OHIC Payment and Care Delivery Advisory Committee
Telemedicine Subcommittee

Recommendations Report – DRAFT – 12/3/2020

Introduction and Background

The COVID-19 pandemic required drastic measures that significantly impacted health care delivery. Shelter in place orders, social distancing requirements, and concerns for patients' and health care workers' health and safety led to a rapid rise in telemedicine as a modality for delivering care. Telemedicine facilitates continuity of care, while reducing infection risk for both patients and providers.

In 2016, Rhode Island (RI) passed the Telemedicine Coverage Act, which requires commercial health insurers to cover services provided via telemedicine to the same extent the services would be covered in-person. However, certain restrictions prevented telemedicine from being used extensively before the pandemic, and more broadly during the public health emergency.

To make telemedicine more widely accessible and facilitate its use during the pandemic, RI Governor Gina Raimondo issued Executive Order 20-06, which temporarily suspended certain telemedicine restrictions in the Rhode Island Telemedicine Coverage Act. Specifically, the Executive Order and accompanying Office of the Health Insurance Commissioner (OHIC) and Medicaid guidance lifted site restrictions to allow patients and providers to conduct a telemedicine visit from any location, and suspended the prohibition against audio-only telephone conversation and limitations on video conferencing that were contained in the Telemedicine Coverage Act. The Executive Order also expanded the types of providers that could deliver telemedicine services, and required insurers to pay for telemedicine services at the same reimbursement rate as in-person services.

RI Medicaid managed care organizations (MCOs) and commercial insurers in the State also implemented many initiatives and policy changes to make telemedicine more accessible, such as expanding the availability of telemedicine behavioral health services to support individuals' mental health and substance use issues, and waiving cost-sharing for in-network telemedicine services.

Recognizing the important role that telemedicine plays in safely delivering care during the pandemic and may continue to play in the long-term, Governor Raimondo requested in July that the Legislature include an article related to telemedicine in the Fiscal Year 2021 Budget Act. The Telemedicine Budget Article, if passed, expands on and extends the provisions in the Executive Order through June 30, 2021. The proposed budget article also included the conduct

of a study of telemedicine impacts and best practices to inform recommendations on how telemedicine should be implemented on a more permanent basis.

In alignment with the proposed Telemedicine Budget Article, OHIC established the Telemedicine Subcommittee of the OHIC Payment and Care Delivery Advisory Committee to develop aligned recommendations to OHIC and Medicaid on future telemedicine policies in the State. Specifically, the Telemedicine Subcommittee was charged with recommending:

- Potential revisions to emergency telemedicine policies to support the State's COVID-19 response; and
- Policies and strategies for how to improve telemedicine as a convenient, cost-effective, accessible and equitable option for patients and providers in Rhode Island over the long-term.

This report presents the work of the Telemedicine Subcommittee and its recommendations for future policy.

Telemedicine Subcommittee Membership and Process

Membership in the Telemedicine Subcommittee was open to any individual or organization that wished to participate. Individual participants included a broad range of stakeholders representing primary care, specialty care and behavioral health providers, hospital-based systems, community health centers, Accountable Entities (AEs), Accountable Care Organizations (ACOs), health insurers, business groups, and consumer advocacy organizations.

The Telemedicine Subcommittee was staffed by OHIC, in partnership with Medicaid and Rhode Island Department of Behavioral Healthcare, Development Disabilities and Hospitals (BHDDH), with project support and meeting facilitation from Bailit Health.

The Subcommittee met via videoconference seven times between August and December 2020 according to the following schedule:

- Meeting 1 – August 27, 2020
- Meeting 2 – September 10, 2020
- Meeting 3 – September 24, 2020
- Meeting 4 – October 8, 2020
- Meeting 5 – October 22, 2020
- Meeting 6 – November 12, 2020
- Meeting 7 – December 10, 2020

Approximately 60 to 80 individuals attended each meeting. Detailed agendas, PowerPoint presentations, meeting summaries, and meeting recordings are available at: http://www.ohic.ri.gov/OHIC%20Telemedicine%20Advisory%20Group%20Materials.html.

