OHIC Payment and Care Delivery Advisory Committee
Telemedicine Subcommittee
September 24th, 2020, 10:00 A.M. to 12:00 P.M.

Welcome and Introductions

- **Marea Tumber (OHIC)** welcomed everyone and reviewed agenda.

- **Commissioner Marie Ganim** reviewed the goals of the Subcommittee. She indicated that given the legislature may not take up the Telemedicine Budget Article until January, she was interested in feedback for both emergency policies and for more permanent changes to telemedicine.

Goals and Process for Developing Consensus-Based Recommendations

- **Marea Tumber** reviewed the process for developing consensus-based recommendations. She reminded the Committee that project staff will note in the final report when there is a clear majority, or if a particular stakeholder group is concentrated in the minority. She asked if there was any feedback on the recommendations document distributed on 9/21. The draft recommendations are intended to be a living document that will updated as we continue discussing various policy options.

- **Al Charbonneau (RIBGH)** said he did not think there was consensus on the decision to allow audio-only telemedicine, noting the need for additional discussion on quality and safety, utilization, and potential for increases in surprise billing. He said that there are few standards as to what telehealth looks like and how to document it and that medically appropriate reimbursement should not be decided upon until quality is discussed. He referenced two recent articles on these topics: 1) a Health Affairs blog post raised the need for standards, research and recommendations for determining situations where audio-only or audio and video is recommended; 2) a Health Affairs article that analyzes the utilization and costs of direct-to-consumer telehealth; and 3) the MA Health Policy Commission reported on a telemedicine pilot of behavioral health and this Committee has not discussed piloting.
    - **Commissioner Ganim** said that the insurers will be determining what types of telemedicine will be medically appropriate, and that it is difficult to define what quality audio-only is in a static statute document. She said that quality and medical appropriateness will continue to evolve over time. She recommended first determining what policies are allowable, and then allowing insurers and providers to develop and evolve policies over time.
    - **Megan Burns (Bailit Health)** indicated that the recommendations document records high-level recommendations but that the final document will have more nuanced perspectives.
    - **Christopher Ottiano (NHPRI)** said he shared Al Charbonneau's concerns. He recommended that the recommendations document be clear that the recommendations are not to mandate audio-only, but enable discussion to occur.
    - **Next step:** Project staff will revise the recommendations document to reflect the nuances of the audio-only recommendation.

- **Peter Hollmann (Lifespan)** commented that some of the concerns raised regarding telehealth can be said about in-person visits. He said that audio-only will likely promote access and reduce health care disparities for telehealth services. **Al Charbonneau (RIGBH)** agreed in respect to access.

Latest Evidence and Research

- **Megan Burns** reviewed the September 2020 Taskforce on Telehealth Policy Findings and Recommendations on the topics of: 1) patient safety and program integrity; 2) data flow, care coordination, and quality measures; and 3) impact on total costs.

Discussion of and Public Comment on Whether to Specifically Prohibit Restrictions on Provider Types Eligible for Reimbursement of Medically Appropriate Telemedicine Services

- **Megan Burns** said RI statute does not restrict provider types eligible for reimbursement of medically appropriate telemedicine services, but some RI payers do and are allowed to do so under the terms and conditions of telemedicine agreements between payers and providers. She emphasized that discussion of this issue is not meant to change scope of practice requirements, and that telemedicine providers would still need to adhere to those requirements as defined by the RI Department of Health. Megan shared how commercial insurers varied with respect to coverage and listed of common telehealth provider types. She shared that 26 states do not have restrictions about eligible provider types including RI. Megan discussed pros and cons and asked for additional pros and cons from stakeholders.

- Participants made the following suggestions for additional pros and cons:
    - **Peter Hollmann** said there is additional administrative simplification if requirements match between in person and telemedicine visits.
    - **Monica Auciello (BCBSRI)** said a concern from the insurer perspective, is that a service may be medically necessary but not appropriate for telehealth. She recommended that the language in statute or regulation allows for flexibility so that distinction can be made.
    - **Mishael Azam (UHC)** said that there should be some limits on what can be billed and recommended that guidance be anchored in what the appropriate specialty society says on the topic.
    - **Megan Burns** refocused the conversation to address the question on restricting provider type.
    - **Beth Lange (pediatrician and co-Director PCMH kids)** raised two culture shift points. She recommended changing the language from "reimbursement" to "payment" to better appreciate these services as clinical care. She also added the pro of "removing" administrative burden is misleading and noted that practice costs still exist for providers, regardless if they are delivering care at home or in their offices.
    - **Jay Lawrence (CNE)** added as a pro that lack of restrictions on provider types eligible for telemedicine reimbursement could promote clinical innovation and provision of high-value care.

