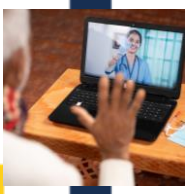

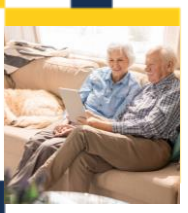

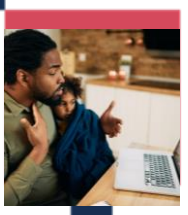

Preserve Telehealth Access Act of 2021

Telehealth Recommendations

Final – December 16, 2022

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THE LAW

Chapter 70 (House Bill 123) and Chapter 71 (Senate Bill 3) of the 2021 Laws of Maryland, *Preserve Telehealth Access Act of 2021* ("Act") requires the Maryland Health Care Commission ("MHCC"), in consultation with certain State agencies, to submit a report[1] to the Senate Finance Committee and the House Health and Government Operations Committee on the impact of providing telehealth services by December 1, 2022.[2] The Act requires the use of appropriate research methods to study select telehealth matters, taking into consideration audio-only and audio-visual technologies in the delivery of somatic and behavioral health services, for purposes of reporting on the impact of telehealth and providing recommendations on coverage and payment levels relative to in-person care.

BACKGROUND

The COVID-19 public health emergency ("PHE") created unprecedented demand for telehealth. Payers made telehealth policy changes building on regulatory actions taken by way of state executive orders and federal waivers. Such actions enabled greater flexibility and operational changes in accessing virtual health care services for both COVID-19 and non-COVID-19 health conditions. This included expanding eligible providers permitted to deliver and bill for telehealth services, waiving certain administrative requirements (e.g., redefining what constitutes a provider and patient treatment relationship and removing restrictions on patient location), reducing or eliminating cost-sharing for telehealth services, and expanding telehealth coverage and reimbursement, including services delivered via audio-only technology and by out-of-network providers. Before the PHE, all 50 states and Washington, D.C. provided some form of Medicaid reimbursement.[3] For private payers, about 36 states required reimbursement for telehealth,[4] 25 states had limits on cost sharing, 15 states mandated payment parity, and three states required audio-only coverage in some capacity.[5] However, the integration of telehealth was very limited due to logistics that made implementation complex and requirements that were not universal.[6]

The PHE demonstrated the utility of telehealth and the potential of telehealth to address disparities in access to care.[7, 8] Barriers in accessing care and related financial costs to the health care system is a concern for many state legislatures.[9] Following the rapid adoption and increased use of telehealth in 2020, many states began exploring the continuation of telehealth policies that were enabled by various waivers set to expire at the end of the federal PHE declaration. States have largely focused on three key areas: 1) coverage of audio-only services, 2) cost-sharing, and 3) payment parity.[10] In 2021, about 37 states introduced nearly 50 bills to make permanent many telehealth flexibilities implemented during the PHE. Roughly 27 states passed legislation making telehealth reimbursement for Medicaid and private payers permanent and about 29 states and Washington, D.C. required Medicaid reimbursement for audio-only telehealth (state listing available in Appendix A).[11, 12, 13] Several states extended temporary telehealth policy changes or required a review of telehealth best practices to inform recommendations for future legislation.[14]

The use of telehealth remains well above pre-PHE levels in Maryland and the nation. Consumer uptake and experience with audio-visual and audio-only technologies has varied across race,[15]

English proficiency levels,[16] age,[17] and income.[18, 19, 20] The highest utilizers of telehealth are individuals ages 28-57, and the leading drivers are convenience, timely care, and safety.[21] Consumers and providers have grown accustomed to hybrid models of in-person and virtual care.[22] While many consumers prefer the convenience of telehealth, for some people, particularly children, telehealth may not be a viable option. Getting children and older youths to engage in telehealth can be difficult. Technology barriers also prevent some consumers from accessing telehealth services (e.g., limited or no access to high-speed internet or technology devices) and having meaningful encounters with a provider (e.g., low digital literacy).[23]

Payers and providers recognize the diverse needs of patient populations that must be considered to improve health care access and equity. These stakeholders' have differing views on telehealth policy expansion once the PHE ends. Most providers strongly support preserving policy changes originating from the telehealth waivers. Payers are somewhat reluctant on preserving all waivers until sufficient data are available to measure the long-term impact on quality and cost.

MHCC'S ROLE IN TELEHEALTH

The MHCC is responsible for advancing health information technology statewide (health information exchange, electronic health records, and telehealth). For more than a decade, MHCC has been regarded as a leader in identifying opportunities for using telehealth to improve health status and care delivery, providing technical guidance to ambulatory care practices implementing telehealth, fostering peer learning about best practices in virtual care, and assessing the utility of select use cases in various settings through demonstrations. A total of 17 grants awarded by MHCC since 2014 have funded innovative telehealth projects that successfully served to advance adoption across the State. Lessons learned from these grants informed development of the Telehealth Readiness Assessment Tool, an online self-assessment questionnaire to guide ambulatory care practices in assessing readiness to implement or scale telehealth services.

The MHCC expanded its initiatives to support providers and consumers with the rapid transition to telehealth. The Telehealth Virtual Resource Center is a dedicated webpage with information on payer telehealth policies, considerations for selecting a telehealth vendor, best practice tips for virtual patient and provider engagement, and guidance on telehealth liabilities and risks. The MHCC launched public service initiatives to build consumer awareness of telehealth and how to become better users of the technology. In the fall of 2020, stakeholders requested MHCC convene a Telehealth Policy Workgroup ("workgroup") to discuss telehealth policy changes implemented in response to the PHE. Discussions centered on the broadened scope of telehealth, benefits and barriers to patients and providers, and the permanency of certain policy changes. The workgroup generally concluded there was need to study quality and cost of telehealth. It was recommended that MHCC examine trends in access and utilization of audio-only and audio-visual technologies and the comparative effectiveness of telehealth to in-person services.

More information about MHCC telehealth initiatives is available at:
www.mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/hit_telemedicine.aspx.

STUDY APPROACH

The MHCC issued a Request for Proposals in June 2021 to obtain a contractor with subject matter expertise in telehealth and new models of integrated care, and proficiency in conducting quantitative and qualitative research and analysis. In September 2021, the National Opinion Research Center ("NORC")[24] at the University of Chicago was competitively selected to complete the study in accordance with the Act. The following study categories consisted of activities that examined use of audio-only and audio-visual technologies in somatic and behavioral health (synonymous with behavioral health care used in the Technical Report) interventions: literature review, behavioral health focus groups, provider survey, consumer interviews, and claims analyses (an explanation of each is included in Appendix B). The MHCC convened two telehealth town halls with payers and providers in July 2022 and engaged consumers in August 2022 to supplement data collected by NORC and provide another platform for stakeholders to share perspectives on the current and future state of telehealth.[25]

ABOUT THIS REPORT

NORC developed a Technical Report based on its findings from the study. The findings were used by MHCC to develop telehealth coverage recommendations (1-5), which are not inconsistent with telehealth policy changes adopted by the Centers for Medicare & Medicaid Services ("CMS") (more information on CMS coverage by key category is included in Appendix C). The technology recommendation (6) aligns with rules established by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The payment level and future study recommendation (7) is based on need to further demonstrate the utility and effectiveness of telehealth to appropriately inform potential approaches to legislation (a table mapping telehealth recommendations 1-7 to study findings is included in Appendix D). Recommendations pertaining to telehealth terms (8-12) include definitions that require clarification in statute. The recommendations are not in full alignment with the 2023 Medicare Physician Fee Schedule, and in some instances, are more stringent, which may present a challenge for Medicaid. Medicaid should have the discretion to pay for telehealth services subject to the limitations of the State budget. The section that follows includes recommendations from the Maryland Insurance Administration ("MIA") (13-15) related to the Act. This report was released on November 21st with a request for comments. The MHCC modified sections of the report and select recommendations based on stakeholder feedback (letters are included in Appendix E).

RECOMMENDATIONS

Permanency of Telehealth Coverage

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.***

Rationale

The option to use telehealth gives health care providers, which includes licensed mental health and substance use disorder programs, and consumers a safe and appropriate pathway to deliver and receive quality care with the potential for improved outcomes for a variety of conditions in somatic and behavioral health. Expanded use of telehealth in value-based care broadens patients' access to health care resources and providers, particularly in rural areas and certain urban areas experiencing provider shortages.[26, 27] Removing telehealth restrictions to meet the needs of underserved and vulnerable populations can result in better access to appropriate and timely care.

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.***

Rationale

Before the PHE, Medicare began reimbursing virtual check-ins (audio-only interactions) for communication technology-based services (January 2019).[28] Broadened use of audio-only was made possible with the expanded definition of telehealth at the onset of the PHE (2020), which was necessary to maintain access to care due to initial restrictions, lockdowns, and stay-at-home orders. Somatic and behavioral health providers and patients find audio-only visits to be of value, resulting in high patient satisfaction, better care, and decreased no show rates.[29] Continuing the option to use audio-only promotes equitable access to care,[30] particularly when circumstances prevent use of audio-visual technology due to unavailable or unreliable broadband, low digital literacy, or limited access to devices. Many diagnoses and treatments for somatic care rely on visual observations.

The U.S. Department of Health and Human Services views audio-only as an important modality to reach patients in rural communities, those with disabilities, and others seeking convenient options for care delivery.[31] For federally qualified health centers ("FQHCs") providing primary care, behavioral health, and specialty services to Medicaid and uninsured patients, audio-only is more likely to be used due to patient preference and clinic adoption barriers to audio-video technology.[32] Audio-only visits peaked in the spring of 2020; since then, its use in most settings has subsided except for behavioral health where it accounts for the highest share of telehealth encounters.[33] Eliminating or restricting use of audio-only could result in provider resistance to offer telehealth services.

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.***

Rationale

Remote patient monitoring ("RPM") enables providers to more timely identify and treat health concerns before they become serious or potentially life-threatening. The noninvasive collection of health-related data can control infectious disease outbreaks and monitor chronic diseases by providing insights that may be unknown during episodic care delivery.[34, 35] A combination of care needs and wearable technology facilitated expanded use of RPM during the PHE.[36] Providers view RPM as a modality to immediately address potential issues, help improve patient adherence, collect health metrics, and improve outcomes for patients with chronic conditions who often have higher hospital admission rates and incur more expenses.

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.***

Rationale

Prior to the PHE, hospice care providers were slow to adopt telehealth compared to other specialties. Greater adoption and use of telehealth has enabled patients to receive hospice care in their home. Patients who live in rural areas are often challenged by provider shortages and geographic distances that present barriers in providing quality end-of-life care. Expanded access to hospice providers via telehealth can identify critical changes in functional decline and symptoms of disease progression, allowing for earlier intervention and less urgent care.[37] Telehealth interventions can also help patients feel more connected with their providers.

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.***

Rationale

Telehealth can support care delivery in inpatient facilities. Use of telehealth for specialty consults in hospital inpatient and nursing home settings expands access to providers and can reduce risk factors in managing patients with acute and chronic conditions.[38] Hybrid models of in-person and virtual services create flexibility in care delivery so as not to overburden existing staff resources. Telehealth can detect clinical deterioration early and treat patients in place.[39] Hospital's use of telehealth can reduce risk factors in managing patients with acute or chronic conditions. Nursing homes leverage telehealth to potentially avoid unnecessary hospital transfers and mitigate certain health issues for frail elders and people with disabilities.

