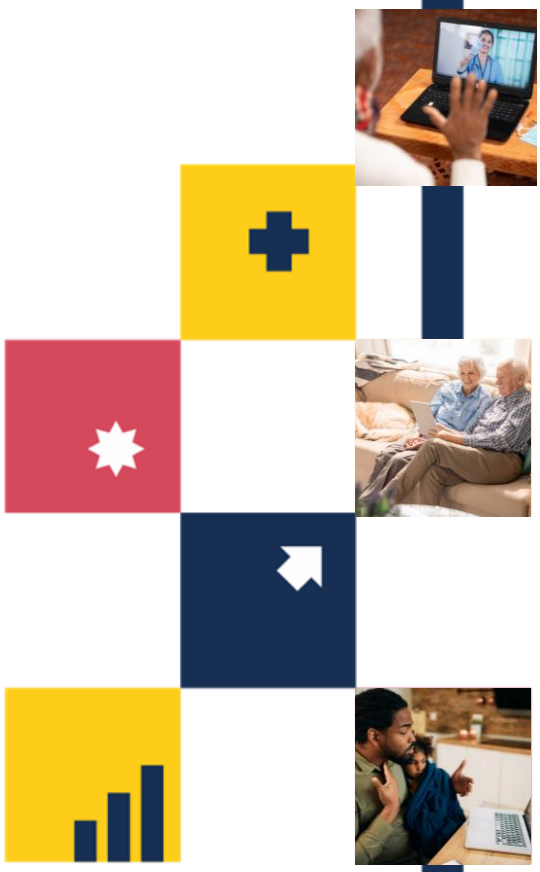
Preserve Telehealth Access Act of 2023 / Behavioral Health Care – Treatment and Access Act



Telehealth Recommendations

October 17, 2024

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MARYLAND LAW

Chapter 382 (Senate Bill 534), *Preserve Telehealth Access Act of 2023*[1] and Chapter 291 (House Bill 1148), *Behavioral Health Care - Treatment and Access (Behavioral Health Model for Maryland)*[2] of the 2023 Laws of Maryland require the Maryland Health Care Commission ("MHCC" or "Commission") to study and make recommendations regarding the delivery of somatic and behavioral health services through audiovisual and audio-only telehealth technologies, including payment parity. The study scope (Figure 1) included a literature review[3] and claims analyses for services delivered via telehealth and in-person. Findings and recommendations are due to the General Assembly by December 1, 2024 and are intended to guide future telehealth policy and legislation.

Figure 1: Study Scope

1. Determine whether it is more or less costly for health care providers to deliver health care services through telehealth;
2. Determine whether the delivery of health care services through telehealth requires more or less clinical effort on the part of the health care provider;
3. To help inform the debate on payment parity, identify the aspects of telehealth that are subject to overuse or underuse or yield greater or lower value;
4. Assess the adequacy of reimbursement for behavioral health services delivered in–person and by telehealth; and
5. Address any other issues related to telehealth as determined necessary by the Commission.

PRIOR TELEHEATLH STUDIES

The telehealth study provisions in Senate Bill 534 and House Bill 1148 (2023) build on previous studies conducted by MHCC in 2022 and 2023. Chapter 70 (House Bill 123) and Chapter 71 (Senate Bill 3), *Preserve Telehealth Access Act of 2021* required MHCC to study the impact of telehealth and make recommendations on coverage and payment levels relative to in-person care. Findings from a literature review, provider survey, behavioral health focus groups, consumer interviews, and claims analyses highlighted the value of telehealth in ensuring access to care during the COVID-19 public health emergency ("PHE") for somatic and behavioral health services, including treatment for mental

[1] Maryland General Assembly Legislation, 2023 Regular Session. Available at: mgaleg.maryland.gov/2023RS/chapters_noln/Ch_382_sb0534T.pdf.
[2] Maryland General Assembly Legislation, 2023 Regular Session. Available at: mgaleg.maryland.gov/2023RS/chapters_noln/Ch_291_hb1148T.pdf.
[3] The literature review included research published in books, scholarly articles, and other relevant sources.

