December 8, 2020

Marea Tumber
Office of the Health Insurance Commissioner
Delivered by email to Marea.Tumber@ohic.ri.gov

Dear Ms. Tumber

Thank you for the opportunity to provide these comments in response to OHIC's draft Telemedicine Advisory Group Final Report. Thank you as well for running an open, transparent, and meaningful stakeholder process, and for ensuring that a variety of perspectives were included and respected in building a consensus set of recommendations.

RIPIN supports the work and recommendations of the Telemedicine Advisory Group as reflected in the final report, particularly in regard to safeguarding that meaningful access to telemedicine is ensured for consumers both during and after the ongoing Covid-19 pandemic. As RIPIN reiterated during the workgroup meetings, many of the individuals most in need of telemedicine services are the same whom will feel the effects of the pandemic the longest, including our family members, friends, and neighbors living with disabilities and chronic conditions. We believe that a comprehensive telemedicine strategy must emphasize ease of access for all Rhode Islanders, knowing that the "end" of the pandemic for some will not mean the end of the pandemic for all.

RIPIN has a handful of specific comments regarding elements of the proposed report:

- RIPIN strongly supports the workgroup's recommendations concerning strategies to resolve disparities in access to telemedicine. As has been noted many times in many arenas, an individual's zip code is among the most reliable predictors of access to health care and health care outcomes. The same communities that lack access to in-person health care services frequently also lack access to the technological tools and channels to receive telemedicine services. A comprehensive strategy to encourage improved access to telemedicine services for underserved communities would pay dividends in improved health care outcomes.
- RIPIN also strongly supports the proposal to include access to telemedicine among network adequacy standards. Insurers have an important obligation to ensure that their subscribers can access medically necessary in-person care. During the ongoing Covid-19 pandemic, it has become clear that many Rhode Islanders must turn to

telemedicine in order to safely access needed care. This need will not go away as in-person services begin to re-open, as there will always be individuals whose medical fragility means that telemedicine is a safer alternative. Emphasizing insurers' obligation to have a network where appropriate, medically necessary services are available through telemedicine would make health care more accessible to Rhode Islanders.

- The proposed recommendations regarding outcome-based quality measurement, especially the emphasis on patient experience, are integral to a successful strategy. RIPIN suggests that OHIC ensure that the data metrics concerning underserved populations be sufficiently robust to allow for comparisons of quality and access between communities of different races, ethnicities, language proficiencies, income strata, and geographic location.
- RIPIN believes that telemedicine has the potential to make some services more available than they are through in-person providers, including services from highly specialized providers, or from culturally competent providers in languages where gaps currently exist in Rhode Island. RIPIN also believes that the highest quality care must be person- and community-centered, and must integrate with a patient's whole body of care. As these two goals can be in tension with one another, it will be important for OHIC to establish regulation and guidance that strikes a balance between those priorities and ensures Rhode Islanders have access to a broad network of integrated care.

Thank you for the opportunity to participate in this stakeholder process. We look forward to discussing the final group recommendations in greater detail in the final workgroup meeting, and are happy to discuss our comments further in that or subsequent discussions as the State implements an enduring telemedicine strategy.

Sincerely,

/s/

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December 7, 2020

Marea B. Tumber, Esq., MPH
Principal Policy Associate
Office of the Health Insurance Commissioner
State of Rhode Island
Marea.Tumber@ohic.ri.gov

Dear Marea:

I am writing to provide comments on the DRAFT *OHIC Payment and Care Delivery Advisory Committee Telemedicine Subcommittee Recommendations Report* as the representative of the Rhode Island Psychological Association and a full-time practicing clinical psychologist in the community. First, I would like to thank everyone who participated in the workgroup for their time and thoughtfulness in considering the issues we addressed. One of the keys to Rhode Island's ability to successfully address health care policy issues has been our ability to include all stakeholders at the table, and this workgroup certainly continued that process. Special thanks to you, Commissioner Ganim, all the OHIC staff, and the Bailit Health consultants for all that has been required to organize and run the meetings.

We largely agree with the core recommendations of the workgroup with these comments:

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.

It is apparent to our professional community that a significant number of Rhode Islanders do not have access to the Internet or the ability to use it to participate in video conferencing. This is an important health disparity we can help to alleviate immediately by allowing voice-only access to continue using telephones and other communications mechanisms. In the long-term we need to look for ways to provide people Internet access; and the hardware, instruction, and tech support they need to participate in telehealth services. These conditions exist in both urban and rural communities. We need to find solutions appropriate for each community.

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

If cost sharing for telehealth is the same for in-person and telehealth services neither patients nor service providers will have a financial incentive to choose one type of service over the others. Patients and their healthcare professionals will choose the modality that is most appropriate for the patient.

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

We agree.

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

Healthcare professionals will provide guidance to patients about privacy and safety concerns when discussing informed consent issues. People can then choose the most appropriate location for them to receive services. A car may be the most private location and it can be relocated proximate to Internet or cell phone access that may not be available at home.

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

Healthcare professionals licensed by the Department of Health should be able to provide services that are within their scope of practice that can be offered appropriately by telehealth.

Insurance plans should allow all services that can be conducted appropriately via telehealth to be provided by telehealth. We disagree that insurers should decide what services are covered. We feel that state regulators (OHIC and DOH) should have that responsibility. If insurers are allowed to make the initial decision, the state should provide providers a feasible mechanism to appeal to state regulators to overrule the insurance company.

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.***

As I stated above, people living in rural communities may have difficulty accessing the Internet as do people living in urban communities. Rhode Island should seek to provide Internet access to all underserved communities and do so in ways that meet the needs of each community.

Network adequacy requirements should include consideration of access to services by telehealth. We feel it is in the interest of the community that the regulations promote the goals of Rhode Island's health care policy to promote population-based health care and with that integrated care. State policy should support our healthcare system by supporting Rhode Island based service providers' infrastructure. Rhode Island based service providers are going to be more attuned to the needs of our local communities, and in turn contribute to the local economy by employing Rhode Islanders and purchasing Rhode Island based support services.

Discussion and Recommendations Related to Telemedicine Payment and Program Integrity

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.

We agree with the consensus that behavioral health services should be paid at the same rate as in-person services. We urge the state to consider extending this parity to medical services as well when the service provided is the same by telehealth as in-person. It is important that service providers and their patients make the decision of treatment modality based on what is the best interest of the patient.

Where services in-person and by telehealth are different we understand payment could be at a different rate. Eventually the American Medical Association's Relative Value Unit Committee may create new Current Procedural Terminology codes (CPT) for telehealth services that are not fully equivalent to in-person services. Until then we feel that if parity of rates is not implemented, the decision of a rate differential should be determined by state regulators.

We disagree with the assumption expressed by some that service providers will see people by telehealth as a scheme to create an extra service before they would see the patient in their office anyway. It is important that service providers and patients decide which modality is in the best interest of the patient.

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.

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.

Our state policy should support the infrastructure of Rhode Island's health care services in support of implementing population health-based services that utilize integrated care, support continuity of care and coordination of care between primary health and specialty care (especially behavioral healthcare). Our policy should support the development and implementation of networks of care. We should support enhancing our workforce with professional and support staff who are multilingual and culturally competent to serve our many diverse communities in Rhode Island. The state should support our current professionals and staff to develop their skills in these realms with education and training opportunities. The state should also seek to encourage healthcare providers to develop and implement services in specialties that we currently lack in the state. Enabling access to specialist services who are outside our networks of care should be addressed as an allowable exception to the rule while we seek to build a more robust workforce and services that meet the needs of all Rhode Islanders.

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

The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) presents small health care providers who do not have standing information technology departments and lawyers a challenge to assess and keep up with vague and changing requirements. Despite that, RIPA members do their best to implement the requirements of HIPAA as they understand them. It is important to recognize that HIPAA does not state clear standards for many aspects of security, and it expects service provider to assess and implement strategies that are scalable to their needs. This vagueness creates a challenge to determine what is appropriate from what is ideal and what is feasible. Further, most healthcare professionals do not have the technical knowledge of IT that they do for their professional field, and as such they are really not able to independently verify whether the claims of any product or service they purchase or use actually are true; and thereby whether the strategies they choose to implement are actually effective. Nevertheless, they do the best they can to do what they understand they are supposed to do.

It is important to recognize that healthcare professionals experience a conundrum trying to navigate the requirements of HIPAA for telecommunications with patients. While they try to implement security requirements for communicating with patients, many patients do not have the resources or skills to do what they need to do to meet those requirements.

Further, some patients when provided information about security issues express that they feel that the level of security offered by whatever communications tool they use and with which they are comfortable is sufficient for them (i.e. Facetime). Beyond, that there are patients are who not concerned about security at all and who are unwilling to do anything to use the security technology we recommend. The conundrum is that while we seek to implement appropriate security technology to protect our patients, we understand that to be effective we must communicate with patients in ways they understand and are willing to use. As such in developing our state policy, we should give consideration of how address the desires of patients who are unable or unwilling to utilize communications tools that are as secure as we would like them to be.

