Preserve Telehealth Access Act of 2021

Chapter 70 and Chapter 71 of the Laws of Maryland require the Maryland Health Care Commission (MHCC) to study the impact of telehealth and develop recommendations on telehealth coverage and payment levels relative to in-person care. The law tasked the Maryland Insurance Administration (MIA) with a limited scope study on the role of telehealth in the context of network adequacy. This document overviews recommendations informed, in part, by a technical findings report prepared by the National Opinion Research Center. A final recommendations report was submitted to the Senate Finance Committee and House Health and Government Operations Committee. For more information, visit MHCC's website.

RECOMMENDATIONS

Justifications are not inclusive of all supporting rationale; see final recommendations report for more information

Coverage, Technology, and Payment Levels/Future Study

1. Continue to allow use of telehealth by any health care provider licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program, or for interprofessional consultation.

   Broadens access to care for underserved and vulnerable populations; ensures telehealth remains an option for providers and consumers

2. Allow a health care provider capable of providing telehealth services using audio-visual technology to deliver services using audio-only technology. Allow use of audio-only for somatic care in the event of an audio-visual technology failure, a request by the patient, or at the clinical discretion of a treating health care provider without requiring documentation in the clinical record. Allow unrestricted use of audio-only for behavioral health based on patient consent to receive care via audio-only technology.

   Promotes equitable access to care especially when circumstances prevent use of audio-visual technology (e.g., unavailable or unreliable broadband); maintains access to care, particularly for behavioral health care services, which account for the highest share of audio-only encounters

3. Allow health care providers using remote patient monitoring to obtain consent at the time services are initiated for new and established patients. Allow remote patient monitoring technologies to minimally collect two days of data over a 30-day period.

   Enables providers to more timely identify and treat health concerns; improves patient engagement, the collection of health metrics, and outcomes, particularly patients with chronic conditions

4. Allow a health care provider to use telehealth to provide hospice care services consistent with their profession standard of care to patients in a facility or at home.

   Eliminates barriers in geography and provider shortages to improve quality end-of-life care; supports identification of changes in functional decline and disease progression to allow earlier interventions and less urgent care

5. Allow telehealth services to be furnished in a hospital inpatient setting and in a nursing home setting. Require a minimum of at least one in-person visit by any treating physician 24 hours following a telehealth hospital inpatient encounter. Require one in-person visit by any treating physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter in a nursing home setting.

   Expands access to specialty providers to detect clinical deterioration and treat patients in place; ensures flexibility in hybrid models of care with safeguards to evaluate certain health conditions in-person

6. Require health care providers to utilize communications technology that complies with privacy and security requirements established by the Office for Civil Rights at the U.S. Department of Health & Human Services to qualify as a telehealth distant site.

   Ensures even baseline protections for privacy and security

7. Continue payment levels for telehealth services relative to in–person care for 24-months. Require MHCC to study payment parity for audio-visual and audio-only technologies and submit a report to the Maryland General Assembly by December 1, 2024 that addresses the following:

   - ✓ Does it cost more or less for providers to deliver telehealth;
   - ✓ Does telehealth require more or less clinical effort for a provider;
   - ✓ Are there aspects of telehealth that yield lower value, overuse, or conversely greater value that inform the debate on payment parity
   - ✓ The adequacy of reimbursement for behavioral health care services delivered in-person and by telehealth
   - ✓ Any other findings and recommendations

   Allows more time to gather data needed to formulate evidence-based recommendations that take into consideration the extent telehealth affects quality and cost, and its impact on health equity; ensures continued focus on identifying and applying lessons learned from the pandemic, coupled with payment and care delivery reform to more broadly address issues affecting behavioral health care

Clarification of Terms *(proposed language is intended to clarify, not replace, select terms in statute)*

8. Behavioral Health – Includes mental health and substance use conditions, life stressors and crises, stress-related physical symptoms, and health behaviors (Health General).
9. Communication Technology-Based Services – Includes a variety of non-face-to-face patient care communications, such as two-way audio-only telephone interactions, remote evaluation of patient videos and images, virtual check-ins, e-visits, and remote patient monitoring (Health General).
10. Established Patient – Means an individual who receives professional health care services from a provider, or another provider who belongs to the same group practice, within the previous three years (Insurance Article).
11. Telehealth Consent – Means an affirmation received prior to or upon initiation of a telehealth encounter from the patient, family member, or caregiver for an audio-video or audio-only encounter and documented in the patient record (Health General).
12. Telehealth – Includes the delivery of medically necessary somatic, dental, or behavioral health services to a patient at an originating site by a distant site provider through communications technology (e.g., synchronous and asynchronous) that includes the use of audio-visual or audio-only technology to permit real-time interactive communication (Health General).

MIA Recommendations

13. Allow the MIA to retain the latitude currently granted by the legislature under § 15-112(d)(2)(viii) of the Insurance Article, which states: "In adopting the [network sufficiency] regulations, the Commissioner may take into consideration …other health care service delivery options, including telemedicine, telehealth…"

    New legislation restricting telehealth considerations for network adequacy would hinder the MIA's ability to determine the most effective ways of leveraging telehealth to enhance network sufficiency

14. Consider whether to permanently codify telehealth coverage expansions for health benefit plans into State law.

    Widespread support from consumers and providers for greater telehealth coverage in the insured market; absent legislation, market uniformity cannot be ensured and carriers would not be prohibited from retracting pandemic-related expansions in telehealth coverage

15. Consider whether to codify additional prohibitions on telehealth-only benefits or telehealth-first benefits for health benefit plans into State law.

    Absent legislation, carriers would be permitted to offer plans in Maryland where telehealth benefits replace or restrict access to coverage for certain in-person services; policy considerations for this item include market demands, pricing impacts, chilling effect on product innovation, consumer convenience, and patient/provider preferences related to telehealth