Mobilizing a Safe and Adequate Health Workforce
The National Conference of State Legislatures is the country’s most trusted bipartisan organization serving legislators and staff. We promote policy innovation, create opportunities for lawmakers to share knowledge and ensure state legislatures have a strong, cohesive voice in the federal system. We do this because we believe in the importance of the legislative institution and know when states are strong, our nation is strong.
COVID-19 WEBPAGE

Information on state policies and responses related to continuity of government, education, fiscal, elections, criminal justice and more.

Go to ncsl.org
<table>
<thead>
<tr>
<th>Webinar Title</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19: Leveraging Medicaid for Coverage, Testing and Treatment</td>
<td>April 21 – Recording available online</td>
</tr>
<tr>
<td>COVID-19: Engaging Private Health Insurance for Coverage, Testing and Treatment</td>
<td>April 29 – Recording available online</td>
</tr>
<tr>
<td>COVID-19: Ensuring Adequate Health Care Facilities</td>
<td>May 13, 1-2 p.m. MDT</td>
</tr>
</tbody>
</table>
▪ Federal and state actions related to the health care workforce

▪ National telehealth trends and related state actions

▪ State trends on waiving licensing requirements

May 6, 2020 | COVID-19: Mobilizing a Safe and Adequate Health Workforce
Emergency Health Workforce Policies to Address COVID-19

May 6, 2020
NCSL Webinar

Patricia Pittman PhD FAAN
Fitzhugh Mullan Professor of Health Workforce Equity
ppittman@gwu.edu
WHY DO WE NEED HEALTH WORKFORCE POLICIES?

How well we handle COVID-19 crisis, depends largely on how effectively our health workforce is used now.

Problems:
1. Historic geographic & specialty misdistribution, driven in part by hospital centric GME system (10B per yr), but mitigated by NHSC
2. Lack of flexibility/adaptability fueled by professional interest groups that compete and heterogeneity of state regulations and licensures which impair mobility
3. Current lack of national standards on occupational safety for airborne pathogens, which puts health workforce at risk.

It's up to state and federal leaders to address system constraints on the workforce to advance 3 goals:
1. SURGE the numbers,
2. FLEX where, how and by whom care is delivered, &
3. PROTECT the workforce.
OVERVIEW OF RELATIVE RESPONSIBILITIES

• **FEDS:** CMS payment rules, HRSA investments in education and rapid training, and support to safety net providers and special programs for vulnerable pops, PHSC and NHSC.

• **STATE:** Scopes of Practice, Licensure, State Reserve Corps, but also:
  • Standards, clear guidelines and policies that support workers to reduce attrition
  • Contract tracing workforce
  • Planning for next phase: surge in primary, mental and dental are w/possible COVID syndrome, log jam of delayed procedures, spike in chronic diseases, mental health problems & addictions. Vulnerability of rural providers.

• **HOSPITALS:** Revise outdated workflows and task delegation protocols to allow repurposing of workers, team work, cross-training health professionals, top of license.

• **EDUCATIONAL & ACCREDITING BODIES:** Students can help with the pandemic, including contact tracing, and it is important to secure the future pipeline of the health workforce.
**SOP Expansion Considerations** *(Source: UCSF HealthForce)*

- **Certified nursing assistants, home health aides, & personal care aides:** Allow them to administer low-risk medications
- **Licensed practical/vocational nurses:** Allow them to do preliminary assessment and allow them to administer medications via an IV line (“IV push”)
- **Nurse-midwives & nurse practitioners:** Allow them to practice without physician supervision & allow hospitals to give them full privileges
- **Clinical nurse specialists:** Allow CNSs to prescribe medications if they took a pharmacology class
- **All advanced practice clinicians (PAs, NPs, midwives, etc.):** Do not restrict number that a physician can supervise
- **Clinical laboratory:** Allow clinical lab specialists to perform testing outside current limits, and eliminate limitations on medical lab techs from doing high-complexity tests
- **Paramedics:** Allow them to practice in all settings
Expedited & Temp Licensing to Surge Workforce

