MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

February 1, 2018

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Shane E. Pendergrass
Chair
House Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

Re: SB 570/HB 658 – *Maryland Medical Assistance Program – Telehealth – Requirements* – Requested Report

Dear Chairs Middleton and Pendergrass:

Pursuant to correspondence between the Department of Health and the Senate Finance Committee and the House Health and Government Operations Committee during the 2017 legislative session regarding SB 570/HB 685 – *Maryland Medical Assistance Program – Telehealth – Requirements*, the Department is submitting this progress report on its telehealth activities to the committees. Since 2010, the Department has implemented a series of expansions to its telehealth program designed to increase access to care across the state. The enclosed report provides an update on the expansion of the Medicaid telehealth program and observations on the impact of the expansion.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Deputy Chief of Staff at (410) 767-6480 or webster.ye@maryland.gov.

Sincerely,

Robert. R. Neall
Secretary

Enclosure

cc: Tricia Roddy
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Progress Report on Telehealth – Maryland Medicaid Program Activities

Submitted by the Department of Health

February 1, 2018

I. Executive Summary

Following correspondence between the Maryland Department of Health ("the Department") with the Senate Finance Committee and House Health and Government Operations Committee regarding SB570 and HB685 in March 2017, the Department committed to submitting a progress report to the General Assembly addressing its recent Medicaid Telehealth Program expansions.

The Department is dedicated to implementing a cost-effective telehealth policy that best serves the needs of Maryland residents enrolled in the Medicaid program. Since 2010, the Department has implemented a series of expansions to its Telehealth Program designed to increase access to care across the state. The Department supports a telehealth policy that aligns across payers. The Department remains committed to developing its Telehealth Program in a way that ensures access to cost-effective services and that quality of care continues to improve across the state.

II. Introduction

The Department, in keeping with the requirements of SB242/HB886 (Ch. 366/367 of the Acts of 2016), submitted a report (1) assessing the telehealth policies of select Medicaid programs in other states; and (2) detailing planned enhancements to the Maryland Medicaid Telehealth Program in January 2017.1 Based on the report's findings, the Department proposed several changes designed to continue to expand the Medicaid Telehealth Program, including expanding coverage to include remote patient monitoring (RPM) services for certain chronic conditions and to add additional distant sites and services, including new substance use disorder (SUD) providers. This report provides a brief program overview and an update on recent telehealth expansions undertaken by the Department.

In 2017, Maryland has (1) registered a substantial number of additional telehealth providers for both originating sites and distant sites; (2) made significant progress to expand coverage to include RPM for certain chronic conditions in January 2018; and (3) expanded the provider types eligible to register with the Telehealth Program.

During the 2016 Legislative Session, SB707/HB1350 (Chapter 420 of the Acts of 2016) *Freestanding Medical Facilities—Certificate of Need, Rates and Definition*, passed into law and was signed by the Governor on May 10, 2016. The legislation established a workgroup on rural health care delivery to oversee a study of healthcare delivery in the Middle Shore region and to develop a plan for meeting the health care needs of the five counties—Caroline, Dorchester, Kent, Queen Anne's, and Talbot. The workgroup issued a report detailing its findings on October 1, 2017, recommending expanding telehealth access and mobile capacity. The Department will collaborate with partners and stakeholders to ensure the recommendations assist Medicaid populations in rural areas.

III. Program Overview

The Department is dedicated to implementing a cost-effective telehealth policy that best serves the needs of Maryland residents enrolled in the Medicaid program. Since 2010, the Department

1 https://mmcp.health.maryland.gov/Documents/JCRs/2016/telemedicineJCRfinal10-16.pdf.

has implemented a series of expansions to its Telehealth Program designed to increase access to care across the state. The Department supports a telehealth policy that aligns across payers.

Telehealth services are administered through three primary modalities—live video (synchronous), store-and-forward (asynchronous), and RPM (also called home health monitoring or telemonitoring). Maryland Medicaid currently pays for the live video (under COMAR 10.09.49 Telehealth Services) and store-and-forward (under COMAR 10.09.02 Physician Services cover teleradiology, teledermatology, and teleophthalmology) modalities. The Maryland Medicaid Telehealth Program governs the live video modality. Live video connects patients virtually with practitioners and may serve as an alternative to an in-person visit. The patient's location is referred to as the originating site, and the telehealth provider's location, the distant site. Store-and-forward uses non-real time communication to transfer clinical information and pictures, such as an x-ray or a high-resolution image, via e-mail or other electronic transmission for follow-up or evaluation. Maryland Medicaid pays for the store-and-forward modality for dermatology, ophthalmology, and radiology services under Physician Services regulations at COMAR 10.09.02.07. RPM allows for the collection and transfer of a patient's vital signs or health data, such as blood pressure or heart rate, for tracking purposes while the patient is at a different site or at home. Participants or their caretakers use technologic devices to gather and report data to a provider at another location. More recently, a fourth modality has also begun to emerge in the form of mobile health or "mHealth." Mobile health uses mobile communications devices, such as smart phones, for health services and information. Mobile health applications are increasingly used to facilitate the three traditional telehealth modalities.

