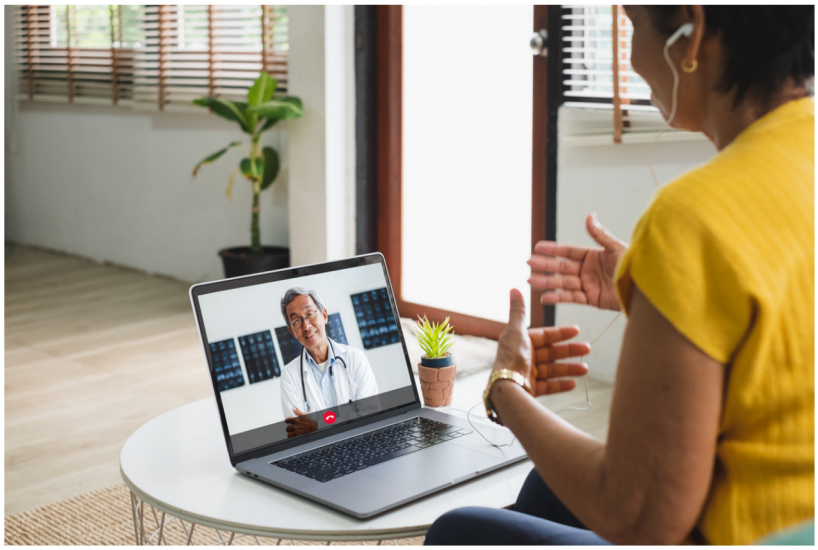
Hancock Daniel Behavioral Health Newsletter

April 2024



Questions to Ask Yourself Before Practicing Telehealth Over State Lines

In the ever-evolving landscape of behavioral health care, the advent of telebehavioral health has revolutionized how professionals connect with their patients. The ability to reach individuals beyond geographical boundaries holds immense promise for expanding access to care in one of the most needed areas. However, with this promise comes a myriad of legal and regulatory considerations, particularly when practicing across state lines. Below are a few specific areas to consider and questions to ask before beginning to provide services across state lines.

Licensure

At the forefront of these challenges is the issue of licensure. Each state maintains its own set of licensing requirements for mental health professionals, encompassing educational qualifications, clinical experience, and ongoing professional development. Practicing across state lines often necessitates compliance with multiple sets of regulations, as well as awareness of interstate licensure compacts – agreements among states that facilitate the practice of certain

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Upcoming Presentations

TELEHEALTH: Reimaging Care Beyond the Unwinding of the PHE

April 14 - 16, 2024
Pocono Manor, PA

Hancock Daniel's Ryan Martin will be presenting:

Navigating the Interstate Maze for Telebehavioral Health Professionals

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professions across borders. Having an understanding of these compacts is essential for telebehavioral health professionals, as they define the specific boundaries within which practitioners can lawfully operate across different jurisdictions.

1. Are my current credentials and licensure recognized in the state(s) where I intend to practice?
2. If I need to obtain a separate license, how long will the application process take and is there an "interim" license available I can use to see patients in the meantime?
3. Are there any interstate licensure compacts or agreements that facilitate practice across state lines, and am I eligible to participate in them?
4. Can I provide services to the patient even when they are temporarily located in another state?

Scope of Practice

Furthermore, variations in scope of practice across states add another layer of complexity to interstate telebehavioral health practice. While some states may permit certain interventions or modalities, others may impose restrictions or require additional certifications. Negotiating these differences requires a more in-depth understanding of each state's regulations to ensure that practitioners operate within the legal boundaries of each jurisdiction.

1. Are there any restrictions or limitations on the types of modalities I can use in telebehavioral health practice?
2. Do I need to obtain additional certifications or training to provide certain services? For example, does my scope of practice allow group psychotherapy?
3. Does my licensure type allow me to provide both mental health and substance abuse services or is additional training required?

