MARYLAND HEALTH CARE COMMISSION

School-Based Telehealth Workgroup

DRAFT RECOMMENDATIONS

BACKGROUND

In March 2018, the Senate Finance Committee (Committee) expressed the need to assess policies in the State governing telehealth in primary and secondary schools. The Committee requested that the Maryland Health Care Commission (MHCC) convene a school-based telehealth workgroup (workgroup). The workgroup was charged with identifying deficiencies in existing policies that impede diffusion of telehealth in schools and developing recommendations – statutory, regulatory, or technical – to improve these policies. The MHCC submitted an interim report to the Committee in January 2019[1]; a final report is due by November 1, 2019.

ABOUT THIS DRAFT

This draft includes suggested recommendations that are intended to provide a practical foundation for diffusing telehealth in schools. The recommendations are a culmination of workgroup deliberations on select technology and policy matters from May 2018 through August 2019; shared goals, priorities, and unique perspectives among workgroup participants informed an iterative approach in developing the recommendations. This penultimate draft provides a summarization of key themes that emerged from workgroup deliberations that in part, form the basis of the recommendations. In general, the recommendations aim to foster discussions that guide strategy for implementing telehealth in schools as a means to augment existing programs. For purposes of this draft, references of "telehealth in schools" or "school-based telehealth" encompass school-based health centers (SBHCs), school health services (SHS), and special education program (IEP)[2] related services.[3]

LIMITATIONS

The recommendations do not represent unanimous agreement among the workgroup. Gradients of agreement in viewpoints range from endorsement to disagreement. Viewpoints are reflective of individual participants, and should not be generalized to reflect the official position of a State agency or stakeholder group that participated on the workgroup.

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[1] Available at:
mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/SBTele/SBT_Interim_Report_Final.pdf.

[2] The Individuals with Disabilities Education Act (IDEA) requires an individualized education program (IEP) be developed if a child is determined to have a disability that requires specialized instruction. An IEP is a written document and process outlining the who, what, when, why, where, and how of instruction and related services that are to be provided to a student with disabilities. More information available at: www.marylandpublicschools.org/programs/Documents/Special-Ed/FSS/BuildingIEPswithMDFamiliesMar2018.pdf.

[3] Related services means services required to assist a student with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, among other things.

SUMMARY

Telehealth is viewed by the workgroup as an innovative technology meant to complement, not replace, traditional in-person health care. In general, use of telehealth in schools can help address provider shortages, improve academic and health outcomes, and increase student access to health care and related services.[4] Telehealth program policy considerations vary among SBHCs, SHS, and special education related services. The Maryland State Department of Education (MSDE) and Maryland Department of Health (MDH) convene program policy workgroups and stakeholder advisory groups (some that are mandated) to discuss various policy-related matters and develop policy recommendations. The workgroup supports expanding policy discussions among these groups as it relates to use of telehealth in schools as a service delivery mechanism. These discussions may require inclusion of diverse subject matter experts, such as those in the field of telehealth, as needed.

Budget limitations are a significant impediment to diffusing telehealth in schools; adoption will remain slow absent funding to support implementation. The workgroup recommends establishing a grant fund for school districts that implement telehealth to foster growth and help offset the costs of telehealth in schools. The workgroup was unable to estimate implementation costs for telehealth in schools due to variability of needs and uncertainty regarding how school districts may choose to implement telehealth technology.

SUGGESTED RECOMMENDATIONS

1. <u>Increasing Awareness</u>

Key Themes

A. Knowledge about the value of telehealth in schools fosters acceptance among students, parents/guardians, school administrators, and community providers

B. Strategies to communicate and develop messages regarding telehealth in schools needs to be culturally and linguistically appropriate

C. Telehealth champions working collaboratively with community providers are essential to promoting diffusion of telehealth in schools

D. Awareness building activities should focus on telehealth in schools as a practical alternative (as needed and medically appropriate) to in-person care

Recommendation

Leverage telehealth champions to promote awareness of telehealth in schools (through stakeholder education) and build community partnerships.

Discussion

Telehealth in schools can enable access to care for a wide range of health care and special education related services. Promoting and advancing telehealth is rooted in far-reaching community partnerships. The workgroup agrees that personal stories from telehealth champions throughout the community can help foster change. Language and cultural

[4] mHealth Intelligence. *Factors Behind the Adoption of School-based Telehealth*. Available at: mhealthintelligence.com/features/factors-behind-the-adoption-of-school-based-telehealth.