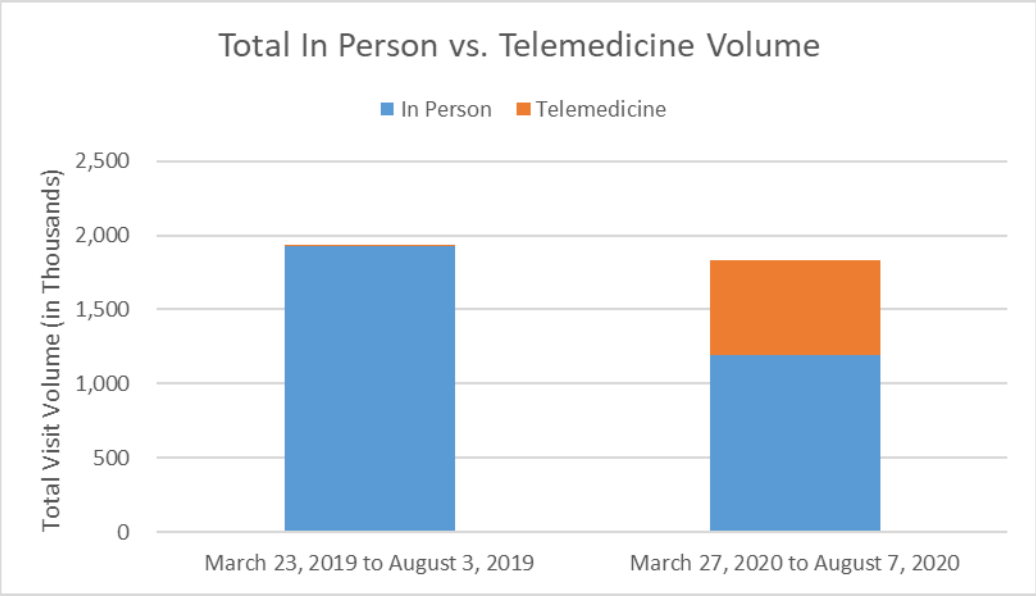
The Telemedicine Subcommittee discussions were facilitated using a consensus-based approach where project staff presented background information about the policy choices, including policies implemented by other states, and considerations for or against adopting a particular policy. Each member had an opportunity to participate in the discussion, share their perspective, identify concerns, offer suggestions, and review and provide input on proposed recommendations.

While these recommendations documented in this report represent the consensus of the Telemedicine Subcommittee, they do not necessarily represent the individual opinions of any Subcommittee member or organization.

