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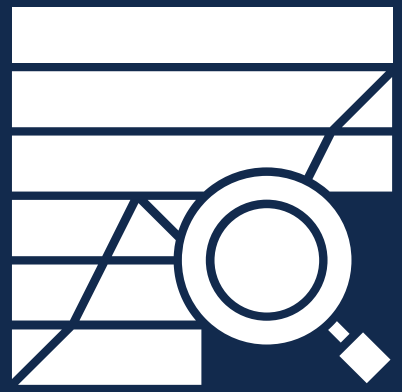


Telehealth Study

FINDINGS AND RECOMMENDATIONS

NOVEMBER 17, 2022

Overview

- The Maryland legislature passed the *Preserve Telehealth Access Act of 2021** (Act) during the 2021 legislative session
  - Prolongs telehealth coverage and payment through June 30, 2023, including services delivered using audio-only technology
  - Requires MHCC in collaboration with state agencies to study the impact of telehealth and develop recommendations on telehealth coverage and payment levels relative to in-person care
- A telehealth study yielded 16 recommendations as it relates to telehealth coverage, technology, payment levels and future study, terms in statute, and network adequacy
  - Recommendations are due to the Senate Finance Committee and the House Health and Government Operations Committee by December 1, 2022

**Effective July 1, 2021*

See Appendix for information on a telehealth policy workgroup that preceded the Act (slide 53) and the telehealth legislative landscape nationally (slide 54)

Background

- June 2021 - MHCC issued an Emergency Request for Proposals to obtain a contractor with subject matter expertise in telehealth and new models of integrated care, and proficiency in conducting quantitative and qualitative research
- September 2021 - NORC at the University of Chicago was competitively selected to complete the study in accordance with the Act

Over the last year, a dedicated stakeholder web page has featured periodic updates on the study's progress: mhcc.maryland.gov/mhcc/Pages/hit/hit_telemedicine/hit_telemedicine_legislative_update.aspx

See Appendix for more information on the stakeholder web page (slide 55)

Study Objectives

- Conduct quantitative and qualitative research on telehealth that considers both **audio-only and audio-visual technologies** relative to in-person care for **somatic (physical) and behavioral health care** interventions in accordance with specified study components in the Act*

- Develop a **Technical Report and Recommendations Report** based on evidence from study findings

**See Appendix for information on study components (slides 56-57)*

Study Activities – At a Glance

PROVIDER SURVEY

Over 1,000 responses

CONSUMER ENGAGEMENT

Structured interviews with 78 English and Spanish speaking Maryland consumers

FOCUS GROUPS

Two sessions with behavioral health care subject matter experts from provider and consumer organizations

CLAIMS ANALYSIS

Explored trends in telehealth use from 2018-2021 for Medicaid and commercial claims and 2018-2020 for Medicare

LITERATURE REVIEW

A review of existing evidence to examine the impact of telehealth on access, utilization, and cost

TOWN HALLS

Two events with providers and payers to discuss the current and future state of telehealth

NORC
Study Findings

Alana Knudson, PhD

Director, NORC Walsh Center for Rural Health Analysis

Access to Telehealth Services

NORC at the University of Chicago

Maryland consumers and providers want telehealth permanence

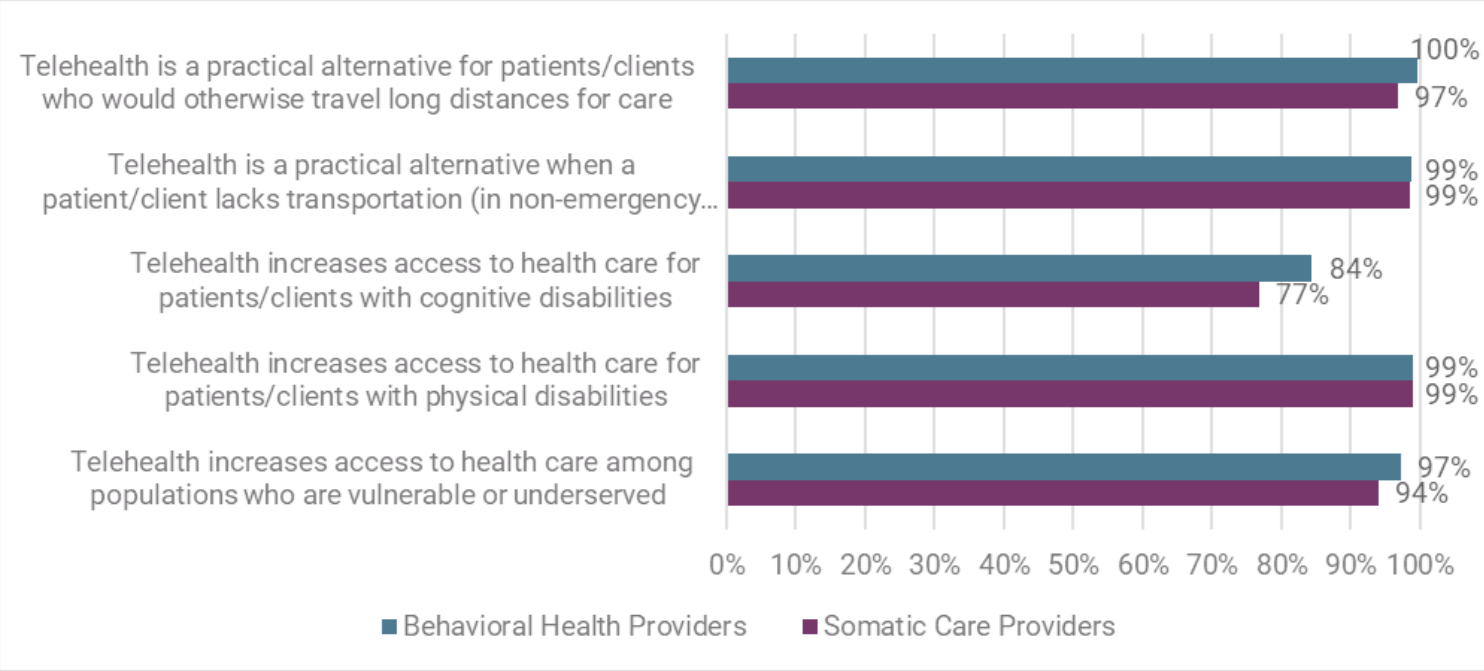
Maintain audio-only and audio-visual technology options

- Preference for audio-visual technology, but want option to use audio-only technology when technical issues occur
  - Lack of access to smartphones, tablets or computers
  - Not having the technological expertise to use audio-visual technology
  - Some sensitive topics may be best discussed using audio-only technology

