SERVICES DELIVERED THROUGH TELEHEALTH MODALITIES
MEDICAID COVERAGE AND PAYMENT PROPOSED REGULATIONS

Public Comments Received February 28, 2023 – April 6, 2023

On February 28, 2023, in compliance with HB265, the Department of Health proposed changes to Alaska Medicaid coverage and payment to significantly expand coverage of services delivered through telehealth modalities. Except for exclusions allowed under AS 47.07.069(b)(1) – (3), the proposed regulations would establish coverage and payment rules for services delivered through a HIPAA-compliant telehealth modality as if the service were delivered in-person. The exceptions allowed under AS 47.07.069 include a service that the department *"(1) specifically excludes or limits the service from telehealth coverage or reimbursement by regulations adopted under this subsection; (2) determines, based on substantial medical evidence, that the service cannot be safely provided using telehealth or using the specified mode; or (3) determines that providing the service using the specified mode would violate federal law or render the service ineligible for federal financial participation under applicable federal law."*

A public hearing was held on March 24, 2023, to allow for oral presentation of comments. The public comment period closed at 5:00pm on April 6, 2023. The Divisions of Health Care Services, Behavioral Health, and Senior and Disabilities Services reviewed each comment submitted during the public comment period. This document contains the Department of Health's responses to those comments. Identical or substantively similar comments have been consolidated for purposes of response. All public comments received are attached to this response documents.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
General support of the proposed changes, in part or in whole	The Department of Health appreciates the provider support.
Providers should be reimbursed for travel, gasoline, computer knowledge, and use of provider-owned equipment, equipment rental, and provider expertise.	A covered service is reimbursed the same rate, whether delivered in-person or via telehealth. Provider travel, gasoline, and equipment are considered costs of doing business and are not separately reimbursed, whether services are delivered in-person or via telehealth. Provider knowledge and expertise are considered requirements of licensure or certification and are not separately reimbursable.
Most recipients are not computer literate.	The proposed telehealth regulations, if filed, will provide for coverage of services delivered by means of a wide array of telehealth modalities, including modalities that do not require computer literacy. Additionally, use of telehealth is allowed, but is not required.
The effective date of the proposed changes, if adopted and filed, will occur after the termination of flexibilities allowed under the COVID-19 public health emergency on May 11, 2023, creating a gap in telehealth coverage.	Following consultation with the Alaska Department of Law, the Department of Health has made the decision, consistent with HB 265, enacted in 2022, to extend Medicaid telehealth flexibilities beyond May 11, 2023, until proposed regulations are effective.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
The State of Alaska needs to pull all telehealth-based fee schedules, trainings, manuals, and regulations to ensure that the required CPT codes are included under telehealth, the definition of service.	These suggestions are outside the scope of the regulatory proposal. Implementation documents are updated as necessary when regulatory changes occur, but those updates cannot be published until a regulatory change is filed and an effective date is known. No telehealth fee schedules will be published, as a service delivered via telehealth is paid at the same rate as if the service were delivered in-person.
Provide the federal requirements for telehealth services, including definitions and fee schedules prior to any implementation of the proposed regulations to assure that HSS is compliant with CMS requirements."	For most Medicaid benefits, federal Medicaid regulations do not specifically address telehealth delivery methods or the criteria for implementation of telehealth. States are given broad flexibility in designing parameters for delivery of services via telehealth, so long as the modalities and delivery are HIPAA-compliant. The proposed regulations are fully compliant with HB265 and with HIPAA privacy and security requirements (P.L. 104 – 191, Health Insurance Portability and Accountability Act (HIPAA) of 1996).
Is Zoom an acceptable "real time" modality? If not, what are the top five preferred/used in Alaska?	A service delivered via a HIPAA-compliant digital application is covered for the purpose of delivery of a service via telehealth. For example, the HIPAA-compliant *Zoom for Healthcare* is acceptable; the standard Zoom version is *not* HIPAA-compliant and is therefore not an acceptable mode of healthcare delivery. The provider is responsible for verifying, prior to use, that a telehealth modality is HIPAA-compliant. The Department of Health cannot recommend or endorse telehealth modalities and does not maintain a public list of modalities from which a provider may select.
7 AAC 110.625(a)(1)(B): add "*including, but not limited to, telephone, two-radio, cellular phone, and internet-based calling*" after "*headphones*" to avoid overly limiting in the types of allowed two-way audio-only modalities. Add "*such as*" language with additional examples in plain language, e.g., telephone, radio. This addition would allow for modalities explicitly called out in HB265.	7 AAC 110.625(a)(1)(B) would allow for use of any HIPAA-compliant real time, two-way communication modality to provide a service if the modality allows the provider and recipient to speak and listen to each other. The proposed regulations are compliant with federal Office of Civil Rights (OCR) requirements and do not limit the use of "telephone, two-way radio, cellular phone, and internet-based calling" so long as they are HIPAA-compliant. Inclusion of examples is not necessary to meet the requirements of HB265 and could be interpreted as limiting of coverage of future technology.
7 AAC 110.625(a)(2): add "*data*". The description of telehealth modalities is not broad enough to include all forms of information that can be included in telehealth delivery; "*telehealt*h" definition includes "*transfer of medical data*."	"*Data*" is implied but will be added to the draft for clarity.
7 AAC 110.630(1) specifies "licensed" providers; should include "certified" providers who also can provide telehealth services. These provider types are called out in HB265. "Licensed" excludes PTs that HB 265 allows to provide svcs via telehealth, e.g., CHA, BHA, DHAT, CDC, QAP, BHA, CMs, CC; new language proposed to replace (1) and (2).	It was the Department's intent to include "certified" providers, as evidenced by inclusion of multiple instances of "certified," e.g., 7 AAC 110.630(4), 7 AAC 110.630(6), 7 AAC 110.639(3)(A). The omission in 7 AAC 110.630(1) was unintended; the draft will be amended to include "certified."

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
ONLINE DIGITAL SERVICES • 7 AAC 110.625(b) uses terms not found in HB265. • "Digital application" could be interpreted to include Zoom and other platforms. • "Digital application" could rule out Zoom and other web-based platforms. • The term "online digital service" is too broad. • The definition of "patient-initiated online digital service" is too broad. • Language is cumbersome, could exclude interactive modalities. • Language excludes coverage intended under HB265. • Patient-initiated online digital service is too broad. • The definition at proposed 7 AAC 110.639(2) is unworkable. • Excludes all online telehealth platforms from coverage despite intent of HB265. • Patient-initiated and provider-initiated online digital service are incongruent. • 7 AAC 110.625(b)(2) disallowance of provider-initiated online digital services excludes follow-up crisis outreach, hampers provision of stabilization services • 7 AAC 110.625(b)(3) limits reimbursement for patient-initiated discussion within 7 days, could be detrimental, would exclude behavioral health encounters. • It should be easy for a recipient to connect with a provider as often as needed. • 7 AAC 110.625(b) would exclude services intended to be covered under HB265. • Delete 7 AAC 110.625(b); work with providers stakeholders to revise. • 7 AAC 110.639(2) revise/remove; may prohibit payment with relation to (b)(3). • 7 AAC 110.625(b) does not cite the appropriate restrictive authority found in AS 47.07.069(b)(1) – (3); legal reason for restriction is not clear. • Alternate language suggested: (X) for the use of patient messaging portals or secure electronic mail for non-evaluative or non-management services, including appointment scheduling and electronic communication of test results. (X) for a telehealth visit within the postoperative period of a completed procedure which is related to the illness, injury, or other reason for the corresponding procedure. This does not prevent payment for services which are unrelated to the procedure, including a new or emergent condition, behavioral health visit, or dental visit.	See pages 10 – 11 of this document for the Department of Health's response.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
7 AAC 110.630(c) add "referring provider" after "rendering provider."	There is no (c) subsection in 7 AAC 110.630, so it is unclear which instance of "rendering provider" in 7 AAC 110.630 to which the commenter is referring. The exclusion of "referring provider" throughout 7 AAC 110.630 was intentional, as the act of referring a patient is not a covered service. A provider who renders a covered service can submit a claim and be reimbursed for that service as a rendering provider. The same provider can also refer the patient to another provider for additional services. In this instance the provider is acting as both a rendering provider and a referring provider; however, only the rendered service is covered.
7 AAC 110.630(7) excludes young children, adults with complex needs where presence of the patient may not be appropriate; excludes use of asynchronous telehealth modalities when data is sent after a patient has left a visit with a rendering pv; (7) should be deleted. Family and caregivers can be present; additionally, this paragraph could be detrimental to the provision of telehealth services delivered via store-and-forward modalities.	The requirement that a patient be present for an in-person visit also applies to a telehealth visit and does not represent a change. The "*except as otherwise provided in 7 AAC 105 - 7 AAC 160*" language was included because patient presence is not required for all instances of some types of behavioral health services, and because the patient does not have to be present during the provision of services via asynchronous modalities. All other Medicaid-covered services currently require the patient to be present, whether in-person or via telehealth. This requirement does not preclude the presence of a family member, caregiver, or other individual from being present.
7 AAC 110.630(9) is overly burdensome; allow for a single durable consent for telehealth annually; patient location is unnecessary and burdensome; HB265 does not impose, and federal statute/regulations do not require, originating and distant site requirements. The support plan serves as written consent.	Consent is a requirement of the HIPAA privacy rule. The proposed language requires annotation of the patient's clinical record that the patient consented to delivery of services through a telehealth modality. Consent in writing is not required for a service delivered via telehealth; documentation that the provider asked, and the patient orally expressed, consent is adequate to meet the requirements of 7 AAC 110.630(9). Because not all services require a support plan, it was necessary to draft consent language that applies to all services. A support plan to which the recipient has consented meets the consent requirement of 7 AA 110.630(9) and must be included the patient's clinical record. Payment for a service that is covered when delivered via telehealth is paid at the same rate as if the service were delivered in person. The patient's location, in some instances, determines the rate that Alaska pays for a service.
There is benefit to surprise face to face visits and short notice video calls.	The proposed telehealth regulations do not prohibit face-to-face visits by care coordinators. In-person and unannounced visits may still occur.
7 AAC 110.635(2) it is possible for a health care provider acting in a supervisory capacity over a certified or licensed professional and acting in a capacity other than supervisory. Recommend revising to read, "…acting only in a supervisory capacity."	The act of supervision is not a covered service. In the event a supervising provider renders a service, that provider becomes a rendering provider; however, only the rendered service is covered, provided the service meets all criteria of a billable service.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
7 AAC 110.635(4) creates concern for certified providers and being covered and reimbursed for the service while facilitating a visit with a physician in a distance site.	The act of facilitating a telehealth visit includes appointment scheduling, ensuring telehealth equipment is working properly, timely connection to the telehealth modality, and ensuring that the connection between client and provider is working. These are administrative services and are thus not reimbursable, whether delivered via telehealth or in-person. When the provider delivering the service (e.g., an evaluation and management - E/M - visit) also acts as their own facilitator, the E/M visit is covered, but the facilitation of the visit is not, just as facilitation is not covered with a third person is acting as facilitator.
7 AAC 110.635(6) is inconsistent with HB265; remove restrictions; blanket exclusions restrict service innovation. HB265 allows exclusion or limiting of telehealth coverage if substantial evidence indicates the service cannot safely be provided via telehealth, if federal law prohibits provision via telehealth, or if provision via telehealth would render the service ineligible for federal funding. Proposed paragraph (6) excludes broad swaths of services and "shows no recognition of what services are currently provided through telehealth". • pharmacy services, including extensive counseling and medication review, e.g., INR follow-up, CGM follow-ups, weight-loss follow-ups. THOs have invested in tele-pharmacy services; loss of reimbursement will negatively impact these investments. • Certain dental services can be delivered via telehealth, e.g., DHA sharing radiographs with consulting dentist via asynchronous telehealth. • DME providers can provide telehealth consultation on set-up/use of DME. Paragraph of exclusions does not cite the appropriate state statute; does not cite medical evidence or federal prohibition for the proposed exclusions; department provides no supporting documentation to defend blanket exclusions. DEA pursuing telehealth regs at federal level; if the federal agency in charge of protecting the public from the dangers of controlled substances is contemplating how the dispensing of those medications can be safely delivered via telehealth, the state should not impose a blanket exclusion.	Flexibilities allowed during the COVID-19 public health emergency were implemented to remove impediments to the delivery of services and with little consideration of efficacy. These flexibilities provided the Department of Health (DOH) the unique opportunity to evaluate what telehealth changes that were already under consideration would look like. AS 47.07.069(b) allows the department to exclude or limit a service provided by telehealth or modality if the department "*specifically excludes or limits the service from telehealth coverage or reimbursement by regulations adopted under this subsection;* (AS 47.07.069(b)(1). Pharmacist: duties described in 12 AAC 52.210 include counseling and medication review, both of which are currently included in the cost of dispensing of a prescription and are not currently a separately billable service. The draft will be modified to clarify coverage of pharmacy dispensing services. The U.S. Drug Enforce Administration (DEA) is not pursuing *dispensing* via telehealth; the regulations proposed by the DEA are connected solely to the *prescribing* of controlled substances under clearly defined circumstances. The DEA proposed regulations are unrelated to pharmacist/pharmacy services. Dental: Historically, Alaska Medicaid has never covered teledentistry and its implementation would require significant program changes. To expedite the proposed telehealth regulations with the public health emergency expiration fast approaching, Alaska Medicaid will consider teledentistry coverage and requirements separately. DME: The cost of a DME item is inclusive of any costs associated with set-up and use consultation; these are not separately billable services, whether provided in person or via telehealth. This proposed change applies to coverage only and does not preclude a DME provider from providing consultation, when appropriate, via telehealth.
7 AAC 110.639(3) "provider" definition is unnecessary…recommend deletion.	The use of the term "provider" without a modifier of "rendering," "consulting," or "referring" means that the provider can be one or more of these types.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
7 AAC 110.639 recommend retaining the current definition of "referring provider." Recommend replacement of proposed definition of "rendering provider" with the following: (x) "rendering provider" means a provider who meets the requirements under 7 AAC 105.200 and 7 AAC 105.210 and evaluates, diagnoses, and treats a recipient, or acts as a referring provider.	The current definition of "referring provider" includes functions of a rendering provider, thus incorrectly implying that the act of referring is a covered service. A provider who renders a covered service can submit a claim and receive payment for that service (render). That provider can also refer the patient to another provider for additional services (refer). In this instance the provider is acting as both a rendering and referring provider; however, only the rendered service is covered. A definition for "referring provider" will be added to the draft for clarity.
7 AAC 110.639(4) recommend adopting definition of telehealth as having the meaning in AS 47.05.270(e).	The definition of "telehealth" mirrors the Centers for Medicare and Medicaid Services MS) definition but is consistent in intent to the definition provided in AS 47.05.270(e). A service that does not meet CMS requirements for billing and would not allow the department to receiving federal Medicaid matching funds. As defined in AS 47.05.270(e), not all telehealth services would meet CMS requirements for federal matching funds (AS 47.07.069(b)(3)).
For mental health physician clinics serving people experiencing homelessness outside of the clinic, we recommend replacing *identified as homeless* with *experiencing homelessness*, similar to that of 7 AAC 135.030(d)(4).	The proposed regulations draft will be revised to replace the single instance of "identified as homeless" with "experiencing homelessness." Although other behavioral health services, as they relate to homelessness, that are not addressed in this draft are outside the scope of the proposed telehealth regulations, your suggestion was shared with the Division of Behavioral Health for their review.
7 AAC 135.150(c)(2) recommend deleting; HB265 does not require a reason for delivery via telehealth to be documented.	7 AAC 110.630.(9) establishes documentation requirements re: location of provider and recipient. The proposed regulations draft will be updated to remove requirement that the provider document the reason for providing family psychotherapy via telehealth versus in-person.
7 AAC 145.020 is inconsistent with FQHC payment (since the payment methodology for FQHCs is not dependent upon charges). We recommend FQHCs be excluded from 7 AAC 145.020 to be consistent with federal requirements for FQHC payment.	7 AAC 145.020 is not referenced, directly or indirectly, in the proposed regulations and is outside the scope of the proposed changes. Please contact the Office of Rate Review if you have any questions or suggestions concerning cost reporting.
7 AAC 145.270(a), (b), and (c) should be amended to include "referring provider."	The exclusion of "referring provider" throughout 7 AAC 110.630 was intentional. The act of referring a patient is not a covered service. A provider who renders a covered service can submit a claim and be reimbursed for that service as a rendering provider. That provider can also refer the patient to another provider for additional services as a referring provider. In this instance the provider is acting as both a rendering provider and a referring provider; however, only the rendered service is covered.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
7 AAC 145.739(3) defines FQHC to be "face to face encounter…at a single location"; amend to allow for telehealth visits.	The proposed regulations draft will be modified; "face to face" will be replaced with "visit," and will include clarification that "visit" includes both an in-person service and a service delivered via a synchronous telehealth modality. This does not impact a FQHC's ability to submit a claim for an asynchronous telehealth service. This reflects the Centers for Medicare and Medicaid Services (CMS) definition of "face to face" as a synchronous encounter, regardless of modality, thus, telehealth is not excluded. "Location" refers to the FQHC's physical location and does not preclude the provision of services via telehealth. The definitions in 7 AAC 145.739 apply to cost-reporting, which is not impacted by the proposed regulations. Please contact the Office of Rate Review if you have any questions or suggestions concerning cost reporting.
Proposed regulations point to broader regulations under Title 7 but do not "interact" with specific portion where further reg changes are needed to implement HB265.	When referring to multiple citations across multiple sections, it can be impractical to cite each regulation. It is standard and acceptable to cite "7 AAC 105 – 7 AAC 160."
Replace "scope of licensure or certification" with "scope of practice" throughout draft for consistency with HB265.	Scopes of licensure and certification are specific to the state in which the license or certification is issued, whereas scope of practice is a less precise term that is not consistent across a profession with respect to states' requirements. For this reason, the Department must move use "scope of licensure or certification."
A care coordinator does not provide services related to the practice of medicine or nursing. I am concerned about misrepresenting my occupation's scope and qualifications.	Each provider must continue to comply with their respective scope of licensure or certification, regardless of modality. Please contact the Division of Senior and Disabilities Services if you have any questions about the provision of services.
Support removal of prohibition on telephone consultations.	Currently there is no prohibition on telephone consultations and the proposed regulations will not prohibit telephone consultations. The proposed regulations clarify the allowable telehealth modalities to require HIPAA-compliance.
"As a care coordinator, I do not understand what "direct supervision communications" or "facilitation" means therefore don't know if my service falls into one of those categories"	The proposed language to which you refer applies to only those provider types who are required to be supervised. Please contact the Division of Senior and Disabilities Services if you have any questions about provision of services.
Care Coordination does not provide treatment, evaluation, and assessment. What is the care coordinator's role, rendering, referring, or consulting?	A care coordinator, when providing covered services, is a rendering provider. Care coordinator certification does not allow for referring and consulting. Please contact the Division of Senior and Disabilities Services if you have any questions.
What license type does a care coordinator need to obtain to deliver services via telehealth? Will the SDS Certification assist with or confirm telehealth license or other requirements?	The proposed regulations would not alter licensure or certification requirements. No separate or special license or certification is required to provide services via telehealth. Please contact the Division of Senior and Disabilities Services if you have any questions about enrollment and the provision of services.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
If a care coordination client is unable to use Zoom, and request a Facetime, Messenger, or alternative video conference method, are those permitted? Or must those be routed through an intermediary like "Simple Visit."	A service delivered via a HIPAA-compliant digital application is covered for the purpose of delivery of a service via telehealth. It is the responsibility of the provider to verify that a telehealth modality is HIPAA-compliant prior to use.
There is language in the CCHP that says that Home and Community Based Waiver services won't be reimbursable. How do we reconcile this?	Neither the Department of Health (DOH) nor the Centers for Medicare and Medicaid Services has published a telehealth-related document titled "CCHP," thus we are unable to identify the document the commenter references. The proposed regulations allow for the provision of specified home and community-based waiver (HCBW) services via telehealth. 7 AAC 110.635 identifies HCBW services that are not covered when delivered via telehealth but exempts specified HCBW services from noncoverage in 7 AAC 110.635(6)(L)(i) – (iv); thus, care coordination, day habilitation, employment, and intensive active treatment services *are* covered when delivered via telehealth. In the event CCHP is an external document or source, DOH reminds the commenter to rely on Alaska Administrative Code, specifically, 7 AAC 105 – 7 AAC 160 and Department of Health-issued documents for coverage rules, and not on information from other sources, unless explicitly adopted or cited by DOH.
The current 7 AAC 110.625(b) identifies what the department will pay for under the telemedicine application; however, this has been omitted under the proposed amended regulation. After reading this section it is my understanding that care coordination under the HCBW program would not be included as it currently is written:	The proposed telehealth regulations do not exclude coverage of care coordination covered services when delivered via telehealth. 7 AAC 110.625 proposes to repeal and replace 7 AAC 110.625 in its entirety; if filed, the current version of (b) will no longer exist. Please contact the Division of Senior and Disabilities Services if you have any questions about the provision of care coordination services.
"I have great concerns regarding the telehealth provider requirements and conditions of payment (section)of the proposed and current regulations vs what care coordinators have been directed to do by SDS for billing purposes. In the proposed and current regulations, it states that a modifier and that POS coding are required to bill under telehealth, however modifiers are not present in the current Care Coordinator fee schedule and have not been provided by the training unit. Furthermore, the fee schedule for telehealth services, which outlines what services can bill as telehealth, do not include care coordination services."	The proposed language in 7 AAC 110.630(5) states, "claim submitted to the department must include *applicable* telehealth modifiers and place-of service coding." If, in accordance with national coding requirements, a modifier is not required, the "modifier" language of 7 AAC 110.630(5) is not *applicable*. However, all providers submitting professional claims must include place of service (POS). All covered HCB waiver services are identified in separate fee schedules that are not included in or impacted by these proposed regulations. Please contact the Division of Senior and Disabilities Services if you have any questions about enrollment and the provision of services.
Targeted case management listed on the fee schedule. The State Medicaid billing manual and State regulation under Targeted Case Management refers solely to the ILP program. To lump care coordination and ILP services together would be inappropriate; care coordination services ARE NOT medical services and were not written into the HCBW program to become a medically based service.	The proposed regulations do not combine care coordination with other services. 7 AAC 110.635(6)(L)(i) excludes care coordination from the list of services that are not covered when provided via telehealth; i.e., care coordination *is* covered when provided via telehealth. Under 7 AAC 110.635(6)(M), long term services and supports targeted case management services, except for case management services provided under 7 AAC 128.010(b)(2), are identified as noncovered services when delivered via telehealth.

