MARYLAND HEALTH CARE COMMISSION

Telehealth Policy Workgroup

February 2021

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MARYLAND HEALTH CARE COMMISSION

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Overview

During the global pandemic, telehealth emerged as a viable solution for prevention, diagnosis, and treatment to mitigate the spread of the Coronavirus Disease 2019 (COVID-19).[1, 2] A State of Emergency declared by Governor Larry Hogan on March 5, 2020 accelerated use of telehealth,[3] quickly moving it from the fringes to the forefront of health care delivery. Actions taken through State Executive Orders and federal waivers made telehealth adoption and use easier for health care providers (providers)[4] and consumers. These actions gave providers a mechanism to deliver safe and uninterrupted care virtually during the public health emergency (PHE).

In the fall of 2020, the Maryland Health Care Commission (MHCC) convened a *Telehealth Policy Workgroup* (workgroup) to discuss changes in telehealth policy implemented in response to the PHE. The workgroup consisted of about 70 participants representing a variety of stakeholder perspectives and interests. The workgroup discussed use of telehealth during the PHE and considered the permanence of certain expansion policies. The general opinion of the workgroup is that telehealth will remain a sought-after option to provide and receive health care post-PHE.

This report includes information about the evolving telehealth landscape in Maryland and the nation, key policy changes enacted during the PHE, and general findings from the workgroup. The information contained in this report is intended to inform stakeholders on the benefits, unintended consequences, and permanency concerns of extending policies beyond the PHE. The workgroup suggested that MHCC study the quality and cost of telehealth and its impact on access to care, alignment with new models of care, and consumer and provider satisfaction.

Telehealth Landscape

Telehealth is the delivery of health care services using electronic communications-based technologies. Technologies include real-time audio and video conferencing, the internet, store-and-forward applications (to transmit images, documents, pre-recorded messages, etc.), streaming media,[5] and wireless communications, such as mobile phones.[6] Telehealth is a convenient option for consumers to be screened and treated by a provider remotely when in-person interventions are not necessary. Services can include symptom consultations, chronic pain management, prescription refills, specialty care, and many others.[7]

Telehealth as a modality to delivering health care services has been slow to gain broad acceptance, unlike other industries, which enable consumers to manage their own digital transactions. Prior to the PHE, roughly 7 out of 10 consumers were interested in trying telehealth; use was uncommon with

[1] HIMSS, Healthcare IT News, *Telemedicine during COVID-19: Benefits, Limitations, Burdens, Adaptation*, March 2020. Available at: www.healthcareitnews.com/news/telemedicine-during-covid-19-benefits-limitations-burdens-adaptation.
[2] WebMD, *Will Telehealth Remain After COVID? Should It?* August 2020. Available at: www.webmd.com/lung/news/20200828/will-telehealth-remain-after-covid-should-it.
[3] The Office of Governor Larry Hogan, *COVID-19 Pandemic: Orders and Guidance.* Available at: governor.maryland.gov/covid-19-pandemic-orders-and-guidance/.
[4] For purposes of this report, a provider refers to a licensed individual who can perform and bill for telehealth services.
[5] Streaming media is media other than video and audio, such as live closed captioning and real-time text.
[6] Health Resources & Services Administration, *Telehealth Programs,* January 2021. Available at: www.hrsa.gov/rural-health/telehealth.
[7] The Joint Commission, *Quick Safety Issue 55: The Optimal Use of Telehealth to Deliver Safe Patient Care,* October 2020. Available at: www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-55/.

only around 1 out of 10 consumers being treated via telehealth.[8] Nationally, about 22 percent of primary care and specialty physicians had used telehealth to see patients before the PHE.[9] Just about 6 percent of consumers were aware their provider offered telehealth services.[10]

Historically, barriers inhibiting use of telehealth were largely attributed to telehealth restrictions on the location of the patient and distant site provider, technology costs and other implementation challenges, and reimbursement. An aging population, growth in chronic illness, and health and health care disparities as it relates to access, quality, and affordability are increasingly driving interest in telehealth.[11] The Centers for Medicare & Medicaid Services (CMS), some state Medicaid programs, and private payers are developing new care delivery and payment models with opportunities for telehealth, to the extent it encourages efficiencies in the system.[12] Use of telehealth in these new models is foundational to achieving better health outcomes, lower costs, and patient-centered care.[13]

Policy Changes – A Turning Point

COVID-19 created unprecedented demand for virtual care. Notably, telehealth use increased in the nation by more than 3,000 percent in 2020 compared to 2019.[14] In the span of a few weeks, providers implemented and scaled virtual care delivery to serve 50 to 175 times more patients via telehealth than they did before the PHE.[15] Consumer adoption of telehealth increased from 11 percent (in 2019) to 46 percent (by April 2020).[16] This shift is attributed to an alignment among payers in response to the PHE (and subsequent extensions), allowing changes in telehealth policies for short-term control of COVID-19. The policy changes empowered providers to quickly pivot their operations and adopt telehealth to minimize unnecessary exposure to the virus.[17]

Prior to the PHE, CMS policies were prescriptive in defining telehealth, limiting how it could be used, the settings and geographic areas where services could be delivered, and provider types that could deliver virtual care. All 50 states and Washington, D.C. provided some form of Medicaid reimbursement, and about 43 states and D.C. had laws governing private payer[18] reimbursement.[19] Coverage varied from state to state. The most commonly covered telehealth modality was real-time

