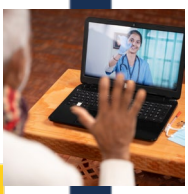
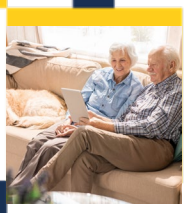
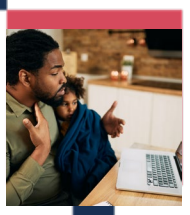
DRAFT







Preserve Telehealth Access Act of 2021

Telehealth Recommendations

DECEMBER 2022

Randolph S. Sergent, Esq.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND
Health Care
Commission

MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq., Chairman
Vice President and Deputy General Counsel
CareFirst BlueCross BlueShield

Arun Bhandari, M.D.
Chesapeake Oncology Hematology
Associates, PA

Cassandra Boyer, BA
Business Operations Manager
Enterprise Information Systems Directorate
US Army Communications Electronics Command

Marcia Boyle, MS
Founder
Immune Deficiency Foundation

Trupti N. Brahmbhatt, Ph.D.
Senior Policy Researcher
Rand Corporation

Kenneth Buczynski, M.D.
Founder of Wellspring Family Medicine

Tinisha Cheatham, M.D.
Physician in Chief of the Mid-Atlantic
Permanente Medical Group

Martin L. "Chip" Doordan, MHA
Retired Chief Executive Officer
Anne Arundel Medical Center

Mark T. Jensen, Esq.
Partner
Bowie & Jensen, LLC

Jeffrey Metz, MBA, LNHA
President and Administrator
Egle Nursing and Rehab Center

Gerard S. O'Connor, M.D.
General Surgeon in Private Practice

Michael J. O'Grady, Ph.D.
Principal, Health Policy LLC, and
Senior Fellow, National Opinion Research Ctr
(NORC) at the University of Chicago

Awawu Ojikutu, CRNP
Nurse Practitioner
AIM Behavioral Health Services

Marcus L. Wang, Esq.
Co-Founder, President, and General Manager
ZytoGen Global Genetics Institute

Karrie M. Wood
Director of Business Development
Community Bank of the Chesapeake

Table of Contents

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 care 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] Barriers exist that 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 care 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 section that follows includes recommendations from the Maryland Insurance Administration ("MIA") (13-15) related to the Act.

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.***

Rationale

The option to use telehealth gives health care providers 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 care. 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 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.***

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 care 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. A justification in the health record for converting from audio-visual to audio-only is necessary to support its use.

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 care, 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 care 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 furnished 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 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 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.***

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.

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 care 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 care. 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 care 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 care accounts for the largest share of telehealth services. The PHE intensified long-standing challenges in meeting a growing crisis to treat behavioral health care conditions, especially among Medicare and Medicaid enrollees.[43, 44] Behavioral health

care 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 care services.

Clarification of Terms

8. ***Behavioral Health Care*** – Includes mental health and substance use conditions, life stressors and crises, stress-related physical symptoms, and health behaviors [amend: Health General §7.5–101(d)].

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 therapeutic monitoring [insert: Health Occupations Article §1-1001(e)].

10. ***Established Patient*** – Means an individual who receives professional health care services from a provider, or another provider of the same specialty who belongs to the same group practice, within the previous three years [insert: Health Occupations Article §1-1002].

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 [insert: Health General Article §15-141.2(a)(7)].

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)].

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 care 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 care. Audio-only care should continue for behavioral health care 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	✓	✓	✓	
Oklahoma		✓	✓	✓

Telehealth Reimbursement Policies and Laws by State and Washington, D.C.				
State	**Medicaid Policy**		**Private Payer Law**	
	Audio-Only	*RPM*	*Law*	*Payment Parity*
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 care 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 care 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 care 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

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**
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
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

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**
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
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.	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 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.	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 furnished 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 to patients in a facility or at home.	Support access where the consumer / patient is physically located	✓	✓	✓		
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.	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:	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,	✓	✓	✓	✓	✓

MHCC Telehealth Study Recommendations						
Recommendation	**Consideration**	**Data Sources that Support Recommendations**				
		Consumer Interviews	**Provider Survey**	**Behavioral Health Focus Groups**	**Claims Analysis**	**Literature Review**
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.	utilization, cost, quality, and value to inform telehealth policy					

