

You have these kind of nuances exceptions to the policy but basically the policy is you can see telehealth to provide mental health treatment but you have to have in person visit six months and one every 12 months.
There are some nuances and exceptions here and these are those.
Audio only.
So, this is one area where I said that it is mainly in statute but CMS found a way to have flexibility here.
Basically what CMS did, they allowed audio-only to be used as a modality to provide mental health services and the way they did this, underneath federal law in the telehealth section, it says that services are delivered via telehealth communication system.
That is left up to CMS to kind of define that and the way they define it, live video and they added in audio-only for mental health services.
This does not mean you can use audio-only to provide other types of services, say for dermatologists or anything like that.
It is only mental health services if you are talking about getting reimbursement from the Medicare program.
It can be used if certain conditions are met.
That is it is for an established patient, the patient is at home, the provider has the capability of live video and the patient doesn't want to or can't do live video.
Maybe they don't have like good connectivity.
And then we see again that six months prior in person visit and

12 months visit requirement in there, too.
You can use audio only but you have to meet the certain conditions plus you have the six month, 12 month in person visit as well required of this as well, too.
This has been a little interesting.
As most of you know, they were allowed temporarily to be telehealth provider during pandemic, but they are not on the permanent telehealth provider list for Medicare.
That would require a statutory change.
So how are they able now to provide services telehealth?
That is because CMS redefined what a mental health visit means for those.
There is a specific definition for these organizations and specific definition for what a mental health visit is.
CMS changed the definition to include interactive real time telecommunication technology.
They can provide mental health services via live video and audio only, but because they redefined it as the mental health visit, they did a redefinition, it doesn't mean via telehealth.
It is just a mental health visit for them.
What that also means, in this situation, they are not going to face the telehealth restrictions because they're not providing telehealth just mental health visits.
They have all of the other requirements they face when providing a mental health visit that is going to apply in the situation, but those telehealth

situations don't necessarily apply to them.
They get the regular rates, but they are going to have to do the six month in person, 12 month in person visit if the patient is receiving services in the home.
There are other conditions attached to it, but as far as the limitations, they're not attached because they're not providing telehealth, they're providing a mental health visit.
Sort of like earlier when I talked about the communication technology based services, labelling it something else so it doesn't face the telehealth requirements.
This is what happened here.
Mental health visit definition was expanded so not facing the limitations.
It is facing other limitations like the six month 12 month in person visit and what other sort of requirements you have to meet.
They have to meet when providing mental health visits but the telehealth limitations don't necessarily apply.
They can provide services over audio-only.
Again, sort of like well, I've had questions of how do we record this?
How do we track it or record that we did it this way.
No clarification yet.
I did see that today that CMS issued a Medicare learning network booklet for RHCs that had a section on this.
It basically said what I just told you.
I provided you the link if you want to see it, but there's really not more clarifying information.

I apologize for that.
We're still waiting for CMS to come out with more directions and instructions on this.
That's the best information I have right now.
Now we're going to get into -- that was the telehealth stuff.
It is complicated, I know.
It will probably take people a while to get used to it.
Right now we're going to move over into the communications technology based services.
Now, it is sort of a little bit of your catch-all in Medicare.
That's where a lot of the remote patient stuff is.
They have them in clusters of different areas, chronic care management there and then they created a new category for 2022.
These are the codes and definitions for what they have set up for that.
My slides are available after the session.
I'm not going to go over all of these things.
I'm not going to spend a lot of time on them.
You can look at them later.
These are a couple of other changes that they made related to connected health or telehealth during the physician fee schedule, a permanent adoption of the virtual check in.
Previously you had one that was five or 10 minutes, they made a longer version.
They made permanent adoption of that.
That is sticking around even if the public health emergency is declared over.
And then they did a couple more codes for chronic care management and personal care

