December 16, 2022

Jourdan Green
Director, Office of Regulation and Policy Coordination
Maryland Department of Health
201 West Preston Street, Room 512
Baltimore, MD 21201

Re: Notice of Proposed Action, 22-225P

Dear Ms. Green:

Please accept this letter as the formal comments of the Community Behavioral Health Association of Maryland (CBH) on proposed regulations governing telehealth and remote patient monitoring.

CBH represents 108 organizations who deliver mental health and addiction treatment to Maryland residents. Our members work across payers, drawing on Medicare, commercial plans, and Medicaid as funding sources for their behavioral health treatment.

CBH welcomes the proposed regulation's more flexible approach to telehealth. In particular, allowing clients to participate in telehealth from their homes and generally allowing licensed professionals to conduct telehealth within the scope of their license and practice standards represents an important step forward for Medicaid. We also strongly support the proposed language that expands coverage of remote patient monitoring (RPM) for Medicaid recipients with chronic conditions that place them at high risk for avoidable hospital utilization. Given the severe behavioral health workforce shortage, the use of technology such as RPM is critical to most efficiently and effectively utilizing our stretched human resources.

Despite these strong, positive steps that promote the adoption of telehealth, CBH is concerned with omissions and limitations reflected in the proposed regulations. These concerns are outlined in greater detail below.

Recommendation 1: Delete convenience from the medical necessity standard

The proposed regulations define medical necessity in .02(B)(8) and include a provision that telehealth may "not [used] primarily for the convenience of the participant, family, or provider." Because the pandemic's experience has demonstrated that the convenience of telehealth should be a permissible

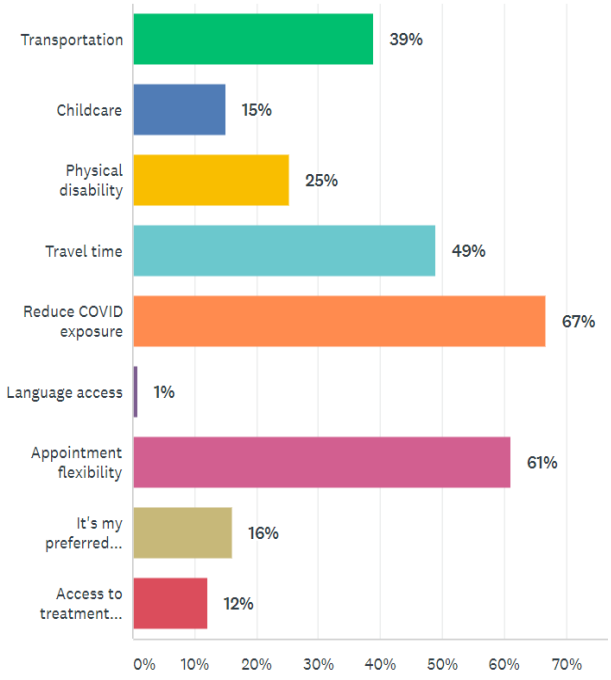
consideration, when otherwise congruent with clinical care and patient choice, we recommend deleting this provision in its entirety.

Convenience should be a permissible factor for patients choosing telehealth over in-person settings, if the service is otherwise clinically appropriate for telehealth delivery. If a patient consents to telehealth, convenience should also be a permissible consideration for providers making the option available to patients in the face of workforce shortages or other access barriers.

Patients cite the convenience of telehealth as one of its primary advantages. In the summer of 2020, CBH surveyed over 4,000 patients in treatment with its member organizations about their experience with telehealth.[1] Although reducing COVID exposure was cited as the primary reason for choosing telehealth at that time, a simple preference for the greater scheduling flexibility afforded by telehealth was a close second. A substantial portion of respondents cited the convenience of telehealth in reducing barriers like transportation, childcare, travel time.

The convenience of telehealth was notable in patient's qualitative responses to the CBH survey. When asked about why they liked telehealth, patients reported:

- "It's hard to get to that office weekly. It takes about 2 hours out of my day just getting there and back."
- "It helps in my current job situation to access services without taking my day off."
- "I work the nightshift. Better appointment times with telehealth."