ENDNOTES

[1] In accordance with § 2-1257 of the State Government Article.
[2] Maryland General Assembly Legislation, 2021 Regular Session. Available at: mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0123?ys=2021RS.
[3] *Center for Connected Health Policy*. (2021). "State Telehealth Laws and Medicaid Program Policies." *National Library of Medicine*. Available at: www.cchpca.org/2021/10/Fall2021_ExecutiveSummary_FINAL.pdf.
[4] Shaver J. "The State of Telehealth Before and After the COVID-19 Pandemic." Prim Care. 2022 Apr 25. doi: 10.1016/j.pop.2022.04.002. Epub ahead of print. PMCID: PMC9035352. *National Library of Medicine*. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/.
[5] Volk, J., Palanker, M., O'Brien, M., & Goe, C. (2021). "States' Actions to Expand Telemedicine Access During COVID-19 and Future Policy Considerations." *The Commonwealth Fund*. Available at: www.commonwealthfund.org/publications/issue-briefs/2021/jun/states-actions-expand-telemedicine-access-covid-19.
[6] See, n. 4, *Supra*.
[7] Colbert, G. B., Venegas-Vera, A. V., & Lerma, E. V. (2020). Utility of telemedicine in the COVID-19 era. *Reviews in Cardiovascular Medicine, 21*(4), 583-587. Available at: pubmed.ncbi.nlm.nih.gov/33388003/.
[8] Chen, J., Li, K. Y., Andino, J., Hill, C. E., Ng, S., Steppe, E., & Ellimoottil, C. (2022). Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic. Springer Link, *Journal of General Internal Medicine*, 37(5), 1138-1144. Available at: link.springer.com/article/10.1007/s11606-021-07172-y.
[9] *National Conference of State Legislatures*. (2022). Health Disparities Legislation. Available at: www.ncsl.org/research/health/health-disparities-laws.aspx.
[10] Joseph, B. (2022). "States Making Pandemic Telehealth Policy Changes Permanent." *LexisNexis Insights*. www.lexisnexis.com/community/insights/legal/capitol-journal/b/state-net/posts/states-making-pandemic-telehealth-policy-changes-permanent
[11] See, n.9, *Supra*.
[12] *National Conference of State Legislatures.* (2020). "State Telehealth Policies." Available at: www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx.
[13] As of 2022, 43 states require telehealth reimbursement by private payers as compared to 15 states in 2015. *LexisNexis Insights.* (2022). Available at: lexisnexis.com/community/insights/legal/capitol-journal/b/state-net/posts/states-making-pandemic-telehealth-policy-changes-permanent
[14] See, n.9, *Supra*.
[15] Eberly, L. A., Kallan, M. J., Julien, H. M., Haynes, N., Khatana, S. A. M., Nathan, A. S., ... & Adusumalli, S. (2020). "Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic." *JAMA Network Open*, 3(12), e2031640-e2031640. Available at: jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488.
[16] Uscher-Pines, L., Arora, N., Jones, M., Lee, A., Sousa, J. L., McCullough, C. M., & Ober, A. J. (2022). "Experiences of Health Centers in Implementing Telehealth Visits for Underserved Patients During the COVID-19 Pandemic." *Rand Health Quarterly*. Available at: www.rand.org/pubs/research_reports/RRA1840-1.html.
[17] Lam, K., Lu, A. D., Shi, Y., & Covinsky, K. E. (2020). "Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic." *JAMA Internal Medicine*, 180(10), 1389-1391. Available at: jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768772.
[18] Remes, J., Manyika, J., Smit, S., Kohli, S., Fabius, V., Dixon-Fyle, S. & Nakaliuzhnyi, A. (2021). "The consumer demand recovery and lasting effects of COVID-19." Available at: www.mckinsey.com/industries/consumer-packaged-goods/our-insights/the-consumer-demand-recovery-and-lasting-effects-of-covid-19.
[19] Karimi, M., Lee, E.C., Couture, S.J.,Gonzales, A.B.,Grigorescu, V., Smith, S.R., De Lew, N., and Sommers, B.D. "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services." (Research Report No. HP-2022-04). *Office of the Assistant Secretary for Planning and Evaluation, U. S. Department of Health and Human Services. February 2022*. Available at: aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021.
[20] Hays, R. D., & Skootsky, S. A. (2022). "Patient Experience with In-Person and Telehealth Visits Before and During the COVID-19 Pandemic at a Large Integrated Health System in the United States." Springer Link, *Journal of General Internal Medicine*, 37(4), 847-852. Available at: link.springer.com/article/10.1007/s11606-021-07196-4.
[21] *J.D. Power*. (2021). *2021 U.S.* "Telehealth Usage Surging but Service Issues and Barriers to Access Strain Patient Experience." *J.D. Power Finds.* Available at: www.jdpower.com/business/press-releases/2021-us-telehealth-satisfaction-study.
[22] Holcomb, D., Faucher, M. A., Bouzid, J., Quint-Bouzid, M., Nelson, D. B., & Duryea, E. (2020). "Patient Perspectives on Audio-Only Virtual Prenatal Visits Amidst the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