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[8] Advisory Board, *10 Takeaways: Covid-19 Transformed Telehealth Overnight. What Does it Mean for the Future?* June 2020. Available at: www.advisory.com/blog/2020/06/10-covid-19-takeaways-june-11.
[9] American Well, *Telehealth Index: 2019 Physician Survey,* 2019. Available at: static.americanwell.com/app/uploads/2019/04/American-Well-Telehealth-Index-2019-Physician-Survey.pdf.
[10] Advisory Board, *Weekly Advisory: Telehealth, COVID-19, and the Watershed Moment for Digital Health*, June 2020. Available at: www.ppnhco.com/wp-content/Benefits/Advisory-Board-Telehealth-Notice-June-11-2020.pdf.
[11] Brookings, *Removing Regulatory Barriers to Telehealth Before and After COVID-19*, May 2020. Available at: www.brookings.edu/research/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/.
[12] Milliman, *Telehealth Under Alternative Payment Models*, September 2017. Available at: www.milliman.com/en/insight/telehealth-under-alternative-payment-models.
[13] Deloitte, *Realizing the Potential of Telehealth: Federal and State Policy is Evolving to Support Telehealth in Value-Based Care Models*, 2016. Available at: www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-realizing-the-potential-of-telehealth.pdf.
[14] HealthLeaders, *Telehealth Usage Rises with Increase of COVID-19 Cases,* January 2021. Available at: www.healthleadersmedia.com/innovation/telehealth-usage-rises-increase-covid-19-cases.
[15] McKinsey & Company, *Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?* May 2020. Available at: www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.
[16] *Ibid.*
[17] University of Minnesota Center for Infectious Disease Research and Policy, *COVID-19 Reveals Telehealth Barriers, Solutions*, May 2020. Available at: www.cidrap.umn.edu/news-perspective/2020/05/covid-19-reveals-telehealth-barriers-solutions.
[18] Certain laws require reimbursement be equal to in-person coverage; most laws only require parity in covered services and not reimbursement amount. Not all laws mandate reimbursement.
[19] Center for Connected Health Policy, *State Telehealth Laws & Reimbursement Policies*, 2020. Available at: www.cchpca.org/about/projects/state-telehealth-laws-and-reimbursement-policies-report.

audio and video; few states permitted audio-only. Many requirements have been relaxed or eliminated by both government[20] and private payers during the PHE. These include:

- Redefining telehealth to include audio-only telephone calls;
- Removing geographic and facility type restrictions;
- Waiving state-specific licensure provisions enabling interstate practice;
- Redefining what constitutes a treatment relationship between a provider and patient;
- Expanding eligible provider types that can deliver telehealth services;
- Allowing reimbursement for more services delivered via telehealth; and
- Reducing or eliminating cost-sharing.

The Office for Civil Rights (OCR) also relaxed certain regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including allowable technologies for the provision of telehealth services (e.g., popular non-public facing applications like Apple FaceTime and Facebook Messenger video chat).[21] When consumers lack broadband internet or an internet-enabled device, audio-only is an alternative to delivering care, as long as a provider determines that care can be provided safely.[22] Audio-only is considered by some stakeholders as an essential modality, particularly in low-income and underserved communities.[23]

Trends

Nationally, telehealth claims[24] processed by private payers in 2020 ranged between 5 and 13 percent since March, compared to less than one percent the prior year.[25, 26] Payers statewide have reported a significant increase in the volume of somatic and behavioral telehealth claims during the PHE. The surge in virtual visits helped offset an estimated 60 to 70 percent decrease of in-person office visits after declaration of the PHE.[27] Social distancing guidance issued by the Centers for Disease Control and Prevention in February 2020, as well as stay at home orders and other restrictions issued by individual states, led to use of telehealth peaking in April 2020.[28] As states began to loosen restrictions in May and throughout the summer, telehealth usage declined.[29] Payers noted an uptick in telehealth throughout the fall as the number of COVID-19 cases increased.

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[20] The Secretary of the Department of Health & Human Services declared a PHE on January 31, 2020 and later authorized waivers and modifications under Section 1135 of the Social Security Act on March 13, 2020, retroactive to March 1, 2020.
[21] U.S. Department of Health & Human Services, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, March 2020. Available at: www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.
[22] See n. 11, *Supra.*
[23] Healio News, *Audio-Only Telehealth: A 'Crucial Option' During COVID-19 Pandemic,* May 2020. Available at: www.healio.com/news/primary-care/20200520/audioonly-telehealth-a-crucial-option-during-covid19-pandemic.
[24] FAIR Health defines a claim line as an individual service or procedure listed on an insurance claim.
[25] See n. 14, *Supra.*
[26] See Appendix A for monthly summary of claim lines in 2019 and 2020.
[27] Office of the Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic*, July 2020. Available at: aspe.hhs.gov/pdf-report/medicare-beneficiary-use-telehealth.
[28] Centers for Disease Control and Prevention, *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic – United States, January-March 2020*, October 2020. Available at: www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm.
[29] See n. 14, *Supra.*

Between March and October 2020, about 25 million Medicare beneficiaries (or 39 percent) received telehealth services.[30] Medicaid and CHIP beneficiaries received more than 35 million telehealth services between March and June 2020, an increase of 2,600 percent compared to the same period in 2019.[31] The volume of virtual visits is anticipated to level off somewhere around one-tenth to one-third of total visits as states continue to gradually reopen and some payers roll back coverage for telehealth (e.g., cost-sharing).[32, 33] In the wake of COVID-19, more health care leaders will elevate telehealth as a strategic priority.[34] Over time, demand for telehealth will significantly change the way health care is obtained, delivered, and reimbursed for virtual and in-person services.[35]

In Maryland, there have been up to sixfold increases in telehealth adoption for certain provider types. Data included in the table that follows was obtained from an environmental scan of providers before and during the PHE. Findings indicate rapid adoption of telehealth as providers quickly responded to meet patient needs during the PHE peak.

Maryland Telehealth Adoption Rates
June, 2020

Provider Type	*Pre-PHE (%)*	*During PHE (%)*
Physician Practices	11	70*
Nursing Homes	9	75
Home Health Agencies	27	53
Hospitals	87	98

Note: *Anecdotal data; hospital adoption was limited to select departments (e.g., tele-ICU) and was deployed across most specialties during the PHE.

