



Barriers & Challenges to FQHC Use of Telehealth for Substance Use Disorder

AN EXAMINATION OF POLICIES AFFECTING FQHCS PRE- AND DURING THE COVID-19 EMERGENCY.

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Executive Summary

Prior to March 2020, opioid use disorder (OUD) was the most prominent national public health concern in the United States classified as a nationwide epidemic and urgent public health issue by the Department of Health and Human Services (HHS). Telehealth was being looked at increasingly as a significant tool to address the needs of patients being treated for OUD. Telehealth is the use of technology to provide services from a distance when the patient and the provider are not in the same location. However, in mid-March 2020 the nation's attention turned to another public health threat, the coronavirus (COVID-19) pandemic. COVID-19 has dominated discussions around public health and upended lives throughout the United States and globally. As stay-at-home orders began being implemented around the country, policymakers were forced to re-evaluate how Americans could access needed healthcare while maintaining safety and social distance for both patients and healthcare workers. Telehealth has been looked to as the solution for accessing healthcare safely during COVID-19. This has spurred a series of policy changes that have eased or eliminated previously existing barriers to the use of telehealth to deliver all types of health services, including treatment of OUD and delivery of medication assisted treatment (MAT).

MAT combines behavioral therapy and medication (most commonly buprenorphine or methadone) to treat OUD and has proven to be a highly effective best practice for treating opioid addiction. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addiction Medicine (ASAM) both endorse MAT as the gold standard of treatment,ⁱ however only 10% of those in need of treatment have access, especially among at-

risk and low-income populations. Federally qualified health centers (FQHCs), which provide primary care as well as mental health and other health services to underserved areas and populations, are in a unique position to both help fill the need for patients needing access to MAT, as well as expand access to healthcare generally for the medically underserved that have been hit hardest by the COVID-19 pandemic. Because of their funding, FQHCs are subjected to a variety of rules and regulations that other Medicare and Medicaid providers are not. In combination with rules and regulations around prescribing controlled substances used in MAT, prior to the pandemic, FQHCs were often deterred from creating telehealth options for OUD patients.

The original intent of this study was to only examine the limitations FQHCs faced when using telehealth to provide MAT. However, in the COVID-19 world, the utilization of telehealth has changed dramatically and with it, at least on a temporary basis, the policies that impact its use, particularly by an FQHC. This study presents the results of research and interviews conducted on the barriers that existed for implementing a telehealth MAT program in an FQHC setting prior to COVID-19 in five states (Kentucky, Maine, Maryland, Ohio and Pennsylvania) with high incidents of OUD and where entities (including FQHCs) have received the 2019 Rural Communities Opioid Response Program Implementation Grant from the Health Resources Services Administration (HRSA). Subsequently, a secondary analysis was conducted on the policies that have impacted FQHCs' ability to deliver MAT via telehealth during the COVID-19 PHE and beyond.



Pre-COVID-19 Policy Barriers

The policy barriers FQHCs faced in utilizing telehealth that existed prior to the COVID-19 public health emergency (PHE) were extensive in comparison to the current landscape. CCHP conducted interviews, and reviewed the laws, regulations and Medicaid policies for five states to identify the barriers that exist, and potential solutions to overcome them. Federal laws, regulations and Medicare policies affecting FQHC's delivery of MAT through telehealth were also examined. Areas identified as issues during the initial phase of research are summarized below.

➤ MEDICARE REIMBURSEMENT

CMS provides coverage for alcoholism and OUD treatment in the outpatient setting for a wide variety of services, many of which encompass components of MAT such as psychotherapy, patient education, opioid treatment program services and prescription drugs used in MAT, such as buprenorphine.ⁱⁱ Despite the availability of these services to Medicare beneficiaries generally, accessing these services as a FQHC patient through telehealth was extremely cumbersome. Medicare reimbursement policy prior to COVID-19 limited reimbursement to live video (except for store-and-forward reimbursement in Alaska and Hawaii demonstration pilots), and limited the types of services and providers that could be delivered via telehealth. Medicare also limited the patient site to specific medical facilities and rural areas, although there was an exception for patients with substance use disorder or a co-occurring mental health condition. The most significant of the restrictions FQHCs faced was that the type of provider eligible to be reimbursed by Medicare when providing a service via telehealth was limited to a list of eight distinct providers (i.e. physicians, nurse practitioners, etc.), excluding FQHCs. Two other limitations included Medicare's definition of a visit (excluding asynchronous forms of telehealth), and restrictions around two or more visits occurring in the same day.

➤ MEDICAID REIMBURSEMENT

Through the research and interviews CCHP conducted for this project, we found that some of the same restrictions in Medicare for telehealth reimbursement of OUD services for FQHCs persisted in the Medicaid program as well. Significant findings include:

- All 5 states studied reimburse for live video delivered services in their Medicaid programs, although not all potential OUD services are reimbursed.
- Two states reimburse for store-and-forward and remote patient monitoring; however all of these states limited these modalities to specific specialties or conditions that do not directly relate to OUD or mental health treatment.
- All states allow a live video interaction to qualify as a visit for an FQHC.
- All states allow an FQHC to act as a distant site provider, however only three states allowed the home to be an eligible originating site for the patient.
- All states had restrictions related to same day visits however interviewees did not report this as a significant issue.
- Additional consent and registration requirements for delivering services via telehealth were found to be cumbersome and problematic for some providers.

Pre-COVID-19 Policy Barriers

cont.

➤ PRESCRIBING

Although prescribing medication generally is controlled at the state level, federal law (the Controlled Substance Act (CSA)) governs the prescribing of controlled substances over the internet. This poses an issue for MAT, since both buprenorphine and methadone (drugs used for treatment) are controlled substances. Under the CSA, prescribing via telemedicine is severely limited except when the patient is located at a facility registered with the Drug Enforcement Agency (DEA). Each of the study states also have their own laws and/or regulations around the prescribing of controlled substances as well, many of which place stricter requirements on providers.

Although there are some pathways for FQHCs to deliver MAT services in some states, interviewees for this study all indicated that prescribing laws, especially for buprenorphine, are extremely complex and have discouraged them from delivering the medication component of MAT via telehealth.

➤ ADDITIONAL ISSUES

Other issues such as lack of high-speed broadband, concerns around malpractice insurance and complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and need for patient and provider education around telehealth were also addressed in the first phase of research.

COVID-19 and Beyond

The complete, though at the time of the writing of this report temporary, transformation of telehealth policy in the United States resulting from the COVID-19 pandemic centered around the challenges noted in the previous section, including reimbursement for both Medicaid and Medicare, and prescribing controlled substances. Some common themes seen in both Medicaid and Medicare include:

- Allowing the home as an originating site for the patient.
- Allowing for the use of telephone to deliver services.
- Expanding the types of providers allowed to provide services via telehealth.
- Expansion of services that can be delivered via telehealth, including remote communication codes typically covered by Medicare.

The PHE also triggered an exception in the CSA that allows eligible providers to prescribe without an in-person medical evaluation in some circumstances, and

the telephone to be used to prescribe buprenorphine. The Health and Human Services' Office of Civil Rights also announced that they would practice enforcement discretion for HIPAA violations that involved the use of commonplace technology that wouldn't typically be considered allowed under HIPAA rules, such as Apple Facetime, Facebook Messenger, Zoom or Skype.

Some of these policy changes are more likely to become permanent than others. Changes that require only administrative action are generally easier to make permanent than those that require statutory change. However, especially in terms of reimbursement, even changes that require legislation will likely remain in some form afterwards. Allowances made to HIPAA rules and prescribing without an in-person relationship will expire at the end of the PHE. However, the temporary waiver may spur discussions on whether telehealth-specific policies in HIPAA are needed. Additionally, there is an opportunity for the DEA to permanently expand their allowance

COVID-19 and Beyond *cont.*

for controlled substance prescribing via a telemedicine registry they are statutorily required to create, but have yet to do so. Even if all the current COVID-19 policies are made permanent, there are still persisting policy gaps that exist for FQHCs. These include the following:

- Even though FQHCs and RHCs have been made eligible distant site providers in Medicare temporarily, they are paid a rate based off of the physician fee schedule, rather than their typical prospective payment system (PPS) rate (which is likely higher). FQHCs and RHCs should be able to bill normally and receive full reimbursement for their services delivered via telehealth.
 - Broadband access and the cost of equipment is still something many providers and patients struggle with. The FCC has tried to address this concern by offering grants for connectivity and equipment, however the FCC has struggled to keep up with the need. Funding and subsidy programs should be expanded to allow increased access for all FQHC providers.
 - In Medicaid programs, although all of the study states have now allowed for reimbursement of some type of audio-only service, reimbursement for remote monitoring and store-and-forward is still limited. The definition of telehealth should be expanded in these circumstances to encompass all potential modalities of telehealth.
 - Now that FQHCs can serve as distant site providers under Medicare, some FQHCs are left wondering if their Federal Tort Claims Act (FTCA) insurance will cover them in the event of a malpractice lawsuit, since telemedicine is not directly addressed under any of the FTCA guidance. FTCA guidance from the Health Resources Services Administration (HRSA) should be updated to address this.
 - Extra registration requirements to deliver telehealth services and telehealth-specific consent requirements that create the perception of telehealth as a separate riskier form of healthcare delivery and extra administrative burdens should be eliminated.
- In all the interviews conducted for this study, interviewees noted that prescribing requirements for MAT drugs are difficult to navigate and serves as a deterrent to them offering the medication component of MAT via telehealth. State requirements should be simplified to align with federal laws/regulations.
 - Although the use of telehealth to deliver care has quickly become increasingly ubiquitous due to COVID-19, there is still a need to educate patients about the benefits of telehealth so that they can feel comfortable connecting with their providers. Providers also may require training to deliver care most effectively via telehealth and understand how to scale their telehealth programs. Additionally, staff in FQHC settings may also need training on how to handle patients suffering from OUD or co-occurring mental health disorders.
 - With the use of telehealth becoming more widespread, certain communities, such as non-English speakers and those with hearing or sight disabilities, have expressed difficulty in the way it is commonly implemented. Methods to increase access for these populations should be identified and executed.

Although the doors are now wide open for telehealth to play a key role in the delivery of healthcare services, including MAT, there is still much work to be done to eliminate all barriers. Telehealth's future will be highly impacted by state and federal policymakers' decisions as it pertains to the topic areas identified in this study in the coming months and years.

Introduction

Prior to March 2020, opioid use disorder (OUD) was the most prominent national public health concern in the United States. The Department of Health and Human Services (HHS) classified it as a nationwide epidemic and an urgent public health issue. Between January 2017 and January 2018, almost 70,000 people in the U.S. died from drug-related overdoses.ⁱⁱⁱ Since 2001, the cost to the United States from the opioid epidemic was estimated to be more than a trillion dollars, with health care expenses alone resulting from the epidemic totaling \$215 billion. However, in mid-March 2020 the nation's attention turned to another public health threat, the coronavirus (COVID-19) pandemic. COVID-19 has dominated discussions around public health and upended lives throughout the United States and world. It has hit communities of color, low-income and medically underserved communities the hardest.^v As stay-at-home orders began being implemented around the country, policymakers were forced to re-evaluate how Americans could access needed healthcare while maintaining safety and social distance for both patients and healthcare workers. Telehealth is the use of technology to provide services from a distance when the patient and the provider are not in the same location. There are three major means by which services are delivered via telehealth: live video, store-and-forward and remote patient monitoring (RPM). See Figure 1. Telehealth has been looked to as the solution for accessing healthcare safely during COVID-19. This has spurred a series of policy changes that have eased or eliminated previously existing barriers to the use of telehealth to deliver all types of health services, including treatment of OUD and delivery of medication assisted treatment (MAT).

FIGURE 1:
Modalities of Telehealth



LIVE VIDEO: Two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service is also referred to as “real-time” and may serve as a substitute for an in-person encounter when it is not available.



STORE-AND-FORWARD: Allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email communication.



REMOTE PATIENT MONITORING: Remote patient monitoring (RPM) uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

MAT combines behavioral therapy and medication (most commonly buprenorphine or methadone) to treat OUD and has proven to be a highly effective best practice for treating opioid addiction. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addiction Medicine (ASAM) both endorse MAT as the gold standard of treatment,^{vi} however only 10% of those in need of treatment have access. Current literature supports the use of telehealth to provide behavioral therapy,^{vii} and initial studies show that using telehealth for medication prescribing and management in MAT delivers equal results to in-person care.^{viii}

Introduction *cont.*

However, access to MAT can be scarce, especially for at-risk and low-income populations. Federally qualified health centers (FQHCs), which provide primary care as well as mental health and other health services to underserved areas and populations, are in a unique position to both help fill the need for patients needing access to MAT, as well as expand access to healthcare generally for the medically underserved that have been hit hardest by the COVID-19 pandemic. They receive increased funding through the prospective payment system (PPS) from both Medicare and Medicaid to serve as safety-net providers for the underserved, and typically furnish services as an outpatient clinic. The PPS rate they receive as reimbursement is a fixed per-visit base payment that is adjusted depending on their geography and reflects 100% of the center's reasonable costs of furnishing FQHC services during a base period.^{ix} Due to their funding, FQHCs are subjected to a variety of rules and regulations that other Medicare and Medicaid providers are not. Many of these rules impact the utilization of telehealth, sometimes creating challenges. Therefore, FQHCs have greatly benefitted from the changes in telehealth policy that have occurred as a result of the COVID public health emergency (PHE).

Prior to COVID-19, FQHCs were subjected to some of the most limiting policies for implementing a telehealth program. In combination with rules and regulations around prescribing controlled substances used in MAT, FQHCs were often deterred from

creating telehealth options for OUD patients. The original intent of this study was to only examine the limitations FQHCs faced when using telehealth to provide MAT. However, in the COVID-19 world, the utilization of telehealth has changed dramatically and with it, at least on a temporary basis, the policies that impact its use, particularly by an FQHC. This study presents the results of research and interviews conducted on the barriers that existed for implementing a telehealth MAT program in an FQHC setting prior to COVID-19 in five states (Kentucky, Maine, Maryland, Ohio and Pennsylvania) with high incidents of OUD and where entities (including FQHCs) have received the 2019 Rural Communities Opioid Response Program Implementation Grant from the Health Resources Services Administration (HRSA). The grant is aimed at strengthening and expanding substance use disorder (SUD) prevention, treatment and recovery services. It encouraged its grantees to utilize telehealth in their strategy. However, the study would be incomplete if the impact of COVID-19 was not taken into consideration. Subsequently, a secondary analysis was conducted on the policies that have impacted FQHCs' ability to deliver MAT via telehealth during the COVID-19 PHE. Utilizing the research and interviews conducted, the paper provides a look into the future, with predictions of where telehealth policy will go from here, how it will impact MAT delivery for FQHCs, and recommendations for policymakers to consider as they try to decide which COVID-19 policies should remain after the PHE.

Pre-COVID-19 Policy Barriers

The policy barriers FQHC's faced in utilizing telehealth that existed prior to the COVID-19 PHE were extensive in comparison to the current landscape.

In order to evaluate the barriers that existed for FQHCs specifically in treating OUD patients through MAT, CCHP selected five states to focus on that have high incidents of OUD and have received HRSA funding to conduct OUD focused projects. The five states include: Kentucky, Maine, Maryland, Ohio, and Pennsylvania. CCHP conducted interviews, and reviewed the laws, regulations and Medicaid policies for these five states to identify the barriers that exist, and potential solutions to overcome them. Federal laws, regulations and Medicare policies affecting FQHCs delivery of MAT through telehealth were also examined, as they were reported as barriers by several interviewees. See Appendix A for a complete explanation of the methodology for selecting states and conducting the research, and Appendix B and C for a list of interview questions and interviewees.

Below are the policy issues identified by the interviewees and through CCHP's research in January and February 2020 prior to COVID-19.

➤ REIMBURSEMENT

Medicare

As the largest payer, Medicare plays a significant role in influencing the telehealth reimbursement policies of other health care insurance companies and Medicaid programs. CMS provides coverage for alcoholism and OUD treatment in the outpatient setting for a wide variety of services, many of which encompass components of MAT such as psychotherapy, patient education, opioid treatment program services and prescription drugs used in MAT, such as buprenorphine.^x Despite the availability of these services to Medicare beneficiaries generally, accessing these services as a FQHC patient through telehealth is extremely cumbersome. Medicare telehealth policy is governed by section 1834(m) in the Social Security Act. Historically, Medicare telehealth policy has been tremendously restrictive, especially for FQHCs, primarily due to federal statute. Medicare only reimburses for live video, except in the rare case that a service occurs in an Alaska or Hawaii demonstration pilot, in which case they will reimburse for store-and-forward. They also limit the services that can be reimbursed through telehealth to a specific list of current procedural code (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. For FQHCs, the most significant of

FIGURE 2: Eligible Pre-Covid-19 Providers

-  Physicians
-  Nurse practitioners;
-  Physician assistants;
-  Nurse midwives;
-  Clinical nurse specialists;
-  Certified registered nurse anesthetists;
-  Clinical psychologists and clinical social workers;
-  Registered dietitians or nutrition professionals.

the restrictions they face is that the type of provider eligible to be reimbursed by Medicare when providing a service via telehealth is limited to a list of eight distinct providers (See Figure 2). FQHCs do not qualify to act as distant site providers (provider providing the service to the patient) in Medicare. They are only allowed to serve as the originating site (the site where the patient is located). Medicare does reimburse a minimal originating site facility fee (approximately \$25), but often that does not cover all of the expenses associated with running a telehealth program within an FQHC.

Pre-COVID-19 Policy Barriers cont.

Additionally, the physical location of the patient (the originating site) and the FQHC is another qualifying factor. Medicare requires the patient to be located in a non-metropolitan statistical area (MSA) or a rural health professional shortage area (HPSA), limiting the FQHCs that would even be eligible as originating sites based on rurality to very few. If an FQHC wants to provide a telehealth option for its patients, they would be required to physically be on the FQHC's premises (assuming the clinic's geographic location qualified for reimbursement), and connect with a distant site provider employed by another entity.

For most services in Medicare, the patient cannot be located in his or her home when receiving services via telehealth. In 2019 there were a few exceptions that were added to federal statute based on the passage of the Bipartisan Budget Act and the SUPPORT Act. The Bipartisan Budget Act allowed for the treatment of an acute stroke, end stage renal disease related visits and treatment of substance use disorder (SUD) and co-occurring mental health conditions regardless of the patient's geographic location. The SUPPORT Act also allowed the patient's home to be an eligible site for purposes of treating individuals with SUD or co-occurring mental health disorders. Despite this, FQHCs were still limited from acting as distant site providers, and were unable to take advantage of these broader policies.