Discussion and Recommendations Related to Performance Measurement in Telemedicine

A. ***Future implementation of telemedicine policies should be accompanied by a measurement strategy that effectively evaluates performance against the goals of improving access, reducing disparities, ensuring quality and safety; and reducing inappropriate care.***
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***

We agree that it is a good goal to assess the effectiveness of our services, and that it would be practical to try to incorporate assessing telehealth services into the same mechanisms used to assess in-person services. The issue for behavioral health clinicians is that electronic medical records that include data collection capabilities are expensive and collaborative data exchange interoperability with physician data systems (now that is EPIC for the most part) are not available to independent practitioners. This issue transcends the implementation of telehealth services.

Thank you for this opportunity to comment.

Sincerely,
Peter M Oppenheimer Ph.D
Peter M. Oppenheimer, Ph.D.
Director of Professional Affairs

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Comments from Dr. Susan Storti (SUMHLC)

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.

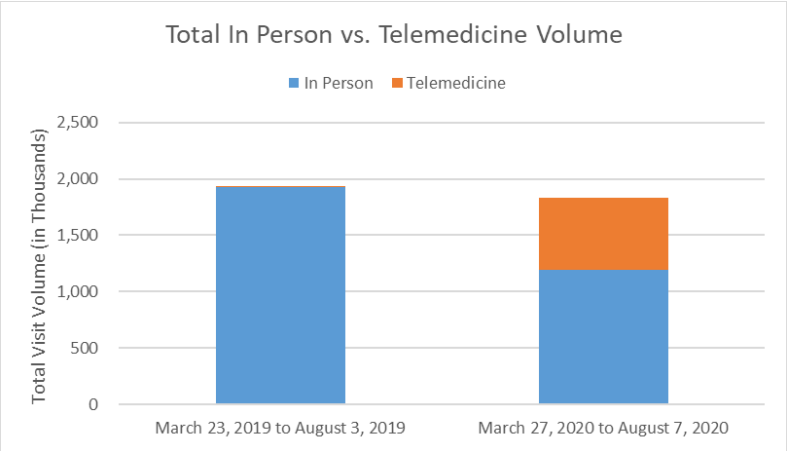
The Telemedicine Subcommittee discussions were facilitated using a consensus-based approach where project staff presented background information about the policy choices, including policies implemented by other states, and considerations for or against adopting a particular policy. Each member had an 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.

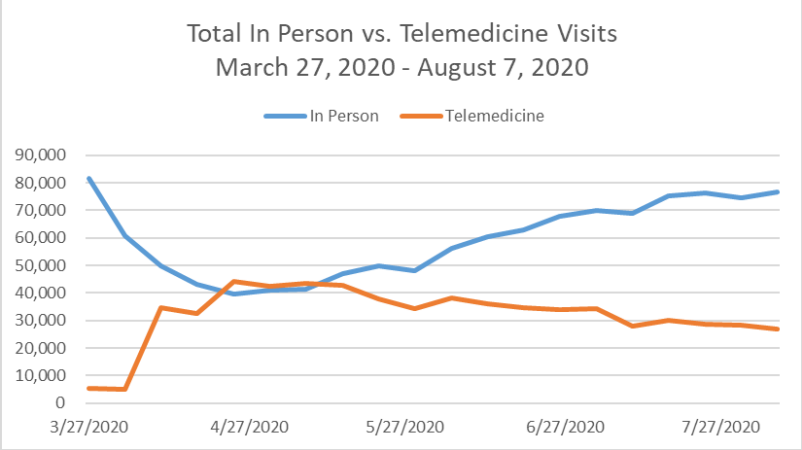
Telemedicine Utilization Rhode Island

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.

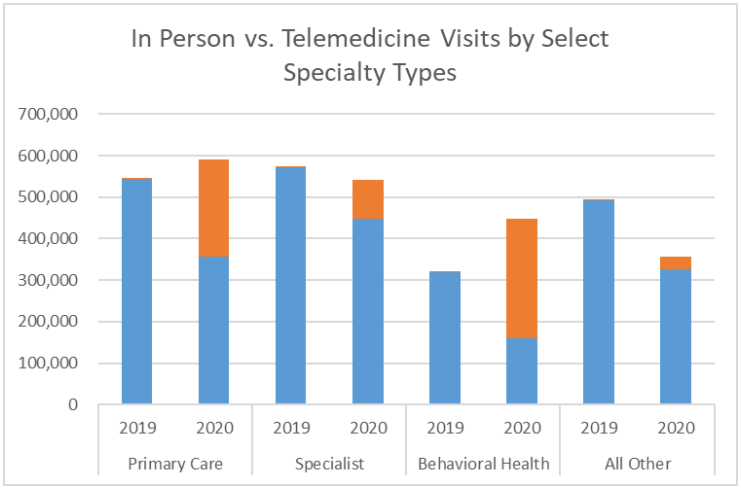
Rhode Island shows a surge in telemedicine claims in the early days of the pandemic when many elective, non-essential procedures were postponed or canceled to minimize infection risk and preserve resources for treating COVID-19 patients. The proportion of visits conducted via telemedicine increased from 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.

Commented [S1]: Guidelines that explain how clinically appropriate services will be determined need to be shared so that providers can bill appropriately.

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.***

[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.

- ***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 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

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[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.
[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.

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.

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.

[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.

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.

Commented [S2]: As above.

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 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

[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/

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.

Comments from Al Charbonneau (RIBGH)

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.

Commented [AC1]: While I think you guys did a great job of facilitating the discussion, the composition of the group really precludes representing the recommendations as the product of a true consensus process.

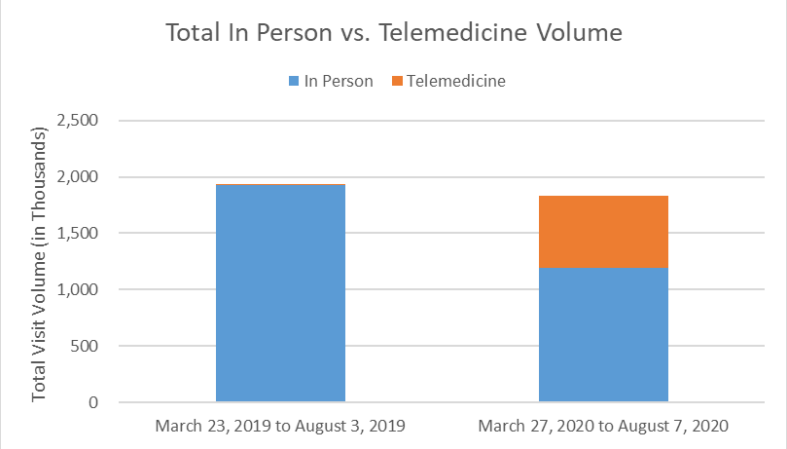
While these recommendations documented in this report represent the consensus of the Telemedicine Subcommittee, they do not necessarily represent the individual opinions of any Subcommittee member or organization.

Telemedicine Utilization Rhode Island

Commented [AC2]: I tried numerous times to introduce the RAND study https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1130 into the group's discussion. I think it is an important document that should be noted in the Subcommittee's report. I also noted, during the various meetings, other resources that should be referenced. For example, the Health Affairs blog that I quoted during one of the meetings, Telehealth Should Be Expanded—If It Can Address Today's Health Care Challenges | Health Affairs raises questions about utilization and cost that are appropriate and should be referenced in this document. It also should be noted that MedPac in its October meeting https://www.healthcaredive.com/news/medpac-commissioners-hint-at-telehealth-policies-that-may-stick-post-covid-/584747/ illustrates that there are utilization concerns with expanding telemedicine in a fee for service environment. It appears that MedPac will be more likely to explore expanding telemedicine with providers participating in non-fee for service value-based payment arrangement, something that we never discussed in the Subcommittee.
Mercer, the benefit consulting firm, recently partnered with the Catalyst for Payment Reform and the /American Benefits Council to publish a point of view on telemedicine that summarizes the feelings of many businesses. us-2020-telemedicine-pov.pdf (mercer.us) The summary page of this POV should be referenced in this report because it represents what a lot of employers are thinking regarding telemedicine.

