Digital Peer Support

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http://digitalpeersupport.org/
Important Terms

- **Digital peer support**—live or automated peer support services delivered through technology media.

- **Telemental health**—remote services for many things such as mental health assessment, treatment, education, monitoring, collaboration, and peer support.

- **Telemedicine**—Remote service for one thing—clinical care
History of Digital Peer Support

2005 First peer-reviewed published article on digital support for mental health challenges (United States);

2008 First peer-reviewed published article for substance use challenges (Norway; United States);

2012 Digital peer support for mental health challenges expands to Australia;

2015 Digital peer support for substance use challenges expands to Australia;

2016 Digital peer support expands to Europe (Italy & Denmark [Mental Health], Russia [Substance Use]);

2017 Digital peer support expands to Asia (Japan);

2018 First older adult digital peer support program (PeerTECH);

2018 Digital peer support for substance use challenges expands to United Kingdom;

2020 Rapid use of digital peer support globally.

Peer Support Specialists are Developing Technology!

What We Know About Digital Peer Support

• No geographical or time limitations;
• Engages service users in digital mental health outside of clinical environments;
• Expands the reach of peer support services;
• Increases the impact of peer support without additional in-person sessions; and
• Can access hard-to-reach groups—rural residents, home-bound adults, etc.

Is Digital Peer Support Effective?

Digital peer support studies have established support for the feasibility, acceptability, and preliminary effectiveness with regard to:

- Enhancing hope, quality of life, empowerment, social support, and recovery;
- Enhancing functioning;
- Reducing symptoms; and
- Improving engagement in services.

Different Ways to Deliver Digital Peer Support

Peer-to-peer networks (i.e., informal groups like Facebook groups)

Peer-delivered programs supported with technology (i.e., trained peer support specialists that use smartphone apps or videoconferences to offer peer support)

Telephone or videos (i.e., synchronous technology and asynchronous technology)

Telephonic Peer Support

- One size does not fit all telephonic peer support is an option
  - Telephone calls and text messaging
- Mastery of new skills may take awhile and that’s OK!
- One-on-one in-person training is not available
Separating Your Work and Personal Life

- Digital peer support can be offered anytime/anywhere
  - May lead to more frequent and more casual interactions and behaviors.
Separate Your Work and Personal Life

1. Maintain Your Normal Hours and Normal Location
2. Ensure Timely and Consistent Feedback and Manage Excessive Communications
3. Ensure a Private, Consistent, Professional, and Culturally Sensitive Setting
4. When in doubt, talk to your supervisor
Checklist Before Each Meeting

✓ Are you dressed as you normally would for work?
Checklist **Before** Each Meeting

- Keep up to date with the latest advice on compliance/
- Is the technology working?
- Do you have everything you need in close proximity to you?
- Is background noise minimized?
- Do you have battery for your computer/smartphone/tablet or a charger near by?
Bonding and Connection through Technology

© Karen Fortuna
How can Peers Connect and Bond with Others Using Technology?

Let people get to know you….
How can Peers Connect and Bond with Others Using Technology?

Meet in real time...
How can Peers Connect and Bond with Others Using Technology?

Preference and availability matters…
Encourage People to Support Their Own Recovery

- Social media (Facebook, Twitch, TikTok)
- Online forums
- Video games
- Smartphone apps

*Doesn’t always have to be mental health or substance use related*
Checklist **After Each Meeting**

- Take care of yourself
- Know your impact
- Trust yourself, trust the process
Stay in Touch!