FQHCs face two additional barriers to Medicare reimbursement that were not within telehealth policy specifically, but instead in other areas of policy specific to FQHCs that limit their ability to fully utilize telehealth. The first is CMS' definition of a visit. The Medicare billing manual defines a "visit" for both an FQHC and RHC as, "a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit **must be a face-to-face (one-on-one)** encounter between the patient and a physician, NP,

PA, CNM, CP or a CSW during which one or more RHC or FQHC services are rendered."^{xi} (emphasis added). This definition would presumably prevent reimbursement to an FQHC or RHC utilizing other forms of telehealth such as store-and-forward and remote monitoring which does not require the immediate presence of the patient with the provider as they do not take place "face-to-face." The second barrier is that FQHCs are not allowed to bill for two or more visits in the same day (except in certain circumstances)^{xii} which creates a loss to the clinic if a patient has an appointment for one condition and during the examination another issue is discovered where telehealth can be employed to reach out to an appropriate specialist that same day without the patient having to come back at another time.

In addition to telehealth services, in 2019 CMS made the administrative decision to significantly expand their reimbursement for 'remote communication technology-based services'. These are services that are not defined as telehealth within Medicare, and therefore are not limited by the previously outlined limitations and restrictions. These services include the following:

- **Brief communication technology-based service (or "virtual check-ins")**: A brief, non-face-to-face check-in with an established patient via communication technology to assess whether or not an office visit or other service is necessary. This service is only available to practitioners who furnish E/M services, and could take place via live video or telephone call.
- **Remote evaluation of pre-recorded patient information**: Remote professional evaluation of patient-transmitted information conducted via pre-recorded video or image technology to determine whether or not an office visit or other service is necessary. This is only available for established patients.

Pre-COVID-19 Policy Barriers cont.

- **Interprofessional internet consultation:** Interprofessional internet consultations between professionals performed via communications technology. This service is limited to practitioners that can independently bill Medicare for E/M visits. This could take the form of either a telephone call or a live or asynchronous internet consultation. Both the consulting and treating provider can be reimbursed for this service.
- **Chronic Care Management (CCM):** Management of patients with multiple chronic conditions through activities such as recording patient health information, maintaining a comprehensive electronic care plan, managing transitions of care and coordinating and sharing patient health information. It can include remote patient monitoring under certain circumstances.
- **Principal Care Management:** The same as CCM, except allows for patients that only have one chronic condition (as opposed to CCM which requires multiple chronic conditions).
- **Transitional Care Management (TCM):** Management and coordination of services as needed for medical conditions after a patient is discharged from the hospital.
- **Remote Physiologic Monitoring:** Monitoring of a patient's physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate).
- **Online Digital/Medical Evaluations (E-Visit):** Allows a patient to communicate with a provider through an online patient portal.

Prior to COVID-19 the only remote communication technology-based services a FQHC could bill for was some CCM services, TCM, the brief communication technology-based service and remote evaluation of pre-recorded patient information. CMS developed

their own G-code to describe those services for FQHCs and calculated a reimbursement amount based off of the reimbursement for those services under the physician fee schedule (rather than the PPS rate).

Medicaid

Through the research and interviews CCHP conducted for this project, we found that some of the same restrictions in Medicare for telehealth reimbursement of OUD services for FQHCs persisted in the Medicaid program as well. Of the five states examined for this project, all reimburse for live video delivered services. Two also reimburse for store-and-forward and remote patient monitoring, however all of these states limited these modalities to specific specialties or conditions that do not directly relate to OUD or mental health treatment. Maine was the only state to reimburse for telephonic services if interactive telehealth was not available and the service was medically necessary.

Four of the five states provided a definition of a visit or encounter for a FQHC. Kentucky explicitly allows a visit to occur via live video, and Pennsylvania explicitly provides a definition for a telepsychiatry encounter which they state is only payable under the behavioral health managed care delivery system. While Maine, Ohio and Maryland don't explicitly say whether or not a visit can occur via telehealth (either because their definition simply refers to the visit as occurring face-to-face or they have no definition), through interviews CCHP confirmed that live video telehealth does count as a visit for FQHCs in each of these Medicaid programs. Store-and-forward and remote patient monitoring would not be allowed under the current definitions of a visit in these states.

Pre-COVID-19 Policy Barriers

cont.

In contrast to Medicare, all five Medicaid programs examined for this study allow FQHCs to be distant site providers for telehealth delivered services and receive their PPS rate. However, Pennsylvania Medicaid only allowed for the delivery of telepsychiatry and mental health services through telehealth for FQHCs in their Medicaid program and prior to February 2020, only reimbursed if the FQHC employed psychiatrists or psychologists to deliver those services. In February 2020, that was expanded to include additional practitioners such as nurse practitioners and physician assistants for delivery of mental health services only.

The remaining four states took a broader approach to reimbursing for telehealth and did not restrict reimbursement to telepsychiatry and mental health. Instead, they allowed FQHCs to provide via telehealth the full range of services allowed by any other distant site provider in their Medicaid program. Ohio Medicaid, for example, reimbursed the CPT/HCPCS codes that are on the Medicare telehealth code list (which includes approximately 100 codes). Kentucky Maine and Maryland allowed all medically necessary services to be delivered via telehealth as long as it meets the standard of care required for services provided in-person. Group therapy, however in Ohio and Maine are not allowed to be delivered via telehealth.

Although none of the Medicaid programs have geographic restrictions like Medicare, many do restrict the types of sites where the patient can be when receiving services. In the case of all five states reviewed for this study, all allow a FQHCs to serve as an originating site. However, only three states (KY, ME and OH) allowed the home to be an eligible originating site. The home being an eligible site is significant because if the FQHC was acting as a distant site, they could deliver services to the patient while

at their home. This has become critical during COVID-19, but even before then, often times OUD patients feel most comfortable in their homes and are more likely to access care if able to do so from their homes. Maine was the only state to pay a facility fee (similar to Medicare) as separate from the clinic's PPS rate.

Like Medicare, each state does have restrictions limiting visits occurring on the same day. All except Kentucky allow for a visit of two different types (for example, a primary care visit and then a mental health visit) on the same day, which Medicare also does. None of the interviewees thought this was a significant issue for them in delivering OUD services via telehealth.

An issue specifically raised by the FQHCs interviewees is the need to acquire additional permissions to deliver such services, beyond what is required federally. In Maryland, behavioral health providers are required to register with the behavioral health administrative service organization (ASO) in order to bill, and prescribers of controlled substances must register for the prescription drug monitoring program and must have a controlled dangerous substance registration number with the state. In Pennsylvania, not only must a provider complete a 'Telehealth Self Attestation Form' and file it with the Office of Mental Health and Substance Abuse Services (OMHSAS) Field Office but they also must acquire a letter of support for the FQHC to deliver those services from the Managed Care Organization (MCO) in the county. Other states either did not have additional registration requirements, or if they did, FQHCs delivering outpatient MAT services are exempt.

Pre-COVID-19 Policy Barriers cont.

> PRESCRIBING

Federal - Controlled Substance Act & DATA Waiver

Although prescribing medication generally is controlled at the state level, federal law (the Controlled Substance Act (CSA)) governs the prescribing of controlled substances over the internet. This poses an issue for MAT, since both buprenorphine and methadone are controlled substances. Under the CSA, telemedicine may be used to prescribe controlled substances only in very limited circumstances, including the following:

- Patient is being treated and physically located in a hospital or clinic registered to distribute under the CSA;
- Is conducted when the patient is being treated and in the physical presence of a practitioner registered to distribute under the CSA;
- The prescribing practitioner is an employee or contractor of the Indian Health Service (IHS) or working for an Indian tribe or tribal organization under contract or compact with IHS;
- The prescribing practitioner is an employee or contractor of the Veterans Health Administration and is registered under a hospital or clinic operated by the Department of Veterans Affairs;
- Is conducted during a public health emergency;
- The prescribing practitioner has obtained a special registration from the US Attorney General; or
- In an emergency situation (21 USC 802(54)).^{xiii}

The first bullet is the most common scenario that (pre-COVID-19) would allow a FQHC to prescribe buprenorphine to a patient while either the patient is located in an FQHC registered with the DEA or the patient is at another hospital or clinic that

is registered with the DEA, and the distant site provider is also registered with the DEA. When prescribing buprenorphine for MAT there is also the option for physicians to prescribe outside of an opioid treatment program (OTP) by completing an eight-hour training course, allowed under the Drug Addiction Treatment Act of 2000 (DATA 2000), which allows physicians to obtain a federal waiver (referred to as a DATA 2000 waiver) to prescribe buprenorphine in the outpatient setting for OUD. Nurse practitioners and physician assistants can also obtain a DATA 2000 waiver and prescribe buprenorphine in the outpatient setting but must first complete 24 hours of training under supervision by a qualifying physician. This has expanded access to providers able to prescribe buprenorphine significantly. There are, however, additional limitations on the prescribing of methadone, and it is rarely prescribed outside of an opioid treatment program.

The onset of the opioid epidemic and potential for telehealth to be used to deliver aspects of MAT resulted in a section in the SUPPORT for Patients and Communities Act which passed in 2018 which requires the Attorney General (AG) to promulgate final regulations to specify the limited circumstances in which a telemedicine special registration may be issued to prescribe controlled substances and the procedure for obtaining a special registration within a year of enactment. The AG was previously required to promulgate regulations related to the telemedicine special registration process under the Ryan Haight Act (see list above), but had no deadline as to when a final rule must be issued. A regulatory posting published in December 2019 suggested the DEA plans to publish a proposal for the special registration that month, but as of the writing of this report has still yet to be published.

Pre-COVID-19 Policy Barriers

cont.

State Restrictions for Prescribing

With the exception of having to comply with the CSA and DATA 2000 federal laws, states have control over prescribing policy within their state. As a result, states often create specific requirements around how a provider can establish a valid provider-patient relationship which is needed to prescribe medication, and sometimes have stricter rules around the prescribing of controlled substances than in the CSA.

All the study states except Pennsylvania explicitly address the need for a provider (or physician)-patient relationship in order to prescribe. These states outline criteria that must be met in order to accomplish a provider-patient relationship when the provider has never physically met the patient. All allow a relationship to be performed and prescribing to occur in the instance of a live video interaction if each of their stated criteria are complied with (i.e. confirm patient's identity, obtain informed consent, conduct an appropriate examination, etc.). Several of the states forbid the telephone or a static questionnaire from establishing the relationship. Maryland is the only state from the study that allows an asynchronous telehealth interaction to establish a practitioner-patient relationship under certain circumstances.

All five study states have laws that address the prescribing of controlled substances specifically, but not all address the use of telehealth to prescribe them. Pennsylvania's law, for example, does not address telehealth, although there is nothing in it that prohibits its use for prescribing controlled substances as long as federal requirements are adhered to. Maine and Maryland allow the prescribing of controlled substances for the purposes of MAT via telehealth as long as the provider complies with federal requirements. Ohio and Kentucky, by contrast, have very detailed standards that must be

met in order to prescribe buprenorphine specifically. Kentucky, for example, requires additional continuing education certifications, and a 'physical exam' but does not specify whether the exam can be accomplished via telehealth. Likewise, Ohio also requires a physical exam to be conducted by the physician who is providing office-based treatment for opioid addiction in order to deliver MAT and prescribe opioids for MAT. Interviews conducted for this project revealed that this Ohio regulation is a major barrier for providers seeking to deliver MAT services in FQHCs via telehealth.

Although there are some pathways for FQHCs to deliver MAT services in some states, interviewees for this study all indicated that prescribing laws, especially for buprenorphine are extremely complex and have discouraged them from delivering the medication component of MAT. The only FQHC that indicated they conduct the medication component of MAT during the interviews was an FQHC in Maine, and they indicated that their model always has the induction (initial medication intake) take place in-person and they only conduct follow-up visits and the counseling portion of MAT over live video. Interviewees in other states reported their MAT services also are limited to only the mental health side of MAT when delivered via telehealth partially due to the difficulty in navigating and complying with state and federal prescribing laws.

> ADDITIONAL POLICY ISSUES

Reimbursement and prescribing are significant, but not the only policy barriers FQHCs face in implementing a telehealth program to deliver MAT services. Below are some additional challenges identified through CCHP's research and interviews.

Pre-COVID-19 Policy Barriers

cont.

Broadband & Equipment: Access to high speed broadband needed in a live video telehealth interaction is not always available in rural and underserved communities. Several of the interviewees for this study mentioned broadband as an issue for FQHC patients in accessing telehealth, especially those attempting to use it from their homes. A FQHC interviewee in Pennsylvania also brought up the cost of telehealth equipment as being a barrier, although acknowledged that products such as the HIPAA compliant version of Zoom has expanded use of telehealth in their center.

Privacy and Confidentiality Requirements: All providers of healthcare services are subject to the rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Although telehealth isn't addressed directly in HIPAA, the use of telehealth does not alter a covered provider's obligations under HIPAA. Therefore, if a covered entity is utilizing telehealth that involves personal health information (PHI), the entity must meet the same HIPAA requirements that it would if the service was provided in-person. Telehealth often requires consultation with technical personnel, independent of the medical team, who may be exposed to patient data. Therefore, providers may need to enter into business associate agreements with these technical personnel organizations, which obligate them to maintain the same confidentiality required of the provider under HIPAA. Use of specific telehealth equipment or technology cannot ensure that an entity is "HIPAA compliant" because HIPAA addresses more than features or technical specifications. Nevertheless, certain features may help a covered entity meet its compliance obligations. For example, a telehealth software program may contain an encryption feature, or the technology might provide security through the use of passwords.

In the substance abuse field, providers also must comply with 42 CFR Part 2 which outlines the limited circumstances information about a patient's treatment may be disclosed with or without the patient's consent. The purpose of this is to help protect patients from stigma in non-healthcare settings. However, because the rules require written consent in many cases, this can pose a challenge when delivering services exclusively via telehealth. Although the rule does allow for electronic signatures to the extent that they are not prohibited by state law, this requires providers to have a system set up to collect and store that information which can be a challenge.

Consent: All five states in the study require some type of telehealth specific informed consent be obtained in order to deliver telehealth services. None of them specify whether the consent needs to be written or verbal, although Maine does require written educational information about telehealth be distributed to the patient. This can create an extra administrative burden, and can create the perception that telehealth is an entirely different service that requires consent, rather than just a tool to deliver the same service a patient would get in-person.

Malpractice/FTCA: All healthcare professionals must ensure that their malpractice insurance will cover services delivered via telehealth. With the exception of Hawaii, there is no law that requires liability carriers to cover telehealth delivered services or prohibits them from charging higher premiums to providers who utilize telehealth in their practice. Healthcare providers employed by FQHCs specifically, are covered by the Federal Tort Claims Act (FTCA) coverage, which provides medical malpractice liability coverage to employees and those with a contract with the federal government.

Pre-COVID-19 Policy Barriers

cont.

FTCA guidance does not directly address the use of telehealth, but specifies that to meet the FTCA's requirements for providing services, a patient-provider relationship must be established. This can only be established by an individual accessing care at an approved site, or if health center triage services are provided by telephone or in person (for example, scheduling the patient an appointment).^{xiv} Because it does not address a telemedicine situation directly, it is unclear if coverage applies when the patient is not at the health center when they receive services. The Health Resources Services Administration (HRSA) has indicated they will update this guidance to incorporate telehealth, but as of the writing of this report has not. In the meantime, FQHCs are forced to grapple with whether or not they are covered when acting as a distant site for telehealth and must consider obtaining gap coverage in case they are not. Pennsylvania FQHCs interviewed expressed concern specifically with this issue.

Scope of Project: As federally funded entities, FQHCs must submit a scope of project to HRSA. Until very recently, it was unclear if telehealth necessitated a change in their scope of project and would require separate HRSA approval. However, in January 2020, HRSA clarified that telehealth is in fact not a separate service and does not require specific HRSA approval. The document also provided some direction on how a health center should accurately reflect sites, services and service delivery methods within their scope of project.^{xv}

Provider & Patient Education: Interviewees in three of the states interviewed for this study indicated that both provider and patient education are an issue for them. For example, Maine's FQHC representatives interviewed indicated that some providers have high no-show rates for telehealth and that it was an issue of educating patients about the benefits of telehealth

and getting their buy-in. Ohio recently expanded their reimbursement for telehealth, allowing FQHCs to be distant site providers. FQHCs interviewed from Ohio indicated that since policy changes in their state expanding telehealth for FQHCs are so recent, there needs to be more provider education so that providers understand the expanded new policies.

Pennsylvania, on the other hand, stated that they have experienced broad acceptance of telehealth by their patient population because it removes the stigma of going into the office for them. Patients only worry that their insurance will not cover the visit and that they will ultimately be responsible for the bill.

Training for Primary Care Staff: One concern raised by FQHC interviewees in Pennsylvania was the issue of properly training their staff to deal with mental health and OUD patients specifically, as their staff is typically not used to dealing with individuals with mental health disorders and are unsure how to respond to situations that may arise. They recommended specialized training on how to handle patients with OUD and how to properly respond to crises that may occur in their office when they are serving as the originating site for patients accessing OUD treatment via telehealth from their facility.

➤ SUMMARY

The original intent of this study was to gather through interviews and research the information outlined in the previous section and synthesize the information into digestible recommendations that if implemented by policymakers might benefit FQHCs' ability to deliver OUD services via telehealth in the future. Recommendations would have included items such as the following:

Pre-COVID-19 Policy Barriers *cont.*

- Expand Medicare reimbursement by allowing FQHCs to serve as distant site providers.
- Allow a wider variety of services to be provided via telehealth in state Medicaid programs, particularly in those states such as Pennsylvania which only allow FQHCs to deliver mental health services via telehealth.
- Through the required special registration process, the Drug Enforcement Agency (DEA) could create some exceptions to the requirement for the patient to be located in a DEA registered clinic in order to prescribe drugs such as buprenorphine, typically used in MAT.
- Remove requirements for an in-person examination in states, to allow the prescribing of drugs used in MAT via telehealth if in compliance with federal rules and regulations.
- Clarify requirements in HIPAA, FTCA and consent requirements found in 42 CFR Part 2 to take into consideration a telehealth model of care.

However, within days of COVID-19 stay-at-home orders being issued in mid-March, many of these policy areas that had been longstanding barriers for telehealth utilization began to be addressed through emergency waivers, legislation and various policy documents issued at both the state and federal levels of government. The following sections will review how those policy changes altered the telehealth landscape for FQHCs delivering OUD services, and the policy challenges that may remain after the current PHE has ended.