Telehealth is not equivalent to in-person care for all conditions in hospital inpatient and nursing home settings. Subtle symptoms about a patient's condition could be overlooked during virtual visits; in-person care is necessary to make diagnoses that require more of a hands-on approach.[40] The future of telehealth is as a complementary modality of care not as a replacement for in-person in-patient care.

Technology

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.***

Rationale

Use of national standards ensures telehealth technology is implemented and operated in a consistent manner that conforms to privacy and security specifications. Standards-based technologies are built upon principles that enable communication and interoperability.[41] Adopting standards ensures even baseline protections for the privacy and security of protected health information required by HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act.

Telehealth Payment Levels – Future Study

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:***

    (a) Does it cost more or less for providers to deliver telehealth;

    (b) Does telehealth require more or less clinical effort for a provider;

    (c) Are there aspects of telehealth that yield lower value, overuse, or conversely greater value that inform the debate on payment parity;

    (d) The adequacy of reimbursement for behavioral health services delivered in-person and by telehealth; and

    (e) Any other findings and recommendations.

Rationale

More data is needed to compare telehealth to in-person care and fully understand the impact of using audio-only and audio-visual technologies in somatic and behavioral health. Data available from MHCC's All-Payer Claims Data Base ("APCD") for the study was through 2021.[42] The data generally follows national trends that illustrate historic utilization of telehealth after removing telehealth restrictions, particularly for behavioral health services. Further insights

can be derived from analyzing additional claims data. This is necessary to formulate data-driven and evidence-based recommendations to guide future telehealth policy and legislation that takes into consideration the extent telehealth affects quality and cost, and its impact on health equity.

Behavioral health accounts for the largest share of telehealth services. The PHE intensified long-standing challenges in meeting a growing crisis to treat behavioral health conditions, especially among Medicare and Medicaid enrollees.[43, 44] Behavioral health providers are often limited in supply and low reimbursement makes providers less likely to participate in payer networks. Identification of and applying lessons learned from audio-visual and audio-only telehealth during and after the PHE, coupled with payment and care delivery reform, are essential to address broader access issues affecting all behavioral health services.

Clarification of Terms

The following terms are proposed for clarification in statute. The included language is not intended to replace existing definitions; rather, it is to add clarity to important health coverage terminology in certain articles.

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***[45] – 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).[46]

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).

MARYLAND INSURANCE ADMINISTRATION

Study Scope and Findings

The Act required the MIA to conduct a limited-scope study of telehealth and insurance coverage pertaining to:

- How telehealth can support efforts to ensure health care provider network sufficiency; and
- The impact of changes in access to and coverage of telehealth services under health benefit plans offered by health insurance carriers on the ability of consumers to choose in–person care versus telehealth care as the modality of receiving a covered service.

The MIA's study focused on the role of telehealth in the context of network adequacy, and how changes in access to and coverage of telehealth services under insurance plans have impacted consumers' ability to choose in–person versus telehealth care. The MIA found that telehealth has tremendous potential to improve access to care in a variety of situations and from a variety of different perspectives, without sacrificing consumer access to in-person services. The MIA's research noted a marked increase in access to and coverage of telehealth over the last few years without a corresponding reduction in coverage of in-person services. The study also demonstrated there are many ways telehealth can be appropriately leveraged to support efforts to ensure health care provider network sufficiency. Based on these findings, the MIA proposes the following recommendations for consideration by the General Assembly.

Network Adequacy 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…"***

Rationale

Over the past several years, the MIA has engaged in a very deliberative process to evaluate and update the existing network adequacy regulations (COMAR 31.10.44) with broad stakeholder engagement and participation. The MIA anticipates finalizing revisions to the regulations in 2022 that include, among other things, detailed new provisions related to telehealth, which will allow the MIA to monitor and reevaluate the impact of telehealth on network adequacy on an ongoing basis. 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.***

Rationale

The MIA's research revealed widespread support from consumers and providers for greater telehealth coverage in the insured market. To the extent the legislature wishes to ensure

market uniformity and prevent any carriers from retracting pandemic-related expansions in telehealth coverage, revisions to § 15-139 of the Insurance Article would be necessary to, for example, make the audio-only coverage requirement permanent, and/or to include more express requirements related to other modalities of telehealth, the specific types of provider specialties and services eligible for telehealth coverage, and permissible cost-sharing levels for telehealth services versus comparable in-person services.

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

Rationale

To the extent the legislature wishes to ensure that telehealth benefits do not replace or restrict access to coverage for in-person services, revisions to § 15-139 of the Insurance Article would be necessary to prohibit carriers from requiring that a service must be received via telehealth in order to be covered. In evaluating whether legislation is appropriate or necessary in this area, several factors warrant consideration, including market demands, product pricing impacts, the potential negative effect on product innovation, convenience for consumers, and overall patient and provider preferences related to telehealth.

CONCLUSION

The magnitude and duration of the PHE provided the impetus for changes in telehealth policy. Waivers that removed telehealth restrictions encouraged all types of providers to adopt technologies that supported efficient, innovative, and the safe delivery of virtual care. Telehealth replaced traditional in-person care during the early months of the PHE, and over the last 18 months, its use has stabilized at significant levels.

Consumer and provider acceptance of telehealth has increased since the onset of the PHE. A significant portion of the population accepts telehealth and voices a preference for telehealth in some situations. As the pandemic became more manageable, most providers offered a choice of face-to-face or telehealth visits as opposed to the early days when telehealth was at times, the only option. Most providers support continued use of telehealth modalities and making the waivers granted during the PHE permanent.

At the end of the first year of the PHE, stakeholders expected that widespread availability of COVID-19 vaccines would mean the rapid return to pre-pandemic health care. Payers expressed concern about the prospect of continuing the waivers given the expectation of a return to normal. Waves of COVID-19 variants and some public resistance to accepting the vaccines has dispelled that perspective; conventional wisdom is that the pandemic and certain PHE precautions will be with us for a long time. Payers' positions on the continuation of the waivers have evolved. Many payers have concluded that telehealth generally and audio-only behavioral health treatment are a permanent feature of health care delivery. All stakeholders recognize that telehealth should remain a feature of care delivery.

Positions on payment parity between telehealth and in-person care continue to vary. Parity questions may resolve themselves as the shift from volume to value-based care gains more momentum. During the height of the PHE, the availability of telehealth advanced population-wide capacity and reduced the impact of provider shortages. Payment parity made provider adoption of telehealth more palatable. The MHCC found there are few rigorous studies comparing practice expenses and clinician time associated with delivering a service via telehealth versus in-person. Studies comparing outcomes between telehealth and in-person care are similarly sparse.

Removing regulatory barriers to telehealth is essential to maximize opportunities to make health care more efficient, coordinated, convenient, and affordable as well as building preparedness for the next PHE. The MHCC recommends maintaining provisions in the Act to ensure coverage flexibilities for somatic and behavioral health. Audio-only care should continue for behavioral health treatment, but some use guidelines in coverage of telehealth for somatic care is warranted.

APPENDIX A

The table represents a snapshot of state policy and law by the Center for Connected Health Policy (CCHP). Nuances exist across states in defining telehealth; refer to a state's specific policy for more information.

Telehealth Reimbursement Policies and Laws by State and Washington, D.C.				
State	**Medicaid Policy**		**Private Payer Law**	
	Audio-Only	*RPM*	*Law*	*Payment Parity*
Alabama		✓		
Alaska		✓	✓	
Arizona	✓	✓	✓	✓
Arkansas	✓	✓	✓	
California	✓	✓	✓	✓
Colorado	✓	✓	✓	
Connecticut	✓		✓	✓
Delaware			✓	✓
Washington, D.C.	✓		✓	
Florida			✓	
Georgia			✓	✓
Hawaii			✓	✓
Illinois	✓	✓	✓	✓
Indiana	✓	✓	✓	
Iowa	✓		✓	✓
Kansas		✓	✓	
Kentucky			✓	✓
Louisiana	✓	✓	✓	
Maine	✓	✓	✓	
Maryland		✓	✓	✓
Massachusetts	✓		✓	✓
Michigan	✓	✓	✓	
Minnesota	✓	✓	✓	✓
Mississippi		✓	✓	
Missouri		✓	✓	
Montana			✓	
Nebraska		✓	✓	✓
Nevada	✓		✓	✓
New Hampshire			✓	
New Jersey			✓	
New Mexico	✓		✓	✓
New York	✓	✓	✓	
North Carolina	✓	✓		
North Dakota	✓	✓	✓	
Ohio	✓	✓	✓	

Telehealth Reimbursement Policies and Laws by State and Washington, D.C.				
State	**Medicaid Policy**		**Private Payer Law**	
	Audio-Only	*RPM*	*Law*	*Payment Parity*
Oklahoma		✓	✓	✓
Oregon	✓	✓	✓	
Pennsylvania	✓			
Rhode Island			✓	✓
South Carolina	✓	✓		
South Dakota	✓		✓	
Tennessee	✓		✓	
Texas	✓	✓	✓	
Utah	✓	✓	✓	✓
Vermont		✓	✓	✓
Virginia	✓	✓	✓	
Washington	✓	✓	✓	✓
West Virginia			✓	✓
Wisconsin	✓	✓		

Notes: A checkmark (✓) indicates telehealth policy for Medicaid reimbursement and laws on private payer reimbursement exist; for Medicaid, all states and Washington, D.C. require coverage for live video

Source: CCHP, www.cchpca.org/2022/05/Spring2022_SummaryChartfinal.pdf.

APPENDIX B

The MHCC contracted with NORC to complete study activities that examine, in part, the impact of audio-only and audio-visual technologies in somatic and behavioral health interventions. More information on the study activities follows.

QUALITATIVE RESEARCH ACTIVITIES

Provider Survey – an online telehealth survey of providers on their use of telehealth in the delivery of care; questions inquired about access and utilization, audio-only and audio-visual technologies, and telehealth in comparison to in-person visits. Providers in rural and urban regions of the State (Baltimore City, the Eastern Shore, Montgomery and Prince George's Counties, South-Central and Western Maryland) were invited to complete the survey, including: 1) primary care physicians; 2) specialty physicians; 3) nurse practitioners; and 4) behavioral health providers (e.g., psychiatrists, psychologists, licensed certified social workers, and other licensed professional counselors).

Consumer Interviews – semi-structured 30-minute telephone interviews with users and non-users of telehealth services across Maryland; interview questions explored patient experiences and perceptions regarding access to and use of audio-only and audio-visual technologies. Consumers were selected to achieve regional-level representation across key demographic characteristics, including age, sex, race and ethnicity, income, education level, insurance coverage, and language spoken (English and Spanish).

Literature Review – identification and review of peer-reviewed and gray literature examining the effectiveness of telehealth to deliver somatic and behavioral health and new and emerging trends and policies regarding telehealth service delivery.

Behavioral Health Focus Groups – two behavioral health focus groups with representatives from provider organizations and consumer advocacy groups; focus groups explored experiences and perceptions of access and utilization of audio-only and audio-visual telehealth technologies.

QUANTITATIVE RESEARCH ACTIVITY

Claims Analysis – statistical analyses of Medicare, Medicaid, and commercial health care claims data from Maryland's APCD to explore trends in telehealth use from 2018 through 2021. Analysts examined key aspects of health care utilization, including the comparison of cost and service utilization for telehealth and in-person visits before and after the PHE; analyses were stratified by patient characteristics, such as age, race and ethnicity, geography, and area-level broadband access.

