

THE FUTURE OF TELEHEALTH IN UTAH

SEPTEMBER 16, 2020



Utah Education and Telehealth Network

PURPOSE OF UETN

53B-17-105. Utah Education and Telehealth Network.

UETN shall:

- in consultation with health care providers from a variety of health care systems, explore and encourage the **development** of telehealth services as a means of reducing health care **costs** and increasing health care **quality** and **access**, with emphasis on assisting rural health care providers and special populations; and in consultation with the Utah Department of Health, advise the governor and the Legislature on:
 - (i) the role of telehealth in the state;
 - (ii) the policy issues related to telehealth;
 - (iii) the changing telehealth **needs** and **resources** in the state; and
 - (iv) state budgetary matters related to telehealth.

INTRODUCTION

- We are in the middle of a global pandemic, which has reminded us there is great value in a technology enabled delivery model:
 - Protect the health of patients and providers by reducing the spread of infection
 - Continue to provide health care when limited face-to-face encounters are possible
- Telehealth is a delivery method and COVID-19 forced us to change our delivery method very quickly...up to 70% of medical encounters in April 2020 (+8,000% increase from 2019).
- Federal regulations regarding telehealth pre-COVID were restrictive of geography, type of service, type of provider & payment/reimbursement amount.



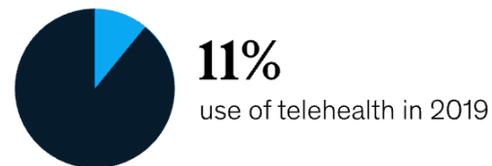
INTRODUCTION

- Payment has been a major barrier for a number of reasons and has resulted in numerous waivers and changes during the pandemic. Uncertain post-COVID future.
- Important to consider appropriateness (service and modality type) & quality of care measures
- Expansion of services: medical, dental, mental/behavioral health, school-based health, PT/OT, audiology & speech-language pathology, SUD treatment, nursing home care.

How has COVID-19 changed the outlook for telehealth?

1 Consumer

Shift from:



To:



While the surge in telehealth has been driven by the immediate goal to avoid exposure to COVID-19, with more than 70 percent of in-person visits cancelled,¹ 76 percent of survey respondents indicated they were highly or moderately likely to use telehealth going forward,² and **74 percent of telehealth users reported high satisfaction.³**

INTRODUCTION

Innovating from necessity

New Models of Virtual Care Delivery:

- Patient at home – Provider at home
 - No originating site/facility fee
- Provider at home – Patient at the clinic
 - Homeless population
 - Rural populations with poor internet access
- Provider at clinic in Room A – Patient at the clinic in Room B
 - Reduce risk of infection
- Patient in nursing home room with iPad – Provider in nursing home in private room.



EXECUTIVE SUMMARY

1. Multiple waivers in place for Medicare during PHE that remove restrictions for geography (urban), place of service (home), type of service (+280), type of provider (FQHC & RHC) & payment amount (audio only).
2. Utah has solid infrastructure in place for telehealth delivery including UETN backbone to over 1,600 locations, excellent healthcare systems who support rural hospitals, wide safety net, effective policies and regulations.
3. Policies that promote adoption of telehealth in rural areas are needed: rural provider to rural provider can increase access to specialty care and reduce cost, payment parity is critical. Originating site fee for rural areas (medical home).

EXECUTIVE SUMMARY

4. Gaps and barriers still exist and include: broadband access, workforce education, patient education and ability to consume, payment parity, value-based payment system, quality measures, and interoperability of telehealth care delivery.
5. Vision for the future includes: increased access and reduced costs, workforce education, patient education, payment parity, value-based payment system, better defined appropriateness and quality measures, interoperability of telehealth care delivery.
6. UETN policy recommendations include: supporting broadband access and network development, payment parity, inclusion of telehealth in insurance plans, originating site fees, development of health care workforce education, school-based telehealth services, and patient/consumer education.

QUESTIONS?

