TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)
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Northwest Regional
Telehealth Resource Center (NRTRC)
Website: https://nrtrc.org
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February 21, 2025

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment.

The BHI brings the expertise of Harborview Medical Center/University of Washington Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

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Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

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DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Please consult with legal counsel, billing & coding experts, and compliance professionals, as well as current legislative and regulatory sources, for accurate and up-to-date information.

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

AHEC WW
AREA HEALTH EDUCATION CENTER
FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

TeleBehavioral Health 2025

Telehealth and TeleBehavioral/TeleMental Health Policy Update

MEI WA KWONG, JD

EXECUTIVE DIRECTOR

CENTER FOR CONNECTED HEALTH POLICY

FEBRUARY 21, 2025

FEDERAL TELEHEALTH POLICY UPDATE

February 21, 2025
University of Washington
TeleBehavioral Health Training

Center for Connected Health Policy
The National Telehealth Policy Resource Center

Mei Wa Kwong
Executive Director, CCHP

CENTER FOR CONNECTED HEALTH POLICY (CCHP)

is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.

DISCLAIMERS

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- Always consult with legal counsel.
- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.

ABOUT CCHP

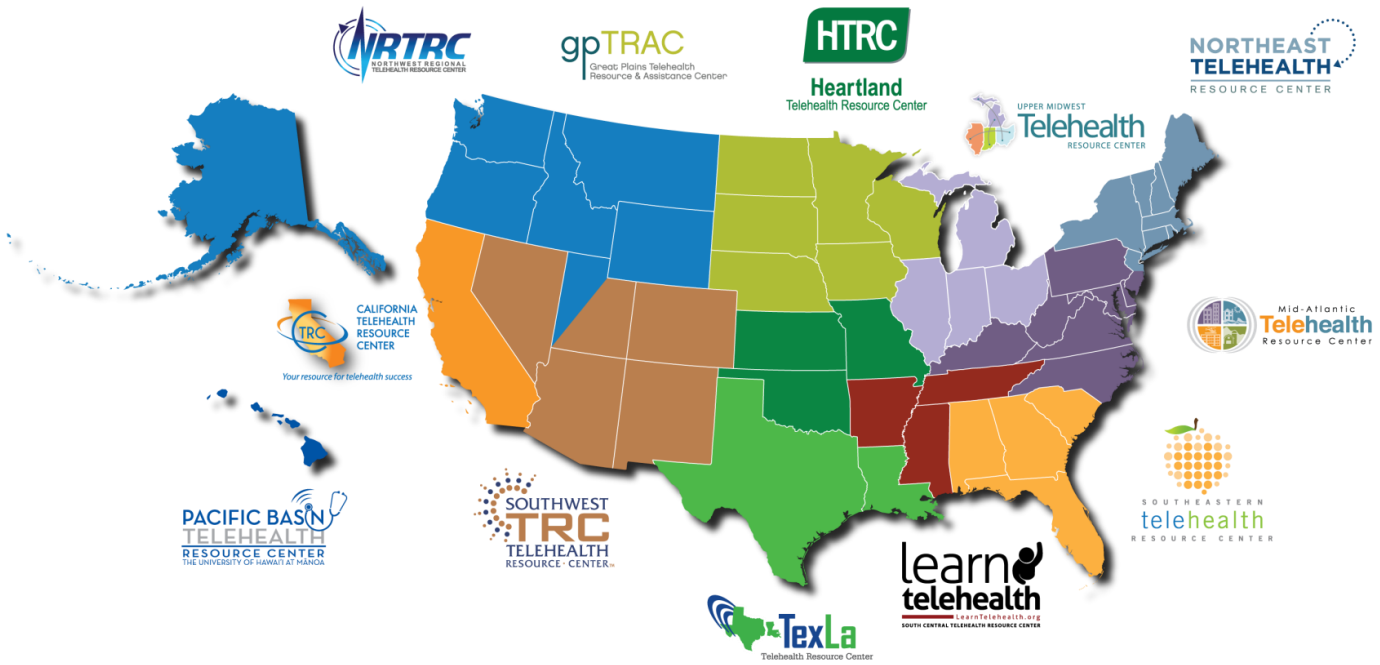
- Established in 2009 as a program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition