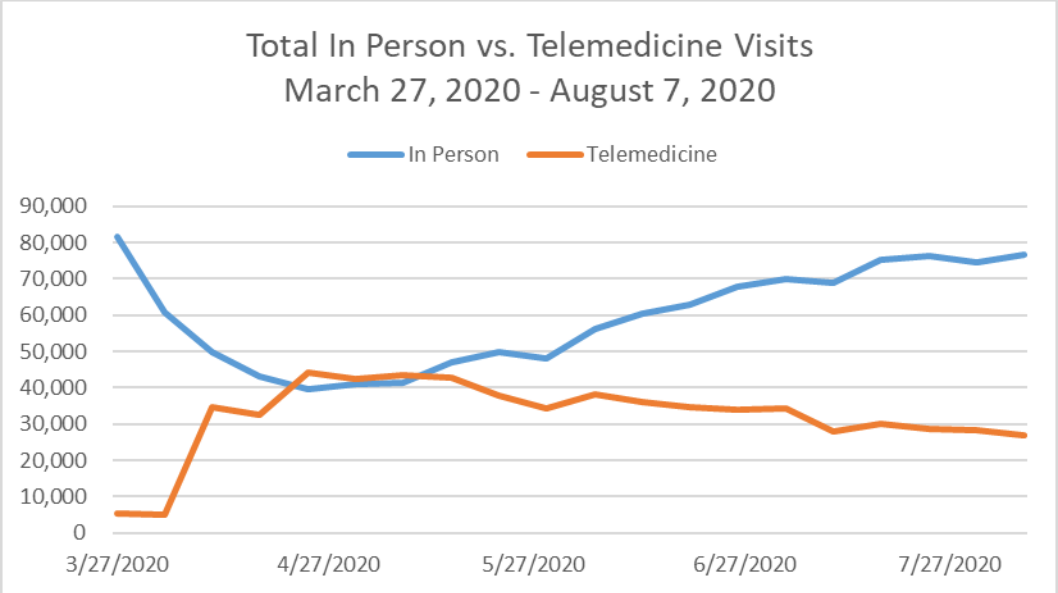
Telemedicine Utilization Rhode Island

To inform the Subcommittee's discussions, project staff researched national trends in telemedicine utilization. In addition, OHIC obtained data from Rhode Island commercial insurers telemedicine usage on weekly visit volume for two time periods: the weeks ending March 2, 2019 – September 3, 2019, and the weeks ending March 6, 2020 – September 7, 2020.

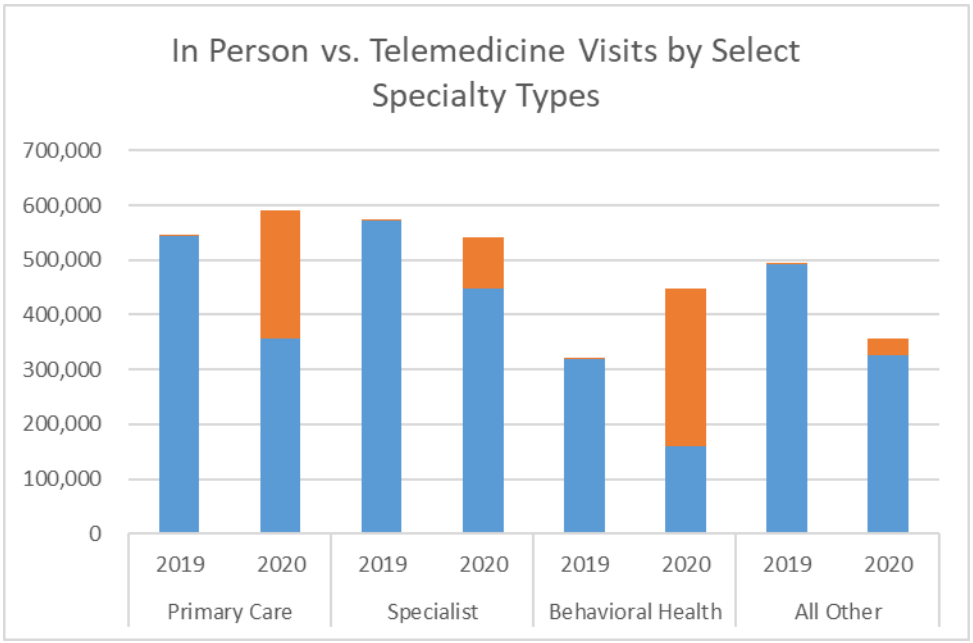
Rhode Island shows a surge in telemedicine claims in the early days of the pandemic when many elective, non-essential procedures were postponed or canceled to minimize infection risk and preserve resources for treating COVID-19 patients. The proportion of visits conducted via telemedicine increased from 0.08 percent to 31.3 percent, though total visit volume from late March to early August 2020 decreased by just one percent compared to total visit volume during the same period in 2019.



Telemedicine in Rhode Island made up for the decrease in in-person visits in April 2020. Telemedicine usage has since plateaued as in-person visits resumed, but utilization remains significantly higher than utilization before the pandemic.



During the March to August 2020 time period, 40 percent of primary care services and 64 percent of behavioral services were delivered by telemedicine. Meanwhile, 17 percent of specialist services and nine percent of other services were delivered through telemedicine. Year-over-year primary care visit volume increased by eight percent, while behavioral health visit volume increased by 40 percent. While the data collected from insurers did not allow for further analysis of what was driving the increase in behavioral health visits, Blue Cross Blue Shield of Rhode Island (BCBSRI) indicated that its internal analyses showed greater utilization among individuals who were already seeking behavioral health care.



