Telehealth Policy Workgroup

January 7, 2021 | 3:00pm-5:00pm EST

Register for Zoom Meeting:

us02web.zoom.us/meeting/register/tZEvdu6spj8sHdGEK5bfhhoncwbw0B5Wfzkj

Agenda

I. INTRODUCTIONS

II. OPENING REMARKS

III. PRESENTATION – DRAFT GENERAL FINDINGS

IV. NEXT STEPS

- Meeting summary and recording
- Information brief release
- Other

Telehealth Policy Workgroup

DRAFT GENERAL FINDINGS – JANUARY 7, 2021

BACKGROUND

The Maryland Health Care Commission (MHCC) convened the Telehealth Policy Workgroup (workgroup) in fall 2020 to discuss select telehealth policy changes temporarily implemented in response to the COVID-19 public health emergency (PHE). The goal of the workgroup was to consider policies that should continue beyond the PHE. The General Findings derive from key themes that emerged during workgroup meetings; these should not be viewed as consensus among workgroup participants.

KEY POLICY CATEGORIES

1. **Removing telehealth restrictions on originating sites** *(included in MHA proposed legislation – 2021 session)*

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
- Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE

B. Modify the definition of originating site to recognize any patient setting where care can be delivered based on consumer needs and preferences, and provider clinical judgement and guidelines on health, safety, and security

- Expanding permissible care delivery sites for telehealth services helps address care access gaps in rural, vulnerable, and underserved populations

Primary Themes

- The need to rely on providers' clinical judgment and consumers' preferences to determine appropriateness
- Removing geographic and originating site restrictions promotes greater access to care, particularly for underserved populations
- Broader use of telehealth can assist in reducing the total cost of care
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion

- A concern that policy changes may be implemented prematurely and will require modification when sufficient data is collected and appropriately analyzed
- Gaps remain (e.g., lack of technology, digital literacy, and access to high-speed internet) that need to be addressed to close health disparities for rural, underserved, and vulnerable communities

2. <u>Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate</u> *(included in MHA proposed legislation – 2021 session)*

General Findings

A. Collect and analyze data to inform policy development

   - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
   - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE

B. Support greater State and federal telecommunications infrastructure investment in less-resourced communities and health care facilities to ensure greater access and use of telehealth

   - Many rural areas lack sufficient broadband to support widespread adoption of telehealth

Primary Themes

- Provides an alternate and easily accessible modality to render care and seek treatment based on provider judgment and consumer preference
- Helps address health care inequities, especially for underserved and underrepresented populations
- Addresses challenges associated with adopting health information technology for resource-limited providers
- Variations exist in determining a method and rationale for payment parity with in-person visits
- Considering audio only as a time-limited transition service to live-visual encounters when statewide access to broadband and other needed technology is achieved
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Balancing expanded access to care and the potential for health, safety, and security concerns

3. <u>Removing telehealth restrictions on conditions that can be treated</u> *(included in MHA proposed legislation – 2021 session)*

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
- Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE

B. Educate consumers on telehealth and services that are appropriate to receive via telehealth

- Develop a consumer education strategy to increase awareness of appropriate care that can be provided via telehealth

C. Adopt uniform behavioral health telehealth use policies that improve access

- Harmonize payer behavioral telehealth access policies to enable timely and coordinated care and improved patient outcomes

Primary Themes

- Fosters timely and coordinated care and may lead to improved patient outcomes and decreased avoidable hospital admissions and emergency department utilization
- Requires consumer education to promote understanding and awareness of the role of telehealth and how to navigate the technology
- Lessening prior authorization requirements for behavior health to expand access, promote patient safety, and avoid adverse outcomes
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion

4. <u>Removing telehealth restrictions on provider types</u> *(included in MHA proposed legislation – 2021 session)*

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed

- Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE

B. Allow licensed health care providers to treat using telehealth within their scope of practice based on consumer preference, provider clinical judgement, and existing guidelines on health, safety, and security

- Expanding provider types helps address provider shortages
- Broadened access reduces hospital readmissions and emergency department utilization

Primary Themes

- Helps address geographic barriers and workforce shortages
- Concern among payers on the potential financial impact of expanded services and a limited Medicaid budget
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Increases potential for health equity, consumer choice, and access to health professionals
- The need for provider training on virtual care delivery and consistency in guidelines

5. <u>Reducing or waiving cost sharing for telehealth services through the end of the PHE or until December 31, 2021, whichever occurs last</u>

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
- Federal requirements on high-deductible plans may impact flexibility to make changes
- Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE

B. Differing cost sharing requirements for an in-office visit versus a telehealth visit may have disproportionate effects on payers and consumers

Primary Themes

- May increase access to care and reduce health implications associated with deferred care
- Educate consumers on appropriate conditions for a telehealth visit

- Supports equitable access to care for underserved populations
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed

6. <u>Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal PHE</u>

General Findings

A. Allow existing OCR telehealth enforcement discretion policies to sunset at the end of the PHE without State intervention
    - Assess the impact of non-HIPAA compliant technology usage on privacy and security during the PHE

Primary Themes

- The utility of non-public facing applications during the PHE does not offset the risks to privacy and security
- Allowable communication options include practice patient portals and secure messaging
- Costs to invest in HIPAA-compliant telehealth infrastructure may stunt provider adoption
- Addressing implications on consumer access and satisfaction

Telehealth Policy Workgroup

POLICY DISCUSSION ITEMS

1: Removing telehealth restrictions on originating sites	
BENEFITS **Providers** • Expands ability to offer telehealth • Avoiding unnecessary utilization (e.g., hospital/emergency room, SNF admissions) • Reduced no-show rates • Increased opportunity to use remote patient monitoring for high-risk patients and chronic care management • Supports care coordination and transitions between care settings with more immediate follow-up • Improves access to interprofessional team care (e.g., social worker, pharmacist) and communication • Potential decreased costs associated with "brick and mortar" facilities • Increases ability to quickly respond to acute non-emergent situations • Allows timely treatment/therapy adjustments when viewing patient in their natural environment • Preservation of protective personal equipment • Ability to assess patients' home environment **Payers** • Greater access and engagement for members • Supports care delivery at the lowest cost setting and potential for reduced health care costs (e.g., Medicaid transport costs) **Consumers** • Expands access to care and flexibility in seeking services • Mostly comfortable with technology • Consumer choice/preference and comfort to receive services where they want (e.g., minimize stigma for seeking certain services) • Increases patient engagement, self-management, and satisfaction in their health care • Increases the potential for health equity • Reduces barriers to care (e.g., financial, transportation, childcare, debilitating conditions, time off work, etc.) • Promotes infection control and public safety	**UNINTENDED CONSEQUENCES** **Providers** • Potential risks to privacy and security of PHI in some circumstances • The ability to accurately diagnose • The impact on patients due to reduced regulatory oversight of providers • Potential loss of local providers/services • Concerns over increases of fraud allegations • Potential lack of comfort with technology and communicating virtually with patients **Payers** • Overutilization of health services • Potential for delivery of partial care **Consumers** • Access and communication barriers for certain populations due to age, socioeconomic status, technology literacy, vision/hearing impairments, etc. • Duplication of services, virtually and in-person • Possibility of pressure to have a telehealth visit against one's preference

PERMANENCY CONCERNS

Providers

- Uneven opportunity across providers due to technology access and infrastructure challenges (e.g., broadband internet, data)
- Addressing challenges of patient engagement in care; no clear pathway to address health literacy and digital divide issues
- Ability to adapt to rapidly changing guidelines

Payers

- Alignment across payers in defining originating site (e.g., home is anywhere) and reimbursement policies
- Impact on Total Cost of Care Model is unknown
- Need to assess metrics pertaining to quality, cost, utilization, and patient outcomes to understand impact
- Facility fee concerns

Consumers

- Infrastructure and technology challenges could impede access, particularly for underserved communities
- Ensuring comfort and appropriate use of the technology
- Need to assess patient satisfaction data to inform policy and training programs

OTHER

Providers

- Consider removing originating site restriction requiring staff to be on site to bill facility fee
- Monitor federal efforts to permit expansion of originating sites

Payers

- Consider CMS guidance and Medicare policies on originating site and payer alignment
- Monitor and analyze quality and cost data to inform policy and advance positive health outcomes

Consumers

- Need for parallel in-person and telehealth pathways
- Continued need for financial support and opportunities (e.g., grants) without geographic restrictions to improve technology infrastructure

Non-Specific

- Inclusion of telehealth training in provider education, accreditations and certifications
- Determination of what constitutes an originating site

PRIMARY THEMES

- The need to rely on providers' clinical judgment and consumers' preferences to determine appropriateness
- Removing geographic and originating site restrictions promotes greater access to care, particularly for underserved populations
- Broader use of telehealth can assist in reducing the total cost of care
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion
- A concern that policy changes may be implemented prematurely and will require modification when sufficient data is collected and appropriately analyzed
- Gaps remain (e.g., lack of technology, digital literacy, and access to high-speed internet) that need to be addressed to close health disparities for rural, underserved, and vulnerable communities

