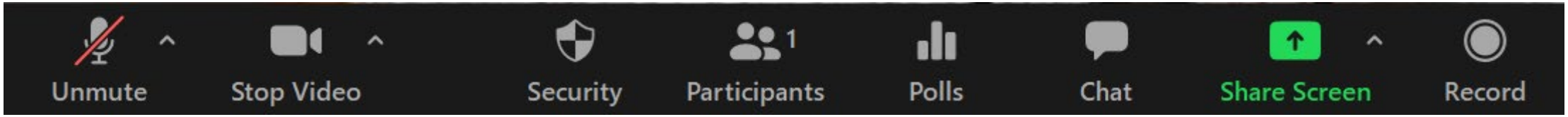
CA Legislative Update
Anticipated New Medicare Policies CY 2025
Federal DEA Regulatory Update

CALIFORNIA TELEHEALTH RESOURCE CENTER
Part of OCHIN

October 16, 2024

Zoom Tips



Muted on Entry

You are muted on entry.

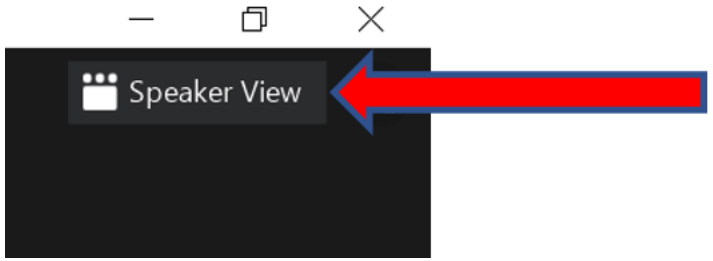
Open the Chat & Q&A

Please open the chat and use it liberally; we want to hear from you!

Send comments and feedback to **“Everyone”**

Session Recording

We are recording today’s session to capture LIVE responses. The recording will be made public on YouTube @CaliforniaTRC.



Speaker View vs Gallery View

At the top right of your screen you can change the video panel to just show the main speaker, or to gallery view to see the speaker and other participants, depending on your preference.

Before We Get Started

CTRC does not provide legal advice. CTRC has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services mentioned in this session.

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About CTRC

Established in 2006, the California Telehealth Resource Center (CTRC) exists to share **unbiased, no-cost digital health resources and consultative support services** with providers and patients located across all 58 California counties and beyond. As part of a collaboration of 12 regional and 2 national Telehealth Resource Centers, CTRC is **committed to implementing digital health programs for rural and underserved communities.**

CTRC became part of OCHIN in 2017. CTRC is also part of a coast-to-coast, federally designated consortium that includes two national and 12 regional telehealth resource centers (TRCs). Our knowledgeable CTRC team teaches others to employ innovative technologies in ways that **enhance connected care and advance health equity**. CTRC insights reflect OCHIN's 22 years of practice-based solutions expertise.

CALIFORNIA TELEHEALTH RESOURCE CENTER

Part of OCHIN

Meet Your Speakers

Jennifer Stoll

Jennifer Stoll is the **President of the California Telehealth Network** and **Chief External Affairs Officer** of **OCHIN**. Jennifer has extensive experience creating **innovative** and **sustainable solutions** to the complex external challenges facing **providers** in **rural and medically underserved communities**. She is on the Health AI Partnership Advisory Board, Chairs the Coalition for Health AI Policy Workgroup, Chairs the Underserved Provider Cybersecurity Advisory Group, serves on the HSCC Cybersecurity Working Group Executive Committee, the KLAS SDOH Board, Epic's AI & Algorithms Expert Committee. She leads OCHIN's advocacy, policy, development, and partnership teams, all who are experts in using **data-driven strategies** to **close care gaps in local communities** nationwide.

Sylvia Trujillo

Sylvia Trujillo is the **Executive Director** of the **California Telehealth Resource Center (CTRC).** She drives initiatives to foster **equitable** and **sustainable** access to health care, especially among **underserved and rural communities**, leveraging **digital modalities** to drive system-level transformation. Nationally recognized for her contributions to advancing the adoption of **evidence-based digital medicine**, Sylvia's expertise encompasses telehealth, eConsult, remote patient monitoring, and the burgeoning field of AI in healthcare—particularly in the areas of **regulation, payment, and coverage**.

California Legislative and Budget Update

Jennifer Stoll, CTN President & OCHIN Chief External Affairs Officer

Level Setting for 2024 General Session

General Election

Budget Shortfall

Battle Over Managed Care Organization Tax

Proposition 35 Changes Which Services Get Funding Increases

Funding Increases in the Short Term (in 2025 and 2026)

	Current Law	Proposition 35[a]
Doctors and other related providers[b]	✓	✓
Specified hospital services		✓
Outpatient facilities		✓
Safety net clinics	✓	✓
Behavioral health facilities		✓
Reproductive health and family planning	✓	✓
Emergency medical transportation	✓	✓
Nonemergency medical transportation	✓	
Private duty nursing	✓	
Certain long-term supports	✓	
Community health workers	✓	c
Continuous Medi-Cal coverage for children up to five-years old	✓	
Medi-Cal workforce programs	✓	✓
Doctor postgraduate training programs		✓

[a] More services are eligible for funding increases in the long term (beginning in 2027).
[b] Current law and Proposition 35 include some differences over which related providers get funding increases.
[c] Eligible for funding increases in the long term (beginning in 2027), depending on how much money is raised by the health plan tax.

2024 California Legislative Themes

Over 900 Bills to Governor: Vetoed 183 – Signed 800

Artificial Intelligence

Addressed growing concern around AI and its implication, New laws targeted deepfakes used in political campaigns and unauthorized AI use in Hollywood, protecting performers from digital cloning.