Consumers identify advantages to telehealth

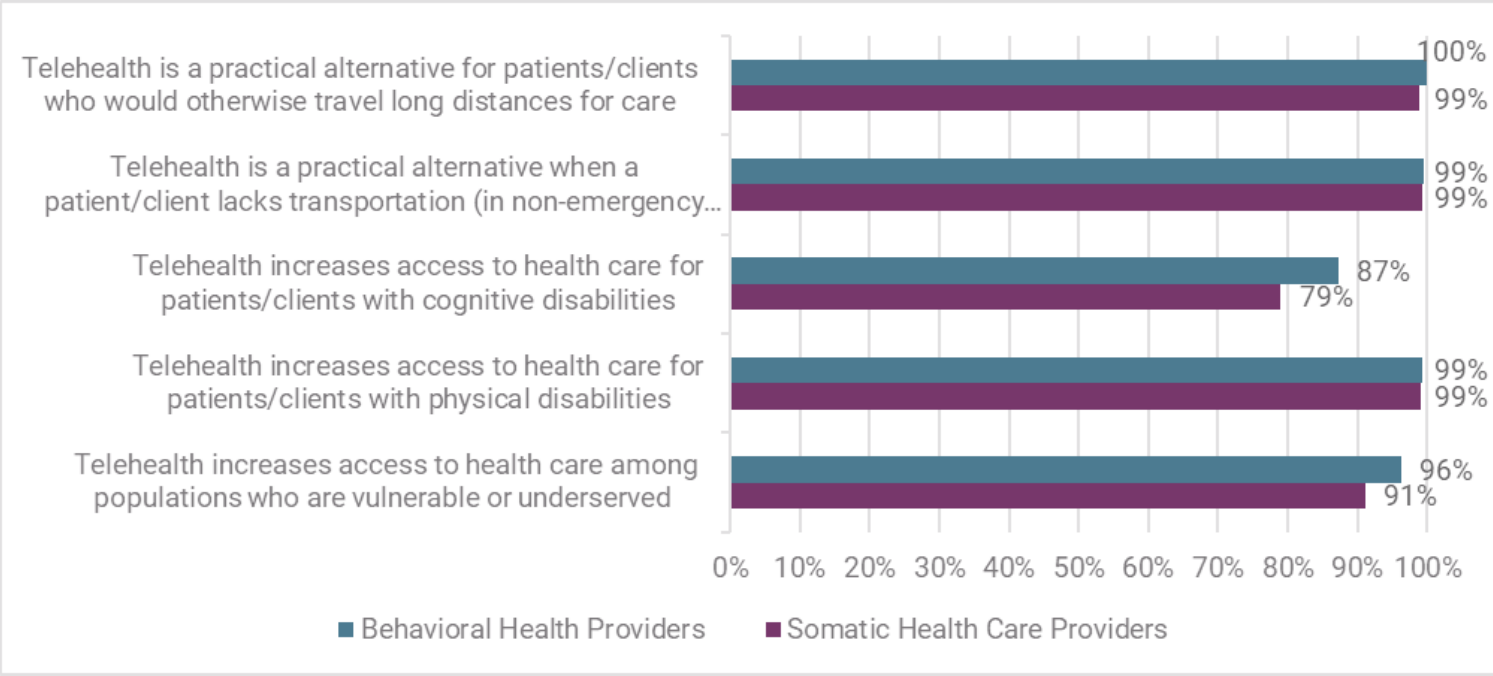
- Convenience, agency in selecting a provider, protects privacy, feeling “more heard” by providers
- Reduces access barriers
  - Transportation costs, wait times, distance to providers, mobility

Provider perceptions on how **audio-only telehealth** has affected care for different groups



Note: The exhibit shows provider perceptions on how audio-only telehealth has affected care for different groups. Both behavioral health care providers and somatic care providers had similar perceptions regarding how audio-only telehealth has affected care for different groups.

Provider perceptions on how **audio-visual telehealth** has affected care for different groups



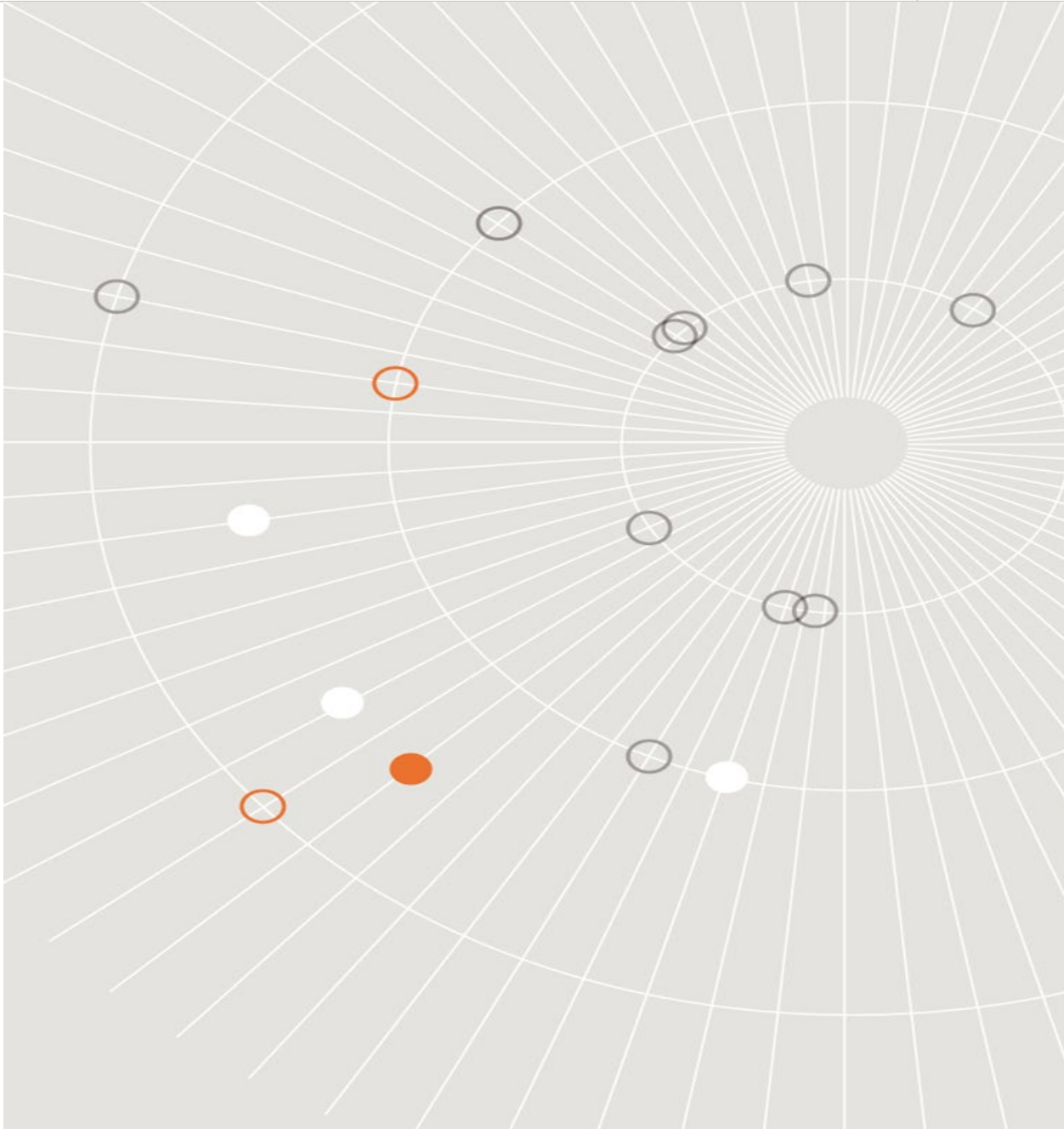
Note: The exhibit shows provider perceptions on how audio-visual telehealth has affected care delivery for different groups. Both behavioral health care providers and somatic care providers had similar perceptions regarding how telehealth has affected care for different groups.