APPENDIX C

Medicare Physician Fee Schedule (PFS) – Telehealth Coverage (2020-2022)				
Coverage Category	**Specific to PHE** (√) No checkmark indicates item is not tied to PHE	**Description**	**Calendar Year** IFC = Interim Final Rule	**Page Location**
Provider Type	✓	Clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can furnish brief online assessment and management services, virtual check-ins, and remote evaluation.	2020 IFC	p. 19244
			2021	p. 84507 p. 84532
Audio-Only – Evaluation and Management (E/M)	✓	Under waiver authority, audio-only can be used as a modality for E/M visits.	2021	p. 84534
Audio-Only - Medical Discussion		CMS established two new codes to allow a 11-20 -minute medical discussion (which could occur via audio-only) to determine the necessity of an in- person visit.	2022	p. 65064
Audio-Only - Mental Health		Audio-only may be used to deliver treatment, evaluation, and diagnosis of mental health if the following are met: established patient, a six-month in-person service provided prior to the telehealth service and a 12-month subsequent in-person visit, provider has the capability to provide live video but is utilizing audio-only because the patient chooses or cannot use live video. The provider is required to document why audio-only was used and the provider is required to have the technical capability at the time of the service to use an interactive telecommunication system that includes video; and the patient is not capable of or does not consent to the use of the video technology for the service.	2022	p. 65057 pp. 65059-62 p. 65622
Codes	✓ (Category 3)	CMS has established a process for adding codes to the list of Medicare telehealth services eligible for reimbursement. The process includes assigning qualifying requests to a category. Category 1 is reserved for services similar to services already approved on the Medicare telehealth list. Category 2 is for services similar to current in-person services on the Medicare list but pose a significant benefit for the patient. Category 3 is included on the Medicare telehealth services list on a temporary basis and includes services that were added during the PHE and are likely to provide a clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or 2. Any service added under Category 3 is proposed and remain on the Medicare telehealth services list through the calendar year in which the PHE ends.	2021	p. 84503 pp. 84506-7
			2022	p. 65047 p. 65054 p. 65623
Communication Technology-Based Service (CTBS)	✓	CTBS can be furnished to new and established patients if they do not result in a visit, including a telehealth visit. Patient consent must be obtained annually and could occur at the time a service is furnished.	2020 IFC	p. 19244

Medicare Physician Fee Schedule (PFS) – Telehealth Coverage (2020-2022)				
Coverage Category	**Specific to PHE** (√) No checkmark indicates item is not tied to PHE	**Description**	**Calendar Year** IFC = Interim Final Rule	**Page Location**
Cost-Sharing	✓	The Office of the Inspector General issued a policy statement notifying providers that they will not be subject to administrative sanctions for reducing or waiving cost-sharing obligations beneficiaries may owe for telehealth services furnished consistent with the then applicable coverage and payment rules.	2020 IFC	p. 19243
Electronic Prescribing of Controlled Substances	✓	Once a patient and a provider have an established relationship, a medical visit can be conducted via telehealth and any necessary prescriptions can be electronically transmitted to the pharmacy without in-person risk.	2021	p. 84803
Established Patients	✓	CMS is exercising enforcement discretion on an interim basis to relax enforcement of the established patient aspect of the code descriptors.	2020 IFC	p. 19244
Facility Rate		When telehealth services are furnished under the waiver to beneficiaries located in places that are not identified as permissible originating sites under 1834(m) (i.e., in a patient's home), no originating site facility fee is paid.	2020 IFC 2022	p. 19233 p. 65054
Federally Qualified Health Centers and Rural Health Clinics	✓	Considered distant site providers under the PHE; able to provide audio-only services when the patient is not capable of or does not want to use live video; subject to six-month/12-month in-person requirements.	2022	p. 65057 p. 65207 p. 65210
Originating Site	✓	CMS removed the geographic and site of service originating site restrictions for the duration of the PHE. Medicare will cover telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence.	2020 IFC 2021	p. 19232 p. 84507
Originating Site - Mental Health		A patient's home is a permissible originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished during or after the end of the PHE (a permanent telehealth policy change no longer tied to the PHE). Home may be defined to include temporary lodging (hotels, homeless shelters, etc.) and if the patient chooses to travel a short distance from the exact home location.	2022	p. 65055 p. 65059
Originating Site - Substance Use Disorder (SUD) or Co-Occurring Mental Health		The SUPPORT Act removed geographic limitations and authorized the patient's home to serve as a telehealth originating site for purposes of treatment of a SUD) or co-occurring mental health disorder, furnished on or after July 1, 2019 to an individual with a SUD diagnosis.	2021	p. 84505 p. 84541

Medicare Physician Fee Schedule (PFS) – Telehealth Coverage (2020-2022)				
Coverage Category	**Specific to PHE** (√) No checkmark indicates item is not tied to PHE	**Description**	**Calendar Year** IFC = Interim Final Rule	**Page Location**
Opioid Treatment Programs (OTP)	✓	CMS is allowing the therapy and counseling portion of the OTP weekly bundle, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communications technology, provided all other applicable requirements are met.	2020 IFC	p. 19258
Payment Parity		Medicare telehealth services under section 1834(m) of the Act are covered at the same rate as in-person services.	2022	p. 65061
Required In-Person Visit - Mental Health		Mental health services can be delivered via telehealth in the home if there is an in-person visit at least six months prior to the telehealth visit. Also, there must be an in-person visit with the provider every 12 months after. A colleague in the same subspecialty and same group may furnish the in-person requirement if the telehealth provider is unable to meet the in-person visit requirement. Exceptions for all in-person requirements: patient meets rural or other previously approved site location limitations, or the patient is receiving treatment for a substance use disorder and being treated for a co-occurring mental health condition or end stage renal disease. Exception for 12-month requirement: If the patient and provider agree the risks and burdens of an in-person visit are outweighed by continuing via telehealth (documentation in medical record is needed)	2022	pp. 65056-8
RPM	✓	RPM services considered to be CTBS and billable only for established patients. During the PHE, CMS is finalizing on an interim basis that RPM services can be furnished to new patients as well as established patients. Patient consent is required, on an interim basis, consent to receive RPM services can be obtained once annually, including at the time services are furnished, during the PHE.	2020 IFC	p. 19264
Services Not Considered Under CMS' Definition of "Telehealth"		Professional services that are commonly furnished remotely using telecommunications technology and do not usually require the patient to be present in-person with the practitioner when they are furnished (i.e., remote physician interpretation of diagnostic test, care management services). These are not covered under section 1834(m).	2020 IFC	p. 19232

Medicare Physician Fee Schedule (PFS) – Telehealth Coverage (2020-2022)				
Coverage Category	**Specific to PHE** (√) No checkmark indicates item is not tied to PHE	**Description**	**Calendar Year** IFC = Interim Final Rule	**Page Location**
Smartphones		While "telephones" are listed as impermissible technology for the purposes of furnishing Medicare telehealth services, Medicare defines interactive telecommunication system as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication." After recognizing this could cause confusion as a smart phone may be used as a telephone but is otherwise an eligible equipment, CMS changed the language specific to prohibitive technology that could be used to furnish telehealth. CMS intends to allow smartphones to be used for audio/video telehealth services and will be included in a technical amendment.	2021	pp. 84531-2

Sources:

CMS, *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency,* April 2020. Available at: www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public.
CMS, *CY 2021 Physician Fee Schedule,* December 2020. Available at: www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part.
CMS, *CY 2022 Physician Fee Schedule*, November 2021. Available at: www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part.

APPENDIX D

NORC created the following table mapping select telehealth recommendations (1 through 7) to considerations based on study findings and the applicable data sources.

MHCC Telehealth Study Recommendations						
Recommendation	**Consideration**	**Data Sources that Support Recommendations**				
		Consumer Interviews	**Provider Survey**	**Behavioral Health Focus Groups**	**Claims Analysis**	**Literature Review**
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.	Maintain access to telehealth services as a compliment to in-person care	✓	✓	✓		✓
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.	Maintain access to audio-only and audio-visual technologies, recognizing that audio-visual technology is preferred but flexibility is needed due to technology issues	✓	✓	✓	✓	✓
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.	Support access where the consumer / patient is physically located	✓	✓	✓		

MHCC Telehealth Study Recommendations						
Recommendation	**Consideration**	**Data Sources that Support Recommendations**				
		Consumer Interviews	**Provider Survey**	**Behavioral Health Focus Groups**	**Claims Analysis**	**Literature Review**
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.	Support access where the consumer / patient is physically located	✓	✓	✓		
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.	Support access where the consumer / patient is physically located	✓	✓	✓		
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.	Require communication technology that addresses privacy and security, particularly for sensitive topics	✓	✓	✓		✓
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: a) Does it cost more or less for providers to deliver telehealth;	Provide adequate insurance coverage and reimbursement for telehealth; additional years of claims data are needed to examine the role of telehealth in access to care, utilization, cost, quality, and value	✓	✓	✓	✓	✓

MHCC Telehealth Study Recommendations						
Recommendation	**Consideration**	**Data Sources that Support Recommendations**				
		Consumer Interviews	**Provider Survey**	**Behavioral Health Focus Groups**	**Claims Analysis**	**Literature Review**
b) Does telehealth require more or less clinical effort for a provider; c) Are there aspects of telehealth that yield lower value, overuse, or conversely greater value that inform the debate on payment parity; d) The adequacy of reimbursement for behavioral health services delivered in-person and by telehealth; and e) Any other findings and recommendations.	to inform telehealth policy					

APPENDIX E

The MHCC invited stakeholders to submit comments on the recommendations. The organizational names and letters follow.

ATA Action, the American Telemedicine Association affiliated trade association

CareFirst BlueCross BlueShield

Community Behavioral Health Association of Maryland

Johns Hopkins Medicine, Office of Telemedicine

Legal Action Center

Maryland Coalition of Families

MedStar Health

Maryland Hospital Association

Planned Parenthood of Maryland

Public Policy Partners clients

University of Maryland Medical System

November 16, 2022

Ben Steffen
Executive Director, Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: ATA ACTION COMMENTS ON DRAFT TELEHEALTH RECOMMENDATIONS

Dear Mr. Steffen,

On behalf of the ATA Action, the American Telemedicine Association affiliated trade association focused on advocacy, I am writing to contribute to the Maryland Health Care Commission's upcoming discussion of draft telehealth recommendations developed by the Commission pursuant to the Telehealth Access Act of 2021. Although we look forward to the MHCC's final report, we have some concerns that the proposed recommendations could unintentionally rollback Maryland's current telehealth policies and create unnecessary confusion for providers and patients.

ATA Action, the American Telemedicine Association's affiliated trade association focused on advocacy, advances policy to ensure all individuals have permanent access to telehealth services across the care continuum. ATA Action supports the enactment of state and federal telehealth policies to secure telehealth access for all Americans, including those in rural and underserved communities. ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system – by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs – if only allowed to flourish.

First, the proposed recommendations include a proposed amendment to the definition of "telehealth" located in both the Maryland general health code and the health occupations code [§ 15-141.2(a)(7)(i) and § 1-1001(e)(1)] affecting every provider in the state delivering care via telehealth, not simply those accepting commercial or public coverage. The proposed amended language states "telehealth" includes "the use of audio-visual or audio-only technology to permit real-time interactive communication" which appears to eliminate the use of asynchronous telehealth technologies and remote patient monitoring.