1. Retired or out of service (reserves lists)
2. Cross state (compacts)
3. Rapid training underutilized occupations (dental and ophthalmology)
4. Consider international professionals
5. Deploy students in provisional roles, eg
   1. CNA in assisted living reduce practice hours required to graduate,
   2. RN students practice as LPNs,
   3. Graduating medical students as interns
Most Executive Orders Focus on Expedited Licensure; A Few Issued Expansions of SOP

<table>
<thead>
<tr>
<th>Indiana EO 20-12 and 20-05</th>
<th>New York EO 202-10</th>
<th>Pennsylvania EO Waiver Under Disaster Declaration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health professionals are permitted to practice via telemedicine.</td>
<td>Temporary Suspension and Modification of Education law and Regulations to permit:</td>
<td>• Governor ordered suspension of the requirement that a collaborative agreement be filed with the State Board of Medicine prior to engaging in the practice of midwifery.</td>
</tr>
<tr>
<td>APRNs permitted to provide services in multiple locations while under a single written collaboration agreement.</td>
<td>• Nurse Anesthetists, NPs, PAs, specialist assistants to practice without supervision of a qualified physician;</td>
<td>• PAs under the State Board of Osteopathic Medicine (only) no longer required to have written agreements with physicians, countersignatures of physicians, and physicians may supervise more than 4 PAs. several other items.</td>
</tr>
<tr>
<td>Suspension of the requirement of a 1:6 ratio of pharmacist to pharmacy technician and authorize a ratio of 1:8; and suspension of the direct supervision requirement by a pharmacist over a pharmacy technician for non-dispensing tasks only (data entry, insurance processing, and ministerial tasks</td>
<td>• RNs to order the collection of throat or nasopharyngeal swab specimens</td>
<td>• NPs allowed to prescribe drugs outside the established formulary, and application for prescription-writing authority requires only one collaborative and one substitute physician(rather than the entire list of substitutes.)</td>
</tr>
<tr>
<td></td>
<td>Certified or registered pharmacy technician, under the direct personal supervision of a licensed pharmacist, to assist such licensed pharmacist as directed, in compounding, preparing, labeling, or dispensing of drugs used to fill valid prescriptions or medication orders.</td>
<td></td>
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<tr>
<td>State</td>
<td>Order Details</td>
<td></td>
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<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Arizona</strong></td>
<td>Exempts Certified Registered Nurse Anesthetists (CRNAs) to be supervised by a physician, as 17 states have done before under CMS rule.</td>
<td></td>
</tr>
<tr>
<td><strong>California</strong></td>
<td>Permits the director of Emergency Medical Services to issue expansion of scope of practice for emergency medical services workforce without consulting local committees.</td>
<td></td>
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<tr>
<td><strong>Florida</strong></td>
<td>Allows pharmacists to dispense up to 30-day emergency prescription refill of maintenance medications.</td>
<td></td>
</tr>
<tr>
<td><strong>Kentucky</strong></td>
<td>Allows pharmacists to dispense up to 30-days of emergency non-controlled substance prescription refills for state residents and dispense drugs necessary to respond to COVID-19.</td>
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</tbody>
</table>

Nebraska, Tennessee and Michigan have also waived restrictions on physician supervision of PAs and APRNs.
CMS Blanket Waivers (3/1/2020 - until end of emergency declaration)

• **Locations expanded**: Clinicians can bill for care outside hospital, e.g., SNFs, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and ambulatory surgical centers (ASCs), and home.

• **Defers SOP and Licensure Requirements**:
  - In hospitals eg CRNA, RTs in CAHs & staff licensure, certification, & registration to state, and local laws and regulations.
  - In FQHCs and RHCs removes requirement that physicians must provide medical direction for FQHCs and RHCs. NP independence to the extent permitted by state law
  - IN SNFs, allows physicians to delegate any tasks to a qualified PA, NP of CNS as long as state law allows.

• **Task Shifting**: Encourages hospitals and health systems to redeploy providers with less work, and ensure everyone “practice at the top of their license”, to assist with triage, telehealth, or supporting patient care to expand capacity of intensivists or other physicians.

