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ARI TELISMAN:
Hello, my name is Aria and I'm the coordinator for national telehealth resource centres. Today's event is Reimagining Reimbursements: Planning for Sustainability for Telehealth Practice. These are hosted by telehealth resource Centre. This is to guide the telehealth support programs, presented on the third Thursday of each month.

Just some background on the Consortium, located around the country there are 12 regional telehealth resource centres, and to national. One focused on policy and one on technology. These are to support telehealth, and help access support in communities.

A few tips before we get started, your audio has been muted. Please use the zoom Q&A to ask questions, these will be presented at the end of the presentation. Please note that close captioning is available and located at the bottom of your screen. Today's webinar is rerecorded and you can access today's, and past webinars on the YouTube channel. With that I will pass it over to Molly Brown, the director of telehealth resource Centre.

Molly, I think you are still muted.

MOLLY BROWN:
Thank you Aria, and welcome everyone to today's presentation. I would like to introduce today's present are today. Richelle Marting is an attorney, registered health information administrator, and certified coder who
focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder,
hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group.
As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations. Important to today’s topic, Richelle successfully assists providers with third party commercial payor audits and has a strong

track record of drastic reductions in alleged overpayments.

I'm happy to turn it over to Richelle.

RICHELLE MARTING:
We go to the
please?
. Thank you, it's a pleasure to talk to you today about sustainability. Along that line I always like to start

 

up presentations with any new, or emerging updates of telehealth, legislation, or coding changes. If you have been tracking telehealth and coding, and billing, and policy in your areas then you know there has been no shortage of those changes in the last couple years.

So, one that I wanted to share with you just as an opening update is a part of the session, just to illustrate what is happening right now at the federal level is just recently, back in July, at the end of July 28. The house just passed a bill, and again, this is just a bill it is not been finalized or passed into law yet. It is at the Senate waiting to be heard and passed -- that would extend a lot of the telehealth flexibilities that we have come to appreciate and use during the public health emergency, through December 31, 2024. So, it is just an illustration of some things that are going on rapidly, potentially changing the kinds of telehealth services that we can provide, the waiver provided, how we get pay for them, and how long, especially as we look forward to potentially knock on wood, hopefully at some point lying down the public health emergency. Next slide, please.

I want to talk to today, in terms of planning the sustainability and the delivery of telehealth services. The first thing I think of is financial sustainability. We cannot continue to offer the services if we cannot find a way to pay for them, meaning to have the resources and technology and resources, and staffing resources to provide the services. So, I want to talk just a little bit about what the telehealth landscape was, in terms of restrictions under the Medicare program, and the way telehealth was delivered in the pre-COVID era, which now I think of as an entire era prior to the announcement of the federal public health emergency. I then want to look at, just at a very high level, a summary of the types of flexibilities that were made available to providers, and patients, during the federal public health emergency with respect to telehealth.

The way could be delivered, who can provide the telehealth services, and how it was built and paid during the public health emergency. As a part of that we have a case study to show with you on a behavioural health provider, and what they were particular health environment looked at pre-, and during the COVID public health emergency, as well as what they are doing looking forward to plan for some of the changes that may come about as public health emergency ends. So, as we look at a case study we will look a bit of tips on what you can do. If you're thinking long term, what factors you can take into consideration to make telehealth delivery sustainable, primarily sustainable financially, based on what we know what will happen after the public health emergency ends. Next slide, please.

I will start with what telehealth looked like pre-COVID, and I focus on the Medicare rules as a national basis. Obviously every state has different rules and policies under the state Medicaid programs for the way telehealth is delivered. Even outside of Medicaid, commercial payers and individual help plans varied significantly on how they handled telehealth payments for services. My purpose today is to focus on the national Medicare standard so you can see how much changed over the last couple of years, and before the federal public health emergency was announced we had telehealth services as a covered, and payable benefit under the Medicaid program. But, there were a lot of restrictions that made that delivery very complicated, and specifically restricted access to telehealth services and limited who can provide, and who can build for telehealth services. So, in the next couple of slides - we can go to the next slide, we will look at what the restrictions were.

