Phillip Stringfield (00:04):

Awesome. Thank you so much, Olivia, and as Olivia stated, my name is Phillip Stringfield, and I serve as the manager of Health Center Operations Training here with the NACHC's training and technical assistance division. I'm glad to have you all with us for our January Telehealth Office Hour session.

(00:20):

Before we get started, I do have a couple quick commercial breaks in here just to make sure you're all aware of our upcoming events. First things first, as always, I'd like to give a shout out to our NACHC-hosted EHR user groups. As you can see on the left hand side of the slides, NACHC currently hosts six EHR user groups amongst different vendors. These groups are led by steering committee of PCA, HCCN and health center leaders on a voluntary basis. Of course, we would always encourage you to join. If you like, you can always email me and we'll make sure to drop in the chat a link to get there as well.

(00:58):

Moving on, I also wanted to give another reminder that is EHR related. We actually just opened up the application for our EHR learning collaborative, and this year it's going to be focused on EHR optimization, and a special feature about this is that it is going to be vendor agnostic. So anyone on any EHR is going to be able to apply for this and it's really aimed at making real changes within your organization and learning real strategies on how to do that. So I'll make sure to put in the link to the application there as well in case folks have any questions. You can always email me.

(01:36):

Then next thing's next for our coders and our quality folks, we do have a billing, coding, documentation and quality webinar series coming up later this year. A special feature about this is if you attend both, you can earn up to three CEU by attending both of those webinars. So we do have The Top Five Documentation and Revenue Tips in Community Health, and on January 31st, we'll be looking at Treating Substance and Opioid Use Disorders Via Medication-Assisted Treatment in Community Health. We definitely look forward to seeing you there.

(02:10):

Then just lastly, I wanted to give you all a plug that there are some innovative telehealth tools that we have coming out of a joint project for FQHC. So as you see on this slide, what you will also get is a tool that you can look at for policy, the policy tracker across 50 states. Then you also have questions, if you do have specific telehealth building questions, you can email FQHCquestions@cchpca.org. We'll definitely be learning and entering more information about that later on throughout this webinar.

(02:45):

So without further ado, we're going to go ahead and get things started. We are done with the commercial break. I hope you enjoyed it. I'll be introducing our partner today with Center for Connected Health Policy, Mei Kwong, who's going to be coming with us with the latest and greatest telehealth policy updates that are going to be impacting you this year. Without further ado, I want to just thank Mei again for her time and pass it over to get started. Thanks again.

Mei Kwong (03:09):

Thank you, Phillip, and thank you, NACHC, for inviting me here today. Good morning or good afternoon, depending on where you are. As Phillip said, my name is Mei Kwong. I'm the Executive Director at the Center for Connected Health Policy. For those who may not be familiar with CCHP, we are the federally designated national telehealth policy resource center. What that all means is we receive federal funding

to provide technical assistance on telehealth policy questions. So we are national, so we cover what happens both on the federal level and on the state level.

(03:39):

Today, I'll be mainly focusing on what has happened on the federal level because there's actually been some recent actions that directly impact clinics as well. So I just wanted to keep you informed on that, but I will be touching upon a couple of things that will be impacting states as well.

(03:55):

However, as Phillip showed on the previous screen, because there are 50 states, actually, we track not only the 50 states but District of Columbia, the Virgin Islands and Puerto Rico as well. So we track 53 jurisdiction, not counting in the federal landscape as well. So as Phillip mentioned on the previous slide, we do have a policy finder on our 50 state policy finders, a section devoted to FQHCs and Medicaid telehealth policies, and because there are 53 different jurisdictions, there are 53 different policies for Medicaid and telehealth as they impact FQHCs.

(04:32):

So I really encourage you to go and use that to figure out what's going on in your particular area, in your particular state or if you cover multiple states or multiple jurisdictions, you'll be able to figure that out as well too or go to those different ones because it is very different, but for the most part, we're going to focus on federal, which is a little bit easier to follow theoretically because it's one policy, and when I say theoretically, you'll understand as I get more into it. It's just there's a few different tracks going on, a few different things going on that might make things a little confusing. So hopefully, I'll be able to clarify and make it a little bit easier for folks to understand exactly what is going on and where we are now.

(05:15):

Before we get started, a quick disclaimer here. Because we are federally funded, the feds like me doing this. So I am not providing anybody with legal advice. This is strictly for informational purposes only. CCHP always recommends that if you are interested in a formal legal opinion that you consult with legal counsel. Also, if I happen to mention a company or show a picture or a product, know that neither I nor CCHP has any type of arrangement or relationship or affiliation with such a company.

(05:45):

So this slide, if you've heard me talk before, you've probably seen this slide at some point. This is my quick one slide summary of the telehealth policy changes that happened during COVID-19 both on the federal and the state level. It's very, very broad and overview. As you can see, not a lot of detail in there, but what it does show you are the certain areas where there were temporary changes made in response to the pandemic, and you see some overlap or at least some commonalities between what was happening on the federal level and what was happening on a state level as far as issues that they're addressing.