California Telehealth Policy Coalition

TRC TELEHEALTH RESOURCE CENTERS

NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org



TTAC
TelehealthTechnology.org
Center for Connected Health Policy
The National Telehealth Policy Resource Center

2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

TRC
TELEHEALTH
RESOURCE CENTERS

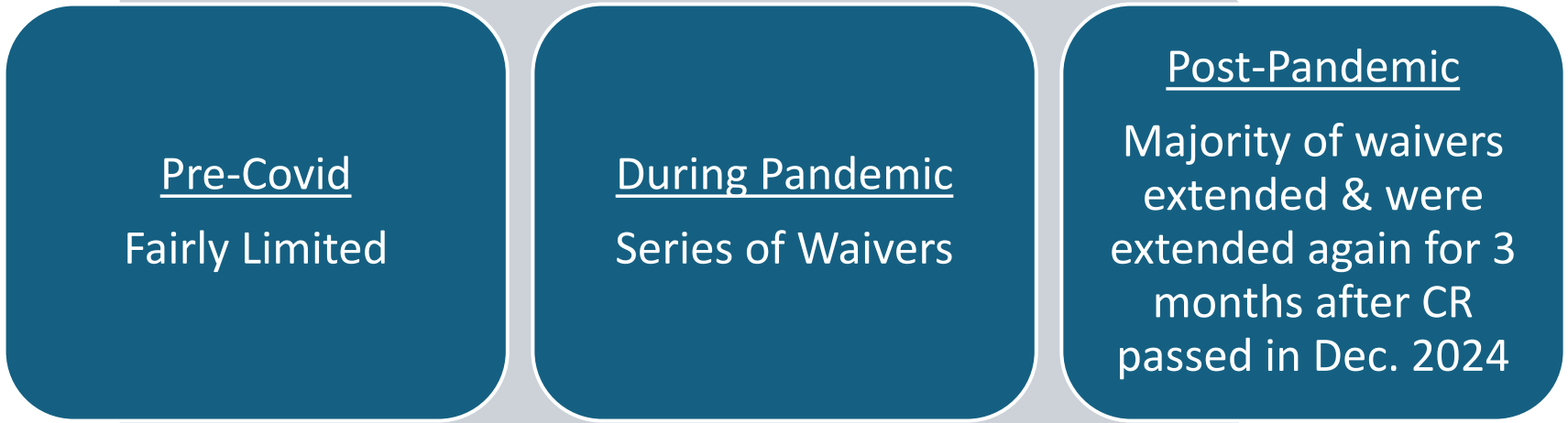
Center for Connected Health Policy
The National Telehealth Policy Resource Center

TODAY'S AGENDA

- Current status of federal Medicare telehealth policy
- Reverting back to Permanent Medicare Telehealth Policy
- Telehealth & Prescribing of Controlled Substances
- What's going on in the states

FEDERAL:
CMS & Medicare
(Reimbursement & Coverage)

MEDICARE TELEHEALTH POLICY EVOLUTION



MEDICARE TELEHEALTH POLICY

WAIVER DURING COVID-19	REMAINS UNTIL MARCH 31, 2025
Waiver of geographic requirement	✓
All eligible providers in Medicare & FQHCs/RHCs to be eligible providers	✓
Site limitation waived (allowing places such as the home)	✓
Allow some services to be provided via audio-only*	✓
Delay of prior in-person visit before telemental health services provided w/o meeting geographic req & in the home	✓

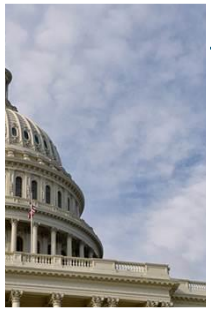
MEDICARE TELEHEALTH POLICY

WAIVER DURING COVID-19	REMAINS UNTIL THE END OF 2025
Allowing provider to use business address rather than putting home address*	✓
Waiving frequency limit on telehealth visits in certain settings*	✓
Allowing for direct supervision to be done via telehealth*	Some remain intact such as supervision of residents when the service is furnished virtually.
Expanded list of eligible services to be provided via telehealth	Varies, but mostly remains intact

WHAT HAPPENS AFTER MARCH 31, 2025?