management.
And then a couple of other policy changes out there, I'm not going to spend a lot of time on this, you can take a look at the slides later.
Or there's a fact sheet and you can look at that.
Some of the other changes they made was there was an increase in facility fee up to $27.59 now.
They also during the pandemic, allowing for availability of supervised in person to be provided through telehealth.
They were asking should we make it permanent.
They decided they're not going to make a decision yet.
They're going to examine the issue.
Those were a couple of other things in the physician fee schedule.
So key points the remember.
All that six month in person visit I was talking about, that is permanent telehealth policy.
What that means is, it does not go into effect right now.
We're still under the public health emergency.
If you are worried about I need to do the six month in person visit, it doesn't kick in yet.
We're still under the public health emergency so we're still operating under the broader telehealth policies.
Once it is declared over, yes, you will have to worry about it.
Right now, it is good to start thinking about it.
How are you going to work with this once the public health emergency is declared over.
But because we are in the public health emergency right now, CMS is not requiring those and that

may be why they have been a little slow in having more explicit policy out.
For those who don't know, the public health emergency was renewed for another 90 days. Unless they declare it over, we have at least another 90 days before the policies kick into gear here.
The changes that allow to provide mental health visits via live video and audio only, it is not considered telehealth.
So they are not something able to provide all of the other services via telehealth.
It has been redefinition of what a mental health visit is to allow them to use those modalities.
It is not called telehealth. They're just providing a mental health visit through these modalities.
Additionally, once the public health emergency is declared over, they transition over to this and have the six month, 12 month in person requirement and everything, saying when do we need to do it, it only applies for them to do that when the patient is receiving services in the home.
So, if the patient comes into your clinic and they receive services from the provider, telehealth provider while in your clinic, you don't need to have that six month in person, 12 month in person element met. They're not at home, they're in your clinic.
It's only when they receive services in the home that the visits kick in.
But, again, because we are right now under the public health emergency, all of the six month,

12 month in person visit thing, all of those requirements is not activated right now.
That probably means that CMS is going to take longer having more explicit policy.
Right now you don't have to put that in place because of the public health emergency.
We're tracking over 100 pieces of federal legislation related to telehealth, a lot of them talking about making temporary changes permanent and COVID in some way.
I get asked a lot on well, are any of these going to pass?
I would say like an individual telehealth bill probably not, but what has happened historically, elements from the bills have been plucked out of them and put into larger bills and that's probably -- there's a likelihood of that happening if there's a larger bill that passed, you may see telehealth stuff in there.
They have taken them from some of the telehealth bills and passed them under the larger bill.
I don't give high odds for a telehealth-specific bill to pass on the federal level.
Other federal things to be aware of.
So always a big issue is the F word in telehealth, that's fraud.
And concerns about that.
So last year, the office of inspector general that really looks at fraud on the federal level in the Medicare program is basically saying what they found at least so far was not necessarily telehealth fraud.
It is not people saying I did telehealth services and billing

for the services.
It wasn't necessarily those things that were happening.
It was more telemarketing fraud, saying I ordered durable medical equipment and the patient didn't need that equipment.
So it was more things like that rather than actual telehealth fraud and they said we haven't really gotten into -- at least at that point or willing to share, COVID cases with telehealth taking place during COVID.
That may change over the next couple of months or year or two from now.
At this time, this is what the office of inspector general has said.
They also have two reports coming out this year to be aware of.
Telehealth during COVID-19 and use of Medicare telehealth services during COVID-19.
They said those will be released this year.
That may change things as far as statements but up to this point so far, they have said we haven't found more telehealth fraud.
A couple of other things the be aware of.
Underneath the no surprises act, there are certain things in there that may impact the use of telehealth or how hospitals are setting up telehealth.
There are notifications or balance billing prohibitions that may touch upon telehealth, if you have a network provider that refers to in network or self pay patient, you may need to provide some of the notifications or may be prohibited.

