COLORADO
Department of Health Care Policy & Financing

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Learning from COVID-19: Telemedicine Background & Policy Considerations

May 2020

Health First Colorado (Colorado's Medicaid Program) Telemedicine Policy Prior to COVID-19

Telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio or interactive video communication instead of in-person contact.

- Physician services may be provided as telemedicine.
- Providers may only bill procedure codes, which they are already eligible to bill.
- State law (CRS 25.5-5-320(2)) requires that the reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person service. This statute does not apply to certain providers like Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Indian Health Services (IHS) who are reimbursed using a different payment methodology.
- Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.

Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine. Additionally, the use of telemedicine does not change prior authorization requirements that have been established for the services being provided.

Telemedicine was a covered benefit prior to COVID-19, but it was not heavily utilized. Under non-emergency policy, telemedicine coverage is limited to live video and, per federal law, does not include consultations provided by facsimile machines, text, email or instant messaging.

Emergency Policy Changes to Address COVID-19 Pandemic

The emergency rule presented and passed by the Medical Services Board during an emergency board meeting on March 20, 2020, altered the current telemedicine policy to address the COVID-19 pandemic. It expanded the providers who could utilize the telemedicine benefit to include physical therapists, occupational therapists, hospice, home

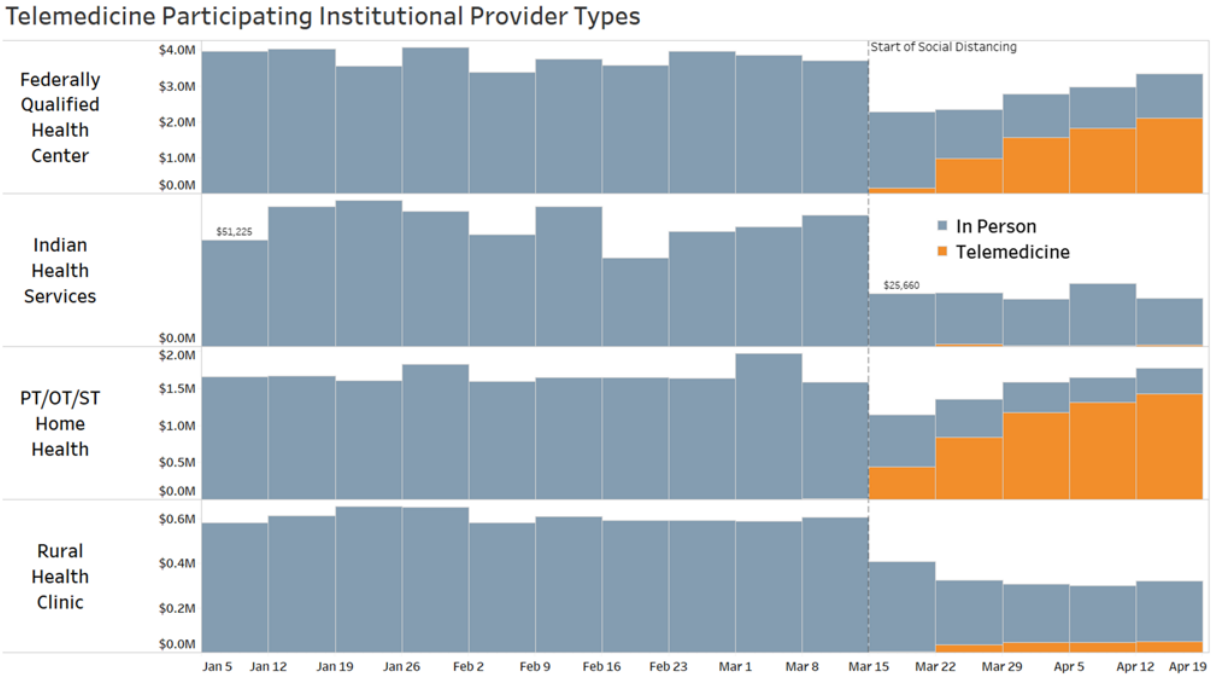
health providers and pediatric behavioral health providers, and expanded the channels to allow the use of interactive audio, such as telephone. It also allowed telemedicine visits to

qualify as billable encounters for Federally Qualified Health Centers (FQHCs), Rural Health Clinic (RHCs), Indian Health Services (IHS), and Community Mental Health Centers (CMHCs). CMHCs most commonly bill services to their Regional Accountable Entity (RAE), which have aligned their telemedicine policies.