Summary of Telemedicine Subcommittee Discussions and Recommendations

Project staff used the proposed Telemedicine Budget Article as a guide for selecting the issues addressed by the Subcommittee, and organized the discussion into the following four topic areas:

1. **Coverage and access,** including potential legislation to increase coverage of telemedicine, and strategies to address disparities and remove barriers to access;
2. **Payment and program integrity,** including payment parity for telemedicine and safeguards against fraud, waste and abuse;
3. **Privacy, security, confidentiality,** including the promotion of HIPAA-compliant technologies in the delivery of telemedicine services; and
4. **Performance measurement,** including ways to measure quality, outcomes and costs of telemedicine.

The following summarizes the Subcommittee's discussions on the four issue areas, and where applicable, consensus recommendations.

Discussion and Recommendations Related to Telemedicine Coverage and Access

Recommendation: Audio-only telemedicine should be covered on a permanent basis when the service is clinically appropriate to be provided using that mode of delivery, as determined by the insurer.

Subcommittee members supported requiring coverage of audio-only visits, emphasizing that doing so is critical to increase access to telemedicine during the pandemic. This is particularly important for vulnerable populations that may not have access to broadband internet or the necessary equipment, or may not have sufficient digital literacy to participate in a live videoconference. Members generally agreed that there is value in covering audio-only visits, particularly for some behavioral health services, such as counseling, that could be delivered effectively without a visual component.

There was significant discussion about the blurring of lines between follow-up telephone calls that should be covered and paid for as part of a previous visit and a separately billed, audio-only telemedicine visit. While some payers have guidelines that help distinguish the difference between a follow-up phone call and a separately billable audio-only visit, additional work is needed to clarify these rules. Subcommittee members also noted that it is important that providers are clear and the patient is fully informed about when a phone call may generate a separate charge to avoid any surprise billing.

Recommendation: Cost-sharing for telemedicine visits should not exceed cost-sharing for in-person visits.

Current Rhode Island law does not specifically address cost-sharing for telemedicine services. While the Executive Order is also silent on the issue, insurers have voluntarily waived cost-sharing for in-network telemedicine services thus far during the public health emergency to ensure that members get the care they need.

Some Subcommittee members argued that setting co-pays for telemedicine and in-person visits at the same level removes any financial incentive for patients to choose one modality over another. This allows patients to choose the modality that they feel is best for them, without cost being an influencing factor. Other members, however, noted that while co-pays should generally be the same across modalities, there should be flexibility to set lower co-pays for services delivered through telemedicine. They noted that allowing for telemedicine services to have lower co-pays is important to incentivize patients to use it when appropriate. Ultimately, a majority of the members agreed to language requiring cost-sharing for telemedicine to not exceed cost-sharing for in-person visits.

Recommendation: There should be no limitations on patient location (originating site) for telemedicine.

Current law allows the patient's home to be an "originating site," or the site at which the patient is located at the time the telemedicine services are delivered, where medically appropriate. However, language in the current law leaves room for insurers to place restrictions on the originating site, indicating "health insurers and health care providers may agree to alternative siting arrangements deemed appropriate by the parties." The Telemedicine Budget Article proposed to remove this language that allows insurers and providers to place restrictions on patient location.

There was broad consensus that it is important to allow patients to conduct a telemedicine visit at a location that is convenient for them, which may be at home, in a private space offered in a public venue (e.g., the library) or within the offices of a health care provider.

Recommendation: Prior authorization requirements for telemedicine should be no more stringent than prior authorization requirements for in-person care.

The Telemedicine Act of 2016 does not specifically address prior authorization. The Executive Order and guidance released in response to the public health emergency do not require insurers to suspend or waive prior authorization requirements, although some insurers in Rhode Island have done so for certain telemedicine and in-person visits to ensure individuals can quickly access services.

The Subcommittee supported implementing a policy that would make prior authorization requirements for telemedicine to be no more stringent than prior authorization requirements for in-person care. In addition, the Subcommittee wished to clarify that this requirement would not limit insurers' ability to impose prior authorization requirements for services delivered out-of-state or out-of-network.