- **Megan Burns** invited discussion on the issue of whether to specifically prohibit restrictions on provider types eligible for reimbursement of medically appropriate telemedicine services. Participants raised the following points:
    - **Peter Hollmann** clarified that by making the statement no restriction on provider types, we are not extending coverage beyond what is provided for in person services.
    - **Peter Oppenheimer** (**RI Psychological Assoc.)** said it is important to have clear guidelines for insurance companies on appropriate restrictions. He recommended avoiding language that restricts innovation while still ensuring appropriate care.
    - **Monica Auciello** indicated that the language in the statute around terms and conditions of a telemedicine agreement is not meant to restrict provider types. Rather, it is about setting standards for how telemedicine is delivered and ensuring that HIPAA and other requirements for privacy, confidentiality and security are adhered to. She also noted that it is difficult to define in statute the provider types that can and can't do telemedicine, and that perhaps the determination needs to be done by service.
    - January Angeles read a comment from **Christy Duran (RI Dental Assoc.)** that said: pre-COVID, dentists were restricted group however COVID has demonstrated tele dentistry services are very useful in certain circumstances.
    - **Karen Malcolm (Protect Our HealthCare Coalition)** said that the power by payers to decide provider types is problematic and is an access barrier for low-income groups and others traditionally prohibited from telehealth services. She agreed with the need for broad guidelines about what services should be accessible.
    - **Melissa Travis (RISCPA)** said that telehealth has led to less cancellations and increased access. She indicated that this will be the new norm and there needs to be a paradigm shift to embrace this.

- **Recommendation:** There is generally support for prohibiting payers from imposing restrictions on provider types that can renders services via telemedicine. However, language needs to allow for payers to have the flexibility to determine which medically necessary services are appropriate to be delivered via telemedicine. There also needs to be a mechanism for distinguishing that certain services may be appropriate to be delivered via telemedicine that includes an audio-visual component, but may not be appropriate for audio-only.

Discussion and Public Comment on Whether to Require Reimbursements at Rates not Lower than the Reimbursement Rates for the Same Services Delivered In-person

- **Megan Burns** indicated that Rhode Island's Telemedicine statute does not specifically address payment parity for in-person and telemedicine services, but that OHIC's emergency guidance for the COVID emergency requires insurers to pay in-network providers for telemedicine at least the same rate of payment for services when delivered in-person. She noted that for Medicaid, federal guidance inherently required payment parity unless a state plan amendment specifically requests different payment. Megan then described some of the pre- and post-COVID-19 policies around payment parity adopted by states in the Medicaid programs and commercial insurance market. She also shared specific statutory language from a few states around payment parity. She then

asked for feedback on whether there are additional existing policies that need to be considered in terms of framing the conversation around payment parity.

- **Al Charbonneau** raised concerns with presenting information from other states, and indicated that it is important to consider whether states that have required payment parity are tightly or loosely managed, and what the results are of those efforts. **Megan Burns** noted that a challenge is that we don't always have ready information on the outcomes of what a state is doing.
- **Andrew Solomon (Northeast Telehealth Resource Center)** noted that there are a number of federal bills looking at telehealth. In the Social Security Act there are some rules for what FQHCs can and cannot pay for in regard to telehealth and modification to these rules would need to be made through federal legislation.
- **Peter Hollmann and Steven Lampert (Lifespan)** discussed the grey line between follow-up telephone calls versus audio-only telehealth. There is concern that what was previously considered a follow-up telephone call that is included in the payment for a prior office visit would not be billed as an audio-only telemedicine visit. There is some work that needs to go into how to manage that interaction and schedule a separate telehealth visit when a follow-up call starts to become a separately billed service.
- **Monica Auciello and Jay Lawrence** noted that there are both documentation and consent requirements in the structure of those encounters to help guide what can be billed as a separate encounter vs follow-up that is included in payment for a previous visit. They indicated that billing for telehealth services should follow those same billing and coding requirements for in-person services.

- **Megan Burns** indicated that given the amount of time left, the full conversation around payment parity would have to be stretched out into the next meeting, and asked participants for their thoughts on feedback on how best to frame the conversation. Participants offered the following thoughts:
  - **Monica Auciello** indicated there are multiple nuances including audio-only versus audio-visual versus in-person visits, and behavioral health versus medical services. She indicated support for payment parity for behavioral health services.
  - **Laurie-Marie Pisciotta (MHARI)** indicated that making a distinction between audio-only and audio-visual telehealth would be harmful to consumers. She said it having different payment levels for an audio-only visit vs an audio-visual visit would disincentivize providers from providing audio-only telehealth services, which would disadvantage patients who may not have access to video equipment. She recommended payment parity regardless of the mode of delivery to better protect consumers.
  - **Karen Malcolm** agreed with Laurie-Marie. She indicated that making such distinctions would only complicate payment and service delivery.
  - **Peter Hollman** noted that recognizing nuance is important and that it should not be taken as an indication of support for or against an issue. He recommended looking at existing codes, how they are currently being used, and the payments associated with those codes to inform the discussion.
  - **Liv King (BHDDH)** raised the importance of considering the impact of recommendations on health disparities. She noted that patients who rely primarily on audio-only visits are most likely to be disadvantaged populations.

She indicated that creating disincentive to provide audio-only services will disproportionately harm populations that are already vulnerable.

- **Next step:** Bailit Health will consider today's discussion in framing the conversation around payment parity, and seek guidance from OHIC and Medicaid on their thoughts for approaching this topic.

Next Steps and Adjournment

- **Megan Burns** said that the next meeting is on October 8 from 10-12 and will focus on payment parity. Participants are invited welcome to share any feedback on payment parity with project staff in advance of the next meeting.

- **Commissioner Ganim** and **Marea Tumber** thanked the group for participation and invited participants to reach out with any input.

Link to the Meeting #3 recording:

https://zoom.us/rec/share/uCYHFYX6nigRV8c2N80mVntICwZ9_4URhakexf-WjosACPhZQ2gZ9ECskI7OCzM4.C3M6DlsPDcjm9488?startTime=1600955822000