CENTER FOR CONNECTED HEALTH POLICY (CCHP) is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.
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ABOUT CCHP

- Established in 2009 as a program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition
Telehealth & Medicaid: A Policy Webinar Series

June 24, 2022: Substance Use Disorders

This webinar is sponsored by the Center for Connected Health Policy through non-federal funding.
TODAY’S SPEAKERS

Representative David Bentz
Delaware House of Representatives
18th District

Kevin P. Beagan
Deputy Commissioner
Massachusetts Division of Insurance

Mike Rhoads
Deputy Commissioner of Health and Life Insurance
Oklahoma Department of Insurance

Chelsey Matter, RRT, MPH
Executive Director of Government Programs Health Integration
Blue Cross Blue Shield of North Dakota
## Telehealth Policy Timeline

<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
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<tr>
<td>2011-2015</td>
<td>Spread of utilization and work on statutory framework.</td>
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<td>May 2015</td>
<td>Legislation passed establishing telehealth statute.</td>
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<tr>
<td>June 2020</td>
<td>COVID-19 related policy changes placed into law.</td>
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<tr>
<td>June 2021</td>
<td>Entire statute revisited to modernize.</td>
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<tr>
<td>May 2022</td>
<td>Interstate reciprocity expanded.</td>
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Initial Use and Advocacy

• Spread of technology, increased demand, and inconsistent coverage creates need for statutory framework.

• Creation of Delaware Telehealth Coalition, Medicaid begins reimbursing, Delaware Telehealth Roundtable, Strategic Action Plan developed.

• Development and passage of legislative framework, HB 69, in May of 2015.
COVID-19 Pandemic

• Utilization expanded dramatically; regulations suspended.

• Learning period for patients and providers alike.

• Industry requests to make certain changes permanent.

• Legislative extension to several emergency order provisions.
Telehealth Modernization

- Entry into interstate licensing compacts
- Addressing broadband shortage challenges
- Behavioral health expansions
- Licensure reciprocity
- Additional payment parity efforts.
Thank You!

David Bentz
Delaware State Representative
Chair, House Health and Human Development Committee

David.Bentz@delaware.gov
1993 – 45 rural, 15 regional hospitals with OU Health Services Center – development and reimbursement of store and forward telemedicine.

1997 – Passage of Oklahoma Telemedicine Act (36 O.S. 6803) – Mandate reimbursement for all healthcare benefit plans (including disability, Workers’ Comp, Medicaid, Managed Care).

2011 – Passage of Oklahoma Special Universal Services Fund – No charge broadband to eligible healthcare entities – rural NFP hospitals, public health departments, correctional facilities, FQHC’s, community mental health clinics.

2016 – 6803 amended to prohibit exclusion of telemedicine, expanded modalities.

2021 – 6803 amended to include reimbursement and benefit parity – effective 1/1/2022.
PROJECT ECHO (2019) “EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES”

- Sponsored by OSU Health Sciences providing virtual clinics to rural PCP’s in underserved populations.
- Specialist teams to discuss treatment for chronic and complex medical conditions including:
  - Mental Health ECHO
  - Education ECHO
  - Veterans ECHO
  - Heal the Harvester ECHO
  - Help the Healer ECHO
REGULATORY AND MARKET TRENDS

• No reported compliance issues regarding 6803.
• Passage of parity in 2021 session allowed for inclusion in rate and form filing for PY2022.
• Consumer complaints on misleading ACA issuer marketing names displayed on healthcare.gov regarding virtual care benefits – copay confusion:
  • CMS required benefit description clarification
  • CMS imposed SEP on one carrier
• No virtual-first primary care product filings (yet) in Oklahoma.
• Decline in telehealth visits in last half of 2021.
• Infrastructure issues continue: one-third of rural counties have limited broadband. ARPA funds being discussed in current special session of legislature.
Commonwealth of Massachusetts

Telehealth in Massachusetts

June 17, 2022
Law permitted carriers to cover services when provided via telehealth

Chapter 224 of the Acts of 2012 created M.G.L. c. 175, Section 47BB

- "Telemedicine" defined as use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" shall not include the use of audio-only telephone, facsimile machine or e-mail.

- An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer.

- Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation.

Limitations of Chapter 224

- Law did not apply to HMOs and did not require coverage of telehealth services

- Law did not comment on reimbursement nor platform to use for telehealth services

Impact of Chapter 224

- Providers and carriers did not develop contracts to include telehealth services

- Limited availability of telehealth through dedicated telemedicine networks
For the duration of Governor Baker’s Emergency Order:

• Carriers must reimburse providers for services delivered via telehealth at least at the rate of reimbursement that the Carrier would reimburse for the same services when provided via in-person methods.

• Providers must be willing to certify that they comply with all applicable state/federal statutes and regulations governing medication management and prescribing services when delivering these services via telehealth.