• **Credentialing**: Allows clinicians whose privileges will expire to continue practicing at the hospital and for new clinicians to be able to practice before full medical staff/governing body review and approval
In addition, at least 11 states have their own 1135 Waivers with other workforce deregulation measures

**SURGE**
- Expediting enrollment of out-of-state providers to provide care, and waiving application fee payments and criminal background checks, among other screening requirements.

**FLEX**
- Removes limits on how many people those doctors can see or how many cases they can treat.
- Allow care in alternative settings from a hospital or doctor's office, with alternative workers (CHWs).

**OTHER REDUCED RED TAPE**
- Suspend certain nursing home screening requirements to lower administrative burden.
- Prior authorization requirements being waived.
Federal COVID-19 Relief Bills

   - CHCs, Telehealth and reimbursement for testing and visits.
   - National Institutes of Environmental Health Sciences: $10M for worker-based training to prevent and reduce exposure of front line workers.

2. Families First Coronavirus Response Act 3/18 3.5B
   - More detection reimbursement and PPE stockpile
   - Secretary of Labor and some employers can exclude certain healthcare workers and emergency first responders from the definition of “eligible employees” for purposes of taking public health emergency leave.
   - Targeted liability protection to certain manufacturers, distributors, prescribers, and users of approved respiratory protective devices
3. The Coronavirus Aid, Relief, and Economic Security (CARES) Act 3/27 $2T:

- **Preparedness/Surge Capacity**
  - Amends PHSA to provide for a Ready Reserve Corp in times of public health emergencies
  - Protects healthcare professionals from liability while providing services in response to COVID-19 in a volunteer capacity
  - Secretary may assign members of the National Health Service Corp to assist during the COVID-19 public health emergency to provide health services

- **Education & Training**
  - Reauthorizes through 2025 health professions workforce programs and allows more grant funding to be used for training of healthcare workers in rural and underserved areas, prioritizing the fields of substance use, geriatrics and maternal and child health.

- **Workforce Preparedness**
  - Secretary of HHS will lead the development of and reporting for a plan on health care workforce issues that establishes performance measures, identifies gaps in workforce, and recommends strategies for filling gaps.

3.5. Paycheck Protection Program and Health Care Enhancement Act 4/24 $484B:

- **More Provider Financial Assistance**
  - $75B to reimburse health care providers for health care related expenses or lost revenues that are attributable to the coronavirus, and $825M CHCs& RHCs.
  - $310M loans for PPE
Other workforce policy ideas being debated

1. Hazard pay/increase in wages for home support services for elderly and folks with disabilities – to allow for child care
2. Better system for paying primary care and dental care, e.g., PMPM to allow population health approach
3. Regional hotlines for H workers to ask questions and report concerns, as well as answer questions about SOP and licensing
4. Free counseling for health workers
5. Access to remote interpreter services
6. National Health Workforce Commission
Data Tools for States
http://www.gwhwi.org/covid-resource.html

1. **State Health Workforce Estimator**: Updated based on IMHE scenarios with modifiable hospital staffing and workforce attrition ratios. (RTs, Intensivists, Critical Care RNs, Hospitalists & Pharmacists)

2. **Contract Tracing Workforce Estimator**: Updated based on JHU last 14 days of county and state level cases, calculates number of CTs to clear classes in one week, with modifiable case load, contacts followed etc.

Other Health Workforce Resources: http://www.healthworkforceta.org/covid-19/
What’s the Future?

• The data and knowledge around Surge and Flex will stick and will help in future outbreaks
• The flex side is likely to stick
  • At org level cross training and task shifting
  • Telehealth
  • SOP
  • Practice hours
• Surge, learning about where we have shortfalls and surpluses to inform education and GME
• Need for standards evident
CMS TELEHEALTH POLICY CHANGES

May 6, 2020
National Conference of State Legislatures

Mei Wa Kwong, JD,
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

• Any information provided in today’s talk is not to be regarded as legal advice. Today’s talk is purely for informational purposes.
• 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
- Program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012
- Work with a variety of funders and partners
CCHP PROJECTS

• 50 State Telehealth Policy Report
• Administrator National Consortium of Telehealth Resource Centers
• Convener for California Telehealth Policy Coalition
TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS

Search by Category & Topic

Medicaid Reimbursement
- Live Video
- Store & Forward
- Remote Patient Monitoring Reimbursement