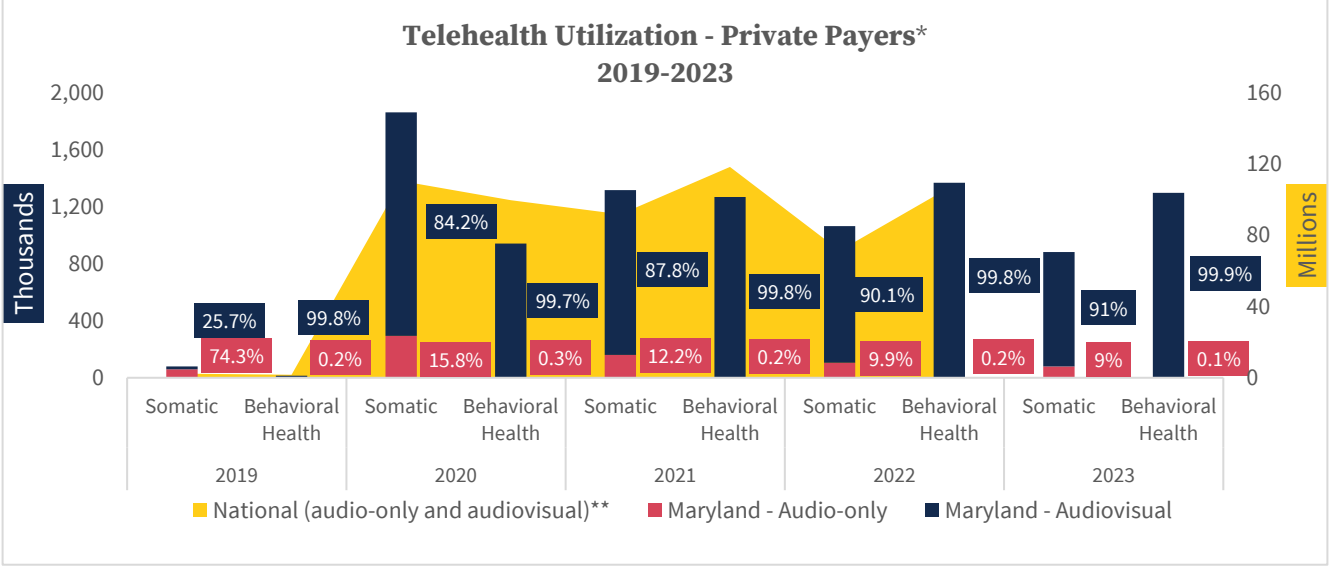
health and substance use disorders. Recommendations generally aligned with telehealth policy changes adopted by the Centers for Medicare & Medicaid Services ("CMS"); further study of payment parity for audiovisual and audio-only telehealth was recommended (see Appendix A for high-level summary of the final report).

In 2023, MHCC was requested by the Health and Government Operations ("HGO") Committee to study the ways interstate telehealth could be expanded. The scope of the study was informed by House Bill 670, *Maryland Health Care Commission – Study on Expansion of Interstate Telehealth*, which bill sponsors elected to withdraw during the 2022 session of the General Assembly. Findings highlighted how interstate telehealth can improve access to care and maintain continuity of care for Maryland residents. The recommendations aimed to inform a progressive framework for advancing interstate telehealth, including alternative licensure pathways, such as compacts (see Appendix B for high-level summary of the final report).[4]

CURRENT LANDSCAPE

Telehealth usage patterns have evolved since the early stages of the pandemic. While overall telehealth visits have declined in recent years both nationally and in Maryland, they remain significantly higher than pre-pandemic levels. Audio-only constitutes a much smaller share than audiovisual telehealth (Figure 2). Behavioral health remains steady as a top telehealth use case and is growing as a share of all telehealth volume (from 15.5 percent in 2019 to 59.5 percent in 2023 for Maryland private payers).[5] Given the long-standing impact of the pandemic, it is challenging to generalize use of telehealth in 2021 and 2022.

Figure 2:



* Maryland data represents number of services; national data represents number of visits; Maryland percentages are of total telehealth claims annually

** National data for 2023 was unavailable; more information is available at: www.trillianthealth.com/market-research/reports/2023-health-economy-trends

[4] More information about MHCC's prior telehealth studies is available at: mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/hit_telemedicine.aspx.

[5] Increase in the share of all telehealth for behavioral health services, Maryland private payers: 2019 – 15.5 percent; 2020 – 33.6 percent; 2021 – 49.1 percent, 2022 – 56.3 percent, 2023 – 59.5 percent. See Appendix C for more information on utilization by modality.