PUBLIC COMMENT	DEPARTMENT OF HEALTH RESPONSE
"Lumping these two services" opens care coordinators up to the requirements of TCM third party liability billing. Care coordination services are not a medical service. Requiring care coordinators to comply with TPL be an unnecessary burden.	The proposed regulations do not combine care coordination with other services. Neither current nor proposed regulations require a care coordinator to comply with TPL requirements.
Alaska care coordinator CPT codes are not included under CMS telehealth billing guidelines, and the description of the scope of telehealth services appears to be limited to virtual check-ins (again our CPT codes are not included under covered services) and only apply to recipients that are established.	If the proposed regulations are filed, all related manuals, training materials, and other DOH publications will be updated accordingly. Remittance advice (RA) messages will be issued when revised materials are available. HCB waiver services are identified in separate fee schedules and are not included in or impacted by these proposed regulations. Please contact the Division of Senior and Disabilities Services if you have any questions.
Registering with the telehealth business registry is listed as a requirement for telehealth billing; this contradicts what care coordinators have been told/instructed to do by SDS and Conduent. Care Coordinators were told that they were exempt from this registration.	7 AAC 110.630(3) states, "the provider***, if*** licensed under AS 08 and ***required under 12 AAC 02.600***, must be registered under 12 AAC 02.600 (telemedicine business registry)." Registry under 12 AAC 02.600 is dependent upon 12 AAC registry requirements. The language "if required" in 12 AAC 02.600 was included because some provider types, including care coordinators, are not required to register.
7 AAC 110.630(7) states the recipient must be present for the telehealth modality however SDS regulation allows the care coordinator to have contact with the legal representative absent the recipient; it's an "and/or" not singular."	7 AAC 110.630(7) states, "*except as otherwise provided in 7 AAC 105 - 7 AAC 160, a recipient must be present during and participate in a telehealth encounter.*" If a service or service category, as established in 7 AAC 105 – 7 AAC 160, does not require the recipient to be present when the service is delivered in-person, the recipient is not required to be present for that service when delivered via telehealth.
Throughout the PHE and posted clarifications, e-alerts, RA messages and directive sessions held by SDS and Conduent there has been continued contradictory information provided to care coordinators.	We are sorry that this has been your experience, however any concerns about publications are outside the scope of this regulatory proposal. Please contact the Division of Senior and Disabilities Services for questions regarding their publications.
7 AAC 140.200 cost reporting needs to be modified; the regulations assume that cost reporting is based on the Medicare template. Under Medicare, "telehealth services" are considered non-FQHC services and paid under a different methodology.	7 AAC 140.200 is not referenced, directly or indirectly, in the proposed regulations and is outside the scope of the proposed changes. The Medicare Cost Report template is modified for Medicaid purposes to include telehealth and other services, as applicable. Please contact the Office of Rate Review if you have any questions or suggestions concerning cost reporting.

Telehealth Modalities: Clarification of *Online Digital Services*

In 2022, House Bill 265 was enacted allowing Alaskan health care providers to render services using a variety of telehealth modalities including, "audio, visual, or data communications, alone or in any combination, or through communications over the Internet or by telephone, including a telephone that is not part of a dedicated audio conference system, electronic mail, text message, or two-way radio."

Alaska Medicaid has covered a wide variety of telehealth services for more than a decade. However, current regulations do not allow the use of some telehealth modalities referenced in HB 265.

The Department of Health (DOH) proposed a telehealth regulations package that clarifies and expands the telehealth modalities currently covered—*audio, visual, data communications (a.k.a. store-and-forward), and telephone*—while defining new telehealth modalities—*internet communications, electronic mail, and text messages*.

Note: Not all telehealth interactions are eligible for reimbursement even if the interaction serves a necessary administrative purpose. This type of telehealth is not prohibited but is not separately reimbursable.

When is it covered?

The proposed regulations do not permit or preclude a patient from connecting with a provider using internet communications, electronic mail, and text messages, but instead establish what is, and what is not, a billable service per national coding requirements.

For a telehealth service to be considered a covered service in Alaska Medicaid, the service must be:

- Compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Meet the requirements of a billable service as defined by American Medical Association (AMA) in the Current Procedural Terminology (CPT) coding criteria for the date of service.

Internet communications (e.g., messaging through an electronic health record or patient portal), electronic mail, and text messages are defined by the American Medical Association (AMA) as a type of **online digital service**.

Per AMA coding guidelines, online digital services may be separately billable if the communication(s) is:

- Evaluative in nature,
- Patient-initiated,
- Not within the post-operative period of a completed procedure (included in the reimbursement of the procedure),
- Not within seven days of an in-person visit and directly related to the illness, injury, or other reason for that visit.

What does that mean?

Use of online digital services for non-evaluative, non-management *administrative* functions such as updating the patient's insurance or scheduling an appointment are not reimbursable.

Providers are not prohibited from initiating communication through methods such as *internet communications*, *electronic mail*, and *text messages* but these are not reimbursable services.

A patient-initiated service that occurs within 7 days of an office visit or telehealth service related to the chief complaint or that is within the post-operative period of a completed procedure, is not separately billable as the online digital service would be included in the primary service or procedure. Patient-initiated online digital services for healthcare-related reasons such as reporting a new symptom, asking a question about a medication, or asking for clarification of test results may be reimbursable as a standalone service.

How are other telehealth services impacted by patient-initiated online digital services?

The coverage or non-coverage of an online digital service does not impact the utilization, frequency, or coverage of concurrent services rendered through a covered live/interactive or a store-and-forward telehealth modality so long as the live/interactive or store-and-forward service meets the AMA CPT criteria for a billable telehealth service.

An online digital service is meant to expand a patient's options to communicate health concerns and request clarification. They also enhance a provider's ability to evaluate and manage a patient's healthcare where an in-person or telehealth encounter is not warranted.

Examples

Patient A

On 11/01/23, Patient (A) messages their provider using a patient-initiated online digital service to report an earache. On 11/03/23, Patient (A)'s provider recommends an in-person or telehealth visit related to the same earache with that same provider or another provider in that group.

In this example, the online digital service occurred within 7 days of the related in-person or telehealth visit and **does not meet** criteria as a separately billable service. Only the in-person visit is billable.

Patient B

Patient (B) receives a behavioral health (BH) service through a HIPAA-compliant audio-video platform on 12/11/23. On 12/13/23, Patient (B) submits a question, via an online digital service, about their hypertension medication (unrelated to the 12/11/23 BH service). On 12/14/23, Patient (B) submits a question to schedule a follow-up appointment to the 12/11/23 appointment, per their treatment plan. The follow-up BH service occurs 12/15/23 through the same audio-only platform.

In this example, the 12/13/23 online digital service **meets** criteria of a separately billable service because it is not related to another billable service that occurred within 7 days. The 12/14/23 online digital service **does not meet** criteria as a separately billable service because it is not an evaluative or management service. The 12/11/23 and 12/15/23 BH services are each billable as live/interactive telehealth services.

Dunkin, Susan M (DOH)

From: Kathy Wallace <kwallace@ninilchik.net>
Sent: Wednesday, March 01, 2023 2:32 PM
To: Dunkin, Susan M (DOH)
Subject: Telehealth SDS Assessments

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Susan:
I cannot even begin to count the number of Telehealth Assessments I have done on my laptop over many years! As far as I know there is no way to be reimbursed for my travel to the assessments, my computer knowledge and use of my equipment. These are my clients but there should be a separate billing compartment on the Cost Sheet to list the cost to me in gas travel, equipment rental, and expertise as it does happen in addition to normally scheduled visits. In addition, most of the people needing assessments are not computer literate or not able to operate equipment and do not own computers or laptops. I do not see that this extra effort being picked up by Care Coordinators is being funded in any way on the pay scale for CCs.

--
Kathy Wallace, *CC*
kwallace@ninilchik.net
11845 Sterling Hwy
Ninilchik, Alaska 99639
Phone: 907-567-3990
Fax: 907-917-2828
Home/Cell: 907-252-2508
Ninilchik Point of Care Coordination

Dunkin, Susan M (DOH)

From: Jared Kosin <jkosin@alaskahha.org>
Sent: Tuesday, April 04, 2023 3:24 PM
To: Dunkin, Susan M (DOH)
Cc: Jeannie Monk; Ryan Johnston
Subject: Comments to Proposed Telehealth Regulations
Attachments: AHHA Public Comments re Telehealth Proposed Changes to Regulations 4-4-23.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Ms. Dunkin,

Please see attached public comments from the Alaska Hospital & Healthcare Association.

Jared

JARED C. KOSIN, JD, MBA
President & CEO
1007 W. 3rd Ave, Suite 301
Anchorage, AK 99501
o. (907) 646-1444
c. (907) 406-0555
alaskahha.org

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION 70 YEARS

April 4, 2023

Ms. Susan Dunkin
Department of Health
Division of Healthcare Services
4601 Business Park Blvd, Bldg K
Anchorage, AK 99503
susan.dunkin@alaska.gov

Re: Proposed changes to regulations for Medicaid coverage and payment for services delivered through telehealth modalities

Dear Ms. Dunkin,

For 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and other healthcare partners across the continuum of care. AHHA members play an invaluable role, both as community providers and essential employers, in cities, towns, and villages across Alaska.

We appreciate the opportunity to provide written comments on the Department of Health's proposed regulation changes in Title 7 of the Alaska Administrative Code to implement the requirements of HB 265. We appreciate the intent of HB 265 and these proposed changes to regulation as they will help continue many telehealth flexibilities that were implemented in response to the COVID-19 public health emergency, and allow Medicaid recipients to access care across Alaska.

AHHA commends the Department on its proposed changes to regulations as they generally align well with the statutory changes from HB 265. However, there are some issues that AHHA wishes to highlight.

The first item for comment is the effective date of the regulations. The federal public health emergency ends May 11, which means it is more likely than not there will be a gap between this expiration and the effective date of regulations implementing the changes to telehealth from HB 265. Since HB 265 and any corresponding regulations are designed to preserve many of the telehealth flexibilities afforded during the public health emergency, it is critical the Department act to prevent any flexibilities or services from ending during this gap to the extent possible under its authority.

Our next comment pertains to telehealth modalities as described in 7 AAC 110.625. More specifically, subsection (a)(2) contains wording that appears to not be broad enough to include all forms of information that can be included in telehealth delivery. We recommend adding the word "data" after "digital images" in that paragraph.

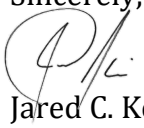
Moving to subsection (b) of 7 AAC 110.625, we are concerned about this entire section because it appears to be using terms that are either not found in the legislation or carefully worded in the definitions section. For example, the term "online digital service" is overly broad.

We are especially concerned by paragraph (3) in 7 AAC 110.625(b), which disallows reimbursement for a patient initiating a discussion within certain timeframes. This limitation could be detrimental for those experiencing a behavioral health crisis because the 24 to 72 hours following such a crisis are often the precise time when a person needs help, and telehealth is crucial to getting that help. If a person is experiencing a behavioral health crisis, we should make it as easy as possible for them to connect with providers as often as needed.

Our last comment is directed at 7 AAC 110.630. Paragraph (1) specifies "licensed" providers, but these are not the only provider-types that provide telehealth services. This can be cured by recognizing appropriately licensed or "certified" providers.

In closing, we thank the Department for its support of telehealth services and its work to increase appropriate access to care for all Alaskans.

Sincerely,



Jared C. Kosin, JD, MBA
President & CEO

Dunkin, Susan M (DOH)

From: Jacoline Bergstrom <jacoline.bergstrom@tananachiefs.org>
Sent: Wednesday, April 05, 2023 4:32 PM
To: Dunkin, Susan M (DOH)
Cc: Carpenter, Heather R (DOH); Marna Sanford; Marilyn Andon
Subject: Comments HB 265, proposed regulation changes Telehealth & Medicaid coverage
Attachments: 2023 TCC comments HB 265, telehealth modalities proposed regulatory changes.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Good afternoon Ms. Dunkin,

Please find our comments and recommendations regarding the proposed regulatory changes on Medicaid payment for services delivered through telehealth modalities as proposed in HB 265, in the attached letter.
Please let us know if you have any additional questions.

Sincerely,

Jacoline Bergstrom

Jacoline Bergstrom
Executive Director of Health Services
Tanana Chiefs Conference
Alfred Ketzler Sr. Building
201 1st Avenue, Ste 300
Fairbanks, AK, 99701
Phone (907) 452-8251 ext. 3142 ; Fax 459-3950

"Healthy People Across Generations"

TANANA CHIEFS CONFERENCE
Health Services
Al Ketzler, Sr. Building
201 First Ave, Suite 300
Fairbanks, AK 99701
(907) 452-8251 Fax: 459-3950
Toll Free in Alaska 1-800-478-7822

April 5, 2023

Susan M. Dunkin, Regulations and Publications Coordinator
Alaska Department of Health, Health Care Services
4601 Business Park Blvd., Bldg. K
Anchorage, AK 99503

Dear Ms. Dunkin,

Tanana Chiefs Conference (TCC) writes to provide comments on the proposed regulatory changes on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities to implement House Bill 265 (HB 265). While we appreciate and welcome some of the proposed changes, there are several proposed changes that are problematic, not only for TCC and our patients, but for all healthcare providers serving patients in remote areas of the State. We appreciate you taking the time to review these comments.

Tanana Chiefs Conference is a Tribal Consortium, representing and serving 42 communities and 37 federally recognized Tribes in the Interior of Alaska, providing health and social services across an area the size of Texas. Only 11 communities are road-accessible at least part of the year, which means that all rural communities rely heavily on airline transportation with small planes. During the Pandemic we have seen a decrease in airline seats availability due pilot shortages.

We appreciate the work the Department has done to develop these regulations and implement HB 265. We welcome some of the positive proposed changes, such as improvements to the Medicaid behavioral health regulations. We must also, however, express serious concerns with other aspects of the proposed regulations. Many of the proposed changes would actively threaten public health and general welfare, harm patients and providers, and reduce access to telehealth services from their current levels. We urge the Department to re-think both the substantive language of the proposed regulatory provisions and its approach to implementing HB 265 and improving access to telehealth services; we look forward to working with you throughout this process.

Before we continue with comments and recommendations on the proposed regulatory changes, we would also like to address the pending telehealth coverage cliff Alaska patients face at the end of the COVID-19 Public Health Emergency (PHE). We have not been made aware of any roadmap for the extension of Medicaid telehealth flexibilities at the end of the PHE to allow beneficiaries to continue to access health care services at the current levels until these regulations are adopted. With a pending coverage cliff, we

urge the State to retain Medicaid telehealth flexibilities established under the COVID-19 PHE and codified into law through HB 265 until final regulations are adopted to implement HB 265. This will allow patients to continue to access critical telehealth services which have saved lives.

We provide our comments and recommendations below:

Proposed 7 AAC 110.625(a)(1)(B):

- We recommend that this sub-clause be amended to append "including, but not limited to, telephone, two-way radio, cellular phone, and internet-based calling;" after "headphones". This recommendation is to avoid the provision being read as overly limiting the types of two-way audio-only technologies.

Proposed 7 AAC 110.625(a)(2):

- We recommend that this paragraph be amended to include "data," after "digital images,". HB 265 is clear that data is an important and integral aspect of telehealth delivery, but the wording of this paragraph is not broad enough to include data. Given the proposed definition of "telehealth," which includes "transfer of medical data, [...], or data", not including "data" in proposed 7 AAC 110.625(a)(2) may have simply been an oversight.

Proposed 7 AAC 110.625(b):

- Although we understand the Department's concern regarding excluding particular patient-messaging services from coverage and reimbursement of telehealth services, the entirety of subsection (b) is not only too imprecise for that purpose, but also would exclude services intended to be reimbursable under HB 265.

- The use of the term "patient-initiated online digital service" is so broad in this subsection, and further in the definition at proposed 7 AAC 110.639(2), as to be unworkable. If left as currently stated, this definition would exclude all online telehealth platforms from coverage, which was clearly not the intent of the legislature under HB 265.

- We recommend that subsection (b) be deleted in favor of new language under the proposed exclusions under 7 AAC 110.635 as follows:

    - New subparagraph "(X) for the use of patient messaging portals or secure electronic mail for non-evaluative or non-management services, including appointment scheduling and electronic communication of test results."

    - New subparagraph "(X) for a telehealth visit within the postoperative period of a completed procedure which is related to the illness, injury, or other reason for the corresponding procedure. This does not prevent payment for services which are unrelated to the procedure, including but not limited to a new or emergent condition, behavioral health visit, or dental visit."

Proposed 7 AAC 110.630:

- This language is inconsistent with HB 265, which allows a wide variety of practitioners to practice via telehealth and receive payment for those services, not only those licensed under Title 8 of Alaska Statute. Other providers who may not be licensed and are qualified under HB 265 to

- Subsection (c) should be amended to add "referring provider," after "rendering provider,".