Private Payer Reimbursement
- Private Payer Laws
- Parity Requirements

Professional Regulation/Health & Safety
- Cross-State Licensing
- Consent
- Prescribing
- Misc (Listing of Practice Standards)
The Medicare policy on the use of technology to provide services is in two buckets.
<table>
<thead>
<tr>
<th>SUBJECT AREA</th>
<th>POLICY DURING COVID-19</th>
<th>POLICY FQHC/RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic/Site location for patient</td>
<td>No geographic restrictions, patient allowed to be in home during telehealth interaction</td>
<td>No geographic restrictions, patient allowed to be in home during telehealth interaction</td>
</tr>
<tr>
<td>Location of provider</td>
<td>Provider able to provide services when at home, need not put home address on claim</td>
<td>Provider able to provide services when at home</td>
</tr>
<tr>
<td>Type of provider</td>
<td>All health care professionals to bill</td>
<td>Temporarily added to list of eligible providers</td>
</tr>
<tr>
<td>Modality</td>
<td>Live Video. Phone will be allowed for codes audio-only telephone E/M services and behavioral health counseling and educational services. Other modalities allowed for Communications Based Services</td>
<td>Live Video. Phone will be allowed for codes that are audio-only telephone E/M services and behavioral health counseling and educational services. Other modalities allowed for Communications Based Services</td>
</tr>
</tbody>
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CMS TELEHEALTH POLICY - NOW

<table>
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<tr>
<th>SUBJECT AREA</th>
<th>POLICY DURING COVID-19</th>
<th>POLICY FQHC/RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>Approximately 180 different codes available for reimbursement if provided via telehealth. List available <a href="#">HERE</a>.</td>
<td>Can only provide the services on <a href="#">THIS</a> list via telehealth and be reimbursed by Medicare.</td>
</tr>
<tr>
<td>Amount of reimbursement</td>
<td>Same as would received if it had been provided in-person (Fee-for-service rate). Some rates for telephone visits have been increased.</td>
<td>$92.03</td>
</tr>
<tr>
<td>Modifiers</td>
<td>Per the final interim rule, providers are allowed to report POS code that would have been reported had the service been furnished in person so that providers can receive the appropriate facility or non-facility rate and use the modifier “95” to indicate the service took place through telehealth. If providers wish to continue to use POS code 02, they may and it pays the facility rate</td>
<td>For services delivered January 27, 2020 – June 30, 2020 <strong>RHCs</strong>: Use G2025 with CG modifier. 95 modifier can be appended, but is not required. <strong>FQHCs</strong>: Must report 3 HCPCS/CPT codes: (1) the PPS specific payment code; (2) the HCPCS/CPT code that describes the service with the 95 modifier; (3) G2025 with modifier 95 <strong>Beginning July 1, 2020</strong> FQHCs/RHCs: Only submit G2025. RHCs should no longer use CG modifier.</td>
</tr>
</tbody>
</table>
## CMS Telehealth Policy - Now

<table>
<thead>
<tr>
<th>Other Issues</th>
<th>Policy During COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dialysis Patients</strong></td>
<td>Secretary has power to waive requirements that home dialysis patients receiving services via telehealth must have a monthly face-to-face, non-telehealth encounter in the first three months of home dialysis and at least once every three consecutive months.</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>During an emergency period, the Secretary may allow telehealth to be used to meet the requirement that a hospice physician or nurse practitioner must conduct a face-to-face encounter to determine continued eligibility for hospice care.</td>
</tr>
<tr>
<td><strong>Providers needing to put their home addresses</strong></td>
<td>Allow 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.</td>
</tr>
<tr>
<td><strong>Hospitals &amp; Originating Site Fee</strong></td>
<td>Hospitals can bill an originating site fee when the patient is at home. <a href="#">Guidance</a>.</td>
</tr>
<tr>
<td><strong>Hospital-Only Remote Outpatient Therapy &amp; Education Services</strong></td>
<td>Hospitals may provide through telecommunication technology behavioral health and education services furnished by hospital-employed counselors or other health professionals who cannot bill Medicare directly. Includes partial hospitalization services and can be furnished when the beneficiary is at the home. <a href="#">Guidance</a>.</td>
</tr>
</tbody>
</table>
### CMS TELEHEALTH POLICY - NOW