The telehealth waivers are extended for a period of time

The telehealth waivers expire and Medicare telehealth policies revert to the permanent policies



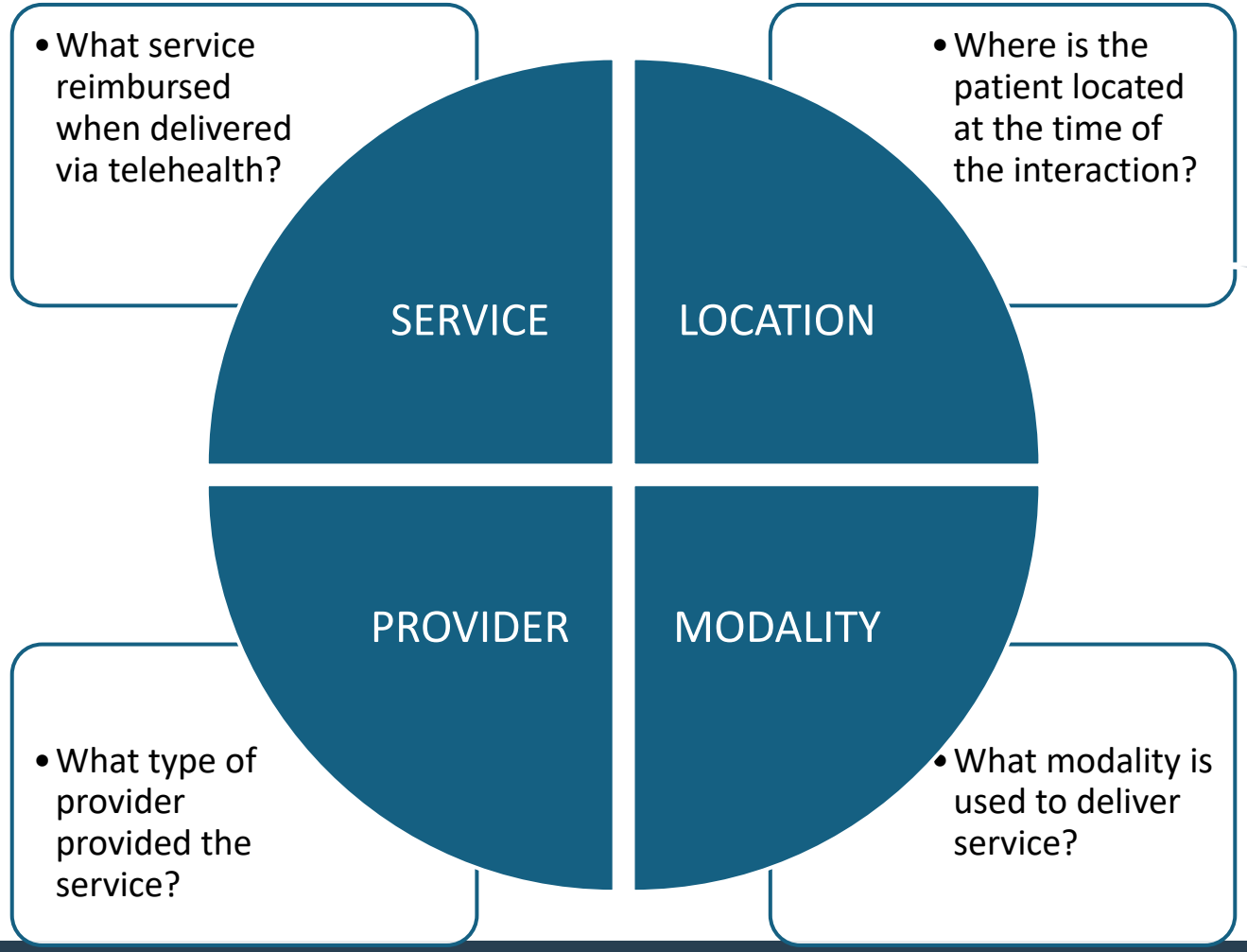
Changes are made to the telehealth waivers (maybe some expire, some extended, new conditions placed, etc)