(06:20):

The reason for that is because a lot of the established telehealth policies that impeded the use of telehealth in response to COVID-19 were around certain elements or certain common elements that they had both on the federal and state level, such as limitation on where the patient had to be when the telehealth service took place, so a geographic limitation or a site limitation, the modality you can use if you're expecting to get reimbursed by either Medicare or Medicaid, and also the type of provider could provide the service and the type of services that were covered.

(06:52):

So those were common issues that both state governments and the federal government had to address if they wanted telehealth to be used more widely, but then there were all of the other issues that were exclusively on the federal, on the state level to decide. So for example, licensure. That's a state issue. So the states were deciding what they were going to do with it, but HIPAA, for example, is a federal issue. So the feds were deciding what to do with it.

(07:18):

So this is just your quick overview of what had happened in response to COVID-19 and the question is, what's going to stay? What's going to remain once we're out of the COVID-19 public health emergency? Now, on the state side of things, a lot of states have actually made that decision already, but they've all done different things. Again, that's why I encourage you to go to the CCHP policy finder because I can't tell you, "Oh, this is what happened," and it applies all 50 states because they all did different things. They all did different approaches. Some of them may have been similar in their approach, but there's variations, little tweaks and things that really make a difference to be aware of.

(08:02):

So a lot of states have already decided what they were going to do after the public health emergency or they were on a track where their waivers were based upon a state public health emergency and that's been over for a couple months or maybe even a year or longer. So as I said, so states have already moved towards, for the most part, their decision on what they're doing in regards to telehealth.

(08:24):

The feds are a different story. So the feds have, over these last couple of years, gone through a lot of different things or a lot of different approaches. So for the most part, it's just been delayed because we've remained in the public health emergency, but there have been some movement that will give us an idea of what it's going to look like after the public health emergencies declared over.

(08:46):

Now, where are we with the public health emergency itself? So we are still in a public health emergency and it was actually just renewed again yesterday. So right now, we know we will still be underneath the public health emergency through April, and a lot of people feel like, "This is probably the last public health emergency renewal. Once we hit April 11th around there, that's going to be it. We're out of a public health emergency." Technically, without that public health emergency declaration, a lot of waivers, a lot that we experienced during COVID-19 will disappear unless some action has been taken by the federal government to keep it around or to make it permanent.

(09:28):

Now, the way the federal government will do that will be through two steps. So they either will do it through legislation, so bill will have to pass Congress, president will have to sign it and becomes law or they will do it administratively or through a regulatory process, and that's CMS, basically, when we're talking about a lot of the telehealth policy on the federal level because it impacts Medicare. So something that the administrating agency such as CMS would need to decide and to go through a regulatory process.

(09:59):

Now, over the last almost three years since we've been in public health emergency, there have been various movements both on the legislative side and on the regulatory side, as I said, to give us an idea of what this post PHE landscape's going to look like for telehealth on the federal level.

(10:16):

On the legislation side, there have three been three major pieces of legislation and, basically, it's been not a telehealth bill, it's been more of a budget or appropriations act. So it's been a bigger bill with stuff in there that telehealth got woven into. It usually takes place towards the end of the year, although 2022 was the beginning of 2022. So it usually takes place around this time of year, December, January, that type of timing as far as when these particular bills have passed. So there was one in 2021.

(10:50):

Now, the one in 2021, some of you may be familiar with it, it didn't actually address any of the temporary waivers, but it created that permanent policy of, "Oh, we'll allow telehealth to be used to provide mental health services without the geographic requirement being applied and it could take place in the home if certain conditions are met," and one of those conditions was having a prior in-person visit with the telehealth provider. So that's where that came from. It came from the Budget Act or the Appropriations Act of 2021 that they passed in Congress.

(11:28):

Then in 2022, we saw what was called the ... I called it the 151-day grace period where they did address the temporary waivers, where they said, "What we're going to do now is when the public health emergency is declared over, we're going to create this, basically, grace period for some of the telehealth waivers," and that's a 151-day grace period. So you may have also heard that too, that number being bandied around of like, "Oh, well, we got 151 day after the public health emergency where some of these telehealth waivers will stick around."

(12:02):

Now, they didn't do all of them. So this was legislation and basically what they included in there was that certain providers can continue to provide services via telehealth during this grace period, and that included FQHCs and RHCs and a couple other specialists. They did waive the geographic limitation. They also allowed the home to continue to be an eligible originating site and they said that audio-only can continue to be used.

(12:26):

So we had this grace period now established and we knew, "Okay. So when the public health emergency declared over, we're going to have 151 days with some of these things." Now, I keep stressing some because they did not address all the waivers. You'll see on here, for example, HIPAA wasn't addressed. For those who may not be familiar, when the pandemic started, the Office of Civil Rights, OCR, which oversees HIPAA said that they would exercise discretion on whether to prosecute or ding a person who was not abiding by HIPAA because they wanted providers to be able to utilize whatever platform was available as quickly as possible and they may not have been HIPAA compliant.