 

There were geographic restrictions. What I mean by this is by the Social Security act passed by Congress, Medicare was prohibited from covering telehealth services outside of these geographic restrictions. They do not have the flexibility through rulemaking to make exceptions. There is very limited circumstances. So, for the vast majority of telehealth services to Medicare beneficiaries the patient had to be geographically located in a rural healthcare perverted shortage area, or in a county that was outside of a metropolitan statistical area. That is just a high-level review. There is very specific criteria and primary motors that determine whether or not the patient's location would fit in the geographic restrictions. That is the geography and limitations we were working under.

Prior to the public health emergency there was a site of services and what I mean by that is the patient had to be located at an eligible, originating site. The patient in general had to present to a provider office, to a hospital, 28 health clinic orc UHC, with very, very limited exception the patient could not be at home for telehealth service to be delivered and paid for by Medicare. There were some very, very narrow exceptions, but for the most part, even in rural health care provider shortages and counties outside of Metropolitan statistical areas the patients physically had to present these types of healthcare locations to have a telehealth care service delivered, and a distant site provider was kind of promoting in to render that telehealth service to the patient. Next slide please.

In terms of the distant site provider, the professional that is actually seeing the patient in a telehealth format, that was also limited and the way that that language was worded under the Social Security act was that it had to be a physician or a practitioner, delivering a healthcare service. The definition of physician practitioners of course were MD, and DO, physician assistants, nurse practitioners, but what you don't see on this list are physical therapists, occupational therapists, PT, OT, ST, speech language pathologist, and people who could build Medicare for their services but are not eligible to provide telehealth services.

-- Telehealth service would only be paid by healthcare services if it was real-time, not emails that were asynchronous, but two-way audiovisual committee Kate in. That last piece was also a significant limitation because if you think of A/V, we cannot have an audio only service. A telephone call would not count. The telehealth, would not count. In rural areas, the bandwidth and technology regarding both the audiovisual component was very challenging. In some places it was not technologically feasible to have enough bandwidth to do a video component of a telehealth service. Next slide please.

So, then we enter the COVID public health emergency era, around March 2020, and we have a number of flex abilities and waivers that kind of fixed, so to speak some of the restrictions, and made telehealth more accessible. The flexibilities that Medicare started to implement, really had the goal, the pulsing purpose of trying to achieve increased access to healthcare services during that time, decrease unnecessary exposure between individuals.

So certainly from infection control perspective, trying to reduce sick patient contact during that time. Also payments during which the payments were delivered, which was truly replacing what would've been a face-to-face, in person service. Next slide, please.

So a lot of those challenging restrictions that we saw in the Medicare, telehealth policy prior to COVID

 

were lifted, and had been lifted and could be during the telehealth emergency declaration. One of those added a patient's home for an eligible originating site, which has been huge. This allows the patient to be seen from their home, or from their residence, rather than having to present physically to an eligible, originating site location. Remember these word locations like physician offices, hospitals, FTC ACs, or commuting mental health centres. So, achieving that goal of trying to reduce in person contact, Medicare was allowed to make it a eligible originating site for all telehealth services. It also limited the requirement that the patient be in a rural geographic location. That is a healthcare provider shortage area, or an area or County outside about your politics statistical area,