The emergency rule was in effect immediately upon passage and will continue until July 18, 2020. The Department communicated the changes to providers, updated member facing communications to include telemedicine options and issued a press release about the emergency policy changes.

Preliminary Utilization Data – Telemedicine Use is Growing

The Department has been examining use of the new telemedicine options by providers. The following chart shows preliminary utilization data for telemedicine by Federally Qualified Health Centers, Indian Health Services, physical/occupational/speech therapy, home health, and Rural Health Clinics before and after the new rule. The new policy became effective March 20. The orange shows telemedicine billing.



The Department is in the process of analyzing other providers types and their use of telemedicine.

What Comes Next & Key Considerations for Future Policy

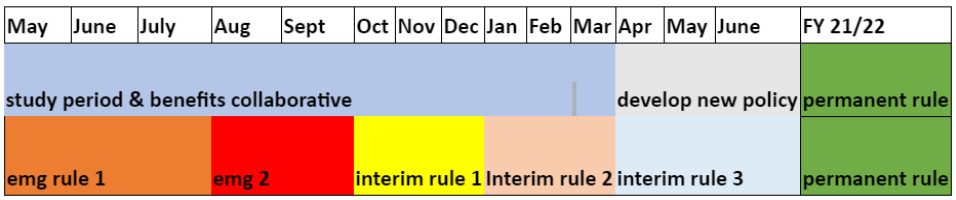
The COVID-19 pandemic will drastically change how medicine is delivered. The Department wants to learn from the emergency policy changes to better understand what an appropriate

permanent policy would include to achieve the shared goals of improving access to care especially to seniors and those with disabilities as well as in rural and frontier areas while, ensuring appropriate use of this medium, and being fiscally prudent in difficult budget circumstances.

To accomplish this, the Department plans to extend the emergency telemedicine rule with a second emergency rule that takes effect *before the temporary emergency provisions expire*. The Department will then bring forward a third set of interim telemedicine rules to enable additional monitoring of utilization and full assessment of the policy's impact. The first interim rule will continue all emergency changes, including use of the telephone for all providers as well as reimbursing telemedicine visits as billable encounters for FQHCs, RHCs, HIS and CMHCs. The policy would need to be reassessed in advance of each of the subsequent interim rules, based on learnings and budget constraints. This process is to ensure adequate insights to properly frame and institute a permanent rule. This approach will also allow the Department and stakeholders to learn more and therefore inform more effective telemedicine policy without having a gap in telemedicine access and coverage during the pandemic. The Department plans to publish a report outlining the use of telemedicine, lessons learned in the uptake of the new policy, and policy implications.

Timing
The study would be conducted with existing resources within the Department and published in early 2021 to inform a new permanent policy. The new policy will be brought forward via the regular MSB rulemaking process, to include robust stakeholder input from members and providers. The final rule will be finalized before the end of the next fiscal year June 30, 2021 and effective July 1, 2021.

Proposed Rulemaking and Telemedicine Study Timeline



Key policy considerations to be addressed in the report and considered in any permanent policy change would include analysis to address key questions, such as:

- What worked well and what did not work well – or worked less well- during with the emergency policy?
- What was the uptake of various populations (rural, seniors, persons with disabilities, etc.)
- What are barriers to utilization by population?
- What was the uptake of various provider types, and how did that uptake in telemedicine impact overall utilization and spend by provider type?
- Where were the outliers in utilization, by community and provider type?
- What policy adjustments need to be made to improve access while reducing costs?

- Which providers and members preferred the audio (telephone) option and why? Does the provision of telephone visits serve as a glide path to adopting other telemedicine modes?
- What are the relative advantages and disadvantages of provider-based telemedicine versus stand-alone options (nurse advice line, doc-in-a-box)?
- Under what conditions is telemedicine more efficient than a face-to-face visit?
- How do Medicaid payment rates and other policies compare to Medicare and other payers, and how do those differences impact utilization and spend?
- What were the fiscal impacts of policy changes?
- What were areas of concern?
- What can be adjusted in the permanent rule to prevent fraud, waste or abuse of telemedicine?
- What did we learn from other states use of telemedicine during COVID-19?

The new permanent policy will be based on the study findings, robust stakeholder engagement, evidence of what was most effective during the pandemic, and budgetary considerations.

For more information visit Colorado.gov/hcpf.