Additional Recommendations:

- We recommend that the Department replace the term "scope of licensure or certification" with "scope of practice" throughout the drafted regulations. "Scope of practice" is more consistent with HB 265.

- 7 AAC 145.739(3) currently defines an FQHC visit to be a "face-to-face encounter" [...] "at a single location". For the purposes of implementing HB 265 and aligning the regulation with law, we recommend that 7 AAC 145.739(3) be amended to allow for telehealth visits within the paragraph and its subparagraphs.

- We note that the proposed regulations point to the broader regulations for Medicaid Coverage and Payment under Part 8 of Title 7, but they do not interact with specific portions of the Part 8 where further regulatory changes will be needed to implement HB 265. When the Department is ready to propose regulatory changes to those pertinent sections, we would be happy to provide feedback to the Department through consultation and public comment.

TCC thanks the Department for the opportunity to provide feedback on these proposed regulatory changes and taking the time to review these comments. We urge the Department to adopt these recommended changes and take a deeper look into how the Department can use the implementation of HB 265 as an opportunity to support access to healthcare for all Alaskans who need it. If adopted as currently drafted, these proposed regulations will actively harm patients and providers who have come to rely on telehealth modalities across the State to access health care. Should you have any questions, you may contact Jacoline.bergstrom@tananachiefs.org.

Sincerely,

Jacoline Bergstrom, Executive Director Health Services
Tanana Chiefs Conference

CC: Heather Carpenter, Health Care Policy Advisor

Dunkin, Susan M (DOH)

From: Alaivanu, Erin E <eealaivanu@anthc.org>
Sent: Wednesday, April 05, 2023 4:51 PM
To: Dunkin, Susan M (DOH)
Cc: ANTHC_IGA
Subject: ANTHC Comments - Proposed Changes on Medicaid Telehealth Coverage
Attachments: ANTHC Comment re DOH Medicaid Telehealth Coverage 4-5-23.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Ms. Dunkin,

On behalf of the Alaska Native Tribal Health Consortium, please find the attached comments and recommendations on the Notice of Proposed Changes on Medicaid Coverage & Payment for Services Delivered Through Telehealth Modalities.

Thank you for the opportunity to provide comment.

Regards,
Erin

Erin Alaivanu, Special Assistant
Intergovernmental Affairs
Alaska Native Tribal Health Consortium
4000 Ambassador Drive, Anchorage, AK 99508
P: (907) 729-2897 // eealaivanu@anthc.org // www.anthc.org

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

SUBMITTED VIA: *susan.dunkin@alaska.gov*

April 5, 2023

Ms. Susan Dunkin,
Health Care Services, Department of Health
State of Alaska
4601 Business Park Blvd., Bldg. K
Anchorage, AK 99503

Re: Proposed Changes to Regulations: Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities.

Ms. Dunkin,

The Alaska Native Tribal Health Consortium (ANTHC) is a statewide tribal health organization serving all 229 Tribes and all Alaska Native and American Indian (AN/AI) individuals in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AI people in Alaska. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for Alaska Native people and their communities.

ANTHC welcomes the opportunity to provide our comments and recommendations on the Department of Health ("DOH" or "Department") proposed changes to regulations: Medicaid coverage & payment for services delivered through telehealth modalities.

First, we appreciate the work the Department has done to develop these regulations and implement HB 265. We welcome the positive proposed changes, such as improvements to the Medicaid behavioral health regulations. However, we have serious concerns with other aspects of the proposed regulations. Many of the proposed changes would actively threaten public health and general welfare, harm patients and providers, and reduce access to telehealth services from their current levels. We urge the Department to reevaluate both the substantive language of the proposed regulatory provisions and its approach to implementing HB 265 and improving access to telehealth services; we look forward to working with you throughout this process.

Before we continue with comments and recommendations on the proposed regulatory changes, we would also like to address the pending telehealth coverage cliff Alaska patients face at the end of the COVID-19 Public Health Emergency (PHE). We have not been made aware of any roadmap for the extension of Medicaid telehealth flexibilities at the end of the PHE to allow beneficiaries to continue to access health care services at the current levels until these regulations are adopted. With a pending coverage cliff, we urge the State to retain Medicaid telehealth flexibilities established under the COVID-19 PHE and codified into law through HB 265 until final regulations are adopted to implement HB 265. This will allow patients to continue to access critical telehealth services which have saved lives.

We provide our comments and recommendations below:

Alaska Native Tribal Health Consortium
4000 Ambassador Drive, Anchorage, Alaska 99508
Main: (907) 729-1900 | Fax: (907) 729-1901 | **anthc.org**

Proposed 7 AAC 110.625(a)(1)(B):

- We recommend that this subclause be amended to append "including, but not limited to, telephone, two-way radio, cellular phone, and internet-based calling;" after "headphones." This recommendation is to avoid the provision being read as overly limiting the types of two-way audio-only technologies.

Proposed 7 AAC 110.625(a)(2):

- We recommend that this paragraph be amended to include "data," after "digital images,". HB 265 is clear that data is an important and integral aspect of telehealth delivery, but the wording of this paragraph is not broad enough to include data. Given the proposed definition of "telehealth," which includes "transfer of medical data, [...], or data", not including "data" in proposed 7 AAC 110.625(a)(2) may have simply been an oversight.

Proposed 7 AAC 110.625(b):

- Although we understand the Department's concern regarding excluding particular patient-messaging services from coverage and reimbursement of telehealth services, the entirety of subsection (b) is not only too imprecise for that purpose, but also would exclude services intended to be reimbursable under HB 265.

- The use of the term "patient-initiated online digital service" is so broad in this subsection, and further in the definition at proposed 7 AAC 110.639(2), as to be unworkable. If left as currently stated, this definition would exclude all online telehealth platforms from coverage, which was clearly not the intent of the legislature under HB 265.

- We recommend that subsection (b) be deleted in favor of new language under the proposed exclusions under 7 AAC 110.635 as follows:

    - New subparagraph "(X) for the use of patient messaging portals or secure electronic mail for non-evaluative or non-management services, including appointment scheduling and electronic communication of test results."

    - New subparagraph "(X) for a telehealth visit within the postoperative period of a completed procedure which is related to the illness, injury, or other reason for the corresponding procedure. This does not prevent payment for services which are unrelated to the procedure, including but not limited to a new or emergent condition, behavioral health visit, or dental visit."

Proposed 7 AAC 110.630:

- This language is inconsistent with HB 265, which allows a wide variety of practitioners to practice via telehealth and receive payment for those services, not only those licensed under Title 8 of Alaska Statute. Other providers who may not be licensed and are qualified under HB 265 to practice via telehealth include Community Health Aides, Behavioral Health Aides, Dental Health

Aide Therapists, Chemical Dependency Counselors, Qualified Addiction Professionals, Master's level behavioral health clinicians, Behavioral Health Clinical Associates, case managers, care coordinators, and facility providers. We recommend that paragraphs (1) and (2) be deleted and replaced with the following:

- "(1) the provider must be an eligible Medicaid provider under 7 AAC 105.200 and enrolled under 7 AAC 105.210; or
  (2) be a provider of one or more of the following services;
  (i) care coordination services under 7 AAC 130.240;
  (ii) day habilitation services under 7 AAC 130.260;
  (iii) employment services under 7 AAC 130.270;
  (iv) intensive active treatment services under 7 AAC 130.275;
  (v) case management services provided under 7 AAC 128.010(b)(2)."

- Paragraph (7) needlessly excludes services for particular types of patients, including young children and adults with complex needs, where the presence and/or participation of the patient may not be not appropriate. Further, this paragraph excludes the use of asynchronous telehealth modalities when data may be sent to a consulting provider after a patient has left a visit with a rendering provider. For these reasons, we recommend that paragraph (7) be deleted.

- Paragraph (9) is overly burdensome as proposed. Although we appreciate the Department's wish to track particular information related to synchronous telehealth encounters, we recommend that this paragraph be adjusted to allow for a single durable consent for telehealth on no less than an annual basis. This will reduce the administrative burden on the patient and provider related to recording such non-medical data into a patient's chart. Further, recording the patient's location in the medical chart is both unnecessary and burdensome. HB 265 does not impose any originating and distant site requirements for telehealth encounters not required by federal statute or regulation.

Proposed 7 AAC 110.635:

- We recommend that paragraph (2) be amended to read as follows:
  - "(2) a provider for communication with that provider's supervising provider or communication with a provider who is acting **only** in a supervisory capacity;".

- Paragraph (6) is inconsistent with HB 265, and should be removed in its entirety. Under HB 265, the Department may exclude or limit coverage or reimbursement for a telehealth service *only* if it "determines, based on substantial medical evidence, that the service cannot be safely provided using telehealth", or if "providing the service using the specified mode would violate federal law or render the service ineligible for federal financial participation under applicable federal law." Proposed paragraph (6) purports to exclude broad swaths of services without providing any evidence of the medical necessity of the exclusion or citation to any federal law. Additionally, paragraph (6) shows no recognition of what services are currently provided through telehealth. Here are some non-exclusive examples of services currently provided through telehealth that may be excluded under the Department's proposal:

  - Pharmacy services can often be delivered via telehealth, including extensive counseling and medication review. Some examples of pharmacy services provided by telehealth

include INR follow-ups, continuous glucose monitoring (CGM) follow-ups, weight loss follow-ups, and hepatitis C follow-ups. Further, Tribal Health Organizations have already invested in tele-pharmacy services through staff hiring and program changes to meet tele-pharmacy needs. Loss of tele-pharmacy reimbursement will negatively impact these programmatic investments. Finally, federal agencies, including the Drug Enforcement Administration, are in the process of finalizing regulations concerning pharmacy telehealth services. There is no evidence that pharmacy telehealth services are legally prohibited or impossible to provide safely.

- Certain dental services can be delivered through telehealth. For example, dental health aides could share dental radiographs with consulting dentists through asynchronous telehealth. There is no evidence that these dental telehealth services are legally prohibited or impossible to provide safely.

- Providers can provide patient telehealth consultation on the set-up and use of durable medical equipment. There is no evidence that these durable medical equipment telehealth services are legally prohibited or impossible to provide safely.

Proposed 7 AAC 110.639:

- As discussed above, we recommend the deletion of paragraph (2).
- Paragraph (3), marked as "provider", is unnecessary. We recommend deletion.
- We recommend that the Department retain the current definition for a "referring provider":
  - "(3) "referring provider" means a provider who evaluates a recipient, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis or treatment;".
- We recommend that the Department deletes the currently proposed definition for a "rendering provider" and adopts the following:
  - (X) "rendering provider" means a provider who meets the requirements under 7 AAC 105.200 and 7 AAC 105.210 and evaluates, diagnoses, and treats a recipient, or acts as a referring provider;".
- We recommend that the Department adopt for paragraph (4) a definition for telehealth as follows:
  - "(4) "telehealth" has the meaning given to it in AS 47.05.270(e)."
- We recommend renumbering the paragraphs of this section as appropriate.

Proposed 7 AAC 135.150(c)(2):

- We recommend deleting this paragraph because HB 265 does not require a reason why a telehealth visit is used instead of an in-person visit.

Proposed 7 AAC 145.270:

- Subsections (a) and (b) should be amended to add "referring provider."
- Subsection (c) should be amended to add "referring provider," after "rendering provider,".

Additional Recommendations:

- We recommend that the Department replace the term "scope of licensure or certification" with "scope of practice" throughout the drafted regulations. "Scope of practice" is more consistent with HB 265.

- 7 AAC 145.739(3) currently defines an FQHC visit to be a "face-to-face encounter" […] "at a single location". For the purposes of implementing HB 265 and aligning the regulation with law, we recommend that 7 AAC 145.739(3) be amended to allow for telehealth visits within the paragraph and its subparagraphs.

- We note that the proposed regulations point to the broader regulations for Medicaid Coverage and Payment under Part 8 of Title 7, but they do not interact with specific portions of the Part 8 where further regulatory changes will be needed to implement HB 265. When the Department is ready to propose regulatory changes to those pertinent sections, we would be happy to provide feedback to the Department through consultation and public comment.

ANTHC thanks the Department for the opportunity to provide feedback on these proposed regulatory changes. We urge the Department to adopt these recommended changes and take a deeper look into how the Department can use the implementation of HB 265 as an opportunity to support access to healthcare for all Alaskans who need it. If adopted as currently drafted, these proposed regulations will actively harm patients and providers who have come to rely on telehealth modalities across the state to access health care. Should you have any questions, I can be reached at mmartin@anthc.org.

Sincerely,

Monique R. Martin
Vice President, Intergovernmental Affairs

Dunkin, Susan M (DOH)

From: Anthony J. Cravalho <anthony.cravalho@maniilaq.org>
Sent: Wednesday, April 05, 2023 11:03 PM
To: Dunkin, Susan M (DOH)
Cc: Carpenter, Heather R (DOH); Tim Gilbert
Subject: Maniilaq Association letter of comment on Proposed Regulations on Medicaid Telehealth Coverage and Payment
Attachments: Maniilaq Association Letter for House Bill 265.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Good morning,

Attached is Maniilaq Association letter of comment to the Department of Health on the proposed regulations on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities. If you have any question please let us know.

Maniilaq Association is one of 12 Regional Native 501 (c) (3) Non-profit Corporations located within the State of Alaska, that serves twelve federally recognized tribes in Northwest Alaska. Maniilaq provides comprehensive health care to all people in our service area, while promoting prevention, fitness, wellness, holistic strategies and incorporating local traditional core values and beliefs.

Regulations Public Notice Reference:
https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=210100

MANIILAQ ASSOCIATION

Anthony J.Y. Cravalho
Director of Planning & Development
P.O. Box 256
Kotzebue, Alaska 99752
907.442.7636
www.maniilaq.org

Letter of Comment

April 5th, 2023

Susan M. Dunkin, Regulations and Publications Coordinator
Alaska Department of Health, Health Care Services
4601 Business Park Blvd., Bldg. K
Anchorage, AK 99503

RE: Proposed regulatory changes on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities to implement House Bill 265 (HB 265)

Dear Ms. Dunkin,

On behalf of Maniilaq Association, I am writing to provide comment on the proposed regulatory changes on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities to implement House Bill 265 (HB 265).

Maniilaq Association is one of 12 Regional Native 501 (c) (3) Non-profit Corporations located within the State of Alaska, that serves twelve federally recognized tribes in Northwest Alaska. Maniilaq provides comprehensive health care to all people in our service area, while promoting prevention, fitness, wellness, holistic strategies and incorporating local traditional core values and beliefs.

First, we appreciate the work the Department has done to develop these regulations and implement HB 265. We welcome some of the positive proposed changes, such as improvements to the Medicaid behavioral health regulations. We must also, however, express serious concerns with other aspects of the proposed regulations. Many of the proposed changes would actively threaten public health and general welfare, harm patients and providers, and reduce access to telehealth services from their current levels. We urge the Department to re-think both the substantive language of the proposed regulatory provisions and its approach to implementing HB 265 and improving access to telehealth services; we look forward to working with you throughout this process.

Before we continue with comments and recommendations on the proposed regulatory changes, we would also like to address the pending telehealth coverage cliff Alaska patients face at the end of the COVID-19 Public Health Emergency (PHE). We have not been made aware of any roadmap for the extension of Medicaid telehealth flexibilities at the end of the PHE to allow beneficiaries to continue to access health care services at the current levels until these regulations are adopted. With a pending coverage cliff, we urge the State to retain Medicaid telehealth flexibilities established under the COVID-19 PHE and codified into law through HB 265 until final regulations are adopted to implement HB 265.

This will allow patients to continue to access critical telehealth services which have saved lives. We provide our comments and recommendations below:

Proposed 7 AAC 110.625(a)(1)(B):

- We recommend that this subclause be amended to append "including, but not limited to, telephone, two-way radio, cellular phone, and internet-based calling;" after "headphones". This recommendation is to avoid the provision being read as overly limiting the types of two-way audio-only technologies.

Proposed 7 AAC 110.625(a)(2):

- We recommend that this paragraph be amended to include "data," after "digital images,". HB 265 is clear that data is an important and integral aspect of telehealth delivery, but the wording of this paragraph is not broad enough to include data. Given the proposed definition of "telehealth," which includes "transfer of medical data, [...], or data", not including "data" in proposed 7 AAC 110.625(a)(2) may have simply been an oversight.

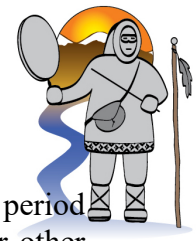
Proposed 7 AAC 110.625(b):

- Although we understand the Department's concern regarding excluding particular patient-messaging services from coverage and reimbursement of telehealth services, the entirety of subsection (b) is not only too imprecise for that purpose, but also would exclude services intended to be reimbursable under HB 265.

- The use of the term "patient-initiated online digital service" is so broad in this subsection, and further in the definition at proposed 7 AAC 110.639(2), as to be unworkable. If left as currently stated, this definition would exclude all online telehealth platforms from coverage, which was clearly not the intent of the legislature under HB 265.

- We recommend that subsection (b) be deleted in favor of new language under the proposed exclusions under 7 AAC 110.635 as follows:

    - New subparagraph "(X) for the use of patient messaging portals or secure electronic mail for non-evaluative or non-management services, including appointment scheduling and electronic communication of test results."



- New subparagraph "(X) for a telehealth visit within the postoperative period of a completed procedure which is related to the illness, injury, or other reason for the corresponding procedure. This does not prevent payment for services which are unrelated to the procedure, including but not limited to a new or emergent condition, behavioral health visit, or dental visit."

Proposed 7 AAC 110.630:

- This language is inconsistent with HB 265, which allows a wide variety of practitioners to practice via telehealth and receive payment for those services, not only those licensed under Title 8 of Alaska Statute. Other providers who may not be licensed and are qualified under HB 265 to practice via telehealth include Community Health Aides, Behavioral Health Aides, Dental Health Aide Therapists, Chemical Dependency Counselors, Qualified Addiction Professionals, Master's level behavioral health clinicians, Behavior Health Clinical Associates, case managers, care coordinators, and facility providers. We recommend that paragraphs (1) and (2) be deleted and replaced with the following:

  - "(1) the provider must be
    (A) an eligible Medicaid provider under 7 AAC 105.200 and enrolled under 7 AAC 105.210; or
    (B) a provider of one or more of the following services:
      (i) care coordination services under 7 AAC 130.240;
      (ii) day habilitation services under 7 AAC 130.260;
      (iii) employment services under 7 AAC 130.270;
      (iv) intensive active treatment services under 7 AAC 130.275;
      (v) case management services provided under 7 AAC 128.010(b)(2);"

- Paragraph (7) needlessly excludes services for particular types of patients, including young children and adults with complex needs, where the presence and/or participation of the patient may not be not appropriate. Further, this paragraph excludes the use of asynchronous telehealth modalities when data may be sent to a consulting provider after a patient has left a visit with a rendering provider. For these reasons, we recommend that paragraph (7) be deleted.

- Paragraph (9) is overly burdensome as proposed. Although we appreciate the Department's wish to track particular information related to synchronous telehealth encounters, we recommend that this paragraph be adjusted to allow for a single durable consent for telehealth on no less than an annual basis. This will reduce the administrative burden on the patient and provider related to recording such non-medical data into a patient's chart. Further, recording the patient's location in the medical chart is both unnecessary and burdensome. HB 265 does not impose any

originating and distant site requirements for telehealth encounters not required by federal statute or regulation.

MANIILAQ ASSOCIATION

Proposed 7 AAC 110.635:

- We recommend that paragraph (2) be amended to read as follows:
    - "(2) a provider for communication with that provider's supervising provider or communication with a provider who is acting **only** in a supervisory capacity;".