pandemic." *Obstetrics & Gynecology*, 136(2), 317-322. Available at: journals.lww.com/greenjournal/Fulltext/2020/08000/Patient_Perspectives_on_Audio_Only_Virtual.16.aspx.
[23] See, n. 21, *Supra.*
[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.
[25] A dedicated stakeholder web page for the telehealth study is available here: mhcc.maryland.gov/mhcc/Pages/hit/hit_telemedicine/hit_telemedicine_legislative_update.aspx.
[26] Gajarawala, S. N., & Pelkowski, J. N. (2021). "Telehealth Benefits and Barriers." The Journal for Nurse Practitioners, 17(2), 218-221. Available at: www.npjournal.org/article/S1555-4155(20)30515-8/fulltext.
27 Totten AM, Hansen RN, Wagner J, Stillman L, Ivlev I, Davis-O'Reilly C, Towle C, Erickson JM, Erten-Lyons D, Fu R, Fann J, Babigumira JB, Palm-Cruz KJ, Avery M, McDonagh MS. "Telehealth for Acute and Chronic Care Consultations." Comparative Effectiveness Review No. 216. (Prepared by Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) *AHRQ Publication No. 19-EHC012-EF*. Rockville, MD: Agency for Healthcare Research and Quality; April 2019. Available at: effectivehealthcare.ahrq.gov/sites/default/files/cer-216-telehealth-evidence-summary.pdf.
[28] *mHealth Intelligence. (2018).* "CMS Gives Telehealth a Nudge with Coverage for Virtual Check-Ins." Available at: mhealthintelligence.com/news/cms-gives-telehealth-a-nudge-with-coverage-for-virtual-check-ins.
[29] *Houston, R. & Ralls, M. (2022).* "The Doctor Will Hear You Now: Audio-Only Telehealth and the Promise of Access, Equity, and Engagement in Medicaid." Center for Health Care Strategies. Available at: www.chcs.org/the-doctor-will-hear-you-now-audio-only-telehealth-and-the-promise-of-access-equity-and-engagement-in-medicaid/.
[30] Schwartz, A., & Sloan, K. (2021). " Audio-Only Technology Can Bridge the Telehealth Divide." *Morning Consult.* Available at: morningconsult.com/opinions/audio-only-technology-can-bridge-the-telehealth-divide.
[31] *U.S. Department of Health and Human Services.* "HHS Issues Guidance on HIPAA and Audio-Only Telehealth," June 2022. Available at: www.hhs.gov/about/news/2022/06/13/hhs-issues-guidance-hipaa-audio-telehealth.html.
[32] See, n. 43, *Supra*
[33] See, n. 18, *Supra*
[34] Pronovost, P. J., Cole, M. D., & Hughes, R. M. "Remote Patient Monitoring During COVID-19 – An Unexpected Patient Safety Benefit—Reply." *JAMA Network*, 328(3), 303-304. (2022). Available at: jamanetwork.com/journals/jama/fullarticle/2789635.
[35] *American Hospital Association (2022).* "Studies Find That Remote Monitoring Advanced Care During Pandemic." Available at: www.aha.org/aha-center-health-innovation-market-scan/2021-09-14-studies-find-remote-monitoring-advanced-care.
[36] Pronovost PJ, Cole MD, Hughes RM. "Remote Patient Monitoring During COVID-19: An Unexpected Patient Safety Benefit." *JAMA Network*. 2022;327(12):1125–1126. doi:10.1001/jama.2022.2040. Available at: https://jamanetwork.com/journals/jama/fullarticle/2789635.
[37] *Journal of Hospice & Palliative Nursing.* "Best Practices for Using Telehealth in Hospice and Palliative Care," June 2021. Available at: journals.lww.com/jhpn/Abstract/2021/06000/Best_Practices_for_Using_Telehealth_in_Hospice_and.13.aspx.
[38] *Centers for Disease Control and Prevention.* (2020). "Telehealth Interventions to Improve Chronic Disease." Available at: www.cdc.gov/dhdsp/pubs/telehealth.htm.
[39] Groom, L. L., McCarthy, M. M., Stimpfel, A. W., & Brody, A. A. (2021). *Telemedicine and Telehealth in Nursing Homes: An Integrative Review. Journal of the American Medical Directors Association*, 22(9), 1784-1801. Available at: pubmed.ncbi.nlm.nih.gov/33819450/.
[40] *Jama Internal Medicine.* "The Disappearance of the Primary Care Physical Examination—Losing Touch," August 2020. Available at: jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769550.
[41] *Federal Register, Vol. 85, No. 77, Rules and Regulation.* "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID–19 Nationwide Public Health Emergency," April 2020. Available at: www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.
[42] Claims data used in the study for commercial payers, Medicaid, and Medicare was for the period 2018 through 2021. Claims level detail for 2021 Medicare data was unavailable; summary level data provided by the Health Services Cost Review Commission was used by NORC to aggregate select data to certain specifications.
[43] Knutson, K., & Rajkumar, R. (2020). "Behavioral Health: A Payer-Based Strategy For Improving Access And Quality During COVID-19 And Beyond." *Health Affairs*. Available at: www.healthaffairs.org/do/10.1377/forefront.20200618.440697/.
[44] Guth, M. (2021). "State Policies Expanding Access to Behavioral Health Care in Medicaid." *KFF*. Available at: www.kff.org/medicaid/issue-brief/state-policies-expanding-access-to-behavioral-health-care-in-medicaid/.

[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.

This page intentionally left blank.

MARYLAND
Health Care
Commission

4160 Patterson Avenue
Baltimore, MD 21215

mhcc.maryland.gov