WashingtonState TelehealthCollaborative

Meeting Minutes

January 29, 2024 | 10:00 am - 12:00 pm

Virtual Zoom Only Meeting

Member attendance					
Sen. Ron Muzzall	Y	Dr. Josh Frank	N	Scott Kennedy	N
Sen. Annette Cleveland	N	Joelle Fathi	N	Mark Lo	Y
Rep. Marcus Riccelli	N	Stacia Fisher	Y	Heidi Brown	N
Rep. Joe Schmick	N	Dr. Frances Gough	Y	Adam Romney	Y
Dr. John Scott	Y	Lisa Woodley	Y	Cara Towle	Y
Dr. Chris Cable	Y	Emily Stinson	Y	Lori Wakashige	Y
Jae Coleman	N	Amy Pearson	Y		
Stephanie Cowan	Y	Dr. Ricardo Jimenez	N		
Kai Neander	Y	Dr. Geoff Jones	Y		

Non-Member Presenters: Katherine Kim (Consumer Health Informatics and Health Science), Michele Radosevich (Davis Wright Tremaine), Nicki Perisho (NRTRC), Hanna Dinh Hsieh (UWM)

Public attendees *(alphabetical by first name)*:
Alpana Banerjee (Mental Health/Public Health Advocate), Barb Wayland (unknown), Carrie Tellefson (Teladoc), Chad Gabelein (MultiCare), Charles Chima (WA DOH), Charlotte Shannon (UWM), Clark Hansen (ALS), Craig Steinfeldt (Rural Healthcare Advocates – Klickitat County), Fawn Ross (HCA), Fumie Watanabe (UW), Gail McGaffick (WSPMA), Galen Alexander (Hims & Hers), Hanna Rasmussen (Virginia Mason), Jaleen Johnson (NRTRC), Jeb Shepard (WSMA), Jeff Reitan (FHCC), Josh Palega (UWM), Kathy Li (UWM), Katie Litwinski (UW), Koji Sonoda (UWM), Lauren Stroupe (Teladoc), Leslie Emerick (WA State Hospice and Palliative Care), Mandy Latchaw (unknown), Marissa Ingalls (Coordinated Care), Mercer May (Teladoc), Molly Shumway (UWM), Nancy Lawton (ARNP, FNP), Nate Symonds (MultiCare), Nomie Gankhuyag (FHCC), Olivia Shangrow (WA Council for Behavioral Health), Preet Kaur (Premera), Rachel Abramson (UWM), Remy Kerr (WSHA), Rob Waters (unknown), Rose Cullen (Hims), Sabrina Lin (UW), Sarah Huling Forks (Public Observer), Sarah Koca (CHPW/CHNW), Sheridan Turner (Mindful Therapy Group), Suzanne Kenedy (unknown), Thalia Cronin (CHPW/CHNW), Tom Holt (ZoomCare), Tyler Bloom (Sea Mar), Wendy Brzezny (Thriving Together).

Meeting began at 10:01 am

Welcome and Attendance

Dr. John Scott [0:00]

Review of Meeting Minutes - November 13, 2023

Dr. John Scott [4:45]

Dr. Scott (Chair) reviews minutes. Mark Lo (Seattle Children's) motioned to approve minutes. Geoff Jones (Newport Community Hospital) seconded. Unanimously approved as submitted.

Action Item:

- Mrs. Dinh Hsieh (Collaborative Program Manager) to post approved November 2023 notes on WSTC website

State/Federal Updates

Hanna Dinh Hsieh and Dr. John Scott (UWM) [7:17]

Federal Updates

- As part of CMS 2024 Physician Fee Schedule's final rule, CMS clarified certain guidance for remote monitoring services, finalized separate reimbursement for remote monitoring provided by rural health centers and FQHCs, and discussed a recent request for information for digital therapies
- See article on CMS coverage updates and payment policies for remote monitoring here.
- The following telehealth regulation areas are to be decided upon in 2024:
    - **Medicare waivers:** The CONNECT Act would eliminate geographic telehealth restrictions for physicians to receive Medicare payments – see bill text here.
    - **Expansion to underinsured:** The Telehealth Expansion Act would allow underinsured patients and those with high deductible plans to access telehealth services permanently – see bill text here.
    - **Controlled substance prescriptions:** The TREATS Act would allow for the prescription of opioid use disorder drugs via telehealth – see bill text here.