Legislative Activity

The CMS has taken action to expand telehealth coverage in its 2021 Physician Fee Schedule,[36] making coverage permanent for 66 of the 144 telehealth services temporarily added for the duration of the PHE.[37, 38] The federal government is currently considering numerous bills aimed at further expanding telehealth coverage and reimbursement post-PHE. A particularly notable bill is the

[30] Centers for Medicare & Medicaid Services, *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients*, December 2020. Available at: www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.
[31] Centers for Medicare & Medicaid Services, *Trump Administration Drives Telehealth Services in Medicaid and Medicare*, October 2020. Available at: www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicaid-and-medicare.
[32] Healthcare IT News, *'Sleeping Giant' of Telehealth Awoke in 2020, and Here's Who Rose to the Challenge*, January 2021. Available at: www.healthcareitnews.com/news/sleeping-giant-telehealth-awoke-2020-heres-who-rose-challenge.
[33] McClelland Law Firm, P.A., *Health Insurers are Rolling Back Telehealth Coverage Due to COVID-19,* December 2020. Available at: mcclellandfirm.com/health-insurers-are-rolling-back-telehealth-coverage-due-to-covid-19/.
[34] KaufmanHall, *A New Approach to Telehealth Strategy: Planning for the Pandemic and Beyond*. Available at: www.kaufmanhall.com/ideas-resources/article/new-approach-telehealth-strategy-planning-pandemic-and-beyond.
[35] *Ibid.*
[36] Centers for Medicare & Medicaid Services, *Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021,* December 2020. Available at: www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1.
[37] These additions allow beneficiaries in rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services such as certain types of emergency department visits, therapy services, and critical care services. Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home. More information is available at: www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.
[38] These services were added using, for the first time, an expedited process (established by CMS in May 2020) that does not involve rulemaking.

Permanency for Audio-Only Telehealth Act[39] that would allow CMS to reimburse Medicare providers for certain audio-only visits.[40] Coverage for audio-only services has received a great deal of attention during the PHE, in part, for providing more equitable access to health care.[41, 42]

The Maryland General Assembly is considering legislation during the 2021 session to make certain regulatory waivers permanent.[43] Other states have introduced bills to make permanent many of the policies implemented during the PHE.[44] Four states[45] have already passed legislation. Changes include expanding eligible originating sites to a patient's home and schools,[46] redefining telehealth to include audio-only visits, and removing established in-person provider-patient relationship requirements.[47]

Workgroup Approach

Providers, payers, consumers, technology vendors, and State agencies[48, 49] met five times between September 2020 and January 2021.[50] Discussions centered on six telehealth policies deemed important by the workgroup given their ongoing relevance during the PHE.[51] A qualitative approach was used to gather the opinions and experiences among workgroup participants. Over 340 observations were categorized as a benefit, unintended consequence, permanency concern, or other consideration.[52] The workgroup's analysis of the data led to the identification of notable patterns in the data, which provided a framework of common themes that were used to formulate general findings.[53] Workgroup participants were not asked to endorse the general findings.

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[39] Congress.gov, *Permanency for Audio-Only Telehealth Act*, December 2020. Available at: www.congress.gov/bill/116th-congress/house-bill/9035/text?r=2&s=1.
[40] The Act is designed to permanently remove technological and geographic restrictions that, amongst other things, have inhibited the provision of telehealth services in rural areas where a lack of adequate broadband connectivity to support audio-visual technology can be a significant impediment to the expansion of telehealth technology. More information is available at: www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.
[41] JD Supra, *Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19*, December 2020. Available at: www.jdsupra.com/legalnews/executive-summary-tracking-telehealth-77278/.
[42] Research suggests that about 80 percent of seniors have a cell phone; however, only about 42 percent have a smartphone. Of these, there is uncertainty about how many feel confident in using all the capabilities of a smartphone. More information is available at: www.pewresearch.org/internet/2017/05/17/technology-use-among-seniors/.
[43] Numerous telehealth bills are being considered by the General Assembly. More information is available at: mgaleg.maryland.gov/mgawebsite/Legislation/Index/senate.
[44] Over 200 bills are pending in legislatures. More information is available at: www.medpagetoday.com/practicemanagement/telehealth/90849.
[45] States include Colorado, New Hampshire, Ohio, and Washington. More information is available at: www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.
[46] The practice of restricting telehealth reimbursement to rural or underserved areas is decreasing. Maryland and four other states (HI, MN, NC, SD) have telehealth geographic restrictions. Some restrictions are limited to certain specialties, such as mental health in Maryland.
[47] Federation of State Medical Boards, *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, January 2021. Available at: www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.
[48] See Appendix B for a copy of the Workgroup Participants.
[49] Over 90 stakeholders were included in the distribution list.
[50] Meeting information, materials, and recordings are available on MHCC's website. More information is available at: mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_telehealth_policy.aspx.
[51] The workgroup was requested to rank twelve telehealth policies by priority via an online survey.
[52] See Appendix C for a copy of the discussion tables.
[53] Thematic analysis is a qualitative research method for identifying, organizing, and categorizing observations to facilitate the discovery of significant themes within a data set.

Limitations

Workgroup participants represented the perspectives of their stakeholder category. Views expressed by the participants were not necessarily the official position of their employer organization. Differing viewpoints provided helpful insight in interpreting the observations. Divergent perspectives and varying levels of familiarity with telehealth may have possibly influenced the findings.

General Findings

Each telehealth policy contains proposed actions to inform policy decision making beyond the PHE. Certain elements of the general findings were deemed relevant across several policies.

Policy 1. Removing telehealth restrictions on originating and distant site locations

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Standardize the definitions of originating and distant site to recognize any setting where care can be delivered based on consumer needs and preferences for telehealth services, provider clinical judgement, and guidelines on health, safety, and security

- Expanding permissible care delivery sites for telehealth services helps address care access gaps in rural, vulnerable, and underserved populations

D. Assess the flexibility and financial impact on the Medicaid program

Policy 2. Permitting audio-only when the treating provider determines it to be safe, effective, and clinically appropriate

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Support greater State and federal telecommunications infrastructure investment in less-resourced communities and health care facilities to improve and ensure equitable access and use of telehealth

D. Assess the flexibility and financial impact on the Medicaid program

Policy 3. Removing telehealth restrictions on conditions that can be treated

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Develop a consumer education strategy to improve awareness of telehealth as an option and when telehealth services are appropriate

D. Adopt uniform telehealth use policies across all health care specialties including, but not limited to, somatic, behavioral health, and rehabilitation services to improve access and coordinated care

E. Assess the flexibility and financial impact on the Medicaid program

Policy 4. Removing telehealth restrictions on provider types

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after the PHE ends or the data analysis concludes

C. Allow licensed health care providers to treat patients using telehealth within their scope of practice based on consumer needs and preferences for telehealth services, provider clinical judgement, and existing guidelines on health, safety, and security