AGENDA ITEMS

- Summary of federal changes and waivers during PHE
- Current infrastructure
- Current payment and delivery systems
- Gaps & barriers
- The vision of telemedicine
- Recommendations for legislative action

PRE COVID-19

- Pre-H.B. 313, no parity for coverage/services or payment
- Medicaid covered most services that were covered in-person
- Medicare:
 - Geographic limitations: Only covered if patient was in a **rural** location (HPSA or non-metropolitan statistical area) and certain originating sites.
 - Service limitations: did not include audio-only E&M visits
 - Provider limitations: Not covered by FQHC and RHC providers or PT/OT and speech-language pathologists.
 - Fee for Service facility-based payment rate
 - HIPAA privacy and security requirements enforced

DURING COVID-19

- State
 - Licensing (DOPL), out of state providers can use telehealth with patients in Utah.
 - HIPAA, security and privacy standards not enforced.
 - Medicaid: Any covered service, no geographic limitations, audio only, payment parity.
- Federal
 - No geographic restrictions for patients
 - No site limitations for patients (FQHC, RHC, Home), loss of facility fee.
 - No site limitations for providers (can be at home and don't have to use home address)
 - Modality (Live video, phone/audio only)
 - No limitations on the type of provider: all health care professionals who bill Medicare
 - 240 different codes added
 - Reimbursement same as in-person (fee-for-service rate)
 - Hospitals can bill originating site fee when patient is at home
 - Supervision/Practice Top of Licensure



Top Five Procedure Codes by Utilization, 2019 vs. 2020

In order from most to least common

Apr. 2019

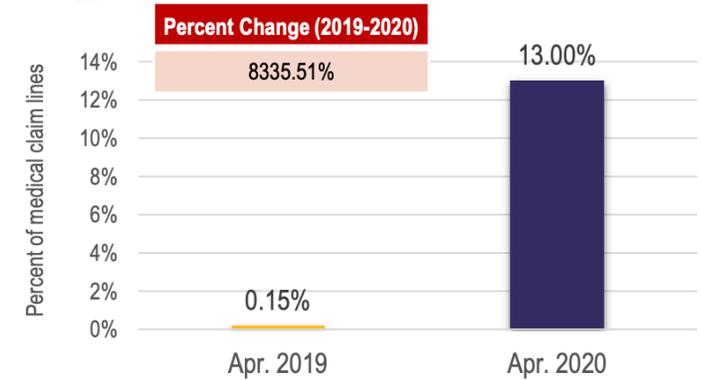
CPT®/HCPCS	DESCRIPTION
99441	PHYSICIAN TELEPHONE PATIENT SERVICE, 5-10 MINUTES OF MEDICAL DISCUSSION
98960	EDUCATION AND TRAINING FOR PATIENT SELF-MANAGEMENT, EACH 30 MINUTES
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 15 MINUTES
99444*	PHYSICIAN OR HEALTHCARE PROFESSIONAL EVALUATION AND MANAGEMENT OF PATIENT CARE BY INTERNET (EMAIL) RELATED TO VISIT WITHIN PREVIOUS 7 DAYS
99201	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES

Apr. 2020

CPT®/HCPCS	DESCRIPTION
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 15 MINUTES
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 25 MINUTES
90837	PSYCHOTHERAPY, 60 MINUTES
90834	PSYCHOTHERAPY, 45 MINUTES
99442	PHYSICIAN TELEPHONE PATIENT SERVICE, 11-20 MINUTES OF MEDICAL DISCUSSION