Recommendation: Insurers should not be allowed to impose restrictions on which provider types[1] can render services via telemedicine while still allowing insurers to determine what services are clinically appropriate to deliver via any telemedicine modality.

Under current law, insurers can restrict what provider types can render telemedicine services. Subcommittee members generally supported prohibiting insurers from imposing restrictions on provider types that can render services via telemedicine so long as the service is clinically appropriate to be provided via telemedicine and can be performed under the practitioner's license and scope of practice, as defined by the Rhode Island Department of Health. Subcommittee members indicated that not having restrictions on providers eligible for telemedicine reimbursement could promote clinical innovation and provision of high-value care. It would also help simplify administration if there was only one set of requirements on who can provide a service for both in-person and telemedicine visits.

Recommendation: To ensure health equity and reduce disparities in access to telemedicine services, the State should pursue the following activities:

- ***Explore opportunities for partnership across state agencies that are working to address access to broadband technology and equipment, and increase digital literacy to leverage resources and share lessons learned.***
- ***Identify ways to support telemedicine use in the community, such as a location for individuals to hold telehealth visits, a lending library for technology, or repurposing donated equipment.***
- ***Utilize community health workers, peer recovery specialists, home health aides, and others who go into the home to assist in digital training.***
- ***Provide statewide access to broadband or hotspots for municipal areas that do not have it.***
- ***Consider including telemedicine access in network adequacy standards.[2]***

The Subcommittee noted that the main barriers patients face in accessing telemedicine are lack of reliable internet connectivity, lack of access to the necessary equipment, and digital literacy. Unfortunately, the individuals living in under-resourced communities who have challenges accessing in-person care and have poorer outcomes also tend to experience these barriers to accessing telemedicine. Moreover, racial and ethnic minorities tend to be disproportionately affected by such access issues. Thus, telemedicine has the opportunity to address disparities in

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[1] According to the Telemedicine Coverage Act "Health care provider" means a health care professional or a health care facility. "Health care professional" means a physician or other health-care practitioner licensed, accredited, or certified to perform specified health-care services consistent with state law.

[2] Network adequacy refers to a health plan's ability to deliver covered services by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract.

care, but could also widen disparities if actions are not taken to address barriers to accessing telemedicine.

Research is beginning to emerge showing disparities in access to care delivered through telemedicine. For example, one study found that in the early months of the pandemic when stay at home orders were first instituted, the proportion of visits attributed to non-Hispanic White and Other patients increased after telemedicine scale-up, but decreased for African Americans, Latinos, and Asians.[3] Data from a 2019 survey shows that three quarters of people between the ages of 18-34 indicated that they were very or somewhat willing to use telehealth, compared with only half of people aged 65 and over.[4] In addition, a survey assessing challenges during the pandemic also found that higher income individuals were more likely to have access to telehealth services.[5]

There was a strong sense among the Subcommittee that the State should invest in multiple strategies to ensure access to telemedicine for individuals living in under resourced communities, including racial/ethnic minorities, individuals with limited English proficiency or low literacy, and those with low-incomes or are experiencing homelessness. In discussing strategies for increasing access to telemedicine, Subcommittee members noted that the barriers people face in accessing telemedicine are the same barriers they face in accessing remote learning. This presents an opportunity for the health and educational systems to partner and work together on strategies to address technology access and literacy issues.

Participants also suggested many ways in which access could be improved by making the technology more widely available in the community. For example, some clinics have set up spaces with the equipment necessary for patients to come in and conduct a telemedicine visit with a provider from a remote location. Some schools facilitate telebehavioral health counseling sessions for students during the school day.

Participants encouraged the State to explore and identify community resources and venues, such as senior centers[6] and libraries, where patients could go to conduct a telemedicine visit using simple but secure setups in a private setting. In addition to providing space and access to the internet and equipment, staff such as librarians could provide assistance and/or training on how to use the technology and log on to the video-conferencing platform. Such strategies are particularly relevant to in a post-COVID future when social distancing will not be an issue.