- Expanding provider types helps address provider shortages and timeliness of care
- Broadened access reduces hospital readmissions and emergency department utilization

D. Assess the flexibility and financial impact on the Medicaid program

Policy 5. Reducing or waiving cost sharing for telehealth services through the end of the PHE or until December 31, 2021, whichever occurs last

General Findings

A. Collect and analyze data to inform policy development

- An analysis of government and private payer data and provider data collected (e.g., value, cost, access, and quality) before, during, and after the PHE is needed to inform policy discussions to ensure recommendations are effective and evidence-based
- Federal requirements on high-deductible plans may impact flexibility to make changes
- Differing cost sharing requirements for an in-office visit versus a telehealth visit may have disproportionate effects on payers and consumers

B. Allow policy flexibility, where feasible, to remain in effect for a period of time after PHE ends or the data analysis concludes

C. Assess the flexibility and financial impact on the Medicaid program

Policy 6. Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal PHE

General Findings

A. Allow existing OCR telehealth enforcement discretion policies to sunset at the end of the PHE without State intervention, unless otherwise addressed through other OCR actions

B. Assess the use of non-HIPAA compliant technology on privacy and security

Conclusion

The MHCC has promoted telehealth adoption over the last 10 years. Throughout this time, uptake of telehealth was slower than anticipated. Proactive policy changes by payers supported and encouraged rapid adoption of telehealth during the PHE. The need to leverage available technology to improve value and efficiency in health care should continue to drive use of telehealth once the PHE ends. The workgroup stressed the importance of making telehealth part of an integrated care

delivery system post-PHE that considers unique characteristics of practices and evolving consumer expectations.[54, 55]

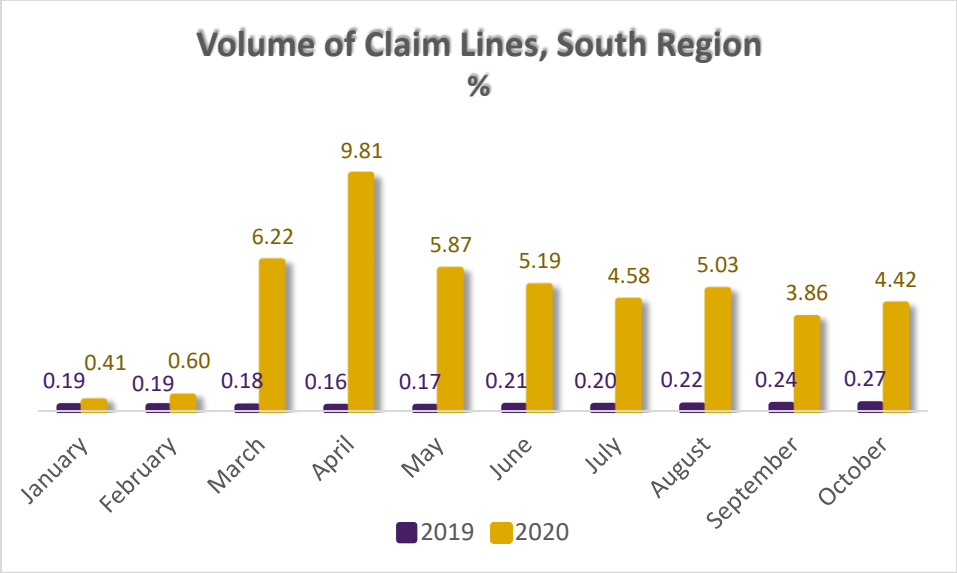
COVID-19 has been a natural experiment that will inform telehealth policy and research moving forward.[56] Important issues exist if telehealth is to expand after the PHE. Audio-only coverage and payment parity for all forms of telehealth are among the biggest areas of payer and provider disagreement. There is general agreement among the workgroup that an approach informed by data would be beneficial. The MHCC is planning to conduct an assessment of telehealth to examine value, cost, access, and quality of audio-only and video visits, and the comparative effectiveness of audio-only, video, and in-person visits.

Acknowledgements

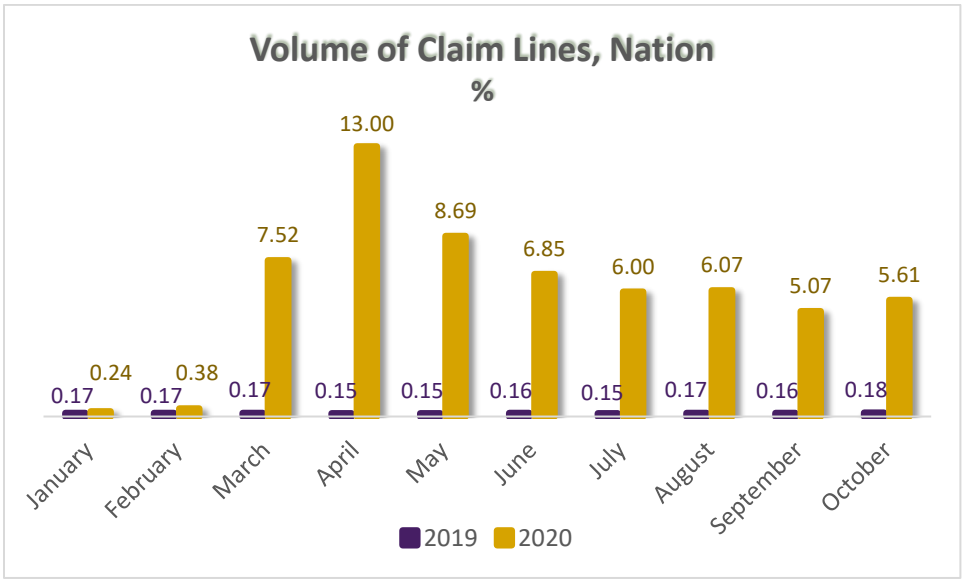
The MHCC appreciates the contributions made by workgroup participants and commends their dedication to advancing adoption and use of telehealth statewide. Stakeholders worked together laudably to meet the objectives of the workgroup.