• Reimbursement should not include any so-called facility fees for distant or originating sites.
Telehealth Standards

• Prior to each patient appointment, the provider must ensure that the provider is able to deliver the services to the same standard as in-person care and in compliance with the provider’s licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access);
• The provider must review the patient’s medical history and any available medical records with the patient during the service;
• The provider must inform the patient of how the patient can see a clinician in-person in the event of an emergency or otherwise.
• Carrier may not impose prior authorization barriers to obtain medically necessary health services via telehealth that would not apply to receipt of same services on in-person basis.
Reimbursement for Health Service Provided via Telehealth

- clear communication about submitting claims for reimbursement.
- same claim submission documentation guidelines as exams for office and outpatient visits.
- continue to evaluate specific CPT code documentation to review that documented reason for the visit medically supports the extent of the exam, the discussion time noted, and the complexity of the visit and assessment.
- reimburse at the same level as for the same services when provided via in-person methods.
Telehealth in the Massachusetts Market

Monthly Utilization - Fully Insured Market
Inpatient (IP)
Percent of Total Paid Claims via Telehealth (%)
Telehealth definition

“Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to:

(i) interactive audio-video technology;

(ii) remote patient monitoring devices;

(iii) audio-only telephone; and

(iv) online adaptive interviews,

for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient’s physical health, oral health, mental health or substance use disorder condition.
Telehealth requirements

- May not require mandated telehealth platform
- May apply utilization criteria to determine about what is not appropriate to be provided by telehealth (e.g., lancing a boil)
- Patient must have access to in-person providers
- Network adequacy not based on telehealth providers

Payment parity for telehealth visits

- Behavioral health permanently
- Primary care and chronic care through 12/31/2022
- All other care through mid-September 2021
Division of Insurance information sessions – February to April 2022

Bulletin 2021-04 issued 4/9/2021; Bulletin 2021-10 issued 9/7/2021
  Continued access to telehealth
  Explain documentation for telehealth visit
  Explain reimbursement codes
  File implementation plans if a carrier wished to reimburse services
    provided via telehealth at less than 100% of pay for in-person visit
    with required notice to providers/patients about changes

One carrier filed implementation plan
  Notified providers by January 1 of changes effective April 1, 2022
  Telehealth services for non-behavioral health, non-primary care,
  non-chronic care services at 80% of in-person visit.
  Plan was permitted but may change with DOI regulation.
Draft Regulations

Draft regulations released and regulatory hearing held on May 11, 2022

https://www.mass.gov/doc/g2022-01-hearing-notice-211-cmr-5200-amendments-issued-april-12-2022/download
https://www.mass.gov/doc/g2022-01-211-cmr-5200-proposed-revisions-marked-issued-april-12-2022/download

The Division received comments from over 40 organizations

Key questions about definitions:

- Synchronous and asynchronous care
- Visit
- Primary care
- Chronic care
- Behavioral health care

Other questions about processes:

- Determination of what types of care are appropriate for telehealth
- Telehealth information in the directory information
- Appropriate coding and billing
Implementing Telehealth Policy: A Private Payer Perspective

Chelsey Matter, Executive Director of Government Programs

June 17, 2022
History of Telehealth

- 1990s: Telehealth in ND begins, BCBSND issues first medical policy
- 2013/14: Interim study on rural health care delivery system (including telehealth)
- 2015: PERS mandate for coverage parity in telehealth
- 2017: Coverage parity mandate
- 2019/20: Interim studies on ND’s behavioral health system and rural health needs

North Dakota Frontier Counties

Counties in darker shade have less than 7 people per square mile per U.S. Census Bureau 2018 data
Telehealth Utilization

- **Pre-pandemic**
  - 2,000 – 3,000 visit per year
  - Behavioral health and infertility

- **First year of pandemic**
  - 2,000 – 7,000 visits per week
  - Average: 4,000 per week
  - Behavioral health (anxiety and depression)

- **Now**
  - Average: 1,500 visits per week
  - Behavioral health

Source: BCBSND claims data incurred 3/1/2022 – 6/10/2022
March 2020: North Dakota Insurance Department brings payers together to discuss telehealth restrictions and removal of barriers to access.


Highlights of coverage expansion:
• Allowed use of software platforms that are not HIPAA-compliant (based on U.S. Office of Civil Rights notice).
• Added audio-only codes 99441-99443 for providers with established patients.
• Allowed therapy provided in a group setting to be delivered via telehealth. There must be a visual component with group therapy (audio-only is not allowed).
COVID-19 Impact on Telehealth

- 2021 Legislative session:
  - Heightened awareness and utilization of telehealth combined with frustration with CMS guidance leads providers to propose legislation including teledentistry, telechiropractic and payment parity
  - More utilization amongst different types of providers prompted many questions

- 2021-2022 Interim legislative study focus:
  - Internet service access
  - Electronic device access
  - Reimbursement
  - Regulations

- BCBSND will focus on education and evaluate expanded payment for specific telehealth services
Member Opinions on Telehealth

Survey participants were asked to choose from a set of options for accepting a virtual appointment versus an in-person appointment.

Reasons for Virtual Appointment

If the cost were the same for a virtual appointment as an in-office visit, how likely would you be to choose the virtual appointment?

N=391 Respondents were able to choose more than one option.

N=438
Moving Forward

- Incorporation of COVID-19 additions in telehealth:
  - Audio only
  - Teledentistry
  - Chiropractic
  - E-visits (subject to definition)
  - Expanded payment for behavioral health (site of service differential removed for highly utilized areas)

- Continued review of policy expansions
- Continued educational efforts related to provider billing
- Audits for inappropriate use of telehealth
- Continued collaboration with State leadership
Key Takeaways

- Seek input from all stakeholders, including members/patients
- State leadership collaboration with payers to work through the details of coverage is important
- Not all services are equally aligned
- Review for inappropriate utilization and/or services
Panel Q&A

Please submit questions using the Q&A function.
THANK YOU!

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### Next Webinar: June 24 – Substance Use Disorders

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<td>Deputy Director, Division of Aging, Adult and Behavioral Health Services, Arkansas Department of Human Services</td>
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<td>Medical Director of the Division of Substance Use Prevention and Harm Reduction, Philadelphia Department of Public Health</td>
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Please don’t forget to fill out your evaluation form!

Thank you and have a great day!