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barriers present challenges for increasing awareness. The workgroup considers the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care,* issued by the Office of Minority Health at the U.S. Department of Health and Human Services, as an appropriate framework to guide messaging.[5]

2. <u>Privacy and Security</u>

Key Themes

A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[6] as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act[7] in 2009, and the Family Educational Rights and Privacy Act of 1974 (FERPA)[8] include adequate privacy and security protections for telehealth in schools[9]

B. The American Telemedicine Association's (ATA) *Core Operational Guidelines for Telehealth Services* includes appropriate technical standards[10] for privacy and security, among other things[11]

Recommendation

Rely on federal privacy laws (HIPAA and FERPA) to protect student privacy; require schools to implement telehealth technology consistent with ATA technical standards.

Discussion

HIPAA, as amended by HITECH and FERPA, provide privacy protections of a student's health record for telehealth in schools.[12, 13] ATA technical standards bolster privacy and security for telehealth, including technical quality and reliability of telehealth encounters; these standards are periodically updated by ATA. The workgroup agrees that federal requirements and ATA technical standards are sufficient protections for students receiving health care and special education related services via telehealth.

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[5] *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* aim to advance health equity, improve quality, and eliminate health care disparities. More information is available at: www.thinkculturalhealth.hhs.gov/clas/standards.

[6] Pub.L. 104–191, 110 Stat. 1936(1996).

[7] Enacted as part of the American Recovery and Reinvestment Act of 2009 (Pub.L 111-5).

[8] FERPA (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

[9] Schools are subject to HIPAA if a provider engages in activities to transmit health care information electronically in connection with certain administrative and financial transactions (covered transactions) outlined in 45 CFR § 160.102 (e.g., billing). FERPA applies to any information that is maintained in student education records, including school health records, by a school/school district that receives funds under any program administered by the U.S. Department of Education. More information is available at: www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf.

[10] American Telemedicine Association. *Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions*, May 2014. Available at: www.uwyo.edu/wind/_files/docs/wytn-doc/toolkit-docs/ata_core_provider.pdf.

[11] ATA guidelines also include standards for communication, devices and equipment, and connectivity for real-time telehealth encounters. These standards are the result of accumulated knowledge and expertise of ATA workgroups and other leading experts in telehealth. Certain technical aspects may vary among schools based on location, resources, and telehealth use cases.

[12] HIPAA and FERPA are designed to protect students' information and prevent anyone without authorization from accessing the information. There is some intersection between these two federal laws and some exceptions. For more information, refer to The U.S. Department of Education's *Joint Guidance on the Application of the FERPA and HIPAA to Student Health Records*: www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf.

[13] FERPA and HIPAA privacy protections for student education records has created confusion for public health efforts. More information is available at: http://www.astho.org/programs/preparedness/public-health-emergency-law/public-health-and-schools-toolkit/comparison-of-ferpa-and-hipaa-privacy-rule/.

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3. Policy Development – Oversight and Innovation

A. Oversight

Key Themes

A. SBHCs, SHS, and special education related services require unique policies for telehealth

B. Diverse stakeholders and participants from MSDE and MDH are needed to develop policies governing telehealth in schools

C. Program standards for telehealth in schools must be agile and complement nationally recognized standards of care for the use of telehealth technology

Recommendation

Leverage existing advisory groups with established programmatic responsibilities for SBHCs, SHS, and special education related services to develop policies for school-based telehealth.

Discussion

Existing advisory groups, such as the Maryland State School Health Council,[14] the Maryland Council on Advancement of School–Based Health Centers (CASBHC),[15] and the School Health Services Practice Issues Committee, have processes for developing policies, guidelines, and standards for SBHCs, SHS, and special education related services, some of which are required by State mandates. These advisory groups, with the addition of select subject matter experts (ad hoc), are well-suited to develop policies to incorporate telehealth as an aspect of existing programs. The unique characteristics and associated challenges pertaining to SBHCs, SHS, and special education related services make it impractical to centralize policy development for telehealth in schools. The workgroup recognizes that stakeholder engagement is essential to ensuring policy is developed in a transparent manner and representative of all constituencies, including special education, somatic, and mental health care providers. The workgroup suggests that advisory groups assess their existing stakeholder involvement strategies, and seek opportunities to maximize engagement when formulating school telehealth policies.