[54] KaufmanHall, *Redesigning Care Delivery for a Post-COVID-19 World.* Available at: www.kaufmanhall.com/ideas-resources/article/redesigning-care-delivery-post-covid-world.
[55] Health Tech, *Telehealth Grew Wildly Popular Amid COVID-19. Now Visits are Plunging, Forcing Providers to Recalibrate*, September 2020. Available at: www.statnews.com/2020/09/01/telehealth-visits-decline-covid19-hospitals/.
[56] Health Affairs, *Establishing a Value-Based 'New Normal' for Telehealth*, October 2020. Available at: www.healthaffairs.org/do/10.1377/hblog20201006.638022/full/.

Appendix A. Volume of Telehealth Claims



Note: South Region includes AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV.



Source: FAIR Health Monthly Telehealth Regional Tracker

Appendix B. Workgroup Participants

Telehealth Policy Workgroup Participants *As of 01/07/21*			
#	**First Name**	**Last Name**	**Organization**
1	Vivian	Aguayo	Maryland Primary Care Program
2	Bimbola	Akintade, PhD	University of Maryland School of Nursing
3	Salliann	Alborn	Maryland Community Health System
4	Emily	Arneson	Kennedy Krieger Institute
5	Paul	Berman	Berman & Killeen, PA, Maryland Psychological Association
6	Arun	Bhandari, MD	Chesapeake Oncology Hematology Associates
7	Richard	Bloch	Maryland Podiatric Medical Association
8	Dave	Brennan	MedStar
9	Jennifer	Briemann	Maryland Managed Care Organization Association
10	Nicole	Brandt	The Peter Lamy Center on Drug Therapy and Aging
11	Alyssa	Brown	Maryland Department of Health, Office of Health Services
12	Rebecca	Canino	Johns Hopkins Medicine
13	Patrick	Carlson	Maryland Department of Legislative Services
14	Matthew	Celentano	League of Life & Health Insurers of Maryland
15	Ann	Ciekot	Public Policy Partners
16	Annie	Coble	Johns Hopkins University
17	Eric	Colchamiro	Government Affairs, Alzheimer's Association
18	Adam	Conway	Greater Baltimore Medical Center
19	David	Cooney	Maryland Insurance Administration
20	Jen	Crockett, MD	Kennedy Krieger Institute
21	Susan	D'Antoni	Montgomery County Medical Society
22	Sherry	Dai	CareFirst BlueCross BlueShield
23	Joe	Dematttos	Health Facilities Association of Maryland
24	Lori	Doyle	Community Behavioral Health Association of Maryland
25	Robyn	Elliott	Maryland Community Health System
26	Sarah	Feeny Price	Maryland Retailers Association
27	Peggy	Funk	Hospice & Palliative Care Network
28	Shannon	Gahs	Zektick
29	Donald	Goldberg	Teledoc
30	Laura	Goodman	Maryland Department of Health
31	Cathy	Grason, JD	CareFirst BlueCross BlueShield
32	Jessica	Grau	Maryland Health Benefit Exchange
33	Jim	Gutman	AARP – Maryland
34	Marina	Hardy	Taft Hardy & Associates
35	Brian	Hasselfeld, MD	Johns Hopkins Medicine
36	Ann	Horton	Maryland National Capital Homecare Association
37	Diana	Hsu	Maryland Hospital Association
38	Helen	Hughes, MD	Johns Hopkins University

#	First Name	Last Name	Organization
39	Jim	Hummer	Lorien Health Services
40	Neal	Karkhanis	League of Life & Health Insurers of Maryland
41	Elizabeth (Pam)	Kasameyer	Maryland Department of Health, Medicaid Planning
42	Niharika	Khanna, MD	University of Maryland Medical System
43	Danna	Kauffman	Shwartz, Metz and Wise, P.A.
44	John	Kornack	Amwell
45	Beverly	Lang	Nurse Practitioner Association of Maryland, Inc.
46	Christopher	Langhammer, MD	University of Maryland Medical System
47	Sonia	Lawson, PhD	Maryland Occupational Therapy Association
48	Cailey	Locklair Tolle	Maryland Retailers Association
49	Kathleen	Loughran	Amerigroup
50	Kelvin	Lucas	Maryland Department of Legislative Services
51	Daniel	Mansour, PharmD	Peter Lamy Center on Drug Therapy and Aging
52	Dan	Martin	Maryland Behavioral Health Coalition
53	Pam	Metz	Schwartz, Metz and Wise, P.A.
54	Michael	Paddy	Maryland Insurance Administration
55	Sarah	Peters	Husch Blackwell Strategies
56	Gene	Ransom	MedChi, The Maryland State Medical Society
57	Maansi	Raswant	Maryland Hospital Association
58	Sharon	Ringley	Chief of Staff for Delegate Kelly
59	Deb	Rivkin	CareFirst BlueCross BlueShield
60	Tricia	Roddy	Maryland Department of Health
61	Magaly	Rodriguez de Bittner, PharmD	University of Maryland School of Pharmacy
62	Lindsay	Rowe	Maryland Department of Legislative Services
63	Dawn	Seek	Maryland National Capital Homecare Association
64	Dan	Shattuck	Barbara Marx Brocato & Associates
65	Lisa	Simpson	Maryland Department of Legislative Services
66	Deborah	Steinberg	Maryland Parity at 10 Coalition
67	Jackie	Stone	Kennedy Krieger Institute
68	Oleg	Tarkovsky	CareFirst BlueCross BlueShield
69	Allison	Taylor	Kaiser Permanente
70	Tequila	Terry	Health Services Cost Review Commission
71	Jennifer	Thomas, PharmD	Maryland Pharmacists Association
72	Jim	Trumble, MD	Peninsula Regional Medical Center
73	Michael	Udwin, MD	CareFirst BlueCross BlueShield
74	Ellen	Weber	Maryland Parity at 10 Coalition
75	Joe	Winn	UnitedHealthcare
76	Steve	Wise	Schwartz, Metz and Wise, P.A.
77	Jennifer	Witten	Maryland Hospital Association
78	Ben	Wolff	Maryland Department of Health, Office of Health Services