While patient choice should primarily determine whether an appointment is in person or via telehealth, there are times when provider availability may also be a critical factor. A psychiatrist supporting an ACT or crisis team can be deployed in the community in response to a call when a second call comes in. Without the convenience of telehealth, the psychiatrist's response to the second crisis call would be delayed for transportation time between locations, rather than an immediate telehealth response.

Convenience and access are core to telehealth's benefit in behavioral health services. Because studies have repeatedly shown that telehealth is effective across the behavioral health continuum[2] – and that no-show rates drop when telehealth access is available – it is not necessary to impose subjective constraints like "convenience" to parse access to behavioral health appointments via

[1] Community Behavioral Health Association of Maryland, "Client Response to Telehealth" (July 11, 2020).
[2] SAMHSA, "Evidence-Based Resource Guide Series: Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," Chapter Two, pp. 13-32 (2021).

telehealth. It is inefficient to attempt to quantify the extent to which convenience is primary or secondary as a rationale, or to second-guess the legitimacy of a patient's choice.

Therefore, in order to allow predictable and equitable regulatory standards for the delivery of telehealth, we recommended deleting "not [used] primarily for the convenience of the participant, family, or provider" from the regulations.

Recommendation 2: Restore audio-only telehealth for behavioral health care

The proposed regulations eliminate audio-only telehealth in the Medicaid program after June 30, 2023. In .07(B)(1), the regulation states, "A service *delivered via telehealth* does not include: … An audio-only telephone conversation between a health care provider and a patient *unless provided on dates of service between July 1, 2021, and June 30, 2023, inclusive*."

We recommend that MDH delete subsection (B)(1) because the blanket prohibition on the use of audio-only telehealth:

1. Pre-empts the General Assembly's deliberation in the upcoming legislative session on the future role of audio-only telehealth; ;
2. Conflicts with MHCC's recommendations for the unrestricted use audio-only telehealth for behavioral health care;
3. Is at odds with policies adopted by the majority of state Medicaid programs;
4. Increases inequitable access to health care for vulnerable Maryland residents; and
5. Is not supported by research.

The support for each of these reasons is described in greater detail below.

A. Prohibiting audio-only telehealth via regulation is at odds with the legislative intent of the *Preserve Telehealth Access Act of 2021*.

The legislative intent of the *Preserve Telehealth Access Act of 2021* (HB123/SB3) was to extend pandemic-related telehealth flexibilities through June 30, 2023, giving the Maryland Health Care Commission (MHCC) time to complete a study and make recommendations to legislators about the future scope and reimbursement of telehealth in Maryland. The proposed telehealth regulations follow neither the timeframe nor the substance established by the *Preserve Telehealth Access Act*.

The legislation explicitly states that "it is the intent of the General Assembly that … the State use the report required under Section 4 of this Act to establish comprehensive telehealth policies for implementation after the Declaration of State of Emergency and Existence of Catastrophic Health Emergency – COVID–19 issued on March 5, 2020, and its renewals expire."[3] With its proposed regulations, MDH appears to have pre-empted the timeline, studies, and conclusions required by the *Preserve Telehealth Access Act*.

[3] *Preserve Telehealth Access Act of 2021* (HB123/SB3) at Section 5(3). *See also* Dept. of Legislative Services, "Fiscal and Policy Note: Senate Bill 3," page 5.

B. Prohibiting audio-only conflicts with MHCC's recommendation of the unrestricted use of audio-only in behavioral health care

The Maryland Health Care Commission recently released the study required by the *Preserve Telehealth Access Act of 2021*. It recommends that Maryland "[a]llow unrestricted use of audio-only for behavioral health care based on patient consent to receive care via audio-only technology."[4] Although the legislation explicitly states that "it is the intent of the General Assembly that … the State use the report required under Section 4 of this Act to establish comprehensive telehealth policies,"[5] MDH disregards MHCC's recommendation by prohibiting the use of audio-only telehealth after the *Preserve Telehealth Access Act of 2021* provisions sunset on June 30, 2023.