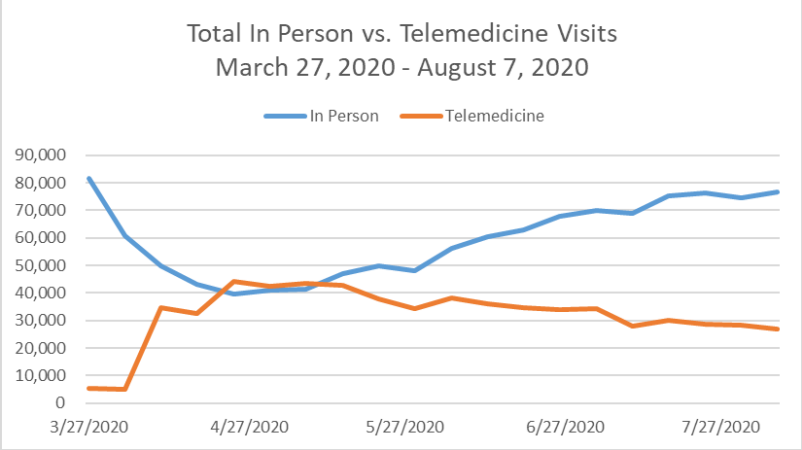
To inform the Subcommittee's discussions, project staff researched national trends in telemedicine utilization. In addition, OHIC obtained data from Rhode Island commercial insurers telemedicine usage on weekly visit volume for two time periods: the weeks ending March 2, 2019 – September 3, 2019, and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

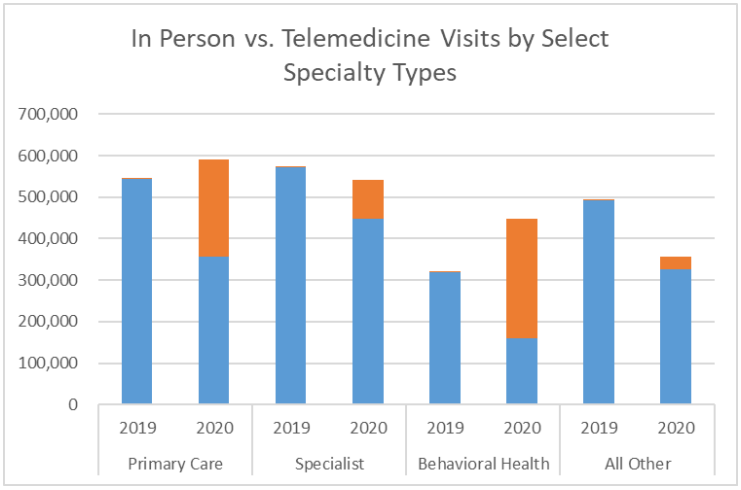


Telemedicine in Rhode Island made up for the decrease in in-person visits in April 2020. Telemedicine usage has since plateaued as in-person visits resumed, but utilization remains significantly higher than utilization before the pandemic.

Commented [AC3]: The literature and this report note that telemedicine seems to have leveled off at a higher rate than during the pre-pandemic period. If it turns out that office visits go back to the pre-pandemic rate and telemedicine is at a higher rate, then health insurance premiums and self-insured employers' cost will increase. The increase could be dramatic because primary care and specialist physician visits represent approximately 30% of small and large group premiums in Rhode Island.



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.

Commented [AC4]: Several times during meetings I mentioned that we need to differentiate between nice and necessary because of the fee-for-service, "loosely managed", as defined by Milliman, Rhode Island market. If policy changes end up stimulating new utilization, at the local level, it will impact commercial insurance premiums and the State's employee benefit costs. It will not impact Medicaid as much or at all because of the largest percentage of recipients are covered under managed care contracts.

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.***

[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.

- ***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 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

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[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.
[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.

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.

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

Commented [AC5]: The Mercer POV on Telemedicine recommends "that employers reject mandates that would require parity in payments to providers for virtual and in-person services and thereby impede employers' flexibility to innovate and pursue value-based care."

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.

[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.

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.

Commented [AC6]: And the service is necessary. The RAND study notes that the ease of use and convenience of the service may have contributed to increased utilization as opposed to utilization based on substitution.
The Mercer report also calls attention to the potential for new utilization.

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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 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

[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/

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.

Comments from Dr. Peter Hollmann (Lifespan)

OHIC Payment and Care Delivery Advisory Committee
Telemedicine Subcommittee

Recommendations Report – DRAFT – 12/3/2020

Introduction and Background

The ongoing COVID-19 pandemic has 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 payment~~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.

Commented [HPM1]: Although brief consider a summary that lists the recommendations as the start.

Commented [HPM2]: Tho this group was formed in the past, the PHE is ongoing and we need to set the psychology that way up front, so minor changes

Commented [HPM3]: Some hate "reimbursement" (eg Dr Lange. I am agnostic)

Recognizing the important role that telemedicine plays in safely delivering care during the pandemic and will~~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 coverage and payment policies should be implemented on a more permanent basis.

Commented [HPM4]: I think you can be more strong

Commented [HPM5]: Very little of this is about implementing the service; it is about payment/coverage.

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. Each meeting was open to the public and a public comment portion of the meeting was observed.

Commented [HPM6]: If accurate. I think this is important to readers outside the group.

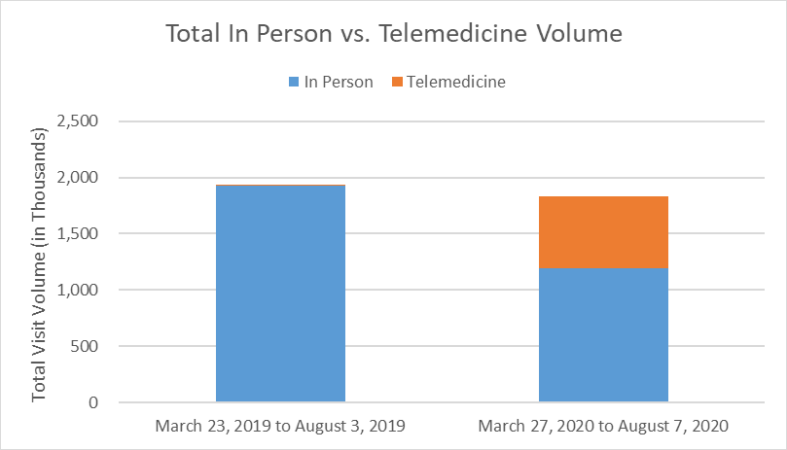
While these recommendations documented in this report represent the consensus of the Telemedicine Subcommittee, they do not necessarily represent the individual opinions of any Subcommittee member or organization.

Telemedicine Utilization Rhode Island

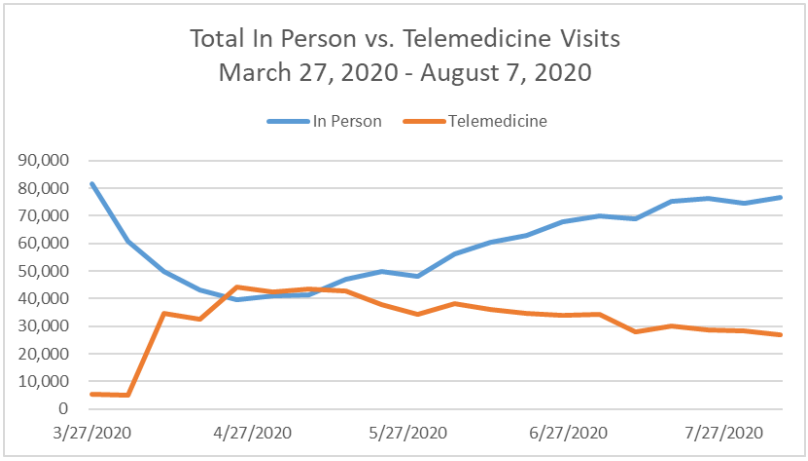
Commented [HPM7]: The comments below are a little technical and may be omitted or maybe explained in a foot note. Do not want to dilute the text too much. The main data issue is what is a visit? Was it any office encounter? (excluding an encounter just for imaging). Was it only certain CPT codes 99201-99215, 99381-99397? Did it include procedures eg skin surgery?

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 its utilization remains significantly higher than utilization before the pandemic.

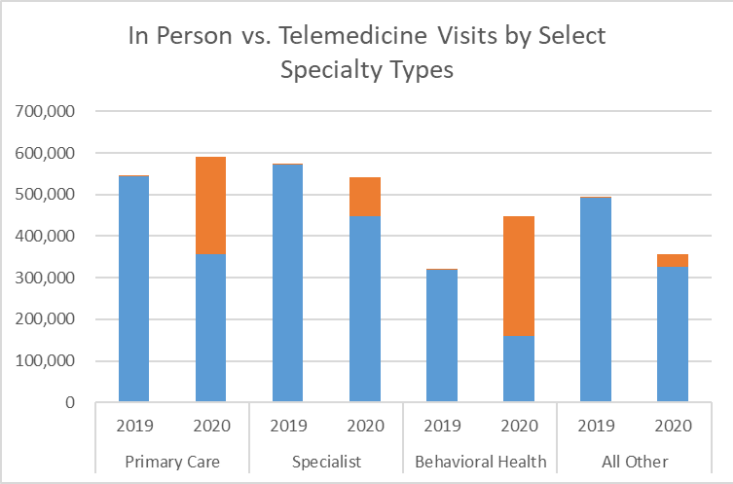


During the March to August 2020 time period, 40 percent of primary care services and 64 percent of behavioral services were delivered by telemedicine. Meanwhile, 17 percent of specialist services and nine percent of other services were delivered through telemedicine. Year-over-year primary care visit 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

Commented [HPM8]: Here is the main issue of concern re definitions. While volume was high, the intensity of the services was lower, so total payment were generally lower. (I saw a BCBSRI stat that suggested one group actually had higher volume and RVU per encounter, but that was not the general case). Can you add something about this if you have any data?
"Visit intensity and therefore cost per visit was decreased in primary care"

Rhode Island (BCBSRI) indicated that its internal analyses showed greater utilization among individuals who were already seeking behavioral health care. Clinicians reported reduced rates of missed appointments.