Healthcare & Consumer Protections

Laws aimed at expanding healthcare access and consumer protections, such as SB 1061, which removed medical debt from credit reports, and SB 729, which mandated private insurance coverage for infertility treatments

Housing & Homelessness

Newsom signed several bills streamlining housing construction and expanding renter protections. These measures also included penalties for local governments failing to comply with state housing mandates

Criminal Justice Reform

Passed several bills aimed at juvenile justice reform and reducing the use of solitary confinement for certain vulnerable populations.

Climate & Environment Policy

Key laws included SB 219, which mandated corporate climate accountability by requiring companies to disclose greenhouse gas emissions, and AB 1866, which increased penalties for failing to clean up idle oil wells

Source: Newsom signs 800 new California laws, vetoes 183 bills (calmatters.org)

Budget Outcome and the Future

Spending plan for **health departments** constitutes a **decrease of $3.8 billion (9 percent)**

Handful of modest augmentations in health programs but major actions used to address the significant General Fund budget problem

Governor Signs AI Legislation

Definitions

AB 2885: Artificial Intelligence. Creates a single, broad definition of AI into the Government Code.

AB 1008: CCPA Personal Information: Expands the definition of "personal information" in the California Consumer Privacy Act of 2018 (CCPA) to include Artificial Intelligence.

SB 1223: Consumer Privacy: Neural Data. Expands the definition of "personal information" in the CCPA to include "neural data," including AI models utilizing neural data.

Transparency

AB 3030: Health care services: Artificial Intelligence. Requires healthcare entities using generative AI tools to create responses for providers' communications with patients to include disclosure.

SB 942: California AI Transparency Act. Places obligations on businesses that provide generative AI systems to develop and make accessible tools to detect whether specified content was generated by those systems.

AB 2013: Generative artificial intelligence: training data transparency. Requires an AI system or service developer to publicly disclose specific information related to the system or service's training data.

Governance

SB 1120: Health Care Coverage: Utilization Review. Creates requirements for health plans or disability insurers using AI for utilization review. Use of AI must not deny or delay healthcare services. Final decision must be made by a healthcare professional.

SB 896: California AI Accountability Act. Guides the decision-making of state agencies, departments and subdivisions in the review, adoption, management, governance ***and regulations of automated decision-making technologies***

AB 302 (signed October 2023): Authorizes the California Department of Technology to conduct a comprehensive inventory of all high-risk Automated Decision Systems used by state agencies.

Governor Vetoed Bills

SB 892: Public Contracts: Automated Decisions

Requires the Department of Technology to establish safety, privacy and nondiscrimination standards for AI and prohibit the state from contracting with any AI service provider that does not comply with these standards

SB 1047: Safe and Secure Innovation for Frontier Artificial Intelligence Models Act.

Imposes strict regulations on the artificial intelligence industry.

(Held in committee) **AB 2726: Specialty care, telehealth and other virtual services.** Creates a grant program aimed at facilitating telehealth and other virtual services.

AB 2339: Medi-Cal Telehealth

Expands existing **Medi-Cal** definitions and exceptions to **allow the use of asynchronous telehealth modalities to establish a new patient relationship when related to sensitive services** and requested by patient (removes reference to patient otherwise attesting to no video access in audio-only establishment exception).

AB 2058: Health information device disclosure

Requires devices that **collect or analyze information originating from a physiological source** to have a legible **disclosure on the product** that includes limitations known by the manufacturer on the effectiveness of the device because of certain characteristics of the person using the device including, but not limited to, age, color, disability, ethnicity, gender, or race.

AB 2250: SDOH Screening and Outreach

A health insurance policy issued, amended, on or after January 1, 2027, shall include coverage and provide **reimbursement to health care providers for social determinants of health screening.**

Outlook Next Year

Budget Challenges include slow economic growth, rising costs for healthcare and infrastructure, and revenue shortfalls if federal aid is reduced

- **Climate Change**
- **Housing**
- **Healthcare**
- **Technology (AI and Data Privacy)**

Payment and Regulatory Updates

Sylvia Trujillo, CTRC Executive Director

Digital Health Services Payment Guide

Welcome to the California Telehealth Resource Center Digital Health Payment Guide! Understanding how to get paid for digital health services can be an intricate and often frustrating task. This guide will clarify the process, starting with the essential principles to ensure you have a solid foundation.

Getting paid for your digital health services is an often complex process in which one needs to know the answer to the following questions:

- ***What modality will be utilized?***
- ***What provider type are you?***
- ***What payer does your patient have?***
- ***What are the coverage requirements?***
- ***What are the codes?***
- ***What are the reimbursement amounts?***

Begin with Door 1 by clicking the button below. Once you've mastered the basics, proceed to Door 2, which provides detailed information tailored to the specific modality of interest, your provider type, and the patient's specific payer. If you're already familiar with the basics, feel free to skip ahead to Door 2 directly.

VIEW HERE

Our latest Digital Health Services Payment Guide offers a novel approach to simplifying the often complex landscape of digital health payments, specifically designed to reduce cognitive burden for healthcare professionals.

By presenting clear, actionable insights and breaking down intricate topics, this guide provides a comprehensive foundation for understanding the multifaceted aspects of digital health payment systems.

It equips professionals with the essential knowledge needed to navigate regulatory requirements, billing procedures, and reimbursement pathways, ensuring they can confidently manage digital health services without feeling overwhelmed by the intricacies of payment structures.