- Paragraph (6) is inconsistent with HB 265, and should be removed in its entirety. Under HB 265, the Department may only exclude or limit coverage or reimbursement for a telehealth service *only* if it "determines, based on substantial medical evidence, that the service cannot be safely provided using telehealth", or if "providing the service using the specified mode would violate federal law or render the service ineligible for federal financial participation under applicable federal law." Proposed paragraph (6) purports to exclude broad swaths of services without providing any evidence of the medical necessity of the exclusion or citation to any federal law. Additionally, paragraph (6) shows no recognition of what services are currently provided through telehealth. Here are some non-exclusive examples of services currently provided through telehealth that may be excluded under the Department's proposal:
    - Pharmacy services can often be delivered via telehealth, including extensive counseling and medication review. Some examples of pharmacy services provided by telehealth include INR follow-ups, continuous glucose monitoring (CGM) follow-ups, weight loss follow-ups, and hepatitis C follow-ups. Further, THOs have already invested in tele-pharmacy services through staff hiring and program changes to meet tele-pharmacy needs. Loss of tele-pharmacy reimbursement will negatively impact these programmatic investments. Finally, federal agencies, including the DEA, are in the process of finalizing regulations concerning pharmacy telehealth services. There is no evidence that pharmacy telehealth services are legally prohibited or impossible to provide safely.
    - Certain dental services can be delivered through telehealth. For example, dental health aides could share dental radiographs with consulting dentists through asynchronous telehealth. There is no evidence that these dental telehealth services are legally prohibited or impossible to provide safely.
    - Providers can provide patient telehealth consultation on the set-up and use of durable medical equipment. There is no evidence that these durable

medical equipment telehealth services are legally prohibited or impossible to provide safely.

Proposed 7 AAC 110.639:

- As discussed above, we recommend the deletion of paragraph (2).
- Paragraph (3), marked as "provider", is unnecessary. We recommend deletion.
- We recommend that the Department retain the current definition for a "referring provider":
    - "(3) "referring provider" means a provider who evaluates a recipient, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis or treatment;".
- We recommend that the Department deletes the currently proposed definition for a "rendering provider" and adopts the following:
    - (X) "rendering provider" means a provider who meets the requirements under 7 AAC 105.200 and 7 AAC 105.210 and evaluates, diagnoses, and treats a recipient, or acts as a referring provider;".
- We recommend that the Department adopt for paragraph (4) a definition for telehealth as follows:
    - "(4) "telehealth" has the meaning given to it in AS 47.05.270(e)."
- We recommend renumbering the paragraphs of this section as appropriate.

Proposed 7 AAC 135.150(c)(2):

- We recommend deleting this paragraph because HB 265 does not require a reason why a telehealth visit is used instead of an in-person visit.

Proposed 7 AAC 145.270:

- Subsections (a) and (b) should be amended to add "referring provider".
- Subsection (c) should be amended to add "referring provider," after "rendering provider,".

Additional Recommendations:

- We recommend that the Department replace the term "scope of licensure or certification" with "scope of practice" throughout the drafted regulations. "Scope of practice" is more consistent with HB 265.

- 7 AAC 145.739(3) currently defines an FQHC visit to be a "face-to-face encounter" […] "at a single location". For the purposes of implementing HB 265 and aligning the regulation with law, we recommend that 7 AAC 145.739(3) be amended to allow for telehealth visits within the paragraph and its subparagraphs.

- We note that the proposed regulations point to the broader regulations for Medicaid Coverage and Payment under Part 8 of Title 7, but they do not interact with specific portions of the Part 8 where further regulatory changes will be needed to implement HB 265. When the Department is ready to propose regulatory changes to those pertinent sections, we would be happy to provide feedback to the Department through consultation and public comment.

Maniilaq Association thanks the Department for the opportunity to provide feedback on these proposed regulatory changes. We urge the Department to adopt these recommended changes and take a deeper look into how the Department can use the implementation of HB 265 as an opportunity to support access to healthcare for all Alaskans who need it. If adopted as currently drafted, these proposed regulations will actively harm patients and providers who have come to rely on telehealth modalities across the State to access health care. Should you have any questions, you may contact Tim Gilbert (tim.gilbert@maniilaq.org) or Dr. Onders (robert.onders@maniilaq.org)

Sincerely,

Tim Gilbert,
President/CEO of Maniilaq Association

CC: Heather Carpenter, Health Care Policy Advisor
Sincerely,

Dunkin, Susan M (DOH)

From: Maggie D. West <mdwest@NSHCORP.ORG>
Sent: Thursday, April 06, 2023 8:30 AM
To: Dunkin, Susan M (DOH)
Cc: agorn
Subject: Proposed Regulations on Medicaid Telehealth Coverage and Payment
Attachments: AK_Dept of Health_Health Care Services.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hello Ms. Dunkin,

Attached is a letter from Norton Sound Health Corporation regarding the proposed regulations on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities. A hard copy will also be mailed to you.

Thank you,
Maggie

Maggie D. West
Safety Program Manager|Administrative Advisor
Norton Sound Health Corporation
P.O. Box 966 | Nome, Alaska 99762
Email: mdwest@nshcorp.org
T: 907.443.9679

NORTON SOUND HEALTH CORPORATION

Providing quality health services and promoting wellness within our people and environment.

April 5, 2023

Susan M. Dunkin, Regulations and Publications Coordinator
Alaska Department of Health, Health Care Services
4601 Business Park Blvd., Bldg. K
Anchorage, AK 99503

Dear Ms. Dunkin,

Norton Sound Health Corporation writes to provide comment on the proposed regulatory changes on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities to implement House Bill 265 (HB 265).

Norton Sound Health Corporation (NSHC) is a tribally owned and operated, independent, not-for profit health care organization, founded in 1970 to meet the health care needs of the Inupiat, Siberian Yupik and Yu'pik people of the Bering Strait region, a 44,000 square-mile section of northwestern Alaska. The main hospital is based in Nome and has 15 village clinics.

First, we appreciate the work the Department has done to develop these regulations and implement HB 265. We welcome some of the positive proposed changes, such as improvements to the Medicaid behavioral health regulations. We must also, however, express serious concerns with other aspects of the proposed regulations. Many of the proposed changes would actively threaten public health and general welfare, harm patients and providers, and reduce access to telehealth services from their current levels. We urge the Department to re-think both the substantive language of the proposed regulatory provisions and its approach to implementing HB 265 and improving access to telehealth services; we look forward to working with you throughout this process.

Before we continue with comments and recommendations on the proposed regulatory changes, we would also like to address the pending telehealth coverage cliff Alaska patients face at the end of the COVID-19 Public Health Emergency (PHE). We have not been made aware of any roadmap for the extension of Medicaid telehealth flexibilities at the end of the PHE to allow beneficiaries to continue to access health care services at the current levels until these regulations are adopted. With a pending coverage cliff, we urge the State to retain Medicaid telehealth flexibilities established under the COVID-19 PHE and codified into law through HB 265 until final regulations are adopted to implement HB 265. This will allow patients to continue to access critical telehealth services which have saved lives.

We provide our comments and recommendations below:

Proposed 7 AAC 110.625(a)(1)(B):

- We recommend that this subclause be amended to append "including, but not limited to, telephone, two-way radio, cellular phone, and internet-based calling;" after "headphones". This recommendation is to avoid the provision being read as overly limiting the types of two-way audio-only technologies.

Proposed 7 AAC 110.625(a)(2):

- We recommend that this paragraph be amended to include "data," after "digital images,". HB 265 is clear that data is an important and integral aspect of telehealth delivery, but the wording of this paragraph is not broad enough to include data. Given the proposed definition of "telehealth," which includes "transfer of medical data, [...], or data", not including "data" in proposed 7 AAC 110.625(a)(2) may have simply been an oversight.

Proposed 7 AAC 110.625(b):

- Although we understand the Department's concern regarding excluding particular patient-messaging services from coverage and reimbursement of telehealth services, the entirety of subsection (b) is not only too imprecise for that purpose, but also would exclude services intended to be reimbursable under HB 265.

- The use of the term "patient-initiated online digital service" is so broad in this subsection, and further in the definition at proposed 7 AAC 110.639(2), as to be unworkable. If left as currently stated, this definition would exclude all online telehealth platforms from coverage, which was clearly not the intent of the legislature under HB 265.

- We recommend that subsection (b) be deleted in favor of new language under the proposed exclusions under 7 AAC 110.635 as follows:

    - New subparagraph "(X) for the use of patient messaging portals or secure electronic mail for non-evaluative or non-management services, including appointment scheduling and electronic communication of test results."

    - New subparagraph "(X) for a telehealth visit within the postoperative period of a completed procedure which is related to the illness, injury, or other reason for the corresponding procedure. This does not prevent payment for services which are unrelated to the procedure, including but not limited to a new or emergent condition, behavioral health visit, or dental visit."

Proposed 7 AAC 110.630:

- This language is inconsistent with HB 265, which allows a wide variety of practitioners to practice via telehealth and receive payment for those services, not only those licensed under Title 8 of Alaska Statute. Other providers who may not be licensed and are qualified under HB 265 to practice via telehealth include Community Health Aides, Behavioral Health Aides, Dental Health Aide Therapists, Chemical Dependency Counselors, Qualified Addiction Professionals, Master's level behavioral health clinicians, Behavior Health

Clinical Associates, case managers, care coordinators, and facility providers. We recommend that paragraphs (1) and (2) be deleted and replaced with the following:

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  (A) an eligible Medicaid provider under 7 AAC 105.200 and enrolled under 7 AAC 105.210; or
  (B) a provider of one or more of the following services:
    (i) care coordination services under 7 AAC 130.240;
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    (iii) employment services under 7 AAC 130.270;
    (iv) intensive active treatment services under 7 AAC 130.275;
    (v) case management services provided under 7 AAC 128.010(b)(2);"

- Paragraph (7) needlessly excludes services for particular types of patients, including young children and adults with complex needs, where the presence and/or participation of the patient may not be not appropriate. Further, this paragraph excludes the use of asynchronous telehealth modalities when data may be sent to a consulting provider after a patient has left a visit with a rendering provider. For these reasons, we recommend that paragraph (7) be deleted.

- Paragraph (9) is overly burdensome as proposed. Although we appreciate the Department's wish to track particular information related to synchronous telehealth encounters, we recommend that this paragraph be adjusted to allow for a single durable consent for telehealth on no less than an annual basis. This will reduce the administrative burden on the patient and provider related to recording such non-medical data into a patient's chart. Further, recording the patient's location in the medical chart is both unnecessary and burdensome. HB 265 does not impose any originating and distant site requirements for telehealth encounters not required by federal statute or regulation.

Proposed 7 AAC 110.635:

- We recommend that paragraph (2) be amended to read as follows:

  - "(2) a provider for communication with that provider's supervising provider or communication with a provider who is acting **only** in a supervisory capacity;".

- Paragraph (6) is inconsistent with HB 265, and should be removed in its entirety. Under HB 265, the Department may only exclude or limit coverage or reimbursement for a telehealth service *only* if it "determines, based on substantial medical evidence, that the service cannot be safely provided using telehealth", or if "providing the service using the specified mode would violate federal law or render the service ineligible for federal financial participation under applicable federal law." Proposed paragraph (6) purports to exclude broad swaths of services without providing any evidence of the medical necessity of the exclusion or citation to any federal law. Additionally, paragraph (6) shows no recognition of what services are currently provided through telehealth. Here are some non-

exclusive examples of services currently provided through telehealth that may be excluded under the Department's proposal:

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- Certain dental services can be delivered through telehealth. For example, dental health aides could share dental radiographs with consulting dentists through asynchronous telehealth. There is no evidence that these dental telehealth services are legally prohibited or impossible to provide safely.

- Providers can provide patient telehealth consultation on the set-up and use of durable medical equipment. There is no evidence that these durable medical equipment telehealth services are legally prohibited or impossible to provide safely.

Proposed 7 AAC 110.639:

- As discussed above, we recommend the deletion of paragraph (2).

- Paragraph (3), marked as "provider", is unnecessary. We recommend deletion.

- We recommend that the Department retain the current definition for a "referring provider":

  - "(3) "referring provider" means a provider who evaluates a recipient, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis or treatment;".

- We recommend that the Department deletes the currently proposed definition for a "rendering provider" and adopts the following:

  - (X) "rendering provider" means a provider who meets the requirements under 7 AAC 105.200 and 7 AAC 105.210 and evaluates, diagnoses, and treats a recipient, or acts as a referring provider;".

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  - "(4) "telehealth" has the meaning given to it in AS 47.05.270(e)."

- We recommend renumbering the paragraphs of this section as appropriate.

Proposed 7 AAC 135.150(c)(2):

- We recommend deleting this paragraph because HB 265 does not require a reason why a telehealth visit is used instead of an in-person visit.

Proposed 7 AAC 145.270:

- Subsections (a) and (b) should be amended to add "referring provider".

- Subsection (c) should be amended to add "referring provider," after "rendering provider,".

Additional Recommendations:

- We recommend that the Department replace the term "scope of licensure or certification" with "scope of practice" throughout the drafted regulations. "Scope of practice" is more consistent with HB 265.

- 7 AAC 145.739(3) currently defines an FQHC visit to be a "face-to-face encounter" […] "at a single location". For the purposes of implementing HB 265 and aligning the regulation with law, we recommend that 7 AAC 145.739(3) be amended to allow for telehealth visits within the paragraph and its subparagraphs.

- We note that the proposed regulations point to the broader regulations for Medicaid Coverage and Payment under Part 8 of Title 7, but they do not interact with specific portions of the Part 8 where further regulatory changes will be needed to implement HB 265. When the Department is ready to propose regulatory changes to those pertinent sections, we would be happy to provide feedback to the Department through consultation and public comment.

Norton Sound Health Corporation thanks the Department for the opportunity to provide feedback on these proposed regulatory changes. We urge the Department to adopt these recommended changes and take a deeper look into how the Department can use the implementation of HB 265 as an opportunity to support access to healthcare for all Alaskans who need it. If adopted as currently drafted, these proposed regulations will actively harm patients and providers who have come to rely on telehealth modalities across the State to access health care. Should you have any questions, you may contact Angie Gorn at agorn@nshcorp.org or 907-443-3286.

Sincerely,

Angie Gorn

Angie Gorn, President/CEO

CC: Heather Carpenter, Health Care Policy Advisor

Dunkin, Susan M (DOH)

From: Stoneking, Marge <mstoneking@aarp.org>
Sent: Thursday, April 06, 2023 9:54 AM
To: Dunkin, Susan M (DOH)
Subject: Comments on Medicaid Coverage & Payment for Services Delivered through Telehealth Modalities

Follow Up Flag: Follow up
Flag Status: Flagged

On behalf of AARP, I am submitting comments on the proposed regulations for the enacted HB265 Telehealth bill passed by the Alaska Legislature in 2022.

We have four primary concerns with the regulations as written as being inconsistent with the underlying enacted legislation:

1) Under **7 AAC 110.630 on page 4**, requires that for telehealth reimbursement a provider have an active license. The enacted law includes certified providers such as Community Health Aides and substance abuse treatment counselors.
2) **Under 7 AAC 110.630** requires that providers document the patient location for each visit. HB265 removed any restrictions on patient location sites so long as the patient is in the state of Alaska. This section should say simply that the provider documents that the patient confirmed they are in the state of Alaska.
3) There are only two ways that Medicaid services can be restricted from being delivered by telehealth—either it is unsafe according to substantial medical evidence, or federal law prohibits it or denies federal financial participation for the service. The analysis based on these two modes of restrictions is not found in the proposed regulations.
   Under **7 AAC 110.635** Excluded services should not include: b) dental services and d) pharmacy services, as these two services cannot be justified as unsafe or ineffective as delivered by telehealth.
4) The state regulation defining FQHC "visits" (7 AAC 145.739) needs to be amended to refer to telehealth visits. The definition currently requires a "face-to-face" visit and this is inconsistent with the underlying legislation.

Further, we have concerns with the timeline for adoption of these proposed regulations with regard to the end of the federal Public Health Emergency on May 11, and request that the Department of Health extend telehealth flexibilities in the interim period under the Department's current authority.

Thank you,
Marge Stoneking

Marge Stoneking | **Associate State Director - Advocacy** | **AARP Alaska**
3601 C Street, Suite 1420, Anchorage, AK 99501
Office: (907) 762-3306| Cell: (907) 227-2991
Email: mstoneking@aarp.org | Web: www.aarp.org/ak | Facebook: @aarpak | Twitter: @aarpak

Dunkin, Susan M (DOH)

From: Davis, Winn <wdavis@anhb.org>
Sent: Thursday, April 06, 2023 10:21 AM
To: Dunkin, Susan M (DOH)
Cc: Alaska Native Health Board; Unok, Alberta; Davis, Winn; Carpenter, Heather R (DOH)
Subject: Public Comment on Medicaid Coverage and Payment on Telehealth Modalities
Attachments: 23.04.06 ANHB to DOH re. Telehealth Regulations - Final.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Ms. Dunkin,

The Alaska Native Health Board is submitting the attached letter in the public comment period on the proposed regulatory changes on the Medicaid Coverage and Payment on Telehealth Modalities. If you have any questions, please contact ANHB at anhb@anhb.org or by telephone at (907) 729-7510.

Winn Davis
Senior Policy Analyst
Alaska Native Health Board
(907) 885-8337
WDavis@anhb.org

ALASKA NATIVE HEALTH BOARD

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALEUTIAN PRIBILOF ISLANDS ASSOCIATION

ARCTIC SLOPE NATIVE ASSOCIATION

BRISTOL BAY AREA HEALTH CORPORATION

CHICKALOON VILLAGE TRADITIONAL COUNCIL

CHUGACHMIUT

COPPER RIVER NATIVE ASSOCIATION

COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS

EASTERN ALEUTIAN TRIBES

KARLUK IRA TRIBAL COUNCIL

KENAITZE INDIAN TRIBE

KETCHIKAN INDIAN COMMUNITY

KODIAK AREA NATIVE ASSOCIATION

MANIILAQ ASSOCIATION

METLAKATLA INDIAN COMMUNITY

MT. SANFORD TRIBAL CONSORTIUM

NATIVE VILLAGE OF EKLUTNA

NATIVE VILLAGE OF EYAK

NATIVE VILLAGE OF TYONEK

NINILCHIK TRADITIONAL COUNCIL

NORTON SOUND HEALTH CORPORATION

SELDOVIA VILLAGE TRIBE

SOUTHCENTRAL FOUNDATION

SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

TANANA CHIEFS CONFERENCE

YAKUTAT TLINGIT TRIBE

YUKON-KUSKOKWIM HEALTH CORPORATION

VALDEZ NATIVE TRIBE

Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

T 907.729.7510 F 907.729.7506 • 4000 Ambassador Drive (ANHB Office) • Anchorage, Alaska 99508 • **www.anhb.org**

April 6, 2023

Susan M. Dunkin, Regulations and Publications Coordinator
Alaska Department of Health, Health Care Services
4601 Business Park Blvd., Bldg. K
Anchorage, AK 99503

Dear Ms. Dunkin,

The Alaska Native Health Board (ANHB)[1] writes to provide comment on the proposed regulatory changes on Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities to implement House Bill 265 (HB 265).

First, we appreciate the work the Department has done to develop these regulations and implement HB 265. We welcome some of the positive proposed changes, such as improvements to the Medicaid behavioral health regulations. We must also, however, express serious concerns with other aspects of the proposed regulations. Many of the proposed changes would actively threaten public health and general welfare, harm patients and providers, and reduce access to telehealth services from their current levels. We urge the Department to re-think both the substantive language of the proposed regulatory provisions and its approach to implementing HB 265 and improving access to telehealth services; we look forward to working with you throughout this process.