CBH encourages MDH to adhere to the legislative intent of the *Preserve Telehealth Access Act of 2021* by adopting MHCC's recommendation to allow the unrestricted use of audio-only for behavioral health care based on patient consent and choice.

C. Prohibiting audio-only telehealth is at odds with the majority of state Medicaid programs

The Maryland Health Care Commission's recommendation to "[a]llow unrestricted use of audio-only for behavioral health care" is in line with a growing number of states and payers, including a majority of state Medicaid programs. In its most recent report, the Center for Connected Health Policy cites ongoing growth in the number of states permanently adopting audio-only telehealth on a permanent basis, with nearly three-quarters of state Medicaid programs now allowing audio-only in some capacity.[6] The Center's report indicates that audio-only as a permissible telehealth modality has shifted dramatically since the pandemic:

> [T]elephone or audio-only service delivery has quickly gone from the least likely modality to be reimbursed to the second most commonly reimbursed modality (just behind live video) over the last several years. That trend has continued with this Fall 2022 Update, with thirty-four state Medicaid programs and D.C. now allowing for telephone reimbursement in some way, representing the telehealth modality with the most significant increase since Spring 2022 with five states being added and more than doubling since Spring 2021. Sometimes states will only reimburse specific specialties such as mental health, or for specific services such as case management.

As the Center for Connected Health Policy notes, audio-only has seen widespread adoption specifically in mental health and addiction treatment programs. Pennsylvania and Missouri, for example, have both recently enacted coverage of audio-only telehealth for a broad range of behavioral health services in their Medicaid programs.[7] Medicare – despite limited coverage of

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[4] Maryland Health Care Commission, "Preserve Telehealth Access Act of 2021: Telehealth Recommendations" page 5 (December 2022).
[5] *Preserve Telehealth Access Act of 2021* (HB123/SB3) at Section 5(3).
[6] Center for Connected Health Policy, "State Telehealth Laws and Medicaid Program Policies," page 8 (Fall 2022).
[7] *See, e.g.,* Missouri Division of Behavioral Health, "Guidance and Clarification on the Definition and Use of Telemedicine and/orAudio-Only Services," Section 4 (July 10, 2022) (describing circumstances where audio-

mental health and addiction services – has also allowed use of audio-only telehealth for behavioral health interventions in many circumstances.[8]

Maryland's blanket prohibition on the use of audio-only telehealth in the Medicaid program is thus far out of step with other Medicaid programs and payers across the country. We recommend that Maryland align its policies to ensure access to behavioral health services with its counterparts and allow the use of audio-only telehealth.

D. Prohibiting audio-only increases inequitable access to behavioral health care

Maryland Medicaid's blanket prohibition on the use of audio-only telehealth will increase inequitable health outcomes for Medicaid beneficiaries. In passing the *Preserve Telehealth Access Act of 2021*, Maryland legislators expressed their intent to "effectively advance health equity in Maryland" via telehealth, as well as a recognition that telehealth was effective in "in reducing disparities in access to those in underserved urban and rural areas by bridging communication gaps."[9]

Access to the devices and internet needed to facilitate audio-visual telehealth participation are not distributed evenly. Americans who are least likely to have smartphone or Internet access include the elderly, people experiencing poverty, and Black or Hispanic populations.[10] Specifically:

- Americans aged 65 and older (18 percent of the population) are most likely to have a chronic disease, but almost half (40 to 45 percent) do not own a smartphone or have broadband Internet access.
- People experiencing poverty report lower rates of smartphone ownership (71 percent), broadband Internet access (59 percent), and digital literacy (53 percent) compared to the general population.
- People who are Black or Hispanic report having lower computer ownership (Black: 58 percent; Hispanic: 57 percent) or home broadband Internet access (Black: 66 percent; Hispanic: 61 percent) than White respondents (82 and 79 percent, respectively), although smartphone access is nearly equal (Black: 80 percent; Hispanic: 79 percent; White: 82 percent).

Given lower rates of the internet access and device ownership needed to participate in audio-visual telehealth, the Maryland residents who will be most likely to lose access to health care as a result of eliminating audio-only telehealth are the populations already experiencing significant health inequities.

