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>> The webinar will begin in about 30 seconds. [Recording in progress]
>> ARIA JAVIDAN: Hello. I'm the project manager for the national consortium of telehealth resource centers. Today's session is on what will 2024 bring for telehealth policy, hosted by the center for connected health policy. These webinars are to support and guide the development of your telehealth programs. A background on the consortium. Located through the country there are 12 resource centers and two national, one focused on telehealth policy and the other on assessment. Each serves focal points for effective
use
of
telehealth
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few tips before we get started. Please use the QA function to ask questions. Questions will be answered at did -- the end of the presentation. Closed captioning is available. Located at the bottom of your screen. Today's webinar is being
record
.
With that, I'll pass it to Mei Kwong.
>> MEI KWONG: Thank you, Aria. If you give me a second. Thank you, everyone, happy new year. I hope everyone is doing well and if you're being hit by storms you're staying safe and warm. Thank you to the consortium for inviting me to this webinar today. Please know any information I provide is strictly formational purposes. Speak with legal counsel if you're interested
in legal continue.
If I show a picture, we have no affiliation
with such company.
Quick background on Center for Connected Health Policy, established as a program under the public health institute to be a California telehealth policy organization. Become available in 2012. Center for Connected Health Policy applied for the grant and got it and have been serving in the capacity ever since. We also work with partners, some include other telehealth resource centers. We act as the administrator for the national telehealth resource centers. They're a wealth of information and resources, they're some of the smartest people in the country today regarding telehealth in all aspects from where do you get started, what it is be how you use the technology, what is the technology, policy

issues as well.
If you have not interacted with your regional telehealth resource center, I encourage you to do that. We're located in the State of California, so we convene a group called the telehealth policy coalition. Made of 175 state and national folks who are interested in California
state telehealth policy.
For today's webinar I'm going to provide an overview of the telehealth policy landscape. What we have and what we know know on January 18, 2024. Where we are with telehealth policy because over the

last couple of years it's been a moving target, especially on the federal level, especially because of the temporary policies put in place because of the pandemic. I will warn you, it's likely going to change or things are going to happen throughout the year but to give you a grounding point for 2024. We'll also talk about what is possibly going to happen in the future and where
things may go.
I want to stress that this webinar is not to be used for specific billing questions. We're just talking about the general policies regarding to reimbursement under Medicare and I'll touch on Medicaid policies that we're seeing throughout the states but for specific billing questions, contact your region telehealth resource center or Center for Connected Health Policy directly. If you don't know who your telehealth resource center is, go to the consortium's website and you can locate the TRC that
covers your state.
Also, when you submit questions to the telehealth resource center, if you can provide as much information as possible, particularly the entity, whether a hospital, private practitioner, that will help us be able to get your answer to you. Because depending on the type of entity or organization you're talking about, the answer might vary. It might be different for a private practitioner as opposed to a federally qualified health center.
Let's get into it.
Keep in mind that while we're talking about telehealth policy, we're talking about 2nd District jurisdictions, federal and state. Sometimes the policies mirror each other, more often than not they don't. There are several issues that the federal policy covers that the state doesn't touch or they touch a different aspect. These are the major issues I'm going to touch on. If I were to try to cover everything that's going on out there, we'd probably be here for a couple of hours and I don't think anyone wants to listen to me for
that long.
We're going to hit on the major
issues in question.
Underneath federal policy, Medicare and C MS, prescribing controlled substance, HIB yeah -- HIPAA privacy and data and license sure. Understate it's Medicaid, private payer, prescribing and licensure. There is some overlap. There may be policies or actions going on that
overlap.
Let's get into the things that influence or impact
policy in general.
When you talk about how telehealth policy is built, there's four main sources of information to keep an eye on. Laws and regulations most people are familiar with but there are two other areas, guidances, and when I talk about guidances, I mean not laws or regulations that perhaps an administering agency issues. They may be, for example, guidances that the office of civil rights which oversee HIPAA issues to the general public about things such as these are things to consider if you're talking about using audio only that relate to privacy. They don't have the force of a law or regulation but it gives you an idea, this is what that oversight agency, how they're looking at that situation. I should align myself to what they're suggesting here. If they decide to enforce something and look for closely at someone, this is probably the areas they're going to look at and how they're probably going to judge you. Guidances are important to get the extra information that may not be present in laws or regulations unlike the thinking of an
administrative agency.