Removing telehealth restrictions on originating sites

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
  - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Modify the definition of originating site to recognize any patient setting where care can be delivered based on consumer needs and preferences, and provider clinical judgement and guidelines on health, safety, and security
  - Expanding permissible care delivery sites for telehealth services helps address care access gaps in rural, vulnerable, and underserved populations

2: Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate

BENEFITS

Providers

- Supports care management and continuity (e.g., chronic care management, follow ups, behavioral health, medication therapy management)
- Supports care delivery during public health emergencies (e.g., COVID-19, natural disaster, etc.)
- Increases ability to quickly respond to acute non-emergent situations
- Expands opportunities to provide patient education
- Provides an option to deliver care when audio-video connection is not accessible or feasible

Consumers

- Allows flexibility to receive services that aligns to their preferences
- Greater likelihood for equitable access to care, particularly for vulnerable populations or patients with limitations (e.g., technology, broadband internet, digital literacy, unstable housing) or when other options (e.g., video visits, in-person) are not available
- Ease of access, particularly for older populations and individuals with limited access to technology

UNINTENDED CONSEQUENCES

Providers

- Increased risk for siloed care/lack of documentation within the EHR if not integrated into care delivery workflows (e.g., video visits and in-person)
- Potential for duplication of services
- Increased risk for missed diagnoses and miscommunication
- May impede provider adoption of video visits

Payers

- Understanding implications of services provided outside a regulated space
- Potential confusion on appropriate use requirements and uneven reimbursement policy across payers, insured and self-insured business
- Potential for billing of new, additional, or duplicate services
- Potential increase of fraud and abuse

Consumers

- Unaware of financial liability for associated services
- Potential to create inequities for patients only able to access audio-visual care
- Potential risks to privacy/confidentiality of visit in certain situations (e.g., domestic violence cases)
- May limit provider/consumer engagement during the visit

PERMANENCY CONCERNS

Providers

- Defining reimbursement levels for audio only services (e.g., payment parity based on provider time or technology used – audio-only; audio and video; audio, video, and RPM)
- Determining services appropriate and effective for audio only
- Lack of guidelines on appropriate uses and processes (e.g., verifying patient identity) resulting in greater risk of liability
- Potential standard of care issues and practice workflow challenges (e.g., standardizing documentation of audio-only visit within EHRs)
- Impact of prior authorization on access

Payers

- Challenging to formulate reimbursement policies (e.g., length of call, visit type, duplicity/coordination of services, who initiates call) and alignment across payers
- Establishing guidelines for determining appropriate services once data from PHE is collected and analyzed
- Long-term effect on care quality, cost, and outcomes unknown

OTHER

Providers

- Need for parity in payment with services provided by telehealth

Payers

- Consider a time-limited phase out approach to allow adequate adoption and use of telehealth by providers and consumers
- Need time to conduct an impact evaluation of audio only services during the PHE on utilization, access, quality, safety, and efficacy

Consumers

- Need for policies to remain patient-centric

Non-Specific

- Use should be based on patient and provider preferences and clinical judgement
- Permit audio only services due to necessity (e.g., rural facilities with lack of broadband)
- Consider MTM comprehensive and targeted review services as reimbursement model

- Demand beyond PHE is unknown
- Determination of quality metrics

Consumers

- Educating consumers on appropriate uses
- How to address language and physical barriers (e.g., hearing and eyesight)
- Need for clarification on copayments/coverage

PRIMARY THEMES

- Provides an alternate and easily accessible modality to render care and seek treatment based on provider judgment and consumer preference
- Helps address health care inequities, especially for underserved and underrepresented populations
- Addresses challenges associated with adopting health information technology for resource-limited providers
- Variations exist in determining a method and rationale for payment parity with in-person visits
- Considering audio only as a time-limited transition service to live-visual encounters when statewide access to broadband and other needed technology is achieved
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Balancing expanded access to care and the potential for health, safety, and security concerns

Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate

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  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Support greater State and federal telecommunications infrastructure investment in less-resourced communities and health care facilities to ensure greater access and use of telehealth
  - Many rural areas lack sufficient broadband to support widespread adoption of telehealth

