SCTA Quarterly Report
CY21 Quarter 3

Progress Achieved on the CY2021 Strategic Plan
July - September 2021

SOUTH CAROLINA
Telehealth
ALLIANCE

Table of Contents

SOUTH CAROLINA
Telehealth
ALLIANCE

SOUTH CAROLINA Telehealth ALLIANCE

South Carolina Telehealth Alliance (SCTA)

CY2021 Q3 Report

Executive Summary

South Carolina Telehealth Alliance (SCTA) partners remained engaged throughout the third quarter of calendar year 2021 (CY21Q3), sustaining and optimizing existing telehealth services, and convening to review and determine strategies to operationalize their respective tactics. To align with the finalized strategic plan, the SCTA quarterly reporting process was modified to categorize report-outs by strategic domains. **McLeod Health**, **Prisma Health**, **SC Department of Mental Health (SCDMH), MUSC Health,** and other partners continued to expand and enhance existing telehealth programs.

Telehealth sustainability efforts remained strong during CY21Q3, with continued discussions around telehealth coverage and reimbursement landscape post-public health emergency (PHE). To guide these efforts, recommendations with supporting evidence and information were submitted to SC Medicaid and other payers (Appendix A).

The following report provides further details on these and other accomplishments from CY21Q3.

South Carolina Telehealth Alliance (SCTA)
CY21Q3 Report

Data and Outcomes

Accurate and accessible data is essential to right-sized telehealth services in South Carolina. To better understand specific areas with access challenges, the data and outcomes team focused its efforts during CY21Q3 on establishing an appropriate data source to identify inpatient and outpatient specialty care utilization by county. Once obtained and analyzed, the team plans to develop a heat map which will show areas of the state on which to focus for strategic deployment of telehealth services.

Sustainability and Reimbursement Advocacy

The SCTA continued its efforts to understand and inform the future decisions around telehealth coverage and payment post-public health emergency (PHE) during CY21Q3. The SCTA Sustainability Committee and Advisory Council submitted recommendations with supporting evidence and information to SC Medicaid and other payers to help inform coverage and reimbursement decisions post-PHE. SCTA representatives look forward to continued conversations with payers and stakeholders as policies are solidified over the coming months.

eConsult Pilot Program

As reported in CY21Q2, the SCTA partnered with ReferWell to extend access to specialty care in South Carolina through eConsults – an asynchronous, provider-to-provider communication connected primary care providers with specialists. During CY21Q3, two new clinics were trained and onboarded to participate in the eConsult pilot project as referring providers. Feedback after the first few eConsults were sent was very positive, with both the referring and consulting provider praising the platform's ease of use. The focus of CY21Q4 will be to continue to increase utilization, including implementation of a streamlined sign-up process for referring providers.

SCTA Doxy.Me

The SCTA continues to partner with Doxy.Me to offer free, premium-level memberships of the telehealth video platform to facilitate the use of telehealth across South Carolina. The SCTA Doxy.Me instance has over 1,600 users, completing over 20,000 visits during CY21Q3. The SCTA aims to continue this offering for the foreseeable future, given the demonstrated ongoing satisfaction and usage from providers in the state, particularly those in smaller rural or community health center settings. Due to continued, widespread use among providers in SC, Doxy.me now has a designated resource section on the SCTA website.

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Center for Telehealth
169 Ashley Avenue
MSC 332
Charleston, SC 29425
Tel 843 792 7512
www.musc.edu

Medical University of South Carolina
Telehealth Service Updates and Progress
July – September 2021

Service Extension

During CY21Q3, the MUSC team continued to optimize and expand a pilot "Virtual Success Center" initiative, with nursing staff dedicated to assisting patients with connectivity issues and troubleshooting, creating a seamless ambulatory video visit experience. Due to expansion and positive feedback, two new nurses have been hired to assist with the project. MUSC looks forward to introducing a new automated client platform that sends appointment links and reminders to patients in CY21Q4.

Hospital Support

Hospital-based telehealth services completed an average of 2,579 consults across SC hospitals during CY21Q3. Using a center-wide team approach, a new telehealth technology platform was successfully integrated at partnering sites. This new application enhances the ability for increased efficiency during the provider visit, as well as increased satisfaction with partners across the state. Additionally, MUSC's acquisition of three hospitals in the midlands has presented the opportunity to strengthen and expand telehealth services in SC. MUSC looks forward to moving telehealth services in operation with its first Rehabilitation Hospital site in CY21Q4.

Convenient Care

MUSC's virtual urgent care program continued to focus its efforts on increasing utilization and demonstrating the value of the service during CY21Q3, conducting 17,727 virtual urgent care visits. MUSC renewed its contract with PEBA's State Health Plan for an additional year to reduce health care costs for South Carolina state employees. Mirroring current trends, MUSC experienced an increase in COVID-19 visits during CY21Q3. Providers did not let this slow them down, as they quickly adapted by reverting to a COVID focus while continuing to address other low acuity concerns.

Primary Care Support

Telehealth services that support and empower primary care practices in the state remained strong during CY21Q3. Project ECHO, including Project ECHO Opioid Use Disorder, and Project ECHO Pregnancy Wellness, received a nomination for the 2021 Program of Excellence Award. MUSC's recently expanded Outpatient Telehealth (OT) Psychiatry program has allowed providers to see over 20 patients a week. This new support model is an asset to mental-health patients, as it allows patients to schedule next-day appointments, and sometimes even same-day appointments. Looking toward CY21Q3, MUSC's OT program is excited to implement a more streamlined process for patient scheduling, as well as an enhanced appointment notification system through a new automated web-based software.