Court cases, that doesn't make it to a lot of people's radars initially. They may not think what are the impact of court cases on telehealth policy? Court cases have a lot of impact because they may be taking those actual laws to court and saying, these are unfair or laws that violate a higher law such as a constitution.
We'll get more into that because in 2024 that is going to be very important to look at
and monitor.
As I mentioned, we'll go into more detail on that
later in the presentation.
Let's start off on the federal level. C MS and Medicare, really about reimbursement and coverage. C MS's telehealth policy, preCOVID it was pretty limited. Those not as familiar with the policies before the pandemic hit, it was pretty restrictive because a lot of the policies are embedded in federal law. They had not been changed much since 1997. It's been a while since the telehealth policies and law had been changed. There have been tweaks made over the years but essentially they remained unchanged.
They were limited such as the patient needed to with in a specific location geographically and the type of site. There was a limited amount of providers eligible to provide the services and still be reimbursed by C MS and you were limited by the type of modality used. That's preCOVID telehealth policy. During the pandemic, that changed drastically. There were a lot of waivers put in place where they opened up the limitations. We're not going to require the geographical requirement be met during the pandemic. A lot of those were waived and the question become last year, what is going to happen to these temporary policies? For the most part what we have post pandemic and going until the ends of this year is the major policies are
sticking around.
The major policies are the waivers that were done to the policies that were embedded in the law, patient location, type of providers able to provide, modality and
limitations.
We'll look at that more
deeply.
Waiver of geographic requirement. Eligible providers, opened up to eligible Medicare providers during the pandemic and that's being kept around and that included federally qualified health centers and professionals such as PTs and OTs. The site limitation, need to take place in a certain type of facility such as a hospital or doctor's office. That's opened up
to the home.
There are some exceptions where they allow certain services to take place in
the home.
During this temporary grace period until the end of 2024, that's opened up to all
eligible services.
Then allow some services to be provided via
audio only.
The expanded list of eligibles services has always been limited. Law has a base level of what services need to be required but that's always been more under C MS's control. They haven't had to wait for congress but they have their own process on what they approve as far as what services can be done via
telehealth

. t's fairly intact from what we saw in the pandemic but there are certain services, unless something changes, January 2025 they will go away. Other things that will remain until the end of the year, this is a big one, provider using business address rather than home address. This is more of one of those kind of tricky administrative thing that aren't directly related to telehealth but has an impact on telehealth. Providers have to put on to their forms the address of where they are primarily doing their
services. If they're doing it from their home or telehealth they have to put that address. Sometimes that data is publicly accessible so those providers were worried, I don't want to put my home address on this.
There was an exception made during the pandemic, because there were a lot of providers moving to the home to do their practice or doing it partly from home as well that CMS said you can put your business address. They've kept that policy until the end of 2024. This policy went back and forth. Initially when CMS came out in the spring, they were saying this is going to expire and then they changed their mind and said we'll extend it. Then they said until the end of 2024. CMS after a little back and forth were aligning a -- allowing policies to the end of the 2024 date. The reason why 2024 is the magic date is because that's what congress decided in 2022 with the consolidated appropriation act. They decided to extend things, that's not CMS, that's embedded federal law. It's the appropriation s bill.
Waiving frequency limit on telehealth visits in SNFs, before it was a telehealth visit every 30 days, they waived the frequency limit in general during the pandemic and kept that policy aligning it to the end of 2024 expiration date. And then there were other things such as allowing for direct supervision to be done via telehealth. This is one of the policies where it was broader during the pandemic and they've narrowing it down or only allowed it for specific things, if you were doing supervision of residents, if the service is furnished in person, you can't use telehealth to
do the supervision.
That's
a distinction there.
This is just an overview. There is a lot more nuanced or specific types of policy changes as well. I encourage you to look at Center for Connected Health Policy's physician schedule. There are a couple of other resources such as the CMS telehealth fact sheet issued in December
of
last year. rescribing controlled substances. I have prescribing on the state and federal level. That's because it's split. Prescribing of drugs is federal, prescribing of everything else the states can oversee. On the federal level, policy that existed before the pandemic. You'll here people say it's the Ryan [indiscernible by captioner] act. That's the shorthand for a lot of
policy folks.
So there were limited exceptions in that policy and that is now in federal law on how you can use telehealth to prescribe a controlled subject. They usually include the patient being somewhere or with someone who is also a DEA license provider and during the time they're interacting with the telehealth provider who is also DE
A licensed.
One of the exceptions that was in there is when a public health emergency is declared, when the COVID-19 pandemic hit, that exception kicked in. A lot of people think, congress -- no, it was already in federal law. It's an automatic switch that happens, that's why there was concern about what is going