Contact us at:
http://digitalpeersupport.org/
Extending Telehealth Flexibilities Beyond the COVID-19 Pandemic
August 5, 2020

Stuart Yael Gordon, J.D., Senior Director of Policy and Communications
NASMHPD Leading Mental Health Liaison Group Charge on Making Telehealth Flexibilities Permanent

- In an interim final emergency rule, “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” (PHE) issued March 31 for the duration of the PHE for the COVID-19 pandemic, CMS permitted the use of telehealth in Medicare for the following services relevant to behavioral health:
  - Group Psychotherapy (CPT code 90853).
  - Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139).
  - Assessment and Care Planning for Patients with Cognitive Impairment (CPT code 99483).
  - Emergency Department (ED) Visits, Levels 1-5 (CPT codes 99281-99285).
  - Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224-99226; CPT codes 99234- 99236).
  - Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239).
  - Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316).
  - Critical Care Services (CPT codes 99291-99292).
  - Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337).
  - Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350).
  - Initial and Continuing Intensive Care Services (CPT code 99477- 994780).
  - Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507).
CMS issued 31 different healthcare-related waivers during the COVID-19 pandemic, including the following telehealth-related waivers:

- Effective for services starting March 6, 2020 and for the duration of the COVID-19 PHE, Medicare would make payment for Medicare telehealth services furnished to patients in broader circumstances.
- These visits would be considered the same as in-person visits and would be paid at the same rate as regular, in-person visits.
- Starting March 6, 2020 and for the duration of the COVID-19 PHE, Medicare would make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- Effective for services starting March 6, 2020 and for the duration of the COVID-19 PHE, Medicare would make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.
- To the extent the § 1135 PHE waiver requires an established relationship, HHS did not conduct audits to ensure that such a prior relationship existed for claims submitted during the PHE.
CMs issued 31 different healthcare-related waivers during the COVID-19 pandemic, including the following telehealth-related waivers:

- CMS waived the requirements of § 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2) of the Code of Federal Regulations which specify what types of practitioners may bill Medicare for their services when furnished as telehealth services from a distant site. The waiver of these requirements expanded the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services, including health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services.

- Pursuant to authority granted under the CARES Act, CMS waived the requirements of § 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) of the Code of Federal Regulations to allow telehealth services to be provided other than through video technology, for certain services. This allowed the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes). (Other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.)
CMS issued 31 different healthcare-related waivers during the COVID-19 pandemic, including the following telehealth-related waivers:

- CMS allowed physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.

- CMS modified the physician supervision requirement under 42 CFR § 491.8(b)(1) mandating that physicians must provide medical direction for a Rural Health Center’s or Federally Qualified Health Center’s health care activities and consultation for, and medical supervision of, the health care staff, with respect to the medical supervision of nurse practitioners, to the extent permitted by state law. The physician was still responsible for providing medical direction for the clinic or center’s health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff, but could do so either in person or through telehealth or other remote communications.

- CMS waived the requirement under 42 CFR § 483.30 that physicians and non-physician practitioners perform in-person visits for nursing home residents, to instead allow visits to be conducted, as appropriate, via telehealth.
CMS issued 31 different healthcare-related waivers during the COVID-19 pandemic, including the following telehealth-related waivers:

- CMS waived the requirement that out-of-state practitioners be licensed in the state where they are providing services—in person or via telehealth—when they:
  1. are licensed in another state in which they are enrolled in the Medicare program;
  2. furnish services in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and
  3. are not affirmatively excluded from practice in the state or any other state that is part of the §1135 PHE area.

- The HHS Office of Inspector General (OIG) provided flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by Federal healthcare programs.
On May 19, President Trump issued an Executive Order directing Federal agencies to review COVID-19-related waivers and guidance documents with an eye toward deciding which should be made permanent to hasten the country’s economic recovery from COVID-19-related isolation measures.

CMS Administrator Seema Verma indicated in public comments that some regulatory waivers used to help the health sector tackle COVID-19 could be extended at the end of the PHE, specifically praising the telehealth flexibilities.

NASMHPD and 40+ other members of the Washington D.C.-based mental health advocacy coalition, the Mental Health Liaison Group (MHLG), sent a letter to the Centers for Medicare and Medicaid Services (CMS) on May 22, copying the Office of Civil Rights of the Department of Health and Human Services, SAMHSA, and Congressional leadership, to ask that a one-year transition period be created after the end date of the COVID-19 PHE declaration during which the telehealth flexibilities created within the Medicaid, Medicare, Children’s Health Insurance Program, and other Federally subsidized health insurance programs, including those relating to audio-only phone telehealth would be maintained.
The letter proposed that CMS and states collect, during and after the declared pandemic emergency, data to assess the use and impact of these telehealth flexibilities. Such data collection would help inform CMS’ decisions on which flexibilities should be made permanent and responsibly administered.