Before we continue with comments and recommendations on the proposed regulatory changes, we would also like to address the pending telehealth coverage cliff Alaska patients face at the end of the COVID-19 Public Health Emergency (PHE). We have not been made aware of any roadmap for the extension of Medicaid telehealth flexibilities at the end of the PHE to allow beneficiaries to continue to access health care services at the current levels until these regulations are adopted. With a pending coverage cliff, we urge the State to retain Medicaid telehealth flexibilities established under the COVID-19 PHE and codified into law through HB 265 until final regulations are adopted to implement HB 265. This will allow patients to continue to access critical telehealth services which have saved lives.

We provide our comments and recommendations below:

[1] ANHB was established in 1968 with the purpose of promoting the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of tribal health programs that serve all of the 229 Tribes and 180,000 Alaska Native and American Indian (AN/AI) people throughout the state. As the statewide tribal health advocacy organization, ANHB helps Alaska's Tribes and Tribal programs achieve effective consultation and communication with state and federal agencies on matters of concern.

Proposed 7 AAC 110.625(a)(1)(B):

- We recommend that this subclause be amended to append "including, but not limited to, telephone, two-way radio, cellular phone, and internet-based calling;" after "headphones". This recommendation is to avoid the provision being read as overly limiting the types of two-way audio-only technologies.

Proposed 7 AAC 110.625(a)(2):

- We recommend that this paragraph be amended to include "data," after "digital images,". HB 265 is clear that data is an important and integral aspect of telehealth delivery, but the wording of this paragraph is not broad enough to include data. Given the proposed definition of "telehealth," which includes "transfer of medical data, [...], or data", not including "data" in proposed 7 AAC 110.625(a)(2) may have simply been an oversight.

Proposed 7 AAC 110.625(b):

- Although we understand the Department's concern regarding excluding particular patient-messaging services from coverage and reimbursement of telehealth services, the entirety of subsection (b) is not only too imprecise for that purpose, but also would exclude services intended to be reimbursable under HB 265.

- The use of the term "patient-initiated online digital service" is so broad in this subsection, and further in the definition at proposed 7 AAC 110.639(2), as to be unworkable. If left as currently stated, this definition would exclude all online telehealth platforms from coverage, which was clearly not the intent of the legislature under HB 265.

- We recommend that subsection (b) be deleted in favor of new language under the proposed exclusions under 7 AAC 110.635 as follows:

    - New subparagraph "(X) for the use of patient messaging portals or secure electronic mail for non-evaluative or non-management services, including appointment scheduling and electronic communication of test results."

    - New subparagraph "(X) for a telehealth visit within the postoperative period of a completed procedure which is related to the illness, injury, or other reason for the corresponding procedure. This does not prevent payment for services which are unrelated to the procedure, including but not limited to a new or emergent condition, behavioral health visit, or dental visit."

Proposed 7 AAC 110.630:

- This language is inconsistent with HB 265, which allows a wide variety of practitioners to practice via telehealth and receive payment for those services, not only those licensed under Title 8 of Alaska Statute. Other providers who may not be licensed and are qualified under HB 265 to practice via telehealth include Community Health Aides, Behavioral Health Aides, Dental Health Aide Therapists, Chemical Dependency Counselors, Qualified Addiction Professionals, Master's level behavioral health clinicians, Behavior Health Clinical Associates, case managers, care coordinators, and facility providers. We recommend that paragraphs (1) and (2) be deleted and replaced with the following:

- "(1) the provider must be
  (A) an eligible Medicaid provider under 7 AAC 105.200 and enrolled under 7 AAC 105.210; or
  (B) a provider of one or more of the following services:
    (i) care coordination services under 7 AAC 130.240;
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    (iii) employment services under 7 AAC 130.270;
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    (v) case management services provided under 7 AAC 128.010(b)(2);"

- Paragraph (7) needlessly excludes services for particular types of patients, including young children and adults with complex needs, where the presence and/or participation of the patient may not be not appropriate. Further, this paragraph excludes the use of asynchronous telehealth modalities when data may be sent to a consulting provider after a patient has left a visit with a rendering provider. For these reasons, we recommend that paragraph (7) be deleted.

- Paragraph (9) is overly burdensome as proposed. Although we appreciate the Department's wish to track particular information related to synchronous telehealth encounters, we recommend that this paragraph be adjusted to allow for a single durable consent for telehealth on no less than an annual basis. This will reduce the administrative burden on the patient and provider related to recording such non-medical data into a patient's chart. Further, recording the patient's location in the medical chart is both unnecessary and burdensome. HB 265 does not impose any originating and distant site requirements for telehealth encounters not required by federal statute or regulation.

Proposed 7 AAC 110.635:

- We recommend that paragraph (2) be amended to read as follows:

  - "(2) a provider for communication with that provider's supervising provider or communication with a provider who is acting **only** in a supervisory capacity;".

- Paragraph (6) is inconsistent with HB 265, and should be removed in its entirety. Under HB 265, the Department may only exclude or limit coverage or reimbursement for a telehealth service *only* if it "determines, based on substantial medical evidence, that the service cannot be safely provided using telehealth", or if "providing the service using the specified mode would violate federal law or render the service ineligible for federal financial participation under applicable federal law." Proposed paragraph (6) purports to exclude broad swaths of services without providing any evidence of the medical necessity of the exclusion or citation to any federal law. Additionally, paragraph (6) shows no recognition of what services are currently provided through telehealth. Here are some non-exclusive examples of services currently provided through telehealth that may be excluded under the Department's proposal:

  - Pharmacy services can often be delivered via telehealth, including extensive counseling and medication review. Some examples of pharmacy services provided by telehealth include INR follow-ups, continuous glucose monitoring (CGM) follow-ups, weight loss follow-ups, and hepatitis C follow-ups. Further, THOs have

already invested in tele-pharmacy services through staff hiring and program changes to meet tele-pharmacy needs. Loss of tele-pharmacy reimbursement will negatively impact these programmatic investments. Finally, federal agencies, including the DEA, are in the process of finalizing regulations concerning pharmacy telehealth services. There is no evidence that pharmacy telehealth services are legally prohibited or impossible to provide safely.

- Certain dental services can be delivered through telehealth. For example, dental health aides could share dental radiographs with consulting dentists through asynchronous telehealth. There is no evidence that these dental telehealth services are legally prohibited or impossible to provide safely.

- Providers can provide patient telehealth consultation on the set-up and use of durable medical equipment. There is no evidence that these durable medical equipment telehealth services are legally prohibited or impossible to provide safely.

Proposed 7 AAC 110.639:

- As discussed above, we recommend the deletion of paragraph (2).

- Paragraph (3), marked as "provider", is unnecessary. We recommend deletion.

- We recommend that the Department retain the current definition for a "referring provider":

  - "(3) "referring provider" means a provider who evaluates a recipient, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis or treatment;".

- We recommend that the Department deletes the currently proposed definition for a "rendering provider" and adopts the following:

  - (X) "rendering provider" means a provider who meets the requirements under 7 AAC 105.200 and 7 AAC 105.210 and evaluates, diagnoses, and treats a recipient, or acts as a referring provider;".

- We recommend that the Department adopt for paragraph (4) a definition for telehealth as follows:

  - "(4) "telehealth" has the meaning given to it in AS 47.05.270(e)."

- We recommend renumbering the paragraphs of this section as appropriate.

Proposed 7 AAC 135.150(c)(2):

- We recommend deleting this paragraph because HB 265 does not require a reason why a telehealth visit is used instead of an in-person visit.

Proposed 7 AAC 145.270:

- Subsections (a) and (b) should be amended to add “referring provider”.

- Subsection (c) should be amended to add “referring provider,” after “rendering provider,”.

Additional Recommendations:

- We recommend that the Department replace the term “scope of licensure or certification” with “scope of practice” throughout the drafted regulations. “Scope of practice” is more consistent with HB 265.

- 7 AAC 145.739(3) currently defines an FQHC visit to be a “face-to-face encounter” […] “at a single location”. For the purposes of implementing HB 265 and aligning the regulation with law, we recommend that 7 AAC 145.739(3) be amended to allow for telehealth visits within the paragraph and its subparagraphs.

- We note that the proposed regulations point to the broader regulations for Medicaid Coverage and Payment under Part 8 of Title 7, but they do not interact with specific portions of the Part 8 where further regulatory changes will be needed to implement HB 265. When the Department is ready to propose regulatory changes to those pertinent sections, we would be happy to provide feedback to the Department through consultation and public comment.

ANHB thanks the Department for the opportunity to provide feedback on these proposed regulatory changes. We urge the Department to adopt these recommended changes and take a deeper look into how the Department can use the implementation of HB 265 as an opportunity to support access to healthcare for all Alaskans who need it. If adopted as currently drafted, these proposed regulations will actively harm patients and providers who have come to rely on telehealth modalities across the State to access health care. Should you have any questions, you may contact ANHB at anhb@anhb.org or by telephone at (907) 885-8337.

Sincerely,

Chief William F. Smith, Chairman
Alaska Native Health Board
Tribally-Elected Leader of the Valdez Native Tribe

CC: Heather Carpenter, Health Care Policy Advisor

Dunkin, Susan M (DOH)

From: John Solomon (ABHA) <ceo@alaskabha.org>
Sent: Thursday, April 06, 2023 10:28 AM
To: Dunkin, Susan M (DOH)
Cc: Carpenter, Heather R (DOH); DOH DBH Public Comments (DOH sponsored)
Subject: Public Comment for Telehealth Regulations
Attachments: ABHA Letter for Telehealth Regulations Public Comment.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Good morning,
Attached you will find the Alaska Behavioral Health Associations public comments for proposed updates to regulation regarding telehealth. Thank you for all your hard work making telehealth access to care a reality in the state of Alaska.
Cheers!
John

John Solomon, LPC
Chief Executive Officer
Alaska Behavioral Health Association

4/6/2023

Heather Phelps
Susan Dunkin
State of Alaska Department of Health
Division of Behavioral Health
Submit to: doh.dbh.public.comments@alaska.gov

Re: Public Comment - Notice of Proposed Telehealth Regulations

Introduction:

The Alaska Behavioral Health Association (ABHA) is a membership organization with nearly eighty statewide mental health and substance abuse treatment providers who constitute the core of Medicaid-funded behavioral health treatment services in Alaska. We are committed to advancing access to quality, cost effective behavioral health treatment services to all people in need across the state, whether in remote, rural, or urban areas. We appreciate the partnership with the Department of Health and Division of Behavioral Health to advance the innovative and critical access that telehealth provides.

Background/Context:

The state of Alaska holds the unique challenge of providing care to a broad background of stakeholders, from urban centers to the most remote areas of the US. In the past, telehealth was limited in scope and did not provide the access to care that Alaskans needed. With the recent telehealth flexibilities afforded through the COVID public health emergency Alaska was able to see the immense benefit of an innovative and accessible health care system. Through legislation Alaska has validated the role of telehealth, including audio-only delivery methods, as a vital part of the care system. These healthcare delivery systems provide new access to care that will save lives, promote healthier lifestyles, and heal communities.

Recommendations:

With respect to the hard work the state has done to bring telehealth regulations to the table by the end of the public health emergency we offer the following recommendations:

Recommendation 1) Section 7 AAC 110.630 (1) be rewritten so as not to contradict telehealth legislation.

> **7 AAC 110.630. Telehealth provider requirements and conditions for payment.**
>
> Subject to the requirements of 7 AAC 110.620 - 7 AAC 110.639, to be eligible for payment under 7 AAC 105 - 7 AAC 160 for providing a service by means of a telehealth modality, a provider must meet the following requirements:
>
> (1) except for providers of the services identified in 7 AAC 110.635(6)(L) - (M), the provider must have an active license to practice under AS 08 or the applicable laws of the jurisdiction in which the provider is located;

Telehealth Legislation signed into law clearly outlines several provider types that are not licensed but instead

hold certifications or deliver services via telehealth within the scope of their practice. Providers outlined in legislation include substance use counselors, behavioral health aides, and similar non licensed and pre-licensed provider types that currently are allowed to practice telehealth. This new section, if adopted as written, will actually further restrict access to telehealth beyond what is already allowable under regulation.

It is our recommendation that this section be rewritten to reflect the allowable provider types currently outlined in Section 7 AAC 105.200 - Eligible Medicaid providers, and clearly outlined in HB 265 legislation.

Recommendation 2) Remove the following two highlighted sections.

> **7 AAC 110.625**
>
> For patient-initiated online digital service, whether synchronous or asynchronous, the following are not reimbursable:
>
> (1) nonevaluative or nonmanagement services including appointment scheduling and electronic communication of test results;
>
> (2) provider-initiated online digital service;
>
> (3) patient-initiated online digital service within the postoperative period of a completed procedure or within seven days of an in-person visit and related to the illness, injury, or other reason for that visit. (Eff. 2/1/2010, Register 193; am_____/_____/_____, Register_____)

(2) This language is cumbersome and could be interpreted to exclude interactive telehealth modalities in common behavioral health encounters. Often services are initiated by providers when dealing with high acuity or crisis situations. By not allowing reimbursement for provider initiated digital services the state excludes the use of follow up crisis outreach and hampers the ability of providers to provide stabilization services to clients at their highest need.

(3) This section also seems to indicate that encounters are not reimbursable for seven days after an in person visit related to the same presenting problem. This would exclude a vast number of behavioral health encounters for high acuity clients as the period after a crisis is the most critical time in a behavioral health client's stabilization. It would also appear to set timeframes around when services are reimbursable outside of regular service details and authorizations that already exist in regulation.

It is our recommendation that two highlighted sections {7AAC 110.625 (2) & (3)} be deleted from regulation.

*Recommendation 3) Remove service specific restrictions on telehealth reimbursement as laid out in **7 AAC 110.635. Telehealth exclusions.***

Blanket exclusions of service lines from telehealth reimbursement restricts service innovation and access to care. Particularly troubling to behavioral health providers is the exclusion of pharmacy services from telehealth. Rural clients do not have access to pharmacies and must rely on telehealth for almost all service delivery. By

excluding pharmacy services, the state is placing client safety at risk by limiting access to care.

Overall, the spirit of telehealth legislation is about access to care and regulations should not have blanket exclusions without clearly defined reasoning that fits within the narrow-outlined parameters of the legislation.

It is our recommendation that these exclusions be deleted from regulations.

Conclusion

In summary, we are grateful for the hard work and dedication of our state partners making telehealth a reality. Alaska is at the forefront of innovative access to care and the partnerships of providers, legislators, and state agencies has made the dream of equitable access to care a possibility for our clients. We respectfully offer these three recommendations and we thank the state for the work bringing regulations in line with the spirit of the legislation. We look forward to partnering to make telehealth a successful service option in the state of Alaska.

In Appreciation,

John Solomon LPC
Chief Executive Officer
Alaska Behavioral Health Association
4/6/2023

Dunkin, Susan M (DOH)

From: Sarah Fontaine <allaboutyoucc2@gmail.com>
Sent: Thursday, April 06, 2023 1:27 PM
To: Dunkin, Susan M (DOH)
Subject: Telehealth open comment period

Follow Up Flag: Follow up
Flag Status: Flagged

To whom it concerns regarding telehealth allowances and requirements in Alaska.

I am in favor of the regulation change in general, but do have some concerns about the application of some of the requirements. I feel like the ability to have a telephone call, or a video conference call is actually more time effective. There tends to be less side chat and interruptions from the environments, and we can discuss the topics of concern more concisely.

But I am concerned about some of the features of the telehealth requirement.

As a care coordinator I am not providing a service “relating to the practice of medicine and the practice of nursing” and as such I worry about mis-representing my occupation’s scope and qualification.

I support the removal of prohibitions on telephone consultations, and that telehealth and in person services are reimbursed at the same rate. This will ensure rural areas have access to providers. As a care coordinator who serves the Kodiak Region and is based in Anchorage, my monthly expenses to travel to Kodiak was sometimes in excess of $1000.00, requiring that I had at least 4 clients to break even. In smaller communities where there may only be 1 or 2 individuals needing care coordination, it was not cost effective to provide to those areas. This allowance will increase the number of CC’s who will be willing to serve those people “off the grid”.

However, I do not understand what “direct supervision communications” or “facilitation” means and therefore don’t know if my service falls into one of these categories which will NOT be reimbursed.

Care Coordination does not provide TREATMENT and no formal EVALUATION OR ASSESSMENTS.

I do not understand what CARE Coordination’s ROLE is (RENDERING, REFERRING, CONSULTING).

There is language in the CCHP that says that Home and Community Based Waiver services won’t be reimbursable. How do we reconcile this?

It would be helpful to have a direct answer as to what Monthly Ongoing Care Coordination is within these terminologies.

I also have concerns over telehealth requirements for Consent. As a Care Coordinator, there are multiple documents the ACC and the Support Plan itself that outlines the requirement and expectation that communications must occur multiple times monthly. The support plan should act as a written consent. Also many guardians are not with the client at the time of the call, video conference, or even an in person visit (as a function of our service is to monitor other services, often the guardians are not present). Many of the recipients are not their own decision maker, so obtaining a specific approval for each contact seems moot given the agreement outlined in the support plan. Additionally, there is a benefit to

surprise face to face visits and short notice video calls. It gives the care coordinator a chance at seeing what is happening without notice to hide evidence that may be concerning.

What is the license type that a care coordinator should obtain in order to deliver “telehealth”?

Will the SDS Certification department assist or confirm “Telehealth” license or other requirements?

Is Zoom an acceptable “real time” video conference modality? If not, what are the top 5 preferred/used in Alaska?

If a client is unable to use Zoom, and request a Facetime, Messenger or alternative video conference method, are those permitted? Or must those be routed through an intermediary like “Simple Visit”

I appreciate any assistance that can be provided that will enable me to evaluate if I can meet the requirements, and how to meet those requirements to the best of my ability.

Kindly,

Sarah Fontaine

All About You Care Coordination LLC

Dunkin, Susan M (DOH)

From: Madsen, Ted <tmadsen@SouthcentralFoundation.com>
Sent: Thursday, April 06, 2023 1:44 PM
To: Dunkin, Susan M (DOH)
Cc: Carpenter, Heather R (DOH)
Subject: SCF Comments on Telehealth regulations
Attachments: SCF Comments on Proposed Telehealth Regulations 04.06.2023.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Good afternoon,
Attached are comments from Southcentral Foundation related to the proposed telehealth regulations. If you have any questions, please reach out.
Thank you,
Ted

Ted Madsen
Policy Analyst, Office of Corporate and Intergovernmental Affairs
Southcentral Foundation
(907) 729-5057

Southcentral Foundation
Est. 1982

Vision
A Native Community that enjoys physical, mental, emotional and spiritual wellness.

Mission
Working together with the Native Community to achieve wellness through health and related services.

Customer-Owners
Serving over 65,000 Alaska Native and American Indian People

Communities Served
Anchorage Service Unit and 55 Tribes to Include:

Anchorage
Chickaloon
Eklutna
Igiugig
Iliamna
Kenaitze
Knik
Kokhanok
Matanuska-Susitna Borough
McGrath
Newhalen
Ninilchik
Seldovia
St. Paul Island
Tyonek

Services Offered
Over 90 Community-Based Programs Including:
Medical
Behavioral
Dental
Co-Own and Co-Manage the Alaska Native Medical Center

April 6, 2023

Susan Miller Dunkin
Department of Health
4601 Business Park Blvd. Bldg. K
Anchorage, AK 99503

RE: Proposed Regulations – Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities

Dear Ms. Dunkin,

Thank you for the opportunity to provide comments on the proposed regulations implementing House Bill 265 – Health Care Services via Telehealth (2022). Southcentral Foundation has been providing telehealth services to customer-owners well before the pandemic. These services help us to meet the needs of the families we walk with on their journey to health and wellness. The expansion of telehealth availability since the start of the pandemic has been a bright spot in a trying time for health care providers, organizations, and customers. It allows providers to help customer-owners when and how they need it, and it allows customer-owners to access health care conveniently — often sparing unnecessary travel from home communities. Finally, the relaxed documentation and authorization requirements due to the public health emergency have led to a welcome reduction in provider and organizational administrative burden.