to happen next. Are we going back to this limited exceptions once the public health emergency is declared over or is some other action going
to be taken?
What happened was when the public health emergency was winding down for its declaration to be over in May 2023, a couple months before that federal agencies were prepping to get ready on what would happen after the emergency. CMS was doing that and DEA was doing it. They issued post pH E regulations, this is what the landscape ask going to look like after the public health emergency. They were not met with a lot of enthusiasm. They said we were going to go back to the preCOVID-19 situation. They were going to create one other exception and create all of these other new requirements that were going on as well too. They gave a little temporary extension for folks but they're saying it's going back to preCOVID type of situation. That was not met with much enthusiasm by a lot of people. They received close to 38,000 comments, which they in no way were going to be able to get through by the time they would have to finalize. So what the DEA said was we're going to create a temporary extension, the COVID-19 waiver we're going to allow to extend out to November 2023. After that, those who had already established a relationship, you can continue to do things vie telehealth. Those who established a relationship, you can continue to do things but you have a year to see that patient in person because everything will end
on November 2024.
Well, people still weren't happy with that. Around September of last year the DEA held listening sessions from
the
public.

[Inaudible]
The DEA said, we're just going to extend this COVID extension until the end of 2024. Aligning with the end date that we saw with the Medicare policy. On the federal level you're seeing this alignment from agencies, we're going to allow these temporary things to continue but come December 2024, once that passes it's over. The good thing about this is what we saw over the course of 2023 is I think more openness by the DEA in listening. If you look at what they were suggesting in March of 2023, it was limited. But towards the fall of 2023 they were talking about an extension because things were going to end, but they were also starting to talk about maybe we'll look at the
registry idea. ome of you may ask, what is the register idea? In the list of exceptions is a register ry for telehealth providerers. The DEA would create this register ry and if a provider was on it, they were considered a good egg and didn't have to meet the other
requirements. hat
never
happened
.
othing was even proposed or sent out and then COVID-19 happened in the beginning of 2020 and that fell by the way side. A couple of congressional members asked throughout the pandemic, where is the registry? As early as the beginning of 2023, or as late, in early 2023 when people brought up the registry. The DEA did not seem interested in doing anything about that but fall 2023 they were talking about it again.
There's a possibility that they may finally get that implemented and started and have that process

created, exceptions for prescribing controlled substances, this is important to watch. Not only is there a specific deadline by the end of the year that the DEA has but there may be a change in when they're going to propose compared to what we saw a year ago, a specific limited exception and we're going to add all of these other requirements. This is something to keep
your eye on.
For the DEA, considering how many comments they got last year, 38,000, which from my understanding is the most that any agency has ever gotten for a proposed regulation, they may need to feel they have to start early because when you do the regulatory process and get those comments, they're required by law to respond. I don't know if they may do something sooner than perhaps CMS or congress simply because they may be concerned that they may get an avalanche of comments and they won't have enough time to process them by the end of 2024, the deadline for
the temporary policy.
HIPAA privacy and data. Before the pandemic HIPAA did not really
address telehealth.
You still had to abide by HIPAA but there was nothing that said, by the way, this is what you would do if you were using telehealth. Providers had to think hard on how they would meet the HIPAA requirements while they're using telehealth because there wasn't specific guidance out there on how to do that. This is underneath the office of civil rights, post COVID-19 people realized HIPAA is outdated for a lot of technology in general. What has been decided is there was a guidance that was issued during the pandemic where OCR would exercise discretion on telehealth technology. This was issued at the beginning of the pandemic because the realization is that a lot of providers were using telehealth for the first time and they were more concerned on those providers actually being able to serve patients, they were like we're going to exercise discretion, we're not going to ding you if you use a platform that doesn't meet
HIPAA requirements.
That was something they had issued, a guidance. Wasn't a regulation or statute. This is why I said guidance is important to keep
an eye on.
They issued that guidance that said we'll give you a break during this pandemic. That ended with the expiration with of the public health emergency. During the pandemic, the realization hit the federal government that HIPAA is out of date when you're talking about telehealth. So the Biden administration, I think in 2021, issued an executive order, HHS you need to look at HIPAA and update things. That's ongoing. That's an executive order that
exists out there.
In the meantime, we've seen that HHS has been issuing guidances on how does telehealth interact with HIPAA and protection
of health information?
Now this is not just about HIPAA. We'll talk about it more. It's also about privacy
and data too.
I put on here a couple of resources for folks if they have not seen it that they can get. Aria does post a copy of my PowerPoint along with the
recording after this.
These are all hyperlinked, you just need to download the PowerPoint and click on the links to get to that