COVID-19 Era Policies

The complete, though at the time of the writing of this report temporary, transformation of telehealth policy in the United States resulting from the COVID-19 pandemic centered around the challenges discussed in the previous section, including reimbursement for both Medicaid and Medicare, and prescribing controlled substances. These have been longstanding barriers for telehealth implementation by FQHCs as well as other entities. Although the temporary changes did not fix all of the current telehealth policy barriers, they have addressed some of the most significant ones, particularly issues that were the most obvious challenges to delivering care to patients in their homes during the COVID-19 pandemic. The policy changes have completely changed the telehealth policy environment from what was outlined in the previous section; but they are all temporary and it is conceivable, (although unlikely) that all of the policies will revert back to their previous form once the COVID PHE passes. However, what is more likely is a hybrid, where some of the COVID-19 policy changes prove long-lasting while others may revert back or adopt a completely new form. The new policy environment has given new urgency to some long-standing issues such as increasing high speed broadband access in rural communities with low or no bandwidth, as well as presented new challenges not previously considered, such as special considerations that need to be made for disabled communities to effectively access telehealth. Below is a discussion of the policy changes that have taken place for telehealth during COVID-19, followed by a section on what needs to take place to make the policies permanent, as well as the persisting policy barriers that still exist that have yet to be addressed by the COVID-19 policy expansions.

COVID-19 Era Policies *cont.*

➤ MEDICARE

As described in the previous section, restrictions around the use of telehealth in Medicare were abundant prior to COVID-19. Even though CMS took some steps to expand coverage by allowing remote communication-based services to be reimbursed, it was limited in expanding telehealth policy due to federal law. COVID-19 rapidly changed the landscape. The passage of HR 6074 (the Coronavirus Preparedness and Response Supplemental Appropriations Act) and HR 748 (the Coronavirus Aid, Relief and Economic Security Act – CARES Act) changed the rules for telehealth on a temporary basis. Legislation either required or allowed CMS to remove barriers and/or administratively expand reimbursement, knocking down many of the longstanding challenges discussed previously. The specific areas, as they relate to FQHCs are bulleted below:

- **Telehealth Modality:** FQHCs may furnish services through a telecommunication system, which prior to COVID-19 was defined as requiring audio and video capabilities. However, CMS is now allowing some audio-only services to be covered.
- **Distant Site Providers:** FQHCs can now serve as distant site providers and deliver all of the codes that are eligible for telehealth (or audio-only) reimbursement under Medicare. Any practitioner working at an FQHC can deliver those services as long as it's within their scope of practice. However, instead of their typical PPS rate, they will receive the same amount for all telehealth

delivered services, which has been calculated from the physician fee schedule fee-for-service system, and equals \$92.03.

- **Originating Site Limitations (Patient Location):** Previously, there was the requirement for the patient to be located in a rural HPSA or non-MSA. That requirement has been removed completely for the duration of the PHE. Additionally, during the PHE the patient can be located at any location for any eligible telehealth delivered services, including their home.
- **Eligible Services:** Previously, the services eligible for Medicare reimbursement were limited to 101 CPT/HCPCS codes. That list has now been expanded to include 238 CPT/HCPCS codes.
- **Remote Communication Based Services:** In addition to being eligible for some CCM services, TCM, the virtual check-in and asynchronous remote evaluations, FQHCs are also eligible for non-face-to-face digital communications on a secure patient portal. They would bill using the same code (G0071) used for the virtual check-in and asynchronous remote evaluations, however the reimbursement amount has been adjusted to take into account the new services to a rate of \$24.76.



COVID-19 Era Policies *cont.*

FIGURE 3:
Medicare Pre-COVID-19 versus COVID-19 Temporary Policies

	Pre-COVID-19	COVID-19 Era – Temporary Policy
Modality	Live Video (<i>Store & Forward in Alaska and Hawaii demonstrations ONLY</i>)	Live Video (<i>Store & Forward in Alaska and Hawaii demonstrations ONLY</i>) Telephone allowed for some CPT/HCPCS codes
Distant Site Providers	Limited to 8 distinct provider types, excluded FQHCs	All healthcare professionals are eligible to bill Medicare. FQHCs & RHCs are also eligible providers.
Originating Site	Limited to 8 distinct facility types, included FQHCs, with allowance for home only for SUD & patients with co-occurring mental health conditions.	Patient is allowed to be located in their home during telehealth service.
Geographic Requirement	Limited to only rural HPSA or non-MSA, with exception for patients with SUD or co-occurring mental health condition, acute stroke or ESRD related services.	No geographic requirement.
Eligible Services	Limited to approximately 101 CPT/HCPCS codes.	Expanded to include 238 CPT/HCPCS codes.
Remote Communication Services	<p>FQHCs only eligible for:</p> <ul style="list-style-type: none"> • Virtual Check-In • Asynchronous Remote Evaluation • Chronic Care Management • Transitional Care Management <p>Virtual check-in, and asynchronous remote evaluation only available for established patients.</p> <p>Prior patient consent required.</p>	<p>FQHCs now eligible for:</p> <ul style="list-style-type: none"> • Virtual Check-In • E-Visit (non-face-to-face digital communication through secure patient portal) • Asynchronous Remote Evaluation • Chronic Care Management • Transitional Care Management <p>Virtual check-in, asynchronous remote evaluation and e-visit can be used for new patients.</p> <p>Patient consent can be obtained at time of service delivery.</p>

COVID-19 Era Policies *cont.*

The new Medicare reimbursement policy now allows FQHCs to not only act as distant site providers, but also deliver MAT services to patients located in their homes as long as the service is on the list of 238 eligible CPT/HCPCS codes for telehealth services reimbursed by Medicare. Services that are typically included in MAT, such as SUD screening and assessment, initial and follow-up evaluations and individual and group psychotherapy are all currently listed as eligible services. However, FQHCs are unable to collect their typical PPS rate for delivering those services, and instead must accept the FFS rate of \$92.03. The impact of that could be significant. In a discussion with several Maine FQHCs, they note that \$92.03 is approximately 56% of their normal rate for services. CMS has also required FQHCs to bill using a different and more complicated billing procedure than what they are used to, creating administrative burden for some FQHCs. There has been legislation (HR 7692) introduced in Congress in an attempt to allow FQHCs to bill as they normally would and receive their typical PPS rate, but as of the writing of this report has yet to see any movement towards enactment.

Additionally, there has been confusion among FQHCs given conflicting policies between different federal agencies. CMS guidance indicates FQHCs may bill for all of the eligible services on its telehealth list, but FQHCs are usually only reimbursed for services that fall under their scope which may not include all of the services eligible for reimbursement on the CMS telehealth list. At the time of the writing of this report, HRSA, who determines an FQHC's scope, has not clarified whether an FQHC may follow the CMS guidance and bill for those services it typically would not be able to.

MEDICAID

Similar to federal actions to address COVID-19, many states also began expanding the ways in which telehealth could be used. The main areas of change in telehealth Medicaid policy immediately following the onset of COVID-19 in the study states included the following:

1. Allowing for the use of telephone to deliver services.

The heavy reliance on technology necessitated by COVID-19 brought to light population disparities. Realizing that not all patients have a computer or access to video capabilities on their phone, all the state Medicaid programs have allowed for the use of the telephone in some way to deliver services within their Medicaid programs temporarily during the PHE or their States declared state of emergency. However, not all allow telephone to the extent Medicare does. For example, Kentucky limits telephone to specific services, although the services are relevant to OUD because it includes the delivery of the mental health component of MAT, including intensive outpatient program services, group outpatient therapy, applied behavioral analysis and therapeutic rehabilitation program services. Maine Medicaid has decided to allow for telephone reimbursement only for three specific codes that describe an audio interaction (99441-99443). Maryland Medicaid also specified that the telephone would be an acceptable form of service delivery if telehealth technology is not available to the patient. They defined the somatic services that can be delivered via telephone to include evaluation and management codes for an outpatient visit, psychotherapy codes, SUD treatment and group treatment. Like the other states, Ohio also expanded reimbursement to cover telephone calls, as well as for images transmitted via facsimile and electronic mail temporarily. Pennsylvania Medicaid is also allowing the telephone to be used during the emergency.

COVID-19 Era Policies *cont.*

- 2. Expansion of distant site providers.** The providers eligible to deliver telehealth services was also an area of telehealth policy expansion for Ohio and Pennsylvania. Both states expanded eligible provider types to include physical therapists, occupational therapists and audiologists. Other study states already had a broad enough policy to allow most providers to deliver telehealth services as long as it is within their scope of practice. For FQHCs, the most important issue is whether they can serve as a distant site provider. For the states studied here, this was not an issue pre-COVID-19 as all five states allowed FQHCs to act as a distant site provider, but is an issue in other states.
- 3. Telehealth Service Expansion:** State Medicaid programs also expanded the services that are reimbursable via telehealth, even when they already had a broad range of services being reimbursed. For example, even though Kentucky Medicaid policy was already quite expansive, including any event, encounter, consultation, visit, store and forward transfer, remote patient monitoring referral or treatment pre-COVID, they expanded even further by allowing all provider types to bill for all eligible services via telehealth. The same applies for behavioral health services with the exception of residential SUD treatment and residential crisis services. Additionally, Maine's Medicaid program is temporarily waiving the requirement for telehealth services to be of comparable quality at their discretion. Ohio Medicaid also expanded their reimbursement of the services eligible for telehealth delivery and specified that FQHCs would be eligible for the majority of them under their PPS when rendered by an eligible FQHC practitioner.
- 4. Remote Communication Codes:** Medicare's strategy of reimbursing for certain remote communication codes was also adopted by some states during the COVID-19 crisis, including Kentucky Medicaid which is allowing for the use of the virtual check-in and asynchronous remote evaluation codes (G2010 and G2012) to be reimbursed for established patients. Likewise, Maine Medicaid is also reimbursing for the virtual check-in and asynchronous remote evaluation codes as well as the eVisit codes (99421-99423 & G2061-G2063), and have specified that FQHCs can be reimbursed for it through G0071, the same as Medicare allows.
- 5. Home as Originating Site:** Ohio, Maine and Kentucky's Medicaid policies already allowed the home to be an eligible patient location (originating site) prior to COVID-19. Because it was critical for prospective patients sheltering in place at home to not venture outside, other study states, including Maryland and Pennsylvania, both modified their policies to allow for the home to be an originating site during the emergency period. Ohio expanded their policy to also schools and homeless shelters.

Other noteworthy changes in Medicaid policy included Ohio adding an originating site facility fee as a non-FQHC/RHC service, and Pennsylvania providing some leeway in their requirement for providers to submit a telehealth self-attestation form, still requiring it, but allowing it to be submitted five days after initiating telehealth rather than beforehand.

COVID-19 Era Policies *cont.*

FIGURE 4:

Medicare & Medicaid Telehealth Policy for FQHC/MAT Services Pre vs. Post COVID-19²

KEY

- ✓ = Allowed
- = Allowed, though significant limitations
- X = Not allowed

		Kentucky		Ohio		Maine		Maryland		Pennsylvania		Medicare	
		PRE	COV	PRE	COV	PRE	COV	PRE	COV	PRE	COV	PRE	COV
WHO	<i>Physician</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Nurse Practitioner</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Physician Assistant</i>	✓	✓	✓	✓	✓	✓	✓	✓	○	✓	✓	✓
	<i>Clinical Psychologist</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Licensed Clinical Social Worker</i>	✓	✓	✓	✓	✓	✓	✓	✓	X	○	✓	✓
	<i>FQHC</i>	✓	✓	✓	✓	✓	✓	✓	✓	○	✓	X	✓
HOW	<i>Live Video</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Store & Forward</i>	○	○	X	✓	X	○	○	○	X	X	○	○
	<i>Telephone</i>	X	✓	X	✓	○	✓	X	○	X	✓	X	✓
	<i>eVisit</i>	✓	✓	X	✓	X	✓	X	X	X	X	✓	✓
	<i>Virtual Check-In</i>	X	✓	X	✓	X	✓	X	X	X	X	✓	✓
	<i>Asynchronous Eval.</i>	X	✓	X	✓	X	✓	X	X	X	X	✓	✓

2 Utilized information regarding most common providers and MAT related services from NACHC report: <http://www.nachc.org/wp-content/uploads/2019/02/MAT-Service-Delivery-Report.pdf>

COVID-19 Era Policies *cont.*

FIGURE 4: Medicare & Medicaid Telehealth Policy for FQHC/MAT Services Pre vs. Post COVID-19²

KEY

- ✓ = Allowed
- = Allowed, though significant limitations
- X = Not allowed

		Kentucky		Ohio		Maine		Maryland		Pennsylvania		Medicare	
		PRE	COV	PRE	COV	PRE	COV	PRE	COV	PRE	COV	PRE	COV
WHAT	<i>SUD Screening & brief intervention</i>	✓	✓	X	X	✓	✓	✓	✓	X	✓	✓	✓
	<i>New Patient Evaluation</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Established/ Follow-Up Visits</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Psychiatric diagnostic Eval.</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Individual Psychotherapy</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Group Psychotherapy</i>	✓	✓	X	X	✓	✓	✓	✓	X	✓	X	✓
WHERE	<i>FQHC</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	<i>Home</i>	✓	✓	✓	✓	✓	✓	○	✓	X	✓	○	✓
	<i>School</i>	✓	✓	✓	✓	X	X	✓	✓	X	X	X	X
	<i>Homeless Shelter</i>	X	X	X	✓	X	X	X	X	X	X	X	X

➤ PRESCRIBING

As outlined in the previous section, the CSA severely limits the use of telemedicine for prescribing controlled substances, including those used in MAT such as buprenorphine. Prior to COVID-19 the most common way a patient could access a prescribing provider via telemedicine is if they were physically located in a hospital or clinic registered with the DEA. The declaration of a Public Health Emergency (PHE) on January 21, 2020 triggered another distinct circumstance included in the CSA that allows for the expanded use of telemedicine in prescribing controlled substances for the duration of

the public health emergency. The DEA outlines on its Coronavirus webpage the conditions that still must be met in order to prescribe controlled substances without having an in-person medical evaluation:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.^{xvi}

COVID-19 Era Policies *cont.*

Additionally, the DEA also issued a letter informing qualifying practitioners that beginning March 31, 2020, during the public health emergency, buprenorphine can be prescribed to new and existing patients with opioid use disorder for maintenance or detoxification treatment on the basis of a telephone evaluation. The evaluating practitioner must determine that it meets their obligations to ensure that the prescription is for a legitimate medical purpose and feel that an adequate evaluation can be accomplished via telephone. The following practitioners would qualify:

- Practitioners who are registered with the DEA as an opioid treatment program (OTP) if a program physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician determines that an adequate evaluation of the patient can be done via phone.
- “DATA-waived practitioners,” who have a special registration to qualify for a waiver to dispense buprenorphine for maintenance or detoxification and are complying with all applicable standards of care.^{xvii}

On the state level, all of the study states, with the exception of Pennsylvania, have also relaxed their rules related to prescribing in some way as well.

- **Kentucky:** Issued guidance stating that providers don’t need to meet the normal standard of care, if they document the circumstances in the patient’s record and only prescribe a controlled substance if the patient record appropriately justifies it.
- **Maine:** Clarified that providers could utilize either telephone or telehealth to prescribe and are allowing the prescription of buprenorphine over the telephone, consistent with the DEA’s policy.
- **Maryland:** For the prescribing of non-controlled

substances, Maryland’s Medical Board has stated that their telehealth regulations do not apply to telephone calls, emails or fax and are not prohibited. For controlled substances, a live video interaction is required with the exception of buprenorphine for OUD in line with federal guidance. After the initial interaction, audio-only communication can be used for future prescriptions.

- **Ohio:** The Medical Board suspended requirements for an in-person physical exam normally required to prescribe controlled substances or perform office-based treatment for opioid addiction. Providers must document their use of telemedicine and meet minimal standards of care.

It is possible that Pennsylvania didn’t see a need to refine or waive any of their prescribing requirements since telehealth isn’t explicitly addressed in their prescribing laws/regulations, and therefore neither prohibited or allowed. They did, however, release guidance indicating the types of health care practitioners permitted to provide services via telemedicine, because none of their professions had anything formally written prior to the guidance.

➤ HIPAA/PRIVACY

Much like regulations around the prescribing of controlled substances, HIPAA requirements have also been relaxed during the COVID-19 crisis. During the national COVID-19 national emergency HHS’ Office of Civil Rights has stated that they will practice enforcement discretion, and not fine providers that use popular applications, such as Apple Facetime, Facebook Messenger, Zoom or Skype as long as the interaction is private and not public-facing.^{xviii} For purposes of the requirements

COVID-19 Era Policies *cont.*

for providers of SUD services under 42 CFR Part 2, this enforcement discretion does not apply.^{xix} However, SAMHSA has clarified that given the increased need for telehealth and telephonic services due to the COVID-19 crisis the requirement under the section to use and disclose patient identifying information does not apply in situations that the provider determines are a medical emergency. In such situations, the provider would make their own determination whether a bona-fide medical emergency exists for purposes of providing needed treatment to patients.^{xx} On the state level, Kentucky, Maryland and Pennsylvania have also released policies indicating that they are deferring to HIPAA's enforcement discretion policies during the COVID-19 PHE.

Although these are all positive developments for the use of telehealth in delivering MAT services, it is important to remember that these policies are temporary and the possibility for them lasting beyond the emergency is uncertain. Many of them would require statutory modifications (requiring legislation) in order to be made permanent. The following section examines which policies are likely to continue in some form, and what that will mean for FQHCs utilizing telehealth to deliver MAT services.

Post COVID-19 - What happens now?

Some of the policy changes made during COVID-19 are likely to remain as people may continue to be confined to their homes for an extended amount of time, especially higher risk groups. Telehealth will continue to be a necessity for those groups to access care from their homes. Figure 5 below shows the temporary changes that have taken effect as a result of COVID-19, the source of the change, its expiration date and the action that would need to be taken in order to make the change permanent.

Some changes are more likely to become permanent than others. Changes that require only administrative action are generally easier to make permanent than those that require statutory change. However, especially in terms of reimbursement, even changes

that require legislation will likely remain in some form afterwards. Specifically, the home will likely continue to be an eligible location where a patient may receive services. There will still be a good portion of the population that will continue to minimize their activities outside of the home, some out of necessity as they may be particularly vulnerable to COVID-19. Others may simply not feel comfortable leaving their homes for the foreseeable future until a cure is developed, which could take years. They will still need to receive services so allowing the home to be a continued eligible originating site will likely be a necessity. This change would be particularly significant in state Medicaid programs that did not already allow the home as an eligible originating site for telehealth. In the study

Post COVID-19 *cont.*

states where the home was not already an eligible originating site before the COVID-19 emergency, the policy is in administrative regulation, not statutory making it easier to change. This is less of an issue for MAT services in Medicare, as they already allowed the home as an originating site for patients receiving treatment for SUD or co-occurring mental health disorders pre-COVID-19.

What is the more significant change for Medicare in terms of FQHCs treating OUD patients specifically, is the addition of FQHCs as eligible distant site providers, along with all other licensed health care professionals that can independently bill Medicare, which was a momentous expansion from pre-COVID-19 policy. This has opened the door for FQHC practitioners to deliver MAT services to the patient home, unencumbered by prohibitions from acting as distant site providers.