Before detailing areas that need revisions, there is need for clarification on the provision of telehealth services prior to adoption of final regulations. The federal public health emergency (PHE) expires May 11, likely before these regulations are finalized. It is our understanding that many of the state's currently implemented telehealth policies are tied to this federal act, rather than the state's telehealth statutes. To relieve provider uncertainties, the department should clarify that in the absence of the federal PHE and adopted regulations, the telehealth laws found in state statute are the policies the department will be following.

The department's proposed regulations go a long way toward capturing the intent of the enacted legislation. The legislation, now law, clearly spells out the broad ways telehealth can be delivered, and possible ways for the department to restrict the provision of these services. While the regulations capture much of the intent of the statutes, especially in the later sections on behavioral health services, there are several areas where we have questions, concerns, and recommendations.

7 AAC 110.625(a)(1)(B) – Telehealth Modalities
This subparagraph details the allowability of audio-only modalities. However, the proposed language may unduly restrict the provision of this modality. A possible change to the language to better reflect statutory intent could be:

- "two-way audio-only technology, that includes an operational microphone and speaker or headphones **including, but not limited to, telephone, two-way radio, cellular phone, and internet-based calling;"**

This change would explicitly allow for telephonic appointments, as well as appointments by two-way radio. These modalities are explicitly called out within HB265.

7 AAC 110.625(a)(2) – Telehealth Modalities
The wording is not broad enough to include all forms of medical information that can be included in telehealth delivery. This should also include "data" to include such items as vital signs and other digital information derived from real-time monitoring devices. Additionally, the definition of "telehealth" found on page 7 includes the term "medical data." Further, the definition for "telehealth" found in law at AS 47.05.270(e), which HB265 uses throughout the legislation, contemplates that "data" is part of telehealth.

7 AAC 110.625(b) – Telehealth Modalities
This section is problematic for several reasons. It uses terms not found within the legislation. Paragraph (2) creates an incongruency between the phrase "patient-initiated online digital service" and the term "provider-initiated online digital service." The definition for "patient-initiated online digital service" found later in the proposed regulations at 7 AAC 110.639(2) is confusingly worded and may prohibit reimbursement for certain essential services when it interacts with (b)(3). That definition also includes the phrase "digital application" which could be taken to include numerous telehealth platforms such as Zoom and other similar programs.

Prohibiting reimbursement for a patient seeking telehealth care within the seven-day period following a prior in-person appointment is dangerous and does not meet the needs of rural Alaskans. Consider the context of a patient who has been or may be hospitalized for a behavioral health crisis. In the former situation, a patient may be hospitalized in Anchorage and then fly home to a small community and need to speak urgently with a care provider via telehealth applications. The 24-72 hours following a behavioral health crisis is commonly a time when crisis re-emerges and should be treated immediately. Telehealth is the fastest and most easily accessible way to provide services during this critical window. Similarly, if a person is having a behavioral health crisis, it is imperative that they can speak to a provider as often as needed to provide the least restrictive care in a community setting and hopefully prevent hospitalization. This is contact that seeks to alleviate the need for hospitalization, which will save the state money in the long run and be better for the customer-owner than an in-hospital stay.

Finally, this exclusionary subsection does not cite the appropriate restrictive authority found in state statute at AS 47.07.069(b)(1-3). It is not clear what legal reasoning the department is using to promulgate this restriction. Therefore, pending the production and distribution of satisfactory reasoning to the broader health care sector, this subsection should be deleted prior to these regulations being adopted.

7 AAC 110.630(1)-(2) – Telehealth provider requirements and conditions for payment
This paragraph contains an oversight in that it requires a provider to have an active license under Title 08 of Alaska's statutes. This is incongruous with current Medicaid policy that allows for reimbursement of certain services by *certified* providers. These providers include community health aides, behavioral health aides, and chemical dependency counselors among others. Additionally, these provider types are explicitly called out within the legislation as allowable for purposes of Medicaid reimbursement, see enrolled HB265 page 10, line 29--page 11, line 7.

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A possible solution to this oversight could be:

- "(1) the provider must be an eligible Medicaid provider under 7 AAC 105.200 and enrolled under 7 AAC 105.210; or
  (2) be a provider of one or more of the following services;
  (A) care coordination services under 7 AAC 130.240;
  (B) day habilitation services under 7 AAC 130.260;
  (C) employment services under 7 AAC 130.270;
  (D) intensive active treatment services under 7 AAC 130.275;
  (E) case management services provided under 7 AAC 128.010(b)(2)."

7 AAC 110.630(7) – Telehealth provider requirements and conditions for payment

This restriction on telehealth services may be inappropriate in certain circumstances. Specifically for children and adults with complex needs, it may not be possible to have the recipient always present, but family and caregivers could be. Additionally, this paragraph broadly applied would be detrimental to the provision of telehealth services delivered via store-and-forward modalities. This paragraph should either be substantially reworked to better capture the intent of the legislation and the exigencies of care delivery, or it should be deleted entirely prior to the adoption of the regulations.

7 AAC 110.630(9) – Telehealth provider requirements and conditions for payment

This section creates additional documentation burdens on providers and will contribute to inefficiencies in care delivery. There are ways to accommodate the needs of the department for data and metrics. However, having someone consent multiple times that they are alright with receiving telehealth services does not provide useful data and impacts the duration of clinical care time. The need to obtain informed consent should only be necessary during the first telehealth encounter and annually thereafter. Additionally, recording the patient's location in the medical chart is unnecessary and burdensome, and not required by HB 265 or federal law. Therefore, the location notation requirement should be removed.

7 AAC 110.635(2) – Telehealth exclusions

While the intent of this paragraph responds to a specific scenario, it may need an additional term to achieve its intended purpose without unduly impacting the delivery of care. It is entirely possible for a health care provider acting in a supervisory capacity over another certified or licensed professional to be acting in a capacity other than supervisory. For example, a medical doctor who supervises a physician assistant could act as a consulting, rather than supervisory, provider for a given situation.

A possible change to this proposed regulation could be made to better capture intent without unintended consequences:

- "(2) a provider for communication with that provider's supervising provider or communication with a provider who is acting **only** in a supervisory capacity with the sole purpose being supervision of that provider."

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7 AAC 110.635(6) – Telehealth exclusions
This paragraph uses overly broad service categories to exclude entire areas of health care from being delivered using telehealth modalities. There are only two ways in state statute for telehealth services to be restricted. These reasons for restriction are found in AS 47.07.069(b)(1-3). Any restrictions on the delivery of, or payment for telehealth services must cite this subsection and at least one of the three possible reasons contemplated in (b)(1-3). These three reasons are that it is unsafe to deliver telehealth for that service according to "substantial medical evidence," the service may not be delivered via telehealth according to federal law or is ineligible for federal financial participation.

This regulatory paragraph of proposed exclusions does not cite the appropriate state statute as the controlling authority, nor does it cite to medical evidence or federal guidance for these proposed prohibitions. To place a blanket prohibition on entire categories of services is inappropriate and does not comport with legislative intent. It should not be necessary for the affected areas of the health care sector to push back on this paragraph as the burden of proof for these exclusions falls on the department. However, to name just one inappropriate exclusion, pharmacy services can be delivered via telehealth, including for things such as medication review and extensive counselling. Additionally, the Drug Enforcement Administration has been pursuing telehealth regulations at the federal level. If the federal agency in charge of protecting the public from the dangers of controlled substances is contemplating how the dispensing of those medications can be safely delivered via telehealth, the state should not put a blanket exclusion on that service category.

Again, the burden of proof for why a telehealth service should be excluded from coverage falls on department analysis. There was no supporting documentation to defend these blanket exclusions published alongside the proposed regulations. Therefore, the entirety of paragraph (6) should be removed prior to these regulations being finalized and adopted.

7 AAC 110.639 – Telehealth definitions
The definition of "telehealth" needs to be changed to match the definition found in AS 47.05.270(e). This will provide additional clarity and certainty to providers and health care organizations. If the department desires to use a definitional term that does not parallel existing state law, the department should detail why this is necessary and why the particular definition has been crafted in such a manner.

7 AAC 135.150(c)(2) – Psychotherapy
The behavioral health regulations found in this area of the regulations are well-crafted and when adopted will help to reassure clinicians that this vital method of care delivery can continue. This paragraph should simply be repealed rather than modified as the legislation does not specify that a justification for telehealth is needed for behavioral health care.

7 AAC 145.739(3) – Definition of "visit"
This paragraph (not currently contemplated in the regulations) needs to be updated to include telehealth encounters, as it currently only contemplates "face-to-face" encounters. This is needed to ensure that different types of providers and organizations continue to be fairly compensated for the care they deliver.

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Thank you for considering these comments, working toward capturing the intent of the legislation, and accommodating the needs of the health care sector. If you have any questions, please contact me at akyle@southcentralfoundation.com.

Sincerely,
SOUTHCENTRAL FOUNDATION

April Kyle, MBA
President and CEO

Dunkin, Susan M (DOH)

From: Phelps, Heather R (DOH)
Sent: Tuesday, April 11, 2023 7:09 AM
To: Dunkin, Susan M (DOH)
Subject: FW: Public comment - Notice of Proposed Telehealth Regulations

Heather Phelps, MA LPC
Policy, Regulations, and Planning
Division of Behavioral Health
Desk Phone: 907-269-3616
Cell Phone: 907-891-9497
Heather.phelps@alaska.gov

Secure Email:
heather.phelps@hss.soa.directak.net

From: Marti Romero <Marti_Romero@assetsinc.org>
Sent: Thursday, April 6, 2023 11:25 AM
To: DOH DBH Public Comments (DOH sponsored) <doh.dbh.public.comments@alaska.gov>
Cc: Matt Jones <Matt_Jones@assetsinc.org>
Subject: Public comment - Notice of Proposed Telehealth Regulations

State of Alaska Department of Health
Division of Behavioral Health
To Whom It May Concern:

As active members of the Alaska Behavioral Health Association (ABHA), Assets, Inc. has collaborated with the Association to voice our collective recommendations regarding the proposed telehealth regulations. ABHA has submitted those recommendations and we support them in their entirety.

Assets, Inc. supports individuals who experience life-long, serious mental illness, often times in addition to a developmental or intellectual disability. Most of the individuals we support are currently receiving state plan and/or 1115 behavioral health waiver services, in addition to services administered through the Division of Senior and Disabilities Services. The increased access to tele-behavioral health services has made a great impact on our ability to provide needed services in a manner that is person-centered and increases attendance and adherence to regulatory requirements. Our client population has seen immense benefit with the role of telehealth, especially that of audio-only delivery.

There is language in the current proposed telehealth regulations that could be misunderstood and seems cumbersome. Specifically, “7AAC 110.625…the following are not reimbursable:…(2) provider-initiated online digital services, (3) patient-initiated online digital services…” This could be interpreted to exclude interactive telehealth modalities in

common behavioral health encounters. Services may be initiated by providers in dealing with high acuity, crisis situations. Not allowing reimbursement for provider initiated digital services will impede our ability to interact proactively and preventatively with a vulnerable population. It is therefore our recommendation that these two areas be deleted from regulation.

We are grateful for the efforts the state is making toward continued accessible tele-behavioral health services. We respectfully support those recommendations set forth by the ABHA, and specifically as noted above, as this would have significant impact on our client population.

On behalf of Assets, Inc. leadership team, thank you for your attention to our comments regarding proposed telehealth regulations.

Dr. Marti Romero
Licensed Psychologist
Director of Behavioral Health Services
907-334-8608

Dunkin, Susan M (DOH)

From: Christine Culliton <cmculliton@gmail.com>
Sent: Thursday, April 06, 2023 2:53 PM
To: Dunkin, Susan M (DOH)
Subject: Public Comment on Telehealth
Attachments: PublicCommentTelehealth (1).docx

Follow Up Flag: Follow up
Flag Status: Flagged

Sincerely, Stacey Messerschmidt

To whom it may concern,

Attached is my public comment pertaining to the proposed telehealth regulation changes.

To begin, I appreciate that the telehealth modalities are being amended to include the use of two-way audio only technology; this allows our recipients who have limited access to different platforms/internet the ability to remain in contact with their care coordinator. This telehealth modality will also provide us with an alternative way to remain compliant with State regulations and billing practices.

Under section (b) it states the limitations of what the department will pay for under the telemedicine application; however, this has been omitted under the proposed amended regulation; is there a reason for this discrepancy? After reading this section it is my understanding that care coordination under the HCBW program would not be included as it currently is written:

"(b) The department will only make a payment for a telemedicine application if the service is limited to (1) an initial visit; (2) a follow-up visit; (3) a consultation made to confirm a diagnosis; (4) a diagnostic, therapeutic, or interpretive service; (5) a psychiatric or substance abuse assessment; (6) psychotherapy; or (7) pharmacological management services on an individual recipient basis."

I have **grea**t concerns regarding the telehealth provider requirements and conditions of payment (section)of the proposed and current regulations vs what care coordinators have been directed to do by SDS for billing purposes.

In the proposed and current regulations, it states that a modifier and that POS coding are required to bill under telehealth, however modifiers are not present in the current Care Coordinator fee schedule; nor have they been provided by the training unit. Furthermore, the fee schedule for telehealth services, which outlines what services can bill as telehealth, do not include care coordination services.

Targeted case management listed on the fee schedule, the State Medicaid billing manual and State regulation under Targeted Case Management refers solely to the ILP program. To lump care coordination and ILP services together would be inappropriate; care coordination services ARE NOT medical services and were not written into the HCBW program to become a medically based service.

By lumping these two services by the State of Alaska opens care coordinators up to the requirements of TCM third party liability billing; again care coordination services are not a medical services by definition at CMS and do not fall under services insurance covers. To require Care Coordinator's to go through every claim and insurance policy for TPL would crash the entire Care Coordination system, place an unnecessary burden and be outside of the scope of practice for which we are certified.

In researching the CMS/national standards for telehealth billing there are greater areas of concern regarding care coordination billing. Alaska care coordinator CPT codes are not included under CMS telehealth billing guidelines, and the description of the scope of telehealth services appears to be limited to virtual check-ins (again our CPT codes are not included under covered services) and only apply to recipients that are established. I am formally requesting that as a part of the follow-up to public comment on this topic that the State of Alaska provide the federal requirements for telehealth services, including definitions and fee schedules prior to any implementation of the proposed regulations to assure that HSS is compliant with CMS requirements.

Within the proposed and current regulation, registering with the telehealth business registry is listed as a requirement for telehealth billing; this contradicts what care coordinators have been told/instructed

to do by SDS and Conduent. Care Coordinators were told that they were exempt from this registration. If the requirement is that all Care Coordinators must register prior to providing telehealth modality based services then this creates large scale billing compliance issue and is not what was stated by Lynn Keilman Cruz and SDS previously.

Under section (7) of 7AAC 110.630 proposed regulation it states the recipient must be present for the telehealth modality however SDS regulation allows the care coordinator to have contact with the legal representative absent the recipient; it's an "and/or" not singular.

Under proposed State regulation 7AAC 110.639 telehealth definitions section (5) telehealth where care coordination falls under health care delivery, evaluation, diagnosis, consultation, or treatment.

Throughout the PHE and posted clarifications, e-alerts, RA messages and directive sessions held by SDS and Conduent there has been continued contradictory information provided to care coordinators.

In order to move forward with these proposed regulations, I believe the State of Alaska needs to pull all telehealth based fee schedules, trainings, manuals (including billing manuals) and regulations to ensure that the required CPT codes are included under telehealth, the definition of service (HCBW care coordination, case management and targeted case management are clearly defines since they currently appear to be used interchangeably; but hold very different regulatory and federal definitions. This needs to be clear and consistent across all regulations, HSS/SDS documents as well as a further exploration/explanation regarding how care coordination services in Alaska would become medically based services as outlined in your proposed telehealth billing regulations.

Sincerely,

Jacquelyn Culliton

Dunkin, Susan M (DOH)

From: Jacquelyn Culliton <cullitonj@live.com>
Sent: Thursday, April 06, 2023 2:45 PM
To: Dunkin, Susan M (DOH)
Subject: Public Comment for Telehealth Services
Attachments: PublicCommentTelehealth (1).docx

Follow Up Flag: Follow up
Flag Status: Flagged

Please see the attached letter.
Thanks!
Jacquelyn

Christine Inc.
(907) 209-8083 ~ Cell
(907) 789-3941 ~ Office

To whom it may concern,

Attached is my public comment pertaining to the proposed telehealth regulation changes.

To begin, I appreciate that the telehealth modalities are being amended to include the use of two-way audio only technology; this allows our recipients who have limited access to different platforms/internet the ability to remain in contact with their care coordinator. This telehealth modality will also provide us with an alternative way to remain compliant with State regulations and billing practices.

Under section (b) it states the limitations of what the department will pay for under the telemedicine application; however, this has been omitted under the proposed amended regulation; is there a reason for this discrepancy? After reading this section it is my understanding that care coordination under the HCBW program would not be included as it currently is written:

"(b) The department will only make a payment for a telemedicine application if the service is limited to (1) an initial visit; (2) a follow-up visit; (3) a consultation made to confirm a diagnosis; (4) a diagnostic, therapeutic, or interpretive service; (5) a psychiatric or substance abuse assessment; (6) psychotherapy; or (7) pharmacological management services on an individual recipient basis."

I have **grea**t concerns regarding the telehealth provider requirements and conditions of payment (section)of the proposed and current regulations vs what care coordinators have been directed to do by SDS for billing purposes.

In the proposed and current regulations, it states that a modifier and that POS coding are required to bill under telehealth, however modifiers are not present in the current Care Coordinator fee schedule; nor have they been provided by the training unit. Furthermore, the fee schedule for telehealth services, which outlines what services can bill as telehealth, do not include care coordination services.

Targeted case management listed on the fee schedule, the State Medicaid billing manual and State regulation under Targeted Case Management refers solely to the ILP program. To lump care coordination and ILP services together would be inappropriate; care coordination services ARE NOT medical services and were not written into the HCBW program to become a medically based service.

By lumping these two services by the State of Alaska opens care coordinators up to the requirements of TCM third party liability billing; again care coordination services are not a medical services by definition at CMS and do not fall under services insurance covers. To require Care Coordinator's to go through every claim and insurance policy for TPL would crash the entire Care Coordination system, place an unnecessary burden and be outside of the scope of practice for which we are certified.

In researching the CMS/national standards for telehealth billing there are greater areas of concern regarding care coordination billing. Alaska care coordinator CPT codes are not included under CMS telehealth billing guidelines, and the description of the scope of telehealth services appears to be limited to virtual check-ins (again our CPT codes are not included under covered services) and only apply to recipients that are established. I am formally requesting that as a part of the follow-up to public comment on this topic that the State of Alaska provide the federal requirements for telehealth services, including definitions and fee schedules prior to any implementation of the proposed regulations to assure that HSS is compliant with CMS requirements.

Within the proposed and current regulation, registering with the telehealth business registry is listed as a requirement for telehealth billing; this contradicts what care coordinators have been told/instructed

to do by SDS and Conduent. Care Coordinators were told that they were exempt from this registration. If the requirement is that all Care Coordinators must register prior to providing telehealth modality based services then this creates large scale billing compliance issue and is not what was stated by Lynn Keilman Cruz and SDS previously.