The Commission's proposed definition appears to contradict prior interpretations of telehealth made by both the General Assembly and the Commission itself. As recently as 2020, the General Assembly chose to recognize both synchronous and asynchronous telehealth services in the Maryland Health Occupations code [see § 1-1001(a), (b)]. Specifically, the Assembly's definition of asynchronous interactions means an exchange of information with a patient that "does not occur in real time" and would also allow for remote patient monitoring. Additionally, the proposed definition appears to contradict the Commission's own interpretation of "telehealth" in its Maryland Telemedicine Task Force 2014 Final Report.[1] The Commission indicated therein that "telehealth" includes both store-and-forward "non-real-time communication" and remote monitoring technologies. It is unclear why the Commission feels the need to change course now.

[1] See pages 4-5, https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/tlmd/tlmd_ttf_rpt_102014.pdf.

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In Maryland and throughout the country, telehealth providers use robust and comprehensive asynchronous visits to perform patient evaluations for both new and established patients in fields including primary care, dermatology, radiology, psychology, and ophthalmology. It is important that policy makers do not preemptively restrict the modalities available to practitioners who can decide, relying on their professional discretion, how best to meet the standard of care. Restricting the use of these technologies also particularly risks reducing the effectiveness and efficiency of care delivery in unintended ways.

The Commission should also take note of the Federation of State Medical Boards ("FSMB") guidelines, which state that a "physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met."[2] We suggest that the Board review and consider the FSMB's Model Guidelines when it is appropriate to promulgate telehealth rules. It is clear that the national momentum is in favor of allowing physicians to use their professional discretion and to determine what the appropriate care delivery modality is for each unique patient. We believe that a divergence from the FSMB's Model Guidelines would needlessly limit a patient's ability to safely access quality, affordable, and remote healthcare, and make Maryland an outlier among states that are adopting telehealth laws.

Second, we are uncertain why the Commission believes a new definition of "Established Patient" needs to be added to the health occupations code, without any further context provided. We are concerned that the implication is a provider must have had an in-person examination with a patient in the 3 years prior to the use of telehealth services. Of course, such a rule would be an arbitrary limit on care delivery and a deviation from the established standard of care. As with recommendation 13, this amendment to the occupations code would also apply to the delivery of all healthcare services, not simply to reimbursement.

ATA Action understands that the Commission is well-respected in the state and the General Assembly values the Commission's feedback. We ask that the Commission remove, or at a minimum clarify, that these recommendations do not intent to restrict the availability of telehealth services in Maryland.

Please do not hesitate to let us know how we can be helpful to your efforts to develop practical telehealth rules in Maryland. If you have any questions or would like to discuss further the telehealth industry's perspective, please contact me at kzebley@ataaction.org.

Kind regards,

Kyle Zebley
Executive Director
ATA Action

[2] See FSMB, The Appropriate Use of Telemedicine Technologies in the Practice of Medicine, page 6, adopted 2022. https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf.

Charlene MacDonald
Senior Vice President,
Chief Government Affairs Officer

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-5207

November 29, 2022

Dear Ms. Majewski:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to contribute comments regarding the Maryland Health Care Commission (MHCC)'s telehealth recommendations report. We believe ensuring equitable access to high-quality, affordable services across the healthcare continuum will improve health outcomes and advance health equity. Telehealth has the potential to expand access to care, increase affordability, and reduce health disparities. To unlock this potential, the value and outcomes for consumers must be fully understood to define appropriate coverage and reimbursement policies.

As the largest health insurer in the Mid-Atlantic region, CareFirst recognizes telehealth has served as an invaluable lifeline during the pandemic in meeting patients where they are. Telehealth is continuing to evolve and addressing the lack of available data measuring the impact of audio-only and audio-visual technologies in somatic and behavioral healthcare should remain a key focus. Bearing this in mind, CareFirst supports the MHCC's Recommendation #7 to continue to study payment parity for audio-visual and audio-only technologies. It is imperative that the MHCC continue to gather more information that support the development of evidence-based coverage and payment recommendations. CareFirst believes that affordability and value for consumers should be at the forefront of this study.

Additionally, CareFirst reiterates the need for providers to appropriately code audio-only and audio-visual telehealth visits. As stated throughout the NORC report, there is a dearth of data comparing audio-only and audio-visual telehealth to in-person care. Our ability to ascertain the differential impacts regarding quality and outcomes can only be realized if providers adhere to coding standards. Specifically, providers must append Modifier 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) to the appropriate CPT codes when rendering care via audio-only interactions.

CareFirst also recognizes the importance of clarifying certain terms associated with telehealth services. Regarding the "behavioral health care" term clarification (Recommendation #8), CareFirst believes there are implications of pathologizing "life stressors and crises" as it relates to coverage and reimbursement due to the subjectivity of the phrase. Therefore, CareFirst recommends the term clarification be revised or removed.

Increasing access to affordable, high-quality care is central to our mission at CareFirst. We stand ready to support the MHCC's work.

Sincerely,

Charlene MacDonald
Senior Vice President,
Chief Government Affairs Officer

Comments on the Maryland Health Care Commission's Telehealth Recommendations
November 18, 2022

The Community Behavioral Health Association of Maryland represents 107 organizations that provide the full continuum of community mental health and substance use disorder services. These services include traditional outpatient mental health centers and substance use disorder clinics to psychiatric rehabilitation, crisis beds, assertive community treatment (ACT), supported employment, targeted case management, and residential programs. Our members serve the majority of the almost-300,000 children and adults who receive services in the public behavioral health system.

CBH commends the Health Care Commission for its outreach to both providers and consumers of behavioral health services and for its recommendations supporting the ongoing use of telehealth for those services. Telehealth has made the difference between accessing care and going without for many of the consumers we serve, who tend to fall on the more severe and chronic end of the behavioral health spectrum. It has also allowed providers to make the most efficient use of a stretched workforce. We very much support and appreciate the Commission's recommendations to continue both audio-visual and audio-only telehealth for behavioral health care, and its recommendation to do so at rate parity with in-person services, at least for 24 months after the current legislation sunsets.

There is one change we urge the Commission to make to its first recommendation, which states, "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."

While this recommendation covers our licensed clinicians providing services in outpatient clinics, it does not cover the programs – such as psychiatric rehabilitation and ACT - that play a critical role in keeping individuals with serious behavioral health conditions out of emergency departments and inpatient care. The legislative committees that worked on the Preserve Telehealth Act of 2021 explicitly included these services by expanding the definition of health care provider to include, A MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAM LICENSED IN ACCORDANCE WITH § 7.5–401 OF THIS ARTICLE;" – referring to Health-General. Telehealth continues to play a significant role in the delivery of services offered by these programs. We urge the Commission to include language that will mirror the enabling legislation in covering licensed mental health and substance use disorder programs.

Thank you again for the great work and for considering our input.

For more information contact Lori Doyle, Public Policy Director, at (410) 456-1127 or lori@mdcbh.org.

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telemedicine

Johns Hopkins Medicine
Office of Telemedicine

November 28, 2022
Re: MHCC Telehealth Recommendations Report and Technical Report call for Comments

We are grateful to the Maryland Health Care Commission (MHCC) and its partners in developing a proposal that overall recognizes the benefits of telehealth for patients across Maryland, particularly groups experiencing barriers in accessing healthcare. Johns Hopkins Medicine (JHM) is in support of recommendations that continue Covid-era flexibilities related to provider types, payment parity, and the use of audio-only care. Uncertainty adds to cost. Given the nearly 3 years of experience and ongoing demand from patients, on top of equity concerns, we encourage MHCC to make each aspect permanent without sunset provisions. However, we recommend that if the proposals in this document are accepted and enshrined in regulations, efforts are taken to ensure documentation and operational requirements are not significantly burdensome to providers and health systems, especially related to audio-only care. **In addition, we are quite concerned about the proposal to limit the frequency of telehealth services for inpatient care and have outlined our reasoning in this letter.**

Frequency Limitations Would Hamper the Ability of Specialty Telehealth Services to Reach Patients in Hospital and Skilled Nursing Facilities

We believe the proposed limitations on hospital inpatient and nursing home settings are arbitrary and will reduce needed access to various services between quaternary and regional hospitals as well as nursing homes. Various consultative services are not available in these venues, and if clinically appropriate, should be permitted without restrictions or other requirements as these telehealth services provide access to needed specialty care. The intention of these limitations is unclear as written – we would agree it is reasonable to have daily in-person care from a primary team during hospital inpatient stays, as well as an expectation around reasonable frequency of in-person primary team visits during nursing home stays.

We have several programs that would be negatively impacted by this proposed regulation. For example:

- NICU patients at Johns Hopkins Bayview, where there are no in person pediatric specialty services, are receiving teleconsultation from pediatric specialists from the JHH East Baltimore campus. These babies may require initial consultation and follow-up consultative care. This specialty care improves the quality of care offered at Bayview and prevents unnecessary transfers. The frequency of these specialty telehealth consults should be dictated by the clinical condition of the patient.

- Geriatric specialists at Johns Hopkins Bayview complete telehealth visits into partner skilled nursing facility under contractual agreements. These specialists should be able to provide

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consultation at a frequency deemed clinically appropriate similar to if a patient were receiving in person consultation or returning for ambulatory care visits.

We recommend that arbitrary limitations on the frequency of telehealth services for inpatient and nursing home care, especially consultative services, be eliminated and be permitted when clinically appropriate (particularly when no corresponding in person service is available to patients).

JHM Strongly Supports Ongoing Support for Payment Parity with Plans for Study

We greatly appreciate and support ongoing parity for both video and audio-only care and would look forward to participating in and supporting the additional MHCC study. We believe this is in line with our belief that "telehealth is health", and in line with CMS billing evolution that "all time is equivalent" (direct care time and indirect care time all included in time-based billing, reinforcing that time spent is not only about "in person time").

JHM Supports Patient Choice for Audio-Only Care

Lastly, as mentioned above, we have shown that audio-only visits are a critical access point for historically marginalized patient populations. We agree with and emphasize that patient choice and clinical appropriateness are always two of the most important considerations. We believe the permissions for audio-only listed in the recommendation broadly encompass all the reasons why audio-only occurs (technology failure, request by the patient, or at the clinical discretion of the provider). Given this, we see no reason to add an additional regulation outlining this permission, which will drive increased documentation burden / cost with little benefit. **We recommend eliminating this specific requirement for when audio-only is permitted for somatic care, especially in context of health equity considerations. If these recommendations are implemented, we recommend adding language to explicitly forego any documentation requirement for clinicians.**

Additional considerations – Remote patient monitoring and other asynchronous telehealth modalities

JHM appreciates recommendations that increase the flexibility of remote patient monitoring technologies. We remain concerned, however, about the broad definition of such technologies. Specifically, patient-owned devices are increasing across all populations, as common day to day technologies such as watches, smartphones, and other wearables (all owned by the patient) are now capable of sending medical and other forms of health data electronically. **We propose clarifying that patient reported data and data transmission that is initiated by the patient and originating from a patient's own device(s) is excepted from the definition of remote patient monitoring. In addition, changes to these definitions would need to be reflected in the Maryland Board of Physicians telehealth regulations for consistency.**

Separately, though not explicitly addressed in the recommendations, we appreciated the initial Preserve Telehealth Access Act language that "may authorize coverage of and reimbursement for health care services that are delivered through store and forward technology or remote patient monitoring." **We would encourage consideration of an expanded recommendation that explicitly adds remote patient monitoring, store and forward, and interprofessional consultation coverage to state-based plans including Maryland Medicaid.** Interprofessional consultation use in Medicaid populations has been

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shown to be associated with an $82 per member per month reduction in specialty related care costs (Anderson et al, Health Affairs 2018).