3: Removing telehealth restrictions on conditions that can be treated

BENEFITS

Providers

- Reduces avoidable hospital admissions and emergency department utilization
- Enables remote patient monitoring (e.g., for mental health and other targeted medication adherence, chronic care management) and rapid interventions when needed
- Relies on providers' clinical judgment
- Holds telehealth visits to same outcome measures as in-person visits
- Promotes more coordinated and interprofessional care
- Allows consistency across payers

Payers

- Potentially reduces costs associated with avoidable hospital admission and emergency department utilization

Consumers

- Allows for more immediate and expanded access to care
- Creates a consumer-centered system of care that accommodates patient needs and preferences (e.g., reduces travel and scheduling challenges, convenience)
- Greater coordination of services, particularly if comorbidities are present
- Promotes access to specialty care, especially for high-risk patients

UNINTENDED CONSEQUENCES

Providers

- May reduce care efficacy of certain services
- Potential risks to patient safety (e.g., certain symptoms may be missed without in-person physical exam)
- Lack of data to determine which conditions can be effectively treated using telehealth

Payers

- Risk of overuse, potential for duplicate services resulting in an increase in health care costs
- Potential negative impact on health care quality
- Possibility of additive rather than substantive services

Consumers

- Confusion could occur when treatment plan is verbal
- Patient dissatisfaction with care services resulting in complaints/dissatisfaction
- Confusion around benefit coverage and out-of-pocket costs

PERMANENCY CONCERNS

Providers

- Malpractice concerns due to increased liability
- Lack of condition-specific telehealth processes
- Re-engineering practice workflows to support the effective use for new conditions
- Support needed to conduct certain services within the home

Payers

- Lack of standards around appropriateness of care
- Lack of data to determine the impact on access, cost, and quality

Consumers

- Increased demand on primary care providers could hinder access/availability

OTHER

Providers

- Prior authorization for behavioral health services may limit access
- Barriers significantly differ depending on geographical location of patients
- Need alignment for conditions appropriate via telehealth and payer reimbursement
- Some conditions and treatments may be limited by federal laws (e.g., medication assisted treatment)
- Need updated provider training (education and professional

Payers

- Compliance oversight

Consumers

Non-specific

- Need for ongoing data collection and analysis to assess policies and ensure they support positive health outcomes
- Compliance with federal anti-discrimination laws (e.g., Mental Health Parity and Addiction Equity Act, American with Disabilities Act)

PRIMARY THEMES

- Fosters timely and coordinated care and may lead to improved patient outcomes and decreased avoidable hospital admissions and emergency department utilization
- Requires consumer education to promote understanding and awareness of the role of telehealth and how to navigate the technology
- Lessening prior authorization requirements for behavior health to expand access, promote patient safety, and avoid adverse outcomes
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion

Removing telehealth restrictions on conditions that can be treated

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- Collect and analyze data to inform policy development
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  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Educate consumers on telehealth and services that are appropriate to receive via telehealth
  - Develop a consumer education strategy to increase awareness of appropriate care that can be provided via telehealth
- Adopt uniform behavioral health telehealth use policies that improve access
  - Harmonize payer behavioral telehealth access policies to enable timely and coordinated care and improved patient outcomes

4: Removing telehealth restrictions on provider types

BENEFITS

Providers

- Supports interprofessional team care, especially if providers are in different locations
- Helps address workforce shortages and funding limitations, especially for specialists (e.g., behavioral health providers)
- Increased timeliness and continuity of care
- Provides flexibility in staffing models (e.g., use of non-licensed or certified staff)
- Allows consistency across payers

Consumers

- Increased access to a broader range of provider types
- Reduces challenges associated with scheduling and travel
- Promotes care consistency
- Greater potential to address social determinants of health
- Supports consumer choice

UNINTENDED CONSEQUENCES

Providers

- Potential impact on patient safety (e.g., certain symptoms may be missed without in-person physical exam)
- Provider avoidance of telehealth due to lack of comfort
- Ensuring adequate provider training
- Potential decline of established patient-provider relationship and continuity of care (e.g., patients see different provider for each visit)

Payers

- Over or underutilization due to the lack of treatment guidelines

Consumers

- Potential confusion on what is covered

PERMANENCY CONCERNS

Providers

- Lack of existing reimbursement for certain provider types (e.g., pharmacists, home health, etc.)
- Potential for wide-range variation in provider determination as to the appropriate service delivery method
- Level of accountability
- Equity in decision making (e.g., discretion)
- Need for coordination among care team

Payers

- Need more data on value, cost, access, and quality
- Lack of standards to determine medically appropriate provider types
- Payment constraints in setting service rates for Medicaid (e.g., lack of flexibility in lowering rate to FQHCs for telehealth services)