Health Equity

The goals of many of MUSC's telehealth programs are to close the gap in access to healthcare services that target high-priority health disparities. Programs such as school-based telehealth, Telehealth for the Homeless, Women's Reproductive Behavioral Health, and many more serve South Carolina's most vulnerable populations. During CY21Q3, MUSC's school-based telehealth program provided almost 374 visits, expanding care to a Liberty Hill Academy in Charleston County. In addition, Colleton County received approval to add an additional telepresenter/children's wellness coordinator, and also received a grant to support telemental health. While school-based-telehealth slowed due to COVID-19, the school team will return strong in CY21Q3 and expects to see returning and new asthma and ADHD patients in schools.

McLeod Health

The Choice for Medical Excellence

Telehealth Service Updates and
Progress July- September 2021

Service Extension
McLeod Health has created a Multi-Disciplinary Review (MDR) program which brings together clinicians and technicians across a variety of specialties for a group consultation with our patients. This program has been extremely successful in bringing all teams together and fully involving the patient in care decisions. The MDR program has improved access to and collaboration of medical experts, resulting in increased levels of care quality and improved provisions of diagnosis, treatment, and follow-up to patients irrespective of their location. As the COVID pandemic continues and the increased concerns with COVID, our Employee Assistance Program (EAP) counseling has seen an increase in telehealth sessions. This program has been instrumental in giving our employees the opportunity to discuss stresses associated with being on the front line of care. McLeod Physicians Associates (MPA) continues to deploy technology solutions and expand virtual visits across all service lines to better meet the healthcare need of the communities we serve. During CY21Q3 our Service Extension programs reached 1,400 consults.

Hospital Support
McLeod Health has experienced increased utilization of telehealth in our Pulmonary & Critical Care programs as we continue to treat the high volume of COVID patients. Our TeleICU program continues to expand. In addition to McLeod Dillion, we have added TeleICU platforms to Mcleod Clarendon and McLeod Cheraw. We have received positive feedback on the benefits of the program. During CY21Q3 our Hospital Support programs averaged over 1,200 consults.

Convenient Care
McLeod Health successfully implemented a new technology platform that strengthens our ability customize, adds flexibility for multiple programs, enhances integration throughout the organization, and enriches the patient and provider experience. During CY21Q3 our Direct-to-Consumer programs averaged over 2,200 visits.

Primary Care Support
McLeod Health now offers Diabetes Education and Pulmonary Nodule Consultation & Education programs to support our Primary Care Service Lines. These programs positivity impact the clinical outcomes for patients with chronic or critical conditions.

Health Equity
The McLeod School-Based Telehealth program continues to grow, expanding to Clarendon School District 4. We are working with other districts in our region for further expansion. McLeod Family Connect continues to be a valuable service that provides inpatients the opportunity to connect virtually with their loved ones, which can aid in the healing process. During CY21Q3 our Health Equity programs averaged over 1,500 visits.

Prisma Health
Telehealth Service Updates and Progress
July – September 2021

Service Extension
Prisma Health continues to implement and broaden the use of core virtual care modalities in our ambulatory settings to extend the reach of services that would otherwise be limited by travel and related barriers to care. The continued expansion and use of enhanced virtual care technology has elevated our care teams' ability to screen and monitor our Senior Care patients from the comfort of their homes. This technology continues to be deployed in Primary Care and Pediatric practices for use by non-complex patients and families who may have frequent urgent care or emergency department visits but are otherwise healthy. Satellite clinics in Sumter, Orangeburg and Oconee counties continue to bring specialty care to these rural communities. Our Behavioral Health continues to expand and provide critical services to Senior Care facilities in our Upstate community. During quarter 3 of calendar year 2021 we have conducted ~75K+ ambulatory virtual care visits.

Hospital Support
Our acute care teams have continued and expanded the use of virtual care modalities to consult and treat patients at our hospitals where specialty care services are not available onsite 24/7. In addition to Infectious Disease and non-stroke Neurology consults, Toxicology consults are now available at all Upstate satellite facilities. Acute care video consults will be expanding to Pediatric Specialties in CY21. During quarter 3 of calendar year 2021 we have conducted ~987 acute care consults.

Convenient Care
The use of convenient care services continues to be a popular choice of Prisma Health patients. Our eVisit platform was integrated with Epic MyChart to allow patients 18 and older, to access this care seamlessly using their MyChart account. During quarter 3 of calendar year 2021 we have conducted ~6K+ on demand video and eVisits.

Primary Care Support
The use of primary support services continues to close the gaps in care for patients between office visits, while also helping our care teams to have a holistic view of the patients' care journey. A pilot for at home health monitoring for hypertension continues to expand using a phased approach in our internal medicine practices. Our diabetes management team continues to help patients manage their condition at home using remote monitoring technology. We continue to expand our programs with adding additional patients as they are identified by our clinical teams.

Health Equity
Health equity continues to be a focus for Prisma Health. Regional access points in our rural communities provide access to specialty care that would otherwise not be available. Our school-based care programs continue to provide both in person and virtual care. All schools have been upgraded to enhanced video and peripheral technology and are ready for the new school and in-person learning. During quarter 3 of calendar year 2021, ~22 school-based care visits have been conducted.

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

Kenneth M. Rogers, MD
State Director

October 31st, 2021

South Carolina Department of Mental Health
Calendar Year 2021 Quarter 3 Report
South Carolina Telehealth Alliance

This year, the South Carolina Department of Mental Health (SCDMH) seeks to remind South Carolinians of the importance of maintaining good mental health and the mental health services available to all, particularly in light of the uncertainty and difficulty so many have experienced over the past year and a half.