Just something to be aware of you may want to look into.
And then regulations for 2023 on health plans in ACA that required plans information on telehealth.
It is more sort of we want information so we can study this a little further.
Just be aware of that as well.
Interestingly, toward the end of last year, executive order that president Biden signed and something on HIPAA, the secretary of labor shall update laws and policies to the extent individuals entitled to medical treatment under workers comp through telehealth.
That has been an issue for workers comp, how does it work in there.
That was passed or that was signed into an executive order and in that executive order, it directed the secretary of HHS for guidance related to HIPAA for compliance with rules to improve patient experience and convenience.
So right now, HIPAA doesn't really have anything telehealth specific in it, it hasn't been updated in a while.
So, this is sort of like the first step, where we're seeing sort of like possible changes to HIPAA that may result in a specific telehealth policy.
I don't know if it is going to happen this year.
It may happen this year or next year.
But it is something that CCHP will watch to see what develops.
States.
What is going on with the states as well.
As far as Medicaid programs, there are programs all of the

states are reimbursing some.
More interestingly, audio-only.
We're seeing that appear more
and more frequently in states,
like reimbursing for audio-only.
Usually a lot of caveats, only
for mental health services, only
in these types of situations,
but definitely a change from
what we had pre-pandemic.
Pre-pandemic, it wasn't
considered under telehealth.
It wasn't something we saw
policies to reimburse for.
We're seeing more and more of
that being adopted as permanent
programs in the states.
Private payers.
So, again, this is likely
another shift.
43 states and DC have some type
of private payer laws.
Usually before the pandemic,
they ranged from laws that said
health plans you can reimburse
if you want to, all the way to
health plans, you shall
reimburse for telehealth
delivered services, same way you
would have in person and pay the
provider the same amount.
There were actually fewer states
on there mandating the parity
and payment side of things.
Now we are seeing more states be
explicit about that in
commercial payer laws.
We have seen more of that crop
up here.
And that has been a change as a
result of the pandemic on
commercial payers and state
results around them.
We had 47 states pass 201 bills
related to telehealth.
We get a lot of questions about
cross-state licensing.
And policies impacting specific
professions were sort of popular
and showed up a lot.

Online prescribing, specific language that telehealth was allowed for certain providers. Before the pandemic, it was limited to a specific group of providers such as doctors and nurses and maybe didn't really say anything about other types of providers such as allied health professionals or excluded them.
Now we're seeing More in -- seeing telehealth to provide services.
Some of the examples of what we saw in 2021, the big one is like the top one.
Temporary extension of COVID-19 waivers.
As I said earlier at the beginning, we have seen some states starting to adopt permanent policies and some states -- I call it kick the can down the road strategy. They will put a date out into the future and say like, we'll leave the policies in place until the end of 2023 or something like that.
California said they would leave things intact until the end of 2022.
Connecticut I think is 2023.
Other states have done that as well.
Licence changes, we saw Arizona and Florida not require a full state licence for their state but require some sort of registration on the registry on there.
That has been a change from what we were seeing before the pandemic, usually it was dealt with, you got a licence in the state or the state belonged to a compact and another way of addressing it.
Now we're seeing at least two

states say we're going to create a registry.
You go through the process and go through the registry, you don't have to get a licence in our state and you can provide services.
That was something we saw emerging from the pandemic.
Private payer laws.
That we have seen more that will require parity of payment and really interest of contracting with just one telehealth company.
Saying we will meet our obligation underneath these commercial payer laws by engaging with a company.
Specific laws saying you have to allow in network providers to use telehealth and get reimbursed and not have them join in order to do that.
Things like that.
I think there's been -- it is appearing because concerns around continuity of care using an outside telehealth company.
Audio only payment, becoming popular again.
Gaining more traction.
A lot of times that is in reaction to understanding that not everyone is going to be able to access live video because they don't have broadband for whatever reason.
That may be the only way people can receive services.
And then the end of the PHEs.
So, on the states it was sort of a mixed bag.
Depending on how they set telehealth policies, did they connect the expiration to a specific date or state, state of emergency or federal one.
It was a little bit all over the place for what some states did