(13:08):

So they said that they basically would not go after anyone if they were using a platform that wasn't quite compliant. That discretion or that memo, basically, will expire once the PHE is over because it was not woven into this federal bill here. So it wasn't in legislation and that's just one of a couple of things that they did not specify in federal legislation. So going into '22, at the start of '22, we knew we had a 151-day grace period after the PHE for at least some of these things.

(13:46):

Fast forward to basically right before Christmas of 2022 in December, they passed another budget bill, essentially. It's Consolidated Appropriation Act of 2023, and what they said was for those temporary waivers that we talked about with that 151-day grace period, we are now extending them for two years.

So they will add not 151 days after the PHE but on December 31st, 2024. We're going to go into a little bit more detail on exactly what all that means instead of just these little bullets that I have here.

(14:22):

So as I said, these are the things that are going to be extended, stick around for an additional two years essentially till December 31st, 2024 and that is the location. So basically, the geographic requirement is not going to apply in Medicare. Keep in mind, I am just talking about Medicare policy. In Medicare, that geographic requirement is not going to apply. They're also going to continue to allow the home to be an eligible originating site.

(14:47):

Now, permanent Medicare policy for those who aren't familiar says that the patient needs to be in a certain geographic location and the home is not eligible originating site except for certain very narrow exceptions. Right now underneath the temporary waiver, that is suspended basically for two years until December 31st, 2024. They're also going to continue to allow some providers who are not eligible providers underneath the permanent Medicare policies for telehealth to continue to be able to provide services via telehealth and get reimbursed by Medicare, and those are PTs and OTs, audiologists, and speech language pathologists.

(15:27):

FQHCs and RHCs, and this is where it's important for you, will also continue to be able to provide services via telehealth. Again, under permanent Medicare telehealth policies, FQHCs and RHCs are not eligible providers, but during this two-year temporary waiver period until December 31st, 2024, you will still continue to be eligible to provide those services via telehealth and get reimbursed by Medicare. Keep in mind though that the services that you provide, it's not all your services, it's only going to be the services that are eligible to provide via telehealth in the Medicare program.

(16:04):

Audio-only can continue to be used to provide certain services beyond mental health services. So right now underneath permanent policy, mental health and behavioral health services will be the only ones that you can use audio-only to provide and still get reimbursed by Medicare. Again, the temporary waivers, the COVID waivers allowed other services to be used or audio-only to be used to provide those other services beyond mental and behavioral health, but they're very specific. For those who are not familiar, CMS does have a list of what are all the eligible telehealth delivery services and then they mark out, "These are the ones," it's not all of them, "These are the ones that you can use audio-only for."

(16:47):

They are delaying implementation of some of the permanent policies that they made decisions to do earlier and such as what I mentioned in the previous slide about the in-person visit before a mental health service can be provided without the geographic restriction taking place. So that's been delayed. That's been delayed till January 1st, 2025. So basically, they're not implementing that when we're in this now two-year grace period.

(17:17):

There was also a delay of having audio-only to require that in-person visit as well too. That was something that CMS has decided administratively with the physician fee schedule a little ways back that's also been delayed. So you don't have to worry about, "Oh, does telehealth provider need to have this prior in-person visit?" That's been delayed. That's been delayed two years as well too.

(17:41):

The thing that is a little bit newer is they are requiring a study on telehealth that will look at data gathered from basically this grace period that they're creating from 2022 to 2024 and looking at various factors of telehealth like utilization and also where it happened, et cetera. The interim report of that will be due towards the end of the grace period, October 1st, 2024 and then the final report in 2026.

(18:09):

Then there was some concern about this, an extension on the safe harbor for the absence of deductible telehealth, and it got a little bit cut off here. So there was, during the COVID-19, during the pandemic, the public health emergency, there was a safe harbor went on deductibles for telehealth on commercial plans there. So they're continuing that as well too.

(18:30):

So as I said, not everything was in here for an extension for two years that applied to telehealth that were temporary waivers in response to COVID-19. These are major things. I don't want to downplay this. These are major things that they are extending for additional two years, but not everything is in here.

(18:54):

Physician fee schedule, now, this is the other way I said that they will make permanent policy. So that was all legislation, but CMS also has a role in deciding what would be permanent policy going forward too and they do this through the regulatory process, through the physician fee schedule. For those who are not familiar with it, the physician fee schedule is the set of proposals that CMS comes out with every year that impacts Medicare for the following year. So they usually come out with it in summer around July. There's about a 60-day comment period where the public can respond to what the proposals are. They take that in, they respond back, and then they make a permanent decision on a final proposal. Usually published in November, sometimes as late as early December, and then they say, "This is the final policy," and it's going to go in effect January 1st the following year unless they give a different date for when it goes into effect.