Nicki Perisho's Testimony to the U.S. Senate Finance Subcommittee on Health Care

- Watch here for Nicki's testimony on telehealth's vital role for Medicare beneficiaries
- Nicki testified in favor of making some of the federal pandemic telehealth policies that remained temporary and have been extended numerous times by Congress, to ideally make them permanent for Medicare beneficiaries
- Dr. Eric Wallace from the University of Alabama in Birmingham, Dr. Chad Ellimoottil from the University of Michigan, and Dr. Ateev Mehrotra from the Harvard Medical School also testified with Nicki.

- All four witnesses spoke in favor of permanently:
    - Allowing FQHC and RHC clinicians to provide telehealth visits beyond mental health visits as distant clinicians
    - Eliminating site location and geographic requirements and allow for video visits for all conditions for Medicare beneficiaries
    - Remove in-person visit requirement before mental health visits
- All four witnesses agreed that:
    - A potential idea would be to introduce selective exceptions to state licensure rules that allow patients to get care from a clinician that they've had a previously established relationship with
        - This is as long as these providers' licenses are at good standings in their home state that is outside of the existing licensure compacts
    - There should be some encouragement around innovation and payment models for telehealth that could use bundle payments
- There were two areas that the four witnesses did not agree on:
    - Payment parity
        - There was a stance from one of the witnesses that payment parity might cause or create distortions in the healthcare market – it could potentially provide the virtual-only telehealth companies a competitive advantage. It may also incentivize brick and mortar clinicians to leave their brick and mortar practice in search of virtual only.
    - Payment for audio-only telehealth visits
        - One of the witnesses expressed that there should be a time-limited period that is introduced, which would require provider attestation that they had offered their patients a video visit. In this same vein, clinics that are providing telehealth visits and have audio only as an option, they should be responsible in providing resources to patients that may face barriers to telehealth visits.
- 11 Senators came to the hearing and asked questions to the witnesses – they were very well versed in the telehealth policies
    - Formal written responses were submitted to their questions

Questions/Discussion:

- Dr. John Scott (UWM) adds that there is broad bi-partisan support in the Senate for the CONNECT Act. Senator Brian Schatz from Hawaii is the prime sponsor of this Act.
    - There hasn't been a companion bill yet in the House
    - Many of the waivers that were put in place during the pandemic for Medicare would be made permanent through this Act. This will help Medicare patients get access to telehealth, especially without being in a particular location.
- Follow this link to learn more about Nicki's testimony and read the full statement: https://nrtrc.org/resources/senate/index.shtml

- The Northwest Regional Telehealth Resource Center (NRTRC) Annual Conference will be held on April 29th – May 1st on the University of Washington campus in Seattle, Washington
    - There is a promo code to receive $15 off your registration fee

    - For more information and to register: https://nrtrc.org/conference/
    - For quality improvement pre-conference workshop information: https://nrtrc.org/conference/qi-workshop.shtml
    - For conference speaker information: https://nrtrc.org/conference/speakers.shtml
    - For conference sponsor/exhibitor information: https://nrtrc.org/conference/sponsorships.shtml

New Collaborative Member: Premera

Preet Kaur (Premera) [12:07]

Sheryl Huchala and Courtney Epps were the previous Collaborative members for Premera. The new Collaborative member for Premera introduced herself and shared her experiences. Her biography was shared with the group as shown below.

