HB 123

Department of Legislative Services

Maryland General Assembly
2021 Session

FISCAL AND POLICY NOTE
Enrolled - Revised

House Bill 123 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations Finance

Preserve Telehealth Access Act of 2021

This bill expands the definitions of "telehealth" and the coverage and reimbursement requirements for health care services provided through telehealth for both Medicaid and private insurance. Insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) must reimburse for a covered service appropriately provided through telehealth, as specified. By December 1, 2022, the Maryland Health Care Commission (MHCC) must submit a report on the impact of providing telehealth services in accordance with the bill's requirements. **The bill takes effect July 1, 2021; the bill's insurance provisions apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Medicaid expenditures increase by $16.1 million (50% general funds, 50% federal funds) in FY 2022 and $32.2 million in FY 2023; federal fund revenues increase accordingly. MHCC special fund expenditures increase by $550,000 in FY 2022 and 2023 combined for contractual services that must be funded with available monies (in this case from fund balance). Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) in FY 2022 from the $125 rate and form filing fee; review of filings requires contractual assistance in FY 2022 only (not shown below). Any impact on the State Employee and Retiree Health and Welfare Benefits Program is not reflected. **This bill increases the cost of an entitlement program beginning in FY 2022.**

($ in millions)	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
FF Revenue	$8.1	$16.1	-	-	-
GF Expenditure	$8.1	$16.1	-	-	-
SF Expenditure	$0.2	$0.4	$0	$0	$0
FF Expenditure	$8.1	$16.1	-	-	-
Net Effect	($8.2)	($16.5)	($-)	($-)	($-)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: Potential increase in expenditures for some local governments to continue to reimburse for certain telehealth services. Revenues are not affected.

Small Business Effect: Meaningful.

Analysis

Bill Summary:

Medicaid

The bill repeals existing language regarding coverage of telemedicine, which is revised and recodified in the bill's new and expanded telehealth provisions.

"Telehealth" means the delivery of medically necessary somatic, dental, or behavioral health services to a patient at an originating site by a distant site provider through the use of technology-assisted communication.

"Telehealth" includes (1) synchronous and asynchronous interactions; (2) from July 1, 2021, through June 30, 2023, an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service; and (3) remote patient monitoring (RPM) services. "Telehealth" does not include the provision of health care services solely through an audio-only telephone conversation (with the exception of the temporary provision for fiscal 2022 and 2023), an email message, or a facsimile transmission.

Medicaid must (1) provide health care services appropriately delivered through telehealth to program recipients regardless of their location at the time telehealth services are provided and (2) allow a "distant site provider" to provide health care services to a recipient from any location at which the services may be appropriately delivered through telehealth.

Telehealth services provided to Medicaid recipients must include counseling and treatment for substance use disorders (SUDs) and mental health conditions.

Medicaid may undertake utilization review to determine the appropriateness of any health care service, whether delivered in person or through telehealth, if the appropriateness of the health care service is determined in the same manner.

Medicaid may not (1) exclude from coverage a health care service solely because it is provided through telehealth and not in person; (2) exclude from coverage a behavioral health care service provided in person solely because the service may also be provided

through telehealth; or (3) distinguish between program recipients in rural or urban locations in providing coverage for health care services delivered through telehealth.

Medicaid must reimburse a health care provider for the diagnosis, consultation, and treatment of a program recipient for a health care service that can be appropriately provided through telehealth. Reimbursement is not required for a health care service that is not a covered service or is delivered by an out-of-network provider (unless the service is an authorized self-referred service).

From July 1, 2021, through June 30, 2023, Medicaid must provide reimbursement for services appropriately provided through telehealth on the same basis and at the same rate as if the health care service were delivered in person. Reimbursement does not include (1) clinic facility fees, except as specified or (2) any room and board fees.

The Maryland Department of Health (MDH) may adopt regulations to carry out the bill and may specify in regulation the types of health care providers eligible to receive reimbursement for telehealth. Any such regulations must include all types of health care providers that appropriately provide telehealth services.