Utilization of Telehealth Services

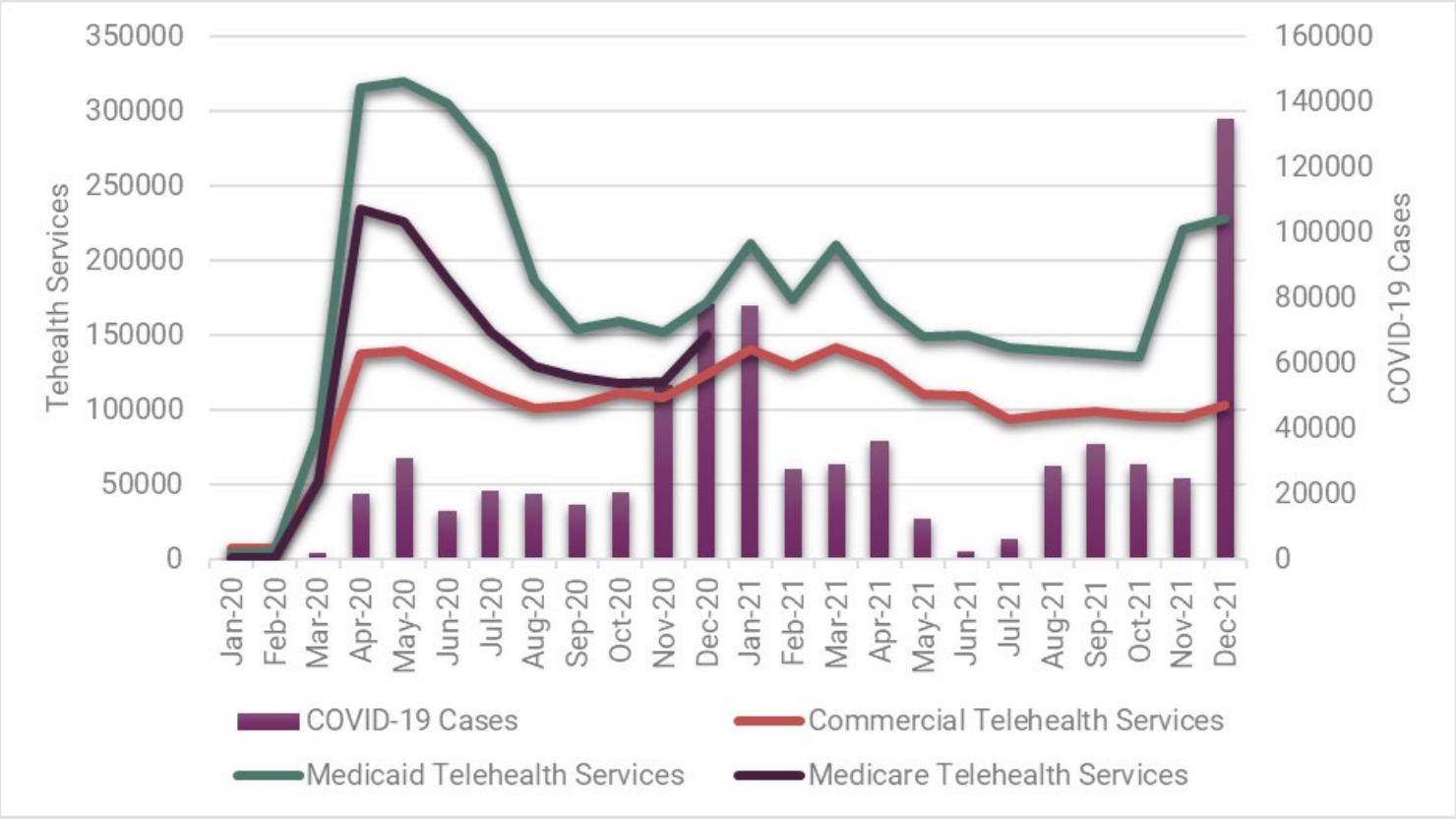
NORC at the University of Chicago

Who used telehealth services in Maryland during the PHE?

- Urban individuals used more telehealth services than rural individuals (claims)
- Younger individuals (27-49 YO) used more telehealth services than older individuals (75+ YO) (claims)
- Patients with limited English language proficiency were less likely to use telehealth services (provider survey)

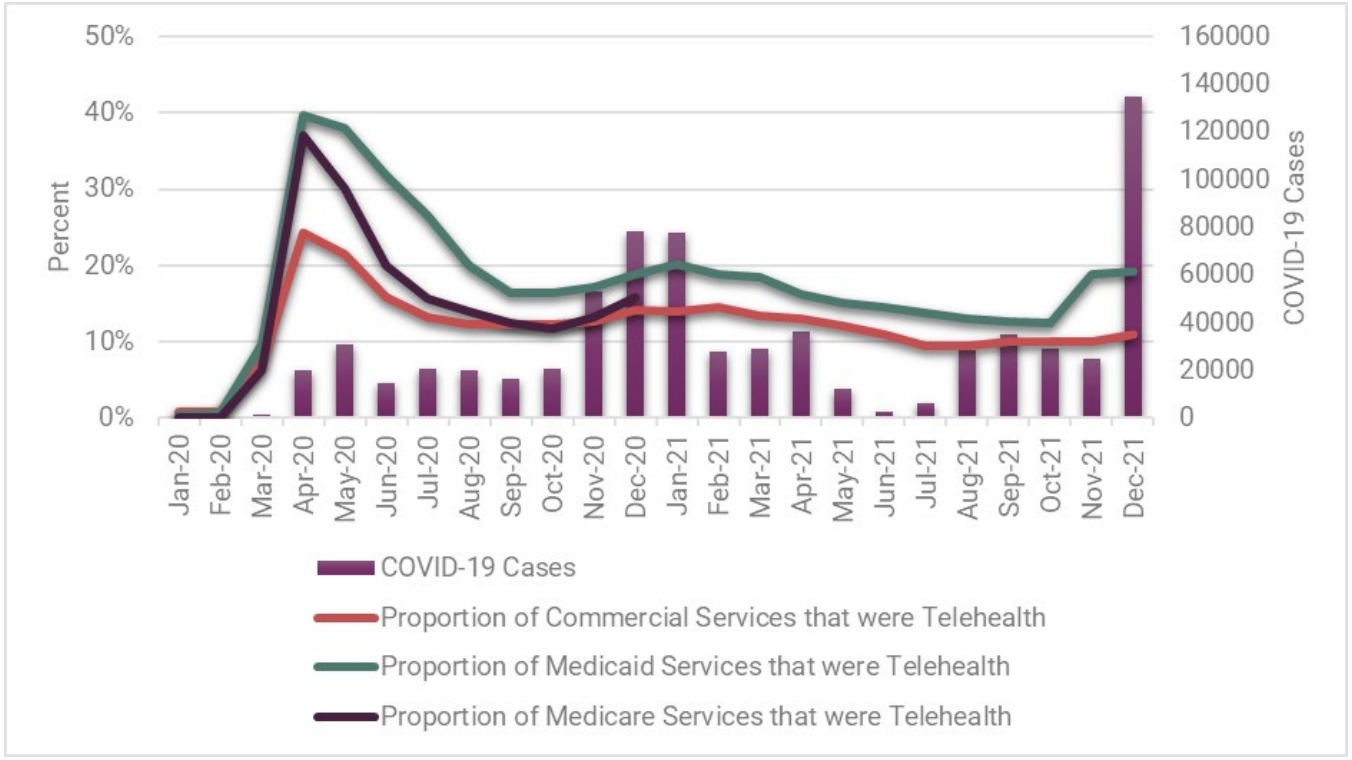


Number of E&M Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the monthly number of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