B. Innovation

Key Themes

A. Policies need to inspire creative approaches to diffusing telehealth in schools and fostering continuity of care

B. Timely development of policies is necessary to support continuous innovation

C. School telehealth pilots should be encouraged and supported more broadly across the State through supportive and nimble policy and program development processes.

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[14] The mission of the Maryland State School Health Council is to promote coordinated school health programs by providing leadership and support to local school health councils and State and local agencies. More information is available at: msshc.wordpress.com/.

[15] Maryland law established the CASBHC in 2015 to improve the health and educational outcomes of students who receive services from SBHCs through integration with health care and education systems at the State and local levels. See House Bill 375, *Education – Maryland Council on Advancement of School–Based Health Centers*: mgaleg.maryland.gov/2015RS/chapters_noln/Ch_417_hb0375E.pdf.

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Recommendation

Advance development of policies to support implementation of innovative approaches and meaningful use of telehealth in schools.

Discussion

Telehealth can augment how schools deliver care to students for health and special education related services. The workgroup aspires for a future state where telehealth in schools can be widely implemented. Flexible policies that foster innovation are essential to achieving this future state. Policies need to support rapidly evolving technology, which can outpace existing policies and legal requirements. The policy framework needs to focus on high-level direction that ensures practical, safe, and equitable telehealth encounters, continuity of care with a student's medical home, and privacy and security of student health information. Many on the workgroup acknowledge the systematic approach and time commitment involved in policy development. The workgroup agrees that a nimble policy framework is necessary to support an evolving process, foster innovation, and maximize the value of telehealth in schools.

4. Funding

Key Themes

A. Telehealth adoption requires a financial investment by schools, community providers, and others

B. Cost to implement telehealth in schools vary by school district

C. Financial incentives are needed to encourage school districts and community providers to invest in telehealth

D. Limitations in Medicaid and private payor reimbursement challenge sustainability of telehealth in schools

Recommendation

Establish a grant fund available to school districts that implement telehealth in SBHCs, SHS, or special education related services.

Discussion

The workgroup considered payor reimbursement (public and private) and a grant fund as options to support implementation of telehealth in schools. Expanding reimbursement by third party payors is viewed favorably among some on the workgroup; however, it requires a State mandate. The workgroup noted several concerns with this approach, including how private payors often pass costs of a State mandate to employers, who in turn pass them onto consumers, and that the self-insured market accounts for nearly 52 percent of commercially insured lives that are excluded from State mandates.[16, 17] Medicaid is the main payor for school-based health care (delivered within SBHCs) and special education related services,

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[16]Maryland Insurance Administration, *2018 Report on The Number of Insured and Self-Insured Lives*, December 2018. Available at: insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2018-Report-on-the-Number-of-Insured-and-Self-Insured-Lives-MSAR7797.pdf.

[17] Employee Retirement Income Security Act of 1975 (ERISA), 29 U.S. Code § 1003(b). Available at: legcounsel.house.gov/Comps/Employee%20Retirement%20Income%20Security%20Act%20Of%201974.pdf.

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and would assume most of the cost imposed by a State mandate. Contract negotiations with Medicaid Managed Care Organizations would be required. It is unlikely the federal government would approve matching Federal Financial Participation (FFP)[18] funds for an enhanced rate resulting in use of State-only dollars (general funds).

A more plausible option is to establish an independent five-year grant fund (approximately $10M)[19] separate from other funding sources to supplement telehealth costs in schools. The grant fund could be derived from more than one source to support the purchase of telehealth equipment, its integration with electronic systems (e.g., the school electronic health record), and other activities related to implementation and training. The grant fund is not intended to replace or conflict with existing State mandates or policy that pertain to SBHC, SHS, and special education related services. Most on the workgroup agree that grants should be competitively awarded with the funding amount determined based on the specificity of the approach (e.g., target audience, scope of work, etc.) and reasonableness (e.g., needs assessment) for telehealth as demonstrated in a school district's application. A collaborative approach among MHCC, MSDE, and MDH was suggested to manage the grant fund.

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[18] FFP is a percentage of State expenditures to be reimbursed by the federal government for administrative and program costs of the Medicaid program.
[19] The duration and amount represents the minimum funding commitment that is required to achieve rapid diffusion of telehealth in schools. An in-depth financial analysis was not completed.