Commented [HPM9]: Several comments I thought should be made are addressed in the closing section, but major ones may warrant being called out earlier. So I will add and you can decide.



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. Defining which services are clinically appropriate to be delivered audio only or audio-video should include input from community providers

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. Others felt the same or lower co-pays would create incentives for patients to pressure clinicians to provide care better delivered in person. 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.

Commented [HPM10]: I guess this is just FYI and you cannot say it is consensus, but I do think the OHIC should convene a group to advises on clinical appropriateness. There is no reason for major variation or a one-sided approach. Maybe this can be added at the end in the areas where you address concepts not universally adopted. This seems the correct section, however. I did say this in one of the meetings with regard to any methodology AV and Audio only. I do not think each case should be subject to UR regs, but the general criteria should treated in a similar manner and overseen by the OHIC. There may be an appropriate reg section that applies. I personally wish it was required that there was a group- just like the quality measures

Commented [HPM11]: FYI only – CPT mostly already addresses the f/u call vs the distinct service in the telephone codes, but with certain coding it is less clear ie using the standard 99201-99215 for audio only.

Commented [HPM12]: One you do later, but I would still mention here

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~~,~~ who has provided a space for patients to reach other members of their health care team external to that practice.

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

[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.

Commented [HPM13]: This is confusing unless you read the concept of a health center having a facility to call a specialist. Or do you mean a patient comes to the office to talk to the doc who is quarantined at home. CMS is very explicit that when the patient and clinician are on the same site, it is not telemed. This was more the issue re inpatient visits when there was no PPE and people went to the unit, but not the room. Maybe just delete that last part?

Commented [HPM14]: I think you must address the key issue of adequacy here, even if mentioned later.

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. As importantly, the need for continuity of care and the capacity for in person services requires that the network not be restricted to telemedicine only providers.

Commented [HPM15]: You can throw in PCMH etc, but it is the same for specialists

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 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

[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.
[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.

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.

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.

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[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.

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 consensus recommendation~~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 all other ~~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,

Commented [HPM16]: Maybe you have it right, but I have to believe this issue came up in multiple meetings, even when not on the agenda.

Commented [HPM17]: Not sure what "medical" means. I think it is to be non PC and non BH

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 rarely some clinical expertise is only available through providers outside of those relationships.

Commented [HPM18]: If the company was domiciled here it would not matter. I heard this, but it is the concept, not the location of a call center.

Commented [HPM19]: I would add this word as it is almost NEVER the case. Or "occasionally"

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 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.

[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/

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.

Commented [HPM20]: EXCELLENT!!!

Commented [HPM21]: Work productivity etc does have monetary consequences. It may not have direct health care cost consequences.

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.

Comments from RIDOH

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.

Commented [BR(1]: Telehealth would be a more generic term or have a preamble that telemedicine is inclusive of various types of clinical services, including dental, PT, SLP, Nutrition.
Idea from Dr. Z: Mail a packet of fluoride varnish to a parent and then walk them through administration via a telehealth visit.
Consulting with the patient by video after diagnostics have been done is another example that Dr. Z provided. Lessens time that patient is in the office.

Commented [BR(2]: You may be aware that NCQA is putting out guidance on telemedicine standards, similar to PCMH recognition. Might recognition be something that we encourage?

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.

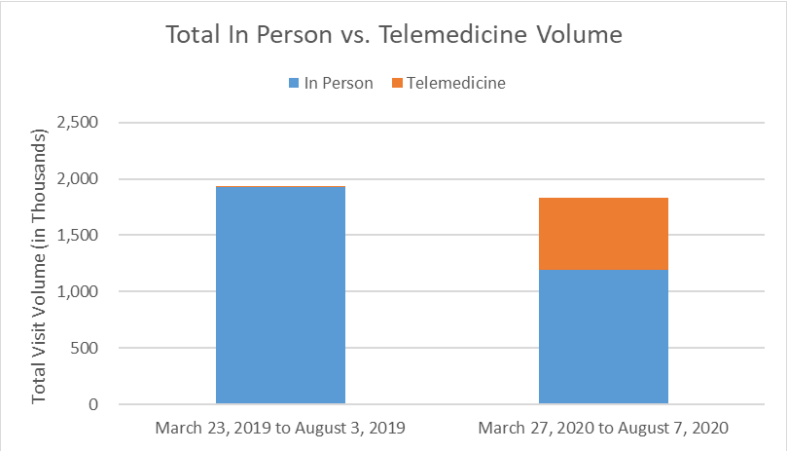
The Telemedicine Subcommittee discussions were facilitated using a consensus-based approach where project staff presented background information about the policy choices, including policies implemented by other states, and considerations for or against adopting a particular policy. Each member had an 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.

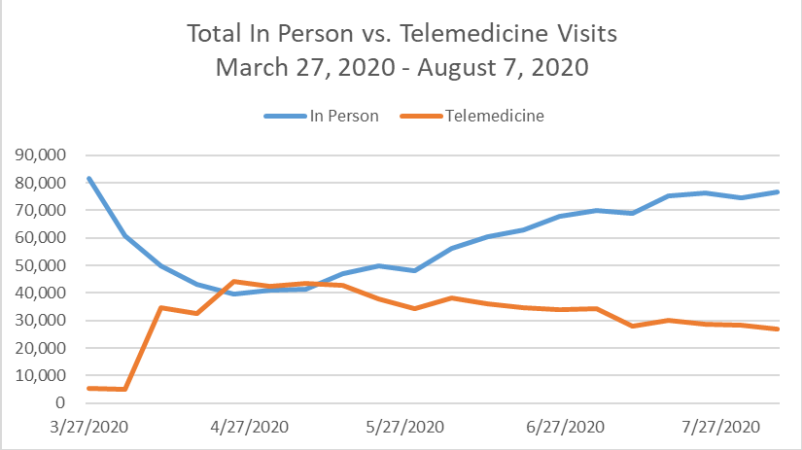
Telemedicine Utilization Rhode Island

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.

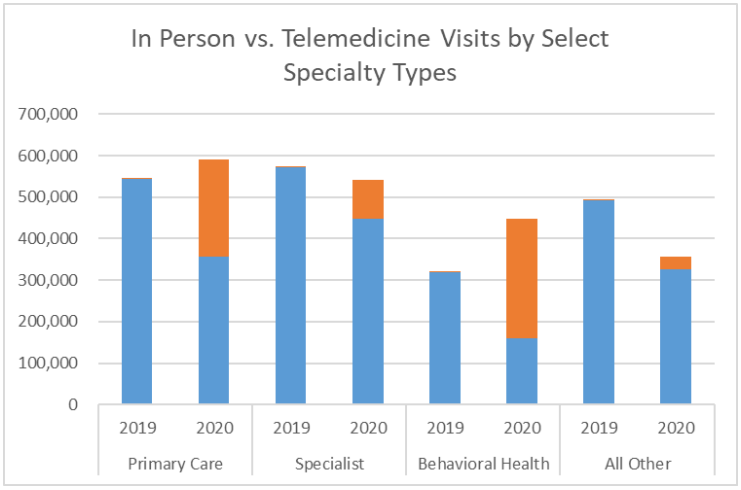
Rhode Island shows a surge in telemedicine claims in the early days of the pandemic when many elective, non-essential procedures were postponed or canceled to minimize infection risk and preserve resources for treating COVID-19 patients. The proportion of visits conducted via telemedicine increased from 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.

Commented [BR(3]: Would continuity of care be included under this section?

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.

Commented [BR(4]: From Dr's Levy and White: Agree with coverage of audio-only telemedicine visits and language "clinically appropriate" - but do not agree that the insurer should necessarily be determining this; Agree with "cost-sharing for telemedicine visit should not exceed cost-sharing for in-person visit" - so patient finances do not factor into the decision. Will this be waived during the pandemic, and if so for all services or only COVID-related care? If waived for now, would favor for all services;

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.

Commented [BR(5]: From Dr Levy and White: Agree with no limit on patient location - favoring convenience for patient, but would recommend safe and private, with good connection

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.***

[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.

Commented [BR(6]: Would dental be included here?

Commented [BR(7]: From Dr. Levy and White: Agree with provider parity for use of telemedicine - and again, that this is best determined by license/scope of practice and not per insurer

Commented [BR(8]: Thank you for this. We agree and underscore its importance.

- ***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 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

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[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.
[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.

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.