Consumers

- Lack of quality measure ratings available to assess provider effectiveness in virtual visits

OTHER

Providers

- Restrictions should align with scope of the license
- Consider federal and State policies related to use of compacts and implications for practicing across borders
- Trust in providers' clinical judgement

Payers

- Need a method to address quality concerns/complaints

Consumers

- Need for education on seeking care from appropriate providers

PRIMARY THEMES

- Helps address geographic barriers and workforce shortages
- Concern among payers on the potential financial impact of expanded services and a limited Medicaid budget
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Increases potential for health equity, consumer choice, and access to health professionals
- The need for provider training on virtual care delivery and consistency in guidelines

Removing telehealth restrictions on provider types

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    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Allow licensed health care providers to treat using telehealth within their scope of practice based on consumer preference, provider clinical judgement, and existing guidelines on health, safety, and security
    - Expanding provider types helps address provider shortages
    - Broadened access reduces hospital readmissions and emergency department utilization

5: Reducing or waiving cost sharing for telehealth services through the end of the public health emergency or until December 31, 2021, whichever occurs last

BENEFITS

Providers

- Incentivizes flexibility in providing care
- Reduces risks associated with COVID-19 positive or presumed positive patients from presenting in-person for care

Increases stability and continuity of care

Payers

- Increased timeliness of care may reduce the risk of deferred/delayed care and increased costs to the health care system

Consumers

- Addresses access to care issues
- Supports financial equity in care, especially for those whose employment has been disrupted
- Greater likelihood that consumers will seek care rather than deferring
- Decreases exposure to COVID-19 and other infectious diseases
- Promotes care continuity and management

UNINTENDED CONSEQUENCES

Providers

- Potential confusion on reimbursement and covered services resulting from variation in coverage across payers (e.g., COVID-19 related services vs. unrelated services, audio only vs. video visits)

Payers

- Potential for inappropriate utilization of telehealth
- May promote and incentivize use of telehealth over in-person visits
- Lack of clarity on which plans must comply

Consumers

- Nuances in payer policies could create confusion on final billed amount (e.g., out-of-network providers, self-insured plans)
- A risk that higher cost-sharing for in-person visits (compared to telehealth) could create inequities in care delivery

PERMANENCY CONCERNS

Providers

- Differing reimbursement structure than in-person visits
- Financial impact on providers due to lost revenue
- Abrupt discontinuation of telehealth when financial benefit stops

Payers

- Potential for overutilization of services and duplicative services
- Funding – Medicaid

Consumers

- Risk that quality of care will be negatively impacted as the volume of virtual care increases system wide

OTHER

Providers

- Consider comparable or commensurate compensation to in-person visits

Payers

- Defer on making a policy recommendation until more data is gathered and analyzed
- The need for flexibility to be nimble and innovative in addressing PHE

Consumers

- Applying copayments in the same manner as in-person visits after PHE ends
- The need to address co-payments collection for those without credit cards
- Coverage options when in-network providers are not adequate or available

PRIMARY THEMES

- May increase access to care and reduce health implications associated with deferred care
- Educate consumers on appropriate conditions for a telehealth visit
- Supports equitable access to care for underserved populations
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed

Reducing or waiving cost sharing for telehealth services through the end of the public health emergency or until December 31, 2021, whichever occurs last

DRAFT – GENERAL FINDINGS

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  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Differing cost sharing requirements for an in-office visit versus a telehealth visit may have disproportionate effects on payers and consumers

6: Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal public health emergency

BENEFITS

Providers

- Lessens privacy and security concerns
- Improves the quality of telehealth encounters
- Increased likelihood technology integration exists with electronic health records
- Fewer workflow challenges

Payers

- Reduces risk of unauthorized access to a patient's protected health information

Consumers

- Ensures adequate protection around privacy and security
- Builds consumer confidence in the use of telehealth

UNINTENDED CONSEQUENCES

Providers:

- Adopting telehealth will require a financial investment in the technology

Consumers

- Potential barrier to access (e.g., patients not allowed to manually send symptoms/vitals to providers, or broadband internet limitations)
- Applications are not always user friendly and may require downloading multiple technology solutions
- Limitation on patient choice

PERMANENCY CONCERNS

Providers

- Costs to invest in a HIPAA-compliant telehealth solution, particularly for small practices
- Solution integration challenges with EHRs
- Addressing barriers to implementation, particularly for those serving underserved communities

Payers

- The risk that payers could be held accountable for technology adoption choices of providers by OCR

Consumers

- Can limit use if applications are oversized
- Burnout by "yet another application" to download
- Challenges in becoming familiar with multiple telehealth solutions

OTHER

Providers

- Consider relaxation of HIPAA-compliant technology under certain circumstances (e.g., documented emergency situations)
- Lack of interoperability for technology that is not HIPAA-compliant
- Need for support in navigating telehealth technology vendor market
- Consider audio only reimbursement or alternative technology options when HIPAA-compliant technology is not feasible/accessible
- Consider reimbursement for services delivered via patient portals, secure messaging, etc.

