OHIC Payment and Advisory Committee
Telemedicine Subcommittee Notes
October 22, 2020 from 10:00 A.M. to 12:00 P.M.

Welcome and Agenda Review

Goals and Process for Developing Consensus-Based Recommendations & Developing Guiding Principles for Future Discussions

- **Marea Tumber** reviewed the Subcommittee's goals and process for developing recommendations. She noted that while the goal is to reach consensus, this is not always possible and in such cases differing opinions will be noted in the final report. She noted that the approach to discussing the remaining topics will shift—moving away from discussing specific proposals for legislation to instead focusing on high-level principles to guide future policy, including areas of agreement, in areas the state's authority can impact.

Payment Parity Follow-Up

- **Megan Burns** presented a summary of areas of agreement from Meeting #4 on payment parity, noting there was no consensus on many topics, except behavioral health.
- **Agreement 1, Telemedicine fills an important need**
    - Participants made no further comments.
- **Agreement 2, Telemedicine should be integrated into existing delivery system infrastructure**

  While there is general agreement among participants to not prohibit telemedicine-only companies, providers are concerned about local providers having to compete with non-local providers and lack of care coordination. Specific comments on the issue included the following:
    - **Al Charbonneau (**Rhode Island Business Group on Health) asked whether this would prohibit companies like Teladoc. **Megan Burns** said no; this statement expresses a desire to promote telemedicine within the existing framework, while not prohibiting entry of telemedicine only companies. **Steve Lampert** (Lifespan); **Megan Burns** proposed adding that it won't prohibit telemedicine-only companies.
    - **Corinna Roy (**BHDDH) raised the concern of not having a quality check of telemedicine-only companies. **Megan Burns** said she will add language about finding ways to check quality.
    - **Gary Bliss** (Prospect) bought up the desire to incorporate care management into the statement. **Howard Schulman (**physician) agreed, and added that he is against encouraging out-of-state independent telemedicine groups out of concern for lack of coordination of care and the stress it will placed on PCPs. **Pano Yeracaris** (CTC-RI) agreed; he is concerned that patients will go directly to telemedicine vendors rather than through a PCP. **Peter Oppenheimer** (RI Psychological Association) suggested adding language that the system will promote comprehensive care for all levels of care.
    - **Steve Lampert (**Care New England) clarified that #2 doesn't have to do with parity issue of who's providing, therefore on its own, it can stand.
    - **Corinna Roy** added that there needs to be a robust screening process for telemedicine companies. **Liv King** (BHDDH) pointed out the difference between state licensing and leaving licensing up to the companies. **Gary Bliss** agreed. **Corinna Roy** responded that requiring them to practice with an existing state-provider may act as a good gatekeeping function. **Ralph Coppola** said having a provider network acts as a gatekeeper.

    - **January Angeles** clarified even if companies are national, they use RI licensed providers to provide services per RIDOH requirements. **Pano Yeracaris** said RI-licensed does not mean RI-based.
    - **Megan** stated that these comments will be noted as concerns.
- **Agreement 3, a value-based health care system that moves away from FFS allows for care using any modality that is most appropriate**
    - Participants had a discussion about the changing the language, but eventually came to consensus to leave the statement as is.
    - **Pano Yeracaris** initially endorsed moving away from FFS payments, but recommended changing "value-based" to "prospective payments."
    - **Steve Lampert** said while everyone is moving away from FFS, not every contract will be prospective, and he was fine with the agreement as written. **Monica Auciello** (BCBSRI) and **Patrice Cooper (**UHC) agreed. They noted that not all providers will be ready for prospective payments, nor is it always the appropriate payment methodology. They indicated that the key is to move away from FFS and that the current language is sufficient as it is. **Pano Yeracaris** agreed.
- **Agreement 4, value of telemedicine is still being defined**
    - Participants discussed the nuances in defining value outside of cost and outcomes, as well as defining value for BH services. Participants also mentioned that value is difficult to define because telemedicine is rapidly evolving.
    - **Corinna Roy** said that in the last meeting there was agreement that behavioral health is an exception and should have payment parity. **Susanne Campbell (**CTC-RI) said that more research is needed about helpfulness of behavioral health for special populations. **Liv King** agreed that telemedicine for BH is not well researched. She suggested adding that the value will differ by stakeholder, modality, and specialty population.
    - **Jay Lawrence** agreed with the statement, and noted that it includes value of behavioral health.
    - **Josh Miller (**RI State Senator) wanted to add ways to document value outside of cost and outcomes, which **January Angeles** clarified will be discussed in the performance measurement portion of the meeting. **Karen Malcolm** (Protect Our Healthcare Coalition) noted that we need more information on value in terms of access to needed care and outcomes for improved health.
    - **Liv King** said the nuance may be that access and value vary by stakeholder, modality, and population.
    - **Barry Fabius (**CMO at UHC) suggested adding, "value and appropriateness of telemedicine is still being defined." **Gary Bliss** agreed and noted that telemedicine is rapidly evolving.
- **Agreement 5, telemedicine BH services should have payment parity**
    - Participants discussed the need for more research on BH utilization and costs.
    - **Al Charbonneau** mentioned the Truven report, which indicated that RI employer costs for BH services are the highest in the country; we need to look at current utilization before agreeing to BH payment parity. **Stephanie deAbreu (UHC)** agreed with Al that more research is needed. **Corinna Roy** responded said high cost for BH services is related to inpatient services, not telemedicine outpatient services, which is what we need telemedicine payment parity for. She also noted that RI has higher incidence of mental health than the rest of the US.