REVERTING BACK TO PERMANENT POLICY

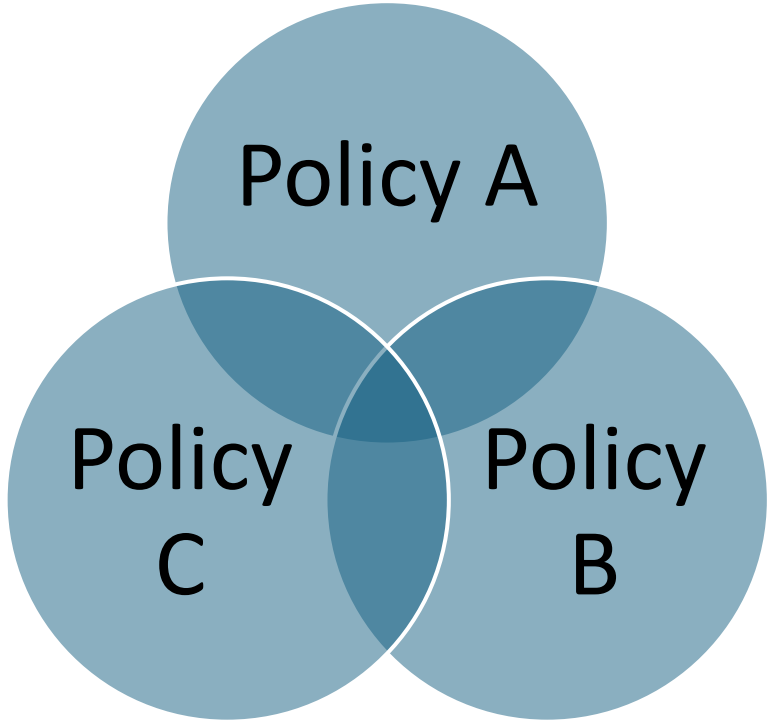
TELEHEALTH REIMBURSEMENT POLICY – 4 AREAS

- **Most established telehealth policies on reimbursement are made up of**
  - 4 typical elements
  - Most limitations are around these 4 elements

- Medicare also has a grouping of services they will reimburse that uses telehealth technology to deliver those services but are not regarded as "telehealth". These services are called Communications Technology Based Services (CTBS) and include remote patient monitoring, evisits, econsult. They are separated out because there is no "in-person equivalent" to them but are services that can be provided because of the technology.



HOW TO CONSIDER POLICIES



Policies may not necessarily operate in silos. Always consider all of the policies to fully understand the extent of the impact a policy may have.

MEDICARE TELEHEALTH POLICY W/NO EXTENSION

POLICY	EXCEPTIONS TO THIS POLICY
Originating site must be in a specifically defined rural area/HPSA or non-MSA	Does not apply to stroke, ESRD and some mental health services if certain conditions met
Limited list of eligible facilities for originating site	Limited exceptions for the home for certain mental health services (if certain conditions met), SUD, ESRD
Limited list of eligible providers, will exclude FQHCs, RHCs, PTs, OTs, SLP	NOTE: Exception discussed on next slide
Audio-only statutory references will expire	NOTE: Exception discussed on next slide
For mental health services taking place in the home & not meeting geographic requirement or falling into one of the previously identified exceptions, prior in-person visit	NOTE: Exception discussed on next slide