<table>
<thead>
<tr>
<th>OTHER ISSUES</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of frequency limits</td>
<td>Subsequent inpatient visit limit of once every three days (CPT codes 99231-99233); Subsequent SNF visit limit of once every 30 days (CPT codes 99307-99310) • Critical care consult of once per day (CPT codes G0508-G0509).</td>
</tr>
<tr>
<td>Stark Laws</td>
<td>Some waivers allowed for Stark including hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians; health care providers can support each other financially to ensure continuity of health care operations</td>
</tr>
<tr>
<td>Supervision/Practice Top of Licensure</td>
<td>Some supervision changes including allowing live video for physician supervision.</td>
</tr>
</tbody>
</table>


Pre-COVID-19, FQHCs & RHCs were not allowed to act as distant site providers in the Medicare program. The CARES Act changed that and during a public health emergency, they can provide services as a distant site provider using telehealth. **UPDATED APRIL 30, 2020.**

# Medicare Guidance to FQHCs/RHCS

<table>
<thead>
<tr>
<th>The Question</th>
<th>CMS Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>What modality may be used?</td>
<td>For telehealth, FQHCs and RHCs may furnish services through an interactive audio and video telecommunications system and certain services via audio-only. Some services not considered “telehealth” but use telehealth technologies also available. See “Virtual Communications Services” below.</td>
</tr>
<tr>
<td>What provider in my FQHC/RHC can provide services?</td>
<td>Any health care practitioner working at an FQHC/RHC as long as it's within his/her scope of practice.</td>
</tr>
<tr>
<td>Can my practitioners furnish services when they are at home?</td>
<td>Yes, the health care practitioner does not need to be located at the FQHC/RHC during the telehealth interaction.</td>
</tr>
<tr>
<td>What services can be provided?</td>
<td>Only the services that are approved for coverage when delivered via telehealth. The list of services can be found <a href="#">HERE</a>.</td>
</tr>
<tr>
<td>THE QUESTION</td>
<td>CMS INSTRUCTION</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Will an FQHC get their PPS rate/RHC their AIR rate?</td>
<td>No. The CARES Act required a methodology based upon the fee-for-service rates be used to calculate an amount to be paid for telehealth services provided by FQHC/RHCs. This amount is $92.03.</td>
</tr>
<tr>
<td>If the FQHC and RHC don’t get their PPS/AIR rate, does the Medicare Advantage (MA) wrap-around payment apply to these services?</td>
<td>No. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.</td>
</tr>
<tr>
<td>Co-pays?</td>
<td>For services related to COVID-19 testing including those done through telehealth, RHCs/FQHCs must waive the collection of co-insurance from beneficiaries. Use the “CS” modifier on the service line.</td>
</tr>
<tr>
<td>THE QUESTION</td>
<td>CMS INSTRUCTION</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Will the costs for providing telehealth be used to determine the PPS/AIR?</td>
<td>No, but the cost still must be reported on the appropriate cost form. For RHCs – Form CMS-222-17 on line 79 of Worksheet A in the “Cost Other Than RHC Services.” FQHCs use CMS-224-14, on line 66 of Worksheet A, “Other FQHC Services.”</td>
</tr>
<tr>
<td>Do I need to get informed consent?</td>
<td>Not for telehealth, but you do for Care Management and Virtual Communication Services. The consent can be obtained at the same time the services are being furnished and can be obtained by someone working under the general supervision of the RHC/FQHC practitioner and direct supervision of obtaining the consent is not required.</td>
</tr>
</tbody>
</table>
BILLING - RHCs

- For RHCs, services provided January 27, 2020 to June 30, 2020, use G2025 with modifier “CG.” The AIR rate will be paid, but these claims will automatically be reprocessed in July with the new payment rate. The RHC will not need to resubmit these claims. Beginning July 1, 2020, CG modifier no longer needed.
For FQHCs, services provided between January 27, 2020 to June 30, 2020 that are also FQHC qualifying visits, three HCPCS/CPT codes for distant site telehealth services must be used: 1) PPS specific payment system code: G0466, G0467, G0468, G0469 or G0470; 2) The HCPCS/CPT code that describes the services furnished via telehealth with modifier 95; and G2025 with modifier 95.