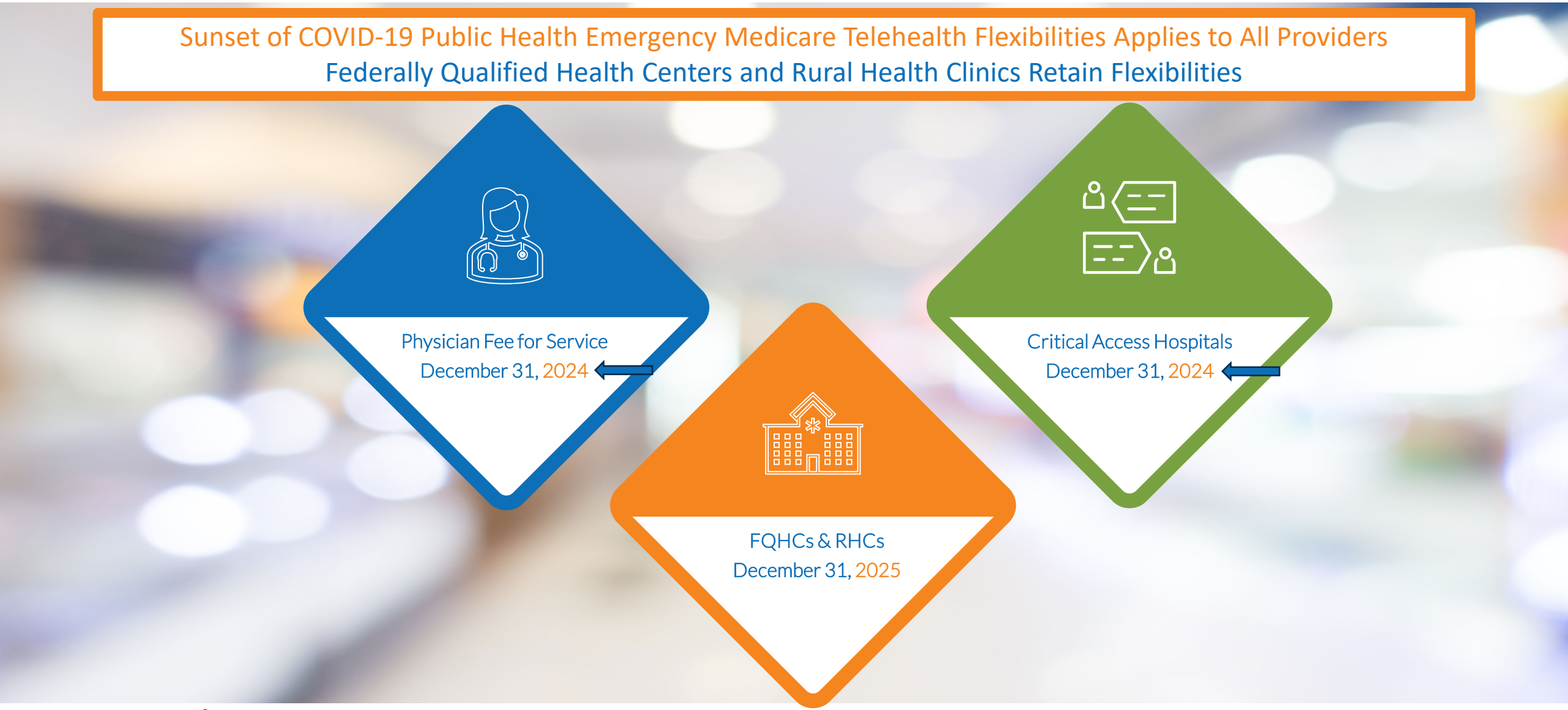
Resources: Digital Health Services Payment Guide

Medicare Update

What We Will Focus on Today *Proposed*

Sunset of COVID-19 Public Health Emergency Medicare Telehealth Flexibilities Applies to All Providers

Federally Qualified Health Centers and Rural Health Clinics Retain Flexibilities



Physician Fee for Service
December 31, 2024

Critical Access Hospitals
December 31, 2024

FQHCs & RHCs
December 31, 2025

Proposed Physician Fee Schedule

Proposed

Medicare Telehealth Physician Fee Schedule

The COVID-19 PHE **digital health flexibilities** are set to **expire at the end of the year – what does that mean for you and your patients?**

If Congress does not act, telehealth will return to a rural-only benefit once again for Medicare enrollees, limit location of service, and practitioners covered

This is not inclusive of all digital health modalities! RPM, RTM, eVisits, and more **will all be permissible** (as long as coverage requirements are followed)

Proposed

Medicare Telehealth Physician Fee Schedule

PERMANENT EXTENSION FOR AUDIO-ONLY

- CMS proposes to permanently allow two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology

PROVIDER LOCATION REPORTING

- CMS proposes to allow through 2026 a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

VIRTUAL DIRECT SUPERVISION

- CMS proposes a new authority for virtual direct supervision of incident to services.
- CMS also proposes to continue broader existing virtual direct supervision authority through 2025.
- Includes the current policy allowing teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in teaching settings who are offering a virtual service.

FREQUENCY LIMITATIONS

- CMS proposed to permanently remove frequency limitations for services associated with subsequent inpatient and nursing facility visits as well as critical care consultation visits when provided via telehealth

Proposed

Medicare Digital Mental Health Physician Fee Schedule

Digital Mental Health Treatment (DHMT) Devices: New Proposed Codes

GMBT1 - Device

- Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan

GMBT2 - Services

- First 20 min of monthly treatment services directly related to the patient's therapeutic use of the digital mental health treatment device...

GMBT3 - Services

- Each additional 20 min of monthly treatment services directly related to the patient's therapeutic use of the digital mental health treatment device...