MEDICARE TELEHEALTH POLICY W/NO EXTENSION

POLICY	EXCEPTIONS TO THIS POLICY (Created by CMS)
Limited list of eligible providers, will exclude FQHCs, RHCs, PTs, OTs, SLP	2025 PFS CMS allowed FQHC and RHC to continue to provide services via telehealth through 2025
Audio-only references will be gone from statute	CMS had redefined telecommunication system to include services provided via audio-only in the home if the patient requested audio-only or couldn't use live video. Still limited, reference back to what services are eligible in the home.
For mental health services taking place in the home & not meeting geographic requirement or falling into one of the previously identified exceptions, prior in-person visit and every 12 months thereafter	CMS allows for exceptions to the subsequent in-person visits every 12 months if the provider and patient determine it would be detrimental to delay services if they can't meet the in-person visit within 12 month timeframe

MENTAL HEALTH UNDER PERMANENT TELEHEALTH MEDICARE POLICY

Substance Use Disorder and a co-occurring mental health condition may be treated in the home without meeting the geographic requirement.

Mental/Behavioral health services may take place without meeting the geographic requirement and in the home, if certain conditions met such as the patient receiving a prior in-person service from the telehealth provider that was paid or would have been paid by Medicare no sooner than 6 months prior to start of telehealth.

AUDIO-ONLY

- Definition for interactive telecommunication system:

*May also include two-way, real-time audio-only communication technology for any telehealth service furnished to a **beneficiary in their home** if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication, but the patient is not capable of, or does not consent to, the use of video technology.*

FEDERAL:
Prescribing & Controlled Substances

CONTROLLED SUBSTANCE PRESCRIBING VIA TELEHEALTH

- Limited Exceptions in Ryan Haight Act (2008), which requires in-person visit prior to online prescribing
- One exception is when PHE declared, COVID activated exception
- Early 2023, DEA Issues Proposed Post-PHE Regs; Receives massive feedback and decides to delay final rule
- Temporary extension issued to 11/2023
- Late 2023, DEA extended the exception through to the end of 2024
- Mid-2024 DEA Attempts Another Proposed Post-PHE Rule – Receives Pushback
- Nov 2024, DEA extends the waiver one additional yaer to the end of 2025

DEA Third Extension on Telehealth Prescribing Waiver (2024)

DEA RULE MAKING

Each of the rules create permanent exceptions to the existing in-person evaluation requirement related to the prescribing of controlled substances – currently waived until end of 2025. The rules are not as broad as what has been seen during the temporary waiver period:

1. Proposed Rule – Special Registrations for Telemedicine and Limited State Telemedicine Registrations
   - Proposes long-awaited telehealth registration process; three tiers including one specific to DTC platforms; includes additional prescribing, recordkeeping, and reporting requirements
2. Final Rule – Expansion of Buprenorphine Treatment via Telemedicine Encounter
   - Finalizes audio-only allowance for buprenorphine – subject to certain conditions/limitations (effective March 21, 2025)
3. Final Rule – Continuity of Care via Telemedicine for Veterans Affairs Patients
   - Finalizes allowing VA providers to prescribe via telehealth without in-person visit – subject to certain conditions/requirements (effective March 21, 2025)

STATE TELEHEALTH POLICY

IMPACT OF FEDERAL LEGISLATION ON STATES

- **Status of federal telehealth Medicare waivers does not have an immediate direct impact on states' telehealth policy**
- **Majority of States have finalized their post-pandemic telehealth policies**
  - A few states had been aligning their dates with the federal waivers, though not necessarily their policy content, but no longer appears to be the case
  - States can still mirror federal telehealth policy, though not necessarily the permanent policies
    - Example – Adoption of Communications Technology Based Services (CTBS) codes for their Medicaid programs