These claims will be paid at the FQHC PPS rate until June 30, 2020, and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate. FQHCs do not need to resubmit these claims for the payment adjustment. When furnishing services via telehealth that are not FQHC qualifying visits, FQHCs should hold these claims until July 1, 2020, and then bill them with HCPCS code G2025. Beginning July 1, 2020, FQHCs will only be required to submit G2025 where modifier 95 may be appended but it is not required.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>MODALITY</th>
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| Virtual Check-In Codes  
G2010, G2012  
Audio-Only Services - CPT codes 98966 -98968; 99441-99443          | Live Video, Store-and-Forward or Phone                                    |
| Interprofessional Telephone/Internet/EHR Consultations (eConsult)      | Can be over phone, live video or store-and-forward                       |
| 99446, 99447, 99448, 99449, 99451, 99452                                 |                                                                          |
| Remote monitoring services:                                            |                                                                          |
| **Chronic Care Management** (CCM); Complex Chronic Care Management (Complex CCM); Transitional Care Management (TCM); Remote Physiologic Monitoring (Remote PM); Principle Care Management (PCM) | RPM                                                                      |
| Online Digital Evaluation (E-*Visit) – G2061-2063                        | Online portal                                                            |
| Online Medical Evaluations – 99421-99423                                 |                                                                          |

VIRTUAL COMMUNICATION SERVICES

➢ Virtual Communication Services are **NOT** considered telehealth services by Medicare. These service use telehealth technologies like live video as well as the telephone.

➢ May provide virtual check-in services which can be done via live video, phone or asynchronously. G2010 or G2012.

➢ May use online digital evaluation and management services. These are non-face-to-face, patient initiated, digital communications on a secure patient portal. CPT Codes 99421-99423

➢ **TO BILL FOR THE ABOVE SERVICES,** FQHCs/RHCs use code G0071 and it can be either alone or with other payable services. For G0071 claims submitted on or after March 1, 2020 to end of the PHE, the rate paid is $24.76.
ADDITIONAL SERVICES

➢ Temporarily altered process in how new services are approved for reimbursement if delivered via telehealth.
➢ During the PHE, will use a subregulatory process to modify services included on the Medicare telehealth list.
➢ When CMS receives a request to add or identifies by internal review a service that can be furnished in full (as described by the relevant code) in a manner similar to in-person, it will post on the listing of eligible services delivered via telehealth.
DEA

The declaration of the national emergency enacted one of the exceptions to the Ryan Haight Act for telehealth (telemedicine as it is referred to in the Act).

For as long as the Secretary’s designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

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

https://www.deadiversion.usdoj.gov/coronavirus.html

For treating OUD, may prescribe via phone buprenorphine if certain conditions met. 
MEDICAID REIMBURSEMENT BY SERVICE MODALITY (Fee-for-Service)

- **Live Video**: 50 states and DC
- **Store and Forward**: Only in 14 states
- **Remote Patient Monitoring**: 22 states

*As of October 2019*
40 states and DC have telehealth private payer laws. Some go into effect at a later date.

Parity is difficult to determine:

- Parity in services covered vs. parity in payment
- Many states make their telehealth private payer laws "subject to the terms and conditions of the contract"

As of October 2019
Common telehealth policy changes

- Allowing home to be an eligible originating site
- Allowing telephone to be used to provide services
  - Note: May only allow G2012/G2010
- Requiring health plans, managed care and private to cover telehealth services and offer parity
Less common telehealth policy changes

- Expanding use of other modalities besides phone
- Expanding the list of eligible providers to include others such as allied health professionals
- Waiving consent requirements, usual an adjustment made such as allowing it to be verbal consent
Telehealth: Health care from the safety of our homes.

During the COVID-19 Public Health Emergency, we don't have to choose between medical care and social distancing. When patients can get health care through telehealth—and doctors can provide it—we protect ourselves, our families, and our communities.