In summary, we greatly appreciate all of the work from MHCC in a thorough approach and analysis around telehealth, and we appreciate the opportunity to work together towards a shared goal of improved health care for Marylanders. We hope MHCC will reconsider some of the proposed regulations and restrictions on access to telehealth as outlined above and would look forward to additional opportunity to meet directly to discuss our comments and potentially share additional data from JHM.

Thank you for your consideration,

Brian Hasselfeld, MD
Senior Medical Director, Digital Health and Innovation
Associate Director, Johns Hopkins inHealth
Johns Hopkins Medicine
Primary Care Physician, Internal Medicine and Pediatrics
Johns Hopkins Community Physicians

Helen Kinsman Hughes, MD MPH
Medical Director, Office of Telemedicine
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LAC LEGAL ACTION CENTER

November 28, 2022

Ben Steffen, Executive Director
David Sharp, Director, Center for Health Information Technology and Innovative Care Delivery
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen and Mr. Sharp,

Thank you for the opportunity to submit stakeholder comments on the Maryland Health Care Commission's (MHCC's) Telehealth Recommendation Report, as required by the Preserve Telehealth Access Act of 2021. The Legal Action Center (LAC) is a non-profit organization that fights discrimination, builds health equity, and restores opportunity for individuals with substance use disorders, arrest and conviction records, and HIV/AIDS. LAC convenes the Maryland Parity Coalition, whose members participated actively in the telehealth study process. We appreciate MHCC's work on this critical issue to improve health equity and access to care, particularly for Marylanders who seek care for mental health and substance use disorders. We commend MHCC for recommending the continuation of audio-only technology for mental health (MH) and substance use disorder (SUD) telehealth services, without restrictions based on consumer consent to receive care through audio-only technology, and for extending payment parity for 24 months as more data is collected. We support MHCC's recommendations, with requested modifications on two issues: covered providers and the definition of "behavioral health care."

Additionally, regarding the Maryland Insurance Administration's (MIA) recommendations, we strongly support codification of telehealth standards that align with MHCC's recommendations in the Insurance Article to ensure greater consistency across payment systems and protect consumers from being steered to all-telehealth or telehealth-first platforms in the future. We object, however, to the MIA's recommendation that essentially asks the General Assembly to defer to it and its yet-to-be published proposed network adequacy regulations, which will offer new standards for the satisfaction of quantitative metrics via telehealth. LAC actively participated in the MIA's regulatory process with the primary goals of (1) preserving patient choice in the use of telehealth services and (2) ensuring that satisfaction of quantitative metrics is based on the documented availability of in-person services, without reliance on a "credit," and demonstrated election of telehealth by consumers. With an incomplete regulatory process, it remains unclear whether the regulations will adequately protect Marylanders.

I. MHCC Recommendations

We recommend the modification of two MHCC recommendations to ensure the continued delivery of MH and SUD care via telehealth, as established under The Preserve Telehealth Access Act of 2021 (SB 3) and consistent MHCC's study recommendations. First, the providers that would be authorized to deliver telehealth services should explicitly include MH

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and SUD facilities, as set out in SB 3 and consistent with pre-pandemic practice. MHCC has appropriately identified practitioners authorized to deliver telehealth service under the Health Occupations telehealth provision, HEALTH OCCUP. § 1-1001(c), including individuals who are licensed, certified and otherwise authorized to provide health care services under the article, including alcohol and drug trainees who are fulfilling education requirements (HEALTH OCCUP. § 17-406(b)). While this provision covers MH and SUD practitioners, it raises questions about the coverage of MH and SUD facilities, which are explicitly authorized as a "health care provider" under SB 3 to deliver telehealth services. HEALTH GEN. § 15-141.2(a)(4). These facilities have delivered care via telehealth pre-pandemic and are essential to Maryland's MH and SUD care delivery system in both the public and private financing systems. Without clarification, MHCC's explicit reference to telehealth services by facilities that deliver somatic care (e.g. hospital and nursing home settings (Rec. 5)) raises questions about its intention for coverage of facilities that deliver SUD and MH services, such as opioid treatment programs, community-based SUD treatment programs, residential treatment programs, psychiatric rehabilitation programs and Assertive Community Treatment (ACT).

Second, the proposed definition of "behavioral health care" creates confusion as it would rename the existing term "behavioral health" (Health-Gen. § 7.5-101(d)) to be "behavioral health care" (Health-Gen. § 7.5-101(e)) and significantly expand the meaning of "behavioral health." To avoid confusion, the proposed term should be named "behavioral health," because "*behavioral health care*" sets out the range of services that may be delivered, not the conditions themselves. Second, while we suspect the proposed definition is intended to include conditions that may not be diagnosed as a MH or SUD "disorder," the proposed terminology goes far beyond a diagnosed condition and may have unintended consequences for other services and programs. We are also confused by the term "health behaviors," which could capture an unlimited range of circumstances that are not clinical in nature. We urge the MHCC to clarify its intent and work with clinical experts to define the term with greater precision, should an amendment of the existing term be required.

II. MIA's Recommendations

Without offering a specific recommendation, the MIA has identified the need to codify in the Insurance Article the telehealth standards that MHCC has proposed to ensure continued expansive coverage of telehealth services in private health plans and consistency across payer systems and, additionally, to prohibit carriers from restricting access to in-person services based on new telehealth products that require telehealth-first or telehealth-only care. **LAC firmly supports legislative action to codify SB 3 standards in the Insurance Article, post-June 2023, and to prohibit telehealth-only, telehealth-first or other products that limit a consumer's right to coverage of and access to in-person services as well as requirements to use specific telehealth vendors.** The MIA's technical report identifies the development of new carrier telehealth products that offer both "virtual" and "telehealth" services – the former restricting or eliminating access to in-person services, requiring the use of specific telehealth vendors and incentivizing all virtual products through cost-sharing standards. We have also learned from behavioral health providers that some health plans have already notified members that telehealth services will be reimbursed only if delivered via Teledoc practitioners. While this practice would violate Ins. § 15-139(e) for state-regulated plans, it foreshadows carrier practices that the General Assembly must address to adequately protect consumers.

LAC also agrees that the MIA should have latitude to consider the role of telehealth service delivery in its network adequacy regulations. Given the important role of telehealth in expanding access to MH and SUD care, commercial carriers should be able to count telehealth appointments towards wait time and travel distance metrics, as they have for the past five years for appointment wait time, **so long as they are truly appropriate, available, accessible, and elected by the consumer**. While the MIA has not yet published its proposed network adequacy regulations, its report previews its intention to (1) allow a telehealth credit for travel distance and appointment wait time metric satisfaction and (2) remove the existing regulatory standard that requires member election of telehealth for satisfaction of metrics.

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We oppose the MIA's recommendation that it have the final word on satisfaction of network adequacy metrics via telehealth or the adoption of a telehealth credit based on (1) the incomplete network adequacy regulatory process, (2) the limited availability of carrier data related to telehealth utilization by provider type and geographic region,[1] (3) the development of new telehealth products and contract provisions that may steer consumers to telehealth platforms,[2] and (4) uncertainty about post-June 2023 legislative standards in the private and public insurance markets. Stakeholders across the board – including providers, carriers, and the Office of the Attorney General's Health Education and Advocacy Unit – are unclear on how the proposed telehealth credit will be implemented and how it will affect a consumer's choice to access in-person care.[3] SB 3 maintains the right of patients with MH and SUDs to receive services in-person, by barring carriers from denying coverage for a covered MH or SUD service "when provided in person solely because the behavioral health care services may also be provided through a covered telehealth benefit." INS. § 15-139(c)(1)(iii). **The General Assembly should retain its authority to protect Maryland's consumers and providers to access and deliver health care services as they determine most appropriate – whether that is in-person, via telehealth or in a hybrid fashion.**

We urge MHCC to recommend the inclusion of a standard that clearly and affirmatively protects a consumer's right to elect how to receive their care, consistent with its obligation under the SB 3 study provision to "review… the appropriateness of...the use of telehealth to satisfy network access standards required under § 15-112(b) of the Insurance Article, as specified in Section 3 of this Act…." (Sec. 4 (c)(5)(iii)). At a minimum, we urge the MHCC to include a recommendation that reinforces the existing statutory provision that bars a carrier from denying coverage of an in- person MH or SUD services solely because the service may be provided through a telehealth benefit.[4]

Enrollee election is uniquely important for patients with MH and SUD conditions to ensure that care is clinically appropriate. Unlike many medical services, MH and SUD care centers primarily on talk therapy and does not inherently require an in-person examination or procedure (except as required by federal law for certain medication administration or prescribing). Unlike somatic conditions, in which the nature of the medical problem itself will largely dictate whether an in-person or telehealth appointment is clinically appropriate, for MH and SUD services, it is the patient's unique circumstances that set the parameters of clinical appropriateness. "Enrollee election" is essentially the proxy for a medical procedure that requires in-person care. The patient and their behavioral health practitioner must determine whether telehealth is clinically appropriate, even though the required service may theoretically be delivered via telehealth.

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[1] The MIA reported that it requested data on the number and percentage of in-network providers who offer telehealth broken down by type of provider and region and found that most carriers "did not track the particular data being requested" or "were not yet able to report results" based on the initial stage of data collection. Technical Report of the Maryland Telehealth Study at 133.

[2] *See* Technical Report, App. K: MIA Analysis of Form Filing Trends in Telehealth Coverage (2022 and 2023 form provisions identify contract provisions related to "virtual" versus telehealth services and cost-sharing variations that favor designated virtual providers).

[3] *See* August 2022 stakeholder comments in response to the draft regulation on the MIA's website: https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx.

[4] While the MIA reported that carrier telehealth practices have not restricted the availability of in-person services, that assessment has been made in the context of regulatory standards that require consumer election of telehealth to satisfy network adequacy metrics and a statutory provision barring carriers from denying coverage of in-person services based on the availability of telehealth benefits. Under these circumstances, one would not expect to see carrier restrictions on the availability of in-person services.

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While the MIA has offered administrative, data-gathering and market incentive reasons for abandoning an explicit consumer election standard,[5] neither federal regulators[6] nor other states have adopted this policy. This is an issue that the General Assembly should address to both advance telehealth services and ensure consumer protection. Without clear statutory protections, the adoption of new telehealth products, as described above, will invariably affect consumer choice, forcing Marylanders to choose between their existing relationships with State-based providers and an online platform that has no connection to local resources should they wish to continue using telehealth.

* * * * *

Thank you for your thorough telehealth study and recommendations. We look forward to working with MHCC and the MIA as the General Assembly crafts updated telehealth standards.

Sincerely,

Ellen M. Weber, J.D.
Sr. Vice President for Health Initiatives
Legal Action Center
eweber@lac.org

[5] *See* Technical Report at 146-147.

[6] It is important to note that the Medicare Advantage network adequacy credit – the foundation for the MIA's proposed credit – only applies to "additional telehealth benefits" offered by a subset of providers, and plans that furnish these additional telehealth benefits are still required to both "furnish in-person access to the specified Part B service(s) at the election of the enrollee" and "advise each enrollee that the enrollee may receive the specified Part B service(s) through an in-person visit or through electronic exchange." 42 C.F.R. § 422.135(c)(1), (2). These additional standards ensure that telehealth is used as a supplement to in-person services and not a replacement, and "preserves a beneficiary's right to choose" the mode of service delivery. Centers for Medicare & Medicaid Services, Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, 85 Fed. Reg. 33796, 33863 (June 2, 2020), https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf.