Proposed Medicare Digital Mental Treatment Codes Versus Remote Therapeutic Management Pricing & Confusion PFS

Similarities to Current CPT RTM codes

- 98975 Education and Onboarding
- 98980 Service (initial 20 minutes)
- 98981 Service (additional 20 minutes)
- 98978 Supply of Medical Device

CMS proposes contractor pricing

- Your Medicare Administrative Contractor will price the code
- **No guarantee of pricing that will result in payment**

GMBT1 valuation = $0.00

- Each contractor can price things differently

Proposed

Medicare Primary Care Mgt Physician Fee Schedule

Advanced Primary Care Management (APCM) Services: New Proposed Primary-Care Codes

Only Applies to Subset of APM Models:

Proposed APCM Codes

- GPCM1, GPCM2, GPCM3 stratified into three levels based on patient risk and describe APCM services furnished per calendar month by the practitioner assuming the care management role for a beneficiary

Bundles Existing Care Management Codes

- Bundle care management services with other Community Technology-Based Services (CTBS) (e.g., remote evaluation of patient videos/images, e-Visits) codes and practices can still bill remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM) concurrently with APCM.
- CMS requested information on whether it should incorporate other

APCM Service Elements including Performance Measurement Requirement

- APCM codes includes 13 service elements including a performance measurement requirement, 24/7 access, and continuity of care

Proposed

Medicare Telehealth Physician Fee Schedule

Opioid Treatment Programs

PROPOSED: Allowance of several telecommunication flexibilities for opioid use disorder (OUD) treatment services provided by opioid treatment programs (OTPs), as along as the use of the technologies are permitted under the applicable SAMSHA and DEA requirements at the time of services are furnished and all other applicable requirements are met

- CMS proposes to **permanently allow periodic assessments to be furnished via audio-only telecommunications starting January 1, 2025**, provided all other applicable requirements are met
- CMS proposed to **allow the OTP intake add-on code (HCPCS code G2076) be furnished via two-way audio-video communications technology** when billed for the initial of treatment with methadone if the OTP determines that they can complete an adequate evaluation of the patient via an audio-visual telehealth platform

Proposed FQHCs and RHCs

Proposed

Medicare Telehealth FQHCs & RHCs

PROPOSED: FQHCs and RHCs will still be able to conduct both interactive two-way audio/video telehealth and audio-only telehealth through 12/31/25

- CMS proposes to allow payment, on a temporary basis, for non-behavioral health visits furnished via telecommunication technology. Under the proposal, **RHCs and FQHCs would continue to bill for RHC and FQHC services furnished using telecommunication technology** services by reporting **HCPCS code G2025** on the claim, including services furnished using **audio-only communications** technology through December 31, 2025.
- CMS proposes to continue to **allow direct supervision via interactive audio and video telecommunications** and to extend the definition of "immediate availability" as including real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025.
- CMS proposed to continue **delaying the in-person visit requirement for mental telehealth visits** furnished by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026.

Centers for Medicare & Medicaid Services. (2024, July 8). Calendar year (CY) 2025 Medicare physician fee schedule proposed rule. CMS.gov. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-proposed-rule

Proposed

Medicare RTM/RPM FQHCs & RHCs

PROPOSED: Allow FQHCs and FQHCs to **use existing care management CPT codes for each service encompassed** in HCPCS G0511

Current State: The CY 2024 PFS added Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services to the list of care management services billable by FHQCs and RHCs under HCPC G0511.

Proposes FQHCs and RHCs be allowed **to bill add-on codes for additional time spent** once the minimum threshold of time was met to account for a complete encounter

Payment would at the **national non-facility payment rate** and i**ncludes proposed APCM codes,** if they are finalized

Regulatory Update

Pre-COVID-19: Prescribing for New Patient

Establishing a Valid Relationship Required an In-Person Evaluation before Telehealth could be used

All DEA-registered practitioners permitted to prescribe schedule II–V controlled medications via telemedicine (interactive video) through December 31, 2024, to new patients as long as all other requirements met.

Extends audio-only new patient initiation via audio-only for opioid use disorder and buprenorphine to December 31, 2024

Awaiting DEA Telemedicine Rules

First Attempt of Post-Pandemic Telemedicine Prescribing Controlled Substance Rule

Prompted massive feedback (over 38,000 comments) and forced delay of the release of a revise rule through now (*Source*)

DEA Conducts Listening Sessions

Held listening sessions to better understand stakeholder concerns with aim to develop a rule that better accommodates diverse needs of all involved parties (*Source*)

Stakeholders Ask Congress for Two-Year Extension

Over 330 organizations wrote to Congress asking for another two-year extension of pandemic-era policies to avoid patient harm of ending flexibilities while allow more time to agree on best way to balance access and enforcement (*Source*)

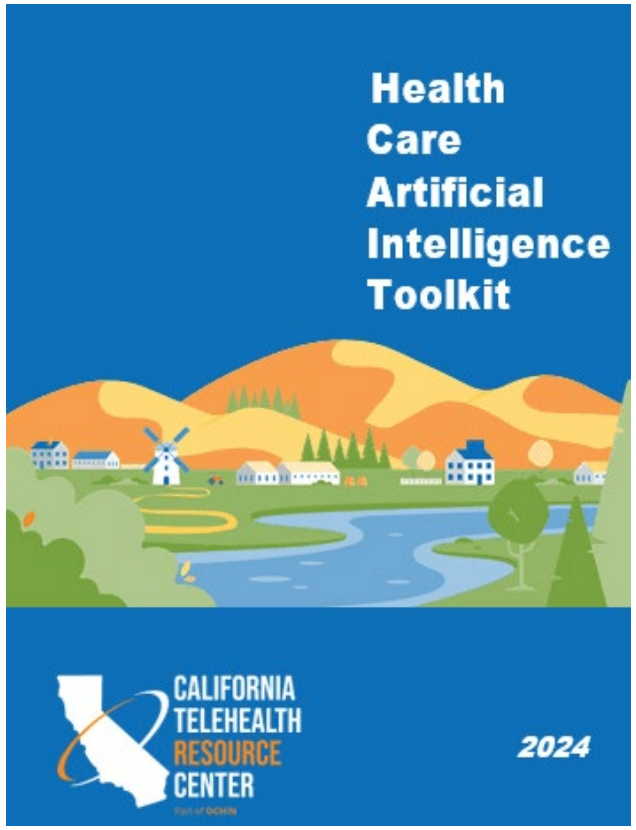
Leaked DEA Draft Rule Still Looks Limiting

Their proposal limits providers to issuing no more than half of their prescriptions virtually, require extensive checks through state prescription drug monitoring programs. The proposal can change. (*Source*)

Latest

New DEA final rule "*Third Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications*" is awaiting OMB clearance before being published for public review

Resources



VIEW HERE

The rapid increase in advanced artificial intelligence (AI) systems and applications in healthcare has occurred seemingly overnight. Clinicians, operational staff, and provider leadership may not be aware that they are utilizing an AI system, may not know what questions to ask, nor know what policies, procedures, processes, and professional training should be in place to ensure that such systems drive improved health outcomes and equity, reduce the burden on their teams, and increase overall sustainability.