Under section (7) of 7AAC 110.630 proposed regulation it states the recipient must be present for the telehealth modality however SDS regulation allows the care coordinator to have contact with the legal representative in place of the recipient.

Under proposed State regulation 7AAC 110.639 telehealth definitions section (5) telehealth where care coordination falls under health care delivery, evaluation, diagnosis, consultation, or treatment.

Throughout the PHE and posted clarifications, e-alerts, RA messages and directive sessions held by SDS and Conduent there has been continued contradictory information provided to care coordinators.

In order to move forward with these proposed regulations, I believe the State of Alaska needs to pull all telehealth based fee schedules, trainings, manuals (including billing manuals) and regulations to ensure that the required CPT codes are included under telehealth, the definition of service (HCBW care coordination, case management and targeted case management are clearly defines since they currently appear to be used interchangeably; but hold very different regulatory and federal definitions. This needs to be clear and consistent across all regulations, HSS/SDS documents as well as a further exploration/explanation regarding how care coordination services in Alaska would become medically based services as outlined in your proposed telehealth billing regulations.

Sincerely,

Jacquelyn Culliton

Dunkin, Susan M (DOH)

From: Rafferty, Renee (She, Her, Hers) <Renee.Rafferty@providence.org>
Sent: Thursday, April 06, 2023 3:05 PM
To: Dunkin, Susan M (DOH)
Subject: Comments on Telehealth regulations
Attachments: Telehealthregulationcomments BTcomments.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Good afternoon!
I have enclosed comments on the regulations for telehealth. Please let me know if you have any questions.

Renee Rafferty, MS, LPC
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April 6, 2023
Susan Miller Dunkin
Department of Health
4601 Business Park Blvd. Bldg K
Anchorage, AK 99503

RE: Proposed Regulations – Medicaid Coverage and Payment for Services Delivered through Telehealth Modalities

Dear Ms. Dunkin,

Thank you for the opportunity to provide comments on the proposed regulations implementing House Bill 254 – Health Care Services via Telehealth (2022). We are very grateful the State has prioritized Telehealth services and is engaging regulations that decrease administrative burden and allow more access to care. Providence has been providing telehealth services to patients across our continuum. These services help us to meet the needs of the community.

Below are our suggested recommendations and explanation of our concerns:

7 AAC 110.625(a)(1)(B) – Telehealth Modalities
This subparagraph details the allowability of audio-only modalities. However, the proposed language may unduly restrict the provision of this modality. A possible change to the language to better reflect statutory intent could be:

- "two-way audio-only technology, <u>including, but not limited to, telephones and devices with</u> an operational microphone and speaker or headphones." [<u>Underline indicates edited language.</u>]

This change would explicitly allow for telephonic appointments, as well as appointments by two-way radio. These modalities are explicitly called out within HB265.

7 AAC 110.625(a)(2) – Telehealth Modalities
The wording is not broad enough to include all forms of medical information that can be included in telehealth delivery. This should also include "data", to include such items as vital signs and other digital information derived from real-time monitoring devices. Additionally, the definition of "telehealth" found on page 7 includes the term "medical data." Further, the definition for "telehealth" found in law at AS 47.05.270(e), which HB265 uses throughout the legislation, contemplates that "data" is part of telehealth.

7 AAC 110.625(b) – Telehealth Modalities
This section is problematic for several reasons. It uses terms that are not found within the legislation. Paragraph (2) creates an incongruency between the phrase "patient-initiated online digital service" and the term "provider-initiated online digital service." The definition for "patient-initiated online digital service" found later in the proposed regulations at 7 AAC 110.639(2) is confusingly worded and may prohibit reimbursement for certain essential services when it interacts with (b)(3). That definition also

includes the phrase “digital application” which could be taken to include numerous telehealth platforms such as Zoom and other similar programs.

Prohibiting reimbursement for a patient seeking telehealth care within the seven-day period following a prior in-person appointment is dangerous. Consider the context of a patient who has been or may be hospitalized for a behavioral health crisis. Research indicates one of the most dangerous times for patients is 48 for patients post hospitalization. This component of the regulation will limit life saving care. Tele-health is the fastest and most easily accessible way to provide services during this critical window.

Finally, this exclusionary subsection does not cite the appropriate restrictive authority found in state statute at AS 47.07.069(b)(1-3). It is not clear what legal reasoning the department is using to promulgate this restriction. Therefore, pending the production and distribution of satisfactory reasoning to the broader health care sector, this subsection should be deleted prior to these regulations being adopted.

7 AAC 110.630(1) – Telehealth provider requirements and conditions for payment
This paragraph contains an oversight in that it requires a provider to have an active license under Title 08 of Alaska’s statutes. This is incongruous with current Medicaid policy that allows for reimbursement of certain services by *certified* providers. These providers include Community Health Aides, Behavioral Health Aides, and Chemical Dependency Counselors among others. Additionally, these provider types are explicitly called out within the legislation as allowable for purposes of Medicaid reimbursement, see enrolled HB265 page 10, line 29--page 11, line 7.

A possible solution to this oversight could be:

- “(1) except for providers of the services identified in 7 AAC 110.635(6)(L)-(M), the provider must have an active license to practice under AS 08 or the applicable laws of the jurisdiction in which the provider is located, or be certified to provide services authorized under the Medicaid state plan.”

7 AAC 110.630(7) – Telehealth provider requirements and conditions for payment
This restriction on telehealth services may be inappropriate in certain circumstances. Specifically for children and adults with complex needs, it may not be possible to have the recipient always present, but family and caregivers could be. Additionally, this paragraph broadly applied would be detrimental to the provision of telehealth services delivered via store-and-forward modalities. This paragraph should either be substantially re-worked to better capture the intent of the legislation and the exigencies of care delivery, or it should be deleted entirely prior to the adoption of the regulations.

7 AAC 110.630(9) – Telehealth provider requirements and conditions for payment
This section creates additional documentation burdens on providers and will contribute to inefficiencies in care delivery. There are ways to accommodate the needs of the department for data and metrics. However, having someone consent for the tenth time that they are alright with receiving telehealth services does not provide useful data and impacts the duration of clinical care time. The need to obtain informed consent should only be necessary during the first telehealth encounter and annually thereafter.

Providence

7 AAC 110.635(2) – Telehealth exclusions

While the intent of this paragraph responds to a specific scenario, it may need an additional term to achieve its intended purpose without unduly impacting the delivery of care. It is entirely possible for a health care provider acting in a supervisory capacity over another certified or licensed professional to be acting in a capacity other than supervisory. For example, a medical doctor that supervises a physician assistant could act as a consulting, rather than supervisory, provider for a given situation.

A possible change to this proposed regulation could be made to better capture intent without unintended consequences:

- "(2) a provider for communication with that provider's supervising provider or communication with a provider who is acting in a supervisory capacity with the sole purpose being supervision of that provider;" [Underline indicates edited language.]

7 AAC 110.635(6) – Telehealth exclusions

This paragraph uses overly broad service categories to exclude entire areas of health care from being delivered using telehealth modalities. There are only two ways in state statute for telehealth services to be restricted. These reasons for restriction are found in AS 47.07.069(b)(1-3). Any restrictions on the delivery of or payment for must cite this subsection and at least one of the three possible reasons contemplated in (b)(1-3). These three reasons are that it is unsafe to deliver telehealth for that service according to "substantial medical evidence," the service may not be delivered via telehealth according to federal law, or is ineligible for federal financial participation.

This paragraph of proposed exclusions does not cite to the appropriate state statute as the controlling authority, nor does it cite to medical evidence or federal guidance for these proposed prohibitions. To place a blanket prohibition on entire categories of services does not align with legislative intent. It should not be necessary for the affected areas of the health care sector to push back on this paragraph as the burden of proof for these exclusions falls on the department. However, to name just one inappropriate exclusion, pharmacy services can be delivered via telehealth, including for things like medication review and extensive counselling. Additionally, the Drug Enforcement Administration has been pursuing telehealth regulations at the federal level. If the federal agency in charge of protecting the public from the dangers of controlled substances is contemplating how the dispensing of those medications can be safely delivered via telehealth, the state should not put a blanket exclusion on that service category.

Again, the burden of proof for why a telehealth service should be excluded from coverage falls on department analysis. There was no supporting documentation to defend these blanket exclusions published alongside the proposed regulations. Therefore, the entirety of paragraph (6) should be removed prior to these regulations being finalized and adopted.

7 AAC 110.639 – Telehealth definitions

The definition of "telehealth" needs to be changed to match the definition found in AS 47.05.270(e). This will provide additional clarity and certainty to providers and health care organizations. If the department desires to use a definitional term that does not parallel existing state law, the department should detail why this is necessary and why the particular definition has been crafted in such a manner.

7 AAC 135.150(c)(2) – Psychotherapy

The behavioral health regulations found in this area of the regulations are well-crafted and when adopted will help to reassure clinicians that this vital method of care delivery can continue. This paragraph should simply be repealed rather than modified as the legislation does not specify that a justification for telehealth is needed for behavioral health care.

7 AAC 145.739(3) – Definition of "visit"
This paragraph (not currently contemplated in the regulations) needs to be updated to include telehealth encounters, as it currently only contemplates "face-to-face" encounters. This is needed to ensure that Federally Qualified Health Centers continue to be fairly compensated for the care they deliver.

Lastly, the federal public health emergency (PHE) expires on May 11th, before these regulations are finalized. To support on-going telehealth services, we request that the department clarify that in the absence of the federal PHE and adopted regulations, the telehealth laws found in State statute are the policies the department will be following.

Thank you for the opportunity to comment and for the work the Department has done to ensure that telehealth services are possible in the State of Alaska. If you have any questions, please contact me at

Sincerely,

Renee Rafferty

Renee Rafferty, MS, LPC

Senior Director of Behavioral Health Services

Providence Health & Services, Alaska

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Anchorage, Alaska 99508

(907)-212-3037

Dunkin, Susan M (DOH)

From: Zelma Clarke <zclarke@akchild.org>
Sent: Thursday, April 06, 2023 3:56 PM
To: DOH DBH Public Comments (DOH sponsored); Dunkin, Susan M (DOH)
Cc: Anne Dennis-Choi
Subject: Public Comment - Telehealth Regulations
Attachments: Public Comment - Telehealth Regulations.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hello All,

Please find attached the above letter. If you should have any questions, please contact Anne Dennis-Choi at 907.346-2101.

Thank you,

Zelma Clarke
Administrative Support Assistant

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.

Zelma Clarke
Administrative Support Assistant

[AK Child & Family Logo]
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AK Child & Family
4600 Abbott Road • Anchorage, AK • 99507 Call 907-346-2101 • Fax 907-348-9230

AKCHILD & FAMILY

April 6, 2023

Re: Public comment – Notice of Proposed Telehealth Regulations

Thank you for the opportunity to provide public testimony on the notice of proposed changes on Medicaid coverage and payment for services delivered through telehealth modalities. AK Child & Family provides a continuum of care for youth ages 3 through 21 and their families to include high fidelity wraparound, outpatient, and intensive psychiatric residential care. As essential service providers, we continued to serve our high risk, vulnerable population throughout the pandemic, never closing our doors. We were able to do so in part due to the increased telehealth flexibilities implemented in response to the COVID-19 public health emergency.

We appreciate that many of these telehealth flexibilities will continue thus allowing Medicaid recipients access to necessary behavioral health care and services. We support the following recommendations made through the Alaska Behavioral Health Association.

Recommendations:

- **Allow unlicensed provider types to bill telehealth services, in line with legislation**
    - Telehealth Legislation signed into law clearly outlines several provider types that are not licensed but instead hold certifications or other designations to deliver services via telehealth within the scope of their practice. Providers outlined in legislation include substance use counselors, behavioral health aides, and similar non 2 licensed provider types. It is our recommendation that this section be rewritten to reflect the allowable provider types outlined in legislation.
- **Remove disallowed services, including provider-initiated services and patient-initiated services in seven days post-visit, remove (2) and (3)**
    - 7 AAC 110.625 For patient-initiated online digital service, whether synchronous or asynchronous, the following are not reimbursable:

Serving one child, one family at a time since 1890.
4600 Abbott Road
Anchorage, Alaska 99507
www.akchild.org
PHONE 907.346.2101
FAX 907.348.9230

- (1) nonevaluative or nonmanagement services including appointment scheduling and electronic communication of test results;
- (2) provider-initiated online digital service;
- (3) patient-initiated online digital service within the postoperative period of a completed procedure or within seven days of an in-person visit and related to the illness, injury, or other reason for that visit. (Eff. 2/1/2010, Register 193; am_____/_____/_____, Register_____

- **Remove blanket exclusions, such as exclusion of pharmacy services**

Thank you for the opportunity to provide recommendations on telehealth services. Telehealth has proven to be a valuable resource for many individuals and communities, particularly those in remote or underserved areas, and those with transportation or other barriers. We appreciate your efforts to remove unnecessary barriers to access to quality care. Thank you for your time and attention.

Sincerely,

Anne Dennis-Choi
President & CEO
AK Child & Family

Dunkin, Susan M (DOH)

From: Robin Dempsey <rdempsey@cssalaska.org>
Sent: Thursday, April 06, 2023 4:11 PM
To: Dunkin, Susan M (DOH)
Subject: Proposed Regulations on Payment for Medicaid Services Delivered through Telehealth

Follow Up Flag: Follow up
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Hi Ms. Dunkin:

Please accept the following email/suggestions regarding proposed changed to regulations on payment for Medicaid services delivered through telehealth. Please note that our suggested changes are in bold.

Proposed Regulations on Payment for Medicaid Services Delivered through Telehealth

CSS Comment:
Similar to the provision in 7 AAC 135.030(d)(4) for mental health physician clinics serving people experiencing homelessness outside of the clinic, we recommend adding the same language for all clinic services when they are provided by a community behavioral health services provider to a person experiencing homelessness under 7 AAC 135.010 as follows:

7 AAC 135.010(d) is amended to read:
7 AAC 135.010(d) The department will not pay for any of the following services as a Medicaid covered service under this chapter:
(16) transportation or travel time as a part of a behavioral health clinic service or rehabilitation service, except as provided under 7 AAC 135.180**;**[.]
(17) behavioral health clinic services not provided on the premises or by means of a telehealth modality under 7 AAC 110.620 - 7 AAC 110.639, unless the service is provided to a person experiencing homelessness.

In addition, we recommend updating the language in 7 AAC 135.030(d)(4) for people experiencing homelessness as follows:

Proposed: 7 AAC 135.030(d)(4) is amended to read:
(4) services are provided on the premises of the mental health physician clinic or **by means of** [THROUGH] **a telehealth modality** [TELEMEDICINE APPLICATION] under 7 AAC 110.620 - 7 AAC 110.639, unless the service is provided to a person **experiencing homelessness** [IDENTIFIED AS HOMELESS].
(Eff. 10/1/2011, Register 199; am 7/1/2018, Register 226; am 11/10/2019, Register 232; am 4/24/2020, Register 234; am____/____/____, Register_____)
Authority: AS 47.05.010 AS 47.07.030

Related current and proposed regulation changes:

Current: 7 AAC 135.030(d) The department will pay for behavioral health clinic services provided by a mental health physician clinic only if the (4) services are provided on the premises of the mental health physician clinic or through a telemedicine application under 7 AAC 110.620 — 7 AAC 110.639 , **unless the service is provided to a person identified as homeless.**

Proposed: 7 AAC 135.030(d)(4) is amended to read:
(4) services are provided on the premises of the mental health physician clinic or **by means of** [THROUGH] **a telehealth modality** [TELEMEDICINE APPLICATION] under 7 AAC 110.620 - 7 AAC 110.639, unless the service is provided to a person identified as homeless.
(Eff. 10/1/2011, Register 199; am 7/1/2018, Register 226; am 11/10/2019, Register 232; am 4/24/2020, Register 234; am____/____/____, Register_____)
Authority: AS 47.05.010 AS 47.07.030

Current: 7 AAC 135.010(d) The department will not pay for any of the following services as a Medicaid covered service under this chapter: (1) outpatient mental health services provided by a hospital or psychiatric facility, unless the outpatient program is a mental health physician clinic that is enrolled in accordance with 7 AAC 105.210; (2) experimental therapy; (3) telephone consultation or coordination with another service provider other than case management; (4) preparation of reports as a separate service; (5) narcosynthesis; (6) socializing; (7) recreation therapy; (8) primal therapy; (9) rage reduction or holding therapy; (10) marathon group therapy; (11) megavitamin therapy; (12) pastoral counseling; (13) explanation of an examination to a family member or other responsible individual that is provided outside of a family therapy session; (14) therapy or evaluation if the documentation required by 7 AAC 105.230 , 7 AAC 135.120 , and 7 AAC 135.130 is inadequate or is absent from the recipient's clinical record or behavioral health treatment plan; (15) room and board costs as a part of a behavioral health clinic service or rehabilitation service; (16) transportation or travel time as a part of a behavioral health clinic service or rehabilitation service, except as provided under 7 AAC 135.180.

Proposed: 7 AAC 135.010. Scope of Medicaid behavioral health services.
7 AAC 135.010(d)(3) is amended to read:
(3) [TELEPHONE] consultation or coordination **by means of a telehealth modality** with another service provider other than case management;
(Eff. 10/1/2011, Register 199; am 4/9/2017, Register 222; am 7/1/2018, Register 226; am 4/24/2020, Register 234; am 7/8/2020, Register 235; am 6/30/2021, Register 238; am 8/27/2021, Register 239; am 12/23/2022, Register 244)
Authority: AS 47.05.010 AS 47.07.030

Regards,

Robin Dempsey, M.C. (*she, her, hers*)
Chief Executive Officer
Catholic Social Services | www.cssalaska.org
3710 E 20th Avenue, Anchorage, AK 99508
907-222-7351
rdempsey@cssalaska.org

Dena'inaq ełnen'aq' gheshtnu ch'q'u yeshdu. (Dena'ina)
I live and work on the land of the Dena'ina. (English)

Catholic Social Services

Catholic Social Services | 3710 East 20th Avenue | Anchorage, AK 99508 | www.cssalaska.org

Dunkin, Susan M (DOH)

From: Jessie Menkens <JessieM@alaskapca.org>
Sent: Thursday, April 06, 2023 4:27 PM
To: Dunkin, Susan M (DOH)
Cc: Carpenter, Heather R (DOH); Nancy Merriman; Jon Zasada
Subject: APCA Comments on Proposed Telehealth Regulations
Attachments: APCA Telehealth Comment Letter 20230406 nm.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Ms. Dunkin,

On behalf of the Alaska Primary Care Association, please see attached for our comments on the, "Notice of Proposed Changes on Medicaid Coverage & Payment for Services Delivered Through Telehealth Modalities."

We appreciate this opportunity to provide these comments and revision requests. Thank you.

Sincerely,
Jessie

Jessie Menkens
Government Affairs Deputy Director
Government & External Affairs Manager

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jessiem@alaskapca.org

Alaska Primary Care ASSOCIATION

Date: April 6, 2023

To: Ms. Susan Miller Dunkin, Department of Health, Division of Health Care Services, submitted via electronic mail: susan.dunkin@alaska.gov

From: Alaska Primary Care Association

Subject: Notice of Proposed Changes on Medicaid Coverage & Payment for Services Delivered Through Telehealth Modalities

The Alaska Primary Care Association (APCA) supports the operations and development of Alaska's 29 Health Centers (also commonly referred to as Community Health Centers or Federally Qualified Health Centers). Health Centers provide comprehensive whole person care, which includes medical, dental, behavioral, pharmacy and care coordination services.

APCA and Alaska Health Centers were pleased to support stakeholder engagement and successful passage of HB265, landmark legislation to support the expansion of telehealth services in Alaska. On July 13, 2022, APCA was honored to host Governor Dunleavy's Bill Signing Ceremony in our conference center, welcoming bill sponsors, key partners, and providers who were instrumental in the crafting and near unanimous passage of the legislation. APCA is pleased to provide comment on these proposed regulations and request the Department of Health take action to address each of the following items to support the intent of this pivotal legislation.