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Hello Nicole:

I am the Director of Public Policy with the Maryland Coalition of Families. MCF provides family peer support and navigation services to parents and caregivers of children with mental health needs, and to any loved on of a person with any behavioral health challenge. We have been in existence since 1999.

My concern with the MHCC Report on Telehealth is that it neglects to note that for some people, particularly children, telehealth is not a satisfactory option. While many families prefer the convenience of telehealth, our family peer support staff related to me time and time again that parents were reporting great challenges with getting their child to engage in telehealth. This was especially true of very young children, but also true for some older youth. They did not participate in treatment like they did with in-person visits.

I am concerned that the failure to note the significant problems that some children experience with telehealth visits in the Report on Telehealth could negatively impact the state's decision on network adequacy requirements. Families must be given the option of in-person visits for their child, within time and distance and appropriateness metrics that currently exist in Maryland. For example, if a family on the Eastern Shore has a child who needs to see a child and adolescent therapist, they should not be forced to accept a telehealth visit with a child and adolescent therapist in Baltimore City or Montgomery County. Their insurer must have an appropriate provider within the established time and distance metrics that their child can see in-person.

That said, we are delighted that the MHCC Report recommends the continued widespread availability of telehealth, both audio-visual and audio-only, with reimbursement rates for providers equal to the rates for in-person visits (until further study). For many behavioral health consumers and providers, telehealth has been of great benefit, and the regulations that were in place during the Public Health Emergency need to be put into place permanently. We thank the MHCC for all of your effort to bring provider and consumer perspectives to your study.

Ann Geddes *(she, her)*

Director of Public Policy

Maryland Coalition of Families

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MedStar Telehealth Innovation Center

Ethan Booker, MD, FACEP
Chief Medical Officer, Telehealth

November 28, 2022

To:
Maryland Health Care Commission
Randolph S. Sergent, Esq, Chairman
and Commission Members
4160 Patterson Avenue
Baltimore, MD 21215
Attn: Nikki Majewski

Dear Mr. Sergent and Maryland Health Care Commissioners,

We appreciate the chance to provide comment on the study recommendations within the Preserve Telehealth Access Act dated December 2022 and released this month. We recognize the effort and attention that was invested by the commission, the many stakeholders and NORC in gathering information and providing a collection of succinct recommendations.

MedStar Health combines the best aspects of academic medicine, research, and innovation with a complete spectrum of clinical services to advance patient care. As the largest healthcare provider in Maryland and the Washington, D.C., region, MedStar Health's more than 300 care locations include 10 hospitals, 33 urgent care clinics, ambulatory care centers, and primary and specialty care providers. We are also home to the MedStar Health Research Institute and a comprehensive scope of health-related organizations all recognized regionally and nationally for excellence. MedStar Health has one of the largest graduate medical education programs in the country, training 1,150 medical residents annually, and is the medical education and clinical partner of Georgetown University. MedStar Health's team of more than 31,000 includes physicians, nurses, and many other clinical and non-clinical associates who together support MedStar Health's patient-first philosophy that combines care, compassion, and clinical excellence with an emphasis on customer service.

The MedStar Telehealth Innovation Center (MTIC) contains the people and resources that support the infrastructure, knowledge and innovation that has driven telehealth at MedStar, with more than 1.7 million total telehealth encounters since the start of the COVID-19 pandemic. MedStar's experience in telehealth far preceded the last two and a half years of crisis response, with programs dating back more than a decade. We currently support clinical care delivery in ambulatory practices across all specialties, with considerable use in primary care and behavioral health, on-demand services, inpatient consultation, remote patient monitoring and growing capacity in asynchronous encounters. In addition to operations, MedStar Health is home to a clinical telehealth fellowship and is the lead institution in the Connected Care Access, Research, Equity & Safety Consortium, a collaboration with Stanford Health and Intermountain Health with R-01 and R-18 AHRQ grant support for the study of telehealth utilization, equity, safety, and outcomes. Data from our initial research of nearly 1 million patients and 4.5 million primary care visits has been presented to the

Congressional Budget Office and MedPAC to demonstrate an economic substitution effect of telehealth, with a current steady state usage of telehealth blended into the care of patients without increasing overall utilization. We would be happy to discuss this research, published in Nature Portfolio Journal Digital and additional pre-publication data with the commission if it can be helpful in informing further recommendations.

As a result of our broad experience in clinical operations, education, and research we feel well informed to provide comment on the study recommendations. Below, we make several comments and request clarification, in particular, with recommendation #5, which if applied as currently written, would increase cost, decrease access, and not align with the years of operational and clinical experience in remote consultation, such as tele-stroke and remote critical care consultation which well preceded the pandemic

We respond to the recommendations:

> ***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.***

The MedStar Telehealth Innovation Center strongly agrees with this recommendation based on considerable experience with many Physician Assistants, Nurse Practitioners, therapists, and others providing the highest quality of care in a patient-centered approach supported by telehealth.

> ***2. Allow a health care provider capable of providing telehealth services using audio-visual technology to deliver services using audio-only technology under certain circumstances. 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. Allow unrestricted use of audio-only for behavioral health care based on patient consent to receive care via audio-only technology.***

The MedStar Telehealth Innovation Center agrees with this recommendation noting agreement with the study rationale that preserving audio-only interactions promotes equitable access. It is also our experience that while all telehealth visits are scheduled as video encounters, and we provide support and user interface optimization to make success likely, patients are not always capable of connecting to video. We agree that systems should not be designed with the intention of only providing audio-only access for all somatic complaints as there is richness in video encounters. We see the issue of this “failure to audio” as a system design issue and would wish to discuss other mechanisms of ensuring good faith efforts at video rather than added documentation requirement for each episode. If the judgment of the commission is that individual encounter documentation is the only consistent method of enforcement, we suggest that the documentation requirement be concise and clear.

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

We agree with comments made within the rationale of this recommendation that remote patient monitoring ("RPM") is a valuable service; however, we find the recommendation unclear. MedStar Health has a several years of experience in providing patient care through RPM with several thousand patients monitored historically and several hundred in active RPM programs for chronic disease currently. Like all clinical services, consent is obtained for the service. We would suggest that consent for services provided in a longitudinal manner have a single, clear consent process at the initiation of the program and ensure that consent is not tied to individual communications or increments of CPT coding, thus we suggest that "initiated" would be a clearer term than "furnished" in this recommendation. Our own experience with RPM programs is that large variability in patient payment responsibility, requirements for enrollment and limits on duration make programs aimed at clinical populations with a mix of payers very difficult to execute and our programs are therefore mostly limited to Medicare beneficiaries. Regarding the duration of monitoring and the quantity of data collected, this is usually spelled out explicitly in codes describing the service. The MedStar Telehealth Innovation Center RPM program leads would welcome the opportunity to speak to the Commission about our experience in RPM and how regulatory language regarding consent, synchronous patient engagement, and patient payment responsibility could improve access to this important service.

4. Allow a health care provider to use telehealth to provide hospice care services to patients in a facility or at home.

The MedStar Telehealth Innovation Center strongly agrees with this recommendation based on several years of extending palliative care services to more patients in our facilities and in their homes through telehealth including both video encounters to the patient bedside, bedside meetings with families brought together through video, video visits with patients at home and remote patient monitoring. We would add that the ability to manage pain through the use of opiate medications should be specifically noted as an important part of hospice care in some situations and would wish to see protection for prescribing of appropriate medications in these circumstances.

5. Allow telehealth services to be furnished once every three days in a hospital inpatient setting and once every 14 days in a nursing home setting. Require a minimum of at least one in-person visit 24 hours following a telehealth hospital inpatient encounter. Require one in-person visit 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.

This recommendation requires clarification, and the MedStar Telehealth Innovation would disagree with the above statement in that it arbitrarily restricts the frequency of care delivery without clinical justification and appears to add unnecessary and impractical in-person encounters that would result in either added overall cost or more likely the lack of access to consultation services that can reasonably and safely be delivered through telehealth. The rationale provided with the recommendation seems well aligned with our experience and the long-standing literature of facility based remote consultation of improving access to specialty services and when used in combination with in-person care can improve safety and decrease costs associated with transfer. Tele-stroke

programs and remote critical care have decades of operational experience providing critical access, especially in rural areas.

We would recommend eliminating any frequency restrictions on telehealth services in the inpatient or nursing home setting. The frequency of consultation services should be related to the clinical needs of the patient and should be in-line with the typical practices of those settings. Typically, in the inpatient setting a consultant will evaluate the patient, in collaboration with the primary team, daily until such time as their input is no longer required. This is a reasonable expectation of consultant services and should be true regardless of the modality of patient interaction.

Regarding the second and third sentences of the above recommendation, we agree that the primary attending and team providing inpatient care should evaluate the patient in-person daily and that the primary provider responsible for skilled nursing facility care should make routine evaluations in person. We suggest this recommendation be clarified. If the intent of the recommendation is that specialists providing consultation by telehealth also provide in-person assessment, we strongly disagree as it would limit access, add cost, is a practice at odds with considerable literature and would be operationally impractical. Rather than provide numerous examples of how MedStar Health improves access, safety and equity with remote consultation we would happily provide greater detail if needed, but it is our assumption that the issue in this recommendation is one of clarifying the role of a primary team in making in-person assessments.

> ***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.***

The MedStar Telehealth Innovation Center supports this recommendation.

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

The MedStar Telehealth Innovation Center agrees that payment levels for telehealth services should continue at parity with in-person services. We recognize the MHCC's responsibility to ensure control of cost for health care delivery and to support payment for clinical services that produce quality clinical outcomes. This clearly will require ongoing data collection and assessment, but we would request clarification in the above recommendation. MedStar Health would be a willing partner in further data collection on cost, outcomes, quality, and safety as MHCC fulfills this responsibility. We disagree that data does not exist to answer some portion of the questions posed

in the recommendations. The question of overuse, for instance, has been well evaluated and disproved in our research, Medicare claims data and data from the EHR vendor Epic. The issue of clinical effort is well described in the relativity of CPT coding. We can agree that fee-for-service billing has limitations, however, it is an effective method of quantifying clinical effort and intensity, time, and risk. The modality of delivery should have no bearing whatever on the level of professional billing as supported by appropriate documentation. MTIC would agree there is work to do in understanding the complete cost of telehealth delivery, and that there may be reason to explore practice expense or facility fee modifiers to coding to capture more accurately those cost if the intent is to continue in a resource based relative value reimbursement structure. While we suggest that much data on the financial impact to payers is available and clear, studies to assess variable costs, outcomes, and value are complex and December 2024 may not permit the longitudinal approach needed. Our AHRQ funded Patient Safety Learning Lab is a four-year study, for example. While we do not believe there is compelling evidence to restrict payment based on modality, effective study of value will be an enduring requirement which should look to large data sets for support.

Clarification of Terms - Items #9 and #12

We appreciate the effort to clarify terms in this set of recommendations as there is often confusion. MedStar Health has taken the practice of being descriptive of the services and attempting to avoid jargon whenever possible, for instance describing a scheduled video visit in primary care, on-demand video encounter for acute care services, or remote, video consultation for inpatient services, as examples. We recognize, however, the need to describe an umbrella term for a collection of clinical activities. In that way, within our health system and in communication with our colleagues in health systems and within the industry, we use the term telehealth to describe activities you have collected in item #12 but also the Communication Technology Based Clinical Services you describe in item #9. If a broader term is desired to capture all these activities, we would suggest connected care.