That may telehealth available to urban and suburban communities that never had access to telehealth services to Medicare before, because of the geographical requirements. I just saw a report from the staff General on telehealth, on metropolitan areas that were more likely to use telehealth services in rural areas during the public health's urgency. It broadened what services can be rendered as a telehealth service. One of these restrictions that I should have mentioned, that continues now as there is a list of codes, billing codes that Medicare will cover when they are delivered as a telehealth service. That list grew by multiples in a telehealth emergency, it allowed a lot of services via telehealth that otherwise Medicare would require in person visits for those billing codes and services. Medicare also expanded the list of providers who can serve as the distant site provider of services. Remember the list of services and practitioners that did not include the therapy of PT and OT speech pathologist. Medicare meeting so that any provider or professional enrolled in the Medicare program and could bill for professional services could provide telehealth with the practice so as that all the other health requirements were met. That was another huge expansion, and a particularly in rural areas, one of the benefits allowed health centres and critical addict tests hospital allowed billing of telehealth services to be taken as a averaging – still original care provider. The issue during our call would waivers that we had. Here half Medicare also made flexible the A/V to wait time also, now in a critical access are -- certain interactive munication), analog services and to be fair and go to the link here on the Medicare website. You'll see a telehealth emergency code and a yes or no as to whether that individual service was allowed to be rendered as a audio only service during the public health emergency.

Another great benefit during the public health emergency was a flexibility in the provider supervision rate requirements. We have clinical staff or people that would typically be billing for patients under the name of a physician or nurse practitioner. Medicare calls that incident to billing. I think of it in a offing setting is a blood pressure check, or checking with the patient on anticoagulation management, if they're having any adequate symptoms of quite Galatian therapy. Those services might be done with a registered nurse, build under their number -- and apply to a physician. When that happens in a normal environment the supervising provider has to provide what they call direct supervision. That the physically be in the office suite where that ancillary optical staff person like a registered nurse is located. And be able to meet with that person in face-to-face service. So, turn COVID when we had these telehealth flexibilities Medicare decided that that direct supervision requirement doesn't really fit telehealth. We may need a physician who needs to be at home quarantining because of a exposure to a positive COVID test. Otherwise it was well enough to be able to for supervisor be. We need that available during telehealth services. So, during the telehealth (indiscernible) we had virtual presence, during the supervision.

 

This means, as long as they are able to intervene during the telehealth session then that was enough to qualify -- satisfy the supervision requirements.

(audio issues)

So, I'm giving you a background on the provider, who they are and what they do. I think their care model is very interesting. They are provider group that specializes on mental and behavioural health. So, they would have professionals like psychologists, psychiatrists, social workers, etc. available to help, primarily adults and seniors, individuals who may be on Medicare. Even more special, they focus on providing that mental and behavioural health expertise to skilled their facilities and long-term care environments. Those nursing communities or long-term-care communities may have medical directors or a group of physicians, nurse practitioners typically in general practice or internal medicine to come in and see their patients as the attending physician of the patient during their stay, though who may not have the specialist expertise in dementia, and other health issues, during COVID-19. This was especially That was filled.

They would provide behavioural and mental health services for those in a long-term care community. Now, they are contracted by the community. They are not employed by the long-term-care communities.

Next slide, please. Prior to the COVID public health emergency, their care model by and large, as many of the care models were face-to-face. They did very little telehealth, unless it was a urgent, cute, or emergent exacerbation of a conditional, where they needed access quickly to a healthcare provider. In terms of the healthcare provider, was not in a geographic area. This group may not have been able to receive compensation for the telehealth visit, trying to keep the patient out of a transfer of an acute care facility, and try to manage that emergent, or urgent exacerbation there within the community.

So, they would primarily physically go on site, see the residents in the long-term care community, work with the physicians and interdisciplinary groups within the communities on the patient's mental and behavioural healthcare needs. Everything from depression screening to medication management, and other coordination within the community.

So, the disadvantage of that is requiring extra time, labour, resources for those healthcare officials to physically travel to a number of different lawnchair care communities, within their geographic reach, certainly reducing the individuals they could serve because the travel time. Again, telehealth pre-COVID was limited -- I should say payment was limited to individuals and facilities that were in rural and geographic areas.