Commented [BR(9]: Do we have bi-directional feedback for this information to get back to the Pediatrician so that we are providing wholistic care?

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.

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.

[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.

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.

Commented [BR(10]: From Drs Levy and White:Still agree with option #5.This option best support coordination of care within the local RI healthcare community
And I still have concerns about out of state telemedicine only options

Commented [BR(11]: What about other services such as nutrition counseling or Physical Therapy?

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.

Commented [BR(12]: Is there guidance for patients in helping them to make the decision on whether to use telemedicine vs. in person? Analogous to something like, Choosing Wisely.

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.

Commented [BR(13]: Agree that this can cause more disjointed and disparate care. IT infrastructure is key.

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

Commented [BR(14]: From Dr. Levy and White: Agree with continued work on maintaining patient privacy through tech access discussed in equity section

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

Commented [BR(15]: From Dr. Levy and White: Agree with including goals of access, reduced disparities, quality and safety. Agree with having wider view of financial impacts to include cost to patient/caregiver of childcare, travel, missed work, along with cost to provider/clinic/hospital/healthcare system, state and payers.

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 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

[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/

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.

Comments from Dr. Beth Lange via email:

Thank you/ This is an amazing compilation of a tremendous amount of discussion and idea sharing. Thank you for making this such an inclusive process. The final product, both as a document and as programmatic implementation, is stronger for this community work. This is a very strong document. Thanks for all of the hard work that went in to writing it,

My only thought, please.

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.

I am concerned about having the insurer be the sole arbiter of which clinical encounters are appropriate for telephone only and which ones are not. How are they to know about the patient access issues, or privacy availability, or whatever causes this appointment to be telephone only. I wonder if there is a separate code, like an SDOH code, we could put on the encounter to the insurer can have an understanding of this telephone only visit.

Thanks again. See you Thursday
Beth

To: Health Insurance Commissioner Marie Ganim and Marea Tumber, Principal Policy Associate

From: Mental Health Association of RI (MHARI) and members of the MHARI Parity Initiative Stakeholder Group

Re: OHIC Telemedicine Work Group Draft Recommendations

Thank you to Commissioner Ganim and her staff for facilitating such an important and quality dialogue on outlining recommendations for enactment of more permanent telemedicine policy for Rhode Island. We appreciate the participation of such a broad group of participants, the quality research and data provided by OHIC, and the efforts OHIC made to facilitate consensus.

Below are MHARI's comments and proposed edits to the final draft of the Work Group recommendations.

- We propose that OHIC strengthen the language related to recommendations for health equity to reduce disparities as follows:
  - "Recommendation: ***To ensure health equity and reduce disparities in access to telemedicine services, it is strongly recommended that the State pursue the following activities:"***

- Additionally, we propose that the final recommendation included on the subsequent list under health equity recommendations be pulled out as a stand-alone recommendation as follows:
  - ***"Recommendation: include telemedicine access in network adequacy standards."***

- Because data demonstrates that behavioral health providers are already under-reimbursed for provided services, we strongly support the recommendation related to ***telemedicine payment and program integrity***, that states: "…telemedicine behavioral health services should be paid at the same rate as in-person regardless of modality."

- We request that the language related to ***integration of telemedicine into the existing delivery system*** be strengthened to highlight Rhode Island's lack of bi-cultural, bi-lingual behavioral health providers. While telemedicine provides an opportunity to expand access to a more diverse network of BH providers, it should be strongly recommended via the work group that the State make **an overt effort to build out our state's network of more culturally and linguistically diverse out-patient behavioral health providers**. We must avoid becoming dependent on out-of-state telemedicine companies that might undercut Rhode Island's existing BH provider network by offering less expensive services that could result in the unintended consequence of pushing out locally based providers.

- We request that the recommendations state that to **accurately and fairly evaluate costs**, it is necessary to **assess the long term impact** of such interventions. While higher rates of utilization of outpatient services may increase costs in the short-term, they decrease costs in the long-term because many medical and behavioral health crises will be avoided, thus reducing utilization of more costly emergency services, inpatient hospitalization, and residential treatment. The recommendations should reflect this.
- Finally, we ask that the **work group recommendations offer more specificity related to the recommendation for a measurement strategy** to effectively evaluate performance, especially as relates to the goals of improving access, reducing disparities, and ensuring quality and safety.

Again, thank you for your hard work to facilitate this important dialogue and to outline recommendations.

Sincerely,

Laurie-Marie Pisciotta
Executive Director
laurie.pisciotta@mhari.org

PATRICK J. QUINLAN, ESQ.
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401-524-2734
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Tuesday, December 8, 2020

Marea Tumber, Esq. MPH
Office of Health Insurance Commissioner
1511 Pontiac Avenue
#69 First Floor
Cranston, R.I. 02920

Re: OHIC Payment and Care Delivery Advisory Committee Recommendations Report-Draft 12/3/2020

Dear Marea:

Please accept these comments and suggestions on behalf of the Rhode Island Dental Association ("RIDA") and the Rhode Island Association of Oral and Maxillofacial Surgeons ("RIAOMS") concerning telemedicine and teledentistry. We agree that telemedicine has served as an integral resource for patients and healthcare providers across our state to allow for the continued delivery of necessary health care services to patients while ensuring optimal safety to patients and providers by mitigating exposure during the height of the COVID-19 pandemic. Such services include the delivery of dental care through the use of teledentistry particularly when dental offices were limited to seeing only urgent and emergent cases during the Spring 2020. Dental practices across the country were encouraged to utilize teledentistry to limit in-person appointments especially in light of the very high-risk category of dental providers of potential exposure to COVID-19 by virtue of the type of aerosol generating services they render.

One thing this pandemic has certainly taught us is that protecting the ability of *all* practitioners to render healthcare via telecommunication systems is essential. For that reason, the RIDA and RIAOMS fully support the efforts of the OHIC Payment and Care Delivery Advisory Committee Telemedicine Subcommittee. Specifically, the OHIC 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.

Clearly, the budget article on telemedicine contemplated the inclusion of teledentistry services in its definitions by stating that that the bill applies to "health-care services" which are defined as "any services included in the furnishing to any individual of medical, podiatric, or *dental care*, or hospitalization……" (*emphasis added*). The Article further established that a "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" and would therefore include dentists.

However, despite the implied inclusion of dentists there are certain key concerns that need to be addressed by this Subcommittee to prevent patients and dentists from facing additional hardship when utilizing telemedicine (teledentistry) services. By way of background, during the duration of the Governor's Executive Order, several dental "insurers" cited ambiguity in the language of Governor Raimondo's Order on Telemedicine to create a loophole for dental "insurers" to argue that telemedicine applied ONLY to medical insurers and not dental insurers. Such alleged ambiguity has resulted in countless dental providers and their patients having to participate in unnecessary claims disputes over the coverage of teledentistry services in the middle of the pandemic. Several dental "Insurers" failed to acknowledge that the term telemedicine encompasses teledentistry. It was only after significant debate and persuasion that certain insurers began to make payment on dental claims submitted for teledentistry services while other claims for payment are still being contested by these dental payment firms.

It is important for this Committee to recognize the distinct differences between dental insurance payment systems and health insurance payment systems. Typically, under health insurance, payment is made by the health insurance company to cover the costs of illness or injury and it ensures that payment will be made to providers for services rendered to address the illness or injury. So-called "dental insurance" on the other hand is essentially a prepaid benefit. By that we mean that the employer typically pays an annual set payment to the dental benefits company and that entitles the covered patient to receive a specific list of approved services from a participating dentist. Once the patient has exceeded the fixed amount of services paid by the employer to the dental benefit company, the patient is responsible for paying all remaining necessary dental bills going forward until the new benefit year begins. It is not insurance in the traditional sense that it covers fully any risk of dental disease; it does not. Plus, when we discuss so-called "dental insurance", we place it in quotes to remind the reader that it is not truly an insurance policy in the common understanding of that term insurance. It is the equivalent to a gift card for dentistry that expires on December 31 of each year. At the conclusion of the "dental insurance" annual term of coverage, all remaining funds paid by the employer are kept by the dental insurance company.

Despite the hard work done by this Committee, we remain very concerned that because specific coverage of teledentistry services is not explicitly addressed in the body of the Telemedicine Subcommittee Report of December 3, 2020 dental insurers will resume the contention that teledentistry is not a covered service. In fact, we have already heard from one major dental insurer that once the Governor's Executive Order expires on telemedicine, it is the company's position that the language under current statute is ambiguous and it will no longer be paying for teledentistry services.

If the report does not address this serious concern, dental providers and their patients in Rhode Island are going to continue to face the same challenges with dental insurers denying applicability to teledentistry despite the intent and purpose of the Article being to make it easier for all licensed healthcare providers to render health services via a telecommunications platform.

