**OHIC Payment and Care Delivery Advisory Committee**
**Telemedicine Subcommittee Notes**
**October 8, 2020**
**10:00 A.M. to 12:00 P.M.**

## Welcome and Agenda Review

- **Marea Tumber** (OHIC) reviewed a change to the agenda and indicated that feedback on the Office of Civil Rights' HIPAA enforcement will be reviewed at the next meeting.

## Goals and Process for Developing Consensus-Based Recommendations

- **Marea Tumber** reminded participants of the group's goals of looking at telemedicine policies and process for developing consensus-based recommendations.
- **Al Charbonneau** (Rhode Island Business Group on Health) raised a concern that he did not think there was consensus on coverage of audio-only visits, and that there is a need to discuss telemedicine's impact on cost and quality before making recommendations.
- **Marea Tumber** indicated that given the group composition, that there may not always be consensus on each topic or recommendation. In such cases, the final report will note areas of agreement and disagreement and specific concerns raised by stakeholders.
- **Commissioner Marie Ganim** said telemedicine's impact on cost will likely be raised as part of the conversation around payment parity.

## Summary of Rhode Island Specific Data

- **Marea Tumber** discussed results from a Press Ganey survey showing that patients were positive about telemedicine, even when facing technical issues. She then described the data request that OHIC made of the largest commercial insurers in Rhode Island. She described the findings from Rhode Island insurer data, which showed sharp increase in telemedicine due to COVID, but an eventual flattening out as in-person services increased over the summer. She noted that telemedicine utilization leveled out at a higher level for behavioral health services than for health care services overall.
- **Megan Burns** (Bailit Health) reviewed some national data and noted that overall volume of visits in RI did not decline as significantly as the rest of the US. When usage is broken down by age, the most significant increase in utilization was in the older age bracket. Megan also indicated that primary care and behavioral health had the largest increase in total volume of visits, more so than specialist or other.
- Participants offered the following reflections on the data:
    - **Steven Lampert** (Lifespan) indicated that Lifespan experienced a greater than 1% drop in visit volume (in-person plus telehealth). In April and May remote visits exceeded in-person.
    - **Ed McGookin (**Coastal Medical) indicated that a patient survey about telemedicine usage at Coastal proved sobering and cautioned against using telemedicine to replace in-person services. Telemedicine has a place, but there is a need to ensure that it is applied to the right problem, in the right situations. It is not always appropriate to substitute telemedicine for in-person services.
    - **Corinna Roy (**BHDDH) indicated that based on the data, it appears as though the industry has been doing what is appropriate. This is likely why there is greater usage of telemedicine for behavioral health visits – which is more suited for the modality of care – compared to specialist visits.

- **Jay Lawrence (**Care New England) cautioned against making assumptions based on data collected during COVID times when in-person visits were not possible, as this does not represent what service delivery will look like. He indicated that with telemedicine being a relatively new platform, it will evolve and we will have more information to know what appropriate use cases are.
- **Matt Collins (**BCBS of RI) noted that this is consistent with what they are seeing. There is an overall increase in visit volume for behavioral health, which would be a result of individuals' mental state.

## Presentation of Payment Parity Issues

- **Megan Burns** explained the framing for the discussion, noting throughout the discussion we should assume the services are medically necessary and clinically appropriate to be provided by telemedicine. Megan also noted that in the discussion, participants should assume that the provision of telemedicine services is allowable within providers' scope of practice.
- **Megan Burns** presented 5 options for discussion on payment parity based on feedback from the last meeting, noting that these options are only meant to stimulate discussion and that participants should feel free to offer modifications. The options presented included the following:
    - Option 1. Parity for equal service, regardless of modality
    - Option 2. Parity for equal service for audio-visual, with an audio-only differential allowable
    - Option 3. Parity for behavioral telehealth services, with differentials allowed for others – regardless of modality
    - Option 4. Differentials allowed based on modality of care
    - Option 5. Parity for telemedicine, regardless of modality, with differentials allowed for providers that do not see patients in person.
- **Megan Burns** described each of the options and the pros and cons associated with each option.

## Summary of Discussion on Payment Parity

- There was no consensus on how telemedicine services should be paid relative to in-person services. Some participants favored payment parity while others did not.
- Providers and consumer advocates generally favored parity, indicating that the medical decision making process, expertise and time is the same, regardless of whether the visit was conducted in-person or via telemedicine, and therefore, payment should be the same. Supporters of payment parity also noted that not paying for telemedicine at the same rate as in-person services would create a disincentive to offer telemedicine services, and decrease their availability. Specific comments on parity include the following:
    - **Dr. Elizabeth Lange (**pediatrician and co-Director PCMH kids) supported payment parity, indicating that the effort put into a visit is the same, whether it's in-person, by videoconference, or by phone. Providers spend the same amount of time talking with the patient and documenting the visit. She indicated that telemedicine should be viewed as a modality, rather than as a different type of care. **Steve Lampert** and **Garry Bliss** (Prospect) echoed Dr Lange's comments. **Garry Bliss** also noted that creating payment differentials would create a disincentive and decrease availability of services through telehealth.