(19:49):

Now, what they have done over the last couple years is they've done incremental changes as well too as far as what they're going to make for a permanent policy. So one of the things they did was they created a temporary holding bucket. It's called Category 3. These were services that CMS decided that they would continue to reimburse if telehealth was used to provide it, but it wasn't a permanent policy yet. So they put them in a temporary holding bucket to decide after they've gathered more evidence to see should it be moved over to the permanent list. It's called Category 3. That's how they labeled it.

(20:30):

Now, this temporary holding bucket only goes through 2023 until the end of 2023. So that has a specific date on there. Now, that's your first clue there, seeing there may be now a misalignment of policies because you're saying, "Well, wait a minute, we have all these temporary policies that you just said in the previous section that go to 2024." Yes, but keep in mind that happened just a few weeks ago in December and it was a congressional action. CMS does things as well and so far they have not made any changes yet.

(21:06):

So I'm only going by what I know has happened so far and what has happened is they created this Category 3. It contains some of the COVID-19 services or services you can provide during the COVID-19 pandemic when you're using telehealth and they said that they will only be eligible or available until the end of 2023.

(21:28):

Now, other permanent policy changed. I'm not going to spend a lot of time on this. It's allowing FQHCs and RHCs to use audio-only and live video to provide mental and behavioral health services, but if certain conditions are met such as having that in-person visit, that's suspended. That is definitely suspended. That was suspended by the congressional bill, but at least suspended until January 1st, 2025. So it's in that two-year grace period there.

(21:57):

The other thing that hasn't quite been aligned yet with what happened with the congressional action was basically the list of eligible telehealth services. So when COVID-19 happened, CMS put on the list of services that you can provide via telehealth and get reimbursed by them other services that were eligible that weren't on the permanent telehealth list. So there was about 150 eligible services you can provide via telehealth underneath the Medicare program that are on the permanent list, and then CMS added another hundred during the pandemic. Some of those they have said they're going to be Category 3. They marked them as Category 3. So we know that they stick around until 2023.

(22:42):

What happened when last year Congress created the 151-day grace period? In the physician fee schedule, CMS aligned their policy as far as what services will be available during that time or that you can do during that grace period to reflect that 151-day grace period. So that's a little bit confusing, so I'll go over it again.

(23:06):

So in the congressional bill, both the one for last year that created the 151-day grace period and the one that extended it to two years, what you will notice in there is Congress did not say anything really about what are eligible services to be covered via telehealth during that time. That's because that is for the most part left up to CMS to decide. There's some very specific things that are allowed, but that's what CMS would had on their permanent list. So that was never in question. It's all those additional services that CMS added during the public health emergency that's the big question mark.

(23:46):

So the question has always been that since Congress did not address that, what will happen? Can you still continue to provide all that big list of services, basically 250 different CPT codes or do we go back to the permanent list which is a smaller list? CMS through the regulatory process over the last couple years has said there's one category, Category 3, that has some of those codes that we know will stick around until 2023. Then last year they said, "Oh, no, the entire list will stick around during 151-day grace period."

(24:21):

Again, we go back to the congressional bill was pretty recent. CMS has not come out with anything yet. They may not have had time yet to come out with something to respond to that. So my guess is at some point they are going to align themselves to the two-year grace period now and not just keep that 151 days, but nothing has come out yet. So I can only say that, well, we know there's going to be 151 days that that full list will stick around.

(24:47):

I can't speak for CMS. I'm assuming they're going to align with what the congressional action has taken place, but right now until they do that, I can only say there's the 151-day grace period. We'll see what happens. In fairness to CMS, this has only been a few weeks since that bill was passed and it was right

before the holidays. Also, CMS doesn't really need to do anything right now because we're still underneath the public health emergency. So this hasn't really quite kicked in yet because we're still underneath PHE. So they may feel okay because they have a little bit of time, at least we know through April before they issue that policy.

(25:25):

So it's a little bit confusing, but just keep in mind because they were doing this process on policy, they do it through different channels that they're just not quite aligned on everything yet. I'm sure we'll hear something about what they're going to do soon. The only concern is the timing because people think that this was our last public health emergency renewal and it only goes through April, and if they are hoping to do it through the physician fee schedule usual process, that usually doesn't take place until the summer. So there's going to be a gap there.

(26:01):

So one thing that they can do is just probably do an emergency regulation or I don't know, maybe the public health emergency will get extended a couple more times, but I don't know. Right now, just know that, as I said, they haven't quite aligned their policies yet, but it's also been very soon. It's only been a couple of weeks. So we got to give them a little bit of time and they do have the cushion of having had the public health emergency renewed again for another 90 days. So they have some time to do that. Hopefully, that made sense. When we get to Q&A, I can go through it again if necessary.