SCDMH offers several Telemental Health programs, including: Emergency Department Telepsychiatry, Community Telepsychiatry, EMS Telehealth, Inpatient Services Telepsychiatry, Nursing Home, School Mental Health, Highway to Hope Community Outreach, SC-HOPES, and After-ED Discharge Clinic Contract. These programs are an integral component of service delivery across SCDMH.

The Emergency Department Telepsychiatry program is in the process of adding additional locations. The program currently has twenty-four (24) hospital partners. Announcements will be made in the coming quarterly reports.

SCDMH's Community Telepsychiatry Program continues to utilize direct-to-consumer (DTC) telemental health. Feedback on DTC services has been positive, with patients and their families enjoying the convenience.

The Highway to Hope (H2H) Outreach Program is providing telehealth services and continues to explore ways to expand telehealth services. H2H serves patients at local businesses and community organizations within the Pee Dee (Florence, Darlington, Marion); Tri-County (Chesterfield, Dillon, Marlboro) and Waccamaw (Georgetown, Williamsburg, Horry) regions. The mobile clinical care team includes an adult mental health professional, child mental health professional, a registered nurse, and a nurse practitioner. Psychiatric Telehealth services are available.

The SC-HOPES program, in collaboration with SC Department of Alcohol and Other Drug Abuse Services, provides financial support for a range of behavioral health services, allowing patients to receive treatment at low to no cost. Services, such as telepsychiatry and telehealth counseling services are provided by SCDMH community-based outpatient mental health centers, are covered. SC-HOPES operates 24/7; visit www.sc-hopes.com for more information.

The Agency has made exceptional progress in expanding service and coverage across South Carolina, offering an extensive network of mental health resources, crisis resources, and connection to non-SCDMH crisis resources. For more information on these resources, please visit our website https://scdmh.net/.

South Carolina AHEC Program Office
Medical University of South Carolina
1 South Park Circle
Suite 203
Charleston, SC 29407

October 31, 2021

The SC Area Health Education Consortium has focused on ensuring up-to-date telehealth education resources are available on-demand for all health professionals and future health professionals in South Carolina. SCTA funding has helped to support SC AHEC's Office for Telehealth Education in developing and supporting online telehealth courses and seven additional telehealth programs including Palmetto Care Connection's Webinar Wednesday and SC AHEC developed programming available for free for health professionals and students in South Carolina via the SC AHEC online learning portal.

The Telepresenter Certification course was redesigned during the first and second quarter of the year to include additional information on safety considerations for direct-to-consumer models and COVID-19 pandemic policy changes. The newly redesigned course has been retitled to: Telehealth Presenter Certification. The course was made available in late April 2021. This quarter, we archived the Billing and Reimbursement Bootcamp course due to the changing policy and reimbursement landscape. We plan to redesign the course once reimbursement policies are more static.

SC AHEC Course Registrations and Course Completers
(Date range 7/1/2021-9/30/2021)

1. Telehealth for High School and College Students – 1 Registration, **0 Completers**
2. Telehealth Presenter Certification – 32 Registrations, **19 Completers**
3. Telemental Health – 42 Registrations, **33 Completers**
4. Foundations of Telehealth – 162 Registrations, **155 Completers**
5. Telehealth Implementation – 11 Registrations, **8 Completers**

310 Total Registrations for all SC AHEC Telehealth Education courses/programs awarded to Participants July 1-September 30, 2021.

South Carolina ETV

1041 GEORGE ROGERS BOULEVARD
COLUMBIA, SOUTH CAROLINA 29201

October 18, 2021

South Carolina ETV
Calendar Year 2021 Quarter 3 Report
South Carolina Telehealth Alliance

This quarter brought Telehealth Awareness Week highlighting new patient-centered content in South Carolina. In addition to TAW content, the *My Telehealth* Team created 5 new videos and a radio story. The video stories were distributed on digital platforms and the SCTA social media channels. The radio story was distributed through South Carolina Public Radio, reaching all major markets including Charlotte, Augusta, and Savannah airing twice per week of broadcast reaching 1.1M weekly listeners.

List of telehealth features:

Video

- Baby Steps: A mother and nurse partnership
- Local library provides connection point for healthcare
- Digital literacy: Overcoming isolation in a connected world
- Two Telehealth Awareness Week videos

Radio

- Awareness Campaign Launches to inspire education and policy updates

This content is shared via television, radio, email newsletters, multiple websites, and social media platforms. The SCTA's monthly newsletter held an average open rate of **17.9%** for Q3. The South Carolina Telehealth Alliance Facebook page has **758** followers up an additional 48 followers from Q2. The *Local library provides connection point for healthcare* story was posted on August 11th and garnered the most reactions of the quarter. On Twitter, the SCTA page has **844** followers, up an additional 40 followers from Q2. The SCTA Twitter page received 6,323 profile visits and 20,026 tweet impressions. Our top Twitter mentions for Q3 came from PCC, MUSC Telehealth, and Charleston County Library.

September brought Telehealth Awareness Week

The South Carolina Telehealth Alliance served as a key player in the first-ever national Telehealth Awareness Week. Five years after running the TAW campaign in South Carolina, the team continued by building out a collaborative strategy with assets to match. In just this one week of TAW alone, the team utilized digital media to drive conversations on the need for incorporating telehealth as a regular healthcare practice.