In 2010, the Mental Hygiene Administration and the Medicaid Program implemented the Telemental Health Program. The program limited coverage to participants located in designated rural counties, with originating sites limited to outpatient mental health clinics (OMHCs), hospitals and federally qualified health centers (FQHCs). Initially, permitted distant site providers were limited to licensed psychiatrists.

In December 2012, pursuant to SB 781/HB 1149 (Chapters 579/580 of the Acts of 2012), *Health Insurance – Coverage for Services Delivered Through Telemedicine*, the Department submitted a report to the General Assembly that included a recommendation on how to provide telehealth for the Maryland Medicaid Program population. Based on a comprehensive literature research and review of other state Medicaid programs, the Department recommended that Medicaid cover medically necessary services that can be reasonably provided via hub-and-spoke. The hub-and-spoke model is a variation of the live video telehealth modality, reflecting the care model's origins in increasing access to care in rural areas. The hub-and-spoke model is when a patient in an originating site at a remote location (the spoke) interacts with a provider at a distant site at a larger health facility (hub). When Medicaid first implemented its Telehealth Program, program provider participation was restricted to physicians, nurse practitioners, and nurse midwives. The Department recommended limiting the areas that could qualify as spokes to rural counties, creating the Rural Access Telemedicine Program.

Following the report, in October 2013, the Department operationalized the Rural Access Telemedicine Program and implemented the Cardiovascular Disease and Stroke Medicine Program. The populations served were located in one of 15 designated rural counties and those

who sought care for cardiovascular disease and stroke in a hospital emergency department, regardless of their geographic location in Maryland. The provider types were physicians, nurse practitioners and nurse midwives. The originating site was a facility in one of the 15 designated rural counties and the consulting providers were the distant sites.

In October 2014, the Department further expanded its Telehealth Program to include coverage of services on a statewide basis pursuant to SB 198/HB 802 (Chapter 141/426 of the Acts of 2014), *Maryland Medical Assistance Program – Telemedicine*. Effective October 1, 2015, Maryland Medicaid combined the Telemedicine and Telemental Health Programs and renamed them as the Telehealth Program. The Telehealth Program serves Medicaid participants irrespective of geographic location within Maryland.

In 2016, the Department expanded the Telehealth Program and authorized several new originating and distant sites. Specifically, in 2016, the Department streamlined the registration process and made it available online for provider's convenience. Subsequently, the provider application and addendum form 2015 were discontinued.

Pursuant to SB 242/HB 886 (Chapters 366/367 of the Acts of 2016), *Maryland Medical Assistance Program - Telemedicine – Modifications*, the Department released a report on telehealth services. The Department assessed the telehealth policies of Medicaid programs in other states, including reimbursement for telehealth services provided in a home setting; and detailed planned enhancements to the Maryland Medicaid Telehealth Program. Based on these findings, the Department proposed several changes designed to continue to expand the Medicaid Telehealth Program, including:

- Expanding coverage to include RPM for certain chronic conditions;
- Expanding coverage to include additional distant sites and services, including SUD providers; and
- Considering modifications to how Maryland Medicaid reimburses for telehealth services in the future.

For a timeline of Maryland Telehealth expansions, please see "Brief Overview: Progression of Maryland's Telehealth Program" on the next page.

Brief Overview: Progression of Maryland's Telehealth Program

2010
Telemental Health Program Begins

- Mental Hygiene Administration and Medicaid Program implemented the Telemental Health Program.
- **Population Served**: Participants located in designated rural counties
- **Originating Sites:** OMHCs, hospitals and federally-qualified health centers (FQHCs)
- **Distant Sites:** Licensed psychiatrists

2012
Recommendations for Expanding Telehealth

- December 2012: Department submitted a report to the General Assembly detailing its recommendations regarding use of telehealth for the Maryland Medicaid population.
- Recommendations included that Medicaid cover medically necessary services that can be reasonably provided via hub-and-spoke.
- The Department recommended limiting the areas that could qualify as spokes to rural counties.