Telehealth is typically comparable to in-person visits across outcomes and clinical areas.[6, 7] The use of telehealth can help address gaps in care by extending access to patients who would either have to forgo needed care or travel long distances to receive it.[8] Virtual options promote health equity for those living in vulnerable and underserved communities.[9] A national survey found that Hispanic, Black, and Asian individuals were more likely to use audio-only telehealth services.[10] Differences in audiovisual telehealth can be due to existing structural barriers, such as access to technology, devices, and broadband.[11]

LEGISLATIVE TRENDS

Since 2020, states and private payers have largely followed federal telehealth policy changes that relaxed rules on where telehealth could originate, what services were reimbursable, and permitted modalities.[12] On July 10, 2024, CMS released the 2025 Medicare Physician Fee Schedule ("MPFS") Proposed Rule (Proposed Rule)[13] that permits the continuation of telehealth services through 2025 on a provisional or permanent basis.[14] Among other things, the Proposed Rule permanently expands audio-only options to any patient (under current rules, permanent policy for audio-only is limited to mental health and substance use disorder services).[15] Since the federal PHE expired in May 2023, states have been transitioning from temporary telehealth coverage and reimbursement policies to enacting permanent policies (see Appendix D).[16, 17]

STUDY APPROACH

Milliman, Inc. ("Milliman") was competitively selected to complete study activities that consisted of reviewing relevant literature and conducting analyses using private payer, Medicaid, and Medicare data (2019-2023) from MHCC's All Payer Claims Database ("APCD"). As part of the study scope

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[6] Kee, D., Verma, H., Tepper, D., Hasegawa, D., Burger, Weissman, M.A., Patient Satisfaction with Telemedicine Among Vulnerable Populations in an Urban Ambulatory Setting. *Mayo Clinic Proceedings: Digital Health*. March 2024. Available at: www.sciencedirect.com/science/article/pii/S2949761223000949.

[7] Hatef, E., Wilson, R.F., Zhang, A., Hannum, S.M., Kharrazi, H., Davis, S.A., Foroughmand, I., Weiner, J.P., Robinson, K.A. Effectiveness of telehealth versus in-person care during the COVID-19 pandemic: a systematic review. *NPJ Digit Med*. June 2024;7(1):157. doi: 10.1038/s41746-024-01152-2. PMID: 38879682; PMCID: PMC11180098. Available at: www.nature.com/articles/s41746-024-01152-2.

[8] *Niskanen Center*. Addressing concerns about permanent telehealth expansion in Medicare. May 2024. Available at: www.niskanencenter.org/addressing-concerns-about-permanent-telehealth-expansion-in-medicare/.

[9] Shah DA, Sall D, Peng W, Sharer R, Essary AC, Radhakrishnan P. Exploring the role of telehealth in providing equitable healthcare to the vulnerable patient population during COVID-19. J Telemed Telecare. 2022 Jul 14:1357633X221113711. doi: 10.1177/1357633X221113711. Epub ahead of print. PMID: 35833345; PMCID: PMC9283958. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC9283958/.

[10] *U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation*. Issue Brief: Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022). April 2023. Available at: aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf.

[11] *Ibid*.

[12] Shaver, J. The State of Telehealth Before and After the COVID-19 Pandemic. *Prim Care*. December 2022;49(4):517-530. doi: 10.1016/j.pop.2022.04.002. Epub 2022 Apr 25. PMID: 36357058; PMCID: PMC9035352. Available at: www.primarycare.theclinics.com/article/S0095-4543(22)00023-9/fulltext.

[13] The Omnibus Budget Reconciliation Act of 1989 contains provisions to reform the system that sets Medicare's payment rates for physicians' services in the fee-for-service sector, effective January 1, 1992. The MPFS is updated annually on a calendar year basis by CMS.

[14] A provisional basis allows additional time for evidence of the clinical benefits when services are furnished via telehealth.

[15] *Health Resources and Services Administration*. Telehealth policy changes after the COVID-19 public health emergency. Available at: telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency.

[16] *American Medical Association*. State telehealth policy trends 2023 year in review. November 2023. Available at: www.ama-assn.org/system/files/ama-state-telehealth-policy-trends-2023.pdf.

[17] Telehealth policies vary among payers; CMS requires managed care plans to provide in-person appointments alongside telehealth to meet wait time standards.

mandated by Senate Bill 534 and House Bill 1148, Milliman developed actuarial models to examine telehealth and in-person reimbursement rates for services delivered by behavioral health and primary care providers. Milliman prepared two Technical Reports based on its findings. *Technical Report One* compares the average allowed cost and clinical intensity per relative value unit ("RVU") for services provided in-person and via telehealth.[18] *Technical Report Two* compares reimbursement rates as a percent of the MPFS[19] for somatic and behavioral health services delivered in-person and via telehealth.[20] Milliman's examination validated the implementation of payment parity for telehealth services across payers.

LIMITATIONS

Milliman's examination does not compare actual payer reimbursement rates to the MPFS. Milliman used the average allowed cost per RVU (work, practice expense, and malpractice costs) for benchmarking select CPT®/HCPCS codes against the MPFS. The impact of service mix, carrier reimbursement mix, provider mix, and area mix used in the analyses was not determined.

