Telemedicine Update Questions and Answers

01/04/21

This document contains answers to questions posed by stakeholders in the November 12 update webinar. Answers provided are reflect information that is current as of January 4, 2021. Additional information from other stakeholder engagements can be found on the Telemedicine Stakeholder Engagement webpage. If you have questions that are not answered here, you may:

- Check the Provider Billing Manuals, including the Telemedicine Billing Manual
- Review information on the Telemedicine – Provider Telemedicine webpage, or
- Contact Betsy Holt, Policy Development Stakeholder Engagement Specialist

General questions

1. Will there need to be legislation to implement the proposals discussed in the November webinar?

   Yes. The Department seeks to remove the provision that allows telemedicine without any previous or follow-up in-person contact. This change will give the Department the flexibility needed to adapt to the new normal and regulate the various types of providers currently using telemedicine to deliver services in Colorado. In particular, it will allow the Department to ensure appropriate integration of telemedicine into the medical home and neighborhood.

2. When is the report coming out?

   The Telemedicine Evaluation Report will be posted on the Telemedicine Stakeholder Engagement page in the first quarter of 2021.

3. What policies will reinforce medical homes?

   During the pandemic, telemedicine has grown as a delivery mode valued by members, providers, employers and payers. The Department is committed to developing comprehensive telemedicine policy with the goals of improving access to high-quality services, promoting health equity, and shepherding taxpayer resources.

   The Department would like to run a bill to increase the Department's flexibility in regulating various types of providers currently using telemedicine to deliver services in Colorado. As we continue to gather data on utilization rates and budgetary impacts, we want to remain committed to encouraging our members to access care within the medical home and within our Regional Accountable Entities (RAEs') provider networks.

4. This budget slide is very difficult to understand. Can you explain further?

   There was a significant reduction in the State's projected General Fund revenue due to the pandemic. The Governor's FY 2021-22 budget request (Governor's 11/12 Budget presentation) included many reduction items across state agencies in order to balance to the lower revenue. The Department's budget includes reductions of $145.7 million General Fund through various savings initiatives. At the same time, the Department expects that total spend on telemedicine will be increasing in the next two budget years.

5. Please explain why the Department thinks the costs for providers decrease when delivering telemedicine care.

   The Department used analysis conducted by the Colorado Health Institute to determine that there are potential cost per visit reductions depending on the provider type's uptake of telemedicine and the staffing model used. This will be discussed in further detail in the Department's forthcoming Telemedicine Evaluation Report.

6. Do patients who do not use telemedicine visits actually end up in the Emergency Department (ED)? What do we know about the impact of telemedicine on the ED use?

   There is scant research around the relationship of telemedicine and ED utilization during the Public Health Emergency. The Department is also curious about the potential benefits for patients using telemedicine as an alternative to ED visits for non-emergent care. The Department, alongside Farley Health Policy Center (FHPC) at CU School of Medicine, will conduct a quantitative analysis of visit attendance rates before and after the telemedicine policy changes. It will also examine ED utilization rate changes. Funding was awarded through an OSPB opportunity for Colorado State Departments. This evaluation will be available by Fall 2021.

7. How will your policies impact RAE coverage and policies such that providers can expect consistency when billing to RAEs vs fee-for-service (FFS)?

   Managed care plans must, at a minimum, cover the services captured under their benefit as they are represented in the state plan. Under managed care state plan, benefits are often referred to as "the floor not the ceiling". Service limits in the state plan are in place to help manage services administered through fee-for-service. Services covered through managed care have additional flexibilities that are not available under FFS:

	Fee For Service	Managed Care Entities
Unit Limitations	If the state plan stipulates that a service has a hard limit, there is no opportunity to exceed that limit.	MCEs must use hard limits in the state plan as "the floor"; they can pay for additional units beyond the hard limit in the state plan.
Authorization	The state plan will stipulate when an FFS benefit requires authorization.	Aside from emergency services, MCEs can determine which services must be authorized.
Providers	The state plan requires that any willing qualified provider can enroll in Medicaid and members can choose which providers they see.	MCEs are required to develop a network of qualified providers that are enrolled in Medicaid. MCEs can choose which providers to contract and can limit the services providers in their network can provide for the MCE's enrollees.
Rates	FFS rates are set by the Department and are codified in the state plan.	MCEs can negotiate rates with their contracted providers. These rates can be above or below the FFS rates.
Additional services	The FFS benefit is limited to what is available under the state plan.	The MCEs that administer the capitated behavioral health benefit are required to cover additional services not covered under the state plan (these are known as (b)(3) services). The Department works with RAEs determine if these additional services, not in the state plan, can be provided through telemedicine. All of the flexibilities that exist for MCEs with FFS services are also permitted for these additional services. The Department is in the process of working with the MCEs to update this policy for 1/1/21.