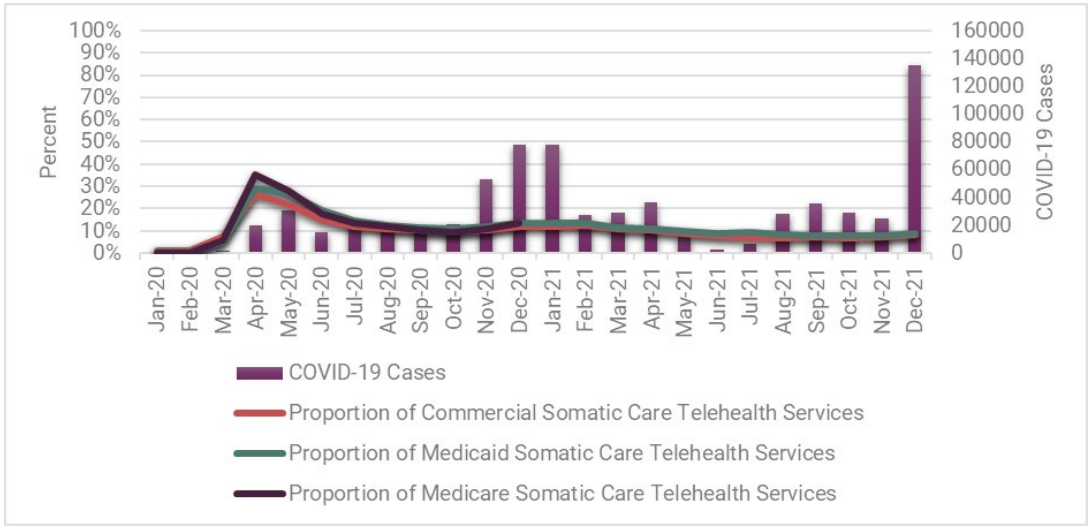
Proportion of E&M Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims



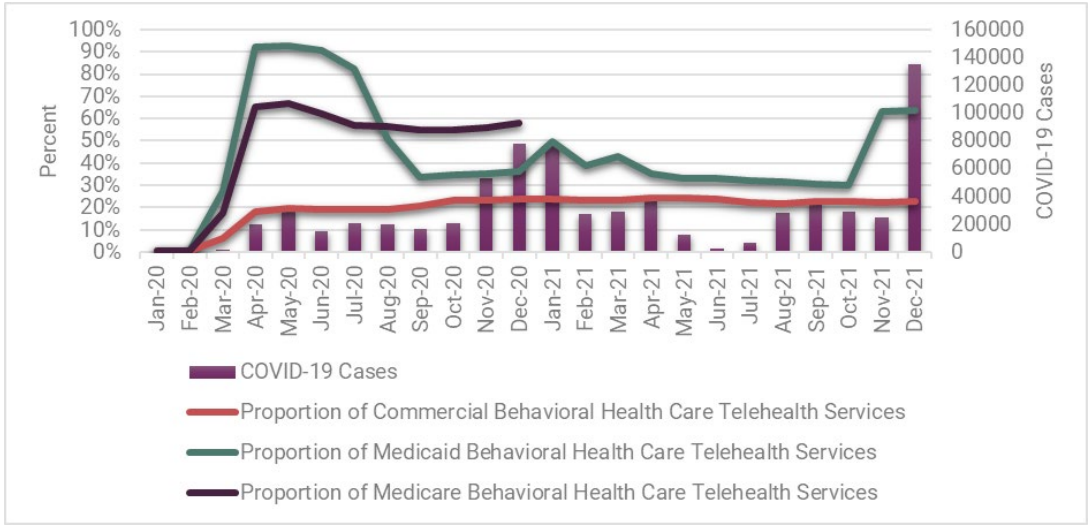
Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the proportion of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Comparing the Proportion of Somatic and Behavioral Health Care Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims, E&M Services