RECOMMENDATIONS

The pandemic has firmly established telehealth as an acceptable mode of care delivery. Lessons learned have informed federal and state telehealth policy decisions. Stakeholders are generally accepting of telehealth. Consumers view telehealth as a way to access care either for convenience or out of necessity. Behavioral health providers delivering mental health and substance use disorder services have maintained their use of telehealth at levels similar to those during the PHE and view virtual options as essential for addressing access issues and workforce shortages. While use of telehealth to deliver somatic care has decreased, it is still considered a necessary option to ensure access to care when needed and a practical solution to help address some workforce challenges. Payers support telehealth expansion although express some doubt about whether outcomes at least match in-person care and the appropriateness of payment parity.

The findings in Milliman's Technical Reports underpin the recommendations for preserving telehealth coverage and reimbursement for somatic and behavioral health services inclusive of mental health and substance use disorder treatments. The MHCC will continue to monitor and report on telehealth modalities, assessing usage patterns and the overall impact on delivering somatic and behavioral health services. If the legislature enacts these recommendations, Maryland will be better aligned with an increasing number of states and CMS.

Coverage and Reimbursement

[18] RVUs are a measurement of value used by CMS to determine physician compensation. RVUs are part of the Resource-Based Relative Value Scale (RBRVS) implemented in 1992. RVUs are used to define the value of a service or procedure relative to other services and procedures. More information is available at: www.ama-assn.org/system/files/development-of-the-resource-based-relative-value-scale.pdf.

[19] The MPFS is based on the RBRVS, which assigns RVUs to procedures.

[20] For purposes of the analysis, 100 percent of the MPFS amount served as the benchmark and does not represent an opinion that 100 percent of the MPFS is or is not an adequate reimbursement level for any service.

1. ***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

Allowing qualified providers to maintain use of telehealth when needed enhances the overall flexibility and responsiveness of the health care system. Telehealth modalities promote patient choice and efficient use of health care resources, reducing geographic and logistical barriers to care.[21] Telehealth has achieved acceptance across somatic and behavioral health settings and specialties.[22] Virtual options enable a broad range of health care providers to improve equitable access and continuity of care. Use of telehealth has remained higher and more consistent for mental health and substance use disorder services since the PHE. Remote consultations for follow-ups or interprofessional consultations are beneficial in cases requiring multidisciplinary input.

Expanded use of telehealth has created new opportunities to receive primary and behavioral health care. Ensuring telehealth remains an option to access care is critical for certain underserved communities. Telehealth is an integral part of care delivery; its use may continue to increase for mental health and substance use disorder services and decline for somatic care until utilization levels stabilize. In Maryland, telehealth as a percentage of all services is highest among private payers (35 percent), followed by Medicaid Managed Care Organizations (24 percent), and Medicare Advantage plans (16 percent).[23, 24] The CMS 2025 MPFS Proposed Rule continues to support telehealth flexibilities; the Final Rule is expected in November 2024.

2. ***Allow unrestricted use of audio-only for behavioral health telehealth services based on patient consent to receive care via audio-only technology. Allow use of audio-only for somatic care if the provider is technically capable of using telehealth, but the patient is not capable of, or does not consent to, the use of audiovisual technology.***

Rationale

Allowing unrestricted use of audio-only for behavioral health services ensures broad access to mental health and substance use disorder treatments, particularly for individuals who lack audiovisual capabilities or prefer audio-only consultations.[25] It also maintains patient choice in how they access care and can improve patient satisfaction. Many patients may choose or require audio-only due to privacy concerns or personal comfort. This modality also effectively serves

[21] *The Commonwealth Fund*. Expanding Access to Equitable Behavioral Health Services. May 2022. Available at: www.commonwealthfund.org/blog/2022/expanding-access-equitable-behavioral-health-services.
[22] Gajarawala, S.N., Pelkowski, J.N. Telehealth Benefits and Barriers. *J Nurse Pract*. February 2021;17(2):218-221. doi: 10.1016/j.nurpra.2020.09.013. Epub 2020 Oct 21. PMID: 33106751; PMCID: PMC7577680. Available at: www.npjournal.org/article/S1555-4155(20)30515-8/fulltext.
[23] Data as of 2023 for private payers and MA plans; data as of 2022 for Medicaid MCOs.
[24] Approximately 25 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans in 2024.
[25] For private payers in Maryland (as of 2023), about four percent of all telehealth services were delivered using audio-only; use of audio-only is higher in somatic care (9 percent) compared to behavioral health (less than 1 percent).

underserved and vulnerable populations who lack the technological resources, financial means, or broadband access needed for audiovisual telehealth. Audio-only offers a viable communication option for maintaining continuity of care and addressing health concerns effectively. Patient consent to audio-only ensures they actively choose a communication mode that best suits their circumstances.