Consent and Duty to Warn

Consent and duty to warn laws further complicate the landscape of interstate telebehavioral health practice. Professionals must navigate differing requirements for obtaining informed consent from clients, as well as obligations regarding disclosure of potential harm to third parties. Failure to comply with these laws can have legal (and ethical) ramifications, underscoring the importance of comprehensive knowledge and adherence to state-specific regulations.

1. What are the requirements for obtaining informed consent from clients in each state where I practice telebehavioral health?
2. Am I required to warn under state law, or does state law allow a "permissive" duty to warn?
3. What documentation should I have in place to ensure that I am meeting my legal obligations regarding informed consent and duty to warn when practicing across state lines?

Despite these challenges, there are strategies that telebehavioral health professionals can employ to mitigate risks and ensure compliance with relevant laws and regulations. Staying informed about licensure compacts, maintaining clear communication with clients regarding the scope of services provided, and seeking legal counsel when necessary are essential steps in staying compliant with the ever-changing landscape.

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Gearing Up for a Safer Workplace Regarding Workplace Violence

Many healthcare employers are increasing their focus on workplace violence prevention, in response to updated Joint Commission requirements, Occupational Safety and Health Administration ("OSHA") guidance, and varying state and federal legislation aimed to reduce this well known risk to healthcare providers that is consistently and alarmingly higher in healthcare settings than other workplace environments.

This article's focus is on the most up-to-date guidelines from OSHA, which technically remain voluntary, but do have significant overlap with the Joint Commission standards and should be included and considered in the development of any workplace violence prevention program. OSHA updated the prior guidelines to help employers address the serious risks and hazards present in healthcare and social service settings.

In general, these guidelines, based on industry best practices, recommend the inclusion of the following elements in any program designed to reduce the risk of workplace violence[1]:

Identification and Assessment of Existing and Potential Hazards

Any effective program will include the identification of patient, client, organization, and setting-related risk factors. An initial and annual (at minimum) worksite analysis and risk assessment from a wide variety of potential risk elements will assist with identifying an organization's vulnerability with respect to workplace violence.

Violence Prevention Program Developed by Management and Employees

A written program for workplace violence prevention with clear management support and employee participation and input is an effective approach to reducing risk. Involvement of the workforce is key to the program's effectiveness. Employee feedback in the forms of referrals and surveys are a vital component of any successful program.

Records Analysis and Tracking to Identify Trends and Patterns

A standardized approach for tracking workplace violence incidents and consistent encouragement for reporting all forms of workplace violence is critical for accurate understanding of an organization's true baseline and identification of improvement opportunities.

Post-Incident Procedures and Services

Early investigation of incidents of workplace violence will assist with employee support as appropriate and rapid identification of an incident's root cause to prevent recurrence and additional incidents. Event and emergency response procedures should be detailed and communicated to the entire workforce.

Safety and Health Training for Employees

Exact training topics may vary based on an individual roles and responsibilities, but an organization's entire workforce should be well versed on any workplace violence prevention program, reporting process, as well as de-escalation and self-defense techniques.

Ongoing Recordkeeping and Program Evaluation

Consistent and regular review of a workplace violence prevention program is necessary to determine its overall effectiveness and identify deficiencies or changes that would improve the program.

Hancock Daniel's Security, Workplace Violence, and Crisis Management Team has experience providing assistance in assessing or creating compliant and effective workplace violence prevention programs, consistent with the OSHA guidelines and other standards. Our team provides the full continuum of services from risk assessment to crisis management as well as handling the legal, regulatory, and operational aspects resulting from safety related events occurring in the health care setting.

[1] Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, OSHA 3148-06R, 2016.

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Unlocking Mental Health: New Medicare Benefits for Marriage and Family Therapists & Mental Health Counselors

The Consolidated Appropriations Act of 2023 has ushered in a significant development in Medicare coverage, extending its benefits to Marriage and Family Therapists ("MFT") and Mental Health Counselors ("MHC"). Effective January 1, 2024, MFT and MHC services directly billed by practitioners will be reimbursed under Part B of the Medicare Program. This expansion of coverage marks a pivotal moment in recognizing the crucial role that MFTs and MHCs play in addressing mental health needs within communities across the nation. The inclusion of these services under Medicare reflects a broader acknowledgment of the importance of holistic approaches to mental health care.

