FAQs about DMS Telehealth Regulation (907 KAR 3:170)

Entries as of August 12, 2022:

1. Does this administrative regulation incorporate recent state legislation such as SB 112 and HB 140?

Yes, administrative regulations are subject to and governed by any statutes that address the same subject. Consistent with KRS Chapter 13A, DMS is required to follow the definitions and practice standards that are contained in KRS Chapters 205 and 211. DMS has incorporated those requirements in drafting this administrative regulation. It is DMS' belief that this administrative regulation establishes a clear statement of the current law relating to telehealth. This administrative regulation is intended to provide guidance and clarity to practitioners in this area. DMS is committed to monitoring and revisiting this administrative regulation as state and federal laws change.

2. Does the regulation require a provider to offer in-person care? In addition, are telehealth-only providers required to offer in-person care?

No, the regulation does not require a provider – including a telehealth-only provider – to offer in-person care if the service is otherwise eligible for telehealth. The regulation allows the provider to provide the encounter via synchronous telehealth or in-person. It is up to the provider which type of encounter is offered (the regulatory language says "or"). The synchronous telehealth option was provided specifically to allow telehealth-only providers to continue to participate. To reiterate, telehealth-only providers are not required to provide in-person visits as a result of Section 2. Section 2 is intended to protect recipients by allowing them to continue to have direct face-to-face interactions with providers *if the recipient chooses.* If providers are securing patient consent prior to offering asynchronous or audio-only encounters then DMS does not expect issues with the provision of these types of care as long as it meets federal and state laws and regulations, professional standards, and correct coding guidelines.

3. Can you explain further some of DMS' concerns about asynchronous telehealth?

A major goal of DMS in implementing expanded telehealth has been to ensure that Medicaid recipients have the same options as other individuals within the healthcare system. Our concern has been that providers will decide to only see Medicaid recipients via audio-only or asynchronous telehealth, preventing direct provider interaction (synchronous or in-person). Beyond granting recipients the right to request a synchronous or in-person service, DMS does not restrict the practice of telehealth. A recipient who wants asynchronous or audio-only telehealth will still be able to get it if it is offered by their provider. A provider, however, should not restrict patients to receiving a certain type of care when they request other options.

4. Can licensure boards further narrow when telehealth is appropriate?

Yes, the scope of practice, qualifications, and capacities of every licensed provider are determined by the provider's licensure board. Consistent with state law, those boards have the authority to restrict or expand their provider's telehealth practice. It is important to emphasize that DMS does not have any ability to control the Commonwealth's licensure boards. The regulation as written allows for Medicaid providers to provide telehealth to the maximum extent that Medicaid can grant. If another initiative – whether executive, judicial, or legislative – were to require the licensure boards to all meet a specific consistent standard, then this regulation as drafted will already authorize the new standard. However,

and as an example, Medicaid can't allow a provider type to provide services that are outside the scope of their licensure and continue to receive federal financial participation for that service. As written, the regulation attempts to be provider-friendly by clearly stating that they can provide any modality of telehealth that is allowed by their licensure board, and not otherwise restricted by federal or state laws and regulations or correct coding guidelines.

5. Does Medicaid intend to craft billing codes to restrict the adoption of telehealth?

Not at this time. It is important, however, to acknowledge the content of the definitions and descriptions of the billing codes that are used by DMS. While none of the "H" codes covered by DMS have an audiovisual requirement, the current state of many codes issued by groups such as the CPT codes of the American Medical Association contain an explicit audiovisual requirement for certain telehealth services. In the limited circumstances where DMS creates the code, they will be subject to this administrative regulation as well as KRS 205.559 and 205.5591. DMS is committed to continuing the expansion of telehealth as technology and federal and state law allows.

6. Can a provider be physically outside the U.S. and deliver services?

DMS' understanding of current federal law is that providers have to be located within the U.S. when providing services. DMS would direct your attention to State Medicaid Director letter 10-026 and 42 U.S.C.1396a(a)(80). If this federal policy and federal statute were to change, DMS would revisit this section. DMS agrees that some providers may have the need and ability to provide services while out of the country temporarily, however federal law currently precludes this option.

7. Can a MCO charge a lower rate for telehealth than for in-person care?

Yes, differential pay was included in HB 140, and DMS does not have the authority to force the MCOs to reimburse identically for telehealth. In fact, in Section 4(1)(b) DMS provides a citation to the controlling state statute that allows for a different rate to be established. (KRS 205.5591(2)(a)1.). While DMS is in favor of identical pay for in-person and telehealth services, state statute specifically prohibits this. If the state statute were to change, DMS would amend this regulation to conform.

8. Why does this regulation not establish a single consistent telehealth standard across Kentucky's healthcare system?

A consistent standard for telehealth is a worthy goal, however, current Kentucky law continues to establish multiple standards. This regulation simply reflects the current reality that licensure boards and scopes of practice differ between provider types. DMS can only expand telehealth to the extent providers are limited by other legal restrictions. In particular, the Medicaid program must be compliant with federal laws and regulations governing how services are to be covered. Section 3 of this administrative regulation is meant to reflect the current state of telehealth and to be an aid to providers in providing care.

9. When does the 3 week time limit start for a request of a synchronous or in-person visit? For example, if a patient has an asynchronous telehealth visit scheduled in five weeks but makes the request at scheduling for the visit to be in-person or via synchronous telehealth instead, does this provision require the provider to schedule the patient within three weeks of that request instead of in five weeks, near the time of the originally planned telehealth visit?

DMS understands the ambiguity between the potential start dates in this section. DMS will operationalize the regulation to begin on the date of the offered asynchronous encounter and not on the scheduling date. Therefore, a request to reschedule should be within 3 weeks of the offered appointment date by the scheduler. To use the example above, the synchronous or in-person visit scheduled within 3 weeks of the date of the audio-only or asynchronous visit scheduled in 5 weeks would meet the requirements of this section.

Please note that this section is only relevant for asynchronous or audio-only encounters that are offered by a provider. If a provider offers a synchronous telehealth visit, or if the recipient requests an asynchronous or audio-only visit then this section does not apply.

10. Does this regulation establish an affirmative duty for a patient, patient’s guardian, other providers, or MCO to report a provider’s failure to schedule a requested synchronous or in-person visit?

No, DMS does not interpret this language as establishing an affirmative duty to report. Rather, the “shall” in the regulation refers to the manner of reporting the failure to accommodate. The individuals involved still retain discretion in whether to report the failure. If any of the listed entities choose to report, they must do so to the Cabinet’s Office of the Ombudsman and Administrative Review.