Possessing the technical capability to support audiovisual services in somatic care sets a standard for telehealth by prioritizing patient visualization whenever possible. This recommendation aligns with CMS's plans to remove restrictions on audio-only telehealth in the 2025 MPFS Proposed Rule.[26]

3. ***Maintain payment parity for behavioral health and somatic care delivered using audiovisual and audio-only technologies.***

Rationale

Preserving payment parity for behavioral health and somatic care delivered via audiovisual and audio-only methods ensures that telehealth options remain practical for providers. Payment parity removes financial disincentives and promotes equity by allowing providers to use telehealth modalities that are most accessible for their patients. This approach also reduces stigma that can be associated with in-person behavioral health visits helping to eliminate barriers to care. Maintaining payment parity acknowledges that telehealth involves the same level of clinical intensity and time as in-person care from the provider's perspective. Evidence on whether audiovisual or audio-only telehealth services are more costly or time-intensive than in-person services is mixed. Anecdotally, providers report that the complexity and duration of care are similar across both modalities, noting telehealth can be as resource intensive as in-person visits.

Most states (42) have coverage parity laws;[27] of these states, 29 require payment parity in some capacity for private payers (five states, including Maryland, have provisional policies). Payment parity for both audiovisual and audio-only telehealth has been enacted by 14 states (permanent policies: AR, CA, CO, CT, DE, KY, NH, NM, OK, OR, VT, WA; provisional policies MD and NY).[28,29] CMS maintains payment parity for audiovisual and audio-only telehealth services in the 2025 MPFS Proposed Rule.

TECHNICAL REPORTS – INSIGHTS

This section provides a snapshot of findings from the Milliman Technical Reports. *Technical Report One* addresses items 1 and 2 from the study scope. *Technical Report Two* addresses items 3 and 4 from

[26] The 2025 Medicare Fee Schedule Proposed rule is 2,250 pages. The fact sheet on the 2025 Proposed Rule is available https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-proposed-rule.
[27] Approaches vary with some states requiring use of certain codes and requirements to deliver in-person services or use in-network providers, among other things. More information is available at: www.foley.com/wp-content/uploads/2024/04/50-State-Telemed-Report-2024.pdf.
[28] *Center for Connected Health Policy*. Policy trend maps. More information is available at: www.cchpca.org/policy-trends/.
[29] The 15 remaining states have payment parity requirements that apply when services are delivered using audiovisual technology and/or by certain specialties (e.g., behavioral health, primary care, occupational health, etc.).

the study scope. The following summarizes some key themes from literature and claims analyses conducted by Milliman using the APCD. Refer to each Technical Report for more comprehensive information and discussion of the findings.[30]

1. ***Is it more or less costly for health care providers to deliver health care services through telehealth?***

   Snapshot

   The cost of telehealth services compared to in-person services varies based on the care site, geographic location, conditions being treated, and provider type. Some costs remain constant regardless of the care modality, which has historically not been reflected in service coding. While telehealth reduces the need for medical supplies, it requires indirect costs, including digital tools, software subscriptions, computers, webcams, equipment maintenance, and technical support. A direct comparison of costs for delivering services via telehealth versus in-person remains inconclusive and requires further clinical assessments. Notably, behavioral health services are delivered by a range of providers with specialized training and credentials. Reimbursement levels for audiovisual telehealth services have been consistent across different provider types, whether in urban or rural locations. *(Technical Report One)*

2. ***Does the delivery of health care services through telehealth require more or less clinical time and clinical intensity on the part of the health care provider?***

   Snapshot

   The level of relative clinical intensity of care provided using telehealth compared to in-person care is mixed and varies by the type of service provided. Trends show a decrease in the relative clinical intensity for behavioral health services and office/outpatient services delivered via audiovisual and audio-only telehealth. Primary care providers ("PCPs") delivered such services consistently at a lower relative clinical intensity compared to non-PCPs in rural and urban locations. There are generally lower relative clinical intensity levels for audiovisual and audio-only telehealth for most types of providers except psychiatrists in rural locations. Audiovisual telehealth services are provided at a lower level of clinical intensity compared to in-person visits for behavioral health and office/outpatient services; there is a small difference in the level of clinical intensity between urban and rural locations (behavioral health services: 92.4 percent urban and 94.6 percent rural; office/outpatient services: 83.4 percent urban and 77.1 percent rural. Payment rates for CPT®/HCPCS codes associated with lower levels of clinical intensity are already reimbursed at lower rates in existing payer fee schedules. *(Technical Report One)*

3. ***Are there aspects of telehealth that are subject to overuse or underuse or yield greater or lower value that help inform the debate on payment parity?***

   Snapshot

[30] The Milliman Technical Report One and Technical Report Two are available at: mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/hit_telemedicine_telehealth_studies.aspx.