particular guidance.
As you can see, there's things around audio only and HIPAA, and then privacy and security tips for patients that might be useful for you to pass on to your
patients as well. rivacy and data.
This discussion over the last 18 months, two years have gone beyond HIPAA. There's been concerns about privacy and data and how data is being tracked and this has been things that are going to impact telehealth that may have not been on
your radar.
But I'm warning you, it's stuff they're taking seriously on the federal and regulatory level. This is not necessarily because of concerns over HIPAA, this is other issues that are impacting
telehealth as well.
It's not necessarily that concerns that sprung from telehealth but the larger concern over what is happening to this data and the privacy of patients too. What we see in 2022 and 2023, government agencies such as HHS and OCR and the Federal Trade Commission issuing warnings about online tracking technologies and what people need to be aware of and the data that's being gathered and how
it's being used.
I put this on here because this may not be an initial thought that you may have when you're selecting software or data to use
in your practice.
Just be aware. This is a concern that's been flagged by regulatory agencies on the federal as being potential issues. They have gone after some companies as well for the tracking of data and maybe utilizing it for marketing purposes and not informing
patients as well.
I'm not saying that providers are doing that, but if you have a contact with a certain vendor who you are using their platform from, be aware how they're
gathering that data.
Something to keep in mind that I wanted to flag because I just don't see this issue going away. So it is probably something that's going to get a lot more attention and probably more regulation down the line as
well
too.
Licensure. This is going to be
the interesting one.
For folks who have listened to me in the past or to any policy folks, you know licensure is in the state jurisdiction to control.
Feds don't have any
control over it.
It's done on a state by state level. Each state decides what it's going to be and roughly it means if you're going to provide health services within a state's border, you need to have a professional license issued
by that state.
That's the general
policy out

there.
Yes, there are exceptions but the general policy is you have to get a license
in another state.
You're probably asking me, what does the federal level have to do with licensure? Good thing you asked that.
Late last year, December 13, 2023, a court case, a lawsuit was filed in U.S. direct court of new Jersey. What the plaintiff said was my constitutional rights are being enfringed upon by new Jersey licensure laws related to telehealth. Why is this important? It's a case specific to licensure laws and telehealth. There have been previous cases that kind of went around on the licensure laws and maybe impacts on providers but there's not been that very specific link in a case -- where they said licensure laws as they relate to telehealth
is a problem.
The second thing is, they make constitution al argument, U.S. constitution. That elevates it into a federal case. This is not a state case. This is not a new Jersey state case, it's an argument about my constitutional rights as a U.S. citizen are
being violated.
It's a
federal case.
They're basing their arguments on four parts of the constitution, the commerce clause, privileges and immunities clause, first amendment and 14th amendment. Commerce clause is something that telehealth folks have been talking about
for a while.
Telehealth licensure and what arguments can be made on it of saying, you know, the Feds can have a part on.
The most talked about argument of saying where the Feds can have an influence on state licensure is the commerce clause much the commerce clause, the theory and what it says in the constitution is that interstate commerce is in congress's jurisdiction to oversee because it
involves multiple states.
If states do something to mess with interstate commerce, that's encouch -- an area that congress has jurisdiction on.
Just because the Feds didn't say something specific about it, doesn't mean it's not under
their jurisdiction.
The argument is that state licensure interferes with interstate commerce because now you can have a telehealth provider in another state providing services in another state but by requiring licensure in another state, you're interrupting the flow of interstate commerce, that has been the most common theory on how to approach the licensure issue or to debate the licensure issue as
a
federal
issue.
Privilege LAEJZ and -- privileges and immunities clause, everybody has the same basic privileges as a U.S. citizen no matter what state they're in. One of those is to earn a living and states aren't supposed to impede on that because
they're from another statement
First amendment, you're familiar with this. This is speech. The theory is because a regulatory agency