2013
Implementation & Further Expansion

- October 2013: the Department operationalized the Rural Access Telemedicine Program and implemented the Cardiovascular Disease and Stroke Telemedicine Program.
- **Population Served:**
  (1) Beneficiaries located in one of 15 designated rural counties.
  (2) Beneficiaries who sought care for cardiovascular disease and stroke in a hospital emergency department, *regardless* of geographic location.
- **Provider Types:** Physicians, nurse practitioners, and nurse midwives
- **Originating Sites:** Facility in one of 15 designated rural counties
- **Distant Sites:** Consulting providers

2014
Statewide Expansion of Telehealth Program

- Telehealth Program expanding to cover services on a *statewide* basis.
- **Population Served**: *All* Medicaid participants are eligible to receive telehealth services regardless of how they qualify for benefits, whether on a fee-for-service (FFS) basis or through the HealthChoice managed care program.

2015
Combining two programs under the same umbrella

- Effective October 1, 2015, Maryland Medicaid combined the Telemedicine and Telemental Health Programs and renamed them as the Telehealth Program.
- **Population Served:** Same as 2014
- **Provider Types**: See below.
- **Originating Sites:** 7 somatic and 56 behavioral health providers.
- **Distant Sites:** 6 somatic and 40 behavioral health providers.
- **Administrative Requirements:** Providers must complete an application and provider addendum to participate in the Telehealth Program.

2017: Maryland's Telehealth Program Today

Providers Registered to Participate in Maryland's Telehealth Program

Originating Sites
- 26 somatic providers
- 146 behavioral health providers

Distant Sites
- 117 somatic providers
- 87 behavioral health providers

Administrative Requirements
- Streamlined registration process available online for provider billing and education purposes.

Initiatives in Progress

RPM Expansion
- Goal: Reduce readmissions and emergency department visits, improve quality of care
- Targets recipients with diabetes, congestive heart failure, or chronic obstructive pulmonary disease (COPD) who have had 2 hospitalizations, 2 ED visits, or 1 of each

Distant Site Provider Expansion
- Community-based SUD providers, OTP, OMHC—*Effective 10/1/17*
- FQHCs and physician assistants—

Maryland Medicaid Telehealth Program: Current Program and Initiatives

Current Program Status

Tables 1 and 2 below detail the number of originating sites and distant sites for both registered somatic and behavioral health sites. The number of originating sites increased from seven somatic providers and 56 behavioral health providers in 2016 to 26 and 146 providers respectively in 2017. For distant sites, the total increased from six somatic providers and 40 behavioral health providers in 2016 to 117 and 87 respectively in 2017.

Table 1: Number of Originating Sites as of October 2017

	Number of Registered Somatic Sites		Number of Registered Behavioral Health Sites	
Provider Type	**2017**	**2016**	**2017**	**2016**
Physician Office	18	3	13	3
Nurse Practitioner Office	2	1	1	-
Psychiatric Nurse Practitioner Office	-	-	1	-
Hospital	4	2	5	1
Nursing Facility	1	1	-	-
Community-Based SUD Provider	-	-	11	2
FQHC	-	-	2	1
Local Health Department	-	-	8	1
Opioid Treatment Program	-	-	13	-
OMHC	-	-	89	46
Residential Crisis Services Site	-	-	3	2
TOTAL	**26**	**7**	**146**	**56**

Table 2: Number of Distant Sites as of October 2017

	Number of Registered Somatic Providers		Number of Registered Behavioral Health Providers	
Provider Type	**2017**	**2016**	**2017**	**2016**
Physicians	97	5	21	12
Nurse Practitioner	13	1	9	2
Nurse Midwife	7	-	-	-
Provider Fluent in ASL	-	-	3	-
Psychiatric Nurse Practitioner	-	-	4	-
OMHCs with Rendering Physician	-	-	50	26
TOTAL	**117**	**6**	**87**	**40**

Remote Patient Monitoring (RPM)

As a part of the Department's 2016 "Report on the Telehealth Policies of Other States' Medicaid Reimbursement for Telehealth Services in the Home Setting and Planned Enhancements for Maryland Medical Assistance," the Department recommended expanding telehealth coverage to

include RPM. RPM is the use of synchronous or asynchronous technologies to collect personal health information and medical data from a patient in the home; this information is then transmitted to a provider for use in treatment and management of unstable or uncontrolled medical conditions that require frequent monitoring. The Department is in the process of implementing coverage of RPM services and anticipates that the new coverage will be available beginning in January 2018.