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[3] Nouri et al., "Addressing Equity in Telemedicine for Chronic Disease Management During the COVID-19 Pandemic," *New England Journal of Medicine Catalyst Commentary*, May 4, 2020.
[4] American Well, "Telehealth Index: 2019 Consumer Survey," August 27, 2019.
[5] Sage Growth/Blackbook Research, "As the Country Reopens Safety Concerns Rise," May 11, 2020.
[6] One example in response to COVID-19 is the partnership between the Rhode Island Office of Health Aging, the University of Rhode Island and Blue Cross & Blue Shield to advance the digiAGE initiative during the pandemic and connect older adults to digital tools to help them access online resources, work remotely and virtually connect with families and friends.

Other strategies identified include using community health workers, peer recovery specialists, family support counselors, and other support providers that are in the community and go into patients' homes to walk patients through how to conduct a telemedicine encounter. There is already a financing stream available for some of these community-based support providers that can be leveraged, and some organizations are already thinking through incorporating support for accessing telemedicine encounters into the training and scope of work for such workers.

Discussion and Recommendations Related to Telemedicine Payment and Program Integrity

The Subcommittee was made aware of general activities to address fraud, waste and abuse, and there was no Subcommittee feedback on this issue.

Subcommittee discussions on whether payment rates for telemedicine should be on par with rates for in-person services were held over the course of three meetings. Five options were presented to the Subcommittee for consideration:

1. Parity for equal service, regardless of modality
2. Parity for equal service for audio-visual, with an audio-only differential allowable
3. Parity for primary care and behavioral telehealth services – regardless of modality. Differentials allowed for medical telehealth services.
4. Differentials allowed for all services based on modality of care.
5. Parity for telemedicine, regardless of modality, with differentials allowed for providers that do not see patients in person.

The following describes consensus recommendations and the discussion around payment for telemedicine services.

Recommendation: Telemedicine behavioral health services should be paid at the same rate as in-person regardless of modality, so long as the modality is clinically appropriate.

There was consensus for paying for telemedicine behavioral health services at the same rate as in person services during the meeting in which the topic was discussed. Subcommittee members agreed that many behavioral health services are appropriate to be provided via audio-only or audio-visual telemedicine. In particular, counseling services can be delivered just as effectively through a phone call or video-conference as an in-person visit. Some noted that the stigma of seeing a behavioral health provider in person have prevented some from seeking treatment, and the reduced stigma associated with telebehavioral health visits is important to getting people to seek needed care. In addition, the convenience of telemedicine could increase the rate of appointment adherence, which could yield better overall outcomes. At a subsequent meeting, UnitedHealthcare (UHC) informed the Subcommittee that it was supportive of payment parity for behavioral health during the public health emergency, but believed it was important to have more data on outcomes before implementing this policy on a permanent basis.

The Subcommittee did not come to a consensus on whether other services should be paid for at the same or differential rates based on modality. The two opposing viewpoints are outlined below.

Key Arguments for Payment Parity

Providers and consumer advocates generally supported payment parity. Providers argued that the medical decision making process, expertise and time required to conduct a visit is the same, regardless of the modality with which the visit is conducted. Providers also noted that many of them have invested a lot of time and resources in building the infrastructure necessary to facilitate telemedicine visits, including having staff reach out to patients ahead of the visit and walking patients through the technology to allow them to connect with their provider more smoothly. They noted that these measures take enormous staff resources, and that delivering care through telemedicine is not necessarily less costly than delivering care in-person.

Consumer advocates indicated that payment parity is important to ensuring that providers build the infrastructure necessary to deliver telemedicine. They also argued against making distinctions in payment for audio-only versus audio-visual visits, indicating that it might disincentivize providers from providing audio-only telemedicine services. This would in turn disadvantage patients who may not have access to video-technology and consumers requiring behavioral health services, who are disproportionally members of racial and ethnic minorities.