would need to examine a conversation between a patient/provider to determine if health services are providered. That's impinging on first amendment rights. The 14th amendment, this is interesting, you're probably all familiar with due process but there are things that apply to civil cases, one ever -- of them is a parent's ability to decide on the education and health care
of their children.
One of the plaintiffs involved in this case is
a minor.
His father is making the argument, my due process rights are being infringed upon by this licensure law because they are requiring this doctor, who is located out of the state of new Jersey, to have a license here. It's a major case because it's specific to telehealth and licensure, it was just filed December 13, 2023. There's no news on that. New Jersey has I think until February 16th to file their response. Definitely something to keep
your eye on.
Also, keep your eye on new Jersey legislation, what the state could do is possibly pass legislation that addresses some of these things and then say to the court, well, this case has no bearing because we passed legislation XYZ to address the
plaintiff's concerns.
This is new and developing here. Definitely
something to watch.
It is a court case, so it may move slowly but even if a decision is rendered, there's an appeal process, this could take a
bit of time.
But definitely a
big policy development.
We're getting into states and I know we're starting to get
short on time.
Because all of the states are really different, I can't go into too many details. I encourage you to go to the CCHP website because we do state tracking on policies for Medicaid and laws and regulations. Go there if you're interested in a specific state policy, this is going to be a
general overview.
Medicaid and
private pay
ers. What we have now are as of October, fall of 2023, all states and DC reimburse for live video. We were not able to find that for Puerto Rico and the virgin islands but in the U.S. states and DC, there's some reimbursement for live video
in Medicaid.
33 states reimburse for so many store and forward. That may be for an E consult or other codes. It may not necessarily be a full blown store and forward of any type of service. Then 37 states have some reimbursement for RPM. 43 states have some reimbursement for audio only. Before COVID-19 I would say only a handful of states had this and they were very hyper specific. They would be situations such as for targeted case management. You show see 43 states have that reimbursement policy for something and a lot of them include it under the umbrella for telehealth. For private payer law, 43 states, DC and virgin islands have some sort of private
payer

law.
There's a wide range on exactly what the policies look like. It's going to be state specific. You will need to look
at that.
All of these policies have exceptions, limitations, et cetera. So it is very important to look at each state's policy for something that you're interested in because it will vary from
state-to-state.
Prescribe ing, all of the other stuff that's not controlled substance falls to the state to
have control over.
How they do their policies around telehealth is usually it starts with how you establish that patient/provider relationship. Would you need that in-person visit before you can prescribe? Most states say you can do that via live video. There are some exceptions to that, if you're talking about a certain type of medication they may require an in-person visit or have a policy that makes it more difficult to use telehealth. There are also a few states that have exceptions to allow the patient/provider relationship for prescribing to be done asynchronously but that's rare. For the more part, you can establish the patient/provider relationship but it has to be via
live video.
There's also limitations that states may impose on prescribe ing and those are related to abortion, vision and hearing. There are some states that have restrictions on using telehealth for that. And also marijuana, limitations on how telehealth may be used or not used. You'll usually see language, federal requirements related to prescribing, that involves the controlled substance area. Licensure, it's underneath the state's control, for now. For the most part what states have been doing over the years in addressing the telehealth licensing issue is to try to do compacts. There are at this point probably close to a dozen different compacts and they're based on profession. You have physicians, nurses, O T-Com pact. They're all structured differently. For example, the physician medical licensure compact is not a one license practice in multiple jurisdictions, it's a license and you are allowed to go through an expedited process to get another license in another compact state. Then you compare it to the nurse compact, it's one license you practice in multiple
jurisdictions
.
It's important to keep in mind what compact you're talking about and what they've agreed to do and allow for that
practitioner.
Another way for states to address the licensure issue has been through registries, this started out -- we saw more activity around creation of registries in the beginning of the pandemic. These are the creation of registry by the state that says if you get on this, you're good, you don't have to get a license. Florida was one of the first ones. It's not something that's been -- had the amount of popularity as com
pactst has.
We've also seen states doing limited exceptions. They may say if you had a prior established relationship we're going to allow you to practice interstate without getting a license. If you've moved, we'll give you a 30-day grace period or if it's a student that's moved into our state for school or something, then you can have a limited number of interactions. That also goes to infrequent interactions, these are exceptions that states have been carving out and another exception is