We would also like the opportunity to address the use of the terminology of originating and distant sites. While this terminology is long standing, it is related to a very limited model of hub and spoke deployments that were dependent upon landlines and purpose-built equipment. While describing the jurisdiction of the patient while receiving services is currently required and the business location of the provider is also needed for operations, the current framing of "sites" may be limiting and risks creating "legitimate" sites and creating inequity to patients who have traditionally had barriers to access such as homelessness. The widespread use of mobile devices and distributed teams of care is increasingly at odds with the legacy of the language of originating and distant sites.

MARYLAND INSURANCE ADMINISTRATION

The MedStar Telehealth Innovation Center agrees that telehealth can be an important component of the care of a patient, with the clinical need, the patient's preference, and the judgement of the provider determining the modality of the encounter. We agree with intent of recommendation number 14 to codify the telehealth coverage in state regulations to ensure uniformity. Variability in coverage, and a lack of clarity regarding patient out of pocket costs is a barrier to programmatic implementation of clinical programs that are appropriate for groups pf patients, remote patient monitoring being the clearest example as previously referenced. MTIC also agrees with recommendation #15 that telehealth services should not be a required modality for certain clinical

services which should always be based on clinical appropriateness, provider judgement, and patient needs. Our experience in delivering services is that a multi-modal approach, using a variety of tools for care delivery creates better opportunities for access, safety, cost control and equity.

We are aligned with the general recommendations of the study, notably finding resonance with the following statements within the conclusion:

> "All stakeholders recognize that telehealth should remain a feature of care delivery… Removing regulatory barriers to telehealth is essential to maximize opportunities to make health care more efficient, coordinated, convenient, and affordable as well as building preparedness for the next PHE. The MHCC recommends maintaining provisions in the Act to ensure coverage flexibilities for somatic and behavioral health care.

MedStar Health wishes to express gratitude for the effort to evaluate the impact of the Preserve Telehealth Access Act and the preceding PHE related allowances that rapidly expanded telehealth access, utilization and data. We appreciate the opportunity to submit our commentary in further support of the ongoing maturation of telehealth in the way we care for people. We look forward to your final recommendations and happily offer our services in partnership with you to improve the care of our community.

Sincerely,

Ethan Booker, MD, FACEP
Chief Medical Officer – Telehealth, MedStar Health
MedStar Telehealth Innovation Center
Ethan.A.Booker@medstar.net

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MedStarHealth.org

Maryland
Hospital Association

November 28, 2022

Ben Steffen
Executive Director
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue
Baltimore, MD 21215

Re: Preserve Telehealth Access Act of 2021 – MHCC Telehealth Recommendations

Dear Mr. Steffen:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on MHCC's Preserve Telehealth Access Act of 2021 Telehealth Recommendations report. We recognize the tremendous work MHCC staff and consultants did to complete this report and value the targeted outreach your team performed with consumers, providers, hospitals, and health systems.

While the field agrees with many of the findings in the report, MHA is concerned some recommendations, if adopted by the legislature without amendment, may create unintended consequences and pose a risk to equitable patient health care access. We endorse a nuanced approach to the issues discussed in the report, especially as policymakers consider the upcoming sunset for audio-only services and telehealth payment parity.

Recommendation #2 suggests placing limitations on the use of somatic audio-only services. As discussed by the Commissioners representing provider groups during the public meeting on Nov. 17, this may jeopardize the strides made for Marylanders living in areas without ready access to in-person services or audio-visual technology. Further, requiring exemptions, either for provider or patients, creates undue administrative burdens and would reduce patient access to care. Providers and hospitals observed the populations most likely to use audio-only services significantly overlaps with medically underserved communities in both rural and urban settings. Moving forward with Recommendation #2 could exacerbate existing health inequities for communities where access is already limited due to infrastructure and workforce challenges. **Legislation should recognize the vital role audio-only services play for vulnerable communities and defer to clinician judgment on whether an audio-only visit is appropriate, without requiring any additional documentation or administrative burden on the provider.**

We are also concerned with the implications of Recommendation #5, which limits the frequency of telehealth services to patients in nursing facilities or hospital inpatient settings. While the Centers for Medicare and Medicaid Services (CMS) had a similar pre-pandemic policy on telehealth visits in those locations, CMS has waived these limitations for close to three years.

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The recommendation does not address the clinical needs of patients and their ability to access specialists routinely. **Intermittent visits as outlined in the recommendation will result in prolonged hospital stays, patient deterioration, and delayed discharges**. **Visits should occur at clinically appropriate intervals—whether provided via telehealth or in-person.** Moreover, mandating in-person follow-up visits for telehealth services delivered at these locations may result in unnecessary services.

Finally, another study on payment parity for telehealth services is not necessary. While we recognize the difficulty in distinguishing services delivered via telehealth through claims data encountered during this study, we believe the benefits of maintaining payment parity for telehealth are clear. **Twenty-three other states have already accepted policies for telehealth payment parity, and we strongly urge Maryland to do the same**.

MHA is committed to moving Maryland's health care capabilities forward to keep communities healthy. We appreciate your attention to our comments and look forward to continuing our partnership with MHCC and the Maryland General Assembly.

Sincerely,

Erin M. Dorrien

Erin Dorrien
Vice President, Policy

Planned Parenthood®
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Planned Parenthood of Maryland

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To: Maryland Health Care Commission

From: Karen Nelson, President and CEO
Planned Parenthood of Maryland

Date: November 22, 2022

RE: Report on Maryland Health Care Commission's Preserve Telehealth Act of 2021

Thank you for the opportunity to submit comments to the Maryland Health Care Commission (MHCC) on the *Report on the Preserve Telehealth Act of 2021*. We agree with the report's recognition of the value of telehealth in increasing access to care, particularly for communities that have been marginalized in our health care system. In its concluding paragraph, the report summarizes that "(r)emoving regulatory barriers to telehealth is essential to maximize opportunities to make health care more efficient, coordinated, convenient, and affordable as well as building preparedness for the next PHE." However, two of the report's recommendations would actually reinstate barriers that were repealed by enactment of HB 448/SB 409 in 2020:

- In Recommendation 10, the Commission appears to be implying that the definition of established patient be limited to a patient that has been seen by a practitioner or a member of the group practice within the last three years. If incorporated into the law as written, we believe the change would make Maryland's law to be one of the most restrictive in the country. Under Health Occupations §1-1001(e)(2), current law allows health care practitioners to establish patient relationships without a history of a face-to-face visit; and

- In Recommendation 12, the Commission's suggested addition to the definition of telehealth is not inclusive of asynchronous technology, which could lead to significant confusion if adopted into statute. In other sections of the report, the Commission seems to indicate support for asynchronous platforms.

We ask the Commission considering removing Recommendations 10 and 12, as these recommendations inadvertently but dramatically limit telehealth by Maryland providers. We cannot afford these limitations, as we are in the midst of the most serious reproductive health care crisis in our lifetime. In the wake of the *Dobbs* decision, many states are moving to ban abortion and limit access to other reproductive health services, such as contraception and gender-affirming care. Providers need to retain the ability to provide care through telehealth to meet the needs of patients seeking services in Maryland.

Please let us know if any additional information would be helpful. You may contact Erin Bradley, Vice President of Public Affairs for Planned Parenthood of Maryland and Robyn Elliott, our policy and governmental affairs consultant, at erin.bradley@ppm.care and relliott@policypartners.net.

To:	Maryland Health Care Commission
From	Robyn Elliott on behalf of Public Policy Partner Clients
Date:	November 22, 2022
RE:	Draft Telehealth Report from MHCC Released November 10, 2022

Thank you for this opportunity to submit comments to the Maryland Health Care Commission's (MHCC's) *Excerpts from the Draft Telehealth Recommendation Report.* We are submitting these comments on behalf of the following Public Policy Partner clients:

Licensed Clinical Professional Counselors Maryland
Health Care for the Homeless
Maryland Addictions Directors Council
Maryland Affiliate of the American College of Nurse Midwives
Maryland Assembly on School-Based Health Care
Maryland Association for the Treatment of Opioid Disorders
Maryland Association of Youth Service Bureaus
Maryland Community Health System
Maryland Dental Action Coalition
Maryland-District of Columbia Society of Addition Medicine
Maryland Nurses Association
Maryland Occupational Therapy Association
National Association of Social Workers – Maryland Chapter
Teladoc

We support the report's underlying narrative about the importance of telehealth in increasing access to health care. Maryland's telehealth reimbursement policies, as codified by House Bill 123/Senate Bill 3 in 2021, should be extended on a permanent basis to ensure the health care system remains flexible enough to meet consumer's needs.

Concerns about Recommended Changes to the Health Occupations Article

Although we support the underlying direction of the report, we have serious concerns about the recommendations regarding definitions to the telehealth section of health occupations code. If implemented in statute, those revisions have the potential to set Maryland back in telehealth progress. Some of the proposed changes are more restrictive than current law, and many of the proposed changes would increase confusion about what health occupations law permits.

- On Recommendation 9, it is not clear why the Commission is suggesting so many changes to the current definition of telehealth under Health Occupations §1-1001(e)(2) which states, "Telehealth includes synchronous and asynchronous interactions." Most of the Commission's recommended changes – including the addition of non-face-to-face patient care communications, remote evaluation of patient videos and images, virtual check-ins, e-visits, and remote therapeutic monitoring- are already covered under the current Health Occupations definition. When the Maryland General Assembly adopted this definition in 2020 with HB 448/SB 402, the language was drafted to be technology neutral, so that they statute would not become outdated when new technology emerged. We acknowledge that there has been some confusion created by "audio-only" being excluded from the definition of telehealth, and we wonder if this is some of the impetus behind Recommendation 10. If so, they we would be happy to support you in developing options for that language.

  If the Commission intends to replace the current definition of telehealth in Health Occupations §1-1001(e)(2) with the definition in the report, then we would be opposed. The Commission's definition does not clearly authorize asynchronous communications more broadly, and therefore could be applied more restrictively than the current definition.

- On Recommendation 10, the underlying intent is unclear. Does the recommendation seek just to clarify that a provider may provide telehealth to a patient of another provider in a group practice? If so, then additional clarification is not necessary as Health Occupation §1-1002 establishes that any health care provider may establish a patient-provider relationship through telehealth. Therefore, there would be no restriction on another provider in a practice establishing a patient-provider relationship with a patient has been seen by another provider in the practice.

  Our concern, however, is that Recommendation 10 could imply the intent of using the proposed definition of established patient to restrict the provision of telehealth to only patients who have seen by the practice within the past three years. If this were the case, our clients would strongly oppose this recommendation.

- On Recommendation 11 which proposes a definition of consent for Health General, that is not be necessary as Health Occupations 1-1002(3) requires consent for all telehealth patients, so providers are responsible for compliance with this provision for patients with any type of insurance, including Medicaid and the uninsured.

- On Recommendation 12, the recommendation suggests insertion of new language into Health Occupations. We are unclear of why this may be necessary, as the only item not covered in the current definition is audio-only. If that is the issue, we would be happy to work with you on alternative approach just as we noted in our comments on Recommendation 10.

  Of significant note, the proposed definition of telehealth in this recommendation is problematic, as it excludes asynchronous platforms. If the intent is to exclude asynchronous communications, many of our clients would oppose.