This is an introductory guide to support these efforts.

AI systems can be applied to clinical care, operations, and research and may involve different AI systems and methods. As a result, the risk profile of the system may be varied. The governance should be built to account for use across the varied operations of a health care provider and the questions asked of vendors/developers will also vary as a result.

Resources: Health Care AI Toolkit

Upcoming Event

REGISTRATION & INFORMATION

Stay Connected – Follow Us!

SCAN ME

Thank **You**

CALIFORNIA TELEHEALTH RESOURCE CENTER

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www.caltrc.org

Introduction to Payment Systems

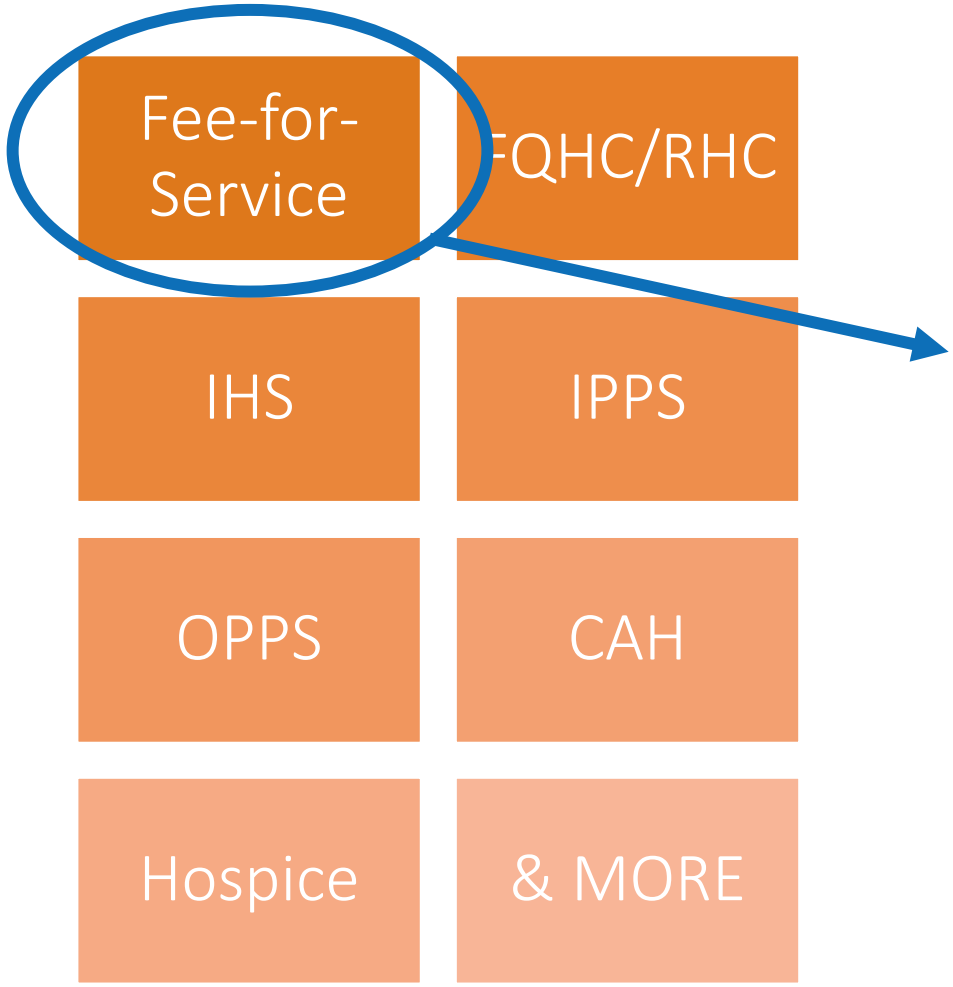
Fee-for-Service	FQHC/RHC	IHS	IPPS
OPPS	CAH	Hospice	& MORE

Why does it matter?

They all have different:

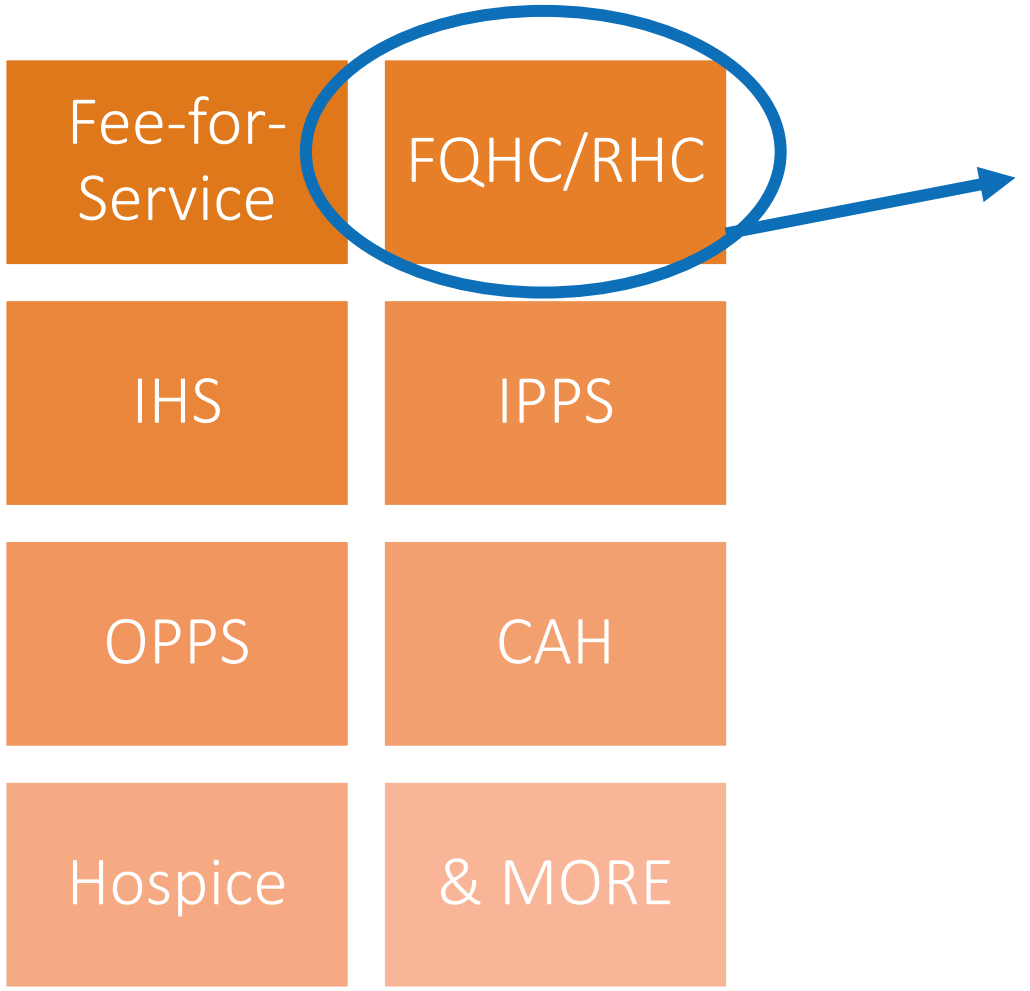
- Covered services
- Coverage requirements
- Payment amounts
- And sometimes codes

Introduction to Payment Systems



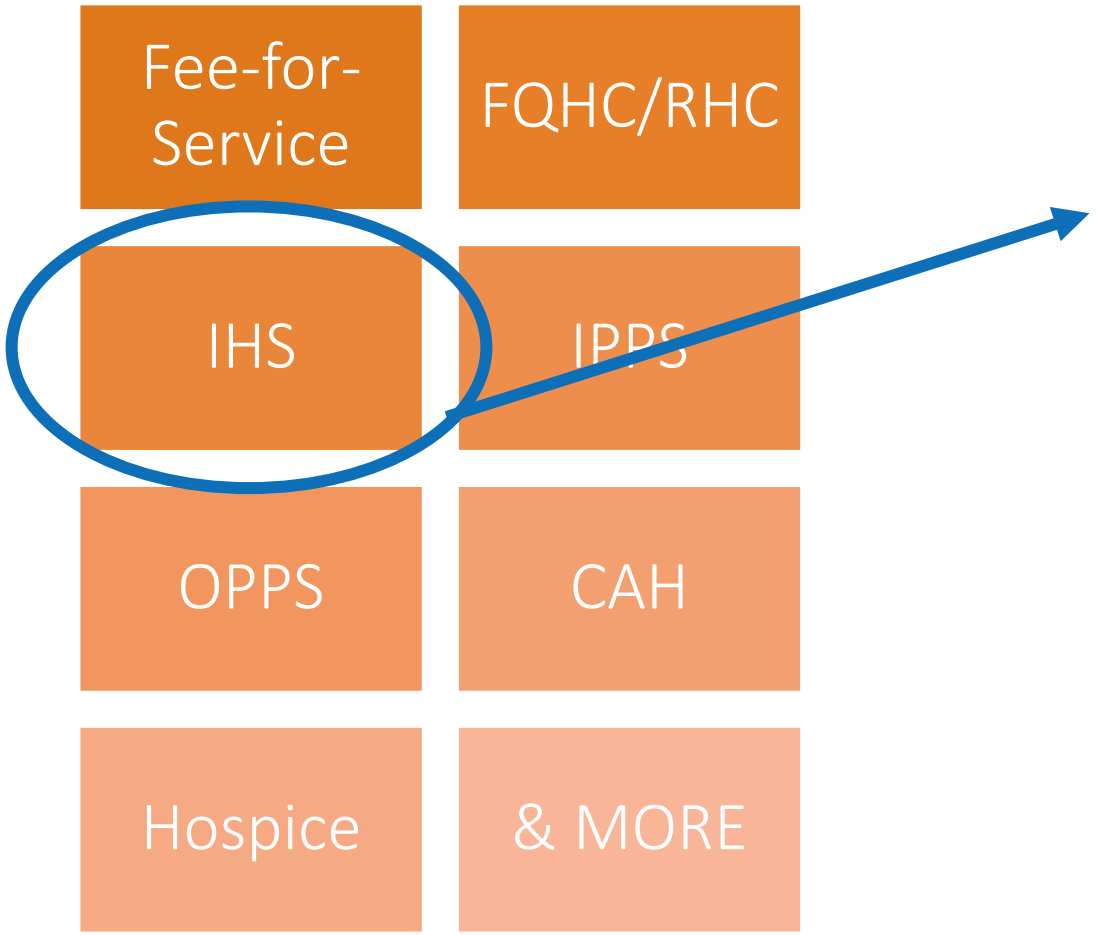
- The FFS model remains one of the **most commonly used payment structures in the U.S.**, particularly in private insurance and Medicare
- Providers are **reimbursed for each specific service they perform**, such as office visits, tests, procedures, or treatments. The **payment** is **based on the volume and type of services** rather than outcomes
- Most **digital health payment guides** tend to be for FFS

