Special Committee on Mental Health Modernization

Telehealth Working Group Meeting

October 13, 2021

1-2:30pm

Meeting Notes

Meeting Materials: https://www.khi.org/pages/2021-MHMR

Agenda:
1:00pm – KOMA/KORA statement
1:05pm – Working Group Introductions
1:15pm – Review of Meeting commitments
1:20pm – Review of vision and 2020 MHMR Telehealth Recommendations
2:25pm – Administrative updates
2:30pm - Adjourn

Meeting Commitments:

- Come ready to discuss and compromise
- Keep remarks succinct and on topic
- Don't hesitate to ask clarifying questions
- Start and end on time

Attendees

Working group members: Sandra Berg, UHC; Jennifer Findley, KHA; Coni Fries, BCBS-KC; Patti Sosa, BCBS-KS, Rep. Brenda Landwehr; Stuart Little, BHAK; Sunee Mickle, BCBS-KS; Christina Morris, Aetna; Brittney Nichols, KDHE; Shawna Wright, KU Center for Telemedicine & Telehealth
Staff: Hina Shah, KHI; Kari Bruffett, KHI; Samiyah Para-Cremer, KHI

Review of 2020 telehealth recommendations

- Members discussed and reviewed the 5 telehealth working group recommendations from last year. See *Figure 1* on page 3 for reference.

Key Discussion on 2020 telehealth recommendations

See *pages 2-5* for key workgroup discussion around enablers, barriers and possible revisions to the 2020 telehealth recommendations.

Recommendation 10.1 Quality Assurance. Develop standards to ensure high-quality telehealth services are provided. This includes:

- Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies.
- Requiring standard provider education and training.
- Ensuring patient privacy.
- Educating patients on privacy-related issues.
- Allowing telehealth supervision hours to be consistently counted toward licensure requirements.
- Allowing services to be provided flexibly when broadband access is limited.

Members discussed the following:

Enablers:

- **Collaboration:** Cross-agency collaboration (BCRSB, leg, KDADS, KDHE) helped facilitate recommendation adoption and implementation

Barriers:

- **Definition of Rate Parity:** After the bill was drafted, an amendment related to rate parity was introduced during the hearings which killed the bill because there was difficulty and lack of consensus in defining rate parity
- **Time:** Working group impressed with progress but noted that quality assurance is complex and requires considerable time for agencies to coordinate and implement
- **Confusion with Kansas Telemedicine Act:** Working group members noticed practitioners and providers reported confusion in what the Telemedicine Act did and did not cover
- **Interstate care:** Confusion of practitioners and patients related to if and how they can receive telemedicine when traveling across state lines. State law currently mandates Kansas residents cannot receive telehealth from Kansas providers while traveling out of state.

Revision:

- **Improved provider and patient education**: Towards the appropriate use of technology to ensure the same quality of care of both in-person and telehealth visits. Additionally, better education about what is covered within the Kansas Telemedicine Act and how it impacts practitioner protocols. Working group members also identified a need to educate patients and providers to improve e-health literacy in relation to privacy, efficacy, and access.
- **Standardized Cybersecurity Practices:** Towards reduced ambiguity of best practices and protocols for maintaining patient privacy and confidentiality when using telehealth without excessive burden on practitioners. Additionally, working group members identified a need to clarify elements of e-health that become part of a patient's record such as recordings.
- **Interstate Compacts:** Incorporation of elements of *10.4 Originating and Distant Sites* acknowledging barrier of inter-state provision of care. Working group members highlighted that practitioner confusion exists between serving patients who may have crossed into a different state temporarily and the licensure requirements. Some working group members highlighted the potential of inter-state licensure compacts to help alleviate some of these problems.

Recommendation 10.2 Reimbursement Codes. Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.

Members discussed the following:
Enablers:

- **Pandemic code expansion:** Many of these codes were added during the pandemic to account for increased telehealth usage
- **Medicaid code framework:** Medicaid already had approved behavioral telehealth codes providing a framework for adoption by other providers and code development
- **Cultural shift:** Patients have become more open, willing, and accepting of telehealth. For some, telehealth is now an expectation.

Barriers:

- **Requirement of physical presence:** Working group members discussed adding regulations around brick-and-mortar locations in state.
- **Unclear cost:** A need exists for research explaining the costs of telehealth. It cannot be assumed telehealth is less expensive than in-person care, depending on the scenario.

Revisions:

- **Payment parity:** Need for further investigation into costs of telehealth and its costs compared to in-person provision of care. Additionally, working group members showed interest in understanding what Kansas' neighboring states have done in relation to payment parity.
- **Clearer definition of telehealth and expansion of codes:** Working group members advised that work on reimbursement codes should also include substance abuse and disorder treatment, autism treatment, peer support, and other services that have been served through telehealth. Additionally, working group members identified a need to address differences between codes for Medicaid and private insurance.

Recommendation 10.3 Telehealth for Crisis Services. Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities.