Key Arguments Against Payment Parity

Payers and business groups generally supported payment parity during the public health emergency, as telemedicine offers a way to deliver care safely when social distancing is required. Over the long-term, however, they supported differential payment, arguing that parity may cause unintended consequences where patients are driven to telemedicine even when a visit is more clinically appropriate to be conducted in person. They argued that evidence is still lacking on the clinical appropriateness and outcomes of telemedicine to require payment parity on a permanent basis. They also noted that alternative payment models, such as primary care capitation, should provide the incentives necessary to ensure services are provided at the right time and through the appropriate modality, and requiring payment parity will undermine such efforts to implement value-based payment approaches. One insurer speculated that requiring payment parity may increase the cost of insurance to the consumer.

While there was no consensus on payment for non-behavioral health services, several points of agreement emerged from the discussion. Specifically, the Subcommittee agreed on the following key themes:

a. **Telemedicine fills an important need during the public health emergency when social distancing requires fewer in person interactions, allowing some patients to continue to receive care via telemedicine.** Subcommittee members recognized that telemedicine will continue to play a larger role in the care delivery, going well beyond the end of the public health emergency. Development of telemedicine policies to address the public health emergency versus care delivery over the long-term needs to consider that

recovery from the COVID emergency will be spread out over time, rather than have one clear end date.

b. **One goal of telemedicine should be that it is integrated into the existing delivery system infrastructure that emphasizes the patient-centered medical home, continuity of care, and coordination between primary, behavioral health, and specialty care, rather than be developed as a separate system.** The use of telemedicine should support existing patient-provider relationships to promote the patient-centered medical home and continuity of care. Some providers and consumer advocates expressed concern about telemedicine delivered by telemedicine-only companies not based in Rhode Island offering limited or no patient continuity of care, which could undermine efforts in the State to integrate the delivery of primary, behavioral, and specialty care. They emphasized that telemedicine needs to fit into Rhode Island's current delivery system that supports local providers to collaborate and coordinate across the continuum of care. Payers agreed with the need to support the local infrastructure, and that the goal should be to integrate care as much as possible, but also recognized that some clinical expertise is only available through providers outside of those relationships.

c. **A value-based health care system that moves away from FFS payments will allow for providers to deliver care using any care modality that is most appropriate for the patient.** There was overall agreement and support for ensuring that telemedicine is part of the move towards value-based payment arrangements.

d. **The value and appropriateness of telemedicine is still being defined, and how telemedicine adds value varies by stakeholder and patient population. Additional study of the use and use cases of telemedicine would provide further input into its value proposition.** Some subcommittee members noted that we are still in the early stages of developing and defining telemedicine's value proposition. While telemedicine's potential to add value is clear, we do not yet have a way to effectively measure the value it is creating. Telemedicine is a relatively new mode of delivery that will evolve over time and is a good modality for delivering care for certain situations. However, we do not yet know all the evolving situations for which telemedicine is suitable. In addition, the value that telemedicine adds may differ for providers, patients and payers. More research is needed on the use cases and outcomes of telemedicine to inform future policies. To avoid unnecessary utilization, such research needs to focus on identifying the aspects of delivering care through telemedicine that contribute to better quality and outcomes. In addition, while the widespread adoption of telemedicine during COVID-19 presents an opportunity to study its impacts, caution must be taken in inferring from data collected during these unique pandemic circumstances.

e. **Telemedicine can provide access to services or provider types that are scarce in Rhode Island and special consideration in payment rates should be given when telemedicine can fulfill a need for access.** While there was some concern about disruption that telemedicine provided by non-local telemedicine companies might bring, there was also

recognition that access to certain services and provider types in Rhode Island are scarce, and that telemedicine can fill a consumer need in such circumstances. Telemedicine has the potential to address shortages of certain specialists in the State. Participants generally agreed that future payment policies should support the use of telemedicine as a tool for addressing access issues, where provider shortages exist.

Discussion and Recommendations Related to Security, Privacy, Confidentiality in Telemedicine

In the discussion around conducting telemedicine through HIPAA-compliant technology, providers indicated that while this may have been a challenge for them at the beginning of the pandemic, it is now largely resolved. For the most part, providers have made the necessary technology infrastructure investments and secured the necessary licenses and agreements to be able to conduct telemedicine visits using HIPAA-compliant technologies.