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only interventions are authorized); Stevens & Lee, "Pennsylvania Permanently Allows Audio-Only Behavioral Health Services" (November 4, 2022).

[8] CMS, "CY2022 Telehealth Update Medicare Physician Fee Schedule," MLN Matters Number: MM12549, page 2 (Jan. 14, 2022). See also CMS, "Calendar year (CY) 2023 Medicare Physician Fee Schedule Final Rule (November 1, 2022) (citing policy expansion for audio-only care in OTPs in certain circumstances).

[9] *Preserve Telehealth Access Act of 2021* (SB3, HB123), preamble.

[10] SAMHSA, "Evidence-Based Resource Guide Series: Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," p. 5 (2021).

In order to promote equitable access to behavioral health care, we recommend that MDH remove the prohibition on audio-only telehealth from its proposed regulations.

E. **Prohibiting audio-only telehealth is not supported by research**

SAMHSA, the federal agency has noted Telehealth is effective across the continuum of care for SMI [serious mental illness] and SUD [substance use disorder]." SAMHSA offers a toolkit to providers and payers that is based on the research-driven premise that telehealth can be used successfully across the continuum of behavioral health programs.[11]

Recommendation 3: Provider-specific telehealth standards should be promulgated concurrently with telehealth regulations and not in subregulatory guidance

The proposed regulations indicate that MDH will promulgate provider-specific telehealth regulations at an unspecified future date, and give MDH the latitude to restrict telehealth in subregulatory guidance. To comply with the legislative intent of the *Preserve Telehealth Access Act of 2021*, provide certainty, adequate notice, and administrative rulemaking protections to providers and patients, we recommend that provider-specific COMAR chapters be promulgated concurrently with MDH's telehealth regulations, and that all telehealth standards be defined through regulation.

We therefore recommend that the proposed regulations at .07(E)(2) be amended to cross-reference the specific "provider specific COMAR chapters" that will reference telehealth standards, and that the language ", and subregulatory guidance issued by the Department" be stricken from the proposed regulation.

A. The plain language of the *Preserve Telehealth Access Act of 2021* requires concurrent promulgation of provider-specific regulations to set the state's telehealth standards

A regulatory approach is consistent with explicit statutory language and legislative intent of the telehealth bill. The *Preserve Telehealth Access Act of 2021* specifically defined "health care provider" to be inclusive both of BHA-licensed programs and licensed health care professionals.[12] The General Assembly further stated:

> If the Department specifies by regulation the types of health care providers eligible to receive reimbursement for health care services provided to Program recipients under this subsection, the regulations shall include all types of health care providers that appropriately provide telehealth services.[13]

[11] SAMHSA, "Evidence-Based Resource Guide Series: Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," p. 13 (2021).
[12] *See* MD Code, Health – General, § 15–141.2(a)(4), "'Health care provider' means: … (ii) A mental health and substance use disorder program licensed in accordance with § 7.5-401 of this article."
[13] Md. Code, Health – General § 15–141.2(h)(2).

Legislators' intent was to ensure that MDH did not unilaterally exclude providers and programs through the regulatory process that the General Assembly clearly determined to be eligible for reimbursement of services rendered via telehealth. Allowing MDH to make unilateral prohibitions involving the use of telehealth without – at a minimum – engaging in the regulatory process would be contrary to, and a further erosion of, the protections outlined in the *Preserve Telehealth Access Act of 2021*.

The statutory language reflects legislative intent that telehealth standards be clearly promulgated. While MDH has broadly outlined its approach to telehealth and defined classes of eligible providers in these proposed regulations, it has not met the bill's standard to "include all types of health care providers." This leaves providers with uncertainty about the future scope of telehealth and no clear timeframe for resolution – the very situation the legislators intended to prevent through the passage of the *Preserve Telehealth Access Act of 2021*.

Without the concurrent promulgation of telehealth standards for all providers, the State may not be in compliance with the requirements of Health - General § 15–141.2(h). CBH therefore recommends that all provider-specific regulations governing telehealth standards be referenced in the proposed regulation and promulgated concurrently.

