

OHIC Payment and Care Delivery Advisory Committee Telemedicine Subcommittee Recommendations Report December 2020

Introduction and Background

The ongoing COVID-19 pandemic has required drastic measures that significantly affect 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 passed the Telemedicine Coverage Act, which requires commercial health insurers to cover services provided via telemedicine. However, telemedicine was not used extensively before the pandemic based on preferences for in-person, face-to-face care, and because of some federal and insurer restrictions on the modality.

Rhode Island Governor Gina Raimondo issued Executive Order 20-06, which temporarily suspended certain telemedicine restrictions in the Rhode Island Telemedicine Coverage Act, to make telemedicine more widely accessible and facilitate its use during the pandemic. 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 in the Telemedicine Coverage Act. The Executive Order also clarified the types of providers that could deliver telemedicine services, and required insurers to pay for telemedicine services at the same payment rate as in-person services. Increased telemedicine access was also supported by key federal policy changes, namely the relaxation of the Health Insurance Portability and Accountability Act (HIPAA) privacy rules, and expansion of covered telemedicine services under Medicare.^{1,2}

¹ Office for Civil Rights Headquarters, U.S. Department of Health and Human Services, Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/notification-enforcement-discretion-telehealth/index.html>

² Centers for Medicare and Medicaid Services, Coronavirus Waivers and Flexibilities, <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>

Rhode Island commercial insurers and Medicaid managed care organizations (MCOs) also implemented many initiatives and policy changes to make telemedicine more accessible, such as expanding the availability of telemedicine behavioral (telebehavioral) health services to further support individuals' mental health and substance use issues, and waiving cost-sharing for in-network telemedicine services. Payers and providers also communicated with their respective members and patients about their ability to receive care via telemedicine during the pandemic.

Recognizing the important role that telemedicine plays in safely delivering care during the pandemic and will likely 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 proposed Telemedicine Budget Article would have extended the provisions in the Executive Order through June 30, 2021. The Subcommittee used the proposed Budget Article as a framework for many of its discussions. While the FY 2021 Budget was pending in the legislature³, 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 to ensure that as many viewpoints as possible were represented. 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 EOHHS Medicaid and the Rhode Island Department of Behavioral Healthcare, Development Disabilities and Hospitals (BHDDH), with contracted project support. To facilitate discussions, project staff presented

³ On December 18, 2020, after the final meeting of the Subcommittee, the proposed Telemedicine Budget Article was not passed as part of the Rhode Island Fiscal Year 2021 budget.

background information about the policy choices, including policies implemented by other states, and considerations for or against adopting a particular policy.

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. Each meeting was open to the public and included a public comment period. Detailed agendas, PowerPoint presentations, meeting summaries, and meeting recordings are available on [OHIC's website](#).

While the nature of the Subcommittee membership allowed for participation from a maximum number of stakeholders, certain groups were at times overrepresented or underrepresented. Thus, agreement from a majority of the those participating may have heavily favored the opinion of stakeholders that were overrepresented. To ensure a balanced discussion, project staff solicited comments and reactions from all stakeholder groups during the meeting facilitation process. 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. In addition, project staff documented various stakeholder groups' viewpoints throughout this report, solicited written feedback on a draft of this report from all stakeholders, and used the final meeting of the Subcommittee to respond to written feedback that was received and solicit further input. This final version reflects the feedback received in writing and orally during the Subcommittee's final meeting.