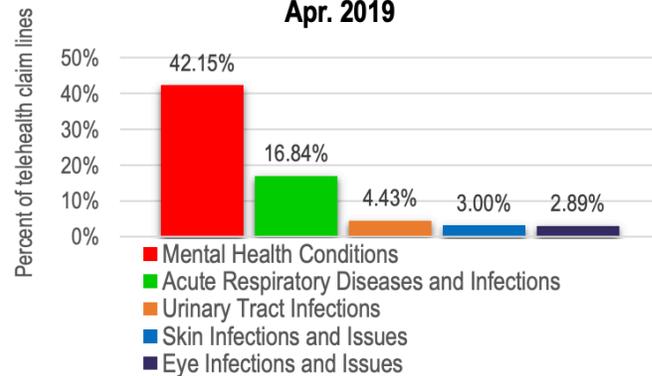


Volume of Claim Lines, 2019 vs. 2020

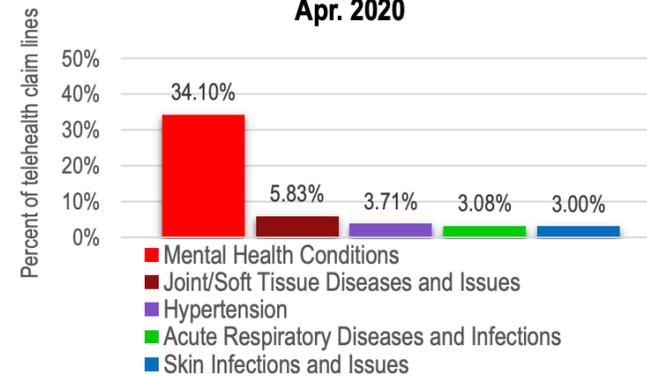


Top Five Diagnoses, 2019 vs. 2020

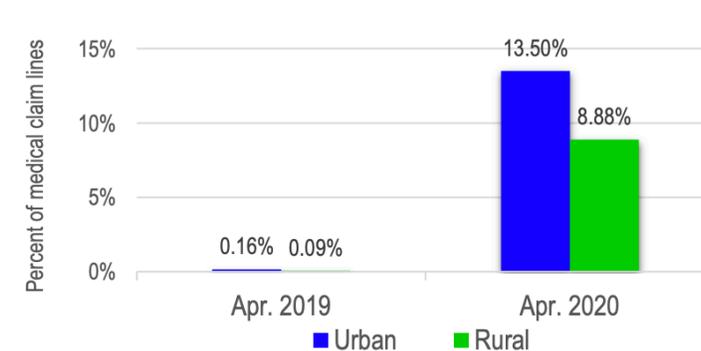
Apr. 2019



Apr. 2020



Urban vs. Rural Usage, 2019 vs. 2020



* Code deleted at the end of 2019.

Source: FH NPIC® database of more than 31 billion privately billed medical and dental claim records from more than 60 contributors nationwide. Copyright 2020, FAIR Health, Inc. All rights reserved. CPT © 2019 American Medical Association (AMA). All rights reserved.

POST COVID

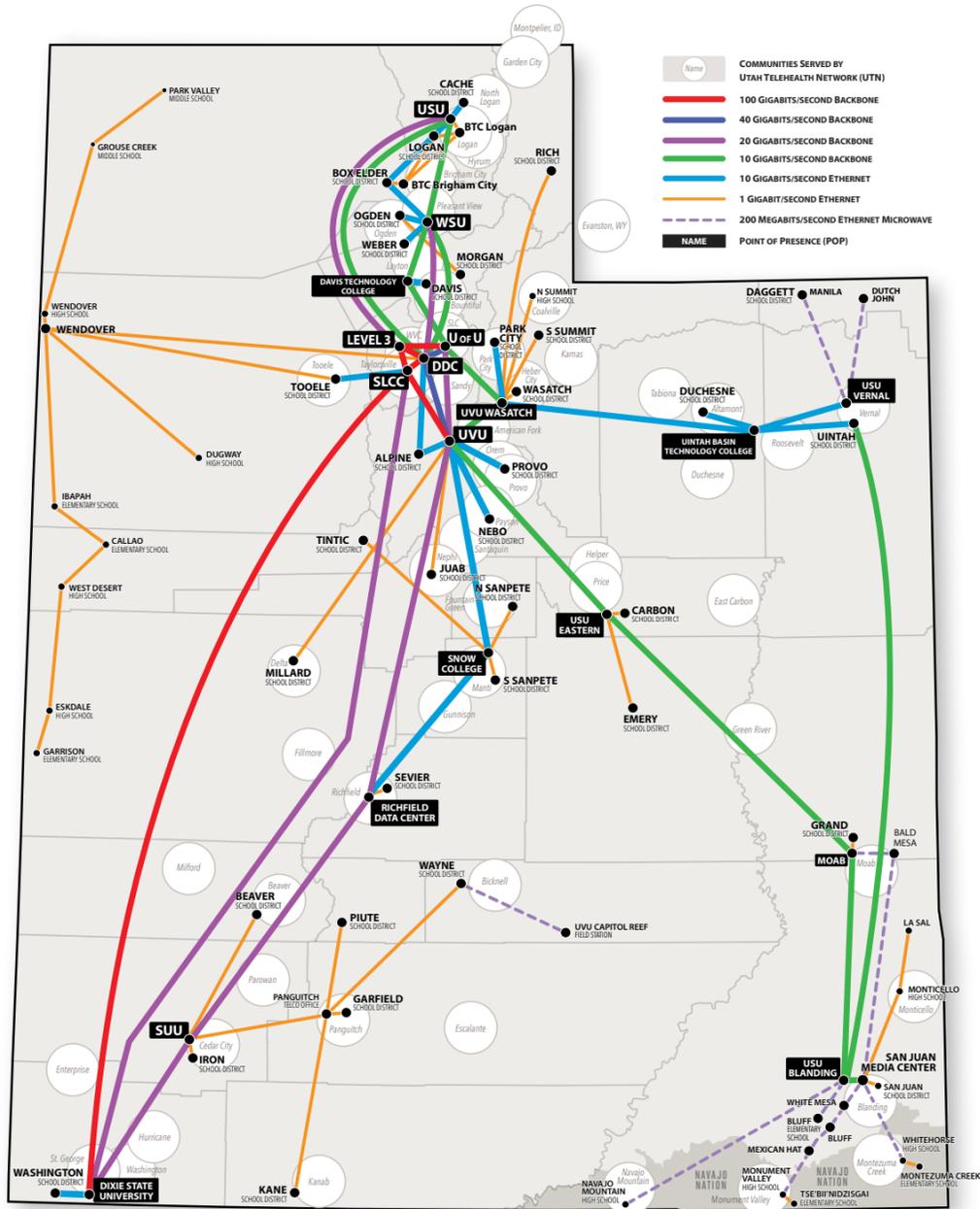
- Telehealth can expand access to care and reduce costs relative to in-person care.
 - Leverage telemedicine services: clinical care, **health education, health administration, home health, self-managed-care and caregiver support, remote patient monitoring** (UT code, 26-60-102)
- Important to consider a value-based payment system, appropriateness and quality.
- Federal waivers may be kept in place until December 2021 to give enough time for a robust evaluation.
- Certain waivers will be hard to roll back such as allowing FQHCs and RHCs to bill as a distant site.
- HIPAA privacy and security will likely return.