WASHINGTON STATE

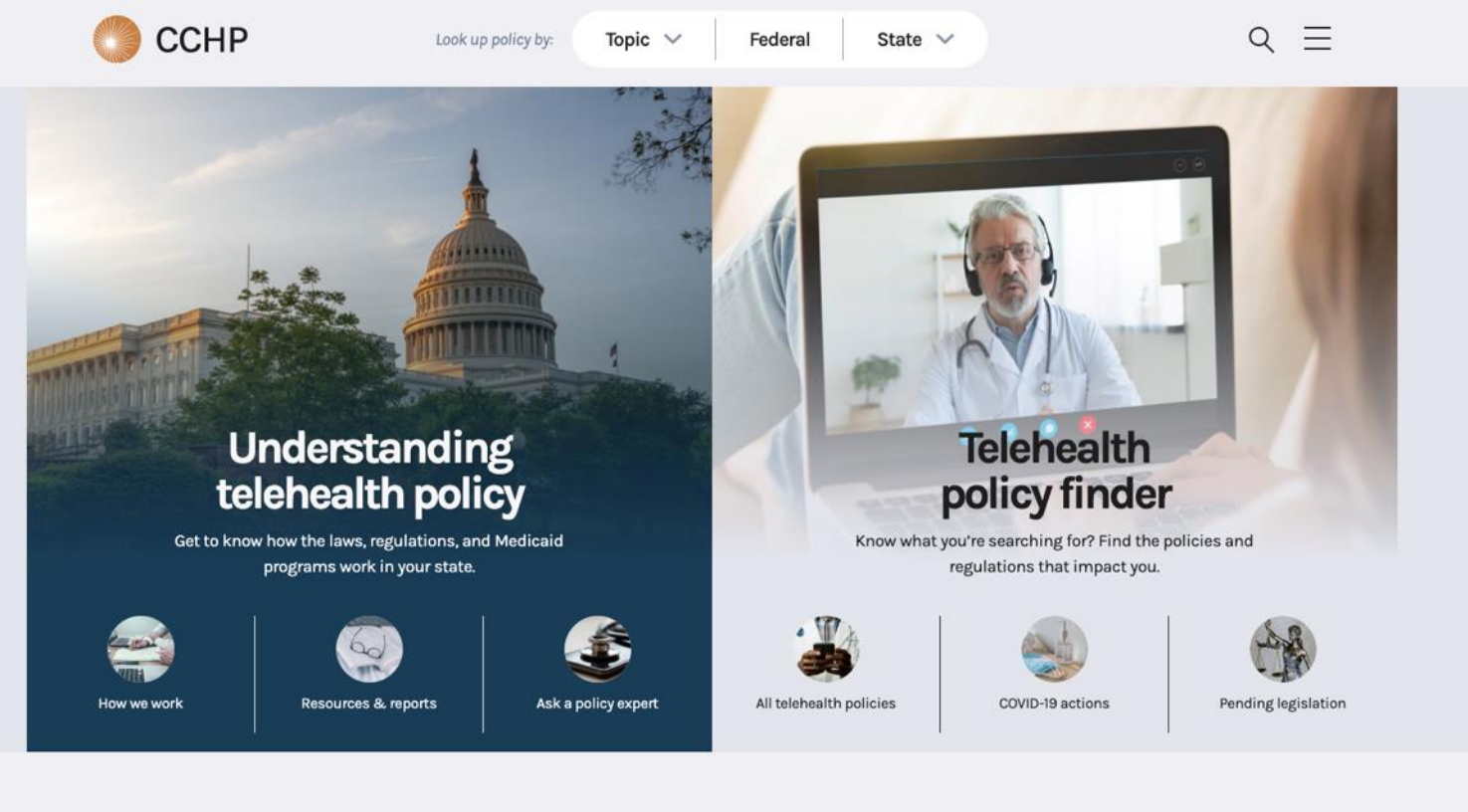
WA MEDICAID	Reimburses for Live Video, S&F and RPM, Audio-only for specific billing codes
	Specific instructions for what services billing for and who the entity that is billing
	Location can be the home or “any location determined by the individual receiving the service
	Allows audio-only for certain services but require additional items such as only for established patient-provider relationships & consent