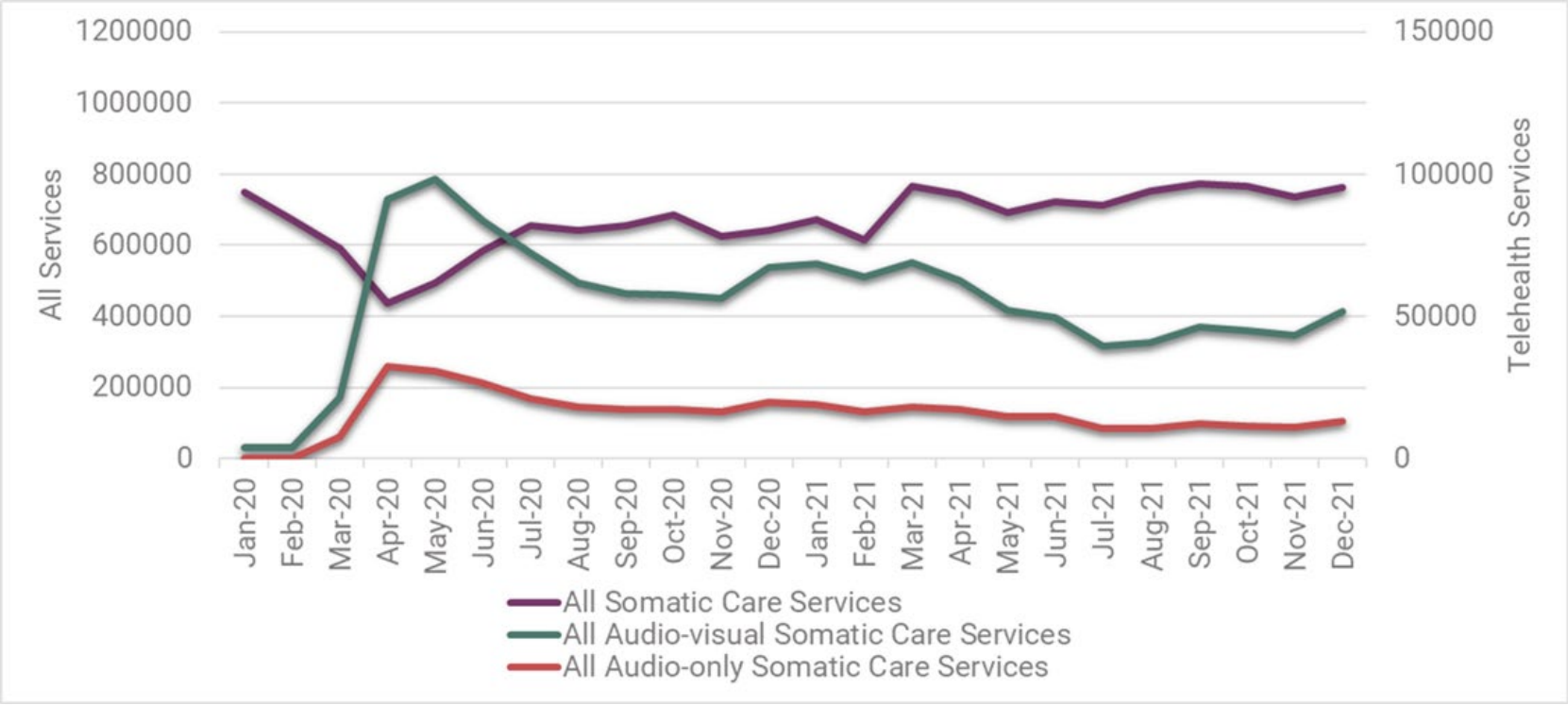
Somatic Care



Behavioral Health Care

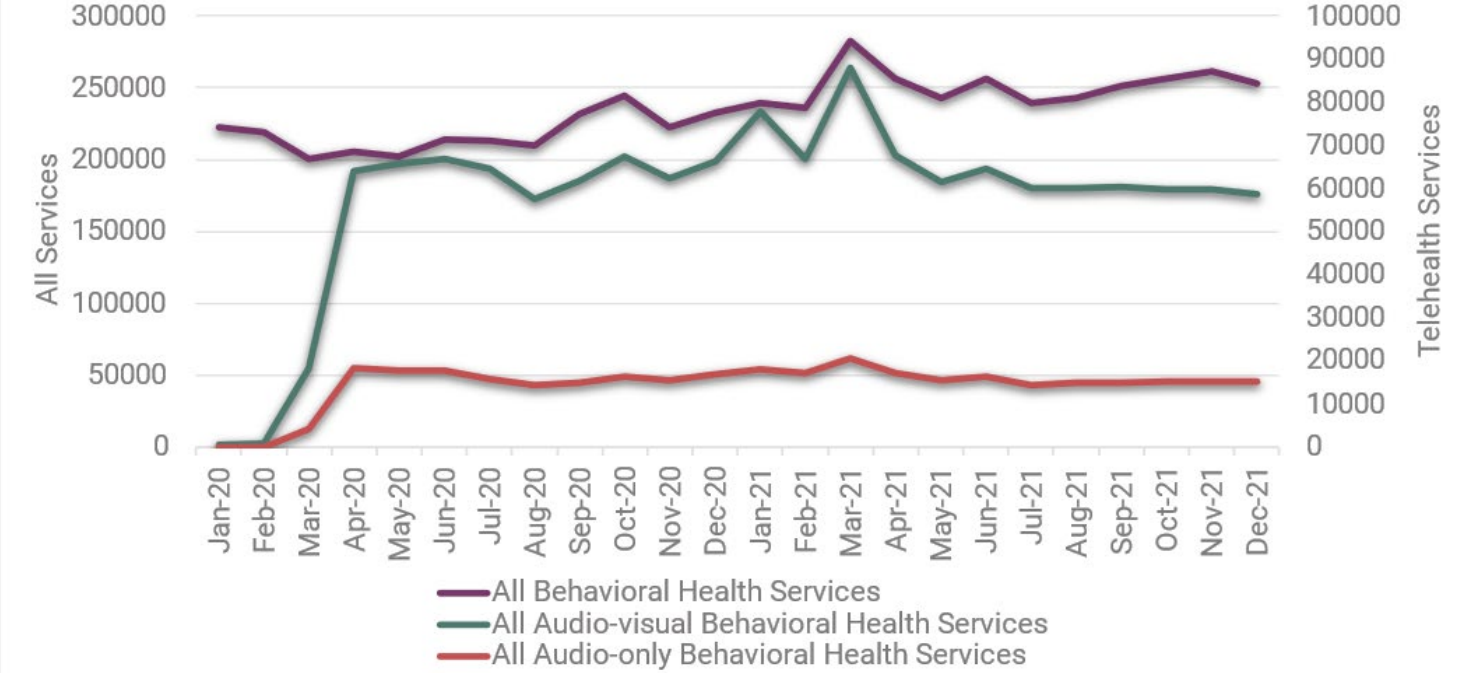


Differences in Utilization of E&M Telehealth Technologies of All **Somatic Care** Services per Month in Maryland, 2020 to 2021, **Medicaid Claims**



Notes: Maryland Medicaid claims data from 2020 to 2021 was used to identify levels of service utilization for all services and for all telehealth services by technology. BETOS codes were utilized to determine somatic care service type. Unlike commercial and Medicare telehealth codes, the Medicaid telehealth codes always distinguished between audio-visual and audio-only services – there are no claims in the "All Audio-visual or Audio-only Somatic Care Services" category. This category was included for all analyses to maintain consistency across all payers.

Differences in Utilization of E&M Telehealth Technologies of All **Behavioral Health Care** Services per Month in Maryland, 2020 to 2021, **Medicaid Claims**



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify levels of service utilization for all services and for all telehealth services by technology. Service type was identified through BETOS codes. Unlike commercial and Medicare telehealth codes, the Medicaid telehealth codes always distinguished between audio-visual and audio-only services – there are no claims in the "All Audio-visual or Audio-only Behavioral Health Care Services" category. This category was included for all analyses to maintain consistency across all payers.

Cost of Telehealth Services

NORC at the University of Chicago

Maryland consumers believe telehealth may reduce costs, but unsure about coverage

Cost savings attributed to convenience

- Consumers
  - No transportation costs, ability to participate from home, providers waived co-pays during COVID-19 PHE
  - Able to maintain preventive care and avoid urgent care and emergency department including associated copayments

Unclear about coverage and reimbursement

- Some telehealth services require an in-person follow-up visit
  - Concerns about additional out-of-pocket costs
  - Potential negative consequences of delayed care

Behavioral health focus group participants believe telehealth services are cost-effective