At the facility itself, if a telehealth, as it was rendered was more the exception than the norm, that it was the facility staff like a nurse aide, or --
access to long-term care communities were significantly omitted at the time. They went through emergencies, and access that was not necessarily was restricted, even to these third-party providers. This mental, behavioural healthcare group then was at the mercy of each individual facility and what they were allowing in terms of, I wouldn't call them visitors, but not employed care staff, coming into

 

the community and having access to their employees, to their resident, in an effort to reduce contacts and try to control spread of the virus. The clinicians themselves, within this mental and behavioural healthcare group are actually reluctant to go into long-term care communities because of the perceived risk, increased risk of an spread of inspection, contained in that facility environment. At the same time, and we know this is still an issue it several years later, the staffing levels were severely strained, reducing the ability for nursing staff to present these patients to the Bayview health group in order to render a telehealth service.

This allowed reimbursement opportunities in the mental healthcare space.. This was available outside of the public health emergencies, but because of COVID, the challenges and access to the residents and communities made them think about what service options were currently out there to enable them to see patients with access to the conditions they were working under, continue a good quality of care. This allows you to pay attention to the patients and their needs, assisting the model, if you will.

One of two of the programs were already options already outside of the COVID health emergency, and they were program similar to what you may have seen called chronic care management under the Medicare program. Under the last several years Medicare is taken that concept and manage patients chronic conditions in a way that is not necessarily a direct, face-to-face service, but it is also not a telehealth service because there is not audiovisual to weigh in real time, it's more behind-the-scenes management of the patient's care plan and management of the patients.

Medicare has expanded this to the mental and behavioural health world to create behavioural health education, and psychiatric care where your providers just like this provide a groupware of expertise and experience, specifically on mental and behavioural health conditions, and coordinate that component with the patient's care with medical providers that are handling other medical conditions, chronic or acute for the patient. There are separate billing codes for behavioural health and psychiatric collaborative care.

These are non-face-to-face which is exactly what the provider group needed because they are face-to-face, in person access was specifically restricted. The group created what they call a social worker liaison which would go into the community to alleviate that burden on the facility staff that were doing everything they could with the resources they had to take care of the patients at that time.

So to alleviate that burden and not acquire the CAA to see the patient. British social worker liaison to present the patient with that psychologist or psychiatrist or any mental health behavioural professional. The social worker was kind of the mental and behavioural health eyes and ears, releasing the patient in person, real-time and could also help with the site provider and go back to the facility staff in life, real-time coordinate with the clinical staff with physicians and practitioners to best manage the Baytril health component at that patient's care.

So, they are really the eyes and ears of that patient, the training that can add enhanced value to the telehealth services. Next slide, please. So, the results that they saw as they adapted to the telehealth flexibilities, the ability to see patients outside of geographic areas, to have social workers and other staff who would typically not be able to render a telehealth service under normal rules, but broadened

 

flexibilities were able to do that, on top of creating a more comprehensive behavioural health integration care model, based on existing Medicare programs that are available, even before the COVID public health emergency came about. They saw some great benefits for the care that they are able to provide for patients. Decreased visit wait times, which is twofold. First, decrease time to actually have a visit with a provider when you have any. If you call your healthcare provider today you might get in next week, it might be a couple weeks, it might be a couple of months, but because the providers were not physically travelling to all of the locations, that travel time was saved and they could see more patients in a day, without compromising the quality of care. So, that allowed patients to get scheduled quicker, when they are starting to have exhibiting behaviours or some signs that medications were not more properly or adequately manage. Get in with a healthcare provider that specializes in mental and behavioural health to intervene quicker, before they become more severe problems. The triggered -- trickle-down effect of that is to reduce visits to the care facility, and areas. Better coordination of care so that the on-site social worker liaison is really there to talk to the facility staff, rather than simply have the distant site provider add a report to the chart, there is a conversation happening with the behavioural mental health provider and the facility staff, right after the telehealth visit. Those interventions can go into effect immediately. Patients were happier, because they could get a visit with mental, behavioural health providers quicker, with specialized providers, their needs are managed quicker, the signs and symptoms are managed quicker, and as a part of a fuzzy patient status factor, during the time that the facilities were locked down there is not a lot of visitors that are coming into the long-term care communities. It was another opportunity, not for socialization, but human interaction between that resident and a healthcare provider that is in the outside world, outside of the long-term care community.