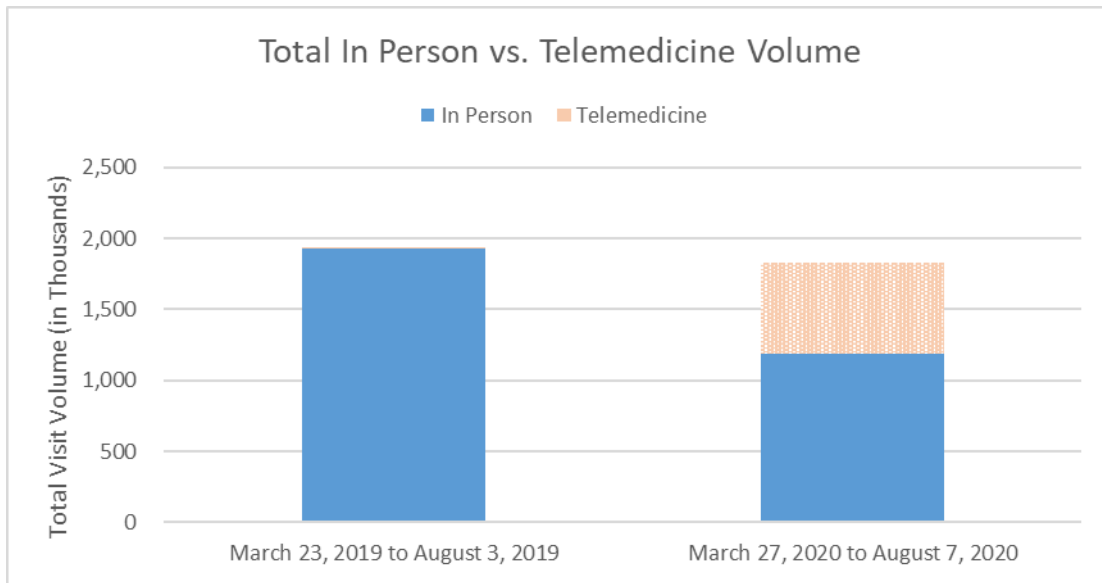
The recommendations documented in this report represent general agreement among the different types of stakeholders represented in the Telemedicine Subcommittee. They do not necessarily represent the individual opinions of every Subcommittee member or organization.

Commercial Telemedicine Utilization in Rhode Island

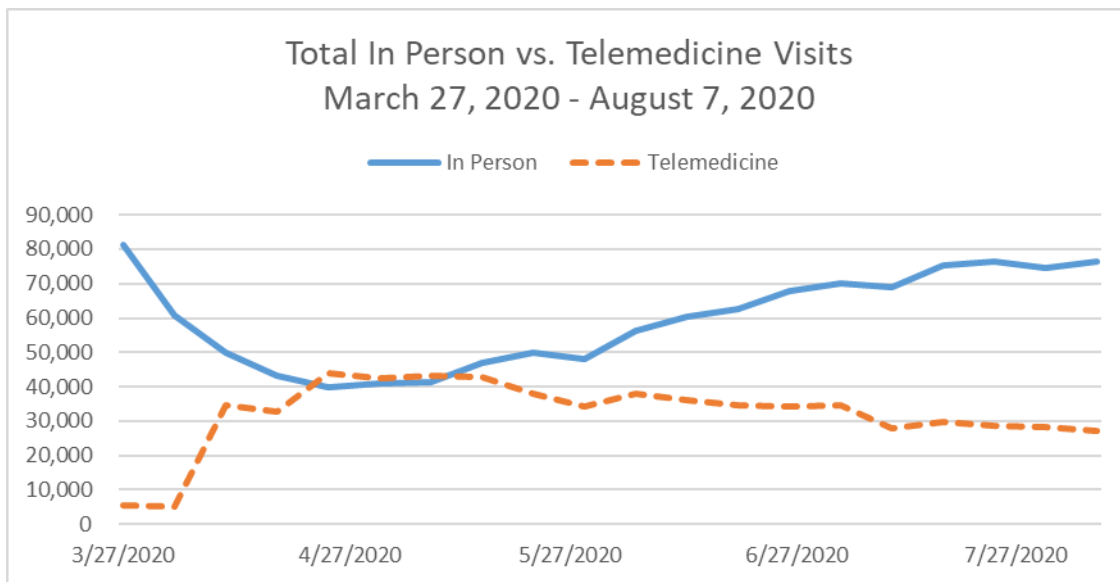
To inform the Subcommittee's discussions, project staff researched national trends in telemedicine utilization. In addition, OHIC obtained telemedicine usage data from Rhode Island commercial insurers based on weekly visit volume for two time periods: weeks ending March 23, 2019–August 3, 2019 and March 27, 2020–August 7, 2020.