CURRENT INFRASTRUCTURE

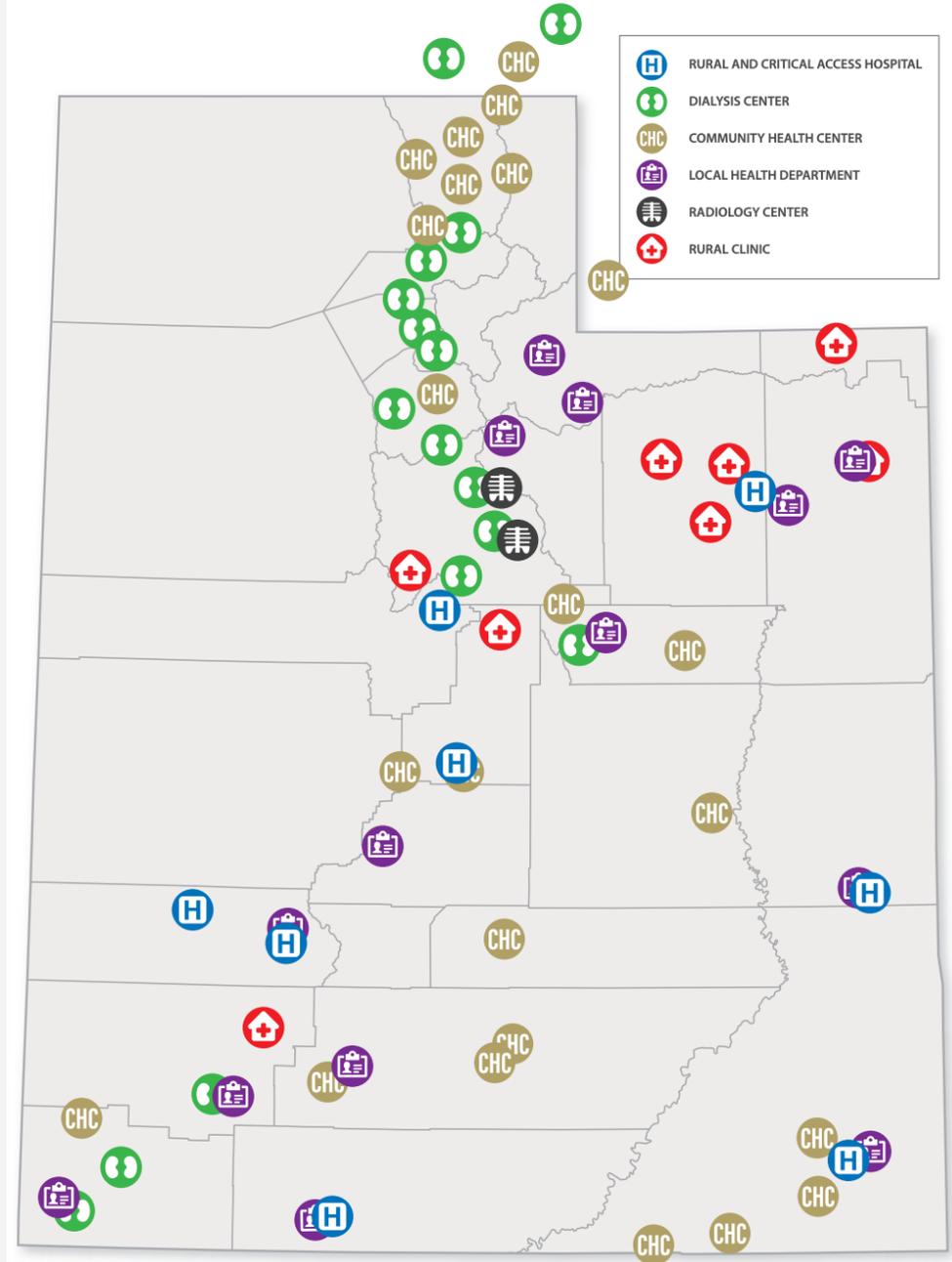
- UETN Infrastructure (Health care and Education)
 - Rural hospitals, clinics (FQHC & RHC), LHDs, U of U Dialysis (70+ locations)
 - K-12 schools (1,130 locations)
 - Colleges, Universities, Technical Colleges (16 locations)
 - Utah Public Libraries (134 locations)
- Telehealth Services in Rural Hospitals
 - Intermountain (Oncology, Dermatology, Critical Care, Hospitalist, Crisis Care)
 - U of U (Tele-Burn, Tele-Stroke, Tele-ICU, Tele-Behavioral Health)
- Behavioral Health
 - Local MH Authorities
 - Crisis access in hospital vs at home
 - SUD care

UETN Infrastructure Map

Connecting 1600+ locations throughout Utah



Health Care Facilities



PAYMENT AND DELIVERY SYSTEMS

- H.B. 313 – Telehealth Parity
 - Coverage Parity
 - Payment: “commercially reasonable rate” needs to be defined (consider direct and indirect costs and quality)
 - Medical home is important for quality control and continuity of care
- Who pays for what?
 - Medicare
 - Medicaid
 - Private payers
- Who can deliver what services?
 - Direct-to-consumer
 - Provider-to-provider
 - Nursing home
 - School-based care

GAPS AND BARRIERS

- Broadband access/infrastructure (healthcare facilities and to the home)
- Patient satisfaction, education, and ability to consume telehealth
- Payment (complexity and parity)
- Standardized processes and protocols (quality control)
- Site of service (originating site vs. distant site)
- Special populations (rural, nursing homes, low income, race and language spoken)

VISION OF TELEMEDICINE

1. Increase broadband access/infrastructure
2. Improved patient education, satisfaction, and ability to consume
3. Multiple modalities (synchronous/live video, asynchronous/store and forward, RPM, phone)
4. Both coverage and payment parity
5. Improved quality & appropriateness of care
6. Interoperability of telehealth care delivery (continuity of care)

All six lead to health equity, improved access and quality

POLICY RECOMMENDATIONS

Regulatory

- Payment parity: define “commercially reasonable rate” more clearly. Equal rate.
- Healthcare workforce education/training in telehealth
- 3rd party payer plans should allow in-network providers to be able to use telehealth and pay them what they would have received had they done it in person.
- School-based telehealth (medical, dental, mental/behavioral health, audiology, SLP, vision.)
- Quality & cost metrics

Appropriation

- Broadband infrastructure (including privacy and security)
- School-based telehealth, including equipment for schools
- Patient/consumer education

SUPPLEMENTAL INFORMATION

Interstate Compacts

- Utah is a member of the interstate medical licensure compact.