The expansion of eligible services is another element that is likely to continue both for Medicaid programs and for Medicare. Medicare already paid for most of the commonly billed services associated with MAT when delivered via telehealth, with the exception of group psychotherapy pre-COVID-19. Because Medicare has the ability to expand the services they cover administratively, which they do every year through the physician fee schedule, it is likely that the expanded services will persist in some form on a permanent basis. Whether or not group psychotherapy will continue to be included in that list will depend on feedback they receive from providers and other stakeholders of its appropriate delivery via telehealth. The expansion of services on the state level are also controlled by administrative policy, and like their Medicare counterparts, state policymakers will face a similar question regarding whether or not to keep the COVID-19 expansion of services. Many of the study states already reimbursed broadly for services delivered via telehealth prior to COVID-19 so it wouldn't be a big shift in policy. Likewise, the ability

to continue use of the remote communication-based technology codes is likely to continue for states that have adopted them since Medicare has also already adopted them as permanent.

Medicare's elimination of the requirement for the patient to be in a rural health professional shortage area or non-MSA has also had a consequential impact on FQHCs because now any FQHC, whether urban or rural can serve as an eligible originating site and collect the originating site facility fee. Although the fee is minimal, and does not cover the complete cost of hosting a patient at their site, it does contribute to the sustainability of their program. This would require legislation to make permanent, though it is likely policymakers will be looking at this possibility as COVID-19 drags on, and providers, including FQHCs, express the need for the continued coverage under Medicare for FQHCs and others to deliver care to patients in the home and in urban areas. Additionally, CMS has some flexibility on what is an eligible originating site, geographically. Federal law requires it to be in a "rural" area, but there is no definition given in statute to "rural" as it applies to telehealth. CMS does have it within their powers to have a definition that would geographically encompass more locations than what was eligible pre-COVID-19 by defining "rural" more broadly. There is also precedent for CMS taking such action as it was redefined in 2014.^{xxi}

The continued allowance for the use of telephone to deliver services and be paid in Medicare and Medicaid as a telehealth/telemedicine service is more difficult to predict. In many states, there is a statutory definition for telehealth (or telemedicine) that explicitly excludes telephone or audio-only. In many of the study states the use of telephone in care delivery would also be prohibited by board regulations which require at least a live video interaction to establish the patient-provider relationship. Medicare could potentially make the

Post COVID-19 cont.

policy permanent administratively through a change in their regulatory definition of a ‘telecommunication system’, but it remains to be seen how willing they will be to take this leap. In order for telephone to be considered a service delivery mechanism long term, studies would most likely be needed to show its effectiveness in delivering care compared to both live video telehealth and in-person options. Additionally, the allowance to utilize telephone to prescribe buprenorphine will also likely be rolled back when the DEA lifts their allowance for the practice. The pandemic has brought to many policymakers’ attention that there is a digital divide that exists in the population, and allowing for the use of telephone is one way to close the gap. As we navigate the post-COVID-19 world and if telehealth becomes more ubiquitous, this disparity will need to be addressed less we leave segments of the population behind, unserved and vulnerable.

The exception to the Controlled Substance Act that allows for the prescribing of controlled substances hinges on the existence of a federally declared PHE.

Once the PHE is over, the option to prescribe via telemedicine will again be limited to very specific circumstances. However, as mentioned previously, the SUPPORT Act did require the DEA to issue regulations on the special telemedicine registry that would presumably create some form of additional allowance for the prescribing of controlled substances to treat OUD through MAT to continue which FQHCs could benefit from. However, it is not yet clear when those regulations will be issued and how it will be implemented. The DEA will likely face increased pressure to issue the regulations once the PHE ends and providers look to other avenues to be able to continue MAT services to their OUD patients.

It is unlikely the temporary discretion exercised on fining for HIPAA violations will remain, but this temporary waiver may spur discussions on whether telehealth-specific policies in HIPAA are needed. Currently, there is nothing in HIPAA that specifically relates to telehealth. Policymakers may decide that this needs to change in a post-COVID-19 world.

FIGURE 5:
Status of COVID-19 Telehealth Policy Changes

		Policy Change	Basis	Expiration	How to make permanent
FEDERAL	Medicare	Removed geographic & facility/site limitation	HR 6074	When PHE is over/ expires	Statutory change needed. However, “rural” is not defined in statute and CMS could administratively decide on a broader definition.
		Added additional providers to eligibility list (Including FQHCs/RHCs & Allied Health Professionals)	CARES Act – HR 748/1135 Waiver	When PHE is over/ expires	Statutory change needed
		Allowed audio-only phone for telehealth services/Increased payment amount	CARES Act – HR 748/1135 Waiver	When PHE is over/ expires	Administrative action can be used as “telecommunication system” not defined in statute
		Expansion of services eligible for reimbursement	Existing Law	When PHE is over/ expires	Existing power for CMS to determine what services can be reimbursed if provided via telehealth

Post COVID-19 cont.

FIGURE 5: STATUS OF COVID-19 TELEHEALTH POLICY CHANGES (cont)

		Policy Change	Basis	Expiration	How to make permanent
FEDERAL	Prescribing	Allowing use of live video to prescribe without falling into one of the other exceptions	Existing law – activates when a PHE is declared	When PHE is over/ expires	Already existing exception
		Allowing audio-only phone to prescribe buprenorphine for opioid use disorder treatment	Current DEA authority	When PHE is over or unless otherwise specified by DEA	DEA authority to continue
	HIPAA	OCR to not fine for violations during PHE	Current OCR authority	When PHE is over/ expires	Legislation and/or regulations likely needed
STATE	KY	Medicaid - Allowance to utilize telephone.	Governor Executive Order/Medicaid Guidance	When KY State of Emergency ends	Definitions/requirements for telehealth would need to be altered in statute and administrative regulation.
		Medicaid - Reimbursement for the virtual check-in/asynchronous eval.	Medicaid Guidance	Until further updates.	Issue an update to guidance making it permanent.
		Prescribing - Allowance to not meet in-person standard of care.	Governor Emergency Declaration/ Medical Board Guidance	When KY State of Emergency ends	Alter regulatory language regarding professional standards for prescribing.
	ME	Medicaid – Utilization of store & Forward	MaineCare Provider Manual Update	Became permanent (6/5/20)	Update provider manual, which they did, although it is pending approval from CMS.
		Medicaid – Clarification of use of telephone.	MaineCare Guidance/ COVID-19 Manual	Became permanent (6/5/20)	Update provider manual, which they did, although it is pending approval from CMS.
		Medicaid – Reimbursement of virtual check-in/asynchronous eval & eVisit	MaineCare Guidance/ COVID-19 Manual	Became permanent (6/5/20)	Update provider manual, which they did, although it is pending approval from CMS.
		Prescribing - Allowance to use telephone to prescribe buprenorphine	Guidance refers to DEA authority to extend flexibility for telephone.	When PHE is over or unless otherwise specified by DEA	DEA authority to continue

Post COVID-19 cont.

FIGURE 5: STATUS OF COVID-19 TELEHEALTH POLICY CHANGES (cont)

		Policy Change	Basis	Expiration	How to make permanent
STATE	MD	Medicaid - Allowance to utilize telephone.	Executive Order/Medicaid Guidance	When MD State of Emergency ends	Definitions/requirements for telehealth & telemedicine would need to be altered in statute and administrative regulation.
		Medicaid - Allowance for the home as the patient site.	Order by Dep. Of Health Secretary based on PHE authority.	Until further notice.	Administrative regulation would need to be changed to add home to originating site list.
		Prescribing - Allowance to use telephone to prescribe buprenorphine	Guidance refers to DEA authority to extend flexibility for telephone.	When PHE is over or unless otherwise specified by DEA	DEA authority to continue
	OH	Medicaid – Allowance for store & forward (S&F)	Executive Order/Medicaid Guidance	When OH State of Emergency ends	Modify Ohio admin. code to include S&F in telehealth definition/reimbursement.
		Medicaid – Allowance for use of telephone	Executive Order/Medicaid Guidance	When OH State of Emergency ends	Modify Ohio admin. code to include telephone in telehealth definition/reimbursement.
		Medicaid – Reimbursement of virtual check-in/asynchronous eval & eVisit	Emergency Rule/Medicaid Guidance	When OH State of Emergency ends	Make Emergency Rule permanent.
		Prescribing - Requirement waived for in-person visit for office-based treatment for opioid addiction.	Ohio Medical Board Guidance	When OH State of Emergency ends	Modify Ohio Admin. Code to allow physical exams to be conducted via telehealth.
	PA	Medicaid – Allowing the home to be a patient location.	PA Medicaid Guidance	When PA State of Emergency ends.	Medicaid can administratively release updated provider bulletin to make policy permanent. Legislation can also be done.
		Medicaid – Additional eligible services.	PA Medicaid Guidance	When PA State of Emergency ends.	Medicaid can administratively release updated provider bulletin to make policy permanent. Legislation can also be done.
		Medicaid – Additional providers.	PA Medicaid Guidance	When PA State of Emergency ends.	Medicaid can administratively release updated provider bulletin to make policy permanent. Legislation can also be done.
		Medicaid – Use of telephone.	PA Medicaid Guidance	When PA State of Emergency ends.	Medicaid can administratively release updated provider bulletin to make policy permanent. Legislation can also be done.

Post COVID-19 cont.

> PERSISTING GAPS IN POLICY

Even if all the current COVID-19 policies are made permanent, there are still persisting policy gaps that exist for FQHCs. With all of the COVID-19 policy changes, some of the barriers identified in CCHP’s initial research or identified by interviewees have still yet to be addressed. The persisting gaps are outlined in Figure 6 below.

FIGURE 6:
Persisting Policy Gaps & Recommendations

GAP	RECOMMENDATION
<p>Even though FQHCs and RHCs have been made eligible distant site providers in Medicare temporarily, they are paid a rate based off of the physician fee schedule, rather than their typical PPS Rate (which is likely higher). There is precedent for paying the full PPS rate, as all five study state Medicaid programs reimburse the PPS rate for FQHC telehealth distant site services, even prior to COVID-19.</p>	<p>Allow FQHCs and RHCs to bill normally and receive their full PPS reimbursement rate for the services delivered, as they would have, had they delivered those services in person. <i>(Requires a statutory change)</i></p>
<p>Broadband access and the cost of equipment is still something many providers and patients struggle with. The FCC has tried to address this concern by offering grants for connectivity and equipment, however the FCC has struggled to keep up with the need.</p>	<p>Expand funding for grant and subsidy programs that provide increased access to broadband and telehealth equipment. <i>(Can be implemented administratively by the FCC but may require additional federal funding).</i></p>
<p>In Medicaid programs, although all of the states have now allowed for reimbursement of some type of audio-only service, reimbursement for remote monitoring and store-and-forward is still limited.</p>	<p>Expand definition of telehealth/telemedicine to allow all modalities to be used to deliver the service, as long as the standard of care is met. <i>(May require state statute change, or may be done administratively, depending on where states’ telehealth policy is housed. States may also need to submit state plan amendment if they are reimbursing in a different way/amount as services delivered face-to-face)</i></p>
<p>Now that FQHCs can serve as distant site providers under Medicare, some FQHCs are left wondering if their FTCA insurance will cover them in the event of a malpractice lawsuit, since telemedicine is not directly addressed under any of the FTCA guidance.</p>	<p>Update FTCA guidance documents to clarify whether or not telehealth models of care, especially ones where the patient is located outside of the FQHC, are covered under FTCA. <i>(HRSA FTCA guidance document can be updated administratively)</i></p>

Post COVID-19 cont.

FIGURE 6: PERSISTING POLICY GAPS & RECOMMENDATIONS (cont)

GAP	RECOMMENDATION
<p>Extra requirements to deliver telehealth services, such as Pennsylvania Medicaid’s ‘Telehealth Self Attestation Form’ and telehealth-specific consent requirements that create the perception of telehealth as a separate riskier form of healthcare delivery.</p>	<p>Eliminate requirements to obtain extra approvals for use of telehealth or consent forms in state policies. <i>(May require state statute change, or may be done administratively, depending on where states’ telehealth policy is housed.)</i></p>
<p>In all the interviews conducted for this study, interviewees noted that prescribing requirements for MAT drugs are difficult to navigate and serves as a deterrent to them offering the medication component of MAT.</p>	<p>Simplify state requirements around prescribing controlled substances to align with federal laws/regulations. <i>(Likely requires a change in state statute and/or regulation)</i></p>
<p>Although the use of telehealth to deliver care has quickly become increasingly ubiquitous due to COVID-19, there is still a need to educate patients about the benefits of telehealth so that they can feel comfortable connecting with their providers.</p>	<p>Create educational materials (i.e. posters, brochures, webpages, online videos) that promote the use of telehealth and its benefits and prepares patients for what to expect during a telehealth consultation. <i>(May be done by providers, insurers, state or local health departments, non-profit associations/organizations)</i></p>
<p>Providers who have rapidly adapted to telehealth in light of COVID-19 may require training to deliver care most effectively via telehealth and understand how to scale their telehealth programs to make it enduring in light of rapidly changing policies and circumstances. Additionally, staff in FQHC settings may also need training on how to handle patients suffering from OUD or co-occurring mental health disorders.</p>	<p>Provide training opportunities for providers and their staff wanting to improve their telehealth programs and adapt to changes in the telehealth policy and COVID-19 environment. <i>(May be done by schools/universities, state or local health departments, non-profit associations/organizations, or federal funding for training programs)</i></p>
<p>With the use of telehealth becoming more widespread, certain communities, such as non-English speakers and those with hearing or sight disabilities, have expressed difficulty in the way it is commonly implemented.</p>	<p>Conduct research and interviews with patient groups experiencing these difficulties to learn how to make telehealth more accessible and friendly for all diverse populations. <i>(May be done by schools/universities, state or local health departments, non-profit associations/organizations)</i></p>



Conclusion

The research for this study began in January 2020, when COVID-19 was largely confined to China and the opioid epidemic was the biggest public health emergency in the United States. Telehealth was utilized sparsely by FQHCs to deliver MAT and other services at that time, and had not yet exploded into a commonplace practice. FQHCs often faced policy barriers to implementing telehealth programs, as flagged by the stakeholders CCHP interviewed for this study. The most significant barriers noted included Medicare and Medicaid reimbursement rules as well as the difficulty of navigating prescribing laws and regulations on both the federal and state levels. When COVID-19 hit in mid-March and telehealth was the only way to keep patients safe at home while still accessing healthcare services, longstanding policy barriers were removed in a matter of days with subsequent revisions further expanding telehealth access following in the subsequent weeks. Although many of the policy barriers originally identified in CCHP's initial research and interviews have

been temporarily resolved, their future remains uncertain. Some, including the allowance for the home to be an eligible originating site, as well as expansions in eligible providers (including FQHCs) and services are likely to remain in some form, while others are less so, such as relaxation of HIPAA requirements. Even with the expansions for telehealth made as a result of COVID-19, some barriers still remain for FQHCs delivering MAT services via telehealth, including the different rate FQHCs receive for delivering telehealth services compared to their normal PPS rate, as well as issues around broadband connectivity, patient and provider education, and FTCA coverage. Although the doors are now wide open for telehealth to play a key role in the delivery of healthcare services, including MAT, there is still much work to be done to eliminate all challenges and the future of the utilization of telehealth to provide MAT by an FQHC hinges on the decisions of federal and state policymakers.

Footnotes

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Appendix A - Methodology

The selection of the five states for this research was made by examining the states that are listed as having the highest mortality rate for opioid use disorder, according to the CDC, and comparing the states in the top ten of that list to those that received funding from the Health Resources Services Administration in 2019 for their Rural Communities Opioid Response Program Implementation Grant. The grant is aimed at strengthening and expanding substance use disorder (SUD) prevention, treatment and recovery services. It encouraged its grantees to utilize telehealth in their strategy. Based on these two sources, seven states were selected for inclusion in the study. These included: Kentucky, Maine, Maryland, New Hampshire, Ohio, Pennsylvania, and West Virginia. After conducting the research and interviews, New Hampshire and West Virginia were eliminated because CCHP was not able to secure any interviews prior to COVID-19, and once the pandemic started, federally qualified health centers (FQHCs) and Medicaid personnel's availability for interviews was limited.

Both interviews and online research were conducted in order to gather the needed information for this study. Interviewees were selected by consulting with the regional Telehealth Resource Centers that cover each of the selected states, as well as the National Association of Community Health Centers in order to determine the appropriate contacts in which to engage in either FQHCs, primary care associations or the Medicaid program. The list of interviewees can be found in Appendix C and the list of interview questions can be found in Appendix B.

To conduct the online research of laws, regulations and Medicaid policies, CCHP utilized Lexis Nexis to locate the sections of law and regulation in each of the five selected states that relate to the Medicaid program, FQHCs, SUD/Opioid Use Disorder (OUD) treatment and the prescribing of controlled substances. Within each of those section, CCHP searched for the following terms:

- “federally qualified health center or FQHC”
- “medication assisted treatment or MAT”
- “controlled substances”
- “substance use disorder” or “opioid use disorder” – variations depending on state
- Buprenorphine
- Telehealth/Telemedicine/Telepractice

State Medicaid websites were also searched, to locate sections of Medicaid manuals that apply to FQHCs, telehealth and SUD treatment. Information applicable to the use of telehealth to deliver MAT in FQHCs was extrapolated from all the sources and organized into the categories in the chart found in Appendix D.

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Appendix B

INTERVIEW QUESTIONS – FQHC/PRIMARY CARE ASSOCIATION REPRESENTATIVES

Are you currently delivering (or considering delivering) MAT services via telehealth? What is your model? For example, are you doing the mental health component and/or the medication prescribing/administration component over telehealth? Is the modality used live video (or telephone, store-and-forward, etc.), and do you have an initial in-person exam? Is the FQHC the distant or originating site?

Have you encountered issues being reimbursed for these services via telehealth? If so, is it Medicaid, Medicare or private payers that is the payer? What are the specific issues?

Have you encountered issues specific to state or federal FQHC rules that creates barriers for delivering services via telehealth? For example, requirements on how to “establish” a patient, how a “visit” is defined or restrictions around same-day billing, just to name a few.

Are FQHCs eligible to bill MAT services in your state Medicaid program, and have you encountered any issues receiving reimbursed for those services?

Are you familiar with the limitations around prescribing over telemedicine in federal law (the Ryan Haight Act)? If so, does that limit your ability to deliver the medication component of MAT for your health center? Do your providers have a waiver to prescribe buprenorphine from SAMHSA? Are there other state laws that place further restrictions on the prescribing of controlled substances that are a barrier?

Are there other barriers that were not discussed above that you have encountered? For example, patient resistance to telehealth, provider buy-in, equipment cost, HIPAA, FCTA, etc.?