Rhode Island data showed 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.

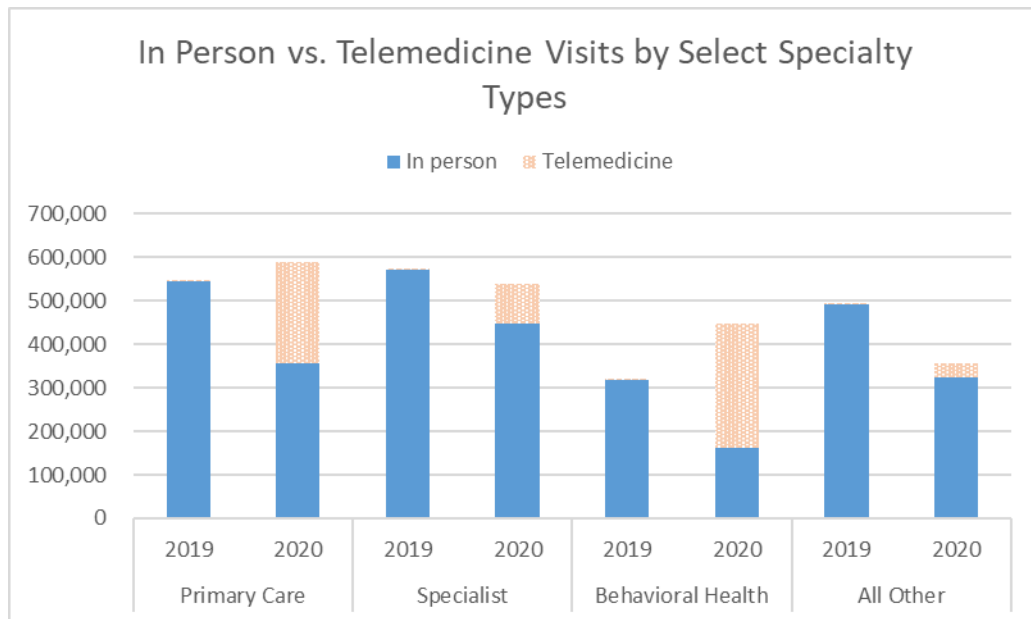


Telemedicine in Rhode Island made up for the decrease in in-person visits in April 2020. Telemedicine usage has since plateaued as in-person visits resumed, but its utilization remains significantly higher than utilization before the pandemic.



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. The data collected from insurers did not allow for further analysis of what drove the increase in

telebehavioral health visits. One insurer indicated that its internal analyses showed greater utilization among individuals who were already seeking behavioral health care. However, it was not possible to confirm those findings and caution should be used in drawing conclusions from these limited data. Providers who attended the Subcommittee meetings anecdotally reported reduced rates of missed appointments.



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. The discussions and recommendations were limited to the virtual delivery of office-based services by medical, behavioral, and dental providers that could be rendered remotely by means of audio-only or audio-visual telecommunication technology. The Subcommittee did not discuss remote patient monitoring, or other digital health technologies designed to collect and transmit medical and other forms of health data; however, participants expressed interest in more widespread use of innovative practices in these areas.

Discussions were organized 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

Subcommittee members predicted that the uptake of telemedicine precipitated by the COVID-19 pandemic will persist to some degree. While there was general support for expanding access to telemedicine services, Subcommittee members emphasized that increased access should be accompanied by added value, whether in the form of improved patient and provider experience, higher quality, better outcomes, decreased costs, or some combination of these factors.

Recommendation: Audio-only telemedicine should be covered on a permanent basis when the service is clinically appropriate⁴ to be provided using that mode of delivery, as determined by the insurer.