Source:[Interstate Medical Licensure Compact. \(Accessed Feb. 2020\).](#)

- Member of Psychology Interjurisdictional Compact.

Source:[PSYPACT. \(Accessed Feb. 2020\).](#)

- Member of the Nurse Licensure Compact.

Source:[Nurse Licensure Compact \(Accessed Feb. 2020\).](#)

- Member of the Physical Therapy Licensure Compact.

Source:[PT Compact. Compact Map. \(Accessed Feb. 2020\).](#)

QUALITY AND COST METRICS

- Percent of total in-person visits vs. telehealth visits
- Percent of telehealth visits that are medical vs. mental/behavioral health
- Most common codes used for telehealth visits
- Urban vs. rural use of telehealth
- Cost difference between in-person and telehealth for basic codes
- Quality: Antibiotic prescriptions in-person vs. telehealth
- Patient location: home, FQHC, RHC, CAH, clinic, hospital, etc.

Utah Professional Regulation/Health & Safety Cross State Licensing

- An out-of-state physician may practice without a Utah license if:
- The physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience;
- The services are rendered as a public service and for a noncommercial purpose;
- No fee or other consideration of value is charged, expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance; and
- The physician does not otherwise engage in unlawful or unprofessional conduct.
- **Source:**[UT Code Annotated Sec. 58-67-305\(7\). \(Accessed Feb. 2020\).](#)

A mental health therapist licensed in another state and in good standing can provide short term transitional mental health therapy remotely if:

- The mental health therapist is present in the state where he/she is licensed;
- The client relocates to Utah, and was a client immediately before the relocation;
- The therapy or counseling is provided for a maximum of 45 days after the client relocates;
- Within 10 days of the client's relocation, the mental health therapist provides a written notice to the Division of Occupational and Professional Licensing of their intent to provide therapy/counseling remotely; and
- The mental health therapist does not engage in unlawful or unprofessional conduct.
- **Source:**[UT Code, 58-61-307\(k\) \(Accessed Feb. 2020\).](#)

Utah Private Payer Laws Requirements

- All health insurance plans must disclose whether the insurer provides coverage for telehealth services in accordance with section 26-18-13.5 and terms associated with that coverage.

Source: [UT Code 31A-22-613.5\(2\)\(f\)](#). (Accessed Feb. 2020).

- A health benefit plan that offers coverage for mental health services shall: Provide coverage for telepsychiatric consultation during or after an initial visit between the patient and a referring in-network physician;
- Provide coverage for a telepsychiatric consultation from an out-of-network board certified psychiatrist if the consultant is not made available to a physician within seven business days after the initial request is made by an in-network provider; and
- Reimburse for the services at the equivalent of the in-network or out-of-network rate set by the benefit plan after taking into account cost-sharing that may be required under the health benefit plan.
- An insurer can also meet the requirement to cover telepsychiatric consultation for a patient by providing coverage for behavioral health treatment (see statute for details).

Source: [UT Code, 31A-22-649](#). (Accessed Feb. 2020).

Utah Professional Regulation/Health & Safety Online Prescribing

Before providing treatment or prescribing a prescription drug, provider must:

- Obtain and document patient's relevant clinical history and current symptoms

Source: [UT Code, 26-60-103\(b\). \(Accessed Feb. 2020\).](#)

- Providers must first obtain information in the usual course of professional practice that is sufficient to establish a diagnosis, to identify conditions, and to identify contraindications to the proposed treatment; or with prescriptive authority conferred by an exception issued under this title, or a multi-state practice privilege recognized under this title, if the prescription was issued without first obtaining information, in the usual course of professional practice, that is sufficient to establish a diagnosis, to identify underlying conditions, and to identify contraindications to the proposed treatment.

Source: [UT Code, 58-1-501\(2\(m\)\). \(Accessed Feb. 2020\).](#)

Utah Professional Regulation/Health & Safety Miscellaneous

- If a hospital participates in telemedicine, it shall develop and implement policies governing the practice of telemedicine in accordance with the scope and practice of the hospital.
- These policies shall address security, access and retention of telemetric data, and define the privileging of all health professionals who participate in telemedicine.

Source: [UT Admin. Code R432-100-33. \(Accessed Feb. 2020\).](#)