OHIC Payment and Care Delivery Advisory Committee
Telemedicine Subcommittee Notes
November 12th, 2020 from 9:00 A.M. to 12:00 P.M.

Goals for Today's Meeting

- **Marea Tumber** reviewed the four issue areas the Subcommittee covers. 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.
- **Al Charbonneau (**Rhode Island Business Group on Health) brought up the previously mentioned Truven report that found that behavioral health has high inpatient utilization and pharmacy cost, not high outpatient costs. He indicated a need for follow-up to look into overutilization, and whether it's a good or bad thing. **Marea Tumber** said the state is doing a BH system review and will hopefully have some related data in the spring. **Matt Collins** (BCBSRI) said primary care utilization generally leads to lower cost and higher quality, and we need to ask what's too high utilization of primary care.
- **Marea Tumber** reviewed what we've covered so far, the day's topics, and how project staff will create report summary and consensus recommendations. She reviewed timeline for circulating the draft and finalizing the report by December 31st.

Wrap-Up of Payment Parity Discussion

- **Megan Burns** noted that there wasn't consensus on primary care and wants to find general areas of disagreement and agreement, rather than single out minority opinions. She outlined three viewpoints: (1) payment parity for audio-visual primary care; (2) full payment parity for primary care; (3) no payment parity. Megan invited feedback and the subcommittee offered the following:
    - **Howard Schulman** (physician) said many of his patients have the technology, but do not have the capability to utilize it because of technological problems.
    - **Beth Lange** (pediatrician and co-chair of PCMH-Kids) said there should be parity across all modalities.
    - **Steve Lampert** (Care New England) noted that three options were not equally supported and asked how to better document the magnitude of disagreement across the 3 options. **Megan Burns** noted the challenge with having an open group and variable membership but hopes the specific feedback for the final report review will allow a more in-depth documentation of opinions.
- **Megan Burns** reviewed the principles that the subcommittee previously agreed to. She then asked for feedback for clarity on these seven principles. Participants discussed the expectations for telemedicine integration, whether there is consensus on behavioral health parity, inclusion of equity in the language of parity, and concerns with national telemedicine groups. Specific comments on the issue include the following:
    - **Matt Collins**, commenting on principle #2, noted that it is not fair to hold telemedicine to a different standard for integration, and argued that other aspects of delivering care, such as urgent care, are not integrated. **Megan Burns** clarified that the principles reflect an ideal and there is acknowledgement that this isn't always possible.
    - **Stephanie deAbreau** (UHC) said UHC did not come to a consensus on principle #5, and there needs to be more research before they can support it. **Megan Burns** noted that the majority of participants did support the recommendation. **Peter**

Oppenheminer (RI Psych Association) said there is strong consensus for #5 in provider community.
  - **Patricia Flannagan** (pediatrician and co-chair of PCMH-Kids) said equity was part of the discussion on parity and should be reflected in #7.
  - **Howard Shulman** expressed concerned about national telemedicine groups that try to solicit patients and business in RI. **Megan Burns** noted that there is a value to organizations not based in RI, but Howard's concern will be reflected. **Matt Collins** noted that telemedicine companies have their own quality and outcome measures such as set protocols, expectations, and feedback on recordings and live sessions. **Howard Schulman** responded that in-person visits are more important than telemedicine, which just compliments in-person visits.

Discussion of Performance Measurement in Telemedicine

- **Megan Burns** discussed how value proposition of telemedicine varies by stakeholder. While telemedicine is still an important resource to aid in social distancing, now is the time to give thoughtful consideration to its impact on quality, patient outcomes, and cost of care. Megan shared RI's quality measurement efforts and noted that the NCQA made adjustments to its HEDIS measures, allowing telemedicine visits to be treated equivalent to in-person visits. She also reminded everyone of how it is important to recognize the non-traditional ways in which telemedicine may benefit the overall system.
- She reviewed the four principles to Guide Measurement of Quality, Outcomes and Cost in Telemedicine:
  1. Telemedicine policies should be accompanied by a quality strategy that measures:
     1) Improved access
     2) Reducing disparities
     3) Quality and safety
     4) Reducing inappropriate care
  2. To the extent possible, the telemedicine modality should be incorporated into existing OHIC and Medicaid efforts to measure quality and outcomes.
  3. Measurement efforts should consider patient experiences with a telemedicine encounter
  4. When considering future policies to expand telemedicine, estimates of its financial impact should consider:
     - Patient or caregiver costs that are not always quantified in monetary terms;
     - The financial impact on the individual clinical provider, hospital or health care system; and
     - The costs for payers.
- Megan asked whether the subcommittee supports these principles. Participants discussed how to align the measures, additional cost savings, and PCH-Kids' patient needs assessment preliminary results. Participants' specific comments include the following:
  - **Howard Shulman** noted that measuring quality of telemedicine for outside companies will be hard, especially if it's a one-episode telemedicine visit. **Matt Collins** responded that HEDIS measures can be applied to one-off episode visits.
  - **Al Charbonneau** said the RAND study indicated that convenience was a factor for having telemedicine visits. He cautions differentiating what's nice and convenient versus necessary to avoid increasing insurer costs.