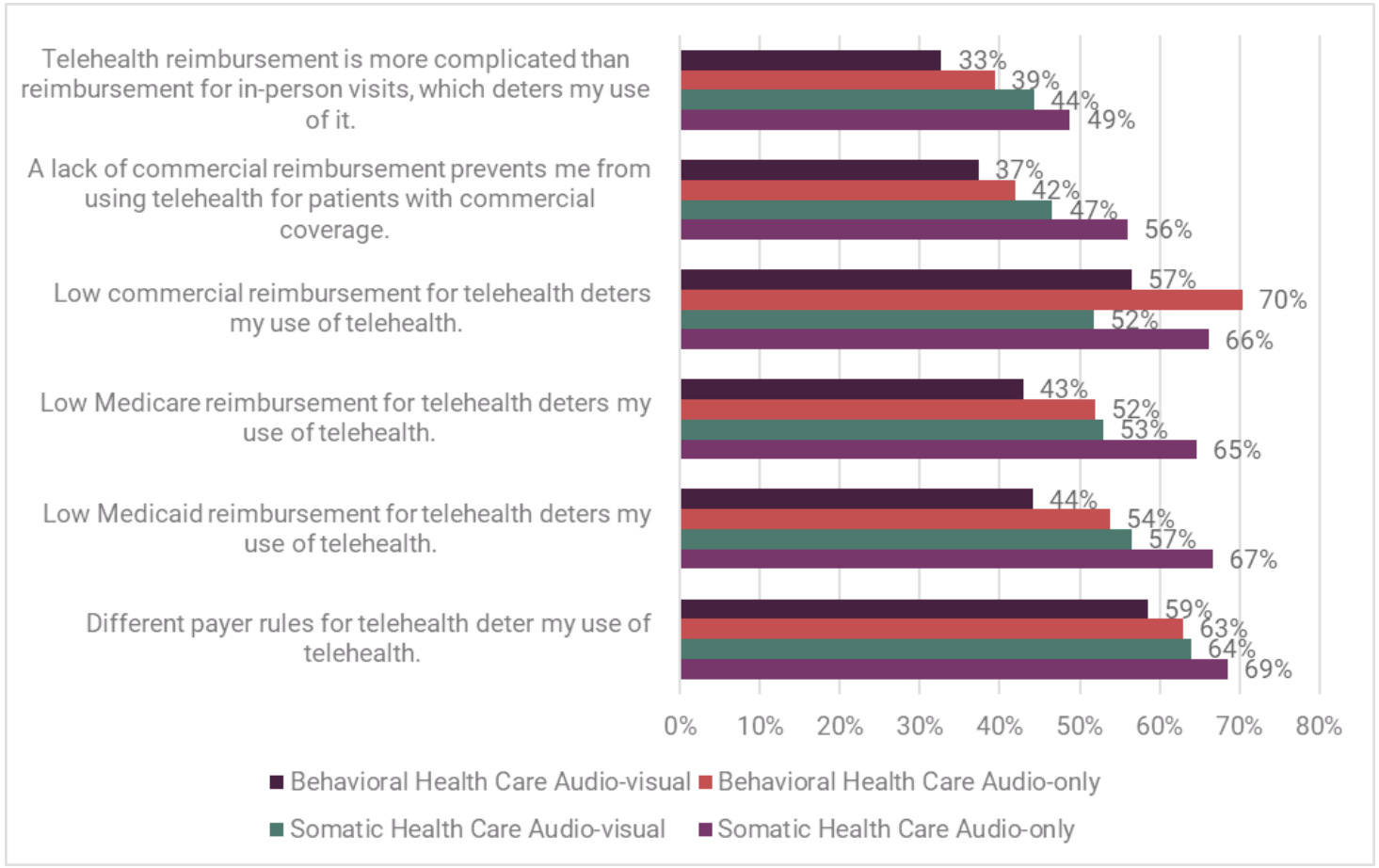
Extend reach of behavioral health services

- Provides immediate access to care during a mental health crisis
  - May avoid urgent care and emergency department visits
  - May provide lifesaving care
- Reduces no-show rates
- Potentially reduces hospitalizations

Recommend payment and coverage parity for telehealth

- Audio-only and audio-visual telehealth visits require same provider effort and fixed costs

Provider Survey: Barriers to Telehealth Access



Note: This exhibit depicts the provider survey responses to barriers to telehealth access. For both types of providers, the audio-visual and audio-only care delivery options were included. Reimbursement for telehealth with varying insurance types seemed to be the most common reason for barriers to telehealth access for providers.

Conclusions

- Consumers and providers value the option of including audio-only and audio-visual technologies to compliment in-person care
- Behavioral health care focus group participants recommend payment parity for audio-only and audio-visual telehealth visits
- Additional claims data analyses are needed to determine telehealth services' cost-effectiveness, quality, and role in advancing health equity

Permanence of Telehealth Coverage & Technology

Study findings

Access

- Consumers and Provider
  - Prefer option for audio-visual and audio-only technologies

Utilization

- Consumers, Providers and Behavioral Health
- Claims Data
  - Telehealth services continue to be used into 2021, particularly for behavioral health care

Cost

- Consumers, Providers, and Behavioral Health
  - Request clarity of coverage and reimbursement

Recommendations

1) **Allow use of telehealth by health care providers**

2) **Allow audio-visual technology and audio-only technology under certain circumstances**

7) **Utilize communications technology that complies with privacy and security requirements**

Meet Consumers/Patients Where They Are

Study findings

Access

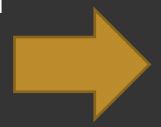
- Consumers and Providers
  - Convenience

Utilization

- Consumers, Providers and Behavioral Health
  - Support access to care where the patient/consumer is physically located

Cost

- Consumers, Providers, and Behavioral Health
  - Saves transportation/travel costs for patient and caregivers



Recommendations

3) **Allow FQHCs to serve as a distant site**

4) **Define and allow remote patient monitoring**

5) **Allow hospice services to use telehealth**

6) **Allow telehealth in hospital inpatient and nursing homes**

Adequate Reimbursement and Insurance Coverage

Study findings

Access

- Consumers
  - Insurance coverage
- Providers
  - Payment parity

Utilization

- Consumers, Providers and Behavioral Health
  - Reduces costs associated with accessing care
- Claims Data
  - Need additional data

Cost

- Consumers, Providers, and Behavioral Health
  - Potential cost savings

Recommendation

8) Continue payment levels for telehealth services relative to in-person for 24 months

Require MHCC to conduct a study to examine payment parity for audio-only and audio-visual technologies

MHCC Recommendations

Justifications are not inclusive of all supporting rationale

See table in Appendix mapping telehealth recommendations 1 through 8 to NORC's findings (slides 58-61)

Coverage

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.*
    - Broadens access to care for underserved and vulnerable populations
    - Ensures telehealth remains an option for providers and consumers

Coverage (*continued…*)

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.*

   - 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 high share of audio-only encounters

Coverage (*continued…*)

3. *Allow FQHCs to serve as a distant site provider for telehealth services. Allow a health care provider to render care at any originating location during the time they are working at the FQHC. Require an in-person visit for somatic care in the six months prior to a telehealth encounter followed by an in-person visit within 12 months; include exceptions for clinical discretion of a treating health care provider. Exclude follow up provision for behavioral health care services.*

    - Removes geographic limitations on where a provider can deliver care
    - Ensures a blended approach to care delivery with in-person visits when necessary to minimize potential risks and ensure continuity of care

Coverage (*continued…*)

4. *Define remote patient monitoring as synchronous or asynchronous technologies that collect or monitor medical, patient reported, and other forms of health data and electronically transmits the data to a distant site health care provider. Allow individuals providing the 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.*

    - Viewed by providers as a way to more timely identify and treat health concerns
    - Improves patient engagement, collection of health metrics, and outcomes, particularly patients with chronic conditions

Coverage (*continued…*)

5. *Allow a health care provider to use telehealth to provide hospice care services 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

Coverage (*continued…*)

6. *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.*

    - 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

Technology

7. *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.*

    - Ensure even baseline protections for privacy and security

Payment Level – Future Study

8. *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*
   - *Any other findings and recommendations*

Payment Level – Future Study *(continued…)*

- Allows more time to gather necessary data needed to formulate data-driven and 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

Terms

9. *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)].*

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

11. *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].*

Terms (*continued…*)

12. *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)].*

13. *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 (MIA) Network Adequacy

David Cooney, FLMI, AIRC

Associate Commissioner, Life and Health

MIA Chapter Overview

- The MIA was required by the Act to conduct a limited-scope study of telehealth and insurance coverage and provide findings to MHCC for inclusion in its comprehensive telehealth report
- Specifically, the MIA was required to study:
  - How telehealth can support efforts to ensure health care provider network sufficiency
  - 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 was also required to consider the requirements of the Act when proposing any revisions to its regulations relating to network adequacy

Changes in Access to and Coverage of Telehealth

- MIA analyzed telehealth benefits in filed and approved health insurance policies and contracts between 2019 and 2022
- Since 2019, the scope of telehealth benefits included in insurance policies has expanded and programs centered around telehealth have been increasingly offered, with the use of telehealth incentivized through preferential cost-sharing
- No provisions were identified in any contracts that impeded the ability of an enrollee to choose in-person care over telehealth and still receive coverage under the insurance policy