- **Preet Kaur – Legislative Policy Manager, Congressional and Legislative Affairs**
    - Preet Kaur is Legislative Policy Manager, Congressional and Legislative Affairs for Premera. Preet joined Premera in February 2021 as a member of the regulatory services team. She holds a Bachelor's in Health Care Administration and Policy from the University of Nevada Las Vegas and a Master's in Health Care Information Management and Informatics from the University of Washington. Before joining Premera, Preet was a Contract Writer for Kaiser Permanente of Washington's health plan and benefits. While working at Kaiser Permanente of Washington the focus of her work was on managing the impact of state and federal mandates on health plan benefits and ensuring implementation in accordance with compliance. In her position in the Congressional and

Legislative Affairs Department at Premera, she is responsible for addressing legislative health policy issues in Washington, Alaska, and at the federal level, including leading the research and analysis of legislative and public policy issues. Preet also supports many different WA state workgroups, including Children and Youth Behavioral Health and Residential SUD Treatment.

Action Items

- Mrs. Dinh Hsieh (Collaborative Program Manager) to update Collaborative membership roster

Patient Representative on the Collaborative

Dr. John Scott (UWM) [12:07]

Sarah Keogh, who was selected as the patient representative on the Collaborative at the September meeting, will no longer be able to serve in this role. There was one patient representative candidate who was interested in the position. His biography was shared with the group as shown below.

- **Clark Hansen**
  - Clark is the telemedicine expert for the Patient Coalition of Washington (PCW), uniting the state's leading patient groups to have one voice for better health care. The PCW is an independent, non-partisan coalition that works on Washington state policy issues. With this experience, Clark can help advance a patient-focused telemedicine vision for the Collaborative. As the Managing Director of Advocacy for the ALS Association, he develops and implements advocacy campaigns that benefit the ALS community in eight western states. Clark has extensive health policy experience with strong relationships with Congress members and their staffs across the western states. He served as a senior policy advisor on Medicaid and long-term care issues to the Connecticut State Senate, worked in provider and government relations for the Connecticut Behavioral Health Partnership, and was the West Coast representative of Bread for World - a national non-profit working to improve national and state level nutrition policy. He also is Vice President of the Board for Columbia Valley Community Health – North Central Washington's FQHC.

Geoff Jones (Newport Community Hospital) motioned to approve Clark Hansen as the patient representative on the Collaborative. Cara Towle (UWM) seconded. Majority of the Collaborative members approved with 12 yes's and 1 abstain.

Action Items

- Mrs. Dinh Hsieh (Collaborative Program Manager) to update Collaborative membership roster

Established Patient-Provider Relationship Follow-Up

Dr. John Scott (UWM) [49:57]

Established Relationship Follow-Up

- (d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:
- ~~(i) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment…~~
- ~~(ii) For any other health care services:~~
- ~~(A) The covered person has had, within the past two years, at least one in person appointment, or, until January 1, 2024 July 1, 2024, at least one real time interactive appointment using both audio and video technology, with the provider providing audio only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio only telemedicine; or~~
- ~~(B) The covered person was referred to the provider providing audio only telemedicine by another provider who has had, within the past two years, at least one in person appointment, or, until January 1, 2024 July 1, 2024, at least one real time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio only telemedicine~~
- Bill text: Senate Bill 5821
- Senator Muzzall co-sponsored this bill
    - This bill passed out of committee, largely unanimously
    - The first rules meeting on this bill will occur this week
    - Washington State Medical Association and Washington State Hospital Association would like to see some changes. Members of the Legislature and their staff are working on revisions.
    - Senator Muzzall's plan is to get this bill to the House as soon as possible so that they can get this through their committee
    - There is much opportunity to get the bill's language amended
- At the last Collaborative meeting in November 2023, it was decided to have a subcommittee to further discuss the requirements of establishing a relationship prior to an audio-only telemedicine visit
    - Subcommittee met in late December 2023
    - There was clarification that there is no sunset date for behavioral health services, which recognizes the importance of behavioral and mental health
    - There was also recognition in the importance of access where there are many parts of Washington where there is not great bandwidth – phone is most likely the only option
        - Also the importance of access for patients who have mobility issues

- There was agreement that one year for an established relationship is too short and would not be consistent with other policies that indicate three years as a standard amount of time after which a patient is considered "new"
  - The recommendation is to standardize the approach to align with the three year definition of an established relationship
- Patient safety concerns were discussed when starting out a visit with phone only
- The overall recommendation from the subcommittee is to continue requiring an in person or audio-video visit and have this be in effect for three years