Do you have any recommendations for policy changes that would facilitate the expansion of your telehealth services to deliver MAT to OUD patients?

INTERVIEW QUESTIONS – MEDICAID REPRESENTATIVES

Does Medicaid cover the mental health component of MAT when delivered by an FQHC via telehealth? Can the FQHC be distant and/or originating site?

Does Medicaid cover the medication prescribing and administration component of MAT when delivered by an FQHC via telehealth? Can the FQHC be distant and/or originating site?

Are there specific requirements an FQHC specifically must adhere to in order to bill for telehealth services?

Would the FQHC be eligible for their PPS rate when billing as the distant site?

Would the FQHC be eligible for a facility fee if they were the originating site?

Does telehealth meet the definition of a “visit” or “encounter” under Medicaid?

Are there any special rules with same-day encounters?



Appendix C - Interviewee List

Kentucky

- Donna Veno – *Telehealth Program Manager - KY Cabinet for Health and Family Services*
- Candace Crawford – *KY Cabinet for Health and Family Services*
- Ann Hollen – *KY Cabinet for Health and Family Services*

Maryland

- Benjamin Wolff, *Medicaid Provider Services Administration - Maryland Department of Health*

Maine

- Darcy Shargo – *Maine Primary Care Association*
- Maine Primary Care Association Opiate Workgroup

Ohio

- Julie DiRossi-King – *Ohio Association of Community Health Centers*
- Dana Vallangeon – *Ohio Association of Community Health Centers*
- Tiffany White – *Ohio Association of Community Health Centers*

Pennsylvania

- Matthew Eckley – *The Primary Health Network*
- Nicole Tarr – *The Primary Health Network*
- Amy Williams – *Pennsylvania Association of Community Health Centers*
- Patti Griggs – *Pennsylvania Association of Community Health Centers*
- Cheri Rinehart – *Pennsylvania Association of Community Health Centers*

National

- April Lewis – *National Association of Community Health Centers*



Appendix D - Applicable State Telehealth Policies Pre/During Covid-19

The following are the applicable telehealth policies that were studied for this project.
The advent of COVID-19 altered some of these policies and those changes are also noted.

Kentucky

Topic	Pre-Coronavirus Permanent Policy	Post-Coronavirus Policy
<p><i>Telehealth Modality Allowed for FQHCs</i></p>	<p>Two-way audio-video. https://apps.legislature.ky.gov/law/kar/907/001/055.pdf</p> <p>NOTE: S&F is allowed in Medicaid (11 specialties reimbursed), but not included in FQHC. https://apps.legislature.ky.gov/law/kar/907/003/170.pdf</p> <p>Interviewee: Asynchronous can be used when it supports upcoming synchronous visit.</p>	<p>Telephone allowed for:</p> <ul style="list-style-type: none"> • Target Case Management (all types) • Peer Support Services • Community Support Services <p>https://chfs.ky.gov/agencies/dms/ProviderLetters/behavioralhealthcovid19.pdf</p> <p>Case management also mentioned in (pg. 9) - https://www.medicaid.gov/state-resource-center/downloads/ky-combined-appendix-k-appvl.pdf</p> <p>The following services can be delivered via synchronous telehealth or as a telecommunication mediated health service:</p> <ul style="list-style-type: none"> • Peer support services • Intensive outpatient program services • Group outpatient therapy • Service planning • Partial hospitalization • Targeted case management • Mobile crisis services • Applied Behavioral Analysis • Comprehensive Community Support Services • Therapeutic Rehabilitation Program • Day Treatment <p>https://chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf</p> <p>The Department will allow level of care evaluations or re-evaluations to be conducted remotely using</p>

		<p>telephonic, video-conferencing, or web-based conferencing platforms that enable direct communication between the individual completing the assessment and participant/participant's representative as permitted by HIPAA. https://www.medicaid.gov/state-resource-center/downloads/ky-combined-appendix-k-appvl.pdf</p> <p>Allowing non-HIPAA technology, as allowed by OCR. https://chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf</p> <p>Telephonic or web-based conferencing platforms that enable direct communication allowed for:</p> <ul style="list-style-type: none"> • Adult Day Training • Adult Day Health • Personal Assistance or Community Living Supports for reminders, cueing and/or monitoring of self-medication administration. <p>May be provided in Day Training or Adult Day Health Care Centers or home setting. https://www.medicaid.gov/state-resource-center/downloads/ky-combined-appendix-k-appvl.pdf</p>
<p><i>Definition of a visit.</i></p>	<p>A visit means an encounter, which includes in person or live video telehealth. https://apps.legislature.ky.gov/law/kar/907/001/055.pdf</p>	<p>No change. See page 5: https://governor.ky.gov/attachments/20200313_State-of-Emergency_907-KAR-1-604E.pdf</p>
<p><i>Who are eligible distant site providers? Is an FQHC included? And do they get the PPS rate?</i></p>	<p>Doesn't explicitly say, but it meets definition of a visit, and definition of "telehealth care provider" is broad enough:</p> <ol style="list-style-type: none"> (a) Currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; (b) Currently participating as a Medicaid provider in accordance with 907 KAR 1:671; (c) Operating within the scope of the provider's professional licensure; and 	<p>All behavioral health service providers can deliver services, with the exception of residential SUD treatment services and residential crisis services. https://chfs.ky.gov/agencies/dms/ProviderLetters/behavioralhealthcovid19.pdf</p>

	<p>(d) Operating within the provider’s scope of practice https://apps.legislature.ky.gov/law/kar/907/003/170.pdf</p>	<p>Can federally qualified health centers (FQHCs) or rural health centers (RHCs) provide medical and behavioral health services via telehealth?</p> <p>FQHCs and RHCs can provide every appropriate service via telehealth as long as it is an approved service that the individual provider’s licensure board allows for the provider providing the service.</p> <p>For an FQHC or RHC to generate the PPS rate, the appropriate provider must provide the service to trigger the payment. A zero pay services code will continue to zero pay regardless of whether it is provided in person or via telehealth or telehealth-like service. Zero pay services would continue to get recorded for data and cost reports.</p> <p>https://chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf</p>
<p><i>Is an FQHC an eligible originating site? And do they get a facility fee?</i></p>	<p>The place of service includes a patient’s home, clinic, school or workplace. https://apps.legislature.ky.gov/law/kar/907/003/170.pdf</p> <p>Interviewee: FQHCs can be originating sites only, and there is no facility fee.</p>	<p>No change.</p>
<p><i>Services Allowed via telehealth</i></p>	<p>Law requires Medicaid reimbursement. https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=48457</p> <p>Telehealth service includes an event, encounter, consultation, visit, store and forward transfer, remote patient monitoring, referral or treatment. https://apps.legislature.ky.gov/law/kar/907/003/170.pdf</p>	<p>DMS is making system changes to allow for all provider types to bill for telehealth services. To the extent possible, providers should provide all services via telehealth. If a service could have been provided via telehealth, but the individual or provider does not have the capability to deliver or participate in the service via telehealth, the service may be delivered via telephone as a “telecommunication or other electronically mediated health service”. If service delivery is audio-only but the</p>

		<p>service would normally be dependent on the exchange of visual information, the provider should facilitate appropriate electronic or other data exchanges to support any treatment delivered.</p> <p>https://chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf</p> <p>All behavioral health service providers can deliver services, with the exception of residential SUD treatment services and residential crisis services. G2010 and G2012 are also allowed with established patients.</p> <p>https://chfs.ky.gov/agencies/dms/ProviderLetters/behavioralhealthcovid19.pdf</p> <p>https://chfs.ky.gov/agencies/dms/ProviderLetters/dmsproviderletterCOVID19.pdf</p> <p>DMS is requiring all Medicaid MCOs to cover all current services that are covered via telehealth during this time. In addition, DMS will require the MCOs to cover all services that are determined to be allowable via telehealth during this declared emergency.</p> <p>https://chfs.ky.gov/agencies/dms/Documents/ProviderFAQs.pdf</p>
<p><i>MAT Services Covered</i></p>	<p>Interviewee: State provides full array of inpatient, outpatient, case management MAT coverage. They also cover Buprenorphine, Vivotrol and Methadone.</p> <p>FQHC Regs indicate there is coverage for substance use disorder and co-occurring mental health disorders. They also cover a number of other mental health services outlined in regulation including, a screening, brief intervention and referral to treatment for SUD, day treatment, comprehensive community support services, outpatient program, therapeutic rehabilitation program by (a long list of providers, see reg.)</p> <p>See page 3: https://apps.legislature.ky.gov/law/kar/907/001/054.pdf</p>	<p>No change.</p>

<p><i>Licensing for SUD Treatment</i></p>	<p>"AODE" means a nonmedical and nonhospital based alcohol and other drug abuse treatment entity owned by an individual or agency which operates one (1) or more of the following programs: detoxification, residential, family residential, residential transitional living, outpatient, or intensive outpatient. AODEs must obtain a license...</p> <p>AODE shall be issued:</p> <ol style="list-style-type: none"> 1. One (1) license which shall apply to all facilities operated by the AODE where an outpatient or an intensive outpatient program is provided; and 2. A separate license for each facility where a twenty-four (24) hour program is operated. <p>Entities need to acquire AODE licensing to deliver SUD services, but FQHCs are exempt.</p> <p>https://apps.legislature.ky.gov/law/kar/908/001/370.pdf</p>	<p>No change.</p>
<p><i>Specific requirements for in-person services</i></p>	<p>Group outpatient therapy; Individual outpatient therapy, crisis intervention, family therapy, collateral outpatient therapy explicitly is face-to-face one-on-one encounter. Face-to-face is defined as including live video. 908 KAR 3:170.</p> <p>https://apps.legislature.ky.gov/law/kar/907/003/170.pdf https://apps.legislature.ky.gov/law/kar/907/001/054.pdf</p>	<p>No change.</p>
<p><i>Same Day Billing</i></p>	<p>The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period. For example, if a recipient is receiving a service from an independent mental health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a primary care center.</p> <p>https://apps.legislature.ky.gov/law/kar/907/001/054.pdf</p> <p>Interviewee: Not identified as an issue.</p>	
<p><i>Informed Consent</i></p>	<p>Law requires Medicaid to form policies around informed consent. Law that applies to professionals, including physicians, nurses and psychologists, requires patient consent be obtained. Does not specify written or verbal.</p>	

<p><i>General Prescribing Requirements/Establishing Physician-Patient Relationship</i></p>	<p>https://apps.legislature.ky.gov/law/kar/201/017/110.pdf</p> <p>Prior to prescribing in response to any communication transmitted or received by computer or other electronic means, physicians must establish a proper physician-patient relationship. This includes:</p> <ul style="list-style-type: none"> • Verification that the person requesting medication is in fact who the patient claims to be; • Establishment of a documented diagnosis through the use of accepted medical practices; • Maintenance of a current medical record. <p>An electronic, online, or telephone evaluation by questionnaire are inadequate for the initial or any follow-up evaluation. Source: KY Revised Statutes § 311.597 (2012). (Accessed Aug. 2019). https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=30538</p> <p>A “good faith prior examination” (needed to establish a physician-patient relationship) can be done through telehealth. https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=48798</p>	
<p><i>Prescribing Controlled Substances? MAT Substances?</i></p>	<p>There are very strict guidelines for prescribing buprenorphine including needing the prescribing physician to be DEA licensed prescriber and obtained buprenorphine certification through completion of a SAMSHA certified course. Also need 12 hours of continuing medical education certified in Category I specific to addiction medicine for each 3 year continuing education cycle. Very detailed requirements for the prescription detailed in regs.</p> <p>There is also regs on controlled substances generally and practice standards. Requires “physical exam” but does not specify whether that exam can be conducted via telehealth.</p> <p>201 KAR 9:270 & 201 KAR 20:065. https://apps.legislature.ky.gov/law/kar/201/009/270.pdf https://apps.legislature.ky.gov/law/kar/201/020/065.pdf</p> <p>Interviews: Special permission from state to prescribe methadone.</p>	<p>If a physician is unable to conform to professional standards for prescribing or dispensing controlled substances due to circumstances beyond the physician’s control, or the physician makes a professional determination that it is not appropriate to comply with a specific standard, based upon the individual facts applicable to a specific patient’s diagnosis and treatment, the physician shall document those circumstances in the patient’s record and only prescribe or dispense a controlled substance to the patient if the patient record appropriately justifies the prescribing or dispensing of a controlled substance under the circumstances.</p> <p>The standards of acceptable and prevailing medical practices that apply under normal circumstances may not apply in a state of emergency. During this time it is</p>

	<p>To prescribe methadone, must be a Narcotic Treatment Program - https://apps.legislature.ky.gov/law/kar/908/001/374.pdf https://chfs.ky.gov/agencies/dms/Documents/ProviderSUDWebinar.6.17%20%28v3%29.pdf</p>	<p>particularly important that licensees responsibly exercise their best clinical judgment on a case-by-case and patient-by-patient basis, balancing a variety of factors (including being mindful not to contribute to the ongoing opioid epidemic). When considering whether to have an in-person patient visit, licensees should ask themselves whether the service provided would be retrospectively deemed necessary if the patient were to become infected by COVID-19 as a result of the visit. Where possible, use of telehealth technologies should be considered in an effort to limit and contain the spread of COVID-19. https://kbml.ky.gov/Documents/Advisory%20on%20Pre%20scribing%20During%20Declaration%20of%20Emergency.pdf</p>
<p><i>Are there telehealth practice standards for specific professions that may be delivering MAT/Behavioral Health Standards?</i></p>	<p>There are Telehealth Professional Standards for the Board of Psychology and Applied Behavior Analysis, which may have implications for MAT. https://apps.legislature.ky.gov/law/kar/201/026/310.pdf https://apps.legislature.ky.gov/law/kar/201/043/100.pdf</p>	<p>Until the state of emergency is lifted, a “treating psychologist or psychological associate” providing or facilitating the use of telehealth services under KRS 319.140 and 201 KAR 26:310, may do so to meet the mandates of social distancing, including any practitioners who are under a requirement for supervision, subject to the below stated requirements for supervision. http://psy.ky.gov/Documents/PSY%20COVID19%20Memorandum.pdf</p> <p>Under Section 1(2), the provision that applied behavior analysis with a client shall not commence via telehealth is suspended. During the State of Emergency contained in Executive Order 2020-215, applied behavior analysis may commence via telehealth. No initial in-person consultation is required.</p> <p>Sections 1(2)(a) and (b), which require an initial inperson meeting for the licensee and client who plan to utilize</p>

		telehealth services is suspended. During the State of Emergency contained Executive Order 2020-215, an initial in-person meeting for the licensee and client who prospectively utilize telehealth is not required. http://aba.ky.gov/Documents/Memorandum%20re%20EO%202020-0243-ABA.pdf
<i>Other</i>	<ul style="list-style-type: none"> • Telehealth services are subject to utilization review for medical necessity, compliance with administrative regulation and compliance with state and federal law. The department shall recoup the reimbursement for previously reimbursed telehealth services if they find that it was not medically necessary, compliant with this administrative regulation, applicable to this administrative regulation or compliant with applicable state or federal law. • Within 48 hours of the reconciliation of the record of the telehealth service, a provider must document within the patient’s record that a service was provided by telehealth and follow documentation requirements. • No issues around ‘establishing a patient’ 	
<i>Issues flagged by Interviewees</i>	<ul style="list-style-type: none"> • Education/training needed. • FQHCs feel that the prescribing regulations are confusing. • No issues with scope of practice or prior authorization • To prescribe Methadone, they would have to get special permission from the state. • No facility fee is an issue. • Need to update regulations and policies so that they align. 	

Maine

Topic	Pre-Coronavirus Permanent Policy	Post-Coronavirus Policy
<i>Telehealth Modality Allowed for FQHCs</i>	<p>Interactive telehealth services are covered.</p> <p>Telephonic Services may be reimbursed if the following conditions are met:</p> <ul style="list-style-type: none"> • Interactive Telehealth Services are unavailable; and • A Telephonic Service is medically appropriate for the underlying Covered Service. <p>Telemonitoring also covered.</p>	<p>The Department, at its discretion, may waive the requirement under Ch. 1, Section 4, Telehealth, Sec. 4.04-1(2), requiring Interactive Telehealth Services be of comparable quality to what they would be were they delivered in person. Requests will be handed on a case-by-case basis through a clinical review by the Department to determine whether members may face imminent harm in the absence of a telehealth mode of delivery for a particular service, given the inability due to the public</p>

	<p>Section 4: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p>	<p>health emergency for that member to receive the service in-person.</p> <p>The Department will reimburse providers for telephone evaluation and management services provided to members. The restrictions set forth in the MaineCare Benefits Manual, Ch. I, Sec. 4.04-2 are waived for this purpose.</p> <p>Telephonic evaluation and management services must be rendered by a qualified professional actively enrolled in MaineCare or contracted through an enrolled MaineCare provider.</p> <p>Relevant CPT codes are:</p> <ul style="list-style-type: none"> • 99441: Telephone evaluation and management service; 5-10 minutes of medical discussion • 99442: 11-20 minutes of medical discussion • 99443: 21-30 minutes of medical discussion <p>Section 5: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p> <p>Additional clarification regarding when telephone is acceptable: https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/03232020-Telehealth-Guidance.pdf</p>
<p><i>Definition of a visit.</i></p>	<p>FQHC unit of service is a visit that includes a face-to-face contact with one or more of the center's core or ambulatory professional and other qualified staff and, where appropriate, receipt of supplies, treatments, and laboratory services.</p> <p>Section 31: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p>	
<p><i>Who are eligible distant site providers? Is an FQHC included?</i></p>	<p><i>In order to be eligible for reimbursement for Telehealth Services, a Health Care Provider must be:</i></p> <ol style="list-style-type: none"> 1. <i>Acting within the scope of his or her license;</i> 2. <i>Enrolled as a MaineCare provider; and</i> 	

<p><i>And do they get the PPS rate?</i></p>	<p>3. <i>Otherwise eligible to deliver the underlying Covered Service according to the requirements of the applicable section of the MaineCare Benefits Manual.</i></p> <p>Telehealth Services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the State. If approved, these facilities may serve as the provider site and bill under the encounter rate.</p> <p>Section 4: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p>	
<p><i>Is an FQHC an eligible originating site? And do they get a facility fee?</i></p>	<p>The site at which the Member is located at the time of Telehealth Service delivery. The Originating (Member) Site will usually be a Health Care Provider’s office, but it may also be the Member’s residence, provided the proper equipment is available for Telehealth Services.</p> <p>When an FQHC or RHC serves as the Originating (Member) Site, the Originating Facility Fee is paid separately from the center or clinic all-inclusive rate.</p> <p>Section 4: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p>	
<p><i>Services Allowed via telehealth</i></p>	<p>If the Member is eligible for the underlying covered service and providing it via telehealth is medically appropriate as determined by the health care provider, and is of comparable quality if it had been delivered in-person, the telehealth service is eligible for reimbursement.</p> <p>With the exception of those services described in Section 4.05 of this policy (Non-Covered Services and Limitations), any medically necessary MaineCare Covered Service may be delivered via Interactive Telehealth Services, provided the following requirements are met:</p> <ol style="list-style-type: none"> 1. The Member is otherwise eligible for the Covered Service, 	<p>Covered virtual services: https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/MaineCare-Telehealth-Summary-New-Codes-and-Info-04022020.pdf</p>