  In addition, the proposed language aims to ensure that somatic, behavioral health, and oral health are included. This is well-intentioned but unnecessary, as the definition of health care practitioner under Health Occupation §1-1001(c) is inclusive of all licensed or certified somatic care, behavioral health, and dental providers.

Suggested Alternative Recommendations Regarding Health Occupations

After discussions with Commission staff, we understand that the Commission's intent is to support health care practitioners by addressing perceived ambiguities in the law. However, the current Health Occupations law is very clear – all health care practitioners are authorized to provide health care using synchronous or asynchronous communications as long as the care is clinically appropriate. We suggest that the Commission consider refocusing its recommendations on explaining the clarity provided by existing law, rather than changing the law. Our recommendations are as follows:

- The Commission's report does not discuss the Health Occupations article's telehealth provisions, which were established just as the pandemic began through HB 448/SB 402. This legislation was only one of a handful of bills signed by the Governor that year, and the bill's language is considered groundbreaking among state telehealth law. Without discussion of this significant and recent development in Maryland's legal telehealth landscape, the Commission's report is incomplete and and may give an inaccurate picture of what is currently allowed under Maryland law. We strongly recommend that the Commission modify its report to recognize the role of HB 448/SB 402 in establishing clear statutory authorization for health care practitioners to provide telehealth.

- Although not included in the technical report, Commission staff reported in our conversations that providers expressed confusion about when telehealth was permitted by law. We are not clear if the providers were confused about health reimbursement policies or health occupation boards policies. If the issue was with health occupation

board policies, we suggest that the Commission adopt a recommendation that the health occupation boards update their regulations and communications with licensees and certificate holders about what is allowed. We will note that some of the health occupation boards have outdated telehealth regulations on the books, and that they have attempted to update those regulations, but that the Secretary's office has not released the revisions for public comment. We think the delay has contributed to health care practitioner's confusion about what is allowed in telehealth by the health occupation boards.

Other Questions about the Commission's Report

We have several other questions about the Commission's report:

- On Recommendation 2, we listened to the Commission's discussion regarding reimbursement for somatic care provided through audio-only platforms. We agree with the Commissioners who raised concerns about the report's recommendation to limit reimbursement for audio-only visits for somatic care. As drafted, the recommendation may just create additional documentation for providers who need to use audio-only to reach their patients. There is no evidence that suggests audio-only visits are being used when face-to-face visits would be more clinically appropriate. In fact, the report details that the number of audio-only visits in somatic care has declined significantly, suggesting that the use of audio-only for somatic care has "right-sized" itself following the return to in-person care;

- On Recommendation 4, we would just like some clarity. The recommendation is to define remote patient technology. We would note that the definition is already defined in statute under Health General §15–141.2. Would MHCC seek any changes to that definition? In a follow-up question, we are unaware of the basis for reaching the conclusion that remote patient monitoring would need to collect minimally 2 days of data over a 30 period. There is no discussion of data that supports this recommendation in the technical support; and

- In Recommendation 6, we agree that health care providers should utilize communications technology that comply with security protocols. We would ask if the Commission has specific recommended changes to the existing law or regulations. We note security requirements are already integrated throughout regulations and in statute, both at the State and federal level. So we are unclear if MHCC may just be reiterating the importance of provider compliance with security or if any statutory, regulatory, or policy changes are recommended as next steps.

Thank you for the opportunity to submit these comments. I would be pleased to be able to support the MHCC in further developing these recommendations. My contact info is relliott@policypartneres.net or (443) 926-3443.

UNIVERSITY of MARYLAND MEDICAL SYSTEM

To Whom It May Concern:

Thank you for the opportunity to comment on the joint MHCC and NORC Report on "Telehealth Recommendations", and for the chance to help shape the future of the Preserve Telehealth Access Act of 2021.

The University of Maryland Medical System, though it's Center for Telehealth, strongly supports advancing digital access to healthcare for the betterment of our patients, and urges evidence based approaches to Telehealth regulation. We strongly support the continued allowance of telehealth by any licensed Maryland provider.

In review of the Recommendations section of the Report, the University of Maryland Medical System Center for Telehealth suggests the following edits and clarifications:

Regarding Recommendation 5:

"Allow telehealth services to be furnished once every three days in a hospital inpatient setting and once every 14 days in a nursing home setting. Require a minimum of at least one in-person visit 24 hours following a telehealth hospital inpatient encounter. Require one in-person visit 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."

The UMMS Center for Telehealth views needed adjustments to this regulation as a **top priority** given how it affects patient care, and strongly recommends the following:

a) **The removal of frequency restrictions, and removal of language that telehealth consultation can only occur every 3 days (or 14 days in SNF):** Proper consultation regularly requires more frequent intervention (typically daily) by consultant providers, and these unnecessarily restrictive requirements are not present when providing in-person care. The frequency of telehealth consultation should be a decision of the treating provider at intervals deemed most appropriate for the patient's diagnosis and acuity. Delaying inpatient consultation follow-ups to 3 days later would delay timely adjustments to patient care plans and ultimately delay patient recovery. This would result in prolonging hospital length of stay (with all of its downstream effects including increased boarding, increased ED left without being seen rates, increased ambulance offload times, etc.), and an *increase in overall cost of care*.
b) **The clarification of the in-person visit requirement after a telehealth consultation:** We certainly understand the point of view that a *primary admitting provider* (for example Internal Medicine, Family Medicine) managing a patient should see their patient *in-person* daily. This is standard practice, as a primary team should lay hands on patients regularly so they can have a whole view of patient status and inform consultants of any changes. If the in-person requirement can be satisfied by any primary provider (not the consultant), then this is reasonable. However, the wording of the restriction should be clarified. **If the restriction**

dictates that the *consulting* provider that does the telehealth consultation (or a provider in the same specialty) must see the patient within 24 hours of a telehealth inpatient visit - this would be extremely restrictive and in the majority of cases would not be possible. Inpatient consultations with specialist consultants (such as Pediatric Critical Care, Oncology, Transplant, Neurology, Neurosurgery, Infectious Disease, Emergency Medicine, Cardiology, Psychiatry, etc.) occur via telehealth because that specialty has constrained or no presence at the originating site hospital otherwise, would be in the best interest of their patient to be followed by a particular provider who would otherwise not be available any other way (for example, the patient's own oncologist or transplant physician), or because of an unexpected surge of a particular type of patient. Furthermore, these telehealth consultations regularly occur at a considerable distance. In the UMMS system, for example, specialty Pediatric ICU physicians from UMMC in Baltimore see critical pediatric patients via telehealth at UM Upper Chesapeake Medical Center to help guide care. This is because UM Upper Chesapeake does not have its own Pediatric ICU, and requires support from off-site specialty physicians to care for their pediatric population. This model is especially important when there are no transportation options or alternative hospital sites that can manage the patient due to bed availability, as is the case in the current Pediatric respiratory viral surge. It would be unreasonable for a UMMC Pediatric ICU physician taking care of these patients at a distance to abandon their own ICU and travel to Upper Chesapeake within 24 hours of a telehealth visit to fulfill the in-person requirement, and there would be no Upper Chesapeake Pediatric ICU physician to perform that duty either. This same logic is true for other specialties and subspecialities as well. Some notable examples include the UMMC Baltimore Neurology and the UM Eastern Shore hospitals, UMMC Baltimore Oncology and UM Upper Chesapeake, UMMC Baltimore Cardiology and UMROI, and more. These services are extremely important as bed availability at the UMMC tertiary care hospital is exceptionally limited. The establishment of an in-person requirement after telehealth by these services would effectively eliminate this practice model, limit the specialty care that can be provided at Maryland hospitals, and further restrict patient access to care.

Regarding Recommendation 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."

The UMMS Center for Telehealth strongly supports this recommendation.

Regarding Recommendation 2:

"Allow a health care provider capable of providing telehealth services using audio-visual technology to deliver services using audio-only technology under certain circumstances. 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. Allow unrestricted use of audio-only for behavioral health care based on patient consent to receive care via audio-only technology."

The UMMS Center for Telehealth recommends audio only without qualification. The "certain circumstances" described are the typical (and essentially only) times when audio only would be used, and therefore this appears to be a documentation requirement that will add "note bloat," increase documentation work for providers unnecessarily, and will worsen satisfaction. We therefore recommend the removal of "certain circumstances."

Regarding Recommendation 4:

"Allow a health care provider to use telehealth to provide hospice care services to patients in a facility or at home."

UMMS Center for Telehealth strongly supports. We also recommend a regulation guided investigation into the allowance of prescribing of controlled substance pain medications to hospice/palliative care patients via telehealth.

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

The UMMS Center for Telehealth supports the continuation of current payment levels for Telehealth services relative to in-person care. We recommend the consideration that more than 2 years of data on this subject has already been collected and the questions listed have already been answered in favor of continuing telehealth payment parity, with evidence for similar provider effort and the ability of providers to accurately determine what diagnoses are best served via telehealth.

Regarding Definition 12: "Telehealth"

"12. Telehealth – Includes the delivery of medically necessary somatic, dental, or behavioral health care services to a patient at an originating site by a distant site provider through communications technology that includes the use of audio-visual or audio-only technology to permit real-time interactive communication [amend: Health General Article §15-141.2(a)(7)(i) and Health Occupations Article §1-1001(e)(1)]. "

The UMMS Center for Telehealth recommends that the definition of Telehealth be expanded to include not only real-time (synchronous) care, but also asynchronous (non-real time) telehealth care. This

definition is accepted by the American Telemedicine Association and various other states and institutions.

Other comments:

The UMMS Center for Telehealth strongly urges the MHCC ***not*** to adopt any regulation that would restrict telehealth accessibility on the basis of prior or subsequent *in-person* visits. We also oppose any limitation on the number or cadence of telehealth appointments a patient can have. The current practice should remain standard and permits flexibility of care while preserving equitable access to care.

For many patients, the choice of accessing healthcare is "telehealth" or "no care" due to social stressors, provider shortages, long wait times for clinic appointments, and hospital capacity. For example, many patients are unable to feasibly take significant time off work, find childcare, or access transportation to get to in-person healthcare appointments. Telehealth, with its increased flexibility, allows these patients to access care regardless. Adding in-person requirements, regardless of interval, or limiting how often a patient can follow up with their provider would create barriers to healthcare access that would unfairly affect disabled, minority, and low socioeconomic status patients.

We recognize that, as noted in the report, there are some diagnoses that benefit from in-person evaluation and the importance of having the *option* of in-person care. However, we feel these decisions between in-person versus telehealth evaluation, and how often those visits should occur, should rest as joint determinations between the provider and the patient, acknowledging the uniqueness of each patients' situation and diagnosis, and each provider's comfort level with treating patients remotely.

Thank you again for the opportunity to comment on this important report and legislation.

Sincerely,

Todd Crocco, MD
VP of the Access Center and Telehealth
University of Maryland Medical System

Heather Beauchamp
Director of Telehealth Services
University of Maryland Medical System

Anthony Roggio, MD
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University of Maryland Medical System

ENDNOTES

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[24] NORC is a nonprofit, nonpartisan research organization that partners with government, corporate, and nonprofit clients to provide the objectivity and expertise necessary to inform critical decision making. More information is available here: www.norc.org/Pages/default.aspx.
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[33] See, n. 18, *Supra*
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[45] Based on a set of CMS billable codes and supports care not originating from a related evaluation and management (E/M) service provided within the previous seven days, nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
[46] The language is intended to establish a covered services timeframe and not meant to impact existing law that allows any health care provider to establish a patient-provider relationship through telehealth.

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