and some did multiple things.
A specific deadline or the state declared their public health emergency over.
So be aware of that, too.
And that's about it.
That's sort of the quick round-up of what is happening, what is going on, the current state of 2022, what we have to look forward to is probably a little bit more solidifying on what some of the permanent policies are going for on state and local.
It is really going to depend on the PHE, when the federal health emergency is over.
With the Omicron here, it is hard to tell, at least we know the PHE has been expanded another three months.
It is quite possible it could be extended again for a couple more months and these temporary policies stay in place.
Somebody said to me that with sort of the extension of the public health emergency, there may be a feeling of less urgency of making a decision on permanent policies but then we don't know when the public health emergency might finally go away.
I don't think it's going to go away -- for at least three months but maybe over the next few months because of the Omicron surge we have now.
They may feel if we declare it over too soon, it could be premature.
It is probably likely going to be renewed one more time I think.
And then we see where we go from there on the policies.
It is still an ever changing landscape.

I hope this has been useful to you.
These are our contact information like our website and newsletter to subscribe to and we have our information box you can send specific questions on.
I'm going to take questions now from the audience.
I see we have some in the Q&A.
Let me take a peek and see what people are asking.
All right.
Is there modifier 93 for audio-only.
So, the AMA recently came out with a modifier for audio-only.
That will probably go into effect, CMS is probably going to tell folks to use that.
I can't remember exactly the number but they did come up with a modifier and I would guess CMS would say for Medicare use the modifier.
They haven't come out with the policy saying use the modifier yet, but usually when AMA comes out with the codes and modifier, CMS says use that one.
So Molly Jones, will they have site restrictions for telehealth services.
So Molly, again, if we're talking about post-pandemic, post-PHE, at least in Medicare, Medicaid is a different story, it depends on the state.
They cannot be distance site providers for telehealth services.
What they did with the policy was redefine a mental health visit, where you can use live video and audio only to provide the services.
That's not telehealth.
The whole thing of them, are they a distant site provider and that sort of thing doesn't apply

because they are telehealth.
It is very confusing, I do understand that.
But that is like the way the policy works.
It is not providing services telehealth, it is simply providing a mental health visit and just happen to be using audio or video only.
Maria, is it not subject to licence restriction?
It is not considered telehealth but you still run into the licensing issues depending where you provide services to.
And licensure is underneath state control.
You'll have like a different situation depending on the state you're in.
For the most part, states say you need to get licensed.
It still applies.
It doesn't mean you get a pass on licensure.
Can you take some time to breakdown what is available for use of audio-only that is non behavioral health and how do we designate it in the chart and is it reimbursable.
Right now under the public health emergency, if anybody has the link, there's a link on CMS's website, telehealth eligible services and lists all of the services on the COVID list.
It lists what is on the permanent and what is on the temporary and what is allowed via audio-only.
That is probably the list you are looking for.
There are services there that are non behavioral health.
I would say go to that list.
I can search now but I need to answer the questions.

If you want to e-mail CCHP afterwards, we can provide you with the link.
Does every state follow federal definition of telehealth?
There's not one specific definition on the federal level and the answer is no.
States a lot of time have their own definition of telehealth and sometimes embedded in state laws.
They have a specific definition.
Sometimes if you're talking about the Medicaid program, they could have their own definition to it.
It will vary from jurisdiction to jurisdiction.
Can we find Category†3 telehealth services list, I believe that is on CMS's website as well, too.
What are you seeing for cross-state telehealth.
It is going to depend on -- I'm going to assume when you say cross-state, you're talking about the licensure issue, it depends on the state you are talking about, whether it is still underneath the PHE or where they allowed it.
Some states have expiration dates on temporary waivers.
If it is expired, what permanent policies are.
It does depend on what the state is.
To clarify, if a service was moved into Category†3, it will be reimbursed through 2023 even if PHE ends.
Yes, it sticks around until 2023 unless CMS changes something again.
Right now it is sticking around until 2023.
Some other services are only on the PHE list and not put in