By doing this and looking at existing care models, like behavioural healthcare intervention, psychiatric collaboration, working it into the telehealth visits, this provider group developed a model that will be sustainable after the public health emergency ends because those codes and services will continue to be available, even after the flexibilities from the public health emergency, with respect to telehealth go away. Now what they're looking at could be a telehealth emergency incorporating all those concepts. Be able to go back into the community's in person to have the visits face-to-face with the patient when that is needed and appropriate, but also having available telehealth services, and this comprehensive, chronic care behavioural health integration model that can go on behind the scenes and address conditions. And all of the conditions that could be able to manage.

Next slide please. So, with that example we want to talk a little bit about the path moving forward, things that are happening at the federal level. If you're looking what you can do, similar to the behaviour healthcare group to make tele-healthcare services and financially stable. We will talk about tips to do that.

I strongly encourage you to go to this exercise that they's provided date, and look at the coding and billing at the payment options under Medicare under your commercial payment agreements, under your state Medicare program to see what's already out there. And we have not been fully tapping into. Chronic care management, whether or not that is a behavioural healthcare management, or just regular chronic care management and other non-face-to-face services. If you are looking for that, a good search term to use is care management services under the Medicare program. It's another

 

benefit, a whole group of services that are not telehealth, but also not in person face-to-face services. These services can be provided to patients, and between those visits to manage the behind-the-scenes. A lot of these are available and options that you can consider. Many times when I talk to providers they say, "I am already doing a lot of those things. We may need to add a few workflows, improve our documentation to support that particular billing code, but we are doing a lot of that were already. So let's captured in an organized program and be reimbursed by the and if it's the program already offers."

I encourage you to take a look at what you've done during the COVID public health emergency. What changes have been made, and which of those changes have been based on flexibilities under the public health emergency?

An example of that is practices that have adopted a flexible work model for nurses, allowing them to flex at work from home periodically because they cannot have telehealth visits with patients. Right now it could potentially be a covered telehealth benefit assuming that you have an appropriate level of provider supervision. Some of those models may be going away when there are -- particularly on-site direct supervision with that provider if that flexibility goes away. Based on what we are seeing in the Medicare proposals right now, the plan is for that virtual present supervision to go away.

At the same time, be aware that there are a lot of legislative changes happening at the state and federal level, trying to take these flexibilities and make them permanent or at the very minimal, extend them.

Around March 29, so part of the annual consolidation appropriation act, we had Congress extend a lot of telehealth services, not all of them, for an additional calendar year. This is a lot of flexibility to give us time for hundred and 51 days after the public health emergency ends, a lot of those flexibilities will continue to be in effect. So, every 90 days when the PHE renewal comes up we are watching and waiting to see if it gets renewed because we know that that gives us 90 days of the next renewal and then 150 days afterwards.

So we still have to certain telephone call with flex abilities in place. And as I mentioned in late summer and Jalal had another bill passes, which is yet to be heard in the Senate that if it were passed by the Senate, and became law, it would extend many of those telehealth flexibilities, even further through the end of 2024. So, that is one that we want to be watching for the end of this year. We have many state bills and flexibilities, and waivers happening with respect to provider licensing and Medicare coverage of telehealth service, and state legislators changing the way telehealth is defined under their state laws also. We are seeing states enact restrictions on the big national telehealth groups, and whether they can provide telehealth services to individuals in the state, and if so how.

Lots of changes are happening on a regular basis, so understanding what changes, flexibility and rules you are currently operating under, and understand which of those flexibilities may go away to impact your model will be very important..