Appendix C. Policy Discussion Tables

DRAFT: 010721

1: Removing telehealth restrictions on originating sites	
BENEFITS **Providers** • Expands ability to offer telehealth • Avoiding unnecessary utilization (e.g., hospital/emergency room, SNF admissions) • Reduced no-show rates • Increased opportunity to use remote patient monitoring for high-risk patients and chronic care management • Supports care coordination and transitions between care settings with more immediate follow-up • Improves access to interprofessional team care (e.g., social worker, pharmacist) and communication • Potential decreased costs associated with "brick and mortar" facilities • Increases ability to quickly respond to acute non-emergent situations • Allows timely treatment/therapy adjustments when viewing patient in their natural environment • Preservation of protective personal equipment • Ability to assess patients' home environment **Payers** • Greater access and engagement for members • Supports care delivery at the lowest cost setting and potential for reduced health care costs (e.g., Medicaid transport costs) **Consumers** • Expands access to care and flexibility in seeking services • Mostly comfortable with technology • Consumer choice/preference and comfort to receive services where they want (e.g., minimize stigma for seeking certain services) • Increases patient engagement, self-management, and satisfaction in their health care • Increases the potential for health equity • Reduces barriers to care (e.g., financial, transportation, childcare, debilitating conditions, time off work, etc.) • Promotes infection control and public safety	**UNINTENDED CONSEQUENCES** **Providers** • Potential risks to privacy and security of PHI in some circumstances • The ability to accurately diagnose • The impact on patients due to reduced regulatory oversight of providers • Potential loss of local providers/services • Concerns over increases of fraud allegations • Potential lack of comfort with technology and communicating virtually with patients **Payers** • Overutilization of health services • Potential for delivery of partial care **Consumers** • Access and communication barriers for certain populations due to age, socioeconomic status, technology literacy, vision/hearing impairments, etc. • Duplication of services, virtually and in-person • Possibility of pressure to have a telehealth visit against one's preference

PERMANENCY CONCERNS

Providers

- Uneven opportunity across providers due to technology access and infrastructure challenges (e.g., broadband internet, data)
- Addressing challenges of patient engagement in care; no clear pathway to address health literacy and digital divide issues
- Ability to adapt to rapidly changing guidelines

Payers

- Alignment across payers in defining originating site (e.g., home is anywhere) and reimbursement policies
- Impact on Total Cost of Care Model is unknown
- Need to assess metrics pertaining to quality, cost, utilization, and patient outcomes to understand impact
- Facility fee concerns

Consumers

- Infrastructure and technology challenges could impede access, particularly for underserved communities
- Ensuring comfort and appropriate use of the technology
- Need to assess patient satisfaction data to inform policy and training programs

OTHER

Providers

- Consider removing originating site restriction requiring staff to be on site to bill facility fee
- Monitor federal efforts to permit expansion of originating sites

Payers

- Consider CMS guidance and Medicare policies on originating site and payer alignment
- Monitor and analyze quality and cost data to inform policy and advance positive health outcomes

Consumers

- Need for parallel in-person and telehealth pathways
- Continued need for financial support and opportunities (e.g., grants) without geographic restrictions to improve technology infrastructure

Non-Specific

- Inclusion of telehealth training in provider education, accreditations, and certifications
- Determination of what constitutes an originating site

PRIMARY THEMES

- The need to rely on providers' clinical judgment and consumers' preferences to determine appropriateness
- Removing geographic and originating site restrictions promotes greater access to care, particularly for underserved populations
- Broader use of telehealth can assist in reducing the total cost of care
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion
- A concern that policy changes may be implemented prematurely and will require modification when sufficient data is collected and appropriately analyzed
- Gaps remain (e.g., lack of technology, digital literacy, and access to high-speed internet) that need to be addressed to close health disparities for rural, underserved, and vulnerable communities

Removing telehealth restrictions on originating sites

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
  - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Modify the definition of originating site to recognize any patient setting where care can be delivered based on consumer needs and preferences, and provider clinical judgement and guidelines on health, safety, and security
  - Expanding permissible care delivery sites for telehealth services helps address care access gaps in rural, vulnerable, and underserved populations

2: Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate	
BENEFITS **Providers** • Supports care management and continuity (e.g., chronic care management, follow ups, behavioral health, medication therapy management) • Supports care delivery during public health emergencies (e.g., COVID-19, natural disaster, etc.) • Increases ability to quickly respond to acute non-emergent situations • Expands opportunities to provide patient education • Provides an option to deliver care when audio-video connection is not accessible or feasible **Consumers** • Allows flexibility to receive services that aligns to their preferences • Greater likelihood for equitable access to care, particularly for vulnerable populations or patients with limitations (e.g., technology, broadband internet, digital literacy, unstable housing) or when other options (e.g., video visits, in-person) are not available • Ease of access, particularly for older populations and individuals with limited access to technology	**UNINTENDED CONSEQUENCES** **Providers** • Increased risk for siloed care/lack of documentation within the EHR if not integrated into care delivery workflows (e.g., video visits and in-person) • Potential for duplication of services • Increased risk for missed diagnoses and miscommunication • May impede provider adoption of video visits **Payers** • Understanding implications of services provided outside a regulated space • Potential confusion on appropriate use requirements and uneven reimbursement policy across payers, insured and self-insured business • Potential for billing of new, additional, or duplicate services • Potential increase of fraud and abuse **Consumers** • Unaware of financial liability for associated services • Potential to create inequities for patients only able to access audio-visual care • Potential risks to privacy/confidentiality of visit in certain situations (e.g., domestic violence cases) • May limit provider/consumer engagement during the visit
PERMANENCY CONCERNS **Providers** • Defining reimbursement levels for audio only services (e.g., payment parity based on provider time or technology used – audio-only; audio and video; audio, video, and RPM) • Determining services appropriate and effective for audio only • Lack of guidelines on appropriate uses and processes (e.g., verifying patient identity) resulting in greater risk of liability • Potential standard of care issues and practice workflow challenges (e.g., standardizing documentation of audio-only visit within EHRs) • Impact of prior authorization on access **Payers** • Challenging to formulate reimbursement policies (e.g., length of call, visit type, duplicity/coordination of services, who initiates call) and alignment across payers • Establishing guidelines for determining appropriate services once data from PHE is collected and analyzed • Long-term effect on care quality, cost, and outcomes unknown	**OTHER** **Providers** • Need for parity in payment with services provided by telehealth **Payers** • Consider a time-limited phase out approach to allow adequate adoption and use of telehealth by providers and consumers • Need time to conduct an impact evaluation of audio only services during the PHE on utilization, access, quality, safety, and efficacy **Consumers** • Need for policies to remain patient-centric **Non-Specific** • Use should be based on patient and provider preferences and clinical judgement • Permit audio only services due to necessity (e.g., rural facilities with lack of broadband internet) • Consider MTM comprehensive and targeted review services as reimbursement model