Category†3.
Yes, there are some services still on the PHE list, they disappear unless they are moved to Category†3 or put on the permanent list.
As of today, if the public health emergency was declared over today, those services not in Category†3 or permanent list go away.
Answered that one.
Courtney, do we have insights into how or what they are tracking for mental health services?
Not at this point.
Hopefully they will come out with further guidance.
Again, I think probably because we're under the public health emergency, they're taking more time to do that.
Right now, nothing, no clarification on that.
In the past, you mentioned that the Biden administration may pull back on telehealth once pandemic expires, what do you think?
There's a new administrator for HHS, I don't really know her.
I was on sort of a CMS leadership overview session where they did mentioned telehealth but there wasn't a definitive answer.
I don't know, I simply don't know where they may be going with this.
Part of it is not really left to the administration, a lot of the telehealth limitations as I mentioned earlier are embedded in federal statute.
We rarely require Congress to act on that.
There's only so much that the administration can do without Congress acting.

And we see how difficult it might be sometimes to get things through Congress.
I don't know what will happen, how much the administration will do or can do simply because a lot of the major barriers to telehealth are going to require Congress to act.
Does the mental health services and Medicare policy include SCD services?
Okay.
It is kind of a little bit of a different beast here.
I did not go over this because I was trying to keep the wire as clear as possible.
So even before all those policies that I mentioned earlier, in permanent Medicare policy around telehealth, there was an exception for SUD.
This was done back in 2018 or 19 was when they passed the policy.
This was a statutory change, a permanent policy.
Basically what they said was, they allow telehealth services to treat substance use disorder and co-occurring mental health disorders in the home.
That was an exception already in there.
It pre-dated the pandemic.
So, your whole question about do I need to do the in person or six months -- no.
This was something that existed and that was a statutory change before the six month visit thing came into play.
Really, again, the six month visit and 12 month follow-up visit, in person visit, why that is there and when have you to meet that, that is only if you are trying to do mental health visits in the home and without the geographic restriction and

don't fit into the exceptions
that existed before the
consolidated appropriation act.
I know it is very complicated.
There was an allowance to allow
that to take place in home and
without the geographic
limitation taking place.
That is still going to stand.
CCHP, we try to break it down on
the website but it is very
nuances.
I understand why there's so much
confusion and hopefully I didn't
confuse you more with the
answer.
If a patient goes to a site that
is urban area for telehealth,
does the requirement apply?
Yes.
You are trying to avoid
essentially that the existing --
I kind of label it original
telehealth Medicare policy,
you're trying to get an
exception from that.
One of the exceptions is the
geographic limitation there.
So, yeah, geographic limitation,
I think it applies even in a
clinic setting.
You are trying to avoid the
geographic limitation.
That would probably still kick
in.
If FQAC has primary services,
can the same visit be done by
private practice member than
behavioral provider?
I don't think it can.
I think it needs to be with the
provider providing the
telehealth service there.
But keep in mind though, if they
are in like the clinic setting,
they don't need to meet the in
person requirement.
If they have come in for like
their primary care visit and
then you connect them with their

behavioral health service via telehealth and still in the clinic setting, that in person visit isn't going to kick in.
The in-person visit for FQACs is only if they receive services in the home.
Are audio-only non mental health services on the Category†3 or COVID list?
It's not only audio-only services.
It is a modality.
It is not an audio-only service.
It is a modality.
Category†3 talks about the service that is covered.
Not the modality being used and the modality post PHE, audio-only can only be used for mental health services.
There's a distinction there, the service is on there but the modality is not connected with the service.
Just saying that service can be provided via modality.
It is two different things.
For telemental health into home, will they need to document or just patients located at the home.
I don't have clarifying policy on how they want the documentation to take place.
So I can't answer that, and I don't have anything -- as far as I know, CMS has not issued clarifying instructions on that.
Mental health provisions apply for Medicaid?
No.
It is going to vary from state to state and what they decide they will do.
Some may adopt similar to what Medicare is doing but not all states.
You can go to CCHP's website to see what the Medicaid program is