The Department came to several conclusions after careful consideration of other states' programs and a comprehensive literature review of studies to assess the effectiveness of different types of telehealth services rendered in the home to increase access to care, improve health outcomes, and be cost effective. Studies demonstrated that RPM can be an effective means of managing certain chronic conditions, such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease (COPD) and reducing hospital admissions and unnecessary utilization of emergency care; thus, improving patient outcomes and in some cases, resulting in cost savings.2 Additionally, most states limited their RPM programs to individuals with certain chronic conditions.

Based on these findings, the Department recommended expanding coverage to include RPM for certain high-risk, chronically ill Medicaid participants. Specifically, the Department is in the process of implementing RPM services for participants who meet the following criteria:

- Has been diagnosed with at least one of the following chronic conditions:
    - Diabetes (type 1 or 2),
    - Congestive heart failure, or
    - COPD;
- Is capable of using the provided equipment and transmitting the necessary data or has an able and willing person to assist them;
- Has internet connections necessary to host the equipment in their home; and
- Has had:
    - Two hospital admissions within the prior 12 months with the same qualifying medical condition as the primary diagnosis,
    - Two emergency department visits within the prior 12 months with the same qualifying medical condition as the primary diagnosis, or
    - One hospital admission and one separate emergency department visit within the prior 12 months with the same qualifying condition as the primary diagnosis.

The Department will pre-authorize RPM services under fee-for-service based on medical necessity.3 Coverage of RPM will not be indefinite and will be discontinued when the patient's condition is determined to be stable or controlled. Medicaid participants will be eligible for

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2 A Broderick and V Steinmetz, "Centura Health at Home: Home Telehealth as the Standard of Care" (Commonwealth Fund, January 2013), http://www.commonwealthfund.org/publications/case-studies/2013/jan/telehealth-centura; Ryan Spalding and Gordon Alloway, "Medicaid HCBS/FE Home Telehealth Pilot: Final Report for Study Years 1-3" (University of Kansas Medical Center, Center for Telemedicine and Telehealth, 2010), http://media.khi.org/news/documents/2011/04/26/Telehealth_evaluation.pdf; American Telemedicine Association and others, "State Medicaid Best Practice."

3 The MCOs may choose to pre-authorize RPM services as well.

coverage for up to two episodes of care each year. The Department will cover two months (for a total of 60 days) of services per episode of treatment.

Physicians, physician assistants, nurse practitioners, and home health agencies will oversee delivery of RPM services when a physician who has examined the patient and with whom the patient has an established, ongoing relationship prescribes RPM. Providers will be paid $125.00 per month (30 days) for RPM services and may bill up to two consecutive months of RPM per authorized participant. Consistent with the vast majority of other states implementing similar programs, the Department will not reimburse for the purchase, repair, or removal of equipment necessary to facilitate for RPM. The Department will also not pay for internet connections necessary to transmit the results to the provider's office.

The Department has been working on implementing this program and anticipates services will be available beginning January 1, 2018. On August 4, 2017, the Centers for Medicare and Medicaid Services (CMS) approved the State Plan Amendment (SPA) after it was submitted by the Department on June 15, 2017.4 Proposed regulations began signoff on June 13, 2017, and will become COMAR 10.09.96.01-.13. They were filed on September 1, 2017. The first printing will be on October 13, 2017 and public comments will be accepted on the proposed regulations through November 13, 2017.

Expansion of Health Care Provider Types

In addition to recommending coverage for RPM in its 2016 report, the Department also proposed expanding the provider types and sites eligible to participate in the Telehealth Program, Specifically, the Department proposed permitting community-based SUD providers, opioid treatment programs, and OMHCs as distant sites. The Department implemented this recommendation, effective October 1, 2017. Final notice of these regulations was printed October 13, 2017. The Department now also permits Urgent Care Centers (UCCs) to bill for telehealth services as an originating site through a registered rendering physician.

Due to interest from providers since the 2016 report's release, the Department is considering adding other new provider sites. For example, the Department intends to add FQHCs as an authorized distant provider once the changes regarding SUD providers have been promulgated. The Department is also considering adding physician assistants as an authorized distant site provider in the near future.

Workgroup on Rural Health Care Delivery

During the 2016 Legislative Session, SB 707 *Freestanding Medical Facilities—Certificate of Need, Rates and Definition*, was passed into law and created a workgroup on rural health care delivery to oversee a study of healthcare delivery in the Middle Shore region. This workgroup was to develop a plan for meeting the health care needs of five counties: Caroline, Dorchester, Kent, Queen Anne's and Talbot County.