In order to prevent such confusion and challenges from happening in the future, we would respectfully request that the Report explicitly state that telemedicine includes teledentistry services. While this Committee may understandably be hesitant to recommend an amendment to the language of the Budget Article to include a specific subcategory of healthcare providers, such as dentists, for fear that other specialties (*eg.* PAs, Radiologists, Nurse Practitioners, PTs, *etc.*) would then want to be individually listed, there is a distinct difference between dental providers and all other specialties and that is the type of insurance that they accept. There are generally two major types of insurance coverage available to patients that cover all healthcare services, medical and dental. The way the Article is currently written unintentionally contemplates all healthcare services are covered by medical insurance and therefore all of the same guidelines and recommendations surrounding telehealth services are applicable; this is simply not true. Dental insurance is entirely different and therefore the guidelines for teledentistry are different. Regardless, necessary healthcare services rendered via telecommunications should be similarly permitted and deserve the same coverage protections and oversight provided by this Article regardless if the health-care professional accepts medical or dental insurance.

If, as the definitions purport to state, this Budget Article is to equally apply to all licensed providers and ensure fairness among providers, it is necessary to have representation from both medical and dental side so that both distinct forms of "insurance" are given adequate oversight as intended. For this reason, we are respectfully asking this Committee to recommend that teledentistry specifically be added to the Budget Article to avoid any future confusion among dental "insurers", patients, and dentists. We are further asking the a representative from the Rhode Island Dental Association be included going forward on any discussions related to telemedicine as equally as a representative from medicine would be included.

Thank you very much for your attention to this very important matter. Should you have any questions or concerns please do not hesitate to contact me at 401-524-2734 or Christy Durant, Esq., the Executive Director and Legal Counsel for the Rhode Island Dental Association at 401-825-7700.

Sincerely yours,

Patrick J. Quinlan

PATRICK J. QUINLAN, ESQ.
On behalf of the Rhode Island Dental Association

cc: C. Durant, Esq.

To: Commissioner Marie Ganim and Marea Tumber, Principal Policy Associate, OHIC
From: Karen Malcolm, Coordinator, Protect Our Healthcare Coalition
Date: December 8, 2020
Subject: OHIC Telemedicine Advisory Group Draft Recommendations

Thank you to Commissioner Ganim and OHIC staff for your work to facilitate the Telemedicine Advisory Group to try to build consensus on permanent telemedicine policy recommendations. We appreciate OHIC's efforts to coordinate the participation of such a diverse group of stakeholders and the office's efforts to provide research and data to support the dialogue.

Below are comments and proposed edits to the final draft of the advisory group recommendations.

COVERAGE & ACCESS: The Coalition supports the first five recommendations, but supports the following edits outlined separately in comments submitted by the Mental Health Association of RI as relates to health equity:

- Strengthen the language related to recommendations for health equity to reduce disparities as follows:
  - "Recommendation: ***To ensure health equity and reduce disparities in access to telemedicine services, it is strongly recommended that the State pursue the following activities:"***

- Pull out the following health equity activity as a stand-alone recommendation as follows:
  - ***"Recommendation: include telemedicine access in network adequacy standards."***

PAYMENT & PROGRAM INTEGRITY: The Coalition strongly supports payment parity in telemedicine regardless of modality, especially in behavioral and primary healthcare. Payment parity ensures providers are incentivized to make services available to consumers. COVID-19 has made it clear that many Rhode Islanders must turn to telemedicine to safely access needed care and this reality is not likely to go away as the pandemic slowly subsides. There will always be medically fragile individuals for whom telemedicine is a safer alternative, as well as individuals for whom work obligations, family responsibilities, and barriers such as transportation, make telemedicine an important alternative. Emphasizing insurers' obligation to maintain a network of medically necessary services through telemedicine will help ensure accessible care for all Rhode Islanders.

We second the comment provided separately by the Mental Health Association of RI that: "the language related to ***integration of telemedicine into the existing delivery system*** be strengthened to highlight Rhode Island's lack of bi-cultural, bi-lingual behavioral health providers. While telemedicine provides an opportunity to expand access to a more diverse network of BH providers, it should be strongly

recommended via the work group that the State make **an overt effort to build out our state's network of more culturally and linguistically diverse out-patient behavioral health providers**."

As regards the 'value and appropriateness' of telemedicine, the Coalition ***urges that the recommendation note the need to evaluate value and appropriateness based FIRST on patient satisfaction and health outcomes BEFORE cost***.

PRIVACY, SECURITY, CONFIDENTIALITY: We support the narrative as written.

PERFORMANCE MEASUREMENT: As noted above, Protect Our Healthcare believes that any performance measurement used to evaluate effectiveness of telemedicine policy must first review its impact based on patient access, satisfaction and health outcomes BEFORE cost – in other words, performance measurements should put patients first. We believe OHIC has an opportunity to improve performance measurements and urge that more specificity related to a potential measurement strategy be added to the recommendations. As suggested by RIPIN in their comments submitted separately, we suggest "that OHIC ensure that the data metrics concerning underserved populations be sufficiently robust to allow for comparisons of quality and access between communities of different races, ethnicities, language proficiencies, income strata, and geographic location."

Thank you.

Protect Our Healthcare Coalition partners include: Economic Progress Institute, Mental Health Association RI, RI NOW, RI Parent Information Network, NAACP Providence Branch, United Way of Rhode Island, Planned Parenthood of Southern New England, SEIU Rhode Island Council, Foster Forward, RI Coalition for the Homeless, RI Working Families Party, Mental Health Recovery Coalition of RI, Senior Agenda Coalition, RI Community Food Bank, RI Interfaith Coalition to Reduce Poverty, Substance Use & Mental Health Leadership Council, RI Coalition for Children and Families, HousingWorks RI, Rhode Island Organizing Project (RIOP), Thundermist Health Center

c/o the Economic Progress Institute, 600 Mt. Pleasant Avenue, Building #9, Providence, RI 02908

Rhode Island Coalition for Children and Families

Promoting safety, health and success from infancy to adulthood.

To: Commissioner Marie Ganim and Marea Tumber, Principal Policy Associate, OHIC
From: Tanja Kubas-Meyer, Executive Director
Date: December 11, 2020
Subject: OHIC Telemedicine Advisory Group Draft Recommendations

The Rhode Island Coalition for Children and Families appreciates the fine work of your office to bring together a widely diverse set of stakeholders and craft a set of valuable recommendations. Telemedicine has proven to be a critical mechanism during the pandemic that we believe will continue to be essential going forward, both through video and telephonic means.

Telemedicine- both video and telephonic- has proven to be invaluable to the safety and health of the children, youth, and families that the members of our Coalition serve. The range of member services includes behavioral health, specialized clinical services to ensure the safety and well-being of children and youth in foster care or residential settings and their parents and/or caregivers, as well as youth in juvenile justice settings, primary healthcare, children and youth impacted by sexual assault and domestic violence, and more. Telemedicine has enhanced access to care and demonstrated the efficacy of combining in person and telemedicine services. In intensive behavioral health treatment and child welfare cases, children, youth, and their caregivers may require very high contact interventions. The pandemic has demonstrated that these services are very effectively provided through a combination of in- person and video and telephonic mechanisms that more realistically can accommodate the complex schedules and barriers to in-person visits for children and young people and their caregivers.

As members of the Protect Our Healthcare Coalition, we support the edits and recommendations regarding Coverage and Access, Payment & Program Integrity, Privacy, Security, and Confidentiality, and Performance Measurement as presented by Karen Malcolm. We additionally support the comments of our member RIPIN by Shamus Durac and those of MHARI's Laurie-Marie Pisciotta. A few specific suggestions:

1)We suggest further strengthening the proposed language (p.7) by fellow advocates to include the critical goal of patient safety:

- "Recommendation: To ensure health equity, **patient safety**, and reduce disparities in access to telemedicine services, it is strongly recommended that the State pursue the following activities:"

2) We suggest noting the value of a combination of in-person and telemedicine visits, especially for high intensity services (p.5). "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. For intensive services and high-risk populations who require frequent contact and/or lack video access, a combination of in-person and telephonic visits will facilitate treatment.

3)We recommend that the report that (p. 8) highlight our system of existing community-based treatment providers: "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 tele-behavioral health counseling sessions for students during the school day. **Community mental health providers, family service agencies, and other community providers provide behavioral health access to populations of all ages.**

4) RICCF strongly supports the recommendation of fellow advocates that: "the language related to integration of telemedicine into the existing delivery system be strengthened to highlight Rhode Island's lack of bi-cultural, bi-lingual behavioral health providers. While telemedicine provides an opportunity to expand access to a more diverse network of BH providers, it should be strongly recommended via the work group that the State make **an overt effort to build out our state's network of more culturally and linguistically diverse out-patient behavioral health providers**." The lack of diversity in the behavioral health workforce is a tremendous barrier to serving children, youth, and families effectively.

We appreciate the opportunity to suggest these comments and edits to the final report.

Thank you for your consideration.