(26:38):

So this is your quick glance as to where all these things align and that's why I was saying things are all on different tracks. So the first column is your permanent policy. This is stuff no matter what, if we're in a PHE or we're now suddenly January 1st, 2025, this is the stuff that sticks around that we know of so far. Keep in mind, I mean, stuff changes. So there could be another bill pass this year and it completely changes everything that I have on the slide. So it is very important to keep track of these things.

(27:10):

If you don't want to do that on your own, just sign up for stuff from CCHP and definitely from NACHC and we can keep you informed of things, but this is your quick glance as to what's permanent policy, what automatically goes away once the PHE is over.

(27:25):

Now, let's take a look at that, what automatically goes away and things that we know, and there's other things that will automatically go away that I didn't list here, but these are some of the bigger things that people have asked about. So one is that HIPAA discretion that I talked about. OCR actually was pretty clear about that. It's buried. They have an FAQ where they have a link saying like, "Oh, no, once the public health emergency is over, that discretionary thing goes away. So yeah, you better be HIPAA compliant."

(27:56):

Also, the PHE exception prescribing control substances, a lot of people are very confused about this. So underneath the Ryan Haight Act, which includes the section on telehealth and prescribing controlled substances, there's a list of exceptions on where you can use telehealth without having the telehealth provider have that in-person visit with the patient. Those exceptions are pretty narrow and a lot of them basically boils down to, "Oh, the patient needs to be in a DEA-registered facility or they need to be with a DEA-licensed provider during the time of telehealth visit."

(28:28):

One of those except exceptions though was when a public health emergency is declared. So when the COVID-19 public health emergency was declared, that kicked in automatically. That was not something that Congress decided to do in response to COVID-19. It was something already in federal law and it just kicked in automatically, but what that also means is once that public health emergency declared over, it automatically works back to, "You got to fall into one of those other narrow exceptions. It automatically goes away."

(28:56):

So unless something is done, that for the most part automatically goes away, except for one potential avenue, well, two potential avenues. I'll talk about that in the next slide, but for the most part, it's like that's going to be something that disappears automatically day after public health emergency is declared over.

(29:17):

Post-PHE, what we know will stick around for the two years, it's all that stuff that I talked about earlier, but you'll see I have an asterisk at bottom saying right now the eligible assist services though in CMS and Medicare, not quite aligned with this policy yet. So that's still talking about being in a 151-day grace period. So as I said, I anticipate probably CMS doing something soon. I can't guarantee it, but they aligned it with the previous legislation for the one 150-day grace period. So that's why I'm assuming they're going to align it with the two-year period. Then what do we know will be here through the year of the end of the PHE, that's those Category 3 services. This is assuming that the PHE is declared over this year in 2023.

(29:58):

So the Category 3 services that I mentioned, sticking around and being in that temporary holding bucket CMS created, and also virtual preference for direct supervision. So during COVID-19, CMS allowed supervision by physicians to take place through telehealth, through virtual presence. That was a temporary waiver, so they have asked for feedback, "Should we continue this?" and they haven't made a final decision on that yet. So we're under, in CCHP, in the assumption that it's over unless some policy change happens in the meantime, and that could happen. I did a recording about what to expect after the PHE in the beginning of December and it definitely is now outdated information because of this congressional action.

(30:43):

A couple other things that have happened, and this is the first one relates to the prescribing controlled substance. There have been proposed regulations put out by SAMHSA that is trying to make permanent the initiation of buprenorphine to be provided via audio-only or live video. If you are an opiate treatment program physician, PCP or other healthcare professional, that can do that though. So that's a narrow exception, but keep in mind, that's not all controlled substances. It is buprenorphine and it's a very specific circumstance, a very specific type of provider too, but that is a proposed regulation that is out there as well.

(31:25):

Then the other thing, and this is where I'm going to touch upon the states a little bit is that for those who may not be familiar, there is something called eConsult that has been used over the last couple years and it is basically patient goes and sees their primary care provider. There is some condition that they have that the primary care provider needs to consult with a specialist and they send that information very robust, a lot of information over to a specialist and the specialist sends their

recommendations back to the primary care provider and then the primary care provider essentially initiates and does the treatment.

(32:03):

So the care stays with the primary care provider. It's usually primary care provider, but I'm using that as an example, and that's been labeled eConsult. There's been a question there on whether Medicaid programs can reimburse through that and the big thing is basically still do that underneath their federal match there, have that partially paid by the federal government and there's been a lot of confusion over that. There's been mixed messages from the feds on, "Is that covered?" and states have been doing different things.

(32:39):

Well, a letter was sent out last week from CMS where they said, "Yes, Medicaid programs can cover that." It's not mandated. So that doesn't mean, Medicaid programs, you are obligated to cover this. It is something that Medicaid programs can cover. That's what the CMS letter is saying. They also would need to, depending on their fee structure or something, they may need to send in an estate plan amendment.