The majority of 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, necessary equipment, or 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 without a visual component. However, one insurer expressed the opinion that telemedicine visits conducted solely via audio may not provide as full of a medical experience as when the visit includes a visual component, and advocated for the ability to pay audio-visual encounters at a higher rate than audio-only encounters. Behavioral health providers, on the other hand, were concerned that a differential between audio-only and audio-video would disproportionately affect payment for behavioral health services, since audio-only can serve behavioral health better than other medical specialties. There was also concern among consumer advocates that restricting payment or use of audio-only telehealth could disproportionately affect low-income and racial/ethnic minorities.

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 payer and American Medical Association Current Procedure Terminology (AMA CPT) guidelines help distinguish the difference between a follow-up phone call and a separately billable audio-only visit, some Subcommittee members noted that additional work is still 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 unanticipated billing.

⁴ Please see pages 10–11 for a discussion about Subcommittee concerns about the use of the term “clinically appropriate.”

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. Of note, at least two insurers have recently announced plans to reinstate cost-sharing in January 2021.

Some Subcommittee members argued that setting cost-sharing for telemedicine and in-person visits at the same level removes any financial incentive for patients or providers to choose one modality over another. This allows patients and providers to choose the modality that they feel is best, without cost being an influencing factor. Other members, however, noted that while cost-sharing should generally be the same across modalities, there should be flexibility to set lower cost-sharing for services delivered through telemedicine. They noted that allowing for telemedicine services to have lower cost-sharing is important to incentivize patients to use it when appropriate. One participant felt that equal or lower cost-sharing would create incentives for patients to pressure providers to provide care via telemedicine that may be 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.

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 restrictions to be placed 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 or location.

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 all 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 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 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 types⁵ can render services via telemedicine while still allowing insurers to determine what services are clinically appropriate⁶ to deliver via any telemedicine modality.

Under current law and regulation, 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 payment 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. As importantly, the need for continuity of care and the capacity for in-person services require that the network not be restricted to telemedicine-only providers.

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.⁷*

⁵ 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.

⁶ Please see pages 10-11 for a discussion about Subcommittee concerns about the use of the term "clinically appropriate."

There was strong support across all the stakeholder groups around the need to address health equity and promote efforts to reduce disparities in access to telemedicine. 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, 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. Subcommittee members generally acknowledged telemedicine's contributions and supported making telemedicine more widely available. They emphasized, however, that attention should also 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.

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.⁸ 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.⁹ In addition, a survey assessing challenges during the pandemic also found that higher income individuals were more likely to have access to telehealth services.¹⁰

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. Similarly, rural communities face numerous barriers in terms of access to broadband technology. 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.

As the State develops strategies to addressing access to telemedicine, providers noted the importance of doing so in a way that meets the needs of each community. Participants suggested many ways in which access could be improved by making the technology more widely available in

⁷ 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.

⁸ 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.

⁹ American Well, "Telehealth Index: 2019 Consumer Survey," August 27, 2019.

¹⁰ Sage Growth/Blackbook Research, "As the Country Reopens Safety Concerns Rise," May 11, 2020.

the community. For example, some clinics have set up private spaces with the equipment necessary for patients to come in and conduct a telemedicine visit with providers external to the practice or 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 centers¹¹ 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 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 who are already visiting patients in their homes, to help walk patients through 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 these community-based providers.

Use of the term “Clinically Appropriate”

In two aforementioned recommendations regarding coverage and access, and in one following this discussion on payment and program integrity, the term “clinically appropriate” is used. Generally, clinical appropriateness refers to the concept of determining the type, frequency, extent, site, and duration of care that is considered effective for the patient’s condition. For example, it is generally clinically inappropriate to perform surgery for shoulder pain without first attempting non-surgical treatments such as physical therapy or steroid treatment. Similarly, it is not clinically appropriate to perform a chiropractic adjustment or fill a cavity via telemedicine because those services require providing physical care to a patient. Insurers make clinical appropriateness decisions in their reimbursement policymaking. In the context of the recommendations contained in this report, explicit mention of clinical appropriateness is used to indicate that insurers will continue to have this responsibility, as they do today.