Payers

- Use caution in adoption legislation that may hinder the evolution of telehealth technology
- Monitor OCR guidance

Consumers

- Need for easy-to-use technology

PRIMARY THEMES

- The utility of non-public facing applications during the public health emergency does not offset the risks to privacy and security
- Allowable communication options include practice patient portals and secure messaging
- Costs to invest in HIPAA-compliant telehealth infrastructure may stunt provider adoption
- Addressing implications on consumer access and satisfaction

Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal public health emergency

DRAFT – GENERAL FINDINGS

- Allow existing OCR telehealth enforcement discretion policies to sunset at the end of the PHE without State intervention

- Assess the impact of non-HIPAA compliant technology usage on privacy and security during the PHE

SENATE BILL 3

J1, C3 1lr0944
(PRE–FILED) CF HB 123

By: **Senators Griffith, Augustine, Beidle, Eckardt, Elfreth, Ellis, Ferguson, Guzzone, Hershey, Kagan, Kelley, Ready, Washington, and West**
Requested: October 13, 2020
Introduced and read first time: January 13, 2021
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Preserve Telehealth Access Act of 2021

FOR the purpose of altering the health care services the Maryland Medical Assistance Program, subject to a certain limitation, is required to provide through telehealth; altering the circumstances under which the Program is required to provide health care services through telehealth; authorizing the Maryland Department of Health to apply to the Centers for Medicare and Medicaid Services for a certain amendment to certain waivers to implement certain requirements of this Act; repealing a certain requirement that the Department apply for a certain amendment to certain waivers to implement a certain pilot program relating to the provision of certain telehealth services; repealing a requirement that the Department administer the pilot program, collect certain data, and submit certain reports to the General Assembly; altering a provision of law requiring certain insurers, nonprofit health service plans, and health maintenance organizations to reimburse certain health care services provided through telehealth to require reimbursement to be provided in a certain manner and at a certain rate; prohibiting certain insurers, nonprofit health service plans, and health maintenance organizations from imposing, as a condition of reimbursement of a health care service delivered through telehealth, that the health care service be provided by a certain health care provider; repealing the termination date of certain provisions of law relating to the Maryland Medical Assistance Program and coverage for telehealth; defining certain terms; altering certain definitions; providing for the application of this Act; and generally relating to the coverage and reimbursement of health care services delivered through telehealth.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 15–103(a)(1)
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–103(a)(2)(xv) and 15–141.2
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–139
Annotated Code of Maryland
(2017 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, with amendments,
Chapter 17 of the Acts of the General Assembly of 2020
Section 4

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Preamble

WHEREAS, A state of emergency and catastrophic health emergency was proclaimed on March 5, 2020 to control and prevent the spread of COVID–19 within the State, and the state of emergency and catastrophic health emergency continue to exist; and

WHEREAS, To respond to the state of emergency and to continue to deliver care to patients with ongoing conditions, health care practitioners were authorized to deliver telehealth care services at sites at which patients are located; and

WHEREAS, The expansion of telehealth capabilities, including audio–only services, was instrumental in maintaining patient care without the risk of infection and provided ways for patients to receive care who were experiencing general difficulty in accessing in–person care; and

WHEREAS, Telehealth was shown to be effective in reducing disparities in access to those in underserved urban and rural areas by bridging communication gaps, allowing for the continuation of care, and reducing patient and clinician exposure to the coronavirus; and

WHEREAS, To enable the use of interactive audio telecommunications or electronic technology to deliver health care services and protect the public health, welfare, and safety, it is necessary to continue to preserve accommodations granted during the coronavirus pandemic; and

WHEREAS, It is critical that health care practitioners licensed, certified, or

otherwise authorized by law to provide health care services be allowed in Maryland to provide those services through telehealth, including audio–only calls, provided that they are held to the same standards of practice that are applicable to in–person health care settings; and

WHEREAS, To effectively advance health equity in Maryland, it is necessary to ensure that individuals with limited access to health care services can benefit from the expansion of telehealth; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

15–103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(xv) Shall provide, subject to the limitations of the State budget, **[**mental**]** health **CARE** services appropriately delivered through telehealth to a patient in **[**the patient's home setting**]** **ACCORDANCE WITH § 15–141.2 OF THIS SUBTITLE**; and

15–141.2.