- The transition period would also provide time to determine which flexibilities would require statutory changes by Congress to be made permanent and allow states to submit to CMS the necessary requests for revisions to Medicaid state plan amendments, waivers, and other legal authority.

The Association of American Medical Colleges, in a May 14 letter to Administrator Verma, urged CMS and Congress to make the COVID--19 changes to Medicare telehealth permanent.

Letters urging the same thing were also sent by the American Telemedicine Association, the National Association for Home Care and Hospice (NAHCH), and the College of Healthcare Information Management Executives (CHIME).
On a June 5 call with the Commissioners, SAMHSA Assistant Secretary Elinore McCance-Katz asked what COVID-19 related flexibilities should be made permanent.

More than a half-dozen Commissioners responded that the telehealth flexibilities should be made permanent.

Following the call, Deepa Avula, chief of staff for the Assistant Secretary emailed NASMHPD and NASADAD to ask that we provide a document by EOD today to support making the telehealth flexibilities permanent.

NASMHPD requested anecdotal evidence and data on all the listservs, including the Commissioners’ listserv and received responses from 21 different states, a number of which included individual responses from individual providers, almost unanimously positive.

- Maryland provided a spreadsheet with responses from 230 different providers.

Many responses repeated the same universal themes.
The use of telehealth and audio-only phone calls in providing services has proved particularly beneficial for:

- Clients with transportation needs generally, and those fearful of the dangers of COVID-19 infection in traveling on public transportation;
- Clients in rural areas lacking nearby providers who must normally travel significant distances for a face-to-face session;
- Individuals with severe anxiety disorders or agoraphobia for whom travel in a vehicle or being in public places is extremely difficult;
- Individuals who feel more comfortable sharing their feelings and thoughts via telehealth or telephone than in person. Said one respondent, “It is almost as they feel being on a screen protects them and makes them feel safer when discussing deeper rooted thoughts and experiences;
- Adolescents for whom the use of telehealth technology enhances the therapeutic relationship;
- Individuals fearing COVID-19 infection during face-to-face encounters;
- Individuals fearing stigma from seeking treatment for mental illness and substance abuse, who are now able to obtain that treatment in the privacy of their own homes;
The use of telehealth and audio-only phone calls in providing services has proved particularly beneficial for (cont’d):

- Clients with disabling co-occurring conditions such as cardio-pulmonary disease that may otherwise negatively impact their ability to travel to treatment;
- Children who, previous to the pandemic, received counseling in no-longer-available school-based counseling sessions but were able to continue their therapy at home through telehealth;
- Clients in crisis, afraid to leave the home to seek help, fearing involvement with law enforcement; and
- Individuals who contracted COVID-19 and were in quarantine.

Missed (“no-show”) appointments and cancelled appointments have dropped by a statistically significant percentage (estimated by respondents as 10 percent or more) since the telehealth flexibilities were enabled.

In at least one state where winter weather continues into early spring and often forces cancelations of therapy sessions, the number of sessions canceled due to weather dropped.

The number of family therapy sessions and family wraparound meetings has increased due to the flexibility of telehealth (overcomes issues of transportation, getting everyone in a family together at one time, etc.).

Individuals in socially isolating residential treatment have been able to maintain contact with family members during the pandemic.
There has been an upward trend in the number of client sessions, due—at least in part—to increased clinician capacity/availability as a result of the elimination of client and provider transportation time.

For those clients remaining in the workforce during the pandemic, telehealth has helped circumvent scheduling conflicts created by work schedules and child care demands.

Enhanced use of telehealth has made forensic evaluation more efficient, by eliminating the travel time to evaluation sites. As a result, states have been able to shorten the wait for evaluations.