Changes in Access to and Coverage of Telehealth (*continued…*)

- MIA conducted a survey of the health carriers to gather additional information on the scope and availability of telehealth benefits
- Survey responses confirmed findings from analysis of contracts, but also suggested:
  - Carriers have begun covering additional modalities of telehealth
  - Carriers are increasingly developing and offering proprietary telehealth platforms while continuing to cover non-proprietary platforms for the delivery of telehealth
  - Carriers are adding telehealth-only vendors to their networks to supplement the telehealth services offered by traditional brick and mortar providers
- Survey responses provided no evidence that changes in telehealth coverage have resulted in any restrictions on the availability of in-person services under Maryland contracts, but one carrier disclosed that they are offering a "telehealth first" product in certain markets nationally

Changes in Access to and Coverage of Telehealth (*continued…*)

- MIA analyzed complaint data related to telehealth between 2019 and 2022
- Telehealth complaints represented a miniscule percentage of total complaints received, and there were no complaints that a carrier denied a telehealth claim for medical necessity reasons
- There were no complaints alleging loss of or reduced access to coverage for in-person services
- All complaints were related to requests for greater access to telehealth services, expansion of telehealth coverage, or increased provider reimbursement for telehealth services
- The most frequently cited issue in the complaints was the denial of coverage for audio-only consultations (these were for claims that predated the passage of the Act)

Changes in Access to and Coverage of Telehealth *(continued…)*

- MIA surveyed other state regulators to identify potential national trends in changes in access to and coverage of telehealth
- Responses suggested national insurance trends are largely consistent with Maryland's experience
- Most states reported an expansion of telehealth benefits, but fewer than expected reported products that offer preferential cost-sharing for telehealth
- Responses revealed that a second national carrier is offering a telehealth-first gatekeeper plan in other states
- Multiple states have enacted laws with express prohibitions against telehealth-only and telehealth-first requirements

Network Adequacy

- MIA found strong evidence of many ways telehealth can improve the sufficiency of health care provider networks used by health insurance plans when telehealth is treated as a complement to, and not a replacement of, in-person services:
  - Fewer missed appointments, indirectly improving appointment wait times
  - Expanded afterhours care options
  - Triage mechanism
  - Mitigate travel, transportation, and mobility barriers
  - Audio-only can address technology/accessibility barriers
  - Research suggests an increasing consumer preference for telehealth in many circumstances, which indicates in-network telehealth services are a critical component of an adequate network

Network Adequacy (*continued…*)

- As one of the few states that currently include express consideration for telehealth in their network adequacy regulations, Maryland is already a leader in this area
- The soon-to-be proposed revisions to Maryland's network adequacy regulations will take a more proactive approach to telehealth that is intended to encourage and incentivize carriers to improve access to in-network telehealth services
- Proposal allows carriers to request a telehealth credit, subject to approval by the MIA, for the travel distance standards and the appointment wait time standards
- Approval of the credit is contingent on documentation justifying that telehealth services are clinically appropriate, available, and accessible in the geographic area and for the particular provider specialty where the credit is being claimed
- Proposal also requires all carriers to report certain data on telehealth utilization
- Regulations do not eliminate the requirement that a carrier must provide access to an in-network provider with a physical office location within a reasonable distance and time

MIA Recommendations

14. *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…"*

    - MIA has already undertaken a multi-year, deliberative process to update its network adequacy regulations, including specific telehealth provisions that will allow the MIA to continually monitor and reevaluate the impact of telehealth on network adequacy
    - 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

MIA Recommendations

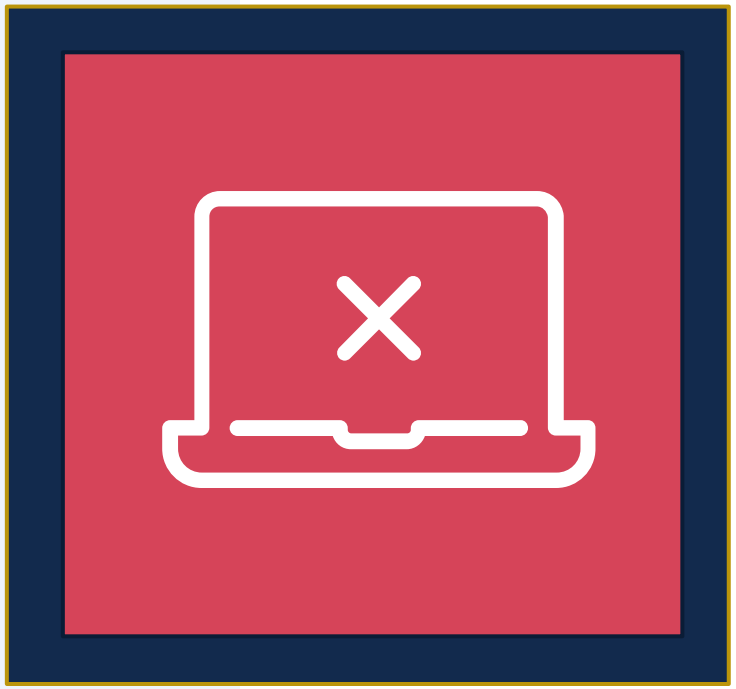
15. *Consider whether to permanently codify telehealth coverage expansions for health benefit plans into State law.*

    - 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

MIA Recommendations

16. *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



Commission Action

Staff proposes the Commission accept the draft telehealth study recommendations report and technical report as final

Stakeholder Recognition

The MHCC greatly appreciates the contribution of stakeholders to the study design and participation in activities that informed development of the recommendations.