(a) **[**(1) In this section, "telehealth" means a mode of delivering health care services through the use of telecommunications technologies by a health care practitioner to a patient at a different physical location than the health care practitioner.**]**

(1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "DISTANT SITE" MEANS A SITE AT WHICH THE LICENSED DISTANT SITE HEALTH CARE PRACTITIONER IS LOCATED AT THE TIME THE HEALTH CARE SERVICE IS PROVIDED THROUGH TELEHEALTH.

(3) "DISTANT SITE PROVIDER" MEANS THE LICENSED HEALTH CARE PRACTITIONER WHO PROVIDES MEDICALLY NECESSARY SERVICES TO A PATIENT AT AN ORIGINATING SITE FROM A DIFFERENT PHYSICAL LOCATION THAN THE LOCATION OF THE PATIENT.

(4) "HEALTH CARE PRACTITIONER" MEANS AN INDIVIDUAL WHO IS LICENSED OR CERTIFIED TO PROVIDE HEALTH CARE SERVICES UNDER THE HEALTH

OCCUPATIONS ARTICLE.

(5) "ORIGINATING SITE" MEANS THE LOCATION OF THE PROGRAM RECIPIENT AT THE TIME THE HEALTH CARE SERVICE IS PROVIDED THROUGH TELEHEALTH.

(6) "REMOTE PATIENT MONITORING SERVICES" MEANS THE USE OF SYNCHRONOUS OR ASYNCHRONOUS DIGITAL TECHNOLOGIES THAT COLLECT OR MONITOR MEDICAL AND OTHER FORMS OF HEALTH CARE DATA FOR PROGRAM RECIPIENTS AT AN ORIGINATING SITE AND ELECTRONICALLY TRANSMIT THAT DATA TO A DISTANT SITE PROVIDER TO ENABLE THE DISTANT SITE PROVIDER TO ASSESS, DIAGNOSE, CONSULT, TREAT, EDUCATE, PROVIDE CARE MANAGEMENT, SUGGEST SELF–MANAGEMENT, OR MAKE RECOMMENDATIONS REGARDING THE PROGRAM RECIPIENT'S HEALTH CARE.

[(2)**] (7) (I) "TELEHEALTH" MEANS THE DELIVERY OF MEDICALLY NECESSARY SOMATIC, DENTAL, OR BEHAVIORAL HEALTH SERVICES TO A PATIENT AT AN ORIGINATING SITE BY A DISTANT SITE PROVIDER THROUGH THE USE OF TECHNOLOGY–ASSISTED COMMUNICATION.**

(II) "Telehealth" includes **[**synchronous**]:**

1. SYNCHRONOUS and asynchronous interactions**;**

2. AUDIO–ONLY CONVERSATIONS BETWEEN A HEALTH CARE PRACTITIONER AND PATIENT USING TELECOMMUNICATIONS TECHNOLOGY; AND

3. REMOTE PATIENT MONITORING SERVICES.

[(3)**] (III)** "Telehealth" does not include the provision of health care services solely through **[**audio–only calls,**]** e–mail messages**[**,**]** or facsimile transmissions.

[(b) (1) On or before December 1, 2020, the Department shall apply to the Centers for Medicare and Medicaid Services for an amendment to any of the State's § 1115 waivers necessary to implement a pilot program to provide telehealth services to Program recipients regardless of the Program recipient's location at the time telehealth services are provided.

(2) Telehealth services available under the pilot program shall be limited to chronic condition management services.

(c) If the amendment applied for under subsection (b) of this section is approved, the Department shall administer the pilot program.

(d) The Department shall collect outcomes data on recipients of telehealth services under the pilot program to evaluate the effectiveness of the pilot program.

(e) On or before December 1, 2020, and every 6 months thereafter until the application described under subsection (b) of this section is approved, the Department shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the status of the application.