Introduction to Payment Systems



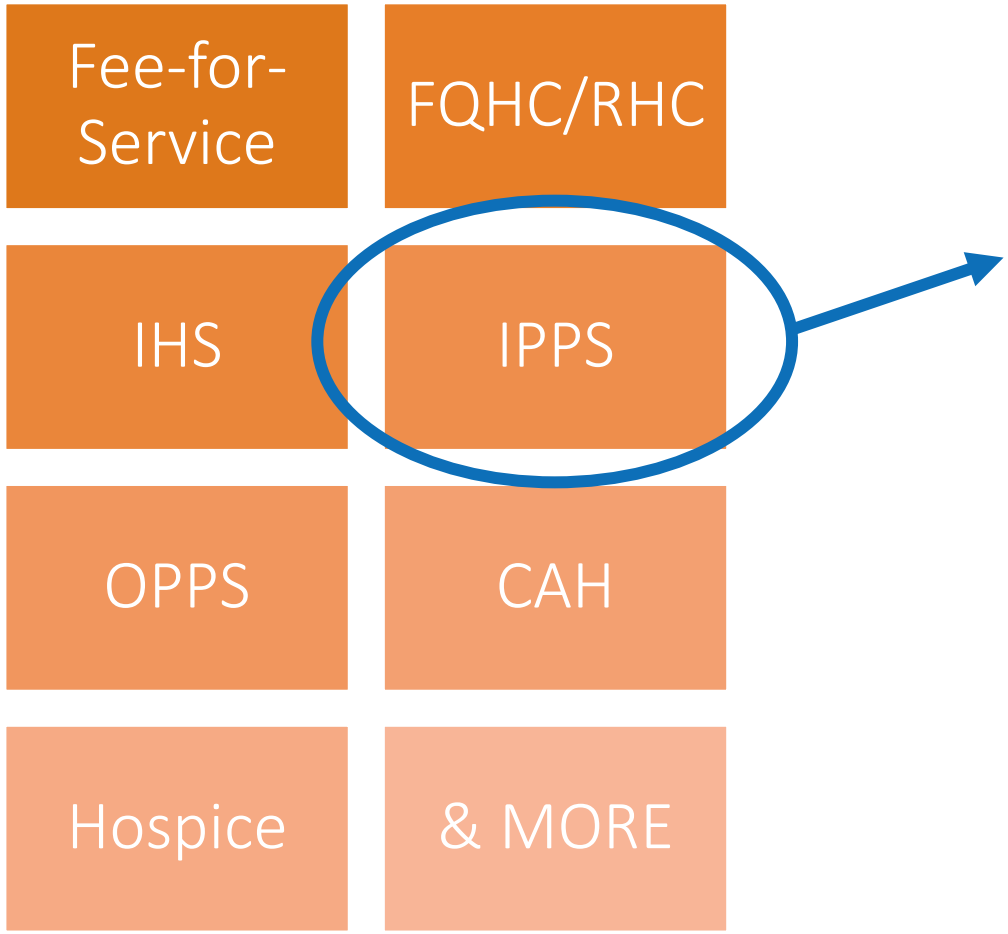
- Specifically for **Federally Qualified Health Centers** and **Rural Health Clinics**
- FQHCs and RHCs are **reimbursed** based on the **actual costs of providing care** rather than a fee-for-service model
- FQHCs and RHCs typically receive a **set payment rate per patient visit**, regardless of the specific services provided during the visit
- Designed to support clinics that **serve medically underserved areas**, ensuring that essential healthcare services are available to r**ural and low-income populations**

Introduction to Payment Systems



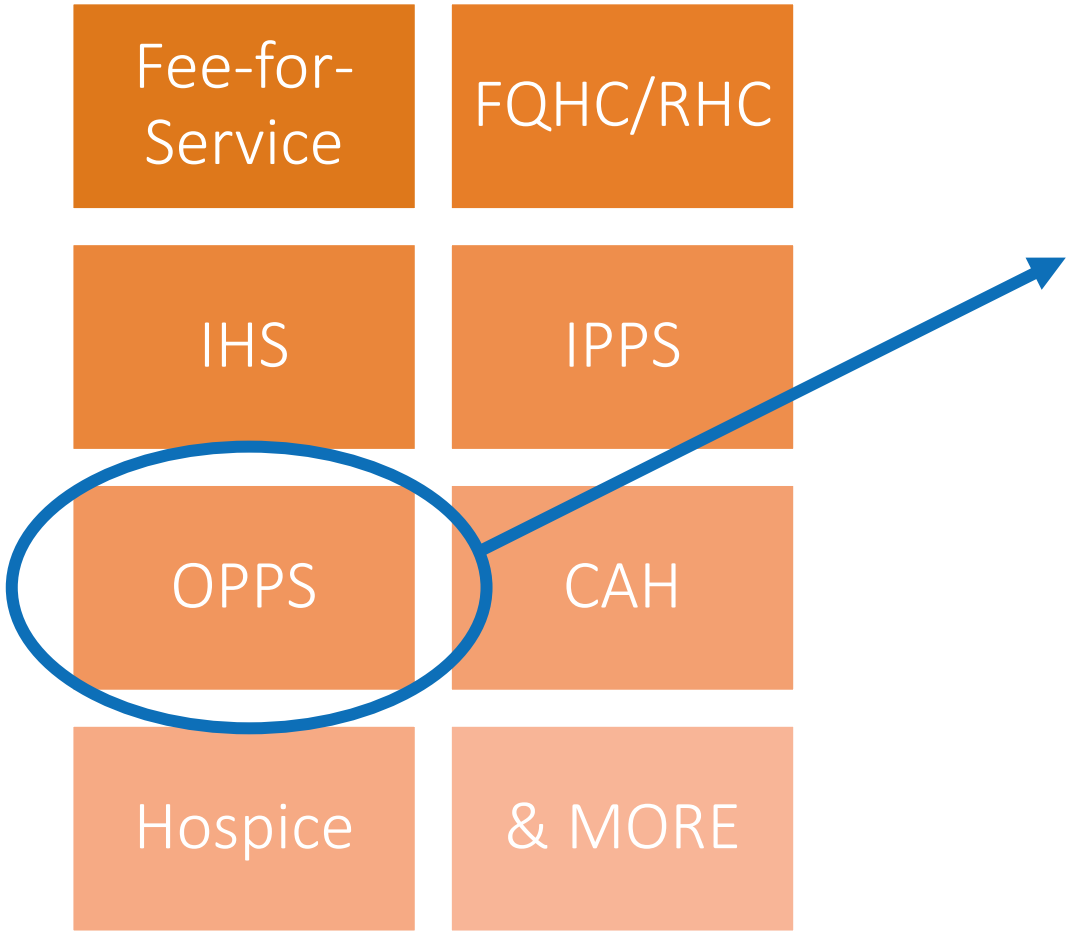
- Indian Health Services (IHS) are primarily **funded by the federal government**, providing healthcare services directly to **American Indian** and **Alaska Native populations** through a network of IHS-operated facilities, tribally operated health programs, and urban Indian organizations
- IHS's mission includes delivering **culturally appropriate care** that meets the specific health needs of Indigenous communities, often **integrating traditional healing practices** alongside Western medicine