- Demand beyond PHE is unknown
- Determination of quality metrics

Consumers

- Educating consumers on appropriate uses
- How to address language and physical barriers (e.g., hearing and eyesight)
- Need for clarification on copayments/coverage

PRIMARY THEMES

- Provides an alternate and easily accessible modality to render care and seek treatment based on provider judgment and consumer preference
- Helps address health care inequities, especially for underserved and underrepresented populations
- Addresses challenges associated with adopting health information technology for resource-limited providers
- Variations exist in determining a method and rationale for payment parity with in-person visits
- Considering audio only as a time-limited transition service to live-visual encounters when statewide access to broadband internet and other needed technology is achieved
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Balancing expanded access to care and the potential for health, safety, and security concerns

Permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
    - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Support greater State and federal telecommunications infrastructure investment in less-resourced communities and health care facilities to ensure greater access and use of telehealth
    - Many rural areas lack sufficient broadband internet to support widespread adoption of telehealth

3: Removing telehealth restrictions on conditions that can be treated	
BENEFITS **Providers** • Reduces avoidable hospital admissions and emergency department utilization • Enables remote patient monitoring (e.g., for mental health and other targeted medication adherence, chronic care management) and rapid interventions when needed • Relies on providers' clinical judgment • Holds telehealth visits to same outcome measures as in-person visits • Promotes more coordinated and interprofessional care • Allows consistency across payers **Payers** • Potentially reduces costs associated with avoidable hospital admission and emergency department utilization **Consumers** • Allows for more immediate and expanded access to care • Creates a consumer-centered system of care that accommodates patient needs and preferences (e.g., reduces travel and scheduling challenges, convenience) • Greater coordination of services, particularly if comorbidities are present • Promotes access to specialty care, especially for high-risk patients	**UNINTENDED CONSEQUENCES** **Providers** • May reduce care efficacy of certain services • Potential risks to patient safety (e.g., certain symptoms may be missed without in-person physical exam) • Lack of data to determine which conditions can be effectively treated using telehealth **Payers** • Risk of overuse, potential for duplicate services resulting in an increase in health care costs • Potential negative impact on health care quality • Possibility of additive rather than substantive services **Consumers** • Confusion could occur when treatment plan is verbal • Patient dissatisfaction with care services resulting in complaints/dissatisfaction • Confusion around benefit coverage and out-of-pocket costs
PERMANENCY CONCERNS **Providers** • Malpractice concerns due to increased liability • Lack of condition-specific telehealth processes • Re-engineering practice workflows to support the effective use for new conditions • Support needed to conduct certain services within the home **Payers** • Lack of standards around appropriateness of care • Lack of data to determine the impact on access, cost, and quality **Consumers** • Increased demand on primary care providers could hinder access/availability	**OTHER** **Providers** • Prior authorization for behavioral health services may limit access • Barriers significantly differ depending on geographical location of patients • Alignment for conditions appropriate via telehealth and payer reimbursement • Some conditions and treatments may be limited by federal laws (e.g., medication assisted treatment) • Need updated provider training (education and professional **Payers** • Compliance oversight **Consumers** **Non-specific** • Need for ongoing data collection and analysis to assess policies and ensure they support positive health outcomes • Compliance with federal anti-discrimination laws (e.g., Mental Health Parity and Addiction Equity Act, American with Disabilities Act)

PRIMARY THEMES

- Fosters timely and coordinated care and may lead to improved patient outcomes and decreased avoidable hospital admissions and emergency department utilization
- Requires consumer education to promote understanding and awareness of the role of telehealth and how to navigate the technology
- Lessening prior authorization requirements for behavior health to expand access, promote patient safety, and avoid adverse outcomes
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Consistent coverage and reimbursement policies are required to reduce provider and consumer confusion

Removing telehealth restrictions on conditions that can be treated

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
  - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
  - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Educate consumers on telehealth and services that are appropriate to receive via telehealth
  - Develop a consumer education strategy to increase awareness of appropriate care that can be provided via telehealth
- Adopt uniform behavioral health telehealth use policies that improve access
  - Harmonize payer behavioral telehealth access policies to enable timely and coordinated care and improved patient outcomes

4: Removing telehealth restrictions on provider types

BENEFITS

Providers

- Supports interprofessional team care, especially if providers are in different locations
- Helps address workforce shortages and funding limitations, especially for specialists (e.g., behavioral health providers)
- Increased timeliness and continuity of care
- Provides flexibility in staffing models (e.g., use of non-licensed or certified staff)
- Allows consistency across payers

Consumers

- Increased access to a broader range of provider types
- Reduces challenges associated with scheduling and travel
- Promotes care consistency
- Greater potential to address social determinants of health
- Supports consumer choice

UNINTENDED CONSEQUENCES

Providers

- Potential impact on patient safety (e.g., certain symptoms may be missed without in-person physical exam)
- Provider avoidance of telehealth due to lack of comfort
- Ensuring adequate provider training
- Potential decline of established patient-provider relationship and continuity of care (e.g., patients see different provider for each visit)

Payers

- Over or underutilization due to the lack of treatment guidelines

Consumers

- Potential confusion on what is covered

PERMANENCY CONCERNS

Providers

- Lack of existing reimbursement for certain provider types (e.g., pharmacists, home health, etc.)
- Potential for wide-range variation in provider determination as to the appropriate service delivery method
- Level of accountability
- Equity in decision making (e.g., discretion)
- Need for coordination among care team

Payers

- Need more data on value, cost, access, and quality
- Lack of standards to determine medically appropriate provider types
- Payment constraints in setting service rates for Medicaid (e.g., lack of flexibility in lowering rate to FQHCs for telehealth services)

Consumers

- Lack of quality measure ratings available to assess provider effectiveness in virtual visits