B. Provider eligibility for telehealth participation should not be defined in subregulatory guidance

CBH recommends eliminating the authority to define program eligibility for telehealth through subregulatory guidance. Regulatory promulgation gives providers the opportunity for notice and comment that is not afforded under a subregulatory policy-making process. CBH sees both protections as necessary in the state's consideration of telehealth standards. For that reason, we recommend deleting "subregulatory guidance issued by the Department" from the proposed regulation.

A key concern facing behavioral health programs is ensuring that the State has the data needed to support effective decision-making about telehealth standards. While payers like Medicaid have had a limited window into telehealth's adoption through the lens of utilization, CBH has engaged with its members over the last three years in outcome analysis and implementation support related to telehealth. The data generated through CBH's work echoes the findings of SAMHSA and conclusions of other state Medicaid programs: telehealth can be used successfully across the continuum of behavioral health programs.[14]

Recent conversations with MDH staff have raised concerns that their intent is to eliminate the availability of telehealth for some behavioral health programs. The state's skepticism about the value of telehealth in behavioral health care endures, without change, in the face of academic research, implementation data from Maryland providers, conflicting policies by the other states, and federal authorities.

[14] SAMHSA, "Evidence-Based Resource Guide Series: Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," p. 13 (2021) ("Telehealth is effective across the continuum of care for SMI and SUD.")

A regulatory framework will ensure that providers have the advance notice required to support financial investments, staff training, patient engagement, and operational workflows necessary for telehealth. It is our hope that the decision-making standards associated with the promulgation of rules will also help ensure that the State has an opportunity to refine its approach to telehealth in behavioral health care by being informed by outcome data, equity, and policy considerations.

Recommendation 4: Incorporate statutory limitations into reimbursement regulation

In subsection .08, the proposed regulation defines the Medicaid providers eligible for reimbursement for services delivered via telehealth. The regulations are silent on some reimbursement-related provisions contained in the *Preserve Telehealth Access Act of 2021*, and we recommend that the regulation be amended to incorporate language in the statute.

Specifically, not all areas of provider reimbursement for telehealth are defined in COMAR. Through subregulatory policy, the Behavioral Health Administration increases reimbursement rates by roughly 30% for two types of licensed programs that are evidence-based practices and required to meet BHA's fidelity standards. These programs are Supported Employment (SE) and Assertive Community Treatment (ACT). The *Preserve Telehealth Access Act of 2021* codified language clarifying that reimbursement could not be reduced for SE and ACT programs that delivered services via telehealth when otherwise meeting telehealth standards. We recommend that subsection .08(B) be amended as follows to include the statutory proscriptions on telehealth reimbursement:

> (3) *(i)* Services delivered via telehealth shall be within the provider's scope of practice as determined by its governing licensure or credentialing board.
>
> *(ii) For the purpose of reimbursement and any fidelity standards established by the Department, a health care service provided through telehealth is equivalent to the same health care service when provided through an in-person consultation.*

Incorporating this statutory clarification into the regulations embraces the legislative intent and helps to prevent misinterpretation of fidelity standards that could lead to significant reimbursement cuts, jeopardizing the viability of critical supports offered by these programs.

Conclusion

Maryland – like other states – is facing a time of unprecedented demand for behavioral health services while, at the same time, facing a severe shortage of licensed clinicians and paraprofessionals needed to meet the demand. The unfortunate results are all too clear. They include an overutilization of hospital emergency departments and inpatient settings by those with behavioral health conditions and a significant rise in suicide attempts by children and adolescents, to name just a few.

The use of technology – including telehealth and RPM – presents us with a unique opportunity to meet this challenge in ways that have been proven effective, efficient, and well-received by both consumers and providers. We urge MDH to embrace this opportunity by making permanent the telehealth provisions allowed in the PTAA of 2021.

Thank you for the opportunity to offer comments on the proposed telehealth regulations. Please do not hesitate to reach out if you have any questions or need clarification. I can be reached at shannon@mdcbh.org.

Sincerely,

Shannon Hall, J.D.
Executive Director