ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

September 20, 2019

Submitted by email to: susan.dunkin@alaska.gov

Dear Ms. Dunkin,

The Alaska State Hospital and Nursing Home Association (ASHNHA) is submitting comments on the Department of Health and Social Services regulations on proposed changes on Medicaid telemedicine services coverage & payment.

ASHNHA is opposed to a number of the proposed changes to the regulations and believe these changes will limit access to telemedicine services for Medicaid recipients and create significant challenges for rural and critical access hospitals to serve rural residents. ASHNHA is concerned that the direction of the regulations is not in alignment with telehealth provisions included in SB74 Medicaid reform legislation passed in 2016.

We support the expansion of behavioral health services that can be provided through telemedicine. Access to behavioral health is a significant challenge and allowing additional services to be paid for could make a big difference in access to care. However, some of the other provisions decrease the likelihood that access will be realized as outlined below.

Summary of concerns:

- Proposed changes could reduce access to care for Medicaid recipients and hamper new models designed to improve care and reduce cost. Proposed regulations may not support Medicaid Reform legislation (SB74) requirements and new definition/scope of telemedicine may conflict with Sec. 47.05.270.
- Removing store and forward and self-monitoring services will reduce access to important services and potentially increase costs to the Medicaid program by requiring direct contact with a provider even when not necessary.
- Removing presenting provider will limit local provision of telemedicine services especially for rural hospitals and clinics. The removal of 7 AAC 135.290 facilitation of a telemedicine session will make it more difficult for a provider or clinic to facilitate behavioral health services.
- Adding a requirement related to Health Professional Shortage Area will limit non-tribal critical access hospitals and larger urban facilities from providing telemedicine services to their community while allowing anyone from outside the community or state to provide services. This will hamper care coordination, continuity of care and increase the financial vulnerability of rural hospitals by not allowing them to serve their own community.
- The regulation introduces potentially onerous documentation requirements that will add to the burden without clear benefit.

- Regulation changes could allow expanded delivery of telemedicine services by out of state providers directly to Medicaid recipients in their home with no coordination of care by local providers. This could both increase costs to the Medicaid program and reduce quality and continuity of care.

Overall, we are concerned that there has not been adequate analysis of data to understand cost and utilization of telemedicine services for Medicaid recipients prior to changing how Medicaid covers telehealth services. Will these changes save the program money or add to the cost of the program? Will access services in rural areas be expanded or restricted. Without analysis we have no idea and must express our concern.

Our concerns are outlined in detail below.

1. **SB 74 Medicaid Reform legislation (2016) included specific requirements for DHSS related to telehealth.** The legislation included the following;
   - Requires the Medicaid program to expand the use of telehealth for primary care, behavioral health, and urgent care. (Section 43)
   - Identify areas of the state where improvements in access to telehealth would be most effective in reducing Medicaid costs and improving access to care for Medicaid recipients;
   - Improve access to telehealth for recipients in those locations; and,
   - enter into agreements with Indian Health Service providers, if necessary, to improve access by medical assistance recipients to telehealth facilities and equipment. (Sec. 43)
   - Requires DHSS to include in an annual report on Medicaid reform to the legislature information on the legal and technological barriers to expanded use of telehealth, improvements in the use of telehealth in the state, and recommendations for changes or investments that would allow cost-effective expansion of telehealth. (Section 43)
   - Allows DHSS to increase the capability for and reimbursement of telehealth for Medicaid recipients. (Section 45)
   - Requires the Department of Health & Social Services to identify legal or cost barriers preventing the expanded use of telehealth and recommend remedies for identified barriers. (Section 46)

In reviewing the draft regulations, there is no evidence that the DHSS is focusing on regulation changes that will support these requirements. Based on our review of the proposed regulations we have concerns that the changes could limit access to care and are not focused on "cost-effective expansion of telehealth".

The Medicaid Redesign Telehealth Stakeholder Workgroup met many times and a report with recommendations was created. The proposed regulations do not appear to incorporate or show consideration of these recommendations. The document is found here: http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/MCDRE_Telehealth_Workgroup_Report.pdf

2. **Amend the modes of delivery and the type of services for which the department will pay.** We are concerned about removing store and forward and self-monitoring services. Some medical services (example dermatology or EEG) can be provided in a cost-effective way using a store and forward delivery. No rationale is provided for why audiologic and radiologic interpretation of digital images, sounds or video recordings are covered, but other clinical services that rely on EEGs, ECG tracings, ear or skin images, etc, are not covered.

   Requiring direct real-time contact with a provider for services that could be provided through store and forward asynchronous telemedicine could increase cost and restrict access to care.

   Remote patient monitoring (self-monitoring) is an emerging way to care for people with chronic health conditions and to reduce readmissions. Eliminating this option could increase costs by removing a lower cost way to monitor a patient at home. Many managed care programs are beginning to rely on these methods of providing care to reduce costs and meet patient needs.

   We are concerned about the removal of "a consultation made to confirm a diagnosis" from the type of services covered. Paying for a consultation to confirm diagnosis or get a second opinion by telemedicine prior to treatment seems like a cost-effective service and a way to improve quality of care.

3. **7 AAC 110.630. Conditions for payment - Removing presenting provider and limiting payment to the distant provider**
   Removing presenting provider will limit local provision of telemedicine services especially for rural hospitals and clinics. Currently a minimal "presentation fee" for a live video encounter provides a small amount of reimbursement to support the presenting site in covering costs associated with providing access to telemedicine. Without this reimbursement, presenting providers will be less able to support telemedicine services.

4. **Include a requirement related to a Health Professional Shortage Area**.
   We are very concerned about the provision that "services can only be provided through telemedicine by "a provider located in the same community as the patient is located only if the location is a federally designated Health Professional Shortage Area (HPSA)." This is will limit the services facilities can provide in their local communities and is especially bad for non-tribal rural facilities. The existing HPSA designation criteria has many problems for rural critical access hospitals that are not operated by a tribal organization. The result of this requirement will be that facilities cannot provide services to patients in their own community while allowing providers from outside the community or the state to directly serve the Medicaid recipients. This does not support good care coordination or continuity.

5. **New documentation requirements**. The regulation introduces potentially onerous documentation requirements such that providers must include within the EHR: a statement

that the service was provided using telemedicine; the address location of the patient; the address location of the provider; the method of telemedicine used; and the names of all persons participating in the telemedicine service and their role in the encounter. There is a lack of clarity on what documentation can be auto-populated on billing forms versus what the provider needs to document themselves in their note.

6. **Removal of 7 AAC 135.290 Facilitation of a telemedicine session.** This will make it more difficult for a provider or clinic to facilitate behavioral health services. There will be no reimbursement for supporting the telemedicine encounter and make it far less likely that Medicaid recipients will receive behavioral health services by telemedicine.

7. **Lack of data to identify high need and/or shortage areas**
   The Telehealth Stakeholder Workgroup report referenced above includes a recommendation related to the lack of data related to telemedicine. Specifically, the report includes the following.
   Recommendation 9: Identify baseline data for cost and utilization of telemedicine services for Alaska Medicaid. Develop and routinely prepare data reports on telehealth utilization among Alaska Medicaid enrollees to analyze telehealth utilization by location, provider type, diagnosis code, and service category. Use reports to determine priorities for targeted telehealth expansion.

   This is an excellent recommendation to complete prior to dramatically changing how Medicaid covers telehealth services.

Thank you for the opportunity to provide comments on the proposed regulations.

Sincerely,

Jeannie Monk
Senior Vice President