Under this new framework, MFTs and MHCs seeking enrollment as Medicare providers must meet specific eligibility criteria:

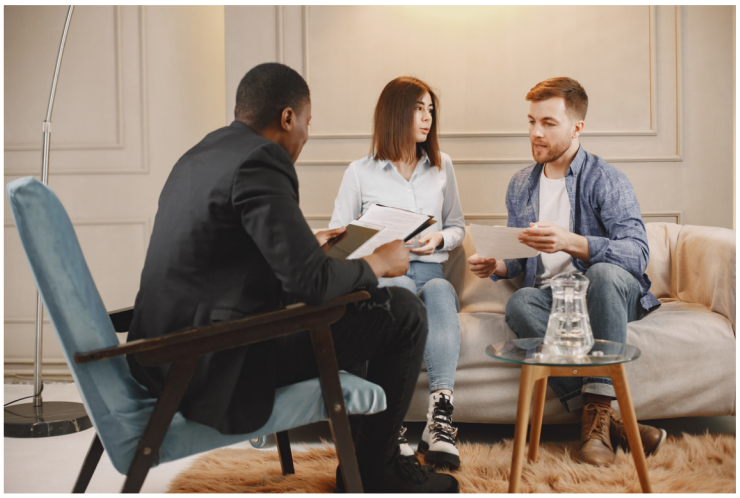
- Possession of a master's or doctorate degree qualifying for licensure or certification as an MFT/MHC under the state law where services are provided;
- Licensure or certification as an MFT/MHC by the state where services are furnished;
- Completion of at least 2 years of clinical supervised experience in marriage and family therapy or mental health counseling post-degree; and
- Compliance with additional requirements as determined by the Secretary of Health and Human Services ("HHS").

Covered Services

Under Medicare Part B, MFT and MHC services encompass "diagnosis and treatment of mental illnesses (excluding services to inpatients of hospitals)" within the scope of state law. These services align with those typically covered by physicians or provided incidentally to physician services. Additionally, CMS has proposed extending telehealth services to Medicare beneficiaries by including MFTs and MHCs among eligible practitioners.

Opt-Out and Billing Considerations

Failure to enroll as Medicare providers will restrict MFTs and MHCs from charging Medicare patients cash for covered services post-January 1, 2024, unless they officially opt out. Once opted out, practitioners can engage in private contracts with



Medicare patients, agreeing to out-of-pocket payments without billing Medicare for rendered services.

Enrollment Details

Before applying for MAC enrollment, MFTs and MHCs must obtain a National Provider Number ("NPI"), unless already assigned through prior Medicare enrollment. Enrollment can be completed electronically via the PECOS portal or through paper submission using CMS Forms 855B or 855I. Electronic PECOS submissions typically result in faster processing times compared to CMS 855 paper form submissions. Enrollment options include individual provider, group provider, or both individual and group owner enrollment.

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Devils' Bargains: Key Kickback Risks in Service Agreements Among Referral Sources

Behavioral health often involves a coordinated effort among various providers, professional practices, and facilities. Such efforts may include compensation or other arrangements among potential referral sources. The federal Anti-Kickback Statute at 42 U.S.C. § 1320a-7b (the "AKS") is a federal law that prohibits offering or paying "remuneration" (essentially, anything of value) in exchange for referrals of services reimbursable under federal health care programs (e.g., Medicare, Medicaid, and Tricare). An arrangement can be considered non-compliant if "one purpose" of the arrangement is to reward referral of federally reimbursable services, even if the arrangement is otherwise legally permissible. Penalties for violations can include fines, exclusion from Medicare/Medicaid, and even imprisonment. Behavioral health providers should be particularly mindful of the following **key risk areas**:

Services arrangements among referral sources that include excessive/above fair market value compensation.