Medicaid or a managed care organization may not impose as a condition of reimbursement of a covered health care service delivered through telehealth that the health care service be provided by a third-party vendor designated by Medicaid.

MDH must obtain any federal authority necessary to implement the bill, including applying to the federal Centers for Medicare and Medicaid Services for an amendment to any of the State's § 1115 waivers or the State Plan.

By October 1, 2021, MDH must revise Medicaid telehealth regulations to ensure that requirements for reimbursement of mental health and SUD services delivered through telehealth comply with the federal Mental Health Parity and Addiction Equity Act.

Health Insurance

The definition of "telehealth" is expanded to include, from July 1, 2021, through June 30, 2023, an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service.

The health care services appropriately delivered through telehealth must include counseling and treatment for SUDs and mental health conditions.

A carrier must reimburse for health care services appropriately delivered through telehealth regardless of the location of the patient at the time telehealth services are provided. A

carrier may not exclude from coverage or deny coverage for a behavioral health care service that is a covered benefit when provided in person solely because the behavioral health care service may also be provided through a covered telehealth benefit.

From July 1, 2021, through June 30, 2023, a carrier must provide reimbursement for a health care service appropriately provided through telehealth on the same basis and at the same rate as if the health care service were delivered in person. Reimbursement does not include (1) clinic facility fees, except as specified or (2) any room and board fees.

A carrier may not impose as a condition of reimbursement for a covered telehealth service that the service be provided by a third-party vendor designated by the carrier.

Reporting Requirements

The bill repeals the requirement that MDH, by December 1, 2021, study and report on whether SUD services may be appropriately provided through telehealth to a patient in the patient's home setting.

By December 1, 2022, MHCC, in consultation with specified entities, must submit a report to the Senate Finance Committee and the House Health and Government Operations Committee on the impact of providing telehealth services in accordance with the bill's requirements. The report must include (1) specified analyses; (2) a study of the alignment of telehealth with new models of care; (3) an assessment of the efficiency and effectiveness of telehealth services and in-person visits (including a survey of health care providers); (4) an assessment of patient awareness of and satisfaction with telehealth coverage; (5) specified reviews of the appropriateness of telehealth across the continuum of care, inclusion of clinic hospital fees in telehealth reimbursement, and the use of telehealth to satisfy network access standards; and (6) study or analysis of any other issues identified by MHCC. MHCC must complete the report using research methods appropriate for the issues identified and available funding.

The bill expresses the intent of the General Assembly that, until completion of the required MHCC report, and no later than June 30, 2023, Medicaid and carriers must continue to reimburse health care providers for covered health care services provided through audio-only and audio-visual technology in accordance with the requirement of the bill and other specified orders; for Medicaid, all applicable executive orders and waivers issued in accordance with Chapters 13 and 14 of 2020, and for carriers, all applicable accommodations made by carriers during the Declaration of State of Emergency and Existence of a Catastrophic Health Emergency – COVID-19.

The bill also expresses legislative intent that (1) MHCC use the data collected from utilization and coverage of telehealth during fiscal 2022 and 2023 (although the report is

due December 1, 2022, only halfway through fiscal 2023) to complete the required report and (2) the State use the report to establish comprehensive telehealth policies for implementation after the Declaration of State of Emergency and Existence of a Catastrophic Health Emergency – COVID-19 expires.

MIA must study (1) how telehealth can support efforts to ensure health care provider network sufficiency and (2) the impact of changes in access to and coverage of telehealth services under health benefit plans offered by carriers on the ability of consumers to choose in-person care versus telehealth care. MIA must provide any findings and recommendations to MHCC for inclusion in the MHCC report due December 1, 2022, and consider the requirements of the bill when proposing any revisions to regulations relating to network adequacy.

Current Law:

Medicaid and Telehealth

Under § 15-103 of the Health-General Article, subject to the limitations of the State budget, Medicaid must provide mental health services appropriately delivered through *telehealth* to a patient in the patient's home setting. "Telehealth" does not include the provision of health care services solely through audio-only telephone calls, electronic mail messages, or facsimile transmissions.

