Telehealth Studies:

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

Report Summary

October 17, 2024

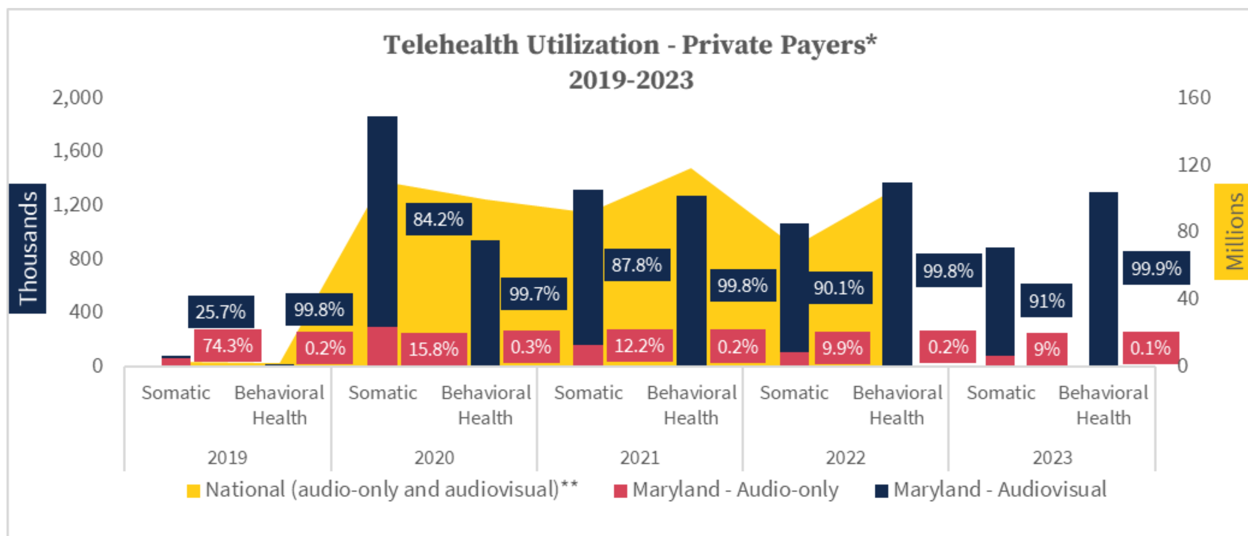
MARYLAND LAW

Senate Bill 534, *Preserve Telehealth Access Act of 2023* and House Bill 1148, *Behavioral Health Care - Treatment and Access (Behavioral Health Model for Maryland)* of the 2023 Laws of Maryland require the Maryland Health Care Commission ("MHCC") to study and make recommendations regarding the delivery of somatic and behavioral health services through audiovisual and audio-only telehealth technologies, including payment parity. Findings and recommendations are due to the General Assembly by December 1, 2024, and intended to guide future telehealth policy and legislation.

CURRENT LANDSCAPE

- 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 1)

Figure 1:



- Behavioral health remains steady as a top telehealth use case and is growing as a share of all telehealth volume
- Virtual options promote health equity for those living in vulnerable and underserved communities and address gaps in care by extending access to patients who would either have to forgo needed care or travel long distances to receive it

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
  - Since the federal PHE expired in May 2023, states have been transitioning from temporary telehealth coverage and reimbursement policies to enacting permanent policies
- On July 10, 2024, CMS released the 2025 Medicare Physician Fee Schedule ("MPFS") Proposed Rule (Proposed Rule) that permits the continuation of telehealth services through 2025 on a provisional or permanent basis
  - 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 behavioral health)

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
- Among other things, Milliman's analysis validated the implementation of payment parity for telehealth services across payers
- Milliman's technical reports informed telehealth coverage and reimbursement recommendations

COVERAGE AND REIMBURSEMENT RECOMMENDATIONS

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

   - Telehealth has achieved acceptance across somatic and behavioral health settings and specialties
   - Allowing qualified providers to maintain use of telehealth when needed enhances the overall flexibility and responsiveness of the health care system, helping promote patient choice and efficient use of health care resources and reduce geographic and logistical barriers to care
   - Expanded use of telehealth has created new opportunities for certain underserved communities to receive primary and behavioral health care
   - Use of telehealth may continue to increase for behavioral health services and decline for somatic care until utilization levels stabilize
   - 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 care and substance use disorder treatments, particularly for individuals who lack audiovisual capabilities or prefer audio-only consultations
- Audio-only offers a viable communication option for maintaining continuity of care and addressing health concerns effectively
- Audio-only 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 effectively serves underserved and vulnerable populations who lack the technological resources, financial means, or broadband access needed for audiovisual telehealth
- 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

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
- State-level snapshot
  - Most states (42) have coverage parity laws; 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)
- CMS maintains payment parity for audiovisual and audio-only telehealth services in the 2025 MPFS Proposed Rule

MILLIMAN'S ANALYSIS - A SNAPSHOT OF FINDINGS

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

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
- There are generally lower relative clinical intensity levels for audiovisual and audio-only telehealth for most types of providers except psychiatrists in rural locations

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

- National data on telehealth use is mixed (defining clinically appropriate levels of telehealth use was beyond the scope of Milliman's analysis)
  - 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
- 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
- The Substance Abuse and Mental Health Services Administration considers telehealth effective for behavioral health

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 somatic care
  - Discrepancy is often attributed to reimbursement models that prioritize physical health and perceived differences in the complexity and duration of behavioral health treatments
- Reimbursements were compared as a percentage of the MPFS
  - 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