WA STATE VS. MEDICARE

WA STATE MEDICAID	PERMANENT MEDICARE TELEHEALTH POLICY
MODALITY: Live video, S&F, RPM, some audio-only	**MODALITY**: Live video, S&F if a demonstration program in Alaska & Hawaii, limited audio-only (RPM considered CTBS)
SERVICES: Medically necessary covered services, consistent w/scope of practice, clinically appropriate	**SERVICES**: Specific list of services
LOCATION: No geographic limits though must be in the US/territories. Allow home to be eligible site.	**LOCATION**: Specific location list, limits types of services in the home.
PROVIDER: Does not limit type of provider.	**PROVIDER**: Limits to specific definition of practitioner/provider

CCHP

- CCHP Website – cchpca.org



- Subscribe to the CCHP newsletter at cchpca.org/contact/subscribe

Center for Connected Health Policy

THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

Thank You!

www.cchpca.org

info@cchpca.org

APPENDIX

CCHP

- Telehealth Policy Finder Tool
  - Includes all state and federal telehealth specific laws, regulations, policies, and active legislation – rolling updates every 3 months
  - Can Search by State, Federal, or by Category/Topic
    - Medicare; Medicaid Live Video, Store & Forward, RPM; Private Payer Laws; Professional Regulation, Licensing, Prescribing & More
- Policy Trend Maps
  - Highlights telehealth trends across the states in Medicaid reimbursement by modality, private payer laws and payment parity, & out-of-state telehealth provider policies – updated yearly to

RESOURCES

- CCHP Newsletter – What Might Happen Next?
- CCHP Fact Sheet – Final PFS 2025
- CCHP Fall 2024 Edition of State Policy Summary Report

Looking for Health Equity & Ethics Training?

Cultural Humility In Behavioral Health Care

- Free two-hour module
- On-demand & self-paced
- Meets **Health Equity** training requirements in WA State

Empowering Recovery: Ethics & Collaborative Decision-Making in Behavioral Health

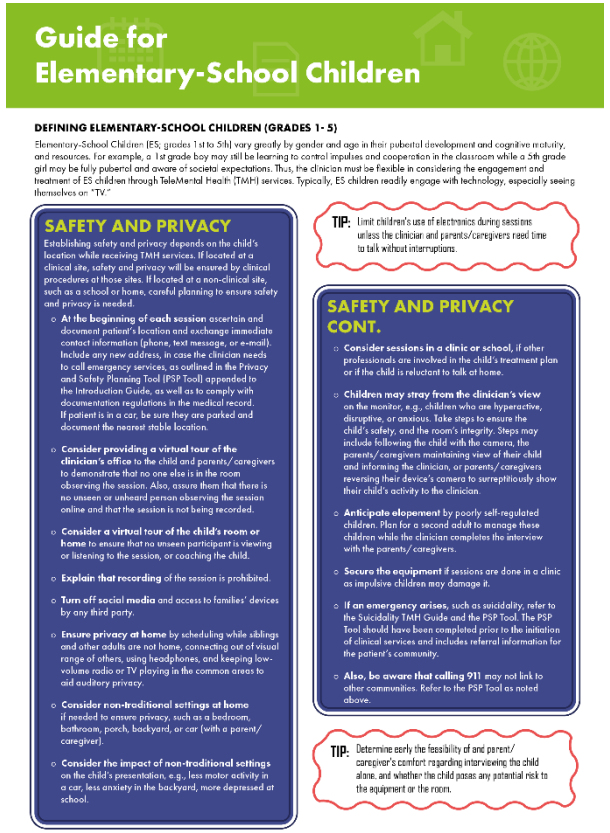
- Free two-hour module
- On-demand & self-paced
- Meets **Law & Ethics** training requirements in WA State

Learn more at: https://bhinstitute.uw.edu/learn-online

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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uwcolab.org/tmh-guides

Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO → →
- UW Psychiatry & Addictions Case Conference ECHO
- **UW TelePain series**

PROVIDER CONSULTATION LINES

- **UW Pain & Opioid Provider Consultation Hotline**
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

Use of Psychedelics with People with TBI
- Nathan Sackett MD

TODAY
12-1.30pm

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Washington State Health Care Authority

Seattle Children's
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