Behavioral health providers should be mindful of risks associated with paying or being paid excessive/above fair market value compensation in arrangements between referral sources. "Fair market value" generally describes a pay rate that could be expected in an "arms'-length" transaction without taking into account the potential volume or value of referrals among the parties. Failure to ensure alignment with fair market value principles can create a risk that an arrangement will be perceived as inducing or rewarding the referral of health care services. To the extent such pay rates could be perceived as rewarding or inducing referrals of services reimbursable by federal payors (e.g., Medicare/Medicaid/Tricare), the parties could be at risk of violating the AKS.

Services arrangements among referral sources that include discounted, below-cost, or below fair market value compensation.

As with payments among potential referrals sources that exceed fair market value, substantially discounted or below fair market value rates for services can also create compliance risks. Arrangements involving the exchange of discounted services for referrals are sometimes referred to as prohibited "swapping" arrangements. A prohibited swapping arrangement could include, for example, a behavioral health practice that offers to serve as the exclusive behavioral health practice that offers to serve as the exclusive behavioral health provider to a nursing home's residents and incentivizes the nursing home to enter the arrangement by offering to charge steeply discounted rates to the nursing home for resident services covered under the nursing home's bundled Medicare Part A payment. Because the behavioral health provider may receive referrals of other services separately reimbursable by federal programs (for example, Medicare Part B or Medicaid), the discounted rates for Medicare Part A services could be perceived as remuneration for referrals. This perception could be compounded by the exclusivity of the arrangement, since this feature of the arrangement effectively guarantees the referral of separately billable services to the behavioral health practice. Providers should remain mindful of compliance risks associated with circumstances like these, in which discounted/below fair market value rates for services could be interpreted as inducing referrals.

Failure to properly keep and maintain records demonstrating that services paid for were actually provided.

Aside from considerations relating to fair market value, providers should also be mindful of risks associated with failing to keep and maintain records demonstrating that compensable services were in fact provided. Failure to keep and maintain such documentation can lead to allegations that services were not in fact provided and that the arrangement is a "sham" intended to conceal payments in exchange for referrals. Risks associated with failing to document the provision of services may be greater in administrative services arrangements (e.g., directorships, consulting agreements, etc.) since such documentation may be the only reliable "proof" of services having occurred.

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Some of the steps providers can consider in order to address such risks could include, for example:

- Ensuring detailed time sheets or similar documentation are reliably and regularly documented for services compensated on an hourly or other time-based basis.
- Making payment of compensation contingent on submission of a services report or time sheet clearly demonstrating services provided.
- Only paying for services when there is clear documentation that services were provided.

Providing free or discounted services/things of value to Medicare/Medicaid/Tricare beneficiaries.

In addition to arrangements among parties in a position to refer services to one another, behavioral health providers should also avoid providing discounts or things of value to Medicare/Medicaid/Tricare beneficiaries that could be perceived as improperly inducing them to seek services reimbursable by federal payors. Beyond potentially violating the AKS by rewarding such beneficiaries for "self-referrals," federal law separately allows for the imposition of significant fines for engaging in improper "beneficiary inducement" under the Civil Monetary Penalties Law at 42 U.S.C. § 1320a-7a (the "CMPL"). Examples of potentially prohibited practices may include offering to waive patient cost sharing charges or providing free transportation/room and board as a means of inducing patient selection of a provider.

Consider state prohibitions on remuneration for referral or health services or fee-splitting.

Beyond the federal AKS and CMPL, providers should also be mindful of state-level prohibitions on remuneration for referrals, fee-splitting, and similar conduct. Many such state-level rules do not limit prohibitions to circumstances involving federal or state payors. For example, certain states have "all-payor statutes" that prohibit remuneration for referrals of health care services or provider fee-splitting regardless of the payors involved, whether governmental, commercial, or self-pay. State laws can also include more granular prohibitions that might not be outlined in a specific "all-payor" or other state anti-kickback statute. For example, state insurance fraud rules and professional licensing standards can also include provisions that prohibit remuneration in exchange for referrals of health care services, including remuneration among clinicians or to patients directly.