Understand too, we are on a ticking time or the day that the federal public health emergency ends. For

 

example, one of those is leased as we sit today, and the rules we are working with today, it is critical access hospitals would no longer be able to serve as distant site providers of telehealth services under the Medicare program. That goes the way the day the public health emergency ends. There are other flexibilities that would continue to be available like the patient's home as an eligible originating site that would continue to be available for 151 days after the public health emergency ends. So, know when those flex abilities go away from you and being able to pivot and shift in time when they do go away to accommodate whatever the rules for telehealth are at that point in time will be important. I cannot emphasize enough keeping an eye on legislation, whether that is through your local telehealth resource Centre. I subscribe to legislative updates in the different states that I work in so I get notices when there are statutory or regulatory change in prayer. So, Medicaid program updates so you can save to look at telehealth updates, and the weekly contracts. I've been seeing more of those in our geographic area for commercial payers changing their telehealth policy, or may be rolling back some of the cost-sharing waivers for telehealth services that had been in effect during the COVID health public emergency. We are also seeing a lot of changes in the way that telehealth services are actually coded and build when you are submitting this for reimbursement. So, there will be no shortage I think of changes in the telehealth world with respect and how they are delivered, the way they are coded and reported and ultimately how they get paid over the next couple of years. So, keep your eyes and ears on it I think it will be a challenging, but an exciting time in the world for telehealth moving forward. Next slide please.

MOLLY BROWN:
Thank you so much, that we have time for questions. You can type questions in the Q&A box. We had one that I indicated when you are finished, we had a participant I was wondering if you could clarify the name of the bill that does extend flexibility to December 2024, possibly were to also find it.

RICHELLE MARTING:
Sure, I think have a leak on the slides here. I think we are sending the slides to those attending, if we are not I can go back to that, I think third slide in the deck if we can navigate to that one.

There we go.

MOLLY BROWN:
Yes, I see it, the link at the bottom. We can coordinate with Aria to see if this can get sent out.

RICHELLE MARTING:
When we are on the topic, if you click the link here will do two things. It will take you to the link of the text of the bill to take a look at, and it will also, something I think it is also interesting, there is a rules committee meeting discussing the bellwether to pass it, why or why not.

I think this conversation among Congress was very interesting. There's a lot of interest in making these provisions permanent, but their hesitation to do that, they didn't feel like they had enough data yet, so I see this as sort of a bridge piece of legislation that while Congress studies in particular the program

 

integrity risks related to telehealth, there still a possibility that these flexibilities become permanent at some point. In the piece I think is important, it was passed by the house in July, so it was moved to the Senate to be considered.

The impression of this all kind of predicting at this point, the impression is that it is likely to wait after midterms to consider this bill, and whether or not to pass it or not. We are looking at a couple of months before we see action in one way or another.

MOLLY BROWN:
OK, so I have one comment that then leads into a question.

So one participant indicates that in their investigations they found that claims to bill for our providers time can be rejected by payers due to how provider roles are set up by NCOs, as CMS does not recognize pediatric emergency goals. They are requesting this be a telemedicine specialty code were each modifier can reimburse for a different specialty like that you one, you too for the 15199.

The question is, they're looking for suggestions on other mechanisms on state offices, where they have submitted several times these requests, as they are very overwhelmed to help adjust this problem. Do you have any other recommendations for shell to make suggestions to the code for adapting modifiers?

RICHELLE MARTING:
That's a great question, I want to make sure I am addressing the piece on claims to bill for the providers time. It could be rejected due to the specialty role, if I'm understanding that correctly. I take that to mean the specialty taxonomy that that invite -- provider is enrolled under the Medicare program and under the MCO, the Medicare advantage programs. So, correct me if I am understanding that incorrectly. I think that is a really good question.