    - **Laurie Marie Pisciotta** (MHARI) said increasing access to BH care reduces likelihood that illness will escalate into higher, more costly level of care.
    - **Howard Schulman's** concern with the clause is that insurance companies will say, that BH telehealth was not medically necessary and therefore won't pay for it.
    - **Susanne Campbell** asked why medical is not included. **Megan Burns** said that was not agreed upon in the last meeting.
- **Agreement 6, Telemedicine can provide access for services/provider types that are scarce**
    - There were no comments or disagreements.
- **Agreement 7, telemedicine should support existing patient-provider relationships to support continuity of care**
    - There were no comments or disagreements.
- **Payment parity for primary care**
    - **Megan Burns** bought forth the question of whether the subcommittee supports payment parity for primary care services, in a similar manner that it supported behavioral health parity.
    - **Al Charbonneau** was concerned that medical necessity and appropriateness would be left to the insurer. **Megan Burns** stated that medical appropriateness determinations will be left to the payer.
    - **Andrea Galgay** (RI Primary Care) stated that audio-visual calls should have payment parity, but not audio calls. **Pano Yeracaris** agreed. **Howard Shulman** was concerned about Andrea's comment and noted some patients are refusing to video and prefer audio-only.
    - **Steve Lampert** supported payment parity in primary care. **Patricia Flanagan** (pediatrician and co-Director PCMH kids) added that many vulnerable patients don't have access to video, so there should be parity for audio-only as well. **Liv King** (BHDDH) said to address equity, we have to be more aggressive in helping those who are disadvantaged, including supporting audio-only parity.
    - **Al Charbonneau** said he supports the development of primary care telemedicine, but we still need to discuss appropriateness for range of services, including for BH.
    - **Jay Lawrence** asked if there's overutilization of primary care in RI. **Ralph Coppola** asked if there's data on misdiagnosis during telemedicine. **Megan Burns** said this is unknown since we don't have any data on this.
    - **Megan Burns** asked us to put this on hold until the next meeting.

Payment Parity Follow-Up

- **January Angeles** indicated that given the limited time left, we will leave program integrity for the next meeting and skip to the topic of privacy, security, and confidentiality to inform an upcoming meeting that Commissioner Ganim is chairing for the NAIC.

Discussion of Security, Privacy and Confidentiality

- **January Angeles** noted that NAIC is developing recommendations on OCR enforcement of HIPAA requirements with respect to telemedicine and Commissioner Ganim is requesting input from the Subcommittee. She provided background on the HIPAA privacy rule and security rule for ePHI, and how those rules relate to telemedicine. January reminded everyone that HIPAA requirements must also be met when utilizing telehealth.

- **January Angeles** solicited feedback from the Subcommittee on principles that should guide HHS' decision on when it makes sense to restart OCR enforcement. Providers felt that there needs to be flexibility to allow patients to use the platforms that are most accessible, even if they aren't the most compliant with HIPAA. The general consensus was that on the provider side, developing the infrastructure to use HIPAA-compliant platforms isn't a barrier; the concern is on the consumer side and their ability to access HIPAA-compliant technology. Participants wanted to ensure there are ways to conduct telemedicine visits by asking consumers to waive HIPAA requirements and privacy rights for that visit, if needed to proceed with the telemedicine visit. Specific comments on the issue include the following:
    - **Peter Hollmann** said the key is continued flexibility for the provider to use safe platforms that patients can access. However, HIPAA-compliant platforms can be more difficult for patients to use. **Steven Lampert** agreed, noting that common platforms like Zoom are becoming HIPAA-compliant. **Shamus Durac** (RIPIN) agreed with Peter and Steven that we need flexibility in audio-visual and audio-only platforms so that high-need patients can access care.
    - **Liv King** said there will be a need for non-HIPAA-compliant telemedicine platforms to be allowed. She heard that currently there isn't a clear way to give disadvantaged patients technology (tablets, phones).
    - **Peter Oppenheimer** said there are huge differences in individual technical skills and access to services. He agreed that there should be documentation of using less secure methods for telemedicine. **Pano Yeracaris** agreed with Ralph and Peter.
    - **Suzanne Campbell** asked if there are any negative outcomes to using non-HIPAA compliant tech and waiving privacy rights. She asked if more research can be done on this and shared with the Commissioner.
    - **Megan Burns** asked if there is concern about abuse, for example consumer private conversations made public.
        - **Laurie-Marie Pisciotta** said providers and consumers are able to sign a form confirming they are in a private location so that there is patient and provider accountability.
        - **Joshua Miller** said the issue of privacy would be discussed as future legislation is discussed and developed.
        - **January Angeles** reiterated that HIPAA is a federal law that sets the floor for what needs to be done in terms of protection of patient privacy. Any additional legislation at the state level would be to impose stricter requirements.
    - **January Angeles** asked the group whether it makes sense for OCR to grant exceptions.
        - **Peter Hollmann** said that getting into specific exceptions will be cumbersome. Patient care delivery must be practical and the consent of patient is what matters most.

Next Steps and Adjournment

- **January Angeles** said we will revisit payment parity for primary care, and then continue with the rest of the topics: privacy & security, program integrity, and performance measurement. We will also circle back to recommendations specific to health disparities.

Link to the Meeting #5 recording:
https://zoom.us/rec/share/-6pLVPDscp9t887mDg50lPyreDb6y6iwRWGH-owYfUttId_2lFU-2TdqDRpJw1Px.POm0nHiAnSZs1geg?startTime=1603375163000