First, due to the timing of the Federal Public Health Emergency ending on May 11, 2023 and the expanse of time it will take to promulgate final telehealth regulations, it is essential that the Department of Health issue emergency regulations based on the Department's current authority to keep current flexibilities in place to support telehealth delivery without disruption.

Health Centers serve hard-to-reach communities. The majority of Health Center patients experience challenges in accessing health care that include long distances to reach local providers, cost of care, transportation, language, and cultural barriers. In Alaska, over half of our patients are racial/ethnic minorities, a majority are low-income, and most patients live in rural communities.

Health Centers can best serve their patient populations if they have the ability to use technology to meet their patients "where they're at". Additionally, workforce shortages, particularly behavioral health providers, impact Health Centers uniquely as nonprofit safety-net providers, and telehealth allows Health Centers to use their clinical workforce most nimbly.

APCA requests the Department of Health make the following regulatory changes to honor the intent of HB265, and the recognition of Federally Qualified Health Centers (FQHCs) therein, also known as Health Centers, or Community Health Centers:

- The State regulation defining FQHC "visits" (7 AAC 145.739) needs to be amended to refer to telehealth visits. The definition currently requires a "face-to-face" visit and this is inconsistent with the underlying legislation.

- The State will need to modify its cost reporting guidance, since the regulation on cost reporting at 7 AAC 140.200 appear to assume that cost reporting is based on the Medicare template and instructions. (Under Medicare, "telehealth services" are considered non-FQHC services and paid under a different methodology.)

- The regulation at 7 AAC 145.020 is inconsistent with FQHC payment (since the payment methodology for FQHCs is not dependent upon charges). We recommend FQHCs be excluded from 7 AAC 145.020 to be consistent with federal requirements for FQHC payment.

Furthermore, we submit the following revision requests to these proposed regulations in keeping with the legislation as passed:

Proposed 7 AAC 110.625 subsection (a) paragraph (1)(B)

- Add "such as" language with additional examples in plain language, e.g., telephone, radio, etc.

Proposed 7 AAC 110.625 subsection (a) paragraph (2)

- The wording is not broad enough to include all forms of medical information that can be included in telehealth delivery. This should also include "data", to include such items as vital signs and other digital information. Additionally, the definition of "telehealth" found on page 7 includes the term "medical data."
- Add "data," after "digital images,"

Proposed 7 AAC 110.625 subsection (b)

- This entire section is problematic because it uses terms that are not found in the legislation and are not carefully worded within the definitional section found later in the regulations.
- The definition of the term "online digital service" is too broad.
- Especially troubling is paragraph (3) which would disallow reimbursement for a patient initiating a discussion with their care provider within a week of hospitalization or another illness. Patients are often anxious in following a hospitalization and may need to reach out for reassurance or to discuss possible side-effects or complications from medication.
- Additionally, consider the context of a patient who has been or may be hospitalized for a behavioral health crisis. In the former situation, a patient may be hospitalized in Anchorage and then fly home to a small community and need to speak urgently with a care provider via telehealth applications. The 24-72 hours following a behavioral health crisis is often a time when crisis re-emerges and should be treated immediately. Tele-health is the fastest and most easily accessible way to provide services during this critical window. Similarly, if a person is having a behavioral health crisis it is imperative that they can speak to a provider as often as needed to provide least restrictive care in community and hopefully prevent hospitalization. This contact that seeks to alleviate the need for hospitalization will save the state money in the long-run and be better for the patient than an in-hospital stay.

- The definition for "patient-initiated online digital service" found in 7 AAC 110.639(2) includes the term "digital application." This phrase could rule out these telehealth appointments when they are conducted via zoom, or other web-based platforms.
- We recommend deleting the entirety of subsection (b) in 7 AAC 110.625, and suggest the Department work with providers and stakeholders to ensure these regulations fully support patient messaging services and accurate reimbursement for telehealth services given the intent of HB265.

7 AAC 110.630 on page 4 of proposed regulations:

- Paragraph (1) contains an oversight that is not consistent with the legislation. It requires that for telehealth reimbursement a provider have an active license. Licensed providers are not the only provider-types that provide health services. Other professionals include those who have certification including Chemical Dependency Counselors, and Qualified Addiction Professionals. We encourage the Department to acknowledge the eligible Medicaid Providers as described under 7 AAC 105.200 and enrolled under 7 AAC 105.210; or (B) a provider of one or more of the following services: (i) care coordination services under 7 AAC 130.240; (ii) day habilitation services under 7 AAC 130.260; (iii) employment services under 7 AAC 130.270; (iv) intensive active treatment services under 7 AAC 130.275; (v) case management services provided under 7 AAC 128.010(b)(2); Paragraph (7), This could be difficult for children and adults with complex needs. A patient is not always present when the information is sent. APCA recommends deleting this paragraph.

7 AAC 110.630 (9)

- We request to have a durable single point of consent and an annual consent process. Furthermore, the requirement of notating the location of the patient is burdensome.

7 AAC 110.635 Telehealth Exclusions

- Paragraph (2) should read, The department will not pay...."a provider for communication with that provider's supervising provider or communication with a provider who is acting **only** in a supervisory capacity;"
- Paragraph (4) creates serious concern for certified providers and being covered and reimbursed for the service while facilitating a visit with a physician in a distance site.
- Paragraph (6) uses overly broad service categories to exclude entire areas of health care from being delivered using telehealth modalities.
    - For example, pharmacy services can often be delivered via telehealth, including extensive counseling and medication review. Additionally, federal agencies including the DEA are working on finalizing regulations to allow for pharmacy telehealth services.
    - Other examples,
        - Dental services
- Furthermore, there are only two ways that Medicaid services can be restricted from being delivered by telehealth given the passage of HB265—either it is deemed unsafe according to substantial medical evidence, or federal law prohibits it or denies federal financial participation for the service. The analysis based on these two modes of restrictions is not found in the proposed regulations.

Definitions 7 AAC 110.639

- Refer to the regulatory definition for telehealth that already exists under AS 47.05.270(e).
- The definition for "online digital services" needs to be revised or removed.
- Adopt the following definition for a "rendering provider":
    - "rendering provider" means a provider who meets the requirements under 7 AAC 105.200 and 7 AAC 105.210 and evaluates, diagnoses, and treats a recipient, or acts as a referring provider;"

7 AAC 135.150(c)(2)

- Remove, no longer necessary given passage of HB265. The legislation does not require a reason for delivery via telehealth to be documented.

Proposed 7 AAC 145.270

- Subsections (a) and (b) should be amended to add "referring provider".
- Subsection (c) should be amended to add "referring provider," after "rendering provider,"

In closing, APCA appreciates this opportunity to submit these comments in response to the Notice of Proposed Changes on Medicaid Coverage & Payment for Services Delivered Through Telehealth Modalities. Health Centers have witnessed how telehealth has provided stronger continuity of care for patients, reduced travel costs, and has resulted in fewer dropped visits and less delayed (and more costly) care. We understand that delivering quality whole person care ultimately leads to better health outcomes, saves lives and in the long run, it saves on cost.

APCA is available to address any questions that arise as the Department evaluates the above requests to support FQHC delivery and payment of telehealth services in Alaska, and the additional revision requests outlined to honor the intent and the promise of HB265.

Sincerely,

Nancy Merriman
CEO
Alaska Primary Care Association

ORAL HEARING RE:
MEDICAID COVERAGE AND PAYMENT SERVICES
DELIVERED THROUGH TELEHEALTH REGULATIONS

Held via Teleconference
March 24, 2023
10:00 a.m. to 12:00 p.m.

Reported by: Leslie J. Knisley
Shorthand Reporter

HEATHER PHELPS: Please note that we're now on record for an oral hearing to receive your comments and suggestions regarding the Medicaid coverage and payment services delivered through telehealth regulations described in the Alaska Online Public Notice dated February 28th, 2023.

My name is Heather Phelps. I'm a mental health clinician with the Division of Behavioral Health within the Alaska Department of Health. I will be facilitating today's oral hearing.

As stated on the Alaska Online Public Notice website, the Department of Health proposes to adopt regulation changes in Title 7 of the Alaska Administrative Code dealing with Medicaid coverage and payment services delivered through telehealth, including the following:

7 AAC 110, Medicaid coverage

professional services is proposed to be amended as follows: Revised title and article titles to reflect new telehealth nomenclature; remove prohibitions on telephone consultations; update telehealth terminology; establish that all services, except those identified in 7 AAC

110.635, are reimbursable when delivered in-person and through a telehealth modality; establish that direct supervision communications and facilitation are not considered telehealth and will not be reimbursed; establish that treatment, evaluation, and assessment are eligible for payment when delivered by means of a telehealth modality; define provider roles in telehealth, rendering, referring, consultation; establish that a service delivered through telehealth must meet the same requirements as if delivered in-person; establish telehealth recordkeeping requirements; establish audio-only coverage based on the Centers of Medicare & Medicaid Services, parentheses, CMS, and the American Medical Association, parentheses, AMA,

definitions and recommendations; amend synchronous and asynchronous telehealth coverage based on CMS and AMA definitions.

Next regulation, 7 AAC 135, Medicaid coverage and behavioral health services is proposed to be amended as follows:

Update telehealth terminology; revise section titles to reflect new telehealth nomenclature.

Next regulation, 7 AAC 145, Medicaid payment rates is proposed to be amended as follows:

Update telehealth terminology; revise section title to reflect new telehealth nomenclature and to reflect section content; establish that a rate for a service delivered through a telehealth modality is the same as if the service was delivered in-person.

Those are all the regulations. I'm going to continue reading from my script here.

The purpose of today's oral hearing

is to allow the public to comment on the proposed changes to the above regulations that were just read. The hearing is scheduled from 10:00 a.m. to 12:00 p.m., and priority will be given to commenters on the line before the beginning of the hearing. The hearing may be extended to accommodate those on the line before 11:30 a.m. who do not have an opportunity to comment.

Before the start of the hearing, the Department of Health may limit the time allotted for each person providing oral testimony as reasonably necessary to conclude the hearing in the time provided.

You may submit written questions relevant to the proposed action to Ms. Susan Miller Dunkin by electronic mail at Susan, S-u-s-a-n, dot Dunkin, D-as in dog-u-n-k-i-n, at Alaska dot gov or email at the Department of Health, Division of Health Care Services, 4601 Business Park Boulevard, Building K, Attention Susan Miller Dunkin, Anchorage, Alaska 99503.

The questions must be received at

least ten days before the end of public the comment period. The Department of Health will aggregate its response to substantially similar questions and make the questions and responses available on the Alaska Online Public Notice System.

After the public comment ends, the Department of Health will either adopt the proposed regulation changes or other provisions dealing with the same subject without further notice or decide to take no action. The language of the final regulation may be different from that of the proposed regulation. You should comment during the time allowed if your interests could be affected.

As we begin the oral hearing, it is

important to remember the following before providing public comment:

The oral hearing is on record. Please clearly state and spell your first and last name and state the organization that you're

representing before providing the public comment. Please state the section of the proposed regulations you are referring to in your comments. Please mute your phone line after you have provided public comment.

If you begin your testimony without stating and spelling your first and last name, I will ask you to do so before continuing with your public comment. I don't mean to be rude, but we do need to get that spelling in there. If there are multiple individuals speaking, I'll ask that one individual speak at a time. It is important that public commenters clearly state and spell their first and last name for public record.

As this oral hearing is held over a teleconference line, please do not put this call on hold as it will be disruptive to the oral hearing process. If you need to take another call, please hang up. You can dial back into the teleconference line when you're ready to rejoin

the oral hearing. We ask that you mute your phone line until you're ready to provide public

comment.

Thank you for your participation. With that, I will now open up the oral hearing for public comment. I'll just remind everyone to speak loudly so we can have our court reporter, Leslie, accurately document the information. Thank you.

Who would like to go first?

MICHELLE BAKER: Good morning, Heather. This is Michelle Baker with Southcentral Foundation.

HEATHER PHELPS: Hi, Michelle. Could you please spell your first and last name for us?

MICHELLE BAKER: Yeah. For the record, my name is Michelle Baker, M-i-c-h-e-l-l-e, Baker, B-a-k-e-r, and I am the Executive Vice President for Southcentral Foundation's Behavioral Services Division.

HEATHER PHELPS: Thank you, Michelle. Please, share your public comment with us.

MICHELLE BAKER: I am offering the following comments related to the Department's proposed regulations implementing the telehealth

legislation from 2022. I want to start off by saying that the Department has done a good job of capturing the intent of the legislation to expand Medicaid services that are allowable via telehealth; however, there are several excluded services that need to be reconsidered.

It is important to keep in mind that the ability to restrict the delivery of Medicaid services via telehealth is narrowly crafted within the legislation. There are two possible reasons for the Department to restrict telehealth delivery. First, there needs to be substantial medical evidence that the service cannot be safely delivered via telehealth.

Second, the service can be restricted if federal law prohibits it or federal financial participation would not be available; and there are no supporting documents associated with the public notice for these regulations that show that this analysis was done to justify the proposed exclusion.

Southcentral Foundation is concerned with the following sections of the proposed

regulation. First, 7 AAC 110.625, Subsection Subsection B, beginning on Page 2 and extending

to Page 3.

This entire section is problematic for using terms that are not found in legislation and are poorly worded within the definitional section found later in the regulation. Especially troubling is Paragraph 3, which disallows reimbursement for a patient initiating a discussion with their care provider within the timeframe of either a surgery, hospitalization, or another illness. Patients often are anxious in the post-operative period and need to reach out for reassurance or to discuss possible side effects or complications.

Additionally, consider the context of a patient who has been or may be hospitalized for behavioral health crisis, in the former situation that patients may be hospitalized in Anchorage and fly home to a small community and need to speak urgently with a care provider via telehealth. The 24 to 72 hours following a

behavioral health crisis is often a time when crisis reemerges and should be treated immediately.

Telehealth is the fastest and most easily accessible way to provide services during this critical window. If a person is having a behavioral health crisis, it is important that they can speak to a provider as often as needed to provide least restrictive care in community and hopefully prevent hospitalization. This contact that seeks to alleviate the need for hospitalization will save the state money in the long run and be better for the patient than an in-hospital stay.

Second, proposed 7 AAC 110.625, Subsection A, Paragraph 2. This wording is not broad enough to include all forms of medical information that can be included in telehealth delivery. This should also include data to include such items as vital signs and other digital information. Additionally, the

definition of telehealth found on Page 7 includes the term medical data.

No. 3, proposed 7 AAC 11.635, beginning on Page 5 and extending through Page 6. Paragraph 6 creates overly broad exclusions for entire categories of services. This is inappropriate in several instances, and the allowability for these exclusions based on the criteria within House Bill 265 is not clear.

Pharmacy services, for example, denying pharmacy care via telehealth is a step backwards. Our pharmacists provide extensive counseling and medication review over the phone when in-person visits are not an option. It would not be possible to be reimbursed for these services under the new regulation.

In addition, durable medical equipment and related services. There are many instances when a patient receives DME and needs to consult with a provider via telehealth to ensure proper utilization, functioning, and care of the equipment. Blanket reimbursement for this

service is inappropriate.

Thank you for your consideration of these comments. Again, we do appreciate the work the Department has done in a relatively short amount of time to propose these regulations implementing House Bill 265. Thank you.

HEATHER PHELPS: Thank you, Michelle and Southcentral Foundation, for providing that public comment. It sounds like you're reading from a document. Are you planning to submit that document as well?

MICHELLE BAKER: Yes, Heather, we do

plan on submitting written comments.

HEATHER PHELPS: All right. Thanks so much. Appreciate it.

Who would like to go next?

Is there anyone else on the line that would like to share public comment at this time?

I'm not hearing anyone wanting to share public comment at this time. We will be on the phone until noon today, so if anyone would

like to share public comment, you have ample opportunity. I will be putting the phone on mute, but I will be doing a reminder at the half-hour and hour about sharing public comment.

SHERRIE HINSHAW: Hi, Heather. This is Sherrie Hinshaw, Interim CEO of the Alaska Behavioral Health Association. I wanted to just briefly state that we have the same concerns that Michelle with Southcentral Foundation brought forward.

HEATHER PHELPS: Okay. Sherrie, could you please spell your first and last name for us, please?

SHERRIE HINSHAW: Sure. For the record, Sherrie Hinshaw. So it's S-h-e-r-r-i-e, last name Hinshaw, H-i-n-s-h-a-w. I am the

Interim CEO of the Alaska Behavioral Health Association.

HEATHER PHELPS: Thanks, Sherrie. Did you want to say more to what you were saying? I didn't mean to interrupt you. I just needed to get your full spelling of your name in there.

SHERRIE HINSHAW: Absolutely. Thank you.

We at the Alaska Behavioral Health Association are still reviewing at this point in time. Those are the same concerns that we have that Michelle went into in detail. In particular, the item one that she spoke to with the post-hospitalization period and the nature of behavioral health crises. We believe that that's an at-risk time that an individual needs fast and easy access to their care provider to avoid adverse events, rehospitalization and/or suicide attempts for death. We think that's a critical period.

So we wanted to echo all of the points that were brought up before by Southcentral Foundation, and that we're continuing to do a review and we will provide written comments. Thank you.

HEATHER PHELPS: Thanks so much, Sherrie. I look forward to the written comments.

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(Waiting for public comment.)

HEATHER PHELPS: This is Heather Phelps with the Division of Behavioral Health, State of Alaska. At this time the oral hearing for Medicaid Coverage and Payment Services Delivered Through Telehealth is now off record. Thank you to all for participating.

(Oral Hearing concluded at 12:00 p.m.)

CERTIFICATE

I, LESLIE J. KNISLEY, Notary Public for the State of Alaska, and Shorthand Reporter, do hereby certify that the foregoing proceedings were taken before me at the time and place herein set forth; that the proceedings were recorded stenographically by me and later transcribed by computer transcription; that the foregoing is a true record of the proceedings taken at that time; and that I am not a party to, nor do I have any interest in, the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 11th day of April, 2023.

_____

LESLIE J. KNISLEY
Notary Public, State of Alaska
My commission expires: 06/06/2024

ORAL HEARING RE:
MEDICAID COVERAGE AND PAYMENT SERVICES
DELIVERED THROUGH TELEHEALTH REGULATIONS

Held via Teleconference
March 24, 2023
10:00 a.m. to 12:00 p.m.

Reported by: Leslie J. Knisley
Shorthand Reporter

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HEATHER PHELPS: Thank you, Michelle and Southcentral Foundation, for providing that public comment. It sounds like you're reading from a document. Are you planning to submit that document as well?

MICHELLE BAKER: Yes, Heather, we do

plan on submitting written comments.

HEATHER PHELPS: All right. Thanks so much. Appreciate it.

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(Waiting for public comment.)

HEATHER PHELPS: This is Heather Phelps with the Division of Behavioral Health, State of Alaska. At this time the oral hearing for Medicaid Coverage and Payment Services Delivered Through Telehealth is now off record. Thank you to all for participating.

(Oral Hearing concluded at 12:00 p.m.)

CERTIFICATE

I, LESLIE J. KNISLEY, Notary Public for the State of Alaska, and Shorthand Reporter, do hereby certify that the foregoing proceedings were taken before me at the time and place herein set forth; that the proceedings were recorded stenographically by me and later transcribed by computer transcription; that the foregoing is a true record of the proceedings taken at that time; and that I am not a party to, nor do I have any interest in, the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 11th day of April, 2023.

_____

LESLIE J. KNISLEY
Notary Public, State of Alaska
My commission expires: 06/06/2024