- **Marti Rosenberg** (EOHHS) agreed with the principles. With #2, she encourages using tech to align the quality measures, because the OHIC aligned measure set feeds into HIT quality reporting system.
- **Matt Collins** agreed with the principles, especially #3 and #4. **Karen Malcolm** (Protect our Healthcare Coalition) agreed with #3, as it's important to consider larger public health outcomes beyond just cost and finance.
- **Liv King** (BHDDH) mentioned the interplay of quality and access and said to consider transportation cost as savings in #4. It's also important to consider what the patient's preferences are for in-person versus telemedicine visit.
- **Beth Lange** said telemedicine provided by physician-based hospitals do not carry facilities fees, indicating a cost saving.
- **Joshua Miller** (RI State Senator) said to consider the financial impact on the state level, perhaps by calculating savings on transport of Medicaid patients.
- **Howard Shulman** was concerned that quality measures will be too simplified, and physicians will be more concerned about meeting quality measure rather than meeting patient needs.
- **Susanne Campbell** (CTC-RI) said they implemented a practice and patient needs assessment that showed in-person visits was good for meeting patient preferences of in-person physicals and continuing their relationship with their provider. Telemedicine was good for staying safe from COVID, meeting immediate needs, and access to care. In addition, patients said if there was no tele offered they might forego care completely, incurring potential future costs and complications. She noted the full report will be available end of December to share.
- **Jay Lawrence** (Care New England) agreed that an increase in engagement on the patient side via telehealth to improve their own health is a good thing.

Wrap-Up of Security, Privacy and Confidentiality Discussion

- **Megan Burns** noted that Commissioner Ganim presented the Subcommittee's feedback to the Health Innovations Work Group of the National Association of Insurance Commissioners, and on her behalf, thanked the participants for the discussion on Telemedicine and HIPAA-Compliant Technologies. One key takeaway was promotion of HIPAA-compliant technologies need not be so provider focused – but it should also be consumer / patient focused. **Megan** noted some activities at the national and state levels that could support providers and facilitate the use of HIPAA compliant technologies for telemedicine, include TTAC, HIT Survey, and The Care Transformation Collaborative of RI/PCMH Kids.
- **January Angeles** added that Marti Rosenberg is also working on an initiative to give technology to telebehavioral health providers.

Follow-Up on Improving Access and Reducing Disparities in Telemedicine

- **Megan Burns** presented the following recommendations made in September – the first four of which address patient access to technology and technology literacy.
    1. Provide state-wide access to broadband
    2. Explore opportunities for partnership of sharing lessons learned
    3. Identify public/private initiative to support telemedicine use in the community
    4. Utilize community health workers
    5. Consider adding telemedicine access to network adequacy standards