8. Is the Department planning to move away from the fee-for-service (FFS) payment model, so that any potential disparity of rates between in-person services and telemedicine services won't be as impactful? How long does the Department plan to make FFS the foundational payment model?

   The Department intends to move away from FFS. Primary care providers will have the option to receive some of their reimbursement on a per population basis beginning in July 2021. Some providers don't currently have the scale or readiness to move away from FFS to alternative payment models. The Department wants participation from every willing provider. Therefore, it

remains important that we have appropriate FFS telemedicine rates to support those remaining, valued providers.

9. How is the provider utilization data accessed?

   Our utilization data is posted on the Provider Telemedicine webpage.

10. On the utilization data, can you tell how many of these claims were via video versus telephone?

    No. We are not able to see how many visits are conducted via telephone versus video.

11. Chronic disease management was one of the top diagnoses. What types of providers are billing these codes?

    A variety of provider types are delivering these services via telemedicine billing office/outpatient visit codes (99212, 99214, 99212). Federally Qualified Health Centers are currently billing the highest volume of these codes.

12. In the presentation, where did the health equity (digital literacy, language, and cultural competency) data originate?

    The Department does not have Health First Colorado specific data on these items. We used findings from national literature and interviews with providers to source this section of the presentation and the upcoming Telemedicine Evaluation Report.

13. Where are dental services in the Department's telemedicine policy consideration?

    The Department appreciates the feedback that stakeholders have provided on innovative ideas occurring in the dental community. We continue to review teledentistry policies and recommendations as they develop on a state and federal level. In the meantime, we will continue to offer coverage for emergency teledentistry visits.

Well Child Checks

14. When will the well-visit code reimbursement via telehealth begin?

    The effective date for coverage of well-child checks (WCC) via telemedicine was November 12, 2020. Information has been posted on the provider telemedicine page in the place of service section and will be noticed in the January and February provider bulletins.

15. Will WCC for new patients be reimbursed?

    The current plan is to reimburse WCC for both new and established patients. Additional information, has been posted on the provider telemedicine page and will be noticed in the January and February 2021 provider bulletins.

Parity/Rates

16. Can you say any more about how the Department would go about authorizing telemedicine-specific rates?

    The Department currently sets rates for services based on a wide variety of factors and benchmarks related to member access, provider costs and budget impact. There will not be any rate changes this fiscal year. When well-integrated within the medical home, telemedicine has demonstrated great potential to provide more care for fewer dollars, which is critical during this economic downturn, and for the future.

    In the future, the Department may want to incorporate telemedicine into provider rate setting, in order to incentivize integrated virtual care models, consider the impact of technological advances, address unintended consequences of emergency policies, and develop aligned payment policy.

17. It used to be that there was a cost to the Department for patients to travel to appointments - particularly from rural parts of the state into the front range. Assuming that is still true, are those savings being taken into consideration with respect to telehealth reimbursement decisions? Also, I would hate to see lower payment for telehealth appointments become a disincentive to provide services remotely, particularly right now when the need is so high. How are you taking this into your assessment and decision-making processes?

    The Department appreciates the suggestion and will incorporate this factor as payment policy evolves for fee-for-service benefits. This has been considered for Home Health services.

18. The way parity is discussed in the webinar was not the same as HB19-1269 Mental Health Parity Insurance Medicaid.

    Parity, as it is concerned in HB19-1269, refers to *mental health parity*. Mental health parity laws require that mental health and substance use disorder benefits are not more difficult to access than medical and surgical benefits. Parity, in the context of this telemedicine discussion, refers to *payment parity*. The use of the term here involves the discussion of the payment rates for telemedicine visits being equal to the payment rates for in-person visits.

19. If you are considering different rates for services provided, I would like to suggest investigating cost for providers to travel to client homes, cost for providers to pay for HIPAA compliant telehealth platforms vs cost for providers who only do clinic-based therapy.

    In assessing Home Health services, the cost of staff travel has been considered and is discussed in the Telemedicine Evaluation Report. Costs for adding new technologies and standing up telehealth platforms are incorporated in our cost modeling, and as more information comes to light will be further considered. One-time start-up costs are distinguished from on-going costs.

20. When you are looking at parity, it's important for you to consider the issues that some parts of our state can't access telehealth due to a lack of high-speed internet

    Broadband access is discussed as part of the Telemedicine Evaluation Report, which will be posted on the Telemedicine Stakeholder Engagement page in the first quarter of 2021.