Questions/Discussion:

- Clark Hansen (ALS Association) has been working on this bill with Senator Muzzall. He shared that if this bill continues to have a sunset date of July 1, 2024, Washington will be the only state in the United States that has the requirement for a physical in-person visit to establish a relationship.
  - All other states do not have this requirement

Telehealth Access & Best Practices in Northern California

Dr. Katherine Kim (Consumer Health Informatics and Health Science; ACTIVATE and Community Connectivity Framework for Digital Health Equity) [1:13:05]

We Aimed to Address Community Challenges

- Initially created to maintain continuity of health services for patients in California community health centers and underserved communities during COVID-19
- **Individual digital health barriers**
  - Individual access to broadband
  - Individual access to up-to-date computing devices
  - Individual access to remote patient monitoring devices
  - Individual digital health literacy
- **Clinics and provider network digital health barriers**
  - Clinic staff and providers with digital experience
  - Technology solutions optimized to the clinic environment
  - Digital health programs adapted to culture and setting
  - Complete and interoperable data
  - Technical assistance and support

Overview

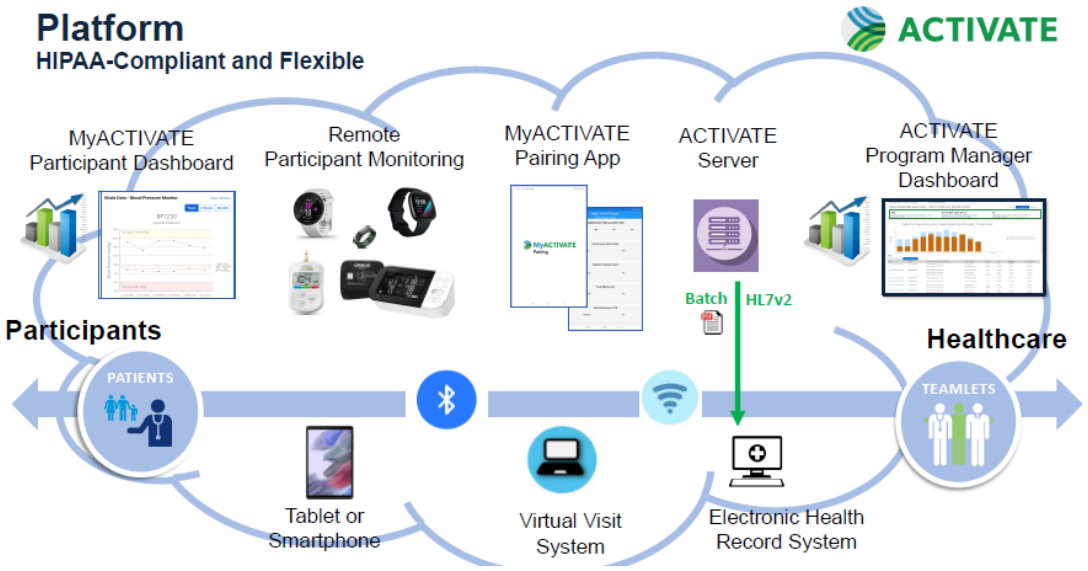
- A uniquely co-designed and flexible platform for remote monitoring and care coordination in underserved communities
- A model implemented in four California health centers

- Phased pre-post study (co-design, feasibility, pilot)
- **Demonstrated health outcomes in California's under-resourced settings**
  - Diabetes: Improvement of 3.5 points hemoglobin A1c
  - Hypertension: Improvement by 20 points systolic blood pressure and 4 points diastolic

Phase 1: Community Co-design Embedded with Agile Development Process

- Care team + participant + community co-designers

Platform



Phase 2: Technical Feasibility Assessment

- **Inclusion and exclusion criteria:**
  - Adults served in the FQHC
  - Diagnosis of diabetes mellitus with most recent hemoglobin A1c ≥ 8.0 (within 1 year)
  - Or diagnosis of essential hypertension with most recent blood pressure ≥ 140/80
  - Speak Spanish or English
  - No end stage or advanced disease
- 12 patients of health center recruited via phone call by health coach sequentially from list of eligible candidates
- Provided Bluetooth connected glucometer and/or blood pressure monitor, tablet with data plan if needed, ACTIVATE app, digital literacy assistance from digital navigator
- Assessed patient usage of technology, automatic transmission of data from devices, and accurate display of data in provider and health coach dashboard