doing.
Does the mental health in person start now?
No, it starts when the public health emergency is over.
What about FQAC -- not considered telehealth.
They didn't say anything on look alikes applying to it.
Just rural health centers -- if providing a mental health visit, via telecommunication technology but they're come nothing to access services, is that allowable?
Again, if the patient is in the clinic setting, the six month 12 months doesn't kick in.
Only receiving services in the home.
Should we use you as an example of mental health.
Have you the same narrative.
I'm not sure I understand that question.
If you want to clarify?
If you want to clarify a bit more then I can see it when I get further down.
What is required for time length visit -- I don't have any specific language.
So it is not necessarily -- I believe there's a coding with a modifier that the service is done via telehealth.
The redefinition of a mental health visit, that does not mean they are able to use telehealth.
To use telehealth to provide the services if they want to be reimbursed by Medicare.
I'm not saying it is illegal, but they won't be reimbursed by the program.
Should we bill for the visit -- no -- if the provider is at home and the patient is at the clinic.
I believe they can if the

patient is at the clinic.
It's really more the patient using the facility that you can bill the original site fee.
Progress in coverage of reimbursement for less than 16 days, requirements -- I have not heard anything on monitoring for less than 16 days.
I haven't heard any new news on that to be quite honest.
Does New Jersey reimburse for audio?
I can't remember offhand.
You can check out the CCHP website.
We follow the Medicaid policies.
You can check there.
I missed the name of the bill passed December†2020 that requires six month in person -- consolidated appropriations act.
CAA, the bill that was passed in December†2020 that did the six month in person visit thing, consolidated appropriations act.
The diabetes prevention program might benefit from telehealth and rural monitoring.
Can it be included -- depends on what code you're talking about.
There's chronic care management, remote therapeutic monitoring.
If you can be more specific.
They have specific definitions on their services there.
You can look at those to see if it applies to the situation you want.
Cross-state provider in New Jersey are not credentialed in other states, are we only allowed to see patients in New Jersey, do you mean if they're not licensed in New York or Pennsylvania?
You have to check to see what their requirements are.
I think you probably meant

licensure and not credentials.
We found telehealth Arizona for MD only, are there other applications for other providers?
I don't think they did it for other providers.
I think they only did it for physicians.
What is the best place website to get state specific telehealth updates?
Probably CCHP's website.
It is on the slide I believe.
Hold on.
Yeah.
It is on the slide as well.
The Q&A was blocking that for me.
With the percentage of -- declaring PHE -- she spoke quickly, I'm not sure I understood all of that.
So what I'm saying, some states, their temporary telehealth policies have expired.
They had an actual expiration date to them and declared that their state of emergency was over or that the waivers had expired so you need to check your state to see if those policies are still in effect.
It is different for each state.
They have had different approaches to it.
Is Medicare -- waived for -- co-pays I don't think are waived.
If you have a co-pay for that service, you have to pay it regardless of the way the service was provided in.
So, difference between Category†1 and Category†2.
So, again, this is CMS's way of deciding whether to put services on a permanent list, on the permanent telehealth list, there's a Category†1 and

Category†2 test.
A Category†1 test, is what is being proposed similar to a service that currently exists on the permanent telehealth list. If it does, it passes Category†1.
Category†2 is does the service you are proposing have enough evidence around it to show it can be provided via telehealth and the efficacy is good. As good as in person, that type of thing.
Category†2 test is harder to pass.
Where you see the services put on the permanent list, they pass the Category†1 test.
That's the difference on those.
In terms of Medicaid telehealth, have many states moved to make it more flexible and more states move in that direction?
I haven't done an analysis on what it is, if I were to guess, I would say probably half and half of like policies made permanent.
Sort of the biggest area I think in where we see Medicaid policies adopt things, they have expanded the telehealth policies.
As far as what is allowed.
And then as I mentioned in my presentation, we have seen more audio-only be allowed too as well.
Will they continue to move in that direction?
I think it will be a mixed bag across the country.
Is there remote patienting monitoring code, if not when it is expected?
For the communication technology services, they can provide some of the services, not all of them.