(f) If the amendment applied for under subsection (b) of this section is approved, on or before December 1 each year following the approval, the Department shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the status of the pilot program.**]**

(B) THE PROGRAM SHALL:

(1) PROVIDE HEALTH CARE SERVICES APPROPRIATELY DELIVERED THROUGH TELEHEALTH TO PROGRAM RECIPIENTS REGARDLESS OF THE LOCATION OF THE PROGRAM RECIPIENT AT THE TIME TELEHEALTH SERVICES ARE PROVIDED; AND

(2) ALLOW A DISTANT SITE PROVIDER TO PROVIDE HEALTH CARE SERVICES TO A PROGRAM RECIPIENT FROM ANY LOCATION AT WHICH THE HEALTH CARE SERVICES MAY BE APPROPRIATELY DELIVERED THROUGH TELEHEALTH.

(C) THE DEPARTMENT SHALL APPLY TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR AN AMENDMENT TO ANY OF THE STATE'S § 1115 WAIVERS NECESSARY TO IMPLEMENT THE REQUIREMENTS OF THIS SECTION.

Article – Insurance

15–139.

(a) (1) In this section, "telehealth" means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient.

(2) "Telehealth" includes**:**

(I) the delivery of mental health care services to a patient in the patient's home setting**; AND**

(II) AN AUDIO–ONLY CONVERSATION BETWEEN A HEALTH CARE PROVIDER AND A PATIENT USING TELECOMMUNICATIONS TECHNOLOGY.

(3) "Telehealth" does not include:

(i) **[**an audio–only telephone conversation between a health care provider and a patient;

(ii)**]** an electronic mail message between a health care provider and a patient; or

[(iii)**] (II)** a facsimile transmission between a health care provider and a patient.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section:

(i) shall provide coverage under a health insurance policy or contract for health care services appropriately delivered through telehealth; and

(ii) may not exclude from coverage a health care service solely because it is provided through telehealth and is not provided through an in–person consultation or contact between a health care provider and a patient.

(2) The health care services appropriately delivered through telehealth shall include counseling for substance use disorders.

(d) An entity subject to this section:

(1) shall reimburse a health care provider for the diagnosis, consultation, and treatment of an insured patient for a health care service**:**

(I) covered under a health insurance policy or contract that can be appropriately provided through telehealth; **AND**

(II) WHEN APPROPRIATELY PROVIDED THROUGH TELEHEALTH, ON THE SAME BASIS AND AT THE SAME RATE AS IF THE HEALTH CARE SERVICE WERE DELIVERED BY THE HEALTH CARE PROVIDER IN PERSON;

(2) is not required to:

(i) reimburse a health care provider for a health care service delivered in person or through telehealth that is not a covered benefit under the health insurance policy or contract; or

(ii) reimburse a health care provider who is not a covered provider under the health insurance policy or contract; and

(3) (i) may impose a deductible, copayment, or coinsurance amount on benefits for health care services that are delivered either through an in–person consultation or through telehealth;

(ii) may impose an annual dollar maximum as permitted by federal law; and

(iii) may not impose a lifetime dollar maximum.

(E) SUBJECT TO SUBSECTION (D)(2) OF THIS SECTION, AN ENTITY SUBJECT TO THIS SECTION MAY NOT IMPOSE AS A CONDITION OF REIMBURSEMENT OF A HEALTH CARE SERVICE DELIVERED THROUGH TELEHEALTH THAT THE HEALTH CARE SERVICE BE PROVIDED BY A HEALTH CARE PROVIDER DESIGNATED BY THE ENTITY.

[(e)**] (F)** An entity subject to this section may undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered through an in–person consultation or through telehealth if the appropriateness of the health care service is determined in the same manner.

[(f)**] (G)** A health insurance policy or contract may not distinguish between patients in rural or urban locations in providing coverage under the policy or contract for health care services delivered through telehealth.

[(g)**] (H)** A decision by an entity subject to this section not to provide coverage for telehealth in accordance with this section constitutes an adverse decision, as defined in § 15–10A–01 of this title, if the decision is based on a finding that telehealth is not medically necessary, appropriate, or efficient.

Chapter 17 of the Acts of 2020

SECTION 4. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly. **[**Sections 2 and 3**] SECTION 3** shall remain effective through June 30, 2025, and, at the end of June 30, 2025, **[**Sections 2 and 3**] SECTION 3**, with no further action required by the General Assembly, shall be abrogated

and of no further force and effect.

Chapter 18 of the Acts of 2020

SECTION 4. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly. **[**Sections 2 and 3**]** **SECTION 3** shall remain effective through June 30, 2025, and, at the end of June 30, 2025, **[**Sections 2 and 3**]** **SECTION 3**, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2022.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2021.