However, provider and consumer stakeholders expressed great concern with respect to the ability of insurers to determine what services are appropriate to be rendered and covered as a telemedicine visit. Behavioral health providers raised specific concerns, as they did not believe that insurers should be making the determination of when a behavioral health service should and should not be provided via audio-only. Stakeholders were concerned that the determination of what is clinically appropriate in the process of making payment policy would not be transparent or fair. Several

¹¹ 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.

suggested that OHIC should convene a group, inclusive of community providers, to set policy for what is a clinically appropriate telemedicine service. The stakeholders recognized that such a group would need expertise and that the work would be intensive and involve making recommendations on a code-by-code basis. In the absence of such a group, stakeholders advocated for transparent reasoning around insurer policymaking on telemedicine, and clear and consistent insurer guidance on proper documentation of care delivered and what services may or may not be payable.

Insurers heard these concerns and noted that determining what is clinically appropriate is not used to restrict access or to limit the use of telemedicine services; instead, it is used to ensure that inappropriate care is not being delivered or paid for.

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 all other 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 visits regardless of modality, so long as the modality is clinically appropriate.¹²

There was consensus for paying for 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, though not all Subcommittee

¹² Please see section immediately above for a discussion of the Subcommittee’s concerns about the use of the term “clinically appropriate.”

members agreed with this. Some participants noted that the stigma of seeing a behavioral health provider in person have prevented some people from seeking treatment, and the reduced stigma associated with telebehavioral health visits is important in seeking needed care. In addition, the convenience of telemedicine could increase the rate of appointment adherence, which could yield better overall outcomes. BHDDH reports that licensed behavioral health providers in the state saw a significant reduction in the number of patients who missed appointments and in some cases had 100% attendance for over a month. At a subsequent meeting, one insurer 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 visit modality. Providers also noted that many of them have invested significant 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. Providers also noted that practice financial sustainability should be a key reason for payment parity. Particularly in the area of primary care, providers are concerned that practices' viability is threatened due to COVID-19 and the dramatic decrease in in-person utilization. Payment parity is important to ensuring that they are fairly compensated for their work, and are able to continue providing the care that patients need virtually.

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, who are disproportionately members of racial and ethnic minorities.

Finally, one provider suggested that until the American Medical Association's Relative Value Unit creates new Current Procedural Terminology (CPT) codes, state regulators should examine payment differentials for telehealth services that do not have parity with in-person services.

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 payments, indicating that parity may cause unintended consequences where patients are driven to telemedicine even when an in-person visit is more clinically appropriate. They 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 business group representative pointed to a report reflecting the view among employers that payment parity would impede employers' flexibility to innovate and pursue value-based care.¹³

One insurer pointed out that requiring payment parity may increase the cost of insurance to the consumer. Payment parity could negatively impact patients with high-deductible health plans or whose cost-sharing is based on co-insurance. Under these plans, patients pay the full rate of some percentage of the fee and payment parity may take away their ability to obtain care at a lower cost.

Key Areas of Agreement

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 may continue to play a larger role in care delivery, extending 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-19 emergency will be spread out over time, rather than have one clear end date.
- b. **To the extent possible, telemedicine should be integrated into the existing delivery system infrastructure to support the patient-centered medical home; continuity of care; and coordination between primary, behavioral health, and specialty care; rather than developed as a separate direct-to-consumer 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 care delivered by direct-to-consumer telemedicine vendors 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. One Subcommittee member shared with the group a study based on 2011–2013 data indicating that utilization of direct-to-consumer telemedicine, which many employers offer as an added lower-cost alternative to urgent care or emergency department utilization, may increase access by making care more convenient