	<p>as described in the appropriate section of the <i>MaineCare Benefits Manual</i>; and</p> <p>2. The Covered Service delivered by Interactive Telehealth Services is of comparable quality to what it would be were it delivered in person.</p> <p>Section 4: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p>	
<i>MAT Services Covered</i>	<p>SUD/ODU/MAT not specifically mentioned in FQHC manual.</p> <p>Interviewees: Indicated MaineCare pays for the MAT services they deliver. They have no issue being paid for it.</p>	
<i>Licensing for SUD Treatment</i>	<p>MAT for buprenorphine and other medications (besides controlled substances) may be provided by a physician's office or other healthcare setting.</p> <p>Source: Office of Substance Abuse and Mental Health Services. Licensing and certifying of substance abuse treatment programs. CMR 14-118-005</p>	
<i>Specific requirements for in-person services</i>	<p>Interviewees: Indicated that group sessions were not allowed via telehealth.</p>	
<i>Same Day Billing</i>	<p>Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, advanced nurse practitioner or visiting nurse, and in addition to that encounter, is seen on the same day by a licensed clinical psychologist, clinical social worker, clinical professional counselor or a clinical nurse specialist licensed as an advanced practice clinical nurse specialist. An additional visit of any other kind will only be reimbursed for unforeseen circumstances as documented in the member's record. The goal remains to treat the whole individual during one visit.</p>	

	<p>FQHC Manual: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p>	
<i>Informed Consent</i>	<p>Providers must deliver written educational information to patients at their visit. See Medicaid policy of details. Section 4: https://www.maine.gov/sos/cec/rules/10/ch101.htm</p> <p>Consent required by medical board. https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/Chapter_6_Telemedicine%20.pdf</p>	Department is waiving consent requirement.
<i>General Prescribing Requirements/Establishing Physician-Patient Relationship</i>	<p>Board of Licensure in Medicine & Board of Osteopathic Licensure</p> <p>Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine in providing health care shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by the licensee.</p> <p>A valid physician-patient relationship may be established between a licensee who uses telemedicine in providing health care and a patient who receives telemedicine services through consultation with another licensee or through a telemedicine encounter if the standard of care does not require an in-person encounter and in accordance with evidence-based standards for practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.</p>	<p>Through emergency rules, going forward the Department will allow for prescribing through telehealth.</p> <p>March 20, 2020 Update: Members do not usually need to see a provider in person in order to receive a prescription. They can connect via interactive telehealth or telephone to get their prescription filled.</p> <p>https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/03232020-Telehealth-Guidance.pdf</p>

	<p>Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The physician prescribing via telemedicine must ensure that the clinical evaluation, indication, appropriateness, and safety consideration for the resulting prescription are appropriately documented and meet the applicable standard of care. Consequently, prescriptions via telemedicine carry the same accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.</p> <p>https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/Chapter_6_Telemedicine%20.pdf</p>	
<p><i>Prescribing Controlled Substances? MAT Substances?</i></p>	<p>There are limits on opioid prescribing, but there is an exception carved out for medication-assisted treatment. Doesn't address telehealth.</p> <p>Source: 32 M.R.S. § 3300-F</p> <p>In order to prescribe buprenorphine for opioid use disorder/addiction, clinicians must apply for a DATA 2000 waiver and be granted an "X" number by the DEA.</p> <p>Source: CMR 02-373-021</p>	<p>Historically, the Drug Enforcement Agency (DEA) had required an in-person assessment before prescribing is allowed for all controlled substances. However, under the current public health emergency, the DEA is now allowing flexibility specifically for prescribing buprenorphine for the treatment of Opioid Use Disorder (per below). For other controlled substances (e.g. opioids), however, the DEA continues to require that providers evaluate the patient for the initial visit in one of the following ways: in person, or via telemedicine using a real-time, two-way, audio-visual communications device.</p> <p>https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/03232020-Telehealth-Guidance.pdf</p>
<p><i>Are there telehealth practice standards for specific professions that may be delivering MAT/Behavioral</i></p>	<p>Medical/Osteopathic Board Practice Standards: https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/Chapter_6_Telemedicine%20.pdf</p>	

<i>Health Standards?</i>	
<i>Other</i>	Dispensers of controlled substances must check the Prescription Monitoring Program for records related to the person and other prescriptions they are on. Source: CMR 14-118-011.
<i>Issues flagged by Interviewees</i>	<ul style="list-style-type: none"> • Educating new patients and getting their buy-in. They have a lot of no-shows. • Lack of parity in reimbursement for private payers and Medicare. They have no issue with MaineCare. • Their model always have induction taking place in person, and counseling being conducted over live video.

Maryland

Topic	Pre-Coronavirus Permanent Policy	Post-Coronavirus Policy
<i>Telehealth Modality Allowed for FQHCs</i>	<p>Multimedia communication equipment permitting two-way real-time interactive communication between a patient at an originating site and a distant site provider at a distant site. COMAR 10.09.49.02</p> <p>A telehealth service does not include:</p> <ul style="list-style-type: none"> • An audio-only telephone conversation between a health care provider and a patient; • An electronic mail message between a health care provider and a patient; • A facsimile transmission between a health care provider and a patient; or • A telephone conversation, electronic mail message, or facsimile transmission between the originating and distant site providers without interaction between the distant site provider and the patient. <p>Store and forward technology does not meet the Maryland Medical Assistance Programs definition of telehealth. The Maryland Medical Assistance Program covers services such as dermatology, ophthalmology, and radiology. COMAR 10.09.49.09</p>	<p>Providers who are not able to meet in-person with a participant should make every effort to use the following technology, in order of priority:</p> <ol style="list-style-type: none"> 1. Traditional telehealth technology which meets all formal requirements is strongly preferred. (These services remain unaffected by the measures in this guidance). 2. If Medicaid participants are unable to access originating sites possessing fully qualified technology (ability to pan/focus camera, multiple views, etc.) this emergency policy will permit the use of notebook computers, smartphones, or audio-only phones. 3. If Medicaid participants cannot access cell-phone based video technology, audio-only telephone calls will be permitted. <p>Somatic services that can be delivered via telephone include 99211999213. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/COVID-</p>

	<p>https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf</p> <p>MD Medicaid reimburses for RPM for certain conditions. https://mmcp.health.maryland.gov/Pages/RPM.aspx</p>	<p>19%204a_Telephonic%20Services%20Guidance_3.21.20.pdf</p> <p>RPM is expanded - https://mmcp.health.maryland.gov/Documents/03.27.2020%20-%20MDH%20Guidance%20COVID-19%206%20-%20Neall%20-%20Remote%20Patient%20Monitoring.pdf</p>
<p><i>Definition of a visit.</i></p>	<p>Interviewee: a synchronous telehealth visit is treated the same in our payment system, or our managed care encounter system, as an in-person visit.</p> <p>No definition for a visit specifically in COMAR.</p> <p>"All-inclusive cost-per-visit rate" means the rate that is established for Federally Qualified Health Centers (FQHCs) which includes all services that are rendered to a participant on a given date of service.</p> <p>"Clinic services" means preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a licensed physician or dentist either in a freestanding clinic, or outside the clinic if the:</p> <ul style="list-style-type: none"> • Recipient does not reside in a permanent dwelling or have a fixed home or mailing address; and • Service is provided by clinic personnel. <p>COMAR 10.09.08.01</p>	
<p><i>Who are eligible distant site providers? Is an FQHC included? And do they get the PPS rate?</i></p>	<p>Distant Site Providers may render services via telehealth within the providers scope of practice. COMAR 10.09.49.06 https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020_Maryland%20Medicaid%20Telehealth%20Program%20Frequently%20Asked%20Questions.pdf</p>	<p>Only those provider types already authorized by existing State regulations to use telehealth technology may deliver public behavioral health system-funded telephone services. To bill Medicaid, a provider must be a current Medicaid provider. There is no longer a separate telehealth registration process. Provider types eligible to provide telehealth include: ... FQHCs who bill through the Specialty Behavioral Health System.</p>

	<p>Interviewee: FQHCs can be distant sites and receive PPS rate.</p>	<p>Providers listed above must be enrolled in the Department’s Speciality Behavioral Health Program.</p>
<p><i>Is an FQHC an eligible originating site? And do they get a facility fee?</i></p>	<p>Interviewee: Maryland does not pay the facility fee, only the service itself, which must be billed by distant site. Specific list of eligible originating sites. Patient’s home is not an allowable originating site.</p> <p>FQHC is eligible originating site. List of specific sites. COMAR 10.09.49.06 https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020_Maryland%20Medicaid%20Telehealth%20Program%20Frequently%20Asked%20Questions.pdf</p> <p>The Department may not reimburse distant site providers for a facility fee. COMAR 10.09.49.09</p> <p>Department does pay a transmission fee to originating site. Transmission fee paid to for line or per minute usage and any additional programmatic, administrative, clinical or contingency support at the originating site. COMAR 10.09.49.11</p>	<p>There is a temporary allowance for the home or any other secure location to be an originating site. https://www.mhaonline.org/docs/default-source/resources/coronavirus/covid-19-temporary-expansion-of-medicaid-regulations-to-permit-delivery-of-telehealth-services-to-the-home-to-mitigate-possible-spread-of-novel-coronavirus.pdf</p>
<p><i>Services Allowed via telehealth</i></p>	<p>Services provided through telehealth are subject to the same program restrictions, preauthorizations, limitations and coverage that exist for the service when provided in-person. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf</p> <p>Services rendered via telehealth are reimbursed on a fee-for-service basis. COMAR 10.09.49.03</p> <p>Services must be:</p>	<p>Codes eligible to be delivered by telephone include E&M codes, psychotherapy codes, SUD treatment codes, group treatment codes. See list. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/COVID-19%204b_Telephonic%20Services%20Guidance_3.21.20%20Final.pdf</p>

	<ul style="list-style-type: none"> • Distinct from services provided by the originating site provider; • Able to be delivered using technology-assisted communication; and • Clinically appropriate to be delivered via telehealth; <p>Services provided via telehealth to the same extent and standard of care as services provided in person; and As determined by the providers licensure or credentialing board, services performed via telehealth within the scope of a providers practice. COMAR 10.09.49.04</p>	
<p><i>MAT Services Covered</i></p>	<p>Interviewee: Medicaid covers consultations/visits via telehealth with providers who may prescribe MAT. Federal rules place some limits on prescribing controlled substances (e.g. Ryan Haight Act), but Medicaid does not mirror these rules. Prior authorization is required for MAT.</p> <p>MAT services require preauthorization for FQHCs. COMAR 10.09.08.09</p> <p>The Department may not reimburse for... Mental health and substance use disorder services that did not receive prior authorization from the Department or its ASO. COMAR 10.09.49.09</p> <p>The distant site shall be reimbursed:</p> <ul style="list-style-type: none"> • For somatic services provided via telehealth, as set forth in COMAR 10.09.02.07D; • For mental health services provided via telehealth, as set forth in COMAR 10.09.59.09; or • For substance use disorder services provided via telehealth, as set forth in COMAR 10.09.80.08. <p>COMAR 10.09.49.10</p> <p>FQHCs can provide community-based substance use disorder services. COMAR 10.09.80.03</p>	<p>Codes eligible to be delivered by telephone include E&M codes, psychotherapy codes, SUD treatment codes, group treatment codes. See list. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/COVID-19%204b_Telephonic%20Services%20Guidance_3.21.20%20Final.pdf</p> <p>Can you clarify which disciplines are eligible to bill telehealth for outpatient SUD services? Presently, all disciplines previously allowed to provide telehealth services for SUD services are allowed to bill for Level 1 Services, including Medicaid PT50 services under a COMAR 10.63 license. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/Follow-up%20on%20Covid%2019%20Telehealth_032420.pdf</p>

	<p>Buprenorphine and other MAT, must be delivered by OHCQ certified or licensed substance use disorder treatment provider with DATA 2000 waiver. Certain requirements are outlined for MAT. COMAR 10.09.80.06</p> <p>Department does NOT cover: Services delivered by federally qualified health centers other than those billed using T-codes that may include the following delivered by two separate appropriately licensed providers:</p> <ul style="list-style-type: none"> • One T-code for mental health services per day with associated mental health procedure code; and • One T-code for substance use disorder services with associated H-code per day; <p>Each health care facility that is not part of a health care system and each health care system shall make available to patients the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine-containing formulations.</p> <p>To comply with subsection (b) of this section, a health care facility or a health care system may:</p> <ul style="list-style-type: none"> • Directly employ, contract with, or refer a patient to a health care provider who is trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine-containing formulations; or • Deliver the services in person or, if appropriate, through telehealth. <p>MD Health-General Code Sec. 8-1101.</p> <p>Requirement to ensure parity of specialty mental health and substance use disorder services with federal acts, and includes the scope of benefits for telehealth services and residential treatment programs that are not institutions for mental disease. MD Health-General Sec. 15-103.6</p>	
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<p><i>Licensing for SUD Treatment</i></p>	<p>Interviewee: All behavioral health providers must register with the behavioral health ASO to bill. No special registration requirements for telehealth. Their practitioners would need to hold Data 2000 waiver authorization to prescribe and dispense applicable controlled substances, but there isn't an additional registration requirement for the clinic itself to perform these services.</p> <p>If a provider is a behavioral health service provider, be registered as a provider through the ASO on the date the service is rendered. COMAR 10.09.49.10</p> <p>["Administrative Service Organization (ASO)"] means the contractor procured by the State to provide the Department with administrative support services to operate the Maryland Public Behavioral Health System.] – COMAR 10.09.80.01</p> <p>For services outlined in Regulation .05 of this chapter, the community-based substance use disorder program shall notify the ASO and obtain authorization to provide substance use disorder services from the ASO. The ASO agent shall authorize services that are:</p> <ul style="list-style-type: none"> • Medically necessary; and • Of a type, frequency, and duration that are consistent with expected results and cost-effectiveness. <p>COMAR 10.09.80.07</p> <p>A person shall register with the Department and obtain and maintain a registration certificate before the person: Manufactures, distributes, or dispenses controlled dangerous substances... COMAR 10.19.03.03</p> <p>Prescribers of controlled substances must register for the Prescription Drug Monitoring Program and must have a Controlled Dangerous Substance registration number. https://egov.maryland.gov/mdh/cds https://bha.health.maryland.gov/PDMP/Pages/Home.aspx</p>	<p>Can I prescribe CDS in Maryland without a Maryland-issued CDS Registration?</p> <p>No, a Maryland CDS Registration is required to prescribe CDS in Maryland. However, if a practitioner will be working solely in a hospital/clinic setting, they may use the facility's DEA registration and facility's Maryland CDS Registration instead of registering independently if the hospital agrees and the situation warrants.</p> <p>https://health.maryland.gov/ocsa/Documents/Controlled%20Dangerous%20Substances%20(CDS)%20Frequently%20Asked%20Questions%20during%20COVID-19.pdf</p>
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<p><i>Specific requirements for in-person services</i></p>		
<p><i>Same Day Billing</i></p>	<p>More than one visit per day is not allowed, unless the additional visit is adequately documented as:</p> <ul style="list-style-type: none"> • An emergency situation; or • A visit to a different specialty <p>COMAR 10.09.08.06</p>	
<p><i>Informed Consent</i></p>	<p>Informed consent required from patient (oral or written). COMAR 10.32.05.04</p> <p>Medicaid: Requirement for consent. COMAR 10.09.49.05 https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf</p>	<p>Medicaid: Consent may be given verbally by the participant. https://www.mhaonline.org/docs/default-source/resources/coronavirus/covid-19-temporary-expansion-of-medicaid-regulations-to-permit-delivery-of-telehealth-services-to-the-home-to-mitigate-possible-spread-of-novel-coronavirus.pdf</p> <p>Audio-only telephone services, or services using video applications that do not meet State regulations, may only be delivered with the explicit consent of the participant. Participants must be provided with a clear explanation of the telehealth or voice service and its confidentiality limitations, including the use of non-HIPAA compliant technology. Providers must ensure that this is documented in the Medicaid participant’s medical record. Attention to ensuring that participants’ confidentiality is protected in terms of private space, etc., must be a priority. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/COVID-19%204a_Telephonic%20Services%20Guidance_3.21.20.pdf</p>

		<p>What is defined as "explicit consent of the participant"? Because we can't meet in person, we're unable to add a signed form to the client/member's medical record. Consent may be verbal and then documented by the staff member. Consent must explicitly note that the specific type of service (televideo, telephone) is not as secure as normal HIPAA requirements. If the participant hasn't signed, the staff member must date and sign. https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/Follow-up%20on%20Covid%2019%20Telehealth_032420.pdf</p>
<p><i>General Prescribing Requirements/Establishing Physician-Patient Relationship</i></p>	<p>A telehealth practitioner shall perform a synchronous, audio-visual patient evaluation adequate to establish diagnoses and identify underlying conditions or contraindications to recommended treatment options before providing treatment or prescribing medication. COMAR 10.32.05.05</p> <p>A telehealth practitioner may not treat a patient or prescribe medication based solely on an online questionnaire. COMAR 10.32.05.06</p> <p>A health care practitioner may establish a practitioner-patient relationship through either a synchronous telehealth interaction or an asynchronous telehealth interaction, if the health care practitioner:</p> <ul style="list-style-type: none"> • Verifies the identity of the patient receiving health care services through telehealth; • Discloses to the patient the health care practitioner's name, contact information, and the type of health • occupation license held by the health care practitioner; and • Obtains oral or written consent from the patient or from the patient's parent or guardian if State law requires 	<p>May I treat patients via telephone calls, emails, or faxes? Yes. The Board's telehealth regulations do not apply to telephone calls, emails or fax. See Health Occ. § 1-1001(E)(3). COMAR 10.32.05.02B (8) (b). For the duration of the state of emergency, the April 1, 2020 Executive Order allows treatment and Medicaid reimbursement for audio-only calls and conversations and asynchronous telehealth. See Executive Order Number 20-04-01-01. Such interactions may not be reimbursable after the state of emergency is lifted, but are not prohibited or otherwise regulated by the Board's telehealth regulations. https://www.mbp.state.md.us/forms/TelehealthFAQs.pdf</p>