- Megan shared that RI Office of Innovations, Digital Equity Initiative, CYC, and ConnectRI are examples of existing local efforts in RI to address Technology Access and Literacy Issues by increasing access to devices, conducting digital literacy trainings, creating and expanding free Wi-Fi access points. Megan then asked what other recommendations to increase access and reduce disparities the Subcommittee wished to add. Participants offered the following:
    - **Patricia Flanagan** said adding a medical interpreter to telemedicine visits is important. **Matt Collins** agrees.
    - **Matt Collins** agrees with #4. **Susanne Campbell** suggested looking at librarians as people who would help individuals learn how to use technology. **Matt Collins** said the URI Cyber Senior programs help those with devices learn how to use it.
    - **Peter Oppenheimer** asked to add rural areas to #1. **Matt Collins** said we need to ask community about #1.
    - **Howard Shulman** was concerned that telemedicine industry will force their store and forward technology to record visits onto patients when not necessary. **Matt Collins** clarified that store and forward is for not storing interaction of patient but storing and sharing patient information. **Mishael Azam** (UHC) added on that its purpose is to share the record of the visit with the PCP, and it's not meant to be inaccessible.
    - **Liv King** suggested modifying #3 to include that providers can provide locations and devices for telemedicine visits. **Marti Rosenberg** said regarding #3, she noted the need to be explicit about what the real disparity is that we want to address. From SUMHLC survey, it seems that providers have technology they need, but patients don't.
    - **January Angeles** reminded the group about consensus in earlier meeting about coverage for audio-only telemedicine, which addresses some of the technology access issues.

Discussion of Program Integrity in Telemedicine

- **Megan Burns** reviewed how fraud, waste, and abuse (FWA) can happen with any healthcare services and does not seem to be more rampant in telemedicine than for in-person services, so it's largely been incorporated into existing FWA efforts by insurers. Megan pointed out that payers have extensive written guidelines, policies and procedures around how to handle fraud, waste and abuse. Megan noted that the subcommittee will not be weighing in on FWA activities. She noted the use of AI technology that can identify fraudulent claims and be integrated into the existing enforcement system.

Public Comment

- **Megan Burns** asked for any public comments. Participants discussed considering utilization in FWA, the data on number of visits, future cost savings, and the future of payment parity. Participants offering the following:
    - **Al Charbonneau** wanted to know what the insurers do about necessary utilization because FWA doesn't address it. **Matt Collins** noted that the threshold for FWA is high, so any violation would be very egregious. Patient has to be informed when an encounter is a billable visit.

- **Al Charbonneau** said it seems that behavioral health utilization is up. **January Angeles** said it's hard to tell if increase in BH visits was more people or increase in patient acuity. **Matt Collins** said it is the latter. **Liv King** agreed.
- **Al Charbonneau** wanted OHIC to release the data on number of visits. **Beth Lange** responded that the purpose of telemedicine is to keep patients safe and fiscally keep practice open. She cautioned making direct line comparisons in the number of telemedicine visits without context. **Al Charbonneau** wants to look at data and use it to inform post-pandemic environment. **Beth Lange** argues telemedicine existed before pandemic. Telemedicine companies brought patients out of the medical home. **Megan Burns** said the collected data is limited and does not provide nuanced perspective or tell the whole story. **Steve Lampert** agrees with Beth on benefits. We do not have data on patients who cancelled or didn't show.
- **Laurie-Marie Pisciotta** (MHARI) said to look to future for cost savings; telemedicine access prevents crises, escalation of problems, and saves money in the long-term. **Linda Hurley (**CODAC) echoed Laurie-Marie; CODAC's 6-month survey found that patients respond very positively to telehealth and she encouraged looking at population specific impact. **Matt Collins** responded that the issue is people not accessing telemedicine care even when it is in supply. He encouraged looking at APMs to improve care in RI. **Al Charbonneau** agreed that employers would support research like this
- **Liv King** as an epidemiologist, we wanted to contextualize that data from past months cannot be generalizable or used to tell us what usage of telemedicine will be like after COVID.
- **Mishael Azam** said there is a middle ground for telemedicine visit payment parity because now there's payment that did not exist before. Telemedicine is more accessible because it is less costly.
- **Marie Ganim** noted that while there is existing payment by state law, insurers were restrictive with interpretation, and we need a way to allow the type of telemedicine visits that is most appropriate. She expressed appreciation to members of Subcommittee for participating, including the business community, patient advocates, and legislators.

Next Steps and Adjournment

- The next Meeting is December 10th, 2020 from 10 AM-12PM. Project staff will circulate the final report prior to the meeting so that Subcommittee members have a chance to review and provide feedback.

Link to the Meeting #6 recording:

https://zoom.us/rec/share/udMpDAd6lL5Td5MNJJQyLBcYPw2f-czd6Ylg6vA8S5zae2VizldJ7mQBF7H92U1-.C8ZBpED_cYjuLNTq?startTime=1605189549000