(33:06):

So I only bring this up because of a couple of things. First off, you will notice this was not a regulatory process nor was this legislation. This was an administrative letter that CMS sent to the state. So that is another way in which policy can be developed that impacts how telehealth is used, that can impact clinics as well.

(33:28):

Second thing, it's great that they did this clarity, and I have the letter link, that's why that's hyperlinked. So when you get a copy of the slides, you can read the letter yourself. I have a couple of questions. There's a couple points to the letter that were a little bit unclear to me. So I will probably be trying to follow up with CMS. I don't know if they'll answer my questions, but I'll follow up with CMS with some clarity. One of them is I'm actually not quite sure how they are regarding clinics being allowed to use eConsult and get reimbursed for it by their Medicaid program. So I'm hoping to get a little clarity on that, but this is a good step forward in that it is basically saying because there was so much uncertainty of, "Well, can state Medicaid programs do this? I mean, what's going on here for CMS to put this forward?" and clear that up at least.

(34:19):

Again, I said, it's another way of policy being established that impacts you guys as far as how you use telehealth and it's not an obvious piece. It's not a piece of legislation that Congress passes or even the physician fee schedule. It's this other piece but it can be a very important piece as well too. So just wanted to put that on your radar so you're aware of it as well. I think that's about it.

(34:45):

Here is the CCHP website. We also do a weekly newsletter where we put out news and information regarding things. I think there are some questions that I'm just going to click on the Q&A and just start looking at and see.

(35:01):

"Legislation applies to Medicare only?" Yes. So if you're interested in Medicaid or commercial health plan, that's really more in the state level. So you're going to have to look at what the state does regarding that.

(35:15):

"For behavioral health patients who may not have been seen in-person, they are not eligible for telehealth?" No. So that's where I know a lot of confusion lies. So that policy where CMS said, "Oh, before you use telehealth to provide mental and behavioral health services, you need to have an in-person visit." Now, that permanent policy, don't worry about it now for the next two years. It's been delayed, but there's also confusion about the policy itself to begin with.

(35:45):

In Medicare, in order for a service to be eligibly reimbursed by Medicare, the patient needs to be in a certain location both geographically and site, the type of building they're in when the telehealth service takes place. Now, underneath that permanent policy, you need to be in a rural location. They have a very specific type of definition for what they mean by rural. The in-person mental health visit requirement will only kick in if you're trying to avoid that geographical requirement or if the patient is trying to have the service in the home. That's when that in-person requirement take place.

(36:21):

So you as a clinic, if a patient came into your clinic and you were connecting them with a telehealth provider for mental health services, they didn't need to have that in-person requirement met. You just needed to have fit into that geographic requirement there. So that does not kick in for two years, but also, it was more if you were trying to avoid other types of requirements such as the geographic requirement, that you're required to have the in-person one.

(36:50):

"When you're in South Carolina, I have an MP that is going to do AWVs via telehealth. The patient will come in the office, the MP will be at her home. Her home is in Georgia. Can we bill for the AWV?" What payer? So it's going to vary from payer to payer. If it's Medicare, you're going to have to look at the Medicare policies to see, is the particular service going to be reimbursed? Is the nurse practitioner an eligible provider? Then if it's Medicaid, those same questions come up on as well. So your first point to start with is who is the payer, who covers that patient, who's paying for that particular visit, and then see what their policies are for their.

(37:37):

"What constitutes an in-person visit? Our telehealth providers are not on site. However, our patients are required to be in the clinic observed by [inaudible 00:37:45] majority of their visits." So the in-person, I'm assuming you're talking about that prior in-person visit, there was actually some specificity by CMS about that when they were talking about it. They were saying that it is an in-person visit that they need to have with that telehealth provider and the service that was provided is actually some service that CMS paid for or would have paid for had the patient been eligible for Medicare. So that is what they mean by that and it's very, very specific. Okay.

(38:18):

"Our FQHC is in Indiana. Behavioral health patient goes to Arizona for the winter. Will Medicare cover a telehealth visit with our BH provider patients located in another state?" Your first issue is actually around licensure. It's not going to be around Medicare. So the question is can you provide that visit when the patient is in another state. That is going to vary. So it's going to depend on what controls is location of the patient. When I say what controls, I mean, what controls is their licensure laws. So whatever state that they're going to, you're going to need to figure out what their licensure laws say.

(38:58):

Now, some states have made exceptions, not all states. Some states have made exceptions such as, "If they're here temporarily, it's fine to do that or if you only do it a couple of times a year, it's okay for you to do that. You don't need to get a license from our state." Not all states do that. You need to look at that and see what happens.

(39:22):

Now, I see that you followed up and saying, "The licensure is fine. Is Medicare going to cover the visit?" They should because as long as you are abiding by the licensure, and also definitely for the two-year period, the originating site requirements have, as I said, been waived. So it should be covered is what I'm thinking because you don't necessarily ... I'm thinking on the patient end. They don't have to be in a clinic setting at this point because, as I said, they're allowing home to be an eligible originating site during the public health emergency and also during the two-year grace period. So it should. The biggest problem, and this is for other folks, it may not apply to your situation, but the biggest problem is really the licensure issue that you're going to run into.