Comments from Dr. Shulman via email:

Regarding the draft report of the OHIC Payment and Care Delivery Advisory Committee, Telemedicine Subcommittee :

****I most strongly disagree with the first recommendation (p. 5) that insurance companies can decide when audio-only is appropriate. Dr Lange, a pediatrician, numerous times mentioned that her professional time is the same regardless of what device used, telephone or website. I believe we were the only two medicine type physicians on the committee, so the report cannot say that there was consensus that the health insurance companies should determine when audio is appropriate to be reimbursed. At least, the report should indicate that there was no consensus on this.

I can't say this more forcefully, the great majority of patients refuse to do website telemedicine in preference to telephone. Many of these people are older and more fragile. If physicians are not paid for telephone care, they will not provide it and insist patients come into the office so they can get paid for their time. The health insurance companies should recognize and reimburse non-procedural physicians for their contribution, and not just proceduralists and people working in a hospital environment.

Please refer to a New England Journal of Medicine article to this point, attached below.

—The 2016 RI Telemedicine Coverage Act, mentioned several times in the introduction, is a piece of legislation pushed very strongly and exclusively by the independent platform, website, telemedicine industry to force health insurance companies to pay for their service, and to make sure their service alone was covered. It specifically excluded telephone services to this end. It was passed 3 years prior to the current pandemic situation, and referring to it with respect to determining what needs to be done with telemedicine today may not be helpful.

—only 2 or 3 practicing full-time, non-behavioral health physicians were on the committee of 60-100 people. they were underrepresented.

—the graph page 4 on the bottom must be mis-labeled (?), as it indicates the number of telemedicine visits in 2019 and 2020 are almost the same, for the different specialty types.

—p.6, just a note about the recommendation that there should be no limitation on patient location. The state of RI can say all they want about this, but the state the patient resides in still has control over health care provided within its boarders, just like RI has control of the care provided within its boarders. Currently, this area is a true mess with each state having it's own regulations. Hopefully, this will be sorted out in in the new presidential administration.

—-p. 7, second recommendation in order to decrease health inequity and reduce disparities, I think it is very important to pay for audio only, equal to website video, otherwise these patients will be forced to make a trip to the office.

—-p. 11, section e.), the exception for telemedicine due to scarcity of providers in a particular specialty will be used to provide a way in, for out of state telemedicine providers, as RI has a fairly robust healthcare community with all the specialties. In my 25 years experience as a primary care physician in RI, patients only go out of state for transplantation, and then almost exclusively to the Boston area. Creating an exception so the Boston area docs could communicate with their RI patients makes sense, but I can't see any reason to open things up to the rest of the nation.

Peripherally referenced in this report is the need to incorporate telemedicine into the existing healthcare structure and not promote a separate platform. To this end, I strongly oppose Article 20 of the Budge H7171 which is 20 pages of the Interstate Medical Licensing Compact, which was introduced to promote independent, out-of-state telemedicine platforms.

Sincerely,
Howard Schulman, MD
General Internal Medicine
East Providence (office)

Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 bcbsri.com

December 8, 2020

Marea Tumber, Principal Policy Associate
Office of the Health Insurance Commissioner
Via email: Marea.Tumber@ohic.ri.gov

RE: Telemedicine Subcommittee Recommendations Report

Dear Ms. Tumber:

Blue Cross & Blue Shield of Rhode Island (Blue Cross) appreciates the opportunity to provide comments on the Office of the Health Insurance Commissioner's (the Office) Payment and Care Delivery Advisory Committee Telemedicine Subcommittee's Recommendation Report of December 3, 2020.

Blue Cross shares the goal of improving access to high quality affordable health care and agrees telemedicine should be part of this. In respect for the significant efforts you and the Office committed to gather stakeholder input, we offer detailed comments here and in red-line in the report. These are listed in the order they appear.

In the introductory section, we suggest edits to the tone and background. Low take-up of telemedicine before the pandemic was very likely due to preferences for in-person care more so than to state law or insurer restrictions (consider there were no restrictions on office visits). We also thought important to make clear insurers covered telemedicine for behavioral health conditions before coronavirus and their changes *further* supported access.

In the "membership and process" section, we suggest replacing "consensus" with "majority." The group was large and weighted towards providers and consumer advocacy groups, alternative voices (namely insurers and employers) were in the minority. We understand the open, public, nature of the work, but without equal weighting of opposing viewpoints and interests, this distinction seems more reflective of the discussion.

In the audio-only telemedicine section, we suggest edits to reflect differences between audio-only and audio-visual care, and billing processes. We propose replacing "surprise billing," which has come to describe bills from out-of-network providers, with "unanticipated billing" as the bill may come from in- or out-of-network providers.

In the cost sharing section, we suggest an edit to more accurately describe the rationale for waiving cost sharing during the public health emergency. An edit is proposed to replace the term "co-pays" with "cost sharing" to reflect the variations in patient liability.

In the patient location section, noting BCBSRI has not placed restrictions on the originating site, we suggest an edit to retain the reference to the law without the negative inference towards insurers.

In the provider type section, we suggest an edit to clarify the intent to not create a more expansive telemedicine coverage rule than applies for in-person services.

In the health equity section, Blue Cross strongly supports exploring the ways in which telemedicine can increase access to care. We suggest an edit to capture the concern practitioner migration to telemedicine could make in-person care less available for the people who most need or prefer that mode of care.

In the payment rate section, while we support paying the same rate for behavioral health services rendered via telemedicine, we suggest an edit to reflect our belief that audio-only services may not be "just as effective" as in-person visits. In the subsequent payment parity section, we suggest the report acknowledge higher fees for telemedicine services will have a direct cost impact on patients depending on their insurance plan, for example high deductible plans.

In the subsequent "other key themes" section, we suggest edits to part (b) to avoid the inference that telemedicine-only vendors might be prohibited and to better reflect those entities ability to add capacity; to (d) to reflect the full breadth of potential further investigation, and; to (e) to reflect that improving access should not be focused on payment rates, future efforts might find other factors such as licensure laws, referral patterns, etc.

In the security and privacy section, we suggest capturing the discussion around the federal rules that meaningfully impacted how telemedicine has been rendered during the pandemic.

In the conclusion section, we suggest an edit to reflect the group's concern for affordability.

Thank you for your consideration of Blue Cross's concerns during the course of the work. We expect these comments are more in-depth than many (or all) you will receive; please know we do so out of respect for the process, your efforts, and the record this report creates.

Sincerely,

Monica Auciello

Monica Auciello
Vice President, Legal Affairs & Policy

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~~ was not used extensively before the pandemic~~, and more broadly during the public health emergency~~ based on preferences for in-person, face-to-face care.

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. Increased utilization was also supported by key federal rule changes, namely relaxation of HIPAA privacy rules and expansion under Medicare.[1]

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 further support

[1] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

individuals' mental health and substance use issues, and waiving cost-sharing for in-network telemedicine services. Payers and care providers together made Rhode Islanders more aware of their ability to receive care through telemedicine during the pandemic.

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.

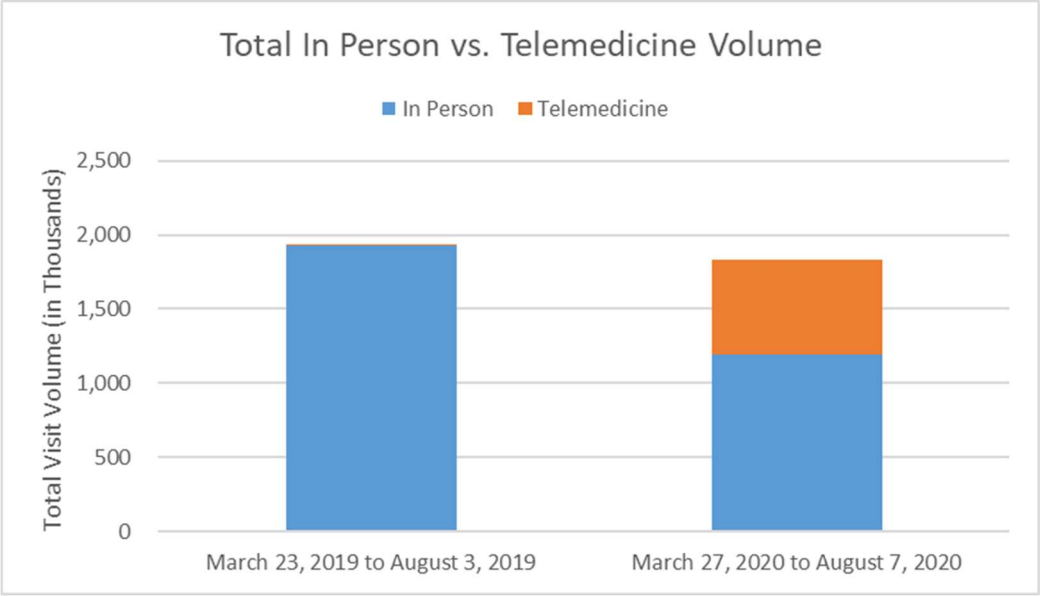
The Telemedicine Subcommittee discussions were facilitated using a consensus-based approach where project staff presented background information about the policy choices, including policies implemented by other states, and considerations for or against adopting a particular policy. Each member had an 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~~ majority opinion of the Telemedicine Subcommittee, they do not ~~necessarily~~ represent the individual opinions of ~~any~~ every Subcommittee member or organization.