Members discussed the following:
Enablers:

- **Geography-based service roll out:** The area-based roll out allowed customization based on urban or rural needs.
- **Awareness:** Public and organizational awareness helped improve access and use of these services

Barriers:

- **None**

Revisions:

- **Increased Education:** Although the working group reported that this recommendation has been adequately completed, they requested further education of providers, practitioners, and law enforcement officers on using telehealth for crisis services.

Recommendation 10.4 Originating and Distant Sites. The following items should be addressed to ensure that individuals receive — and providers offer — telehealth in the most appropriate locations:

- Adopt a broad definition of originating site, consistent with the Kansas Telemedicine Act.
- Allow staff to provide services from homes or other non-clinical sites, if patient privacy and safety standards can be met.
- Examine issues related to providers practicing, and patients receiving, services across state lines, such as by exploring participation in interstate licensure compacts.

Members discussed the following:
Enablers:

- **SB170:** Legislation passed May 17, 2021, and effective January 1, 2022, established an interstate compact for psychologists
- **SB283:** Legislation which amends a provision allowing an out-of-state physician to practice telemedicine to treat Kansas patients to replace a requirement that such physician notify the State Board of Healing Arts (Board) and meet certain conditions with a requirement the physician hold a temporary emergency license granted by the Board.

Barriers:

- **Confusion over Kansas Telemedicine Act:** As previously mentioned, the working group identified ambiguous definitions that create barriers to patient care.
- **Increased demand for telehealth services:** There is increased demand for telehealth services in crisis situations. However, definitions and parameters vary greatly in crisis situations compared to regular sessions. Providers, practitioners, and law enforcement require more training in order to preserve quality of care in crisis scenarios
- **Demand for flexibility:** Crisis services cannot mandate a uniform standard of care because every situation is different. Regulations must permit some level of discretion to account for situational challenges (e.g., calls from cars or closets)
- **Out-of-state providers:** As the number of out of state providers increases, it is crucial to maintain accountability and oversight to ensure these providers maintain Kansas patients' standard of care
- **Consistency with PSYPACT:** Working group members expressed concerns that Kansas regulations do not currently align with best practices of PSYPACT
- **Enforcement mechanism:** Confusion exists over how site regulations are enforceable and whether enforcement would disproportionately affect access for those who do not work from home or have access to private places to receive telehealth services

Revisions:

- **Improved provider and patient education:** The working group identified a greater need for clarification of the regulations around originating and distant sites and education of patients and providers about how these regulations impact their services.
    - ***Update Definitions:*** *(add language about better defining origination and distant site)*
    - ***Geolocate*** *patients*
    - ***Identifiable location*** *for provider and patient.*
- **Quality of Care:** Working group members identified a need to ensure standard of care remains consistent across different originating sites
- **Regulation and Administrative Burden:** Working group members flagged a need to clarify and standardize the regulation around telehealth but cautioned against increasing administrative burden. Suggestions included seeking language around telehealth that has been successful for other states.

Recommendation 10.5 Child Welfare System and Telehealth. Utilize telehealth to maintain service and provider continuity as children, particularly foster children, move around the state. Consider how the unique needs of parents of children in the child welfare system can be met via telehealth.

Members discussed the following:
Enablers:

- **Prior behavioral health screenings:** Because in-person screenings may not easily translate to telehealth screenings, a key enabler is previous work with behavioral health screenings for children on Medicaid which provides a framework for practitioners.

Barriers:

- **Consistent care:** Frequent placement changes for children in DCF custody create challenges for ensuring consistent access to telehealth
- **Technology access:** Children may lack access to required audio visual equipment required to receive telehealth services

Revisions:

- **Telehealth for Parents of Children in Child Welfare System:** Working group members identified an opportunity for telehealth to aid in addressing the unique needs of parents of children in the child welfare system. They recommend further consideration of how telehealth could help address these needs.
- **Increased focus to address consistency of care:** The working group identified this as a challenge that telehealth could help address and requested greater effort towards maintaining contact and continuation of therapy for these children.

Follow up items

Working group members were asked to complete a worksheet to draft language around Telehealth Payment Parity to allow for discussion around the issues during the upcoming meeting (Wednesday, 10/20 at 1pm)

Figure 1. **Working Group High-Priority Recommendations for Telehealth**

TELEHEALTH
Immediate Action
Recommendation 10.1 Quality Assurance. Develop standards to ensure high-quality telehealth services are provided. This includes: • Establishing consistent guidelines and measures for telehealth in collaboration with licensing and regulatory agencies. • Requiring standard provider education and training. • Ensuring patient privacy. • Educating patients on privacy-related issues. • Allowing telehealth supervision hours to be consistently counted toward licensure requirements. • Allowing services to be provided flexibly when broadband access is limited.
Recommendation 10.2 Reimbursement Codes. Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.
Recommendation 10.3 Telehealth for Crisis Services. Establish coverage of telehealth for crisis services to allow for the use of telehealth with law enforcement and mobile crisis services. Explore virtual co-responder models for law enforcement to aid police departments and other law enforcement agencies as they respond to mental health crisis in rural and frontier communities.
Strategic Importance
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