Phase 3: Pre-post Pilot

- Pre- and post-intervention with outcomes included regularly collected hemoglobin A1c for participants with diabetes and blood pressure for those with hypertension

- Same inclusion criteria as feasibility phase
- Weekly 30 min program huddle with providers, health coach, digital navigator
- Health coaching enrollment visit and regular check-ins driven by patient and huddle (typically every 2 weeks)
- Health coach and digital navigator used ACTIVATE dashboard but health coach charted in EHR
- Provider telehealth or virtual visits as appropriate
- ACTIVATE data integrated into EHR for providers

Combined Results from California Health Centers (n=243 who started monitoring)

Characteristic Number (%)	All Adults 18 to 64 years (n = 243)	Older Adult Subgroup 65 years and older (n = 43)
Age, mean (range)	55.2 (31 – 83 years)	70.1
Female at Birth	95 (60.1%)	27 (62.8%)
Hispanic or Latinx	216 (88.9%)	34 (79.1%)
Spanish Primary Language	178 (73.3%)	32 (74.4%)
Diabetes	195 (80.3%)	31 (72.1%)
Hypertension	151 (62.1%)	31 (72.1%)
Remote Patient Monitoring Measures Transmitted in 6 months, number	41,675	9,979

Diabetes in Target Control: 3.5 point improvement in A1c (unpublished, rolling enrollment)

	All Adults Target 7 – 8 %		Older Adult Subgroup Target 7.5 – 8.5%	
Pre-Post Measures	Number of patients	Hemoglobin A1c % m (SD)	Number of patients	Hemoglobin A1c % m (SD)
Pre-enrollment	153	10.96 (1.89)	26	10.95 (1.55)
3-month[1]	153	7.89 (1.78)	26	7.47 (1.29)
3-month Change*		3.07 (2.72)		3.48 (2.19)
6-month [2]	89	7.57 (1.59)	16	8.28 (1.71)
6-month Change*		3.49 (2.50)		2.58 (2.38)

[1] Glucose readings over months 1-3 were averaged and converted to A1c using the ADA eAG to A1c conversion calculator[4]
[2] Glucose readings over months 4-6 were averaged and converted to A1c using the ADA eAG to A1c conversion calculator[4]
*Indicates reduction in measure

Hypertension in Target Control: 20 point improvement in systolic blood pressure (unpublished, rolling enrollment)

	All Adults Target below 130/80			Older Adult Subgroup Target below 140/90		
Hypertension	Number of patients	Systolic mmHG m (SD)	Diastolic mmHG m (SD)	Number of patients	Systolic mmHG m (SD)	Diastolic mmHG m (SD)
Pre-enrollment	70	151.46 (15.81)	82.61 (8.12)	20	156.55 (13.84)	78.05 (7.25)
3-month [3]	70	136.23 (16.64)	82.06 (9.88)	20	141.68 (15.41)	78.48 (9.91)
3-month Change*		15.23 (16.66)	0.56 (10.17)		14.87 (18.44)	0.43 (10.09)
6-month[4]	40	132.83 (16.52)	79.53 (9.73)	9	139.99 (13.41)	74.96 (6.50)
6-month Change*		19.51 (14.95)	4.34 (8.82)		17.56 (5.94)	5.04 (6.55)

[3] Blood pressure measures were averaged over month 3
[4] Blood pressure measures were averaged over month 6
*Indicates reduction in measure

Patient Quotes

- "I was very happy to see that someone worries about us and is checking up on the sick people… this program has motivated me a lot because before I was signed up for this program, well, I was checking my blood once a day, or sometimes once a week. Or once or twice a month, so, I didn't have this check-in that I have now. And that's motivated me, every day, to see the numbers I get, and sometimes I'm very happy, other times I don't know why it shows a bit high…"

  -Patient 536144
- "It has encouraged me to change my lifestyle because prior to ACTIVATE… I check my blood sugar… I didn't know the why behind it… But when I went to the Zoom classes and then I met [outreach worker] and [medical assistant health coach], and then they put it all together in perspective to me… it just made a world of a difference for me… It's making me want to do more, it's making me want to get better."