OTHER

Providers

- Restrictions should align with scope of the license
- Consider federal and State policies related to use of compacts and implications for practicing across borders
- Trust in providers' clinical judgement

Payers

- Need a method to address quality concerns/complaints

Consumers

- Need for education on seeking care from appropriate providers

PRIMARY THEMES

- Helps address geographic barriers and workforce shortages
- Concern among payers on the potential financial impact of expanded services and a limited Medicaid budget
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed
- Increases potential for health equity, consumer choice, and access to health professionals
- The need for provider training on virtual care delivery and consistency in guidelines

Removing telehealth restrictions on provider types

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
    - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Allow licensed health care providers to treat using telehealth within their scope of practice based on consumer preference, provider clinical judgement, and existing guidelines on health, safety, and security
    - Expanding provider types helps address provider shortages
    - Broadened access reduces hospital readmissions and emergency department utilization

5: Reducing or waiving cost sharing for telehealth services through the end of the public health emergency or until December 31, 2021, whichever occurs last

BENEFITS

Providers

- Incentivizes flexibility in providing care
- Reduces risks associated with COVID-19 positive or presumed positive patients from presenting in-person for care

Increases stability and continuity of care

Payers

- Increased timeliness of care may reduce the risk of deferred/delayed care and increased costs to the health care system

Consumers

- Addresses access to care issues
- Supports financial equity in care, especially for those whose employment has been disrupted
- Greater likelihood that consumers will seek care rather than deferring
- Decreases exposure to COVID-19 and other infectious diseases
- Promotes care continuity and management

UNINTENDED CONSEQUENCES

Providers

- Potential confusion on reimbursement and covered services resulting from variation in coverage across payers (e.g., COVID-19 related services vs. unrelated services, audio only vs. video visits)

Payers

- Potential for inappropriate utilization of telehealth
- May promote and incentivize use of telehealth over in-person visits
- Lack of clarity on which plans must comply

Consumers

- Nuances in payer policies could create confusion on final billed amount (e.g., out-of-network providers, self-insured plans)
- A risk that higher cost-sharing for in-person visits (compared to telehealth) could create inequities in care delivery

PERMANENCY CONCERNS

Providers

- Differing reimbursement structure than in-person visits
- Financial impact on providers due to lost revenue
- Abrupt discontinuation of telehealth when financial benefit stops

Payers

- Potential for overutilization of services and duplicative services
- Funding – Medicaid

Consumers

- Risk that quality of care will be negatively impacted as the volume of virtual care increases system wide

OTHER

Providers

- Consider comparable or commensurate compensation to in-person visits

Payers

- Defer on making a policy recommendation until more data is gathered and analyzed
- The need for flexibility to be nimble and innovative in addressing PHE

Consumers

- Applying copayments in the same manner as in-person visits after PHE ends
- The need to address co-payments collection for those without credit cards
- Coverage options when in-network providers are not adequate or available

PRIMARY THEMES

- May increase access to care and reduce health implications associated with deferred care
- Educate consumers on appropriate conditions for a telehealth visit
- Supports equitable access to care for underserved populations
- A concern that policy changes may be implemented prematurely requiring modification when sufficient data is collected and appropriately analyzed

Reducing or waiving cost sharing for telehealth services through the end of the public health emergency or until December 31, 2021, whichever occurs last

DRAFT – GENERAL FINDINGS

- Collect and analyze data to inform policy development
    - An analysis of government and private payer data collected (e.g., value, cost, access, and quality) during the PHE is needed to inform policy discussions to ensure recommendations are prudent and data-informed
    - Federal requirements on high-deductible plans may impact flexibility to make changes
    - Allow existing State telehealth waivers/policy flexibilities, where feasible, to remain in effect until some period after the end of the PHE
- Differing cost sharing requirements for an in-office visit versus a telehealth visit may have disproportionate effects on payers and consumers

6: Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal public health emergency

BENEFITS

Providers

- Lessens privacy and security concerns
- Improves the quality of telehealth encounters
- Increased likelihood technology integration exists with electronic health records
- Fewer workflow challenges

Payers

- Reduces risk of unauthorized access to a patient's protected health information

Consumers

- Ensures adequate protection around privacy and security
- Builds consumer confidence in the use of telehealth

UNINTENDED CONSEQUENCES

Providers:

- Adopting telehealth will require a financial investment in the technology

Consumers

- Potential barrier to access (e.g., patients not allowed to manually send symptoms/vitals to providers, or broadband internet limitations)
- Applications are not always user friendly and may require downloading multiple technology solutions
- Limitation on patient choice

PERMANENCY CONCERNS

Providers

- Costs to invest in a HIPAA-compliant telehealth solution, particularly for small practices
- Solution integration challenges with EHRs
- Addressing barriers to implementation, particularly for those serving underserved communities

Payers

- The risk that payers could be held accountable for technology adoption choices of providers by OCR

Consumers

- Can limit use if applications are oversized
- Burnout by "yet another application" to download
- Challenges in becoming familiar with multiple telehealth solutions

OTHER

Providers

- Consider relaxation of HIPAA-compliant technology under certain circumstances (e.g., documented emergency situations)
- Lack of interoperability for technology that is not HIPAA-compliant
- Need for support in navigating telehealth technology vendor market
- Consider audio only reimbursement or alternative technology options when HIPAA-compliant technology is not feasible/accessible
- Consider reimbursement for services delivered via patient portals, secure messaging, etc.

Payers

- Use caution in adoption legislation that may hinder the evolution of telehealth technology
- Monitor OCR guidance

Consumers

- Need for easy-to-use technology

PRIMARY THEMES

- The utility of non-public facing applications during the public health emergency does not offset the risks to privacy and security
- Allowable communication options include practice patient portals and secure messaging
- Costs to invest in HIPAA-compliant telehealth infrastructure may stunt provider adoption
- Addressing implications on consumer access and satisfaction

Reinstating technology standards that require providers to use HIPAA-compliant technology, which were relaxed by OCR during the federal public health emergency

DRAFT – GENERAL FINDINGS

- Allow existing OCR telehealth enforcement discretion policies to sunset at the end of the PHE without State intervention
    - Assess the impact of non-HIPAA compliant technology usage on privacy and security during the PHE

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