continuous date exception.
If your from a certain amount of distance of border from the states they'll allow it or if they've come to an agreement -- DC, Maryland and Virginia came to an agreement that they would allow for exceptions on licensure. They're really close and you have people daily just going in and out of the different jurisdictions. That's where licensure is. Could this all change with that court case? Definitely. We'll have to see how that goes, but that court case was just
filed in December.
It is far from a done deal. They have to try that case, a decision
has to be made.
There may be an appeal afterwards by whatever party loses, there could be changes to it because maybe the new Jersey legislature does something and then the case
gets thrown out.
That's still unsettled here, but we'll see what happens over the
coming months.
What to look out for in 2024. On the federal level, they have to make decisions, time is running out. Things are expiring this year. So what we need to see is what are they going to do with the temporary Medicare policy and prescribing of controlled substances, I don't think a telehealth stand alone bill has much of a chance. What they've done is put telehealth policy changes in a larger bill, usually an appropriations bill.
For those who track what is going on in the federal government, we don't have an appropriation or budget bill. They're talking about a continuing resolution. I don't expect policy changes in that continuing resolution, it's going to be in the big bill. If they put policies in to change telehealth or address the deadlines, it would be in the big bill, would be my guess and not a stand alone telehealth bill. Doesn't mean it wouldn't happen, I'm just saying the last couple of years it's been in the
larger
bills
.
DEA will probably go the regulatory route and are not going to wait for congress, another thing to keep your eye on. There is the physician fee schedule but a lot of these things are statutory changes, they may not be able to go through the physician fee schedule process to be able to change. They will have to wait for congress to decide. There supposedly is a HIPAA update later this year. AI. Big topic of conversation, there's not really policy around it, there was an executive ordinary from the White House aren't AI. This is a developing area, I don't have too much to say about it but definitely something we need to keep our eye on. And broad brand, the affordable connectivity program, technically the funding for that ran out. The FCC said they were working on winding down that program because there wasn't more funding but there has been congressional members saying we want to continue funding this. But we don't have a budget
bill
right
now
.
e need to keep an eye on that
and see what happens.
On the state level, a lot of states have settled on what their post COVID-19 policies on telehealth are,

 

at least what temporary
policies carryover.
However, what we see with a lot of states, interest in data collection and efficacy of telehealth. That's something to keep
an eye on.
There are also some temporary extensions in several states, Maryland and Connecticut extended their telehealth policies to a future date. Keep an eye on those states if they related to -- of interest of you because they have -- they're in the same position of the federal government, they're going to need to address what
is happening soon.
Areas for further development and discussion, people are talking about expanding telehealth for use in Medicaid but the big thing that is going to influence some of this, a lot of states are experiencing budget shortfalls, if you're talking about expanded telehealth in the Medicaid program or keeping temporary policies, the fiscal people are going to see that as more cost to the state and there may be more resistance to expanding
those policies.
That's also something faced on the federal level. You have a lot of budget hawks. Budget shortfalls play into the policies and what we may get because fiscal people are going to see this ex--- expanding policy
costing
more
.
That is it, again, that's the CCHP website. We also have a newsletter that you may want to subscribe to, especially if you want to hear more about the court case. With that, I have a little time to
take
some
questions
.
'm going to go to the QA
, top down.
First is from
anonymous
.
edicare documentation requirement for telehealth is too onerous. Medicare recouped 100% of our audited claims saying the office visit did not meet requirements. We now no longer plan to offer any telehealth appointments for our patients. How shall we navigate this without inconvenience to our patients?