    - **Tanja Kubas-Meyer (**RI Coalition for Children and Families) noted that there are many non-traditional settings where both behavioral health and other services are provided, like schools, residential day programs, day care centers via telephone. She said that audio-only telemedicine is going to be integrated into broader set of services that are part of in-person with occasional telephonic only support. She expressed concerned that a much lower audio-only rate would undermine the fabric of these services.
    - **Shamus Durac** (RIPIN) noted that we need to think about how payment incentives and differential payments impact both in-person and telemedicine infrastructures and how both impact availability and accessibility of care.
- Insurers generally favored paying differently for telemedicine services, noting that parity may cause unintended consequences where patients are driven to telehealth even when the visit should be in-person. Furthermore, supporters for differential payment noted that value-based payment models, particularly primary care capitation, should provide incentives to ensure services are provided at the right time and in the right way (i.e., modality of care). Finally, payers suggested that if parity were required, it will increase the cost of insurance to the consumer. Specific comments against parity include the following:
    - **Matt Collins** did not support parity and indicated that there should be differential for audio-only visits. However, there is value in parity for BH services. **Monica Auciello (**BCBS of RI) reiterated Matt's comments and also said that the payment parity may undermine efforts to transition to alternative payment models, such as primary care capitation, which should provide incentives to ensure services are provided in the right setting, at the right time.
    - **Brendon Peppard (**AHIP) said payment parity would increase cost for members and can have the unintended consequence of driving people to telehealth when they should be seen in person.
- There was general agreement that telemedicine should support state efforts to integrate primary care and behavioral health, and should support existing patient-provider relationships to support continuity of care. Participants expressed concern that telemedicine delivered by non-local, or telemedicine-only providers could undermine such efforts because they would not be well positioned to engage in care coordination. Specific comments on this issue included the following:
    - **Peter Oppenheimer** (RI Psychological Association) said that telehealth needs to fit into our current delivery system. In RI, this means supporting local providers to collaborate and coordinate the delivery of primary care and behavioral health. **Corinna Roy**, **Karen Malcolm** (Protect our Health Care Coalition of RI), and **Laurie Marie Pisciotta** (Mental Health Association of Rhode Island), agreed with Peter and expressed concern about allowing a telemedicine-only provider that may be out-of-state to compete with in-state providers based on cost and potentially undercutting RI's own provider network, particularly in psychiatry where there is already a shortage.
    - **Matt Collins** agreed with Karen and Laurie that we do need to invest locally. He also noted that some rare provider types can require an out-of–state provider or a payment differential. BCBSRI also wants to retain the ability to decide what services are clinically reasonable to deliver via telemedicine.
    - **Monica Auciello** clarified that even with its out-of-state telemedicine service, they still use local providers to deliver services. This is part of state licensure requirements.

**Brendon Peppard** and **Mishael Azam** (UHG) expressed concern about separating out telemedicine companies, and echoed Monica's comments that telemedicine companies partner with RI licensed physicians who rarely only do telemedicine.

- Participants agreed that having telehealth be part of a value-based health care system that is not based on FFS will allow for providers to deliver care using any care modality that is appropriate for the patient's needs. Specific comments on this issue included the following:
    - **Al Charbonneau** suggested looking at telemedicine expansion in alternate payment models to move away from FFS and have more flexibility for practitioners.
    - **Steve Lampert** indicated that telemedicine is a great modality when in a VBP setting. He agreed that value-based payment encourages telemedicine use, but it's difficult to encourage providers to use telemedicine if they are not in a VBP contract.
    - **Jay Lawrence** noted that this is a complex and nuanced process. It is important for telemedicine to create value, but the difficulty is how to define value. We are still in the process of figuring out which options provide value. He also indicated that pulling payment away from FFS addresses a number of concerns about cost, appropriateness of modality, etc., and noted that it would impede providers' journey to shift away from FFS towards having more of a value-orientation if there is no opportunity to innovate based on modality.
- There was overall support for payment for behavioral health services at same rate regardless of modality, so long as the service and the modality by which the service is provided is medically necessary and clinically appropriate.
- Participants recognized that telemedicine can provide access to services or provider types that are scarce in Rhode Island, and many noted that special consideration in payment rates be given when telemedicine can fulfill a need for access.
    - **Garry Bliss, Matt Collins** and **Steve Lampert** noted that there needs to be consideration of where we have local provider shortages, and that in those areas, reimbursement needs to acknowledge and reflect that.

## Next Steps and Adjournment

- **Megan Burns** indicated that the final report will clearly articulate that there are multiple points of view with respect to payment parity, but an overarching desire for telehealth to be in a permanent part of the system where it makes sense. She noted that the project team will summarize today's conversation and identify the high level themes that emerged and review it with the group.

**Link to the Meeting #4 recording:**

https://zoom.us/rec/share/4xSyELZJ04ksSjyldfPqOjBDRpNYAfnd83Hr97USZp3QAnP6QwQeiOAMRKXW_PqR.V3qvfTJVnAjsDFv-?startTime=1602165568000