	<ul style="list-style-type: none"> the consent of a parent or guardian. <p>A health care practitioner shall perform a clinical evaluation that is appropriate for the patient and the condition with which the patient presents before providing treatment or issuing a prescription through telehealth.</p> <p>A health care practitioner may use a synchronous telehealth interaction or an asynchronous telehealth interaction to perform the clinical evaluation</p> <p>Health Occupations Code 1-1002 & 1003</p>	
<p><i>Prescribing Controlled Substances? MAT Substances?</i></p>	<p>A telehealth practitioner may not prescribe opioids for the treatment of pain through telehealth except if the patient is in a health care facility as defined in Health-General Article, § 19-114(d)(1), Annotated Code of Maryland.</p> <p>COMAR 10.32.05.06</p> <p>A prescription for a controlled dangerous substance may be issued only by an individual practitioner who is:</p> <ul style="list-style-type: none"> Authorized to prescribe controlled dangerous substances in the State of Maryland, in which the practitioner is licensed to practice the practitioner's profession; and Either registered or exempted from registration pursuant to 21 CFR § 1301.22(c) and 21 CFR § 1301.23. <p>COMAR 10.19.03.07</p> <p>The administering or dispensing directly, but not prescribing, of narcotic drugs listed in any schedule to a narcotic drug dependent individual for "detoxification treatment" or "maintenance treatment" as defined in 21 U.S.C. § 802 shall be deemed to be within the meaning of the term "in the course of his professional practice of research" as provided in 21 U.S.C. § 828(e) and 21 U.S.C. § 802(21), if the practitioner is separately registered with the United States Attorney General as required by 21 U.S.C. § 823(g) and complies with the regulatory standards for treatment qualification, security, records, and unsupervised use of drugs pursuant to the federal Act.</p>	<p>During the Maryland State of Emergency, may I prescribe Opioids for the treatment of pain through telehealth? Yes, during the state of emergency, prescriptions for Opioids may be prescribed for pain. Please see the Office of Controlled Substances Administration frequently asked questions for more details about prescribing Controlled Dangerous Substances during the State of Emergency.</p> <p>https://www.mbp.state.md.us/forms/TelehealthFAQs.pdf</p> <p>Prior to issuing a CDS prescription for a new patient, a practitioner must complete a two-way, real-time (synchronous) telehealth medical evaluation, with the exception of prescribing buprenorphine for opioid-use disorder in line with federal guidance. After an initial telehealth communication occurs, the practitioner may use audio-only communication for any future prescriptions.</p> <p>https://health.maryland.gov/ocsa/Documents/Controlled%20Dangerous%20Substances%20(CDS)%20Frequently%20Asked%20Questions%20during%20COVID-19.pdf</p>

	<p>A physician who is not specifically registered to conduct a narcotic treatment program may administer, but may not prescribe, narcotic drugs to an individual for the purpose of relieving acute withdrawal symptoms if necessary while arrangements are being made for referral for treatment. More than one day's medication may not be administered to the individual, or for the individual's use, at one time. This emergency treatment may not be carried out for more than 3 days and may not be renewed or extended. COMAR 10.19.03.07</p> <p>Prohibition against prescribing an opiate for pain unless there is a catastrophic health emergency, or the individual receiving the prescription is a patient in a health care facility.</p> <p>Regulations adopted by a health occupations board under subsection (a) of this section:</p> <ul style="list-style-type: none"> • May not establish a separate standard of care for telehealth; and <p>Shall allow for the establishment of a practitioner-patient relationship through a synchronous telehealth interaction or an asynchronous telehealth interaction provided by a health care practitioner who is complying with the health care practitioner's standard of care. Health Occupations Code 1-1003 & 1006</p>	
<p><i>Are there telehealth practice standards for specific professions that may be delivering MAT/Behavioral Health Standards?</i></p>	<p>There are practice standards that apply to all practitioners. COMAR 10.32.05.04</p>	
<p><i>Other</i></p>	<ul style="list-style-type: none"> • Documentation, technical and confidentiality requirements in Medicaid telehealth regs: COMAR 10.06.49.06 & 07, https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020%20Telehealth%20Program%20Manual.pdf 	

	<p>https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/April2020_Maryland%20Medicaid%20Telehealth%20Program%20Frequently%20Asked%20Questions.pdf</p> <ul style="list-style-type: none"> • HIPAA requirements relaxed during PHE. • Department is required to identify evidence based information about OUD and share with facilities, among others. -MD Health General Code Sec. 8-407. • Interviewee: Behavioral health services are carved out of our managed care benefit and paid separately, so the MCOs do not pay for them. They are paid fee-for-service through our behavioral health ASO. • Interviewee: Maryland pays the same rates for telehealth services as for in person services. Any practitioner may render reimbursable services delivered via telehealth if consistent with their scope of practice rules. Our behavioral health analysts report that SUD services were 17% of the total services paid to FQHCs, based on amount paid for services in FY2019.
<i>Issues flagged by Interviewees</i>	<ul style="list-style-type: none"> • None.

Ohio

Topic	Pre-Coronavirus Permanent Policy	Post-Coronavirus Policy
<i>Telehealth Modality Allowed for FQHCs in Medicaid</i>	<p>Live video only - "Telemedicine" is the direct delivery of services to a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements.</p> <p>https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/TelehealthBilling.pdf?ver=2019-07-08-105111-487</p>	<p>Telehealth definition for Medicaid is live video, but also includes activities that are asynchronous and do not have both audio and video elements such as telephone calls, images transmitted via facsimile machine, and electronic mail.</p> <p>Remote monitoring will be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM's payment schedules).</p> <p>https://medicaid.ohio.gov/Portals/0/Providers/COVID19/TelehealthBillingGuidelinesDuringCOVID-19StateofEmergency04132020.pdf?ver=2020-04-13-165849-963</p> <p>https://www.cchpca.org/sites/default/files/2020-03/OHIO%20Telehealth%20appendix_emergency%20rule%205160-1-21.pdf</p>

<p><i>Definition of a visit.</i></p>	<p>"Visit" is a single instance of service.</p> <p>(1) For cost-based clinic services other than transportation, it is a face-to-face encounter between a patient and a provider of cost-based clinic services. For transportation services, it is one trip to or from a service site.</p> <p>Admin code doesn't define face-to-face so it is unclear if telehealth is included.</p> <p>A visit must take place at an approved service site, in a patient's home, at another appropriate location (e.g., an outpatient hospital setting used by a cost-based clinic for providing services to patients, the scene of an accident), or (for transportation) between a service site and another location.</p> <p>http://codes.ohio.gov/oac/5160-28</p>	<p>No change.</p>
<p><i>Who are eligible distant site providers? Is an FQHC included? And do they get the PPS rate?</i></p>	<p>Eligible Rendering Providers</p> <ul style="list-style-type: none"> • Physician and Psychiatrist (20) • Podiatrist (36) • Psychologist (42) • Physician Assistant (24) • Clinical Nurse Specialist (65)» Certified Nurse Midwife (71) • Certified Nurse Practitioner (72) • Licensed Independent Social Worker (37) • Licensed Independent Chemical Dependency Counselor (54) • Licensed Independent Marriage and Family Therapist (52) • Licensed Professional Clinical Counselor <p>Provider Types eligible to bill</p> <ul style="list-style-type: none"> • Rendering practitioners listed above • Professional Medical Group (21) • Federally Qualified Health Center (12) • Rural Health Clinic (05) • Public Health Department (50/501) • Primary Care Clinic (50/500) 	<p>» Physician and Psychiatrist (20) » Podiatrist (36) » Psychologist (42) » Physician Assistant (24) » Dentist (30) » Advanced Practice Registered Nurses: o Clinical Nurse Specialist (65) o Certified Nurse Midwife (71) o Certified Nurse Practitioner (72) » Licensed Independent Social Worker (37) » Licensed Independent Chemical Dependency Counselor (54) » Licensed Independent Marriage and Family Therapist (52) » Licensed Professional Clinical Counselor (47) » Dietitians (07) » Audiologist (43) » Occupational Therapist (41) » Physical Therapist (39) Speech-language pathologist (40) » Practitioners who are supervised or cannot practice independently: o Supervised practitioners and supervised trainees defined in 5160-8-05 o Occupational therapist assistant o Physical therapist assistant o Speech-language pathology aide o Audiology Aide o Individuals holding a conditional license as described in section 4753.071 of the Revised Code o Licensed health professionals providing medically necessary supportive services » Registered Nurses (RN) and Licensed Practical</p>

	<p>Family Planning Clinic (50/503) https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/TelehealthBilling.pdf?ver=2019-07-08-105111-487</p> <p>FQHCs do get their PPS rate: https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/NonInst/MAL635.pdf</p>	<p>Nurses (LPN) working in a hospice or home health setting » Non-Agency Nurses (38) » Medicaid School Program (MSP) practitioners described in 5160-35 of the Administrative Code » Other providers as designated by the Director of ODM</p> <p>Rendering practitioners listed above except: o Supervised practitioners and supervised trainees defined in 5160-8-05 o Occupational therapist assistant o Physical therapist assistant o Speech-language pathology and audiology aides o Individuals holding a conditional license o Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting » Professional Medical Group (21) » Professional Dental Group (31) » Federally Qualified Health Center (12) » Rural Health Clinic (05) » Ambulatory Health Care Clinics (50) » Outpatient Hospitals (01) » Psychiatric Hospitals providing OPHBH services (02) » Medicaid School Program Provider (28) » Private Duty Nurses (38) » Other providers as designated by the Director of ODM https://medicaid.ohio.gov/Portals/0/Providers/COVID19/TelehealthBillingGuidelinesDuringCOVID-19StateofEmergency04132020.pdf?ver=2020-04-13-165849-963</p>
<p><i>Is an FQHC an eligible originating site? And do they get a facility fee?</i></p>	<p>Practitioner’s office b. Patient’s home c. School d. Federally Qualified Health Center (FQHC), e. Rural Health Clinic (RHC) f. Public health department g. Primary care clinic h. Family planning clinic i. Inpatient hospital j. Outpatient hospital k. Nursing facility l. Intermediate care facility for individuals with intellectual disability (ICF/IID)</p> <p>They eliminated their facility fee. https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/TelehealthBilling.pdf?ver=2019-07-08-105111-487</p>	<p>Medicaid covered individuals can access telehealth services wherever they are located. This includes:</p> <ul style="list-style-type: none"> o Home o School o Temporary housing o Homeless shelter o Nursing Facility o Hospital o Group home

		<p>o Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)</p> <p>Serving as the originating site for a telehealth service is not an FQHC or RHC service. If conditions of the originating site fee are met, an FQHC or RHC may submit a claim under its ambulatory health care clinic (provider type 50) provider number. The fee-for-service payment amount for the originating site fee will be listed in Appendix DD to OAC rule 5160-1-60.</p> <p>The originating site fee may be paid to a practitioner site who either: o Provided no other service to the presenting patient; or o Provided a separately identifiable evaluation and management service. https://medicaid.ohio.gov/Portals/0/Providers/COVID19/TelehealthBillingGuidelinesDuringCOVID-19StateofEmergency04132020.pdf?ver=2020-04-13-165849-963</p>
<p><i>Services Allowed via telehealth?</i></p>	<p>There is a specific list of CPT/HCPCS codes. Includes psychotherapy codes. https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/TelehealthBilling.pdf?ver=2019-07-08-105111-487</p>	<p>Expanded list of CPT/HCPCS codes.</p> <p>During the COVID-19 state of emergency, most of the covered telehealth services listed in the appendix to rule 5160-1-21 will be covered under the prospective payment system (PPS) as FQHC or RHC services when rendered by eligible FQHC and RHC practitioners.</p> <p>Group therapy will continue to be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM’s payment schedules). - Services under the Specialized Recovery Services (SRS) program are not currently covered FQHC or RHC services. https://medicaid.ohio.gov/Portals/0/Providers/COVID19/TelehealthBillingGuidelinesDuringCOVID-19</p>

		19StateofEmergency04132020.pdf?ver=2020-04-13-165849-963
<p><i>Eligible Telehealth services/MAT covered?</i></p>	<p>Admin codes requires mental health or substance use disorder codes to be covered via telehealth, but limited to list of codes above. http://codes.ohio.gov/oac/5160-1-18</p> <p>Under amended rule 5160-4-06, separate payment may be made for the provision of self-administered take-home medication, in addition to an E&M service, if: (a) a waiver issued under Section 303(g)(2) of the Drug Addiction Treatment Act of 2000 (DATA 2000), 21 U.S.C. 823(g)(2) (as in effect January 1, 2019), permits the rendering provider to treat narcotic dependence without registering separately with the United States Drug Enforcement Administration as an opioid treatment program; (b) the provider complies with all applicable rules and requirements of the Ohio Board of Pharmacy and the Ohio State Medical Board; (c) the medication is a pharmaceutical prescribed for the treatment of opioid addiction; and (d) the provider includes in the patient's medical record documentation that the amount of take-home medication provided was medically necessary. See doc. For more. http://codes.ohio.gov/oac/5160-4-06</p> <p>Beginning July 1, 2019, separate payment may be made for the provision of self-administered take home medication for the treatment of substance abuse disorder, including opioid use disorder, in addition to payment for an E&M service, as long as the following three conditions are met:</p> <ul style="list-style-type: none"> • The rendering provider receives a waiver, as permitted under Section 303(g)(2) of the Drug Addiction Treatment Act of 2000 (DATA 2000), to treat opioid dependence in office-based settings. (DATA 2000 waivers permit certain rendering providers to treat opioid dependence without registering separately with the United States Drug Enforcement Administration as an opioid treatment program.) • The medication is a pharmaceutical prescribed for the treatment of opioid addiction. 	<p>Telehealth services expanded (see above).</p>

	<ul style="list-style-type: none"> The provider complies with all applicable rules and requirements of the United States Drug Enforcement Administration, the Ohio Board of Pharmacy, and the Ohio State Medical Board. <p>A new provider specialty 704 will be added, on request, to the MITS profile of each DATA 2000 waiver practitioner. (Source: Transmittal Letter & http://codes.ohio.gov/oac/5160-4-06v1)</p>	
<i>Licensing for SUD or mental health services</i>	<p>Requirements to receive a Methadone Treatment License: http://codes.ohio.gov/oac/5122-40</p>	<p>Allowing take home program for methadone, but think it only applies to OTPs - https://www.samhsa.gov/sites/default/files/sample-otp-covid-19-faqs.pdf</p>
<i>Specific requirements for in-person services</i>	<p>Group therapy does not meet the definition of face-to-face. Source: FQHC Letter</p> <p>Interviewees felt that Admin code 4731-33-03 titled “Office Based Treatment for Opioid Addiction is restricting for the use of telehealth (although not explicitly), for example it requires a urine drug screen to be conducted to establish a patient which isn’t possible over telehealth. Interviewees feel that this code is very restricting for MAT in general, and especially for telehealth. The code was just reviewed, and isn’t up for another review until 2024. It would require legislation to address. http://codes.ohio.gov/oac/4731-33-03v1</p>	<p>Group therapy will continue to be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50 (using ODM’s payment schedules). https://medicaid.ohio.gov/Portals/0/Providers/COVID19/TelehealthBillingGuidelinesDuringCOVID-19StateofEmergency04132020.pdf?ver=2020-04-13-165849-963</p>
<i>Same Day Billing</i>	<p>Multiple encounters with one health professional or encounters with multiple health professionals (e.g., a nurse and a physician) constitute a single visit if all of the following conditions are satisfied:</p> <p>(a) All encounters take place on the same day; (b) All contact involves a single cost-based clinic service; and (c) The service rendered is for a single purpose, illness, injury, condition, or complaint.</p> <p>(3) Multiple encounters constitute separate visits if one of the following conditions is satisfied: (a) The encounters involve different cost-based clinic services; or</p>	<p>No change.</p>

	<p>(b) The services rendered are for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment. http://codes.ohio.gov/oac/5160-28</p>	
<i>Informed Consent</i>	<p>Informed consent is required under general admin code (not Medicaid policy) in order to prescribe over telehealth. http://codes.ohio.gov/oac/4731-11-09</p>	
<i>General Prescribing Requirements/Establishing Physician-Patient Relationship</i>	<p>Non-controlled substances detailed criteria here: http://codes.ohio.gov/oac/4731-11-09</p>	
<i>Prescribing Controlled Substances? MAT Substances?</i>	<p>The state medical board shall adopt rules that establish standards and procedures to be followed by physicians in the use of all drugs approved by the United States food and drug administration for use in medication-assisted treatment, including controlled substances in schedule III, IV, or V. The rules shall address detoxification, relapse prevention, patient assessment, individual treatment planning, counseling and recovery supports, diversion control, and other topics selected by the board after considering best practices in medication-assisted treatment.</p> <p>The board may apply the rules to all circumstances in which a physician prescribes drugs for use in medication-assisted treatment or limit the application of the rules to prescriptions for medication-assisted treatment for patients being treated in office-based practices or other practice types or locations specified by the board.</p> <p>Source. Sec. 4731.056 http://codes.ohio.gov/orc/4731.056v1</p> <p>To prescribe must be a APRN, PA or Physician Before initiating medication-assisted treatment, a prescriber shall give the patient or the patient’s representative information about all drugs approved by the United States food and drug administration for use in medication-assisted treatment. The information must be provided both orally and in writing. The prescriber or the prescriber’s delegate shall</p>	<p>Effective March 9, 2020, providers can use telemedicine in place of in-person visits. Throughout the declared Covid-19 emergency, the SMBO will not enforce in-person visit requirements normally required in SMBO rules.</p> <p>Suspension of these enforcement requirements includes, but is not limited to:</p> <ul style="list-style-type: none"> • Prescribing controlled substances • Prescribing for subacute and chronic pain • Prescribing to patients not seen by the provider • Pain management • Medical marijuana recommendations and renewals • Office-based treatment for opioid addiction <p>Providers must document their use of telemedicine and meet minimal standards of care. The Medical Board will provide advance notice before resuming enforcement of the above regulation when the state emergency orders are lifted. https://med.ohio.gov/Portals/0/Resources/COVID-19/3_18%20Telemed%20Guidance%20Updated%20March%2018.pdf?ver=2020-03-18-215407-857</p>

	<p>note in the patient’s medical record when this information was provided and make the record available to employees of the board of nursing or state medical board on their request.</p> <p>If the prescriber is not a qualifying practitioner and the patient’s choice is opioid treatment and the prescriber determines that such treatment is clinically appropriate and meets generally accepted standards of medicine, the prescriber shall refer the patient to an opioid treatment program licensed under section 5119.37 of the Revised Code or a qualifying practitioner. The prescriber or the prescriber’s delegate shall make a notation in the patient’s medical record naming the program or practitioner to whom the patient was referred and specifying when the referral was made.</p> <p>Source: Sec. 3719.064 http://codes.ohio.gov/orc/3719.064v1</p> <p>OAC Sec. 4731-33-03 has very detailed instructions on how to deliver MAT and prescribe opioids for MAT. They state a physical exam needs to be conducted but don’t specify whether that can be done over telehealth. There are requirements to “see” the provider frequently after getting a prescription, which seems like telehealth would be useful for. There are also specific instructions for the use of naltrexone in MAT as well in OAC 4731-33-04. http://codes.ohio.gov/oac/4731-33-03v1</p>	
<p><i>Are there telehealth practice standards for specific professions that may be delivering MAT/Behavioral Health Standards?</i></p>	<p>N/A</p>	
<p><i>Other</i></p>	<p>FQHC Letter has special billing instructions.</p>	

	<p>https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/NonInst/MAL635.pdf</p> <p>State has liability insurance reimbursement program for eligible FQHCs. Doesn't specify whether there are restrictions for telehealth. (Source: FQHC Letter)</p>
<i>Issues flagged by Interviewees</i>	<ul style="list-style-type: none"> • They really feel that admin code 4731-33-03 is restricting – Isn't up for review until 2024. It would require legislation to address before then. • Ability for FQHCs to use telehealth was very limited until policy change in July 2019. Now they can, but there is an education issue. • They don't see other issues for FQHCs, such as definition of a visit being face-to-face (since Medicaid only covers live video anyway), or establishment of a patient relationship. They said that they were at first concerned about FTCA and "scope of service" changes but they now feel like they are much more comfortable with it and know what to do. • For same day visits, they mentioned that in Ohio a patient can have a medical (which includes psychiatry) and counseling visit on the same day, so they don't feel like same day visits are an issue.