Telehealth has reduced the rates of readmission to psychiatric hospitals because of the ready availability of treatment, keeping people from decompensating and landing in the emergency room, particularly in the midst of a pandemic likely to engender anxiety and depression.

For providers of children’s services, telehealth provides an opportunity to view and engage the client in his or her own environment, and in interactions with family members that might not otherwise be visible in a more public environment.
Providers report that therapy with elementary school children via telehealth has proven to be more effective than the provider thought it would be, with clients able to make great strides in those sessions. Said one respondent, “The children were very happy to see their staff person face-to-face [after months of audio-only sessions by telephone]. It is very difficult to engage younger service users without technology. The smiles on their faces told the story. ‘I am so happy to finally get to see you.’”

Group therapy sessions have been facilitated, and have been better attended, due to the ability of therapists to hold telehealth group sessions during evening hours not previously convenient to the provider or the clients.

Other services provided in a home environment, made possible by telehealth during the pandemic, included medication management, psychosocial assessment, and diagnostic evaluation.

Telehealth allows for more continuity of care. An inpatient- or outpatient-treating physician is more likely to follow their clients via telehealth given the flexible scheduling options.

Telehealth facilitates patient privacy and builds patient autonomy and self-confidence.

While some respondents said that older clients found the telehealth technology challenging, not everyone found that to be so. One respondent stated that “The older population learning new technology to be able to participate in telehealth empowers them and gives them more motivation and confidence for continued change in all areas of their lives.”
NASMHPD Leading Mental Health Liaison Group Charge on Making Telehealth Flexibilities Permanent (cont’d)

- Telehealth has helped to alleviate the impact of provider shortages and resulting wait times.
- In at least one state with a Medicaid wait list for specified types of behavioral health services, telehealth has made it possible to serve those individuals on the wait list.
- Effective evidence-based tools have been used with telehealth with very positive outcomes. This includes an increase in the use of Assertive Community Treatment (ACT) in at least two states; one state reported a 50 percent increase in the use of ACT.
- Audio-Phone Based Services
  - Phone-based services are critical as an alternative for clients that either do not have access to video technology or may be wary of video and simply prefer phone (e.g., clients with body-image concerns, clients who feel video is more risky from a privacy perspective, etc.) or find it easier to open up via phone than in a face-to-face session. Said one provider respondent: “While I appreciate the value of seeing a client in session, I cannot dismiss the importance of being able to provide phone sessions to consumers that have poor internet quality or limited data.”
  - Phone-based services also have been instrumental in engaging an older population that may not use the internet/video technology. As one State Commissioner phrases it, “The ability to provide telephonic services or audio-only telehealth is the cherry on top.”
- While most of NASMHPD’s allies support retaining all flexibilities, including the audio-only flexibility, the Association for Behavioral Health and Wellness (ABHW), the association for the behavioral health managed care plans, is not supporting retaining audio-only.
NASMHPD Leading Mental Health Liaison Group Charge on Making Telehealth Flexibilities Permanent

- NASMHPD presented the findings of the survey conducted by NASMHPD and NASADAD to a Patient-Centered Outcomes Research Institute (PCORI) virtual meeting on June 24.
  - Kripa Sreepada, aide to Senator Tina Smith (D-MN), told attendees at the PCORI event that there is support in Congress for a transition period after the PHE period ends, to continue the flexibilities and collect supporting data.

- On May 21, Reps. Paul Tonko (NY-D) and Tom Emmer (MN-R) and 30 Congressional colleagues sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Mitch McConnell asking that the flexibilities be made permanent.
  - The letter argues that making telehealth access permanent would "assure patients that their care will not be interrupted when the pandemic ends." It could also signal to health care providers that "costs to prepare for and use telehealth would be a sound long-term investment."

- On June 15, Senator Brian Schatz (HI-D) led a letter, signed by 29 other senators, that calls for the Trump administration “to permanently implement the pandemic policies that have allowed for an unprecedented uptick in virtual visits.”
On August 3, President Trump issued an Executive Order on Improving Rural Health and Telehealth Access.