Conclusion

Considering the prohibitions on providing remuneration for referrals of services under the AKS, CMPL, or analogous state rules, providers are encouraged to exercise caution with respect to arrangements that could be perceived as rewarding referrals of services. Given the risks involved, providers should consult counsel to the extent they have questions about whether or not an arrangement is permissible or prohibited.

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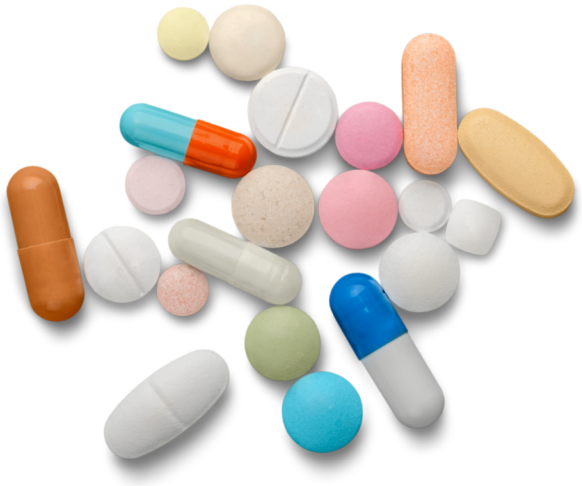
Psychotropic Medication Consents: Notable Patient Populations

With prescription of psychotropic medications on the rise, behavioral health providers should be aware of certain patient populations which may require extra care and attention when obtaining informed consent.[1] For children in foster care, providers may be required to submit forms and treatment plans to the state, or even petition a court to permit the administration of psychoactive medication. For patients with disabilities, including elderly individuals with complex behavioral health needs, providers may soon be required under the federal regulations to accommodate supported decision-making, where possible, to obtain a patient's informed consent for the administration of psychotropic medications.



Children & Adolescents in Foster Care

Per the American Academy of Pediatrics, "One in every three children in foster care are on psychotropic medications designed to alter their mental status or mood, a significantly higher percentage than children who are not in foster care within the Medicaid program."[1] The rate at which children and youth in foster care are prescribed psychotropic medications continues to draw public scrutiny and has resulted in the development of state-specific policies to address behavioral health concerns in this patient population.

Under 42 U.S.C. 622(b)(15)(A)(v), states are required to coordinate with Medicaid programs, pediatricians, and child welfare experts to develop guidance regarding the appropriate use and monitoring of psychotropic medications for children and youth in foster care.[2] Protocols developed under this framework share a common purpose but lack procedural consistency between states. For example, California not only developed technical guidance for providers,[3] but has also enacted state laws which require prescribing physicians to submit treatment plans and secure judicial approval for the administration of psychotropic medications to minors in the state's foster care program.[4] State policies differ on the age at which adolescents may independently consent to or refuse treatment, the role of biological and foster parents in consenting to treatment on behalf of a minor, and reporting requirements, among other factors.[5]

Given the notable disparities in state guidance, it is critical for behavioral health providers to approach the administration of psychotropic medications to foster care children with an awareness of relevant consent requirements. In general, these policies emphasize the need for routine assessment of trauma in foster care children; highlight the risks of over-prescription; and encourage providers to engage in holistic assessments regarding the necessity of administering psychotropic medication to a foster child, especially where an adolescent and/or other responsible parties do not consent. Before prescribing psychotropic medication to a foster child, consult state-specific guidance to ensure you have satisfied the relevant standards for obtaining and documenting consent.