Q & A

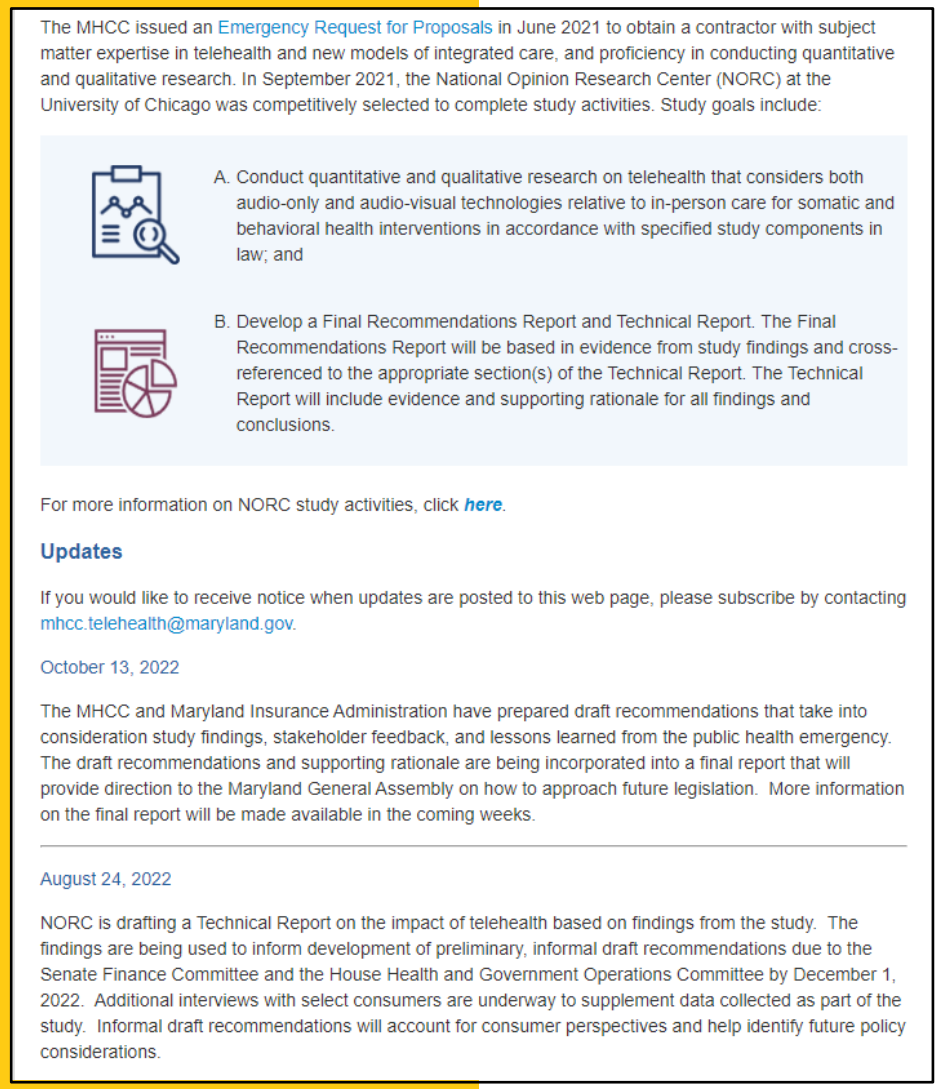
Appendix

Telehealth Policy Workgroup

- The MHCC convened a stakeholder workgroup five times from September 2020 through January 2021 to discuss telehealth policy changes in response to the COVID-19 public health emergency
  - Over 90 stakeholders, including providers, payers, consumers, technology vendors, and State agencies
- 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 a need to study quality and cost of telehealth
- A briefing paper was released in February 2021

Telehealth Legislative Landscape

- Following rapid adoption of telehealth in 2020, many states continue to explore the continuation of telehealth policies that were enabled by various waivers
- States have largely focused on three key areas:
    1. Coverage of audio-only services
    2. Cost-sharing
    3. Payment parity



The MHCC issued an Emergency 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. In September 2021, the National Opinion Research Center (NORC) at the University of Chicago was competitively selected to complete study activities. Study goals include:

A. Conduct quantitative and qualitative research on telehealth that considers both audio-only and audio-visual technologies relative to in-person care for somatic and behavioral health interventions in accordance with specified study components in law; and

B. Develop a Final Recommendations Report and Technical Report. The Final Recommendations Report will be based in evidence from study findings and cross-referenced to the appropriate section(s) of the Technical Report. The Technical Report will include evidence and supporting rationale for all findings and conclusions.

For more information on NORC study activities, click ***here***.

Updates

If you would like to receive notice when updates are posted to this web page, please subscribe by contacting mhcc.telehealth@maryland.gov.

October 13, 2022

The MHCC and Maryland Insurance Administration have prepared draft recommendations that take into consideration study findings, stakeholder feedback, and lessons learned from the public health emergency. The draft recommendations and supporting rationale are being incorporated into a final report that will provide direction to the Maryland General Assembly on how to approach future legislation. More information on the final report will be made available in the coming weeks.

August 24, 2022

NORC is drafting a Technical Report on the impact of telehealth based on findings from the study. The findings are being used to inform development of preliminary, informal draft recommendations due to the Senate Finance Committee and the House Health and Government Operations Committee by December 1, 2022. Additional interviews with select consumers are underway to supplement data collected as part of the study. Informal draft recommendations will account for consumer perspectives and help identify future policy considerations.

Stakeholder Web Page

- A dedicated stakeholder web page features:
  - Information about the Act
  - Study goals, scope, and timeline
  - Periodic updates, such as:
    - Activities underway, including links to complete the provider survey
    - Summaries and recordings of provider and payer town halls

mhcc.maryland.gov/mhcc/Pages/hit/hit_telemedicine/hit_telemedicine_legislative_update.aspx

Study Components

- Analyze the impact of telehealth on disparities in access to health care services; take-up rates among different communities and patient populations; and the comparative effectiveness and efficiency of telehealth and in-person visits on the total costs of care and patient outcomes of care
- Study alignment of telehealth services with new models of care that addresses opportunities for using telehealth to improve patient–centered care; health care services for which telehealth can substitute for in–person care while maintaining the standard of care (e.g., remote patient monitoring); and the impact of alternative care delivery models on telehealth utilization, coverage, and reimbursement
- Assess the efficiency and effectiveness of telehealth and in–person visits that includes peer–reviewed research on the impact of different communication technologies on patient health; a survey of health care providers; and a review of the resources required to sustainably provide telehealth services for the continuum of health care providers, including private and small practices

Study Components *(continued…)*

- Conduct an assessment of patient awareness of and satisfaction with telehealth coverage and care that includes the availability and appropriate uses of telehealth services; an understanding of privacy risks, benefits of telehealth services, and approaches for resolving privacy issues; and barriers to care and levels of patient engagement that have been addressed by audio-only and audio–visual telehealth
- Conduct a review of the appropriateness of telehealth across the continuum of care, ranging from virtual telecommunications services used for patient check-ins to in-person evaluation and management services; inclusion of clinic hospital facility fees in reimbursement for hospital provided telehealth; and the use of telehealth to satisfy network access standards

Mapping of Recommendations to Study Findings

Recommendation	Consideration	Data Sources that Support Recommendations				
		Consumer Interviews	Provider Surveys	Behavioral Health Focus Groups	Claims Analysis	Literature Review
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.	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	✓	✓	✓	✓	✓

Mapping of Recommendations to Study Findings

Recommendation	Consideration	Data Sources that Support Recommendations				
		Consumer Interviews	Provider Surveys	Behavioral Health Focus Groups	Claims Analysis	Literature Review
3. Allow FQHCs to serve as a distant site provider for telehealth services. Allow a health care provider to render care at any originating location during the time they are working at the FQHC. Require an in-person visit for somatic care in the six months prior to a telehealth encounter followed by an in-person visit within 12 months; include exceptions for clinical discretion of a treating health care provider. Exclude follow up provision for behavioral health care services.	Support access where the consumer/patient is physically located	✓	✓	✓		
4. Define remote patient monitoring as synchronous or asynchronous technologies that collect or monitor medical, patient reported, and other forms of health data and electronically transmits the data to a distant site health care provider. Allow individuals providing the 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	✓	✓	✓		

Mapping of Recommendations to Study Findings

Recommendation	Consideration	Data Sources that Support Recommendations				
		Consumer Interviews	Provider Surveys	Behavioral Health Focus Groups	Claims Analysis	Literature Review
5. 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	✓	✓	✓		
6. 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	✓	✓	✓		
7. 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	✓	✓	✓		✓

Mapping of Recommendations to Study Findings

Recommendation	Consideration	Data Sources that Support Recommendations				
		Consumer Interviews	Provider Surveys	Behavioral Health Focus Groups	Claims Analysis	Literature Review
8. 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.	Support access where the consumer/patient is physically located	✓	✓	✓	✓	✓