The Executive Order notes that internal analysis by CMS showed a weekly jump in virtual visits for beneficiaries, from approximately 14,000 pre-PHE to almost 1.7 million in the last week of April and that a recent report by HHS shows that nearly half (43.5 percent) of Medicare fee-for-service primary care visits were provided through telehealth in April, compared with far less than one percent (0.1 percent) in February before the PHE. Telehealth visits continued to be frequent even after in-person primary care visits resumed in May.

The EO directs:

- the Secretaries of HHS and Agriculture to, within 30 days of the Executive Order, consistent with applicable law and subject to the availability of appropriations, and in coordination with the Federal Communications Commission and other executive departments and agencies, as appropriate, develop and implement a strategy to improve rural health by improving the physical and communications healthcare infrastructure available to rural Americans;
- the Secretary of HHS to, within 30 days, submit a report to the President, through the Assistant to the President for Domestic Policy and the Assistant to the President for Economic Policy, regarding existing and upcoming policy initiatives to increase rural access to healthcare by eliminating regulatory burdens that limit the availability of clinical professionals; and
- the Secretary of HHS to, within 60 days, review the following temporary measures put in place during the PHE, and spropose a regulation to extend these measures, as appropriate, beyond the duration of the PHE:
  - the additional telehealth services offered to Medicare beneficiaries; and
  - the services, reporting, staffing, and supervision flexibilities offered to Medicare providers in rural areas.
At the same time as the release of the Executive Order, the Medicare program issued its annual Physician Fee Schedule and Quality Payment Program regulations for the coming benefit year, adding 9 HCPCS codes for reimbursement which it felt matched the flexibilities provided in during the PHE, including:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
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<tbody>
<tr>
<td>GPCIX</td>
<td>Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)</td>
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<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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<tr>
<td>96121</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)</td>
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<tr>
<td>99XXX</td>
<td>Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)</td>
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<tr>
<td>99483</td>
<td>Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.</td>
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At the same time as the release of the Executive Order, the Medicare program issued its annual Physician Fee Schedule and Quality Payment Program regulations for the following benefit year, adding 9 HCPCS codes for reimbursement which it felt matched the flexibilities provided in during the PHE, including:

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<td>99334</td>
<td>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.</td>
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<tr>
<td>99335</td>
<td>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.</td>
</tr>
<tr>
<td>99347</td>
<td>Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
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<tr>
<td>99348</td>
<td>Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.</td>
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The regulations note that while the patient’s home cannot serve as an originating site (where the patient is located) for purposes of most Medicare telehealth services, the SUPPORT for Patients and Communities Act amended §1834(m)(4)(C) of the Social Security Act and added a new paragraph at § 1834(m)(7) to remove geographic limitations and authorize the patient’s home to serve as a telehealth originating site for purposes of treatment of a substance use disorder or a co-occurring mental health disorder, furnished on or after July 1, 2019, to an individual with a substance use disorder diagnosis.

CMS says it believes that, due to the vulnerability of this particular patient population, it should maximize the availability of telehealth services for the treatment of substance use disorders and co-occurring mental health disorders.

Before eliminating the full range of these services added by waiver during the PHE from the Medicare telehealth services list and potentially jeopardizing beneficiary access to those services that have been clinically beneficial, based primarily on the timing of annual rulemaking, CMS suggests it would be prudent to collect information from the public regarding which, where, and how various telehealth services have been in use in various communities during the COVID-19 response. It says feedback from patients and clinicians is essential to help CMS understand how the use of telehealth services may have contributed positively to, or negatively affected, the quality of care provided to beneficiaries during the PHE for the COVID-19 pandemic in order to understand which services should be retained on the Medicare telehealth services list until the agency can give them full consideration under the established rulemaking process.
Currently, there are two categories of services added to the Medicare telehealth services list:

- **Category 1**: Telehealth services that are similar to the office visits that are already on the Medicare telehealth services list.