Patients with Disabilities

On September 14, 2023, the Department of Health and Human Services ("HHS") released a Proposed Rule addressing the application of Section 504 of the Rehabilitation Act of 1973 to healthcare settings.[7] Among other reasonable modifications detailed in its proposal, HHS outlined the use of supported decision-making and third-party support as a means of obtaining informed consent from patients with disabilities. "Supported decision-making is an approach used to assist individuals with disabilities in making decisions in an informed and accessible way, through the provision of person-centered decision-making that focuses on the wants and needs of the individual receiving support. Supported decision-making allows an individual with a disability to collaborate with trusted sources and make their own decisions without the need for a substitute decision-maker."[8]

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Although the Proposed Rule has yet to be finalized, behavioral health providers should be equipped to pivot towards supported decision-making models for obtaining informed consent from certain disabled individuals, where possible. While seeking the appointment and input of a surrogate healthcare decision-maker or court-appointed guardian or conservator may ultimately prove necessary, providers may wish to assess a disabled individual's decision-making capacity with the assistance of a trusted third party before recommending a more aggressive approach. The proposed rule notes that "a health care provider may need to modify their policy on disclosing information to third parties about a medical procedure, if the individual with a disability needs their supporter to help understand their treatment options."[9]

Individuals with disabilities, especially elderly individuals with cognitive disabilities, receive behavioral health treatment in the form of psychotropic medications at disproportionately high rates. Providers should be aware of proposed changes from HSS and equipped to promote supported decision-making models if such a regulation is finalized.

[[1] See Terlizzi & Norris, Mental Health Treatment Among Adults: United States, 2020, NCHS Data Brief, Oct. 2021, 1] Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, OSHA 3148-06R, 2016. .
[2] See Lisa Black, Children in Foster Care Much More Likely to be Prescribed Psychotropic Medications Compared with Non-Foster Children in Medicaid Program, American Academy of Pediatrics, Oct. 7, 2021, https://www.aap.org/en/news-room/news-releases/aap/2021/children-in-foster-care-much-more-likely-to-be-prescribed-psychotropic-medications-compared-with-non-foster-children-in-medicaid-program/.
[3] 42 U.S.C. 622(b)(15)(A)(v).
[4] See California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, California Dept. of Social Services, Mar. 23, 2022, https://www.dhcs.ca.gov/services/HCPCFC/Documents/CA-Guidelines-for-Use-of-Psychotropic-Medication-3-23-22.pdf.
[5] California Rules of Court 5.640, 2018.
[6] Compare, e.g., Informed Consent for Psychotropic Medication, Tennessee Dept. of Children's Services, with Health Care Oversight and Coordination Plan, Virginia Dept. of Social Services, 2021, https://dss.virginia.gov/files/division/dfs/cfs/apsr/2021/2021_Health_Care_Oversight_and_Coordination.pdf.
[7] 88 FR 63392.
[8] Id.
[9] Id.

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Behavioral Health Service Offerings

Behavioral health providers face unique industry challenges. Hancock Daniel's team has extensive experience providing legal services in all facets of the behavioral health space including:

- Regulatory support in the planning and development of behavioral health services
- Licensure and certification of new providers/suppliers and/or new service lines
- Integration for population health strategies
- Telehealth/Telepsychiatry
- Medicare approval of IPPS excluded psychiatric distinct part units ("DPU")
- Behavioral Health Patient Safety Organizations ("PSO")
- 42 CFR Part 2 expertise
- HIPAA/HITECH compliance assessments, breach analysis, and breach notifications
- EMTALA behavioral health issues and surveys
- Advice on psychiatric Emergency Departments
- State licensure requirements and surveys
- Risk management for behavioral health
- Compliance
- Behavioral health reimbursement, billing and audits
- Issues related to substance abuse and residential treatment centers
- Clinician scope of practice
- Fraud and abuse
- Guardianships
- Changes of ownership, mergers, acquisitions, consolidations and joint ventures
- Issues surrounding consent and patient rights
- Value-based care models/programs
- Employment and labor issues
- Litigation

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