OHIC Payment and Care Delivery Advisory Committee
Telemedicine Subcommittee Notes
December 10, 2020 from 10:00 am to 12:00 pm

Welcome and Agenda Review

- **Marea Tumber** (OHIC) opened the meeting and reviewed the agenda
- **Commissioner Ganim** thanked everyone for their participation and their thoughtful insights.

Goals for Today's Meeting

- **Marea Tumber** outlined the meetings goals, which is to discuss comments on the final report and ensure it is appropriately balanced and reflects the points of view of the different stakeholders. She provided a summary of the comment process and timeline, and the organizations/individuals from whom OHIC received written feedback.
- **Marea Tumber** noted that project staff will be accepting and incorporating feedback received up until the end of the day. She also noted that all comments will be posted as public comments on the OHIC website.

Discussion of Feedback Received

- **Megan Burns** (Bailit Health) summarized the approach taken to analyzing feedback and identifying key themes to be discussed at the meeting. Megan noted that while we will only be discussing feedback on issues that many stakeholders commented on, we will be considering all comments received. She outlined the themes to be discussed at the meeting, which were a) membership and process; b) the term "clinical appropriateness;" c) health equity; d) performance measurement, and e) payment parity. She indicated that there will also be time to discuss and identify other topics for feedback at the end of the meeting.

Membership and Process

- **Megan Burns** summarized comments received regarding the nature of Subcommittee membership, and the concerns that that there wasn't always balanced representation of stakeholders at each meeting.
- **Al Charbonneau** (RI Business Group on Health) requested clarification in the final report that that consensus-based in this context is a broader definition than typically used.
- **Steve Lampert** (Care New England) suggested including a list of participants.
- **Megan Burns** suggested adding more discussion around what the membership and process means for representation of certain stakeholder and building consensus. The report will also define consensus as general agreement. Megan indicated that project staff would consider including a participant list but noted that it was at times difficult to identify who was at each meeting.

Clinical Appropriateness

- **Megan Burns** reviewed what the report said around clinical appropriateness, and reminded participants about current practice around clinical appropriateness. She described comments outlining concerns about who determines clinical appropriateness and suggestions received on how to address this.
- **Steve Lampert** commented that there should be a process for defined exceptions.

- **Andrea Galgay** (RIPCPC) noted that it seems strange to open up a state regulatory process for telemedicine when this doesn't apply to other services.
- **Peter Hollman** (Lifespan) indicated that we may not want to set up a new regulatory process, but since it is a new area it would be useful to have community input to have consistency in the approach across insurers. He suggested a process similar to way the State is addressing quality measures.
- **Al Charbonneau** indicated that it is not clear that clinically appropriate and medically necessary are same thing, and he would like some discussion around this.
- **Monica Auciello** (BCBSRI) agreed that medically necessary is different from clinical appropriateness. She noted it is important to keep the distinction, not for purpose of cost but for making sure the service is rendered in way to achieve necessary outcomes. She indicated that clinical appropriateness would be difficult to address through some sort of workgroup setting since it will take a long time and a lot of work. She noted that this does not happen for medical services delivered in person.
- **Laurie-Marie Pisciotta** (MHARI) indicated that providers are the experts and should be the ones determining what level of care is clinically appropriate. She would like to see across the board that insurers are subject to evidence-based practices based on medical expertise and guidance from medical and behavioral health professionals.
- **Megan Burns** indicated that as a next step, the report will more fully articulate the pros and cons of the recommendation. She noted that topic warrants a deeper dive to provide balanced viewpoints on the use of the language, the intent behind it as insurers describe, as well as concerns stakeholders' concerns.

Health Equity

- **Megan Burns** noted there was strong support for the recommendations, and there could easily be more text around arguments to support health equity. She noted that there were requests to pull out the recommendation to include telemedicine access in network adequacy standards and have it as its own recommendation. She indicated that the final report will not do so since this wasn't thoroughly vetted with the Subcommittee to fully understand the implications.
- There were no additional comments from the group on this issue.

Remote Monitoring

- **Susanne Campbell** (CTC-RI) asked where remote monitoring falls in the discussion/report, noting that remote-monitoring is not covered by Medicaid.
- **Megan Burns** responded that conversations have been around types of services that could be rendered in office, and the final report could note that this is a gap.
- **Steve Lampert** commented that there are other items that fall under this bucket as well.
- **Megan Burns** responded that the report will state what types of services we talked about and that not all issues related to telemedicine were covered. It is probably not possible to list all the topics that weren't covered.
- **Peter Hollman** commented that at federal level, remote monitoring is not defined as part of telehealth. The budget article followed this framework, which is why it was out of scope.
- **Garry Bliss** (Prospect) commented that it would be good to be able to clearly say remote monitoring was not part of charge of group and therefore was not addressed. But also add that as a topic, it merits further review and consideration by a group similar to the

Telemedicine Subcommittee. **Peter Hollman** and **Liv King** (BHDDH) agreed with this suggestion.

- **Megan Burns** responded that the report can be a little more specific on what the charge is and what it is not and how that affected conversation.

Performance Measurement

- **Peter Oppenheimer** (RI Psychological Association) commented that it is important for the report to recognize that the mechanics of doing measurement is particularly difficult on the behavioral health side.
- **Peter Hollman** noted that it is important that language is high level and not too specific so as not to lock us into doing something that can't be done.
- **Howard Shulman** (physician) and **Beth Lange** (pediatrician and co-chair of PCMH-Kids) noted that telemedicine is still evolving. Trying to come up with measurements now is going to be difficult and recommended waiting on developing performance measures. However, they both indicated there needs to be enough lead time to prepare providers.
- **Andrea Galgay** noted that there are certain areas we know we want to evaluate so we could at least start the conversation around things that we expect to track.

Payment Parity

- **Beth Lange** commented that many arguments around affordability and payment parity fail to consider affordability of primary care offices in state. The state has an aging workforce, and is not able to afford PCP salaries to attract more PCPs. Payment parity is important to keep offices open.
- **Al Charbonneau** wanted to clarify that when we are talking about affordability, he is referring to affordability of consumers and employees. He also noted the issue with trying to introduce telemedicine in a largely FFS environment. He referenced a MEDPAC report where the Commissioners were more agreeable to expanding telemedicine coverage when payment is linked to APMs.
- **Karen Malcolm** (Protect Our Healthcare Coalition) commented that payment parity for behavioral health and primary care is a critical access issue. She noted that behavioral health providers are already paid less for in-person services. Paying less for telemedicine exacerbates this inequity.
- **Liv King** noted that it is important to provide the context of telemedicine as a way of delivering service that is already covered. Increases in cost and utilization means people are accessing services they otherwise would forgo.

Link to the Meeting #7 recording:

https://zoom.us/rec/share/2KHjM8dWnO4kuvHzJiIRAJmP3Yb4bgGkHw4Y6cG178q3EESaISO4gnJc51m1gtLY.qEV8iV8fvO9o4WqH?startTime=1607612362000