- **Category 2**: Services that are not similar to those on the current Medicare telehealth services list, but where the service is accurately described by a corresponding code when furnished via telehealth and the use of a telecommunications system to furnish the service produces demonstrates clinical benefit to the patient. These are services recommended in a public comment response where submitted evidence includes both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. The clinical benefit cannot be minor or incidental.

CMS proposes to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis that would include the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria.

Recognizing that the services added on a temporary basis under Category 3 would ultimately need to meet the Categories 1 and 2 criteria to be permanently added, CMS conducted a clinical assessment to identify those services with a foreseeable reasonable potential likelihood of clinical benefit when furnished via telehealth outside the PHE.
When assessing whether there was a potential likelihood of clinical benefit for a service such that it should be added to the Medicare telehealth services list on a Category 3 basis, CMS considered the following factors:

- Whether, outside of the circumstances of the PHE, there are increased concerns for patient safety if the service is furnished as a telehealth service;

- Whether, outside of the circumstances of the PHE, there are concerns about whether the provision of the service via telehealth is likely to jeopardize quality of care; and

- Whether all elements of the service could fully and effectively be performed by a remotely located clinician using two-way, audio/video telecommunications technology.

CMS says adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would be adjudicated on a Category 1 or Category 2 basis during future annual rulemaking, while maintaining access to telehealth services with potential likelihood of clinical benefit.

CMS proposes that the Category 3 criteria and basis for considering additions to the Medicare telehealth services list would be temporary, to expire at the end of the calendar year in which the PHE expires.
### Services Proposed for Temporary Addition to the Medicare Telehealth Services List Under Category 3

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<tr>
<th>Service Type</th>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
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<tbody>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>96130</td>
<td>Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.</td>
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<td></td>
<td>96131</td>
<td>Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).</td>
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<tr>
<td></td>
<td>96132</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.</td>
</tr>
<tr>
<td></td>
<td>96133</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).</td>
</tr>
</tbody>
</table>

Also:
- Domiciliary, Rest Home, or Custodial Care services, Established Patients (HCPCS Codes 99336 & 99337)
- Home Visits, Established Patient (HCPCS Codes 99349 & 99350)
- Emergency Department Visits (HCPCS Codes 99282 & 99283)
- Nursing Facility Discharge Day Management (HCPCS Codes 99315 & 99316)
The following are examples of the kinds of information CMS is seeking from the public to help inform its decisions about proposed additions under Category 3:

- By whom and for whom are the services being delivered via telehealth during the PHE;
- What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed;
- What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit;
- How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person. Certain services on the Medicare telehealth services list prior to the PHE, specifically the office/outpatient E/M code set, involve a physical exam. With the telehealth expansions during the PHE, clinicians may have had valuable experience providing other telehealth services to patients in higher acuity settings of care, such as an emergency department, that involve a hands-on physical examination when furnished in person;
- Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care;
- Whether furnishing this service or services via telecommunication technology promotes prudent use of resources;
- Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth; and
- What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded).
Services Proposed for Temporary Addition to the Medicare Telehealth Services List Under Category 3

In addition, CMS wants to know how the new temporary services meet the following agency goals:

• Maintaining the capacity to enable rapid assessment of patterns of care, safety, and outcomes in the Medicare, Medicaid, CHIP and Marketplace populations;

• Establishing system safeguards to detect and avert unintended patient harms that result from policy adjustments;

• Ensuring high quality care is maintained;

• Demonstrating ongoing quality improvement efforts by Medicare participating providers, while maintaining access to necessary care;

• Establishing protections for vulnerable beneficiary populations (those with multiple chronic conditions, functional limitations, heart failure, COPD, diabetes, dementia), and sites of heightened vulnerability (such as nursing homes, rural communities) with high risk of adverse outcomes;

• Ensuring appropriate resource utilization and supporting cost efficiency;

• Supporting emergency preparedness and maintaining capacity to surge for potential coronavirus resurgence or other healthcare issues; and

• Considering timing and pace of policy corrections in light of local and regional variations in systems of care and the impact of the COVID-19 pandemic.
Audio Only Telehealth Remains in the Air

- In the March 31 COVID-19 interim final regulations, CMS established separate payment for audio-only telephone evaluation and management (E/M) services.