Pennsylvania

Topic	Pre-Coronavirus Permanent Policy	Post-Coronavirus Policy
<i>Telehealth Modality Allowed for FQHCs in Medicaid</i>	<p>Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services.</p> <p>The Pennsylvania Medical Assistance Program provides reimbursement for live-video under some circumstances. There is no reimbursement available for store-and-forward or remote patient monitoring. https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/d_005993.pdf</p> <p>"Telehealth" in this bulletin refers to the delivery of compensable behavioral health services at a distance using real-time, two-way interactive audio-video transmission. The site at which an individual receives behavioral health services using telehealth is the "originating site." The site at which a practitioner delivers behavioral health services using telehealth is the "distant site."</p>	<p>During this state of emergency, telephone only services may be utilized in situations where video technology is not available.</p> <p>https://www.dhs.pa.gov/providers/Providers/Documents/Coronavirus%202020/COVID-19%20Telemedicine%20Guidance%20Quick%20Tip%20.pdf</p> <p>During this state of emergency telehealth will allow the use of telephonic video technology commonly available on smart phones and other electronic devices. In addition, telephone only services may be utilized in situations where video technology is not available. https://www.dos.pa.gov/ProfessionalLicensing/Documents/OMHSAS-COVID-19-Telehealth-Expansion.pdf</p>

	<p>The Pennsylvania Medical Assistance Program provides reimbursement for live-video under some circumstances. There is no reimbursement available for store-and-forward or remote patient monitoring.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/d_005993.pdf</p>	
<p><i>Definition of a visit.</i></p>	<p>They define an “encounter” instead of visit.</p> <p>An encounter is a face-to-face contact between a patient and the physician, dentist or mid-level practitioner who exercises independent judgment in the provision of health care services. They have different kinds of encounters depending on the personnel, (Physician, Mid-level practitioner, telepsych, dental).</p> <p>A telepsych encounter is a real-time, two-way interactive audio-video transmission between a patient and only the FQHC/RHC psychiatrist or psychologist, who is licensed by the Commonwealth of Pennsylvania to provide mental health services. A telepsych encounter is only payable under the Behavioral Health Managed Care delivery system. To meet the encounter criterion for independent judgment, the physician, dentist, nurse or mid-level practitioner must act independently and not assist another practitioner.</p> <p>https://www.dhs.pa.gov/providers/PROMISE_Guides/Documents/appendix%20E.pdf</p>	
<p><i>Who are eligible distant site providers? Is an FQHC included? And do they get the PPS rate?</i></p>	<ul style="list-style-type: none"> • Physicians • Certified registered nurse practitioners • Certified nurse midwives • Providers under a managed care system should contact the appropriate managed care organization. <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/d_005993.pdf</p> <p>In the FFS delivery system, psychiatrists, psychologists, CRNPs and PAs certified in mental health, LCSWs, LPCs, and LMFTs can provide services using telehealth in Psychiatric Outpatient Clinics, Psychiatric Partial</p>	<p>The service is rendered by one of the following provider types:</p> <ul style="list-style-type: none"> • 01: Inpatient Facility – ONLY for Specialty Code 183 (Hospital Based Medical Clinic) • 08: Clinic • 09: Certified Registered Nurse – ONLY for Specialty Code 093 (Nurse Practitioner (Primary Care)) • 17: Therapist – ONLY for Specialty Codes 176 (Physical Therapy/Early Intervention), 177 (Occupational Therapy/Early Intervention), and

	<p>Hospitalization Programs, and Drug & Alcohol Outpatient Clinics. BH-MCOs may allow additional provider settings to utilize telehealth.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MHSAS/Final%20-%20MHSAS%20Telehealth%20Bulletin%2020.20.20.pdf</p> <p>Interviewees indicated that FQHCs were allowed to employ the psychiatrist delivering services. It's considered an encounter, so they get their PPS rate.</p>	<p>178 (Speech/Hearing Therapy/Early Intervention). Guidance issued by the Office of Child Development and Early Learning applies to these provider specialty types and may include requirements in addition to those included in this Quick Tip.</p> <ul style="list-style-type: none"> • 31: Physician (Physician's Assistants may provide services under the usual direction of their supervising physician) • 33: Certified Nurse Midwife <p>https://www.dhs.pa.gov/providers/Providers/Document/Coronavirus%202020/COVID-19%20Telemedicine%20Guidance%20Quick%20Tip%20.pdf</p> <p>The practitioner types that can provide services through telehealth will not be limited to psychiatrists, licensed psychologists, Certified Registered Nurse Practitioners and Physician Assistants certified in mental health; Licensed Clinical Social Workers; Licensed Professional Counselors; and Licensed Marriage and Family Therapists. Other individuals providing necessary behavioral health services will be permitted to utilize telehealth for services that are within their scope of practice.</p> <p>The provider types that can bill for telehealth under MA FFS will not be restricted to Psychiatric Outpatient Clinics, Psychiatric Partial Hospitalization Programs, and Drug & Alcohol Outpatient Clinics. When completing the Attestation Form (Appendix B), the "Other" Field (section I.a.) is not limited to HealthChoices during this state of emergency. BH-MCOs may continue to allow billing for any provider type they determine appropriate.</p>
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<p><i>Is an FQHC an eligible originating site? And do they get a facility fee?</i></p>	<p>Interviewees indicated that FQHCs were allowed to be originating sites.</p> <p>A patient is allowed to access a telemedicine consultation at any enrolled office of the referring provider or any other participating physicians, certified registered nurse practitioner, or certified nurse midwife. https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/d_005993.pdf</p> <p>Telehealth cannot be utilized to deliver services to individuals in their homes, unless services are being delivered as part of Assertive Community Treatment (ACT), Dual Diagnosis Treatment Team (DDTT), or Mobile Mental Health Treatment (MMHT) services and only if staff trained in the use of the telehealth equipment and protocols to provide operating support and staff trained to provide in-person clinical intervention are present.</p> <p>Providers seeking to provide behavioral health services using telehealth should complete and submit Attachment B, “Telehealth Attestation Form” to the electronic resource account RAPWTBHS@pa.gov and to the appropriate OMHSAS Field Office. Upon receipt of the attestation form, OMHSAS will review the form for completeness and inform the provider whether it is approved to utilize telehealth based on the assurances made in the attestation form. An updated attestation form must be submitted when any of the information provided in the attestation form is changed, including the addition of a new service location as an originating site. https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMHSAS/Final%20-%20OMHSAS%20Telehealth%20Bulletin%202.20.20.pdf</p> <p>A patient is allowed to access a telemedicine consultation at any enrolled office of the referring provider or any other participating</p>	<p>https://www.dos.pa.gov/ProfessionalLicensing/Documents/OMHSAS-COVID-19-Telehealth-Expansion.pdf</p> <p>Medicaid will pay for services when a member is quarantined, or self isolated due to COVID-19. https://www.dhs.pa.gov/providers/Providers/Document/s/Coronavirus%202020/COVID-19%20Telemedicine%20Guidance%20Quick%20Tip%20.pdf</p> <p>Staff trained in the use of the telehealth equipment and protocols to provide operating support and staff trained to provide in-person clinical intervention will not be required to be present with the individual while they are receiving services.</p> <p>Provision of telehealth services in homes will not be limited to Assertive Community Treatment, Dual Diagnosis Treatment Team, or Mobile Mental Health Treatment. https://www.dos.pa.gov/ProfessionalLicensing/Documents/OMHSAS-COVID-19-Telehealth-Expansion.pdf</p>
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	<p>physicians, certified registered nurse practitioner, or certified nurse midwife.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/d_005993.pdf</p>	
<p><i>Services Allowed via telehealth?</i></p>	<p>Eligible Services: Lists CPT/HCPCS codes, mostly general office visits. Nothing specific to MAT or SUD.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/d_005994.pdf</p> <p><u>Eligible Services list:</u> https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MHSAS/Final%20-%20MHSAS%</p> <p>FQHC/RHC: Telepsych Encounter (applicable only to Behavioral Health Managed Care delivery system claims; telepsych encounters are not payable under the fee-for-service delivery system): Commonwealth of Pennsylvania and a patient, in which mental health services are provided through the use of approved electronic communication and information technologies to provide or support clinical psychiatric care at a distance. Qualifying telepsych services utilize real-time, two-way interactive audio-video transmission, and do not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a service recipient, or a consultation between two healthcare practitioners, although these activities may support the delivery of telepsych services. Telepsych services require service providers to have a service description approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) and deliverable through the managed care option.</p> <p>[Please note that the availability of telepsych services is limited to psychologists and psychiatrists only. Other professionals such as LCSWs may not provide services through the telepsych program.]</p>	<p>The services (procedure codes) that can be provided through telehealth under MA FFS will not be restricted to the procedure codes identified in Attachment A of the Bulletin OMHSAS-20-02. BH-MCOs already have the flexibility to do this.</p> <p>https://www.dos.pa.gov/ProfessionalLicensing/Documents/OMHSAS-COVID-19-Telehealth-Expansion.pdf</p> <p>Program requirements for the number or percentage of face-to-face contacts for various behavioral health services may be met with the use of telehealth.</p> <p>Program limits on the amount of service that can be provided through telehealth are temporarily suspended.</p> <p>https://www.dos.pa.gov/ProfessionalLicensing/Documents/OMHSAS-COVID-19-Telehealth-Expansion.pdf</p>

	<p>https://www.dhs.pa.gov/providers/PROMISe_Guides/Documents/appendix%20E.pdf</p>	
<p><i>Eligible Telehealth services/MAT covered?</i></p>	<p>Interviewees: MAT is not covered via telehealth, only telepsych.</p> <p>Generally, FQHCs can offer SUD/MAT services, just not through telehealth.</p> <p>http://www.pachc.org/Clinical-Quality/Substance-Use-Disorder</p> <p>KFF says PA covers Methadone, Bup and Naloxone (but dispensing is not covered through telehealth).</p> <p>https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/</p>	
<p><i>Licensing for SUD or mental health services</i></p>	<p>Interview: To provide telepsych, need approval to provide services, need support from county, need support from MCO in the county, need to submit a letter to state from county, takes a few months and it's a county-by-county process. Used to only allow for telepsych, but as of Feb. 20, now allowing for more practitioners, including certified nurse practitioners and PAs.</p> <p>Providers seeking to provide behavioral health services using telehealth should complete and submit Attachment B, "Telehealth Attestation Form" to the electronic resource account RAPWTBHS@pa.gov and to the appropriate OMHSAS Field Office. Upon receipt of the attestation form, OMHSAS will review the form for completeness and inform the provider whether it is approved to utilize telehealth based on the assurances made in the attestation form. An updated attestation form must be submitted when any of the information provided in the attestation form is changed, including the addition of a new service location as an originating site.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMHSAS/Final%20-%20OMHSAS%20Telehealth%20Bulletin%202.20.20.pdf</p> <p>Telepsych services delivered in FQHCs and RHCs require providers to have a service description approved by the Office of Mental Health and</p>	<p>Providers that are currently approved to provide services through telehealth technology may immediately begin to implement the expanded use of telehealth. Providers that are not currently approved to provide services through telehealth technology may immediately begin to implement the use of telehealth; however, new providers are still required to submit the Attestation Form as required by Bulletin OMHSAS-20-02. The Attestation Form must be submitted within 5 business days of initiating telehealth. When submitting an attestation to RA-PWTBHS@pa.gov for the COVID-19 state of emergency, please identify in the subject line "COVID-19 Emergency".</p> <p>https://www.dos.pa.gov/ProfessionalLicensing/Documents/OMHSAS-COVID-19-Telehealth-Expansion.pdf</p>

	<p>Substance Abuse Services and the service must be deliverable through the managed care option. Telepsych services are limited to psychologists and psychiatrists.</p> <p>https://www.dhs.pa.gov/providers/PROMISE_Guides/Documents/appendix%20E.pdf</p>	
<i>Specific requirements for in-person services</i>	<p>Telepsychiatry is the only service allowed, no other limitations.</p>	
<i>Same Day Billing</i>	<p>Services are limited by encounter type (physician, mid-level, telepsych, dental). FQHCs/RHCs may bill for more than one encounter (such as a medical encounter, and a dental encounter) for the same patient on the same day. Additional other health encounters may be billed with the applicable type of service; however, medical necessity for the billing of such multiple encounters on the same day must be fully documented (including the time individually spent with the patient during each encounter) and justified in the patient’s record. Medical necessity for multiple daily encounters is verified by periodic site audit, and must meet the federal standard mandated at 42 CFR §405.2463.</p> <p>https://www.dhs.pa.gov/providers/PROMISE_Guides/Documents/appendix%20E.pdf</p> <p>RHCs and FQHCs may report only one encounter per patient, per day. Clinics may not report a medical services encounter (physician, CRNP/CRNA, midwife, other nurse, psychologist or physician assistant) and a family planning encounter or EPSDT screen encounter for the same patient on the same day. Clinics may not report a dentist encounter and a dental hygienist encounter for the same patient on the same day. A PHDHP or a dental hygienist is credited with an encounter only when (s)he provides services independently, not jointly with a dentist.</p> <p>https://www.dhs.pa.gov/providers/PROMISE_Guides/Documents/appendix%20E.pdf</p>	

	<p>Also addresses issue here: http://www.pachc.org/Portals/71/Docs/UPDATED%20FQHC%20RHC%20FAQs.pdf</p>	
<i>Informed Consent</i>	<p>Prior to utilizing telehealth, providers must obtain the consent of the individual to receive services utilizing telehealth. The individual must be informed of all persons who will be present at each end of the transmission and the role of each person. Individuals may refuse services delivered through telehealth. Providers cannot use such refusal as a basis to limit the individual's access to services delivered face to face.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MHSAS/Final%20-%20MHSAS%20Telehealth%20Bulletin%202.20.20.pdf</p>	
<i>General Prescribing Requirements/Establishing Physician-Patient Relationship</i>	<p>A practitioner may prescribe, administer, or dispense a controlled substance or other drug or device only (i) in good faith in the course of his professional practice, (ii) within the scope of the patient relationship, and (iii) in accordance with treatment principles accepted by a responsible segment of the medical profession. A practitioner may cause a controlled substance, other drug or device or drug to be administered by a professional assistant under his direction and supervision.</p> <p>35 PS Sec. 780-111</p>	
<i>Prescribing Controlled Substances? MAT Substances?</i>	<p>The have a controlled Substance Act but it doesn't address telehealth and there is nothing in it that prohibits use of telehealth.</p> <p>In 2019 2 bills (HB 1358 and SB 675) were introduced on MAT and prescribing buprenorphine but neither have passed.</p>	
<i>Are there telehealth practice standards for specific professions that may be delivering</i>		<p>"Telemedicine provides health care professionals flexibility to continue treating their patients while following best practices on social distancing as outlined by the Department of Health," Secretary Boockvar said. "The department requested, and Governor Wolf granted us, the authority to allow health care professionals from</p>

<p><i>MAT/Behavioral Health Standards?</i></p>		<p>out-of-state to treat Pennsylvania residents using telemedicine, when appropriate, due to COVID-19."</p> <p>This new guidance applies to the following boards:</p> <ul style="list-style-type: none"> • Chiropractic • Dentistry • Medicine • Nursing • Optometry • Pharmacy • Podiatry • Psychology • Osteopathic Medicine • Nursing Home Administrators • Occupational Therapy Education and Licensure • Physical Therapy • Social Workers, Marriage and Family Therapists, and Professional Counselors • Examiners in Speech-Language Pathology and Audiology • Veterinary Medicine <p>https://www.media.pa.gov/Pages/State-Details.aspx?newsid=375</p>
<p><i>Other</i></p>	<p>Services should be rendered face-to-face whenever practical and appropriate. Providers may consider if the recipient must travel more than 60 minutes in a rural area or 30 minutes in an urban area.</p> <p>https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_005993.pdf</p> <p>the FQHC/RHC shall not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may suggest the services of another clinic provider or practitioner; automatic referrals between providers continue to be prohibited (Chapter 1101.51).</p> <p>https://www.dhs.pa.gov/providers/PROMISE_Guides/Documents/appendix%20E.pdf</p>	

	<p>COE coordinate care through community-based care management team. They can bill Medicaid for that with certain codes. https://www.dhs.pa.gov/about/Documents/Find%20COEs/c_291268.pdf https://www.pa.gov/guides/opioid-epidemic/ COEs: https://www.dhs.pa.gov/Services/Assistance/Pages/Centers-of-Excellence.aspx</p>
<p><i>Issues flagged by Interviewees</i></p>	<ul style="list-style-type: none"> • Worried about FTCA if the patient isn't coming into health center. • Don't have hesitation from patients, only due to insurance coverage. Stigma of going into office is removed with telehealth. • But worried about the cost of equipment, although use of Zoom (HIPAA compliant version) has expanded access. • Training staff is an issue because they are not trained how to deal with mental health disorder patients. • No issues with broadband. • They focus on prevention, rather than providing MAT. They are fine with being originating sites, but their providers don't want to be trained to prescribe MAT. Don't feel comfortable with it. • Need clarification on Ryan Haight Act – PA PCA • Medicaid reimbursement for Full range of MAT through telehealth. – PA PCA • Broader high speed internet coverage – PA PCA