  -Patient 805014

Remote Participant Monitoring and Care Coordination Program

- Program Toolkit
  - **Digital Health Pathway Care Model**
    - RPM used by participants at home supported by Digital Health Navigator
    - Self-management supported by regular sessions with Health Coach by phone and video
    - Team-led huddles to coordinate care
    - Telehealth and/or in-person visits per usual care
  - **Planning**
    - Implementation checklist
    - Budget template

        - EHR health coach notes template
    - **Training**
        - ACTIVATE platform training
        - Health coach training
        - Digital health navigator training
    - **Outreach and Health Education**
        - Enrollment & readiness tool
        - Patient device usage agreement template
        - ACTIVATE flyers and videos
    - **Evaluation**
        - Data use agreement for analysis and evaluation
        - Outcomes data analysis template

Questions/Discussion:

- Given that ¾ of your patients are Spanish-speaking, what are some of the language challenges or barriers that patients encountered and how were you able to address them?
    - The application is only available in English at this time and there aren't any/enough resources to translate materials in Spanish
    - However, the intervention included health coaches who are bilingual, including in Spanish
    - Their educational videos are in English and Spanish narrations
        - Also included Hmong and Punjabi captions to accommodate this patient population
- Did the intervention also screen patients who may be traveling out of state during the monitoring period?
    - There was no screening for these patients as many of the patients that go to the FQHCs are migrant farm workers.
    - If there were any patients traveling out of state and they would like to keep monitoring during this time period, the program will continue to receive their calls
    - There were 2 patients who did not enroll in the program because they were going to be out of state and asked if they could call when they returned to start the program, which was acceptable
- Patients could do this program from any location including in agricultural fields because they were provided tablets and full data plans
- Without notifications and only a check in every two weeks, positive results were achieved and high participation rates were also maintained. What is your hypothesis on being able to maintain these positive results?
    - To clarify, this is data from only 2 health centers. Currently, the program as 400 patients, which results are being aggregated.
    - From Dr. Kim's first research project, she learned about the patient empowerment approach vs. a compliance approach towards changing patient behaviors.

        - Medical assistants are trained to call the patients and ask them what they think they need the most help with regarding their diabetes or hypertension. Then, they shared resources about the program and asked if patients would like to try this.
        - The purpose is not to enroll patients in the program, but talking to patients about what they needed and whether they were willing to try this program to meet their needs
        - When health coaches call during the two-week check-in, they start asking patients on their progress in the program and what they need from the health coaches.
        - This patient empowerment approach builds the relationship where the patient begins to trust in the program and staff, and believe that they are there for them – harness the patient's own motivation
- Were there any patients who declined to participate in the program?
    - Out of the 243 patients from the first two health centers, almost no patient declined.
    - The two patients who were traveling out of state asked if they could start the program when they returned, which was acceptable.
    - There were a few patients who were not in favor of using technology or did not know how to use technology. However, the program still asked them if there was anything else they could those patients with.
    - Overall, very few patients declined to participate, most likely due to the patient empowerment approach that they used for the program.
    - Dr. Kim does anticipate that the qualitative data will be different in the next health center sites as the health coaching approach is foreign to them, and the approach was more about enrollment/compliance vs. patient empowerment. These health centers reported more patient declinations.
        - Currently there is no data to support this, but Dr. Kim heard this anecdotally through these health centers.
- Is the toolkit applicable in other states?
    - Yes, the toolkit can be applicable in other states as there isn't anything unique to California.
    - The co-design process was tailored for each clinic.
    - Clinics would share their resources with each other for best practices.
    - The cultural aspects of the toolkit is more focused on farm worker communities and particular Spanish communities in California that is different from other states
- Could this toolkit be adapted to other types of services like mental and behavioral health?
    - Yes, this toolkit can be adapted. Dr. Kim did a small investigation of how the program can support mental health in primary care in the FQHCs (not specialty care) – looked into guided videos, web-based applications, printed materials that could be delivered through the application, etc.
    - Dr. Kim mapped out workflows and touch points for mental health in primary care. If there is remote monitoring (e.g. monitoring of sleep, etc.) and if it's delivery of medication tools or mindfulness applications, this can be delivered through the same infrastructure