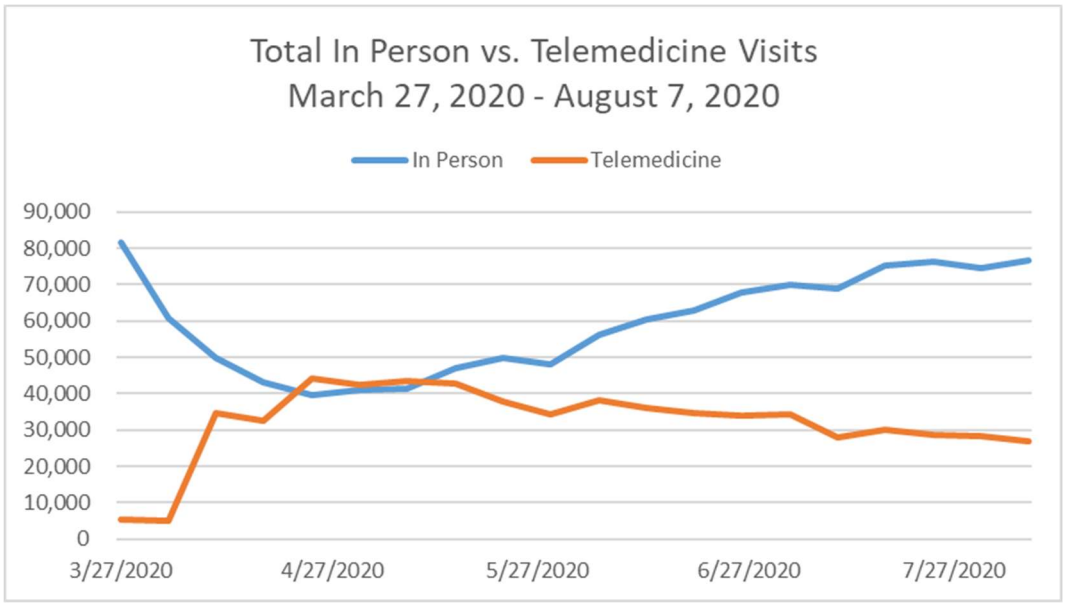
Telemedicine Utilization Rhode Island

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.

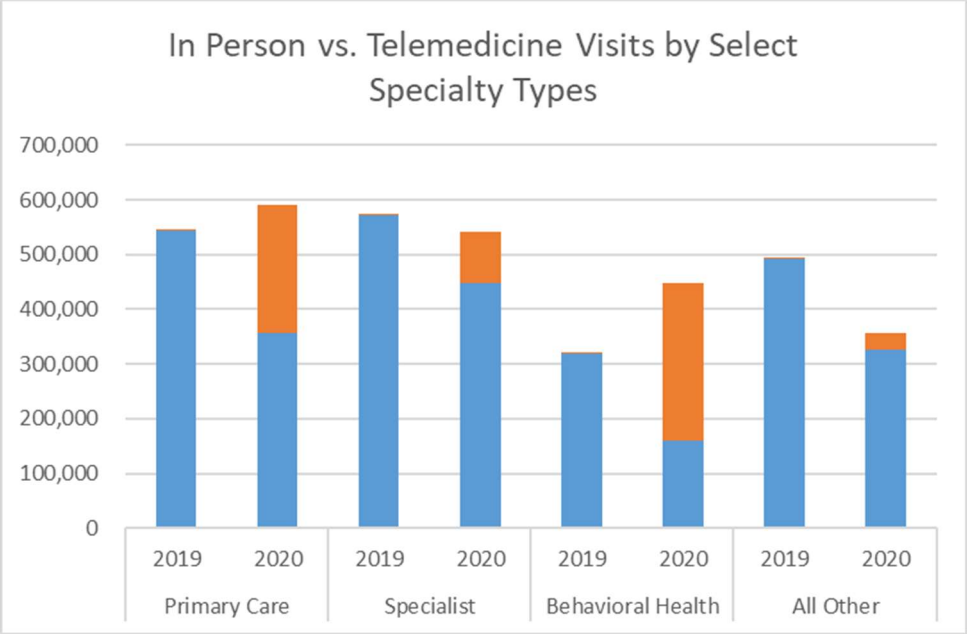


Telemedicine in Rhode Island made up for the decrease in in-person visits in April 2020. Telemedicine usage has since plateaued as in-person visits resumed, but utilization remains significantly higher than utilization before the pandemic.



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~~available when the service is clinically appropriate to be provided using that mode of delivery, as determined by the insurer.

Some subcommittee members supported ~~requiring coverage of~~availability 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. It was recommended that an audio-only telemedicine visit should be properly coded in accordance with the American Medical Association Current Procedure Terminology (AMA CPT) standards for these services.

Members also discussed that telemedicine visits conducted solely via audio may not provide as full of a medical experience as when the visit include a visual component. Even where care *can* be rendered in an audio-only manner, adding a visual component enhances the medical value of the visit enabling the patient to receive more complete care. To be sure incentives are aligned, telemedicine services that include a visual component might be paid at a higher rate than audio-only, as discussed below.

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. Similarly, when a telephonic visit is the initial interaction and an in-person or audio-visual visit is needed, the telephonic visit should be coded appropriately so as not to add cost to the system. ~~While some payers have~~ Payer and AMA CPT 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~~ unanticipated 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.~~ mindful of members' heightened financial concerns caused by the pandemic's economic uncertainty.

Some Subcommittee members argued that setting ~~co-pays~~cost sharing 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 cost sharing ~~co-pays~~ should generally be the same across modalities, there should be flexibility to set lower cost sharing~~co-pays~~ for services delivered through telemedicine. They noted that allowing for telemedicine services to have lower ~~co-pays~~cost-sharing 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~~recommends 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~~ recommendation 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[2] 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, is medically necessary, and is a covered service when rendered in-person by that provider type. 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.[3]***

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

[2] 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.
[3] 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.

Subcommittee members also expressed concern that adoption of the other recommendations in their totality might increase the amount of care delivered via telemedicine or otherwise change the economics of care delivery. Practitioner migration to that mode of care delivery could result in a decrease in the delivery of in-person care. Attention should be paid to assure access to in-person care remains available for those preferring or needing it, or those unable to access services via telemedicine for the reasons expressed above. In addition, in the event a telemedicine visit is insufficient or in-effective in detecting or treating a condition, it could add cost and negatively affect outcomes for Rhode Islanders.

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.[4] 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.[5] In addition, a survey assessing challenges during the pandemic also found that higher income individuals were more likely to have access to telehealth services.[6]

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.

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[4] 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.
[5] American Well, "Telehealth Index: 2019 Consumer Survey," August 27, 2019.
[6] Sage Growth/Blackbook Research, "As the Country Reopens Safety Concerns Rise," May 11, 2020.

Participants encouraged the State to explore and identify community resources and venues, such as senior centers[7] 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.

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.

[7] 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 of Rhode Island 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.

There was consensus for paying for telemedicine behavioral (telebehavioral) health services at the same rate as in person services during the meeting in which the topic was initially 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 generally can be delivered just as effectively through ~~a phone call or~~ video-conference as an in-person visit. Some do not believe that audio-only is just as effective as in person or audio-visual services. 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~~ noted 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~~ pointed out that requiring payment parity may increase the cost of insurance to the consumer. Payment parity would negatively impact patients with high deductible health plans or who's cost sharing is based on coinsurance. These patients pay the full rate or some percentage of it. "Payment parity" takes away their opportunity to obtain care at a lower cost.

Other key themes

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. **To the extent possible, ~~One goal of~~ telemedicine should be ~~that it is~~ integrated into the existing delivery system infrastructure ~~that emphasizes~~ to support 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, ~~to the extent practical~~.** The use of telemedicine should support the patient and ~~existing patient-provider relationships to~~ promote the patient-centered medical home and support 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, whoever delivers it, ~~needs to fit into~~should integrate with 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. Subcommittee members ~~, but also~~ recognized that ~~some~~ additional clinical expertise and capacity could be made ~~is only~~ available through ~~providers outside of those relationships~~ services provided via telemedicine.

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 quality, outcomes or 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,~~ and 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~~ may ~~provide~~ improve 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, especially 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.

The Subcommittee recognized that during the public health emergency, the Office for Civil Rights at the Department of Health and Human Services relaxed enforcement of HIPAA rules relating to privacy and security.[8] As those privacy protections are reinstituted, health care providers will need to reassess the methods of delivering telemedicine services. Further consideration was felt to be beyond the scope of the Subcommittee.

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.[9] 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 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**

[8] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

[9] 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/

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, and mindful of affordability. 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.