Defining clinically appropriate levels of telehealth use was beyond the scope of Milliman's analysis. Data on telehealth use is mixed; a 2017 study found that use of telehealth was associated with fewer in-person visits suggesting telehealth is substitutive (not additive) to in-person care. Other research indicates that telehealth is additive, which doesn't necessarily suggest overuse if telehealth visits help close gaps in access to care. Additionally, telehealth may be underutilized in areas with limited broadband access and other technical limitations. Even so, increased use of telehealth since the PHE is partly due to the growing recognition of its value in improving accessibility. Some evidence suggests that telehealth can be as effective as in-person care for some somatic conditions, enhancing patient outcomes, satisfaction, and adherence, while reducing hospital admissions.[31] The Substance Abuse and Mental Health Services Administration also considers telehealth effective for behavioral health. Further research is needed to evaluate the cost-benefit of telehealth for behavioral health services at scale and its impact on consumers. *(Technical Report Two)*

4. ***Is reimbursement adequate for behavioral health services delivered in-person and via telehealth?***

Snapshot

Historically, provider reimbursement for behavioral health services has been lower than for somatic care because somatic care often involves more procedural and surgical care and less cognitive services that are reimbursed in evaluation and management codes. This discrepancy is often attributed to reimbursement models that prioritize procedural and diagnostic tests and perceived differences in the complexity and duration of behavioral health treatments. Reimbursements were compared as a percentage of the MPFS; primary care services delivered via telehealth and in-person are reimbursed at relatively higher levels compared to behavioral health services by private payers and Medicare Advantage plans. Average reimbursement rates relative to the MPFS for behavioral health services is higher among Medicare Advantage plans for telehealth and Medicaid Managed Care Organizations for in-person care. Generally, gaps in reimbursement levels between behavioral health and primary care services still exist but have narrowed over time for private payers and Medicare Advantage plans.[32] Given the ongoing role of telehealth in health care delivery, continued monitoring and analysis will be crucial to ensure that reimbursement policies are equitable and that virtual options remain available to consumers and providers. *(Technical Report Two)*

[31] National Library of Medicine, July 2024. Ezeamii V C, Okobi O E, Wambai-Sani H, et al. (July 05, 2024) *Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care*. Cureus 16(7): e63881. doi:10.7759/cureus.63881. Available at www.ncbi.nlm.nih.gov/pmc/articles/PMC11298029/.

[32] A study conducted by RTI International demonstrated that out-of-network use is much higher for behavioral health care than medical care, with greater financial burden for patients. More information available at: www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue.

APPENDIX A

Preserve Telehealth Access Act of 2021

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

RECOMMENDATIONS – January 2023

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

Coverage, Technology, and Payment Levels/Future Study

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

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

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

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

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

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

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

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

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

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

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

- *Ensures even baseline protections for privacy and security*

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

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

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

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

8. Behavioral Health – Includes mental health and substance use conditions, life stressors and crises, stress-related physical symptoms, and health behaviors (Health General).

9. Communication Technology-Based Services – Includes a variety of non-face-to-face patient care communications, such as two-way audio-only telephone interactions, remote evaluation of patient videos and images, virtual check-ins, e-visits, and remote patient monitoring (Health General).

10. Established Patient – Means an individual who receives professional health care services from a provider, or another provider who belongs to the same group practice, within the previous three years (Insurance Article).

11. Telehealth Consent – Means an affirmation received prior to or upon initiation of a telehealth encounter from the patient, family member, or caregiver for an audio-video or audio-only encounter and documented in the patient record (Health General).

12. Telehealth – Includes the delivery of medically necessary somatic, dental, or behavioral health services to a patient at an originating site by a distant site provider through communications technology (e.g., synchronous and asynchronous) that includes the use of audio-visual or audio-only technology to permit real-time interactive communication (Health General).

MIA Recommendations

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

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

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

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

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

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

APPENDIX B

Interstate Telehealth Expansion Study

In May 2022, the Health and Government Operations (HGO) Committee requested that MHCC study the ways interstate telehealth can be expanded to provide more options for State residents to receive telehealth services from out-of-state providers. The study scope was informed by House Bill 670, *Maryland Health Care Commission - Study on Expansion of Interstate Telehealth*, which was withdrawn by bill sponsors during the 2022 session. A multi-stakeholder workgroup discussed barriers and opportunities to expanding interstate telehealth that informed development of nine recommendations and four notable considerations in a **final report**. The need for legislation, regulation, or policy changes is noted in parenthesis for each recommendation and notable consideration; justifications that follow are not inclusive of all supporting rationale. The following are intended to guide first steps and should not be viewed as an exhaustive list of all things to be considered to advance interstate telehealth.