Under § 15-105.2 of the Health-General Article, to the extent authorized by federal law or regulation, coverage of and reimbursement for health care services delivered through *telemedicine* must apply to Medicaid and managed care organizations in the same manner they apply to carriers. Subject to the limitations of the State budget and to the extent authorized by federal law, MDH may authorize coverage of and reimbursement for health care services that are delivered through store-and-forward technology or RPM.

MDH may specify by regulation the types of health care providers eligible to receive reimbursement for telemedicine health care services provided to Medicaid recipients. If MDH does so, the types of providers must include primary care providers, and psychiatrists and psychiatric nurse practitioners who provide Assertive Community Treatment or mobile treatment services to Medicaid recipients in a home or community-based setting.

All Medicaid participants are eligible to receive telehealth services. Telehealth services are subject to the same program restrictions, requirements, and other limitations as services provided in person. Telehealth providers must be enrolled as a Medicaid provider to be reimbursed; however, certain originating site providers may participate even though they are not eligible to enroll as a Medicaid provider. Medicaid allows all distant site provider types to participate and provides coverage for RPM for chronic conditions.

Private Insurance Coverage and Telehealth

"Telehealth" means the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service at a location other than the location of the patient. "Telehealth" does not include audio-only telephone calls, electronic mail messages, or facsimile transmissions.

Carriers must provide coverage under a health insurance policy or contract for health care services appropriately delivered through telehealth (including counseling for substance use disorders). Carriers may not exclude from coverage a health care service solely because it is provided through telehealth and is not provided through an in-person consultation or contact between a health care provider and a patient.

A carrier must reimburse a health care provider for a covered service provided through telehealth. A carrier is not required to reimburse a health care provider who is not a covered provider under the health insurance policy or contract.

A carrier may impose a deductible, copayment, or coinsurance amount on benefits for health care services delivered either through an in-person consultation or through telehealth. A decision by a carrier not to provide coverage for telehealth constitutes an adverse decision.

Telehealth Coverage during COVID-19

Emergency legislation, Chapters 13 and 14 of 2020, authorized the Governor, for the duration of the COVID-19 public health emergency (PHE) to, among other things, establish or waive telehealth protocols and order MDH to reimburse certain Medicaid telehealth services for COVID-19 patients.

Executive orders from the Governor and waivers from federal requirements increased Medicaid coverage for telehealth services, while the federal Coronavirus Aid, Relief, and Economic Security Act and federal regulatory changes increased Medicare coverage. Expanded coverage includes coverage for telehealth services (1) originating at a participant's home or other secure location; (2) delivered by audio-only technology, including by phone; and (3) delivered by technology that is not compliant with the federal Health Insurance Portability and Accountability Act (HIPAA). These expansions will terminate with the end of COVID-19 emergency orders unless extended through additional executive orders or legislation.

While State and federal law exclude audio-only (telephone call) telehealth visits from insurance coverage, these visits are currently covered under federal and State emergency health declarations. Carriers have expanded telehealth coverage to additional systems and

platforms, additional provider and service types, and telephone-only consultations. Additionally, carriers have waived cost-sharing for telehealth visits and provided reimbursement parity between virtual and in-person consultations. Accommodations have varied by carrier, however, and carriers have indicated that some expanded coverage will be terminated or reduced at the end of the federal and State PHEs.

State Fiscal Effect:

Audio-only Services for Dual-eligibles

Medicaid provides coverage for individuals who are dually eligible for both Medicare and Medicaid (dual-eligibles). During the PHE, Medicare has covered audio-only telehealth through waivers. However, this coverage is set to expire at the end of calendar 2021, as Medicare is prohibited from covering a service that can be a substitute for an in-person visit after the pandemic. In the absence of Congressional action to make Medicare coverage for audio-only telehealth permanent, Medicaid must cover the full cost of any services delivered to dual-eligibles that are not covered by Medicare.