(40:22):

"Does the Consolidated Preparation Act supersede the 151-day extension period in the context of the permanent health services made eligible because of the PHE?" I'm not quite sure I completely understand that question, but the first part of it, does it supersede it? Yes. So the 151-day grace period, essentially no longer applies except for the list of eligible services. Again, I go back to it's because CMS hasn't quite aligned it. They may not have had time to align their policies to what happened in Congress.

(40:58):

I'm not quite sure what you mean in the context of permanent telehealth services made eligible because of the PHE. So there have been some services. Maybe this is what you mean. Over the last three years, there have been some services that were temporarily allowed during COVID-19 on that list that CMS has made permanent. There's been a handful. There has not been a lot. It's maybe been about 20 or 25 different service codes that were put onto the permanent telehealth list. So yeah, those would stick around no matter what.

(41:30):

I'm not quite sure if that's what you're asking about, but if it is, whatever happens, 151-day grace period, two-year grace period in a PHE, not in a PHE, what's on the permanent list, that sticks. So yeah, I hope I answered that question.

(41:48):

"As an FQHC, is it correct we are still billed 2025?" You know what? For that, that's actually a good question and I hadn't wondered about that. I'm not sure if CMS is going to come out with new policy for you on how they want the billing done in that two-year grace period. So I actually don't know. So this is one of those questions of we're going to have to wait and see what CMS does because I'm wondering if they might particularly because of the data that they're now going to have to collect because of that congressional report for that two-year period, for that two-year grace period. That might change. I mean, unless you hear differently from CMS at this point, you're probably using still using G2025, but it was a question I had in my mind and it's like, "Oh, are they going to do different billing instructions?" So that's going to be a wait and see from CMS.

(42:37):

"Is there a limited number of telehealth visits per day for each provider? Also, can RNNs bill insurance for their telehealth services?" So is there a limited number? There are for skilled nursing facilities? FQHCs, I don't believe there is, but visits per patient there is. So let me put that. So when you have a

limited number, it's usually for the patient on the patient end. So for skilled nursing facilities, it is limited. I think it's once every two weeks at this point or something like that. I can't remember that offhand.

(43:18):

Then for FQs and everybody else, it needs to be something different. It's like the usual policies that you go through and that it needs to be a different type of visit in order to justify the additional billing. So for example, I go in with a cough that's being treated and then that's done via telehealth. They can do that, but then I maybe need a mental health service at the same time and they do that at the same time. You can build those two visits. So that's what I mean by there's that limit in that it needs to be something different, but as far as using telehealth, the only thing explicit that I can think of offhand is for skilled nursing facility.

(44:04):

Mostin, I'm going to skip to another person's question just so I make sure I'm being fair. "Am I correct in thinking that telehealth services for medical care will be eliminated ...?" No, you are not Correct. What we're saying is ... So Corey, let me repeat the question so everybody knows. "Am I correct in thinking the telehealth services for medical care will be eliminated after 2024?" In general, no, it's not. The question is, can clinics continue to do that? Right now with the policy, the question is no you won't be able to but there's been like a lot of talk on making FQHCs and RHCs eligible providers. FQHCs and RHCs will continue post 2024 grace period to provide mental health services via live video and audio-only if certain conditions are met.

(44:58):

Now, keep in mind, also for that mental health services via audio-only and live video, that is specifically mental health services. So the way CMS did that, they did not suddenly make FQHCs and RHCs telehealth providers. That requires a law change. So Congress would need to act on that. What CMS did to make that available to FQHCs and RHCs was redefine what a mental health visit meant for you guys. So you are technically, in CMS's eyes, not a telehealth provider. You're just providing a mental health visit like you normally would type of thing. You're just allowed now to use these technology options.

(45:38):

So that will be around, but as far as medical visits, the way the policy is right now, it won't disappear in general being able to do that. It will disappear for FQHCs and RHCs just because of where the policies are right now, but there's been a lot of talk about allowing FQHCs and RHCs to do it permanently in Medicare. So that could change over the next two years and that's part of the reason I think for the two years is gives them time to possibly work on more permanent policies.

(46:10):

"As of what date will audio-only services be limited to behavioral health?" Right now, we're looking at January 1st, 2025. Keep in mind though, again, those audio-only services, that list is uncertain right now because CMS hasn't aligned it. So technically, my answer should be, well, we know they'll still be around 151 days after the public health emergency just because that CMS policy hasn't aligned yet, but probably what we're looking at is January 1st, 2025.

(46:45):

"We are in California. Does the new consent requirement for Medic still going to effect as the bill directs on January 1st, 2023 or does it get postponed to April 11th due the public health emergency?" So for the California folks, DHCS will be coming out with their more explicit provider information regarding their new policies next week. They said January 16th. That's a holiday. I don't think it's going to come

out January 16th. Might come out on Friday and they might get it out early, but next week, they'll have more explicit instruction about that.