¹³ Mercer, American Benefits Council, and Catalyst for Payment Reform, "Telemedicine in the Post-COVID-19 World," <https://www.mercer.us/our-thinking/healthcare/telemedicine.html>. Last accessed December 14, 2020.

but may also increase utilization and spending.¹⁴ This has complicated discussions around the utilization of telemedicine during the public health emergency, as virtual visits with a patient's own health care provider and direct-to-consumer telemedicine visits are not equivalent. Yet not a lot is known about whether virtual visits with a patient's own provider will increase cost or utilization as was predicted with direct-to-consumer vendors in the aforementioned study, since the rapid expansion of this service was a direct result of the ongoing pandemic. However, Subcommittee members emphasized that future telemedicine utilization 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 recognized that additional clinical expertise and capacity could be made available through services provided via telemedicine.

- c. **A value-based health care system that moves away from fee-for-service (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. Some stakeholders expressed concerns that making coverage and payment of telemedicine services in what is largely a FFS environment could lead to increased costs without necessarily adding value. Therefore, it is important to include telemedicine in alternative payment methodologies and other efforts to promote value-based care.

- 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. The use of telemedicine during the public health emergency rapidly increased but as the emergency wanes its use will evolve over time and may prove to be 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 to inform future policies, and 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.

¹⁴ Ashwood, JS et al. "Direct-to-consumer telehealth may increase access to care but does not decrease spending." *Health Affairs*. March 2017. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1130>

- e. **Telemedicine may 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 telemedicine vendors 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. Many patients do not have the resources or skills to use the provider's HIPAA-compliant technology platform. The ability to use familiar technology, even if it does not meet HIPAA security requirements (e.g., Facebook Messenger or Apple's FaceTime), has been essential for many patients accessing telemedicine visits during the pandemic.

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, internet, and technology access issues that were identified during the access and disparities discussion above.

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.¹⁵ As those privacy protections are reinstated, providers will need to reassess the methods of delivering telemedicine services. Further consideration of this topic was beyond the scope of the Subcommittee.

¹⁵ Office for Civil Rights Headquarters, U.S. Department of Health and Human Services, Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/notification-enforcement-discretion-telehealth/index.html>

Discussion and Recommendations Related to Performance Measurement in Telemedicine

Throughout discussions of coverage 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 group's scope. Instead, discussions focused on developing principles to guide future quality measurement efforts. The development of such principles was guided by recommendations of the Taskforce on Telehealth Policy, a national effort to develop consensus recommendations for policymakers on quality and safety standards for digital health care delivery nationwide.¹⁶ 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 can help build the evidence base to inform future policies. However, some members noted that it may be premature to move forward with a measurement strategy given the pandemic still exists and circumstances continuously evolve. They advised waiting until conditions have stabilized and the public health emergency has ended.
- 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 Set and the Executive Office of Health and Human Services (EOHHS) Medicaid AE Incentive Measure Set. 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. However, such efforts should recognize the challenges that small providers have in developing the infrastructure for data exchange and interoperability.
- c. **To the extent possible, measurement efforts should consider patient experiences with a telemedicine encounter, including the modality of care; impact on appointment adherence; video and audio quality; and connectivity.** While the

¹⁶ 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/>

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 connectivity. To the extent possible, these measures should consider the race, ethnicity, and language of the patients.

- 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 wholly 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 (d) 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 when considering future policies. It is important to recognize and account for benefits that telemedicine brings, such as time savings to patients and reductions in lost work time for employers that do not directly add to health care costs. In addition, such evaluations need to consider long-term impacts; greater use of telemedicine may increase costs in the short-term but may result in long-term savings by avoiding utilization of more costly services had telemedicine access not been available. It may also represent improved access to individuals who would have challenges accessing the same services in person.

Conclusion

The Telemedicine Subcommittee of OHIC's Payment and Care Delivery Advisory Committee sought to put forth thoughtful recommendations on how to maximize telemedicine's benefits and make it more widely available, while ensuring quality, safety, program integrity, and 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.