RECOMMENDATIONS – September 2023

Health Insurance Coverage and Medical Liability

a. Payers should continue to expand consumer awareness efforts on potential out-of-pocket costs for in and out-of-network providers when seeking services in-person or by telehealth (policy)

- *Services delivered by an out-of-state provider who is out-of-network can result in higher out-of-pocket costs (i.e., deductibles, copayments, and coinsurance) for consumers; use of out-of-network providers for behavioral health services is about 10 times more common in certain states, including Maryland*

b. Health occupation boards should require medical liability coverage for out-of-state providers who do not have an existing medical liability insurance policy through employment or by contract with an in-State hospital, facility, program, practice, carrier, or managed care organization licensed or certified under Maryland law (policy)

- *Uneven requirements for provider liability insurance, which is not required by federal law; about 30 states, including Maryland, do not mandate coverage*

Interstate Heath Compacts

4. The General Assembly should continue adopting legislation to implement interstate compacts to improve consumer access to providers, particularly for consumers in communities experiencing a practitioner shortage – uncodified language in Chapter 15/HB 448, *Health Care Practitioners – Telehealth and Shortage* (2020) (regulation)

- *Compacts are viewed as one approach to advance interstate telehealth with about 40 states, including Maryland, having passed legislation to support implementation of one or more interstate compacts*

5. Health occupation boards should continue to develop new pathways to licensure; continue to begin/renew conversations regarding the development of licensure by reciprocity and endorsement agreements between Maryland and contiguous states (regulation)

- *Compacts are not broadly adopted by all states, and some limitations exist (e.g., the Interstate Medical Licensure Compact can be cost prohibitive for physicians since it is the only compact requiring applicants to complete all state specific licensing requirements and pay fees to the applicable state(s) and compact)*

Practitioner Licensure Requirements

6. Allow the adoption of a mutual recognition for licensure by health occupation boards consistent with the Nurse Licensure Compact where the board recognizes the home state license; disciplinary action notifications are pushed to participating boards; any board can investigate and discipline a provider practicing in the State; and any participating board can discipline a provider based on findings in another state except where prohibited by State law (legislation)

   - *Coordinate health care licensing processes across state lines to support access to care and ease administrative requirements*

7. The General Assembly should enact legislation to allow health occupation boards to adopt a limited use telehealth out-of-state license (legislation)

   - *Support alternative approaches to licensure for providers that practice in contiguous states and meet certain conditions; about a dozen states have laws for a telehealth-specific license or registration process*

8. Health occupation boards should permit providers with an active unencumbered license in another state to deliver telehealth services to preserve continuity of care for existing patients (legislation)

   - *Minimize gaps in care in certain circumstances (e.g., follow up care, second opinions, and specialty assessments)*

9. The General Assembly should enact legislation to allow an out-of-state health care entity***** under common ownership with an in-State entity to deliver telehealth services to preserve the continuity of care for existing patients (legislation)

   - *Need for shared decision-making when a valid treatment relationship exists; credentialling processes among health care organizations that ensure providers meet and maintain certain qualifications and standards review many of the same documents required for licensure (e.g., education, training, work history, and peer references)*

*****Includes hospitals and organizations that deliver health care services through a broad array of coverage arrangements or other relationships with practitioners, either by employing them directly or through contractual or other arrangements

Promoting Out-of-State Telehealth

Health occupation boards should require out-of-state health care providers who treat Maryland residents to access and securely share patient health information electronically with primary care providers, except where prohibited by law (legislation)

- *Electronic health data sharing using a health information exchange, such as CRISP, is critical to ensure providers can make informed decisions about patient care and support continuity of care*

NOTABLE CONSIDERATIONS

Related Matters

a. Where practical, health occupation boards should maintain comparable education and training requirements (policy)

- *Minimize potential patient safety issues as licensure standards and processes vary among state health occupation boards*

b. Encourage health occupation boards to increase licensure digitization processes (policy)

- *Improve licensure application processes to reduce burden and increase efficiencies*

c. Improve processes related to Maryland licensure requirements for service members, veterans, or military spouses (policy)

- *Military-related moves between states pose significant challenges for families; higher unemployment among military spouses as compared to the general population largely due to mobility of military life*

d. Encourage the Maryland Department of Public Safety and Correctional Services (DPSCS) to identify an alternative pathway to accept electronic background record checks from out-of-state vendors recognized in their state of origin (policy)