Learn more about telehealth

For patients
Find out what telehealth is, what you'll need (not much!), and what to expect from a visit. You can also check out our tips on finding telehealth options.

For providers
Get information to help you provide telehealth, get up to speed on recent COVID-19 related policies, and learn what patients will need to use telehealth.

For providers
Wading through telehealth? Check out the information below to better understand your options.

COVID-19 self-assessment tools
For the sake of everyone's safety and to reduce the impact on the healthcare system, increased screening tools may be necessary for those seeking services.

Finding telehealth options
To find telehealth options, visit the Health Resources and Services Administration (HRSA) Telehealth Resource Center.

Understanding telehealth
For more tools and self-assessment tools, visit the COVID-19 Resources section of the HRSA Telehealth Resource Center.

For patients
For providers

https://telehealth.hhs.gov/
➢ CCHP Website – cchpca.org
   ▪ Telehealth Federal Policies -
     https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies
   ▪ State Emergency Waivers/Guidances -
     https://www.cchpca.org/resources/covid-19-related-state-actions
➢ Subscribe to the CCHP newsletter at cchpca.org/contact/subscribe
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LICENSING CHANGES TO MOBILIZE HEALTH WORKFORCE

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NCSL is tracking 49 states who have taken some sort of executive, legislative and/or regulatory action related to health care worker licensing and COVID-19.

- Reciprocity
- Expedited Licensure
- Licensing Changes for Students
- Temporary or Emergency Licensure
- Licensing Changes for Retired Workers
- Reducing Administrative Burden on Current Licensees
INCREASED RECIPROCITY

- Many states are modifying their licensing reciprocity to allow nurses, doctors, respiratory therapists and other health professionals to offer their services across state lines.
- Many health professions are regulated in such a way that can restrict the flow of workers across state lines.

Licensed Health Workers: Under Normal Circumstances
INCREASED RECIPROCITY CONTINUED

- **Temporary changes to allow for greater reciprocity**: Alaska, Colorado, Delaware, Florida, Kentucky, Maryland

- **Foreign-Trained health reciprocity**: Some states are allowing foreign-trained health workers to assist in state pandemic-response efforts: Nevada, New Jersey and New York

- **Federal actions**: The Centers for Medicare and Medicaid Services are temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services.
Temporary/Emergency Licensure

- Allow states to still have some level of regulatory review, but also allow them to bypass certain requirements such as residency requirements and fees.
- Issued quickly, valid for a temporary period.
- Alabama, Georgia, Kansas, Louisiana, Massachusetts, North Dakota, Oklahoma, Texas

Expedited Licensure

- Allows states to continue their regulatory review processes, but on a condensed timeline.
- Alabama’s Board of Medical Examiners: 48 hours
- Ohio’s Board of Nursing: 3 days
- South Carolina’s Medical Board: 24 hours
Retired Health Workers

- Many states are asking recently retired health professionals to return to work to assist with the pandemic response.
- Some states are allowing retirees to practice immediately: California, Delaware, Indiana, Louisiana, Oregon, Tennessee
- Others are requiring some form of regulatory review before reinstating workers whose licenses have lapsed or expired: Massachusetts, New Jersey, Texas
Students

- States are also asking students close to graduation or who have graduated, but not yet had the chance to take their licensing exam, to offer their expertise.

- Some states are allowing current medical, nursing and other students with some clinical experience to offer a limited scope of services to patients: Arkansas, California, Kentucky

- Others are expediting graduation for students and expediting the licensing process as well: Rhode Island, Louisiana
REDUCING ADMINISTRATIVE BURDENS FOR CURRENT WORKERS

- **Delaying license renewals**: Arizona, Indiana, Minnesota, Wisconsin, Wyoming
- **Waiving license renewal fees**: Illinois, Nebraska
- **Waiving continuing education requirements**: Michigan, New Mexico, Tennessee
Thank You!

Contact
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Questions and Answers

Please type your questions into the chat box in the lower left-hand corner of your screen.
ADDITIONAL RESOURCES

- www.scopeofpracticepolicy.org
- www.gwhwi.org/covid-resource.html
- www.cchpca.org
- www.ncsl.org/stateslicense