However, Subcommittee members noted that barriers around patients' ability to use the specific HIPAA-compliant technology platform that the provider is using still remain. Subcommittee members indicated that the bulk of the work needed to promote the use of HIPAA-compliant technologies by patients is similar to the work needed to address digital literacy and internet and technology access issues that were identified during the access and disparities discussion.

Discussion and Recommendations Related to Performance Measurement in Telemedicine

Throughout discussions of coverage of and payment for telemedicine, several Subcommittee members raised the importance of evaluating telemedicine quality and outcomes to inform future policies. The Subcommittee did not discuss specific proposals for measurement, which were beyond the scope of the group. Instead, discussions focused developing principles to guide future quality measurement efforts. The development of such principles were guided by recommendations of the Taskforce on Telehealth Policy, a national effort to develop consensus recommendations for policy makers on quality and safety standards for digital health care delivery nationwide.[7] During the November 12, 2020 meeting, the Subcommittee agreed to support the following principles:

a. **Future implementation of telemedicine policies should be accompanied by a measurement strategy that effectively evaluates performance against the goals of**

[7] The Taskforce on Telehealth Policy was a joint effort between the National Committee for Quality Assurance (NCQA), the Alliance for Connected Care, and the American Telemedicine Association. The final report can be found here: https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-ttp-findings-and-recommendations/

improving access, reducing disparities, ensuring quality and safety; and reducing inappropriate care. Subcommittee members agreed that the value of telemedicine should be defined by its ability to achieve these goals and such a measurement strategy can help build the evidence base to inform future policies.

b. **Telemedicine should be incorporated into existing OHIC and Medicaid efforts to measure quality and outcomes, to the extent possible, and not developed as a separate quality measurement effort.** Consistent with the Taskforce on Telehealth Policy's recommendations the Subcommittee agreed that measures of telemedicine's impact should be incorporated into current measurement efforts, including OHIC's Aligned Measure Sets, the OHIC Patient Centered Medical Home (PCMH) Recognition Measure Set, and the Executive Office of Health and Human Services (EOHHS) Medicaid AE Incentive Measure Set. Further, incorporating telemedicine measures into the OHIC measures is particularly important for aligning the measures with the technology, since the OHIC and EOHHS AE measures feed into the Quality Reporting System.

c. **To the extent possible, measurement efforts should consider patient experiences with a telemedicine encounter, including patient preferences for modality of care, impact on appointment adherence, video and audio quality, and connectivity.** While the Subcommittee recommended incorporating telemedicine into established measurement efforts, they also recognized the need to potentially adapt current measures to account for patient experiences with a telemedicine encounter that might not be relevant to an in-person visit, such as quality of the connectivity.

d. **To the extent possible, when considering future policies to expand telemedicine, estimates of its financial impact should consider: (a) patient or caregiver costs and benefits that are not always quantified in monetary terms such as child care and hours taken from work; (b) the financial impact on the individual clinical provider, hospital or health care system; (c) the financial impact on state spending, including any estimates of savings that may be made through the reduced use of non-emergency medical transportation and services; and (c) the costs for payers.** Many stakeholders indicated that state policymakers should take a broad view when assessing the financial impact of telemedicine, and consider costs and savings to all stakeholders. In addition, it is important to recognize and account for the non-monetary benefits that telemedicine brings, such as time savings to patients and reductions in lost work time for employers, when considering future policies.

Conclusion

The Telemedicine Subcommittee of OHIC's Payment and Care Delivery Advisory Committee sought to make thoughtful recommendations on how to maximize telemedicine's benefits and make it more widely available, while maintaining standards for quality, safety and program integrity. The consensus recommendations identified by the Telemedicine Subcommittee presents a path for OHIC and Medicaid to explore as it develops future policy on the use of

telemedicine. The State should continue to evaluate telemedicine's impact on quality, outcomes, and cost, but it is widely accepted that telemedicine has been an integral part of Rhode Island's pandemic response, and will continue to play a larger role in health care delivery in the future.