MEDICAL ALLEY ASSOCIATION

State Telehealth Policy Framework

INTRODUCTION

Medical Alley has always been at the forefront of healthcare transformation; the unique makeup of the Medical Alley ecosystem facilitates opportunities to innovate and collaborate that cannot be found elsewhere. Healthcare professionals and patients from around the world rely on Medical Alley's leadership to identify and drive the developments defining the future of healthcare.

The transformation of healthcare delivery through the use of telehealth is no different. With a strong digital health industry, collaborative care delivery models, as well as providers and plans committed to improving the value of care, Medical Alley was already leading the enhanced integration and adoption of telehealth prior to the pandemic — leadership that was critical for the entire country as the COVID-19 pandemic evolved.

This framework is another chapter in Medical Alley's history of leadership and identifies opportunities for policymakers in Minnesota to build on Medical Alley's legacy of foresight in telehealth policy. By ensuring state law does not unnecessarily restrict innovation in care delivery, policymakers will promote increased access, lower costs, and improved outcomes for people throughout the state.

THIS FRAMEWORK PROVIDES POLICYMAKERS WITH A LENS THROUGH WHICH TO ANALYZE EXISTING AND FUTURE TELEHEALTH POLICIES

BACKGROUND

Although telehealth has been touted as the future of healthcare for decades, the COVID-19 pandemic accelerated this telehealth revolution in just a few months.[1] Before the pandemic, telehealth had high potential to transform care models, yet only 14% of Americans had participated in a telemedicine visit at least once.[2] But when the novel coronavirus came to the United States, policymakers eased regulations to encourage the use of telemedicine by patients in all locations, and the number of Americans who reported having participated in at least one telehealth visit increased by 57%.[2] By early April, just one month after the federal government and most states had declared a state of emergency, telemedicine accounted for 69% of health visits, and the home had become a hub of healthcare delivery. [3,4]

Telehealth played a critical role in the beginning of the response to the pandemic by helping reduce the spread of COVID-19 and lessen the strain on hospital systems by minimizing the surge of patient demand on facilities and equipment. [5] Nearly half of Americans have chronic conditions, and many needed non-virus-related care throughout the

pandemic.[1] Telehealth helped patients with chronic illnesses or other non-virus-related problems to continue their care plans without increasing their risk of infection.[5]

Looking ahead, telehealth has the strong potential to provide value beyond the pandemic. In most cases, telehealth drives down the cost of care by decreasing hospital admissions, reducing opportunity costs, and improving management of chronic diseases.[6] Critically, telehealth also improves patient engagement and satisfaction, ultimately leading to better clinical outcomes, as telehealth is convenient and allows patients to receive care in the comfort of their own homes. [5,7,8,9] It offers a new means to locate health information, communicate with practitioners, and access follow-up care.[5]

Despite these positives, too many seniors, people of color, and low-income individuals have reduced access to the internet, less technological expertise, or face other language, cultural, or social barriers limiting their ability to access and use telehealth.[10] Health equity must be a focus of efforts to expand telehealth and a key consideration when performing outreach during and beyond the pandemic.[11]

> HEALTH EQUITY MUST BE A FOCUS OF THE EFFORTS TO EXPAND TELEHEALTH

Many state and federal telehealth policy changes are temporary, ending after relevant public health emergencies (PHEs) subside, prompting the question: What policy changes should be made permanent and what policy changes are still needed? Further, as a result of PHEs, the expanded use and awareness of how telehealth can be integrated into care delivery has provided an opportunity to update and modernize state law so it does not prevent patients from receiving care in the most efficient and effective manner possible.

With a diverse cross-sector membership, the Medical Alley Association, as The Global Epicenter of Health Innovation and Care™, is uniquely positioned to provide insight and expertise to policymakers on the future of telehealth policy beyond the pandemic. The framework laid out here captures that insight and expertise and provides policymakers with a lens through which to analyze existing and future policies to ensure Medical Alley remains a leader in telehealth.

DISTINCTION BETWEEN 'TELEHEALTH' AND 'TELEMEDICINE'

- To avoid potential confusion between the terms "telehealth" and "telemedicine", it is helpful to set a clear understanding of how these terms will be used from the start. The Center for Connected Health Policy (CCHP) neatly differentiates between the two:

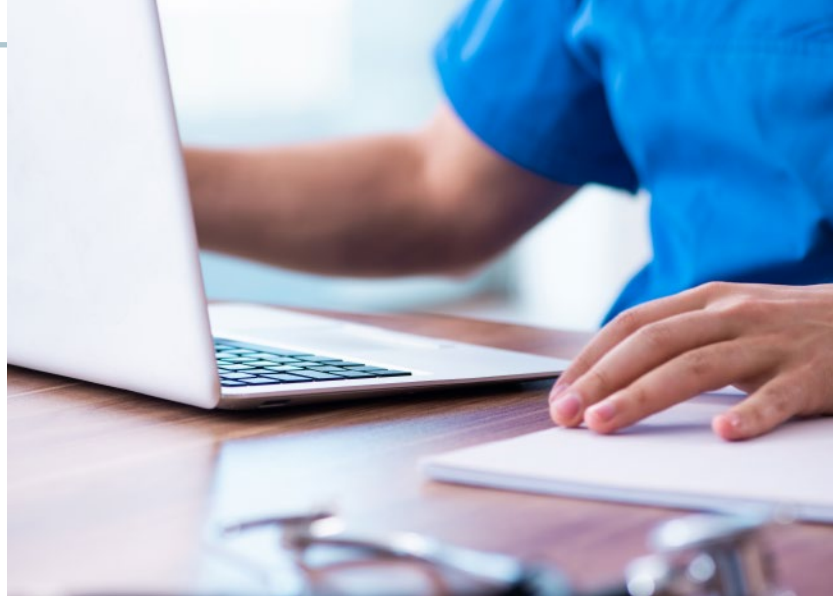
  > "'Telemedicine' is often still used when referring to traditional clinical diagnosis and monitoring that is delivered by technology. However, the term 'Telehealth' is now more commonly used as it describes the wide range of diagnosis and management, education, and other related fields of health care."[12]

- CCHP also provides distinctions between telehealth modalities, which are useful when considering or applying the framework laid out here.

1. Live Video Conferencing (synchronous)
2. Store-and-Forward (asynchronous)
3. Remote Patient Monitoring (RPM)
4. Mobile Health (mHealth)[12]

PRIMARY OBJECTIVE

This framework seeks to expand on Minnesota's legacy of leadership in telehealth by ensuring patients realize the benefit of the increased access, improved outcomes, reduced costs, and enhanced personalization telehealth can provide through the delivery of safe, secure, innovative, and high-quality care that is uninhibited by unnecessary state laws and regulations.



STATE TELEHEALTH POLICY FRAMEWORK

1 Allow patients to access safe and effective care from the most convenient location for them that does not compromise the quality of the care and ensures the safety of the patient

- Ensure that "place of residence" is an eligible originating site location so hotel rooms, domestic violence shelters, etc. are also eligible
- Fund broadband grants to ensure sufficient internet access in the home
- Create and fund grants for providers to help pay for in-home monitoring devices and/or internet access for patients in need

2 Provide and protect the flexibility to use the most effective care delivery methods available to manage and treat chronic or acute conditions to keep patients at home, resulting in lower costs through the avoidance of costly emergency room visits or hospital readmissions

- Specifically define and allow for the use of RPM[13]
- Permanently eliminate the "three visits per week" limitation for Medicaid patients
- Incentivize arrangements that provide "hospital in the home" services

3 Prevent unnecessary utilization of telehealth in care delivery, while retaining flexibility for willing patients to conveniently, safely, and securely access care through all eligible synchronous and asynchronous telehealth modalities

- Provide for coverage of telephonic (no A/V) delivery of certain telehealth services without imposing a blanket coverage mandate
- Enable flexibility in care coverage where geographic, socioeconomic, and other factors impact overall access to care
- Allow for arrangements that provide qualifying individuals living in designated areas to receive subsidized devices or broadband access as part of a care plan

4 Ensure sustainable payment for delivery of telehealth services without restricting innovation in care delivery while accruing as many benefits as possible for the patient, including lower costs, time saved, reduced work and transportation challenges, and improved outcomes

- Provide flexibility for payers and providers to agree on payment rates for care delivery via telehealth modalities
- Explicitly acknowledge that there are real and significant costs required to deliver telehealth services, but that not all care delivery provided via telehealth requires payment equal to a full in-person visit, such as Remote Patient Monitoring (RPM)
- Provide incentives for providers to invest in, and maintain, telehealth delivery services and technology

5 Continue the increased adoption and use of telehealth to treat all conditions – when medically appropriate – safely and effectively:

- **Regularly evaluating and expanding provider types eligible to deliver care via synchronous and asynchronous telehealth modalities; and**
- **Enabling access to digital devices and technology, such as artificial intelligence (AI), virtual coaching, and other asynchronous telehealth delivery modalities**

- Encourage the evidence-based use and growth of AI in "virtual coaching" and other care delivery
- Allow for medical staff (e.g., diabetes educators, pregnancy support) to use telehealth modalities to deliver care
- Enable the regular evaluations of who can provide care via telehealth and be responsive to areas of need, potentially through temporary expansions by the Department of Health; evaluations should consider efficacy of care, patient safety, and coverage/reimbursement eligibility

6 Identify opportunities to use telehealth to better understand, track, and approach social determinants of health (SDOH) impacting patients and more effectively provide access to the care or other assistance necessary to help meet their needs

- Establish public–private partnerships to aggregate and analyze de-identified data for trends or patterns in SDOH to better target efforts to expand access to care through telehealth modalities
- Examine the use of existing methods of documenting non-medical factors influencing a patient's health status, such as ICD-10-CM "Z-codes," and identify opportunities to increase their usage to improve the efficacy of their use in the coordination of patient care, development of care plans, and outreach to patients
- Ensure that neither state law nor regulations disincentivize the collection of SDOH information, nor its application within a patient's treatment or care plan

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Founded in 1984, the Medical Alley Association supports and advances the global leadership of Medical Alley's healthcare industry, and its connectivity around the world. MAA delivers the collective influence, intelligence, and interactions that support Medical Alley.

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