(47:19):

"Our behavioral health counselors are not located at all of our clinic locations, so the counselor does telehealth visits and the patient is at home. How can we meet the requirement of the six month prior and there were two months our behavioral health counselors worked for their homes. Do you see that grace going away once the PHE is over?" You're an FQHC though, so it's a mental health visit. That's in the permanent policy, but for an FQHC, that was something that CMS did on the regulatory side. My initial answer is say no, that will probably not go away, but because CMS did that on the regulatory side, they could change it and they wouldn't have to wait for Congress to do that because they did that on the regulatory side. So at this moment, no. It's not going to go away. There's no policy that says it'll go away, but we've got two years. It could change.

(48:28):

I am trying to find folks I have not answered questions for yet just to be fair here. So I'm sorry if people feel like I might be skipping over them, but I just wanted to be fair here. "Looking at the policy on CCHP, I see that the policies was last reflected 8/2022." Hold on, sorry. The thing shifted on me. "Also, these policies reflect ACAs that we were referred to. Do you have additional resources?"

(48:53):

I'm not quite sure what you're referring to. If you are referring to some of the Medicaid policies for the states, that's on a continuous updated policy, updated repatient. So we just may not have gotten to that. So that may happen a couple weeks. The federal stuff, again, because that was new and actually happened when a lot of the staff and when we were closed down for part of the holidays, we may not have had time to update that, but it should be updated soon.

(49:23):

All right. So getting back to questions that are still ranking. "Is it legal for providers to do telehealth who is in a different state, whether temporary or permanently and also can bill insurance?" Again, that is a licensure issue. So I'm not quite sure if you are talking about the provider being in a different state, a provider who's licensed in California goes to Nevada for vacation and then sees their California patients if you mean, is that illegal? No. So in the scenario where I'm a provider who's licensed in California, I have California patients, I go to Florida for vacation and then I see my California patients over telehealth. That's not illegal as long as I'm licensed by California.

(50:12):

If you are talking about if it's reversed, if I'm a California provider and my patient goes to Florida, can I see that patient via telehealth? Is that legal? That depends on the other state, the other state laws on what they have with licensures. So it depends on what you're talking about as far as the scenario.

(50:35):

"We are in California and our FQHC and have endo that is telemedicine only. How will these changes ..." Sorry. The thing shifted here. "How will these changes affect the patients in the future? Is that the same as behavioral health?" Endocrinology, I'm going to assume you're talking about Medicare. I mean, if what you're doing now has been allowed during COVID-19 and this is Medicare that you're talking about, again, you have essentially two-year grace period here, again, if those services are going to still be allowed. I don't know why CMS wouldn't align it, wouldn't align what Congress did for the two-year extension. So for the two-year services, that would be allowed.

(51:28):

How are these changes affect patients in the future? Again, it sound for the most part, for a lot of this, we have this two-year grace period. So we'll see you in two years. I'm not quite sure. Is it the same behavioral health? Barring any change and assuming CMS aligns everything with what Congress just did a few weeks ago, once we hit 2025, for FQHCs, for Medicare, you are only going to be allowed to use audio-only and live video to provide behavioral and mental health services. That's it.

(52:08):

Barring any change happening, that's what's going to happen. So if you are providing other types of clinical services right now via telehealth because it's out underneath the PHE, it's going to be allowed during the grace period, barring any change, policy change, once we hit January 1st, 2025, that goes away. So the question's going to be like what might happen for changes between that time there, between those two years.

(52:35):

"Our understanding was the provider, patient had to be in the same state for telehealth services. Provider is not licensed in the state California. Would not be able to practice ..." Well, now you're talking about Medicaid. So I thought you were talking about Medicare policy. So now you're talking about Medicaid. So it's going to vary. Again, I go back to state policies vary from state to state and you need to check with the state to see what their policies are going to be.

(53:05):

So you're talking about California. Again, California is updating their policies and they said that they would have them out next week. So hold on and see what updates they have for you next week. Hopefully, I hope they send them out next week, but sometimes there could be a little bit of delay in that. I think we're probably at time here and there's no more questions. So Phillip, I'm going to turn it back over to you.

Phillip Stringfield (53:28):

Awesome. Thank you so much, Mei. I really appreciate this time being able to get through those 15 to 20 questions. It was really insightful, and what will make sure to do with our participants is we'll send the recording and we will make sure to send the slides. I understand there was a lot of information to get through. We did include it in the chat, but once again, we will send those out to you. Then just as a final reminder, we will be closing this out and you will receive a evaluation. If you could just please complete the evaluation, we would greatly appreciate your feedback. With that, I'll go ahead and close us out. Everyone, hope you have a great year and enjoy the rest of your week. Take care, everyone.

Mei Kwong (54:07):

Bye.