There are allowances for some of them to provide.
And you can -- CMS has some learning network booklets on those as well where they signify what they are.
I can't remember off the top of my head.
There are remote patient monitoring codes, some of the codes, not all of them that they can provide.
Medication therapy be involved asthma and inhaler is -- that question I don't know the answer to.
I apologize.
Regarding medication therapy for severe asthma and inhaler -- that I don't really know the answer to.
My apologies on that.
We are actually over on time.
I only have about 10 questions left.
I'm going to stick around and answer the rest of the questions here.
So but if people need to drop off, it is being recorded.
Back to cross state telemedicine offering.
If the patient is on Medicare, can they do cross-state telemedicine because we are in the federal PHE.
Again, I think I understand the question.
Again, licensure is a state issue.
So even if they're a Medicare patient, they have to follow the state laws on licensure.
It is going to depend on what state the patient is located in.
Because when you talk about the licensure laws, where the patient location is.
Depending on where the patient location is in that state and

what their policies are around licensure.
It doesn't matter if they're a Medicare or Medicaid patient or self pay.
Can you provide a link for the overview of what is and not in Category†3.
That would require me to search for it.
If you would just contact CCHP afterwards, I'm sure people don't want to watch me search for that right now.
If we get on registry to provide services, do we first have to see the patient we are licensed in would allow that?
I'm not sure 100%.
It would probably be something like you need to be in good standing with the state you are licensed in.
That is probably a question more for your medical board to see if they would require anything of you if you did get on the registries in other states.
Repeat there.
Do you anticipate the modifier code to be required -- it is going to depend on the Medicaid program and commercial payer.
I do know that can get confusing for folks.
It is like different payers require different billing requirements.
So I don't have a definitive answer for you.
It depends on what they're going to say.
A requirement six month, 12 month in person follow up visit or prior -- it is six months, 12 months prior to services being delivered via telehealth.
If you had an in person patient seven months ago and then start telehealth seven months, that

doesn't count.
It has to be six months before providing telehealth.
Do you have guidance on modifiers FQ in place of service -- no, sorry, I don't.
Kendra, if you want to e-mail me afterwards, I'm not quite sure I understand your question.
If you want to e-mail me afterwards, I can take a look at the question then.
Any provisions for telehealth delivered in the school setting?
Not on the federal level, but check on the state level.
States have been a little more open about school settings.
Cross-state -- that's a repeat of that.
Yes, not licensed, I'm not sure what that refers to.
Apologize.
Tracking this -- are there viable means to update to policy makers?
Yes, one thing you can talk to your policy maker about this.
They probably prefer to hear from clinicians and patients than from me saying these are the hardships you face.
And the last question, besides the codes, how can we help telehealth move forward for society.
The thing you can do, as I mentioned earlier, talk to policy makers both on the state and federal level.
They like to hear more from patients and providers, like people actually receiving services and providing the services rather than, you know, from me who is like this policy person.
They hear from me all the time.
They want to hear the stories from folks.

I would say contact both congressional members and both of your congressional and state legislative members as well, too.
They really do want to hear those stories.
Those are the things that have the most impact on them.
That's what I would recommend.
All right then.
That's it for the questions.
Thank you so much, thank you for having me and sticking around to the folks who stuck around.
Aria, back to you to wrap-up.
ARIA: Thank you Mei.
For the next webinar on the 17th, it will focus on the pandemic response action plan, registration information is listed on the website on the events page.
Next slide please.
We do value your opinion and ask that you take a few short minutes and complete the online survey that will pop up at the conclusion of the webinar.
Thank you to Mei Wa Kwong for presenting today and the Center for Connected Health Policy for hosting the webinar.
Have a great day everyone.
[Concludes at 3:10pm]