I'm not sure there's a question there. Again, the documentation of what they were asking for, that is something you can try to have a conversation with CMS and also what exactly did they say in your audit as far as, you know, that they can claim that you did not meet their requirements take a closer look at that to see exactly what was their issue on the documentation that you lack or did not meet their requirements there or their
specifications.

Will private Medicaid providers be eligible? I'm not sure what that's referring to. If you're talking about Medicaid, you'll have to check
with the individual state.
I'm not sure what you mean, eligible for what? If you're talking whether the Medicaid provider would be eligible for reimbursement for a particular state, some states, again, do have a limited list of eligible providers. For any Medicaid program a provider would need to become a Medicaid provider
to begin with.
There's not necessarily a separate category to do things via telehealth. You'll have to become a Medicaid provider to begin with. You'll have to see what providers they will allow to use telehealth to provide the services and that they will reimburse. A provider would need to become a Medicaid enrolled provider and then check to see if that type of provider, whether they would qualify or whether their services are allowed to be provided via telehealth. Do you need to follow Medicare guidelines if you don't bill Medicare and provider super Bills for their patients? You need to follow Medicare if your patient is being covered by Medicare and you're intended to seek
reimbursement from them.
If your patient is covered by a private payer plan, you need to follow that policy. If they're paying out-of-pocket, no. You don't need to follow the Medicare
policies on that.
You would need to follow state policy. There may be state policies around things such
as licensure.
There are policies that impact you, maybe not on the reimbursement side. If you're not billing Medicare, you don't need to follow the Medicare policies. Depends on how payment
is
being
made
.
hat are your thoughts on CMS’s assertion that video-telehealth doesn’t fulfill statutory requirement for equivalency to in-person visit?
o I don't think they've made that assertion -- I think what you may be referring to is the services they say are not comparable to in-person
.
I think this is what the questioner is asking. When I said earlier that actually the eligible services underneath Medicare, that's more under CMS's discretion. They have a certain protocol in how they approve the services and those are certain levels of what they say would qualify and one of those is showing that it has, you know, equivcy of in-person -- that's the set up that they've had there. That's the requirements that they
have gone with.
They changed the process with last year's physician fee schedule. If there were concerns about that, that was the time to raise the concerns. Ray, if it's not what you're referring to, please put
a
follow-up
question
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or supervision of residents, I was under impression that virtual supervision for Medicare patients

remains available. For instance, inpatient consult can be staffed with hipaa compliant telehealth where attending provides medical decision making using telehealth service.
es, I was talking about residents, earlier I was talking about supervision of the
residents.
There are some supervisory allowances via telehealth that are there. I would go to some of the resources I put if you're able to download a copy of this PowerPoint you'll
be able to
see
that
.
o established patients need an in person visit prior to the end of 2024 to continue medication management?
he in-person visit requirement is regarding -- that I was talking about earlier was related to prescribing controlled substance. Amanda, are you asking about Medicare? It depends on where and what you're talking about. If there's a controlled substance involved, we're not sure yet what the DEA is going to require. It's also going to depend on who you're talking about, Medicare or Medicaid and whether they're requiring it in general -- yeah. If you could be more specific, that would
be helpful.
We're starting to run out of time. I'm going to take one more question.Can controlled substances be prescribed by audio-only or does it have to be video-audio?

Right now the controlled substance, there is an exception for bupernorphine (phonetic), it's a very limited exception. Something that the DEA agreed to and I think it's still applicable. It's only for a highly specific situation. If you want to reach out to me, I don't have time to go into it. I can give you the parameters
that they have there.
But for the most part, it's no except for this highly
specific scenario.
Right now, I know there's a lot more questions but I need to turn it back to Aria because we're out of time.
>> ARIA JAVIDAN: Thank you, Mae. Our next webinar will be on Wednesday February 21st. Registration information is on the events page. We ask that you take a few minutes to complete the survey that will pop up at the conclusion of this webinar. Feedback is valuable. We will download the Q and A and I'll send it to Mei. Have a great
day
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everyone
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