This year in the Medicare physician schedule, the proposed rule that has not yet been finalized, but once finalized will going to the January 21, 2023 talks will provider specialties and how it impacts billing. Under the traditional service Medicare program, Medicare has a very limited number of specialties that they recognize on the providers 855 enrolment. I was working with an orthopedic group a few we weeks ago, and even among the orthopedic group there were subspecialties that Medicare simply doesn't recognize. So, I'm trying to read between the lines here, so if I misunderstand the quick please let me know when you have specialties, some specialties that are not recognized by the payor, those subspecialties can get denied or rejected, particularly when it is being reported on the same day, as another provider of the same primary specialty designation in the same group practice that is being rendered to that patient and reported to the payor. So, there are couple of things there.

One, at the beginning of the FR publication you can contact it with exactly these types of questions. I've had great luck with folks responding in the past, sometimes it takes a few days but I almost always get a response on those types of questions. The second thing I am thinking of, if I'm understanding that scenario correctly where there is a subspecialty of the provider's time, or billing code may get denied, because it is getting reported on the same day as the provider in the same specialty provider

 

of the practice for the NCO – rack when that happens and you have multiple providers you look at the Medicare provider guidelines in the manual and there are some conditions where you can combine time and work into determining the level of service. In some instances you may even have prolonged service or add-on codes that can potentially be available for combined work. Those would be the two suggestions at the top of my head you might look into.

MOLLY BROWN:
We have quite a few questions coming in, I will make this announcement for the greater good. We document these questions and what we can do is pose them to Rochelle after the seminar and she can answer them after the seminar if we can't get to it.

Another question is do you have after QC recommendations for telehealth and bullet still be at the reduced rate? Currently it is not the PPS rate.

RICHELLE MARTING:
I am needing some more information on this question, but the thing that comes to mind when it says reimbursement for telehealth, we may need some information on whether they are talking about the originating site for the F2 HC, which is not the tea – my great, it's what they're providing for the telehealth service and being rendered by a distanced site at a different location. If we were talking with the FQ HC distant site provider, now with the current flexibilities and as we stand today

I have to do some research on that to see where that reduction may be coming from.

MOLLY BROWN:
We have quite a few questions coming in and I'm trying to be mindful. Do you think they will extend the Q HC in October?

RICHELLE MARTING:
Oh gosh, I laugh at trying to predict because as Molly knows we have a session for HT RC last July, and all signs and indications pointed to me to one year renewal, and here we are still in the federal health emergency.

I will say, I don't know about October. I'm trying to think of the exact day in October. We should have 90 to 60 days in advance of this, prior to the expiration. So my inclination based on that it is likely to be renewed for another 90 day period. I'm saying that because although it is not binding, and HRS could preside -- decide to do anything different, they have made a commitment to try and let the states and others know, at least 60 days in advance to when they plan to let the public health emergency expire, for a lot of these reasons. There are still flexibilities the day that this will end, and they have been -- at the onset of the public health emergency we will know ahead of time what we need to renew it. They're making the decision pretty far in advance and at the last several times there is been an afternoon, or the date that it has been expired. It feels like a nailbiter that they announced that they are renewing it. So, because they have not made a notification of an attempt to allow it to expire by next month,

 

excuse me, my best guess would be that it is likely to renew in another 90 day period.

MOLLY BROWN:
Thank you. OK, it looks like we are getting towards the end and I will be turning it back toward Arianna. I will note that if you would like to continue the conversation, ask additional questions, you can email the Heartland Telehealth Resource Center at htrc@knuc.edu. It is on the screen now we do document all of the questions and we will be sending that to Rachelle will be helping send some helpful information and providing that the aria as a National Consortium for information as well. So, we will be working on this. Please be patient with us.

I will turn it over to aria, thank you again Michelle and as always, great job.

ARIA JAVIDAN:
Thank you, just as a reminder our next webinar will be Thursday, October 20, by the Southeast telehealth resource Centre. The website will have the information. We do ask you to complete the short survey in a few minutes that will pop up after the seminar. Your feedback is very valuable to us. Thank you to the heartland telehealth resource Centre, and Richelle Marting for hosting this seminar.

MOLLY BROWN:
Thank you, Richelle.

Live captioning by Ai-Media

 