Introduction to Payment Systems



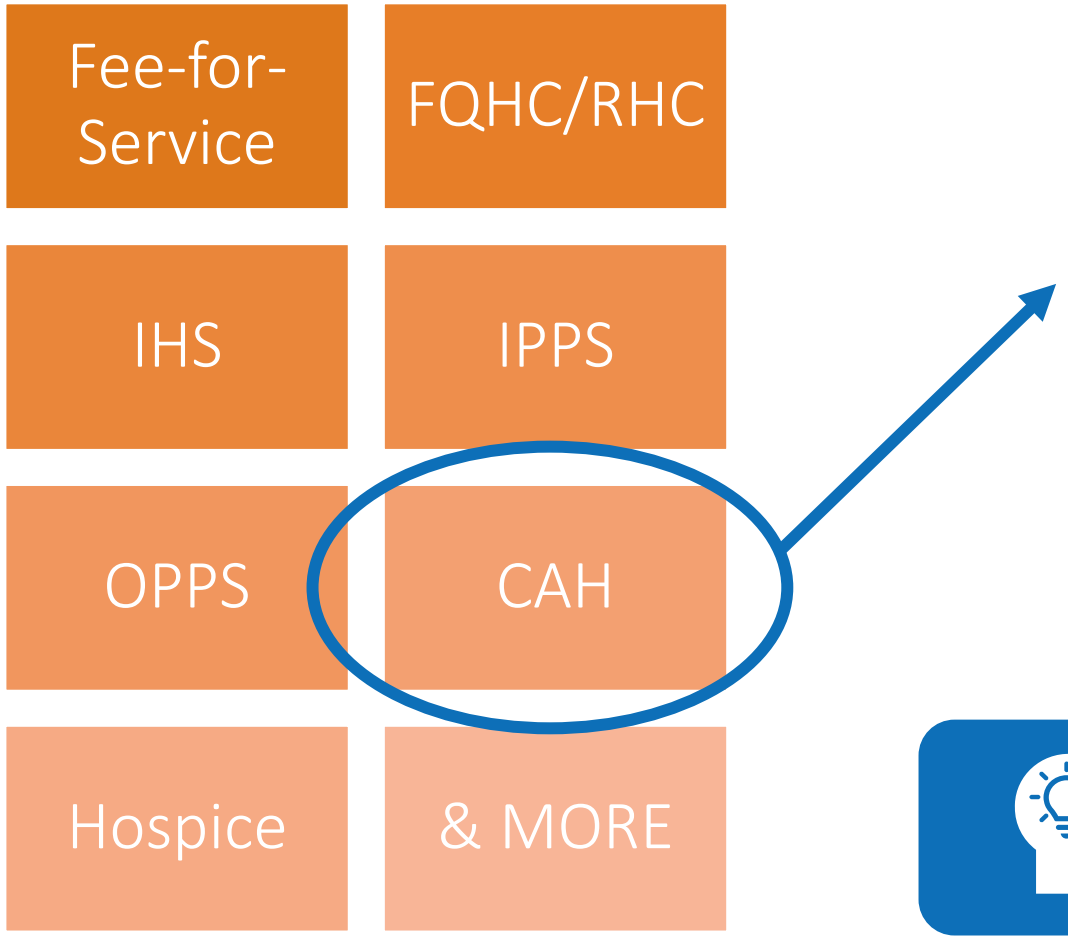
- Through the **Inpatient Prospective Payment System (IPPS)**, Hospitals are **reimbursed** based on **DRGs**, which group patient cases by **diagnosis** and **procedures**
- Payments are **adjusted** for **patient complexity**, hospital **location**, and teaching status
- Primarily applies to hospitals serving **Medicare patients** for **inpatient care**

Introduction to Payment Systems



- Through the **Outpatient Prospective Payment System (OPPS)**, services are grouped into **Ambulatory Payment Classifications (APCs),** which determine the **reimbursement for outpatient services**
- Primarily applies to hospitals serving **Medicare patients** for **outpatient care**

Introduction to Payment Systems



- Through the **Critical Access Hospital (CAH)** payment system, CAHs receive **101% of allowable costs** for **Medicare** services, helping cover the actual cost of care
- CAHs are required to provide **24/7 emergency care** to ensure access in **underserved** areas
- CAHs are **small**, with a maximum of 25 inpatient beds, serving **rural communities**

To learn more about the different payment systems, check out CTRC's Digital Health Services Payment Guide!

VIEW HERE