Thus, to the extent Medicare coverage of audio-only telehealth coverage ends, Medicaid expenditures increase by an estimated $16.1 million (50% general funds, 50% federal funds) in fiscal 2022 to cover 100% of the cost of audio-only telehealth services for dual-eligibles (rather than 20%) effective January 1, 2022. Federal fund revenues increase accordingly. This estimate is based on the following information and assumptions:

- As Medicare is currently covering audio-only services, data is not available from the period of the PHE to specifically estimate potential costs; thus, a proxy is used.

- The total annual cost for services to dual-eligibles (including behavioral and somatic health services) that could be delivered via audio-only telehealth are estimated at $805.3 million (this excludes inpatient services and other expenditures unlikely to be provided via audio-only).

- Approximately 5% of these services will be provided via audio-only and are estimated to cost 5% of the total for all services ($40.3 million).

- Medicaid currently pays 20% of Medicare services ($8.1 million).

- Thus, Medicaid incurs an additional 80% of these costs ($32.2 million), as Medicare will no longer cover audio-only services.

Medicaid expenditures increase by $32.2 million (50% general funds, 50% federal funds) to reflect a full year of services in fiscal 2023. Future year expenditures are indeterminate

and depend on the findings of the MHCC report required under the bill and the comprehensive telehealth policies the State must establish and implement after the Declaration of State of Emergency and Existence of a Catastrophic Health Emergency – COVID-19 expires.

Previous MDH estimates on telehealth legislation included projected impacts on utilization; however, no such information was provided for this analysis and any utilization impact has not been accounted for in the estimate.

MDH can revise Medicaid telehealth regulations to ensure that requirements for reimbursement of mental health and SUD services delivered through telehealth comply with federal parity law using existing budgeted resources.

Maryland Health Care Commission

By December 1, 2022, MHCC must conduct multiple analyses and submit a substantial report to specified committees of the General Assembly on the impact of providing telehealth services in accordance with the bill's requirements. The bill specifies that MHCC must complete the report using available funding.

Given the breadth and depth of analysis required to produce the report, contractual services are required. Thus, MHCC advises that special fund expenditures increase by a total of $550,000 over fiscal 2022 and 2023 (approximately $181,500 in fiscal 2022 and $368,500 in fiscal 2023) to complete the required report. MHCC further advises that sufficient fund balance is available to cover these costs. While the balance in the MHCC Fund at the close of fiscal 2020 was $6.2 million, it is projected to be $682,128 at the close of fiscal 2022.

Maryland Insurance Administration

Special fund revenue increase minimally for MIA in fiscal 2022 from the $125 rate and form filing fee; review of filings requires contractual assistance in fiscal 2022 only. However, MIA can perform the studies required, provide any findings and recommendations to MHCC, and consider the bill's requirements when proposing any revisions to regulations relating to network adequacy using existing budgeted resources.

Small Business Effect: Health care providers can receive reimbursement for telehealth services provided through audio-only conversations through fiscal 2023. Carriers must reimburse health care providers for telehealth services on the same basis and at the same rate as if the service were delivered in person.

Additional Comments: MHCC convened a Telehealth Policy Workgroup in 2020 to discuss select telehealth policy changes temporarily implemented in response to the

COVID-19 PHE and consider policies that should continue beyond the PHE. The workgroup's draft general findings include key categories of (1) removing telehealth restrictions on originating sites; (2) permitting audio only when the treating provider determines it to be safe, effective, and clinically appropriate; (3) removing telehealth restrictions on conditions that can be treated; (4) removing telehealth restrictions on provider types; (5) reducing or waiving cost-sharing through the later of the end of the PHE or December 31, 2021; and (6) reinstating technology standards that require providers to use HIPAA-compliant technology.

Additional Information

Prior Introductions: None.

Designated Cross File: SB 3 (Senator Griffith, *et al.*) - Finance.

Information Source(s): Maryland Insurance Administration; Maryland Department of Health; Department of Legislative Services

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