- At that time, CMS stated that, given its understanding that audio-only services were being furnished as substitutes for office/outpatient E/M services, it felt that they should be considered as telehealth services, and added them to the Medicare telehealth services list for the duration of the PHE.

- For these audio-only E/M services, CMS separately issued an § 1135 waiver of the requirements under § 1834(m) of the Social Security Act and 42 CFR § 410.78 that Medicare telehealth services must be furnished using video technology.

- CMS is not proposing to continue to recognize those codes for payment for audio only visits after conclusion of the PHE because, outside of the circumstances of the PHE, it says it is not able to waive the statutory requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology.
However, it recognizes that the need for audio-only interaction could remain as beneficiaries continue to try to avoid sources of potential infection, such as a doctor’s office and, in that circumstance, a longer phone conversation may be needed to determine if an in-person visit is necessary.

CMS seeks comment on whether CMS should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with an accordingly higher value. It is seeking input from the public on the appropriate duration interval for such services and the resources in both work and practice expense associated with furnishing them. It also seeks comment on whether separate payment for telephone-only services should be a provisional policy to remain in effect until a year or some other period after the end of the PHE or if it should be PFS payment policy permanently.

Public comments on the telehealth changes included in the Medicare Physician Fee Schedule regulations are due October 5.
Legislative Measure to Make Telehealth Flexibility Permanent

On July 2, Senators Bill Cassidy (R-LA) and Tina Smith (D-MN) led 35 of their Senate colleagues in sending a letter calling on HHS and CMS to provide Congress with a written plan and timeline about any potential changes to Medicare rules governing telehealth, specifically requesting:

• A written plan and timeline for making permanent the administrative changes—including the expansion of the definition of telecommunications systems—made to Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) rules governing the provision of telehealth under §1135 Waivers that includes sufficient public notice and comment periods to ensure that these permanent changes are not at the expense of access for patients in rural or underserved communities, patient privacy, protections against fraud, waste, and abuse, or quality of patient care.

• A timeline for if and when the agencies intend to end enforcement discretion by the Department of Health and Human Services Office for Civil Rights (OCR) for non-compliance with the Health Insurance Portability and Accountability Act (HIPAA) so that health care providers and patients have a reasonable expectation as to when the use of everyday technologies may be discontinued. In addition, an analysis of the non-HIPAA compliant platforms used during the pandemic and report to Congress their impact on providers, consumers, and patient data security.

• Clarification whether the agencies intend to extend existing in-office Medicare reimbursement parity to telehealth services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the duration of the pandemic or whether doing so would require Congressional action.

• A detailed list of permanent telehealth changes to Medicare, Medicaid, and CHIP rules that the agencies can adopt within their own authority and those that require Congressional action.

• Guidance for private health plans to provide advance notice to their enrollees on future changes to coverage of telehealth services.
Senators Angus King (ME-I) and Todd Young (R-IN) have introduced S. 3999, the Mental and Behavioral Health Connectivity Act, making permanent the telehealth flexibilities made available under the Medicare program during the pandemic.

Senator Ron Wyden (D-OR) planning introduction of bill making Medicare telehealth changes permanent.

Full Energy and Commerce Committee on July 15 reported out H.R. 5201, the “Telemental Health Expansion Act of 2019,” introduced by Reps. Doris Matsui (D-CA) and Bill Johnson (R-OH). The legislation would permanently include a patient’s home as an eligible originating site for mental health services delivered via telehealth and remove Medicare’s geographic restrictions for such services, enabling providers to be reimbursed by Medicare for mental health services delivered via telehealth in urban and rural areas and in the patient’s home. The bill was favorably reported, as amended, by voice vote.

Assistant Secretary Eleanor McCance-Katz, on a call with Commissioners several weeks ago, promised to be a strong advocate for making the telehealth flexibilities permanent.

The Senate 4th COVID relief package maintains reimbursement for telehealth services at pandemic levels through 2021.