        - The program is not a vendor system, but more of a platform-based where they tailor to the use case
    - Dr. Kim believes that there is a lot of applicability in mental health, maternal health, and adolescent health, which she is interested in trying to adapt this program for

Action Items

- If the Collaborative members have any further questions or have additional comments, reach out to Dr. Katherine Kim at kkim@mitre.org.

Uniform Telehealth Act

Michele Radosevich (Davis Wright Tremaine) [1:36:27]

Uniform Telehealth Act

- Bill Text: Senate Bill 5481 – Substitute
- Can follow progress of this bill at the Washington State Legislature here.
- The Act was passed unanimously on the Senate Floor on Wednesday, 1/24 (49-0). An agreed upon substitute version of the bill amended the language with the following:
    - Removes the definitions for "telemedicine," "store and forward technology," and "telemedicine services." Adds definitions for "telehealth" and "telehealth services," and replaces reference to "telemedicine" with "telehealth."
        - There are no carve-outs and all types of telehealth are authorized in Washington
    - Allows a provider to establish a relationship through telehealth.
    - Clarifies that an out-of-state practitioner may use telehealth services to consult with an in-state practitioner regarding a patient, but the in-state practitioner remains responsible for providing the care.
    - Prohibits a disciplining authority from adopting practice standards for telehealth that are different from in-person practice standards.
    - Adds a new section clarifying that this act does not require reimbursement for telehealth services if they do not meet the reimbursement requirements for telemedicine in statute.
    - Updates the due date for the Telemedicine Collaborative to review the idea of a registration system for out-of-state practitioners and to report back to the Legislature (Dec 2024)
- There was not much disagreement on the concept, but there was effort to make sure that the language was consistent with the Washington State Medical Commission's language in their policy on this area – this is in progress
- The Act will now move to the House Health Care & Wellness for consideration
- The Washington State Telehealth Collaborative is tasked with looking at the registration piece over the course of the next year to see if this would be an appropriate way to extend the availability of medical care in Washington state.
    - This can be subjected to change regarding defining this differently or revising the timeline

Action Items

- If the Collaborative members have any further questions or have additional comments, reach out to Michele Radosevich at MicheleRadosevich@DWT.COM.
- Dr. Scott / Mrs. Dinh Hsieh to review the language on the Collaborative's task in studying the registration piece of the Act

Wrap Up/Public Comment Period

[1:58:50]

- Next meeting: Monday, March 18, 2024 at 10:00 am – 12:00 pm
- Meeting materials, including presentation slides and recording, will be posted on the Collaborative's website and sent out via the newsletter
- Changes related to the 2024 Physician Fee Schedule
- Does CMS require clinicians who are doing telemedicine visits from their home to register their home address?
    - As stated in the 2024 Physician Fee Schedule, you do not have to register this.
- What are the changes around hospital-based facility fees per the 2024 Physician Fee Schedule?
    - This ended with the pandemic and the Hospital Without Walls provision expiring. There are new schedules for place of service (POS) 10 and 2, which are based on where the patient is.
    - To view all of the changes from CMS's 2024 Physician Fee Schedule, please see this link: https://www.cms.gov/files/document/mm13452-medicare-physician-fee-schedule-final-rule-summary-cy-2024.pdf

Action Items

- Collaborative members to share agenda topics for future Collaborative meetings and email them to Dr. Scott / Mrs. Dinh Hsieh

Tentative Next Meeting Items:

Interstate Licensure Updates
Presentation from a new Collaborative member

Meeting adjourned at 11:30 am

Next meeting: March 18, 2024: 10 am-12 pm
Via Zoom.