- *Challenges with completing the required background check can discourage out-of-state providers from seeking a Maryland license since fingerprinting must be completed at select Maryland sites or after written request for a fingerprinting card by mail*

APPENDIX C

Telehealth Services by Modality *Maryland Private Payers, 2019-2023*			
Telehealth Services	**Audio-only**	**Audiovisual**	**Total**
2019			
Overall	62.85% (59,391)	37.15% (35,104)	100% (94.495)
Somatic	99.96%	58.42%	84.53%
Behavioral Health	0.04%	41.58%	15.47%
2020			
Overall	10.59% (296,614)	89.41% (2,504,863)	100% (2,801,477)
Somatic	99.02%	62.56%	66.42%
Behavioral Health	0.98%	37.44%	33.58%
2021			
Overall	6.31% (163,028)	93.69% (2,420,387)	100% (2,583,415)
Somatic	98.61%	47.72%	50.93%
Behavioral Health	1.39%	52.28%	49.07%
2022			
Overall	4.45% (108,135)	95.55% (2,322,901)	100% (2,431,036)
Somatic	97.82%	41.23%	43.75%
Behavioral Health	2.18%	58.77%	56.25%
2023			
Overall	3.68% (80,282)	96.32% (2,098,474)	100% (2,178,756)
Somatic	98.69%	38.25%	40.48%
Behavioral Health	1.31%	61.75%	59.52%

Note: Refer to Figure 2 for information on telehealth utilization as a percentage of somatic and behavioral health services.

APPENDIX D

The following table is a national snapshot of telehealth coverage and reimbursement for Medicaid and private payers. Different approaches exist across states as it relates to telehealth coverage and payment parity. Refer to a state's specific telehealth policy or law for more information.

Telehealth Reimbursement Policies and Laws by State and Washington, D.C. *As of July 2024*				
State	**Medicaid Policy**	**Private Payer Law**		
	Audio-Only	*Coverage Parity*	*Payment Parity* **Provisional*	
			Audiovisual	Audio-Only
Alabama	✓			
Alaska	✓	✓		
Arizona	✓	✓	✓	✓
Arkansas	✓	✓	✓	✓
California	✓	✓	✓	✓
Colorado	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓
Delaware	✓	✓	✓	✓
District of Columbia	✓	✓		
Florida				
Georgia	✓	✓	✓	✓
Hawaii	✓	✓	✓	
Idaho	✓			
Illinois	✓	✓	✓	✓
Indiana	✓	✓		
Iowa	✓	✓	✓	
Kansas	✓	✓		
Kentucky	✓	✓	✓	✓
Louisiana	✓	✓	✓	✓
Maine	✓	✓		
Maryland	✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓
Michigan	✓	✓		
Minnesota	✓	✓	✓	✓
Mississippi		✓		
Missouri	✓	✓		
Montana	✓	✓		
Nebraska	✓	✓	✓	✓
Nevada	✓	✓	✓	✓
New Hampshire	✓	✓	✓	✓
New Jersey		✓	✓	✓
New Mexico	✓	✓	✓	✓

Telehealth Reimbursement Policies and Laws by State and Washington, D.C. *As of July 2024*				
State	**Medicaid Policy**	**Private Payer Law**		
	Audio-Only	*Coverage Parity*	*Payment Parity* **Provisional* Audiovisual	 Audio-Only
New York	✓	✓	✓	✓
North Carolina	✓			
North Dakota	✓	✓		
Ohio	✓	✓	✓	
Oklahoma	✓	✓	✓	✓
Oregon	✓	✓	✓	✓
Pennsylvania	✓			
Rhode Island		✓	✓	✓
South Carolina	✓			
South Dakota	✓	✓		
Tennessee	✓	✓	✓	
Texas	✓	✓		
Utah	✓	✓		
Vermont	✓	✓	✓	✓
Virginia	✓	✓		
Washington	✓	✓	✓	✓
West Virginia		✓	✓	✓
Wisconsin	✓			
Wyoming				
Totals	45	42	29	25

A checkmark (✓) indicates:
Medicaid Policy

- **Audio-Only**: Policy for Medicaid reimbursement of audio-only telehealth exists

Private Payer Law

- **Coverage Parity**: Law exists that requires the same services be covered via telehealth as would be covered if delivered in-person (does not guarantee the same rate of payment)
- **Payment Parity:** Law exists that requires the same payment rate or amount to be reimbursed via telehealth as would be if it had been delivered in person for at least one specialty (e.g., behavioral health) or site type (e.g., FQHCs)

Source: The Center for Connected Health Policy, www.cchpca.org

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