Telephone Only

21. Can you explain more about how the Office of Civil Rights (OCR) discretion on HIPAA enforcement is the reason why telephone-only might not be permanent? It isn't clear to me why audio-only telehealth is less secure.

    The telephone only decision is related to standard of care, not HIPAA. CMS relaxed standard of care to allow services via telephone only and also signaled a relaxation of HIPAA, but they are different. IF CMS changes their approach to standard of care and telephone only, the Department will have to determine its course of action.

22. Are state regulations in alignment with federal regulations? If there are differences between state and federal, which one overrides the other?

    Colorado must follow Federal regulations on HIPAA. See the answer above regarding standard of care decisions for telephone-only services.

23. You said telephone-only would be available for certain services. Which services do you anticipate being allowed via this modality?

    Refer to our Provider Telemedicine webpage and the Telemedicine Billing Manual for information about which services are allowed information about provider limitations on providing for telephone-only services. These pages are updated as Department policy changes.

24. I would like to make a recommendation if I may. The broadband internet is not always available in Rural Colorado. Being able to communicate by telephone as the modality has been the only way we have been able to connect with a number of patients. Some patients reside over 25miles from our hospital and clinic so the only modality they have is a telephone. They may have some internet but most times it is not a good enough signal for video. I would ask that they keep telephone-only visits until we can come up with broadband solutions for rural Colorado. Thank you!

    The Department agrees that there are equity challenges in relying solely on video. There are no state level recommendations at this time, but the Department will continue to consider long-term solutions.

eConsults

25. What providers are considered "specialists?"

    The Department's development team is working to create a list of specialty provider types and services that would be eligible for eConsults participation. The Department will work with stakeholders to refine the list and priority for a phased roll out of the tool.

26. Will there be provider education opportunities based on the number of eConsults requested? For example, if a PCP continues to request eConsults, will the algorithm help identify topics for that practice to educate the provider on that topic?

    Yes, this feature will be part of the RFP requirements. We want to include this not just for individual PCPs, but across the system to educate all primary care providers on the most commonly asked questions and how to manage those concerns in the primary care setting

27. Will part of the eConsult implementation include Primary Care eConsultation with Behavioral Health specialists?

    As referenced in the presentation, the implementation of eConsults will be phased, beginning with specialties where there is the most opportunity and clear practice guidelines. As a result, behavioral health would likely be implemented in a later phase.

28. Would the eConsult platform be appropriate for BCBAs billing 97155, or is it more directed for primary care physicians?

    The eConsult tool is intended for PCP -Specialist interface.

Behavioral Health

29. I know you were addressing the FFS side in this webinar, but all these questions (ability to continue telephonic, quality of care, impact on utilization/frequency/intensity, and parity

are all highly relevant in behavioral health. Would the Department and the RAEs together plan to do any similar analyses?

These topics are discussed in the Telemedicine Evaluation Report which will be posted on the Telemedicine Stakeholder Engagement page in the first quarter of 2021.

30. Since LPC, LCSW, etc. can offer psychotherapy across the state, how can this workforce be supported in terms of a single contracting process with all RAEs?

This question is outside the scope of the telemedicine conversation. Please refer to the ACC Behavioral Health Provider Contracting Guidance Fact Sheet.

31. Will these proposed policy changes address telehealth for mental health/counseling?

This will address telehealth for mental/counseling as it relates to the 6 short-term behavioral health service that can be provided in a primary care medical provider setting.

However, the majority of the mental health and substance use disorder services are covered under the capitated behavioral health program, a managed care benefit. Services covered through managed care have additional flexibilities that are not available under FFS. Managed care plans must, at a minimum, cover the services captured under their benefit as they are represented in the state plan. Under managed care state plan, benefits are often referred to as "the floor not the ceiling". Changes to FFS will carry over as "the floor", but they have additional flexibilities to negotiate rates and to contract with providers.

The table in question 7 can be a helpful reference to this question as well.

Remote Patient Monitoring

32. The definition of telehealth now includes remote patient monitoring (RPM). Is HCPF still looking at RPM for those other than Home Health Agencies?

The Department is currently exploring different options for RPM by provider types other than Home Health. The discussions are preliminary and were initiated by Hospital providers looking to provide outpatient services to members who are in their home with the intention of alleviating hospital capacity issues. The Department has requested that these providers supply the codes of the services for which they are requesting reimbursement. In anticipation of the list of services the Department is reviewing the regulatory changes needed in order to provide reimbursement for these services.