4 https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MD/MD-17-0005.pdf.

In collaboration with the University of Maryland School of Public Health and the Walsh Center for Rural Health Analysis, the workgroup released a report entitled "Health Matters: Navigating an Enhanced Rural Health Model for Maryland – Lessons Learned from the Mid-Shore Counties." This report highlighted several recommendations to improve healthcare access based on interviews with stakeholders, focus groups with county residents, and healthcare data analysis.

The report recommended investing in fundamental programs that expand the health care workforce, elevate community-based health literacy, and enable technology amongst other recommendations. In regards to telehealth, the report advocated for enhancing the use of technology to promote health and well-being and to improve access to health services. Increasing the use of telehealth and telemedicine by health care providers and residents would extend access to primary and specialty care for residents. The report advocated for special attention to be given to needs and accommodations for vulnerable populations, such as those with limited access to transportation and limited mobility. The report stressed, however, that in order to make a business case for providers to expand telehealth options stable reimbursement needs to be established.5

As the Department continues to monitor and develop its Telehealth Program, it will take into consideration the Rural Health Care Delivery Workgroup's recommendations moving forward.

Reimbursement Modifications

As noted in the Department's 2016 Report, of the 49 Medicaid Programs that reimbursed for telehealth services, nearly forty percent (nineteen in total), do not reimburse originating or distant sites for an additional facility or transmission fee. Technological advances are reducing barriers to access while reducing the cost of providing services to patients. Enhanced access at a reduced cost is having an impact on how many payers, including Medicaid, reimburse for services. Given these considerations, the Department will continue to monitor this trend and determine whether future changes are warranted.

Monitoring Policy Changes at the Federal Level

The Department will also continue to monitor changes in telehealth legislation at the federal level. Currently, the Department's Telehealth Program is more expansive than Medicare's telehealth program; however, there are several bills proposed in Congress that would make the two programs more comparable. S. 870, *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*, has been proposed in Congress. This bill amends title XVIII (Medicare) of the Social Security Act to:

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5 "Health Matters: Navigating an Enhanced Rural Health Model for Maryland – Lessons Learned from the Mid-Shore Counties."
http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/rural_health/September%2025th%202017%20Meeting/lgsrpt_SummaryReport_rpt_20170928.pdf.

- Extend the Independence at Home demonstration program;
- Modify provisions regarding access to home dialysis therapy under Medicare and special needs plans under Medicare Advantage (MA);
- Expand testing of the MA Value-Based Insurance Design test model;
- Allow an MA plan to provide additional telehealth benefits to enrollees and, to chronically ill enrollees, certain supplemental health care benefits;
- Modify other provisions regarding the use of telehealth services;
- Allow prospective, voluntary assignment of Medicare fee-for-service beneficiaries to accountable care organizations (ACOs); and
- Allow ACOs to operate beneficiary incentive programs.

The legislation also requires the Government Accountability Office to conduct studies on:

- The establishment of a payment code for a visit for longitudinal comprehensive care planning services,
- The extent to which Medicare prescription drug plans and private payors use programs that synchronize pharmacy dispensing to facilitate comprehensive counseling and promote medication adherence, and
- The use of prescription drugs to manage the weight of obese patients and the impact of such drug coverage on patient health and health care spending.

The legislation unanimously passed in the Senate on September 27, 2017, and will head to the House.

In addition, H.R 3727, *Increasing Telehealth Access in Medicare Act,* would also allow Medicare Advantage plans to include the cost of providing telehealth services in their bids and increase funding in the Medicare Improvement Fund.

IV. Conclusion

The Department remains committed to developing its Telehealth Program in a way that ensures access to high quality and cost effective services that improve quality of care across the state. The Department further recognizes that availability of telehealth services serves as an important entry point for recipients who might otherwise face challenges accessing services. These are some of the many reasons the Department has expanded the Medicaid Telehealth Program significantly since 2010. The most recent program expansions for 2018 to include coverage for RPM will help to ensure that some of Medicaid's high-risk, chronically ill participants have access to this critical modality of care.

The Department also remains dedicated to exploring opportunities to further enhance and expand its Telehealth Program in the future. In collaboration with other departments and agencies, including the Health Services Cost Review Commission and the Maryland Health Care Commission (MHCC), the Department will continue to monitor developments in this area. The Department will also continue to monitor telehealth policies in other states' Medicaid programs as well as research studies that examine the effectiveness, both in outcomes and cost, of telehealth services.