Social Media spotlight: Organic (unpaid/not sponsored) posts about Telehealth Awareness Week from our SCTA accounts on Twitter and Facebook reached over 5,500 individuals – that one-week count exceeds the total reach achieved by those same social media handles in 4 different months from the past year. Our audience was highly engaged with our TAW content as we received more engagements (likes, retweets, comments, etc.) over the course of this one week than we have in 11 of the past 12 months. Content was key in this success. The My Telehealth Team created, and working with the SCTA, distributed to partners a content plan spanning over one week with new video stories, radio stories, photos, and graphics.

SCTA CY21 Q3 Report
SC Center for Rural and Primary Healthcare

Telehealth Hubs

Nationally and in South Carolina, libraries have increasingly been serving their communities to connect patrons to healthcare. The SC Center for Rural and Primary Healthcare launched the Rural Libraries and Health Cooperative Agreement program in 2020, which supports innovative pilot projects in five libraries systems across South Carolina to test alternative models of community care and healthcare engagement via a library system. In September, the Center partnered with the University of North Carolina at Greensboro to conduct a needs assessment opened to all public libraries in the state. Along with understanding the current landscape of services offered, libraries were asked about areas of opportunities to expand their healthcare services, with a focus on being an access point via telehealth. Results are currently being analyzed, but we are excited to use this information to learn how we can continue to mobilize libraries to be innovators through telehealth utilization and support their efforts.

Telehealth Survey and Qualitative Interviews

In CY21, The SC Center for Rural and Primary Healthcare built upon the previous work of the SCTA and the Office of the National Coordinator for Health to assess the barriers and facilitators of successful telehealth adoption among smaller rural and primary healthcare practices in South Carolina amidst the COVID-19 pandemic. This work also explored the impact of COVID-19 on telehealth utilization patterns. In summary, findings indicated that the biggest facilitators to telehealth adoption include: 1) increasing access to services for patients during COVID-19, 2) increasing access for current patients, 3) improving patient experience of care, 4) improving patient outcomes and attracting new patients.

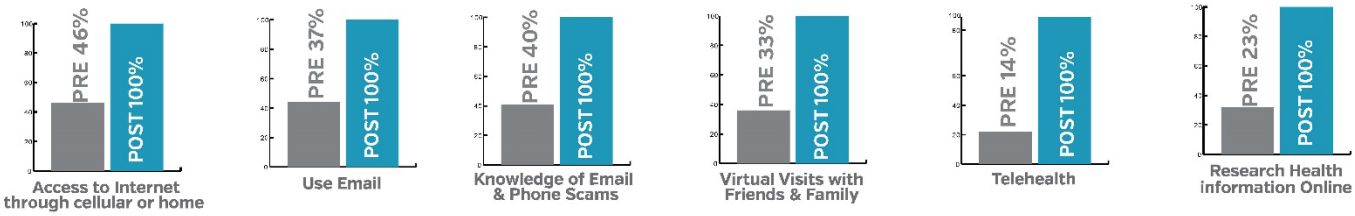
The Center partnered with the University of South Carolina College of Social work to further understand the current utilization of telehealth in practices and assess the impact of COVID-19 on telehealth use. Interviews were conducted with stakeholders across South Carolina who represented a variety of practice settings, including community clinics and mental health services. In addition, patients who received services through telehealth within the last two years were interviewed to gain insight into patient experiences. A summary report is currently being developed with thematic analysis to inform policy changes and advocate for further support of telehealth services in South Carolina.

Broadband

FY 2021 broadband subsidy filings were submitted in June 2021. By the end of the month of September, PCC received funding commitment letters (FCL) for approximately 25% of the Funding Requests submitted in 2021 from USAC for just over $1,000,000 for broadband subsidy for South Carolina Healthcare providers over three years. These subsidies have allowed many healthcare providers to add redundant circuits to increase uptime and/or re-invest those dollars into healthcare services. PCC is already preparing FY2022 Funding Requests for the April 30, 2022 deadline.

Digital Literacy

Palmetto Care Connections was awarded a Rural Local Initiatives Support Corporation (LISC) grant and additional funding from the S.C. Office on Aging to implement a digital inclusion pilot program for senior citizens (age 65 and up) in five counties (Allendale, Barnwell, Clarendon, Richland, and Williamsburg) in South Carolina. To date, PCC has trained 87 senior citizens. Below are our pre and post assessments results to date.



Palmetto Care Connections has received a $35,000 Spectrum Digital Education grant as part of its five-year, $7 million commitment to digital education in Spectrum communities across the country. PCC will use the funding to provide digital literacy classes for senior citizens in rural South Carolinas communities. This project will primarily focus on telehealth training for seniors and participants will receive a digital device upon completion of the program.

Telehealth Education

PCC partners with other telehealth leaders to provide free monthly webinars focused on technology, broadband, and telehealth topics. In Quarter 3, there were over 300 registrants for Webinar Wednesdays.

Date/Title of Webinar
July 21, 2021 Expanding Access to Specialty Care through eConsults
July 28, 2021 Benefits of Telehealth in Palliative Care
August 25, 2021 Using Telehealth to Tackle Autism
September 22, 2021 RPM and RTM: What to do Now and the Possibilities for 2022

Appendix A :
Payer Priorities Document

SOUTH CAROLINA
Telehealth
ALLIANCE

Information and Recommendations Regarding Sustained State-level Telehealth Reimbursement and Coverage After the Public Health Emergency Declaration

Since March 2020, healthcare organizations of all sizes have relied on telehealth to provide essential healthcare services to their patients during the COVID-19 pandemic, thanks to temporary coverage expansions during the Public Health Emergency (PHE) declaration. While certain flexibilities have been solidified through 2023 at the federal level, many state Medicaid agencies and private payers are currently evaluating future plans for telehealth coverage. Uncertainty around the future of the expanded coverage negatively affects providers and patients, as telehealth has become both an important component of healthcare operations and patients' access to care. In order to truly leverage the benefits of telehealth, healthcare providers must plan staffing and build appropriate infrastructure, which may, in turn, lower the cost of care and expand access to patients. In the following memorandum, The South Carolina Telehealth Alliance (SCTA) has provided information and recommendations as SC payers evaluate their future coverage policies, including the overarching recommendation to align with CMS covered codes. At the very least, we urge SC Medicaid and private payers to extend the temporarily expanded coverage through 2023 for further study and informed future permanent recommendations.

Table of Recommendations

SOUTH CAROLINA
Telehealth
ALLIANCE

Recommendation: Permanently remove originating site restrictions

Description

- During the PHE originating site restrictions were temporarily removed, allowing patients to receive telehealth services in their homes instead of having to travel to a clinic site. Last year in South Carolina, over 1.2 million visits were performed across the state with the vast majority video-based and directly with the patient in their home.[1]
- All outpatient specialties utilized video visits during the pandemic, with the percentage of visits performed virtually following similar trends across the country.
- These trends have continued to stabilize by specialty and are now predictable. Evolving patterns of use by specialty indicate that new patient visits are more often low acuity and are used for both new and established patients, while telehealth is being leveraged more frequently for established visits for more complex patients.[2]

Payer Coverage Considerations

- *Virtual care utilization trends are consistent across specialties*. Physician specialty types have utilized virtual visits in consistent patterns nationally, indicating clinical judgement and appropriateness is consistently applied.[3] While specialty-specific care protocols are anticipated to emerge in the near future, it can be expected that the providers will continue to utilize virtual care at current stable levels, which range across specialties from low single digit percentages to over 40% virtual, and over 70% virtual for some mental health providers.[4]
- *Virtual care can serve as adjunct to in-person care.* Incentivizing use of telehealth as part of the care continuum will encourage the most efficient application of telehealth services to in-person visits. Mechanisms to encourage this include:
    - Allowances for use of virtual care to achieve certain value-based care metrics and pay-per-performance arrangements.
    - It is currently difficult to precisely assess changes in the cost of care delivery using pandemic-related data, as support staffing and infrastructure are dynamic. However, moderate reduction in payment for virtual care may be appropriate, particularly in the setting of value-based contracts and other incentivized care plans.
        - Private Insurers: A 5-10% reduction in payments have been deemed reasonable to continue virtual care at appropriate levels while encouraging in-person care for comprehensive assessments, particularly while the payer and provider have a value-based care arrangement.[5] While limited data exist, this is in line with a similar improvement in no-show rates for the use of virtual care and encourages efforts to adopt efficient models.
        - Medicaid: Medicaid reimbursements trend lower and such payments are essential for many safety net practices, so a period of evaluation of impact on those practices is recommended before implementing a change in fee structure.
        - Facility Fees: Where applicable, facility costs should continue to be reimbursed until the scope of payment adjustments can include the costs of technology and staffing to perform efficient virtual visits.

- *Ongoing Coding and Documentation Education.* As high-quality care delivery includes use of both in-person and virtual care, referral to in-person care from a virtual visit should be expected and easily available. Continued education regarding appropriate documentation and coding when a virtual care modality is determined to be inadequate by the provider will also reinforce the hybrid model of care delivery.
- *Addressing concerns over fraud and overuse*. While there is little compelling evidence that continuing expanded telehealth policies will lead to increased healthcare spending post-pandemic, concerns persist over fraud and overuse. Although telehealth increased exponentially at the onset of the pandemic, rates have tended to settle around 20%, and visit volumes have not exceed pre-pandemic levels.[6] However, as virtual care continues post-pandemic, it is reasonable to have increased coding audits for a period of time. Audits and safeguards could address:
    - Outlier clinicians with irregular telehealth billing patterns, including limited use of in-person care outside what is expected for specialty.[7]
    - Appropriate medical decision management coding for assessment performed.
    - Review of patterns of care with limited in-person care associated with high-cost medical interventions, such as the prescription of durable medical equipment (DME) over a certain dollar amount.[7]

References

1. *2020 Annual Report - SC Telehealth*. South Carolina Telehealth Alliance. (n.d.). Retrieved from: https://sctelehealth.org/-/sm/sctelehealth/f/reports/2020-scta-annual report.ashx.
2. *Tracking U.S. Telehealth Adoption a Year Into the COVID-19 Pandemic - Trend Analysis & Implications for Health Systems*. The Chartis Group. (2021, April). Retrieved from: https://www.chartis.com/resources/files/WP_Telehealth-Trend-Analysis_2021-0428.pdf.
3. Patel SY, Mehrotra A, Huskamp HA, Uscher-Pines L, Ganguli I, Barnett ML. Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States. *Health Affairs.* 2021;40(2):349-358. doi:10.1377/hlthaff.2020.01786
4. *Telehealth Adoption Tracker*. The Chartis Group. (2021, April 29). Retrieved from: https://reports.chartis.com/telehealth_trends_and_implications-2021/.
5. Mehrotra, A., Wang, B., & Snyder, G. (2020, August 5). *Telemedicine: What should the post- pandemic regulatory and payment landscape look like?* The Commonwealth Fund. Retrieved from: https://www.commonwealthfund.org/publications/issuebriefs/2020/aug/telemedicine-post-pandemic-regulation.
6. Ellimoottil, C. (2021, May 10). *Understanding the case for Telehealth Payment Parity: Health Affairs Blog*. Health Affairs. Retrieved from: https://www.healthaffairs.org/do/10.1377/hblog20210503.625394/full/ .
7. *Report To the Congress Medicare Payment Policy* . MEDPAC. (2021, March). Retrieved from: http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.

SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Cover all CMS approved mental health and registered dietician provider types as well as rehabilitation therapists

Description

- Clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals are currently CMS-approved distant site practitioners who can furnish and receive Medicare payment for covered telehealth services.
- Allowing these South Carolina-licensed practitioners, as well as licensed professional counselors, to receive payment for their Medicaid services supports the growth of resource-efficient and sustainable business models that use interdisciplinary, collaborative care teams and address statewide health epidemics, such as obesity and opioid use disorder.
- During the COVID-19 public health emergency, rehabilitation therapists were reimbursed for telehealth services provided to patients directly in their homes. Though not currently permitted by CMS, coverage of rehabilitation services via telehealth would enable cost-effective, high-quality care and help reduce geographic disparities in access.

Payer Coverage Considerations

Mental Health Providers

- There is a demonstrated need for increased access to mental health in SC. Among states, SC ranks 45th in terms of mental health care access, yet nearly 1 in 5 adult South Carolinians have a mental health disorder.[1] Moreover, mental health professionals are concentrated in urban areas of SC, making access particularly challenging among rural communities.[2]
- Telehealth has become the predominant modality for mental health provision for many practitioners. At MUSC many mental health clinical areas exceed 70% of visits occurring virtually, accounting for well over 400 clinical encounters daily. In addition to scheduled new and established visits, longstanding telehealth programs in this domain include support of primary care clinics, inpatient consults, emergency room consults, school-based consults, and emergency room diversion initiatives.
- Telemental health can be effectively delivered by practitioners with non-MD backgrounds. Several clinical programs offered across the state routinely use non-MD practitioners to deliver telemental health care, including licensed clinical psychologists, social workers, clinical psychology trainees (e.g., postdoctoral fellows, residents, clinical counseling trainees), and licensed professional counselors working under the supervision of psychologists and psychiatrists.
    - Some examples offered through MUSC since 2015-2016 include:(1) the Telehealth Outreach Program (TOP), which provides mental health services to low-income children and families; (2) Women's Reproductive Behavioral Telehealth program (WRBT), which provides maternal mental health and substance use treatment to pregnant and postpartum women; and (3) Trauma/Telehealth Resilience and Recovery Program (TRRP), which provides multidisciplinary needs-adjusted care to adults and children who develop posttraumatic stress disorder or depression after traumatic injury.
    - Notably, a number of clinical trials have been conducted at MUSC and regionally/nationally that have illustrated high patient satisfaction with telemental health

care as well as clinical and functional outcomes that match outcomes for in-person care. All of these trials were conducted with non-MD practitioners delivering services, consistent with the programs described above. These trials found that:

- Telemental health care increases the reach of evidence-based mental health care without diminishing its effectiveness.[3,4,5,6,7]
- Patient satisfaction with care is equal across telehealth and in-person modalities.[3,7,8]
- Telehealth care yields cost benefits (e.g., lower healthcare utilization costs 1-year post-treatment for depression).[9,10]

  - Consistent with these findings, the MUSC TOP, WRBT, and TRRP programs described above consistently have yielded strong patient satisfaction and clinical and functional outcomes data.[11,12,13]

- Multidisciplinary care is superior care and is facilitated by telehealth-based solutions. The use of telemental health services has not presented any major challenges or barriers to multidisciplinary care and, in fact, has facilitated the capacity to deliver multi-disciplinary services more efficiently. Patients who receive multidisciplinary services in-person typically are required to travel to different hospital settings, often across multiple days, to receive services. Telehealth-based multidisciplinary care is more accessible, more convenient, and yields high patient satisfaction.
- Telemental health providers can adhere to the same policies that apply to in-person care. As our telehealth programs have evolved and become more advanced, SC providers have developed the capacity to complete treatment consent processes seamlessly using established platforms (e.g., doxy.me) that are widely available and integrated into health systems and the electronic medical records, assist patients in resolving technology challenges efficiently, and involve MD providers in care as appropriate. Telemental health services delivered in patients' homes and satellite clinics can adhere to all of the same policies that govern traditional in-person, office-based mental health services.
- Metrics-informed care should be encouraged for in-person and telehealth services. The use of metrics-informed care will allow continuous evaluation as well as quality improvement opportunities to ensure that patient satisfaction is high, quality of care is high, and that clinical and functional patient outcomes are strong and continue to be consistent with in-person care. This should be used both for in-person and telehealth-based services, and will support transparency in ensuring that providers and programs using telemental health services are adhering to, and can provide continued evidence of, standards-based practice.

Registered Dieticians (RDs) or Nutritional Professionals

- Telehealth allows nutrition counseling to be delivered to more patients across the state without requiring patients to travel and outside their medical homes. Nutrition counseling is a key intervention needed to combat South Carolina's diabetes and obesity epidemic; however, there is a lack of qualified registered dietitians to provide their evidence-based services consistently throughout our state.

- Covering telehealth nutrition consultations for Medicaid patients would also help our state achieve the South Carolina Obesity Action Plan goals (H.1.1b and H.2.7b) to increase the number of adult and pediatric patients that receive nutritional counseling services by a dietitian.[14]
- A recent randomized controlled trial evaluated the efficacy of a registered dietician telehealth program to improve the health of diabetic patients and demonstrated significant improvement in the number of clinical measures (e.g. A1c, blood pressure) at follow-up compared to the control group.[15] A systematic review and metal-analysis of DTC for diabetes management, which includes nutrition education, found that the interventions were effective in improving glycemic control for patients with diabetes, reducing the number of hospitalizations, and had high levels of patient satisfaction.[16]

Rehabilitation Therapists: Physical Therapists (PTs), Speech Therapists (SLPs), and Occupational Therapists (OTs)

- During the pandemic telehealth use among all provider types accelerated, including the use among rehabilitation therapy providers.
- Certain PT, OT, and SLP services can effectively be delivered via telehealth. The literature demonstrates that many therapeutic assessments and treatments delivered via telehealth are valid and reliable[17,18,19] and can be associated with similar outcomes to in-person care.[20,21] Moreover, rehabilitation-related therapies are often most effective when adapted to a patient's life and home environment.
- Rehab clinicians have demonstrated clinical discernment in determining rehab services suitable for telehealth. During the period of authorization and payment to provide virtual services during the pandemic, MUSC's PT, OT, and SLP providers conducted nearly 3000 visits. While this provides important access for specific patients, the overall proportion of care provided virtually is small at 4%. This indicates that these therapy-providing clinicians use prudent clinical judgment when determining which patients would most benefit from telehealth visits.
- As with other telehealth services, provisions can be implemented to help avoid fraud and abuse (e.g., frequency limits, periodic in-person requirements, etc.).

Resources

- MUSC's Telemental Health Programs: Telehealth Outreach Program (TOP), Women's Reproductive Behavioral Telehealth (WRBT), & Trauma Resiliency & Recovery Program (TRRP)
- Telebehavioral Health Center of Excellence (Mid-Atlantic TRC)
- Medicare Telehealth Services and Registered Dietitians (Academy of Nutrition and Dietetics)
- State Occupational and Physical Therapy Telehealth Laws and Regulations: A 50-State Survey (CCHP)

References

1. Mental Health America Inc. Access to Care Ranking 2021. Retrieved from: https://mhanational.org/issues/2021/mental-health-america-access-care-data
2. Lacey L, McCleary N. South Carolina Health Professions Data Book. 2019. Retrieved from: https://www.scohw.org/projects/databook/
3. Egede LE, Acierno R, Knapp RG, et al. (2015). Lancet Psychiatry, 2(8), 693-701.
4. Egede LE, Acierno R, Knapp RG, et al. (2016). J Clinical Psychiatry, 77(12), 1704-1711.
5. Acierno R, Gros DF, Ruggiero, KJ, et al. (2016). Depression & Anxiety, 33(5), 415-433.

6. Acierno R, Knapp R, Tuerk P, et al. (2017). Behaviour Research and Therapy, 89, 57-65.
7. Yuen E, Gros DF, Price M, et al. (2015). J Clinical Psychology, 71(6), 500-512.
8. Gros DF, Lancaster CL, López CM, et al. (2016). J Telemedicine and Telecare, 24, 51-55.
9. Acierno R, Knapp R, Tuerk P, et al. (2017). Behaviour Research and Therapy, 89, 57-65.
10. Egede LE, Dismuke C, Walker R, et al. (2018). J Clinical Psychiatry, 79(5):17m11888
11. Guille C, Simpson A, Douglas E, et al. (2020). JAMA Netw Open, 3(1).
12. Ruggiero KJ, Davidson, T, Anton M, et al. (2020). J Am College Surgeons, 231(2), 223-230.
13. Stewart RW, Orengo-Aguayo R, Young J, et al. (2020. J Psychotherapy Integration, 30(2), 274.
14. SCDHEC (n.d.). *South Carolina Obesity Action Plan 2014 – 2019*. Retrieved from: https://scdhec.gov/sites/default/files/docs/Agency/docs/NewsReleaseDocs/EXECUTIVESUMMARYObesityActionPlan.pdf.
15. Kempf, K., Altpeter, B., Berger, J., Reuß, O., Fuchs, M., Schneider, M., Gärtner, B., Niedermeier, K., & Martin, S. (2017). Efficacy of the Telemedical Lifestyle intervention Program TeLiPro in Advanced Stages of Type 2 Diabetes: A Randomized Controlled Trial. Diabetes care, 40(7), 863–871. https://doi.org/10.2337/dc17-0303
16. Polisena J, Tran K, Cimon K, Hutton B, McGill S, Palmer K. Home telehealth for diabetes management: a systematic review and meta-analysis. Diabetes Obes Metab. 2009 Oct;11(10):913-30. doi: 10.1111/j.1463-1326.2009.01057.x. Epub 2009 Jun 16. PMID: 19531058.
17. Mani, S., Sharma, S., Omar, B., Paungmali, A., & Joseph, L. (2017). Validity and reliability of Internet-based physiotherapy assessment for musculoskeletal disorders: a systematic review. *Journal of telemedicine and telecare*, *23*(3), 379–391. https://doi.org/10.1177/1357633X16642369
18. Szekeres, M., & Valdes, K. (2020). Virtual health care & telehealth: Current therapy practice patterns. *Journal of hand therapy : official journal of the American Society of Hand Therapists*, S0894-1130(20)30213-1. Advance online publication. https://doi.org/10.1016/j.jht.2020.11.004
19. Molini-Avejonas, D. R., Rondon-Melo, S., Amato, C. A., & Samelli, A. G. (2015). A systematic review of the use of telehealth in speech, language and hearing sciences. *Journal of telemedicine and telecare*, *21*(7), 367–376. https://doi.org/10.1177/1357633X15583215
20. Cramer, S. C., Dodakian, L., Le, V., See, J., Augsburger, R., McKenzie, A., Zhou, R. J., Chiu, N. L., Heckhausen, J., Cassidy, J. M., Scacchi, W., Smith, M. T., Barrett, A. M., Knutson, J., Edwards, D., Putrino, D., Agrawal, K., Ngo, K., Roth, E. J., Tirschwell, D. L., … National Institutes of Health StrokeNet Telerehab Investigators (2019). Efficacy of Home-Based Telerehabilitation vs In-Clinic Therapy for Adults After Stroke: A Randomized Clinical Trial. *JAMA neurology*, *76*(9), 1079–1087. https://doi.org/10.1001/jamaneurol.2019.1604
21. Menon, N., Turcotte, J. J., Stone, A. H., Adkins, A. L., MacDonald, J. H., & King, P. J. (2020). Outpatient, Home-Based Physical Therapy Promotes Decreased Length of Stay and Post-Acute Resource Utilization After Total Joint Arthroplasty. *The Journal of arthroplasty*, *35*(8), 1968–1972. https://doi.org/10.1016/j.arth.2020.03.031

SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Permanently allow federally qualified health centers (FQHCs) and rural health centers (RHCs) serve as distant sites for telehealth

Description

- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are critically important healthcare providers in South Carolina, specifically for SC's rural and underserved communities.
- Before the COVID-19, FQHCs and RHCs were able to be reimbursed by Medicare as originating sites for telehealth, but were not able to serve as distant sites, meaning they could not be reimbursed for providing care via telehealth directly to their patients.
- During the COVID-19 pandemic Public Health Emergency declaration, CMS temporarily allowed RHCs and FQHCs to serve as distant sites for their patients and be reimbursed by Medicare, and SC DHHS followed suit.

Payer Coverage Considerations

- Covering FQHCs and RHCs as distant sites for telehealth improves health equity.
    - Serving special populations: Nationally, health centers care for more than 1 in 5 Medicaid beneficiaries, and 63% of health center patients are members of racial/ethnic minorities. Additionally, health center patients tend to suffer from chronic conditions at higher rates than the general populations.[1]
    - Decreasing travel burden: Health center patients are by definition a lower income patient population, and in turn are less likely to be able to take time from work for medical appointments, or have access to reliable transportation.
- Coverage of telemedicine services should be looked at through the lens of value.[2]
    - High value telemedicine services include those that are focused not only on the condition treated, but the patient receiving care.[2] Patients for whom telehealth provides increased access rather than additive access, such as those living in rural areas or of lower economic status tend to experience more access barriers. For these patient populations telemedicine services should be considered high-value, as the patients may not receive care any other way.

Resources

- National Association of Community Health Centers (NACHC) Telehealth Website

References

1. Community health CENTER Chartbook 2020 - home - NACHC. (2020). Retrieved September 14, 2021, Retrieved from: https://www.nachc.org/wpcontent/uploads/2020/01/Chartbook-2020-Final.pdf.
2. Mehrotra, A., Wang, B., & Snyder, G. (2020, August 5). Telemedicine: What should the post- pandemic regulatory and payment landscape look like? Commonwealth Fund. Retrieved September 14, 2021, Retrieved from: https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/telemedicine-post-pandemic-regulation.

SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Continue coverage of virtual check-ins and audio-only telehealth services

Codes: HCPCS code G2010, HCPCS code G2012, HCPCS code G2252, 99441, 99442, 99443, BH Codes

Code	Description	Provider Time
HCPCS code G2010	Remote evaluation of image/video submitted by established patient	NA
HCPCS code G2012	Brief check-in by MD/qualified health professional (for established patients)	5-10 minutes medical discussion
HCPCS code G2252	Brief check-in by MD/qualified health professional (for established patients) – temporarily allowed, included as permanent in proposed 2022 physician fee schedule	11-20 minutes medical discussion
99441	Telephonic E/M	5-10 minutes medical discussion
99442	Telephonic E/M	11-20 minutes medical discussion
99443	Telephonic E/M	21-30 minutes medical discussion
Behavioral Health Codes (90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90853, 90875)	Various behavioral health services approved by CMS for audio-only during public health emergency and included in proposed 2022 physician fee schedule.	Varies

Description

Virtual Check-Ins (G2010, G2012, G2252)

- Virtual check-in codes allow reimbursement for a provider's engagement with established patients across a number of modalities including phone, secure text messaging, email, or use of patient portal. This engagement can often help the provider and patient determine whether an in-person visit is needed for a particular medical concern.
- To be reimbursed, virtual check-ins may not originate from a related E/M service provided within the previous 7 days nor lead to an E/M service or procedure within the next 24 hours or soonest available appointment.
- Medicare began covering virtual check-ins in 2018, and numerous state Medicaid agencies have followed their lead.
- While use of G2010 can be asynchronous, G2012 and G2252 must involve synchronous audio communication.

Audio-Only Telehealth (99441-99443)

- Audio-only telehealth has been a critical tool to meet the healthcare needs of rural, elderly, and low-income patients during the public health emergency, many of whom may lack access to the appropriate technology, broadband, or digital literacy needed to utilize video-based services.
- Use of audio-only telephonic services are encouraged only when interactive video telehealth services are unavailable and when telephonic service is deemed medically appropriate for the underlying covered service.

- In the CY 2022 Physician Fee Schedule, Medicare has indicated plans to make audio-only telehealth a permanently covered service for the treatment of behavioral health so long as certain provisions are met.

Payer Coverage Considerations

- Coverage of audio-only telehealth supports health equity. Early research on utilization of telehealth during the pandemic has indicated the importance of audio-only telehealth for reaching patients that may face various social determinants of health. Blanket bans on audio-only telehealth exacerbates disparities for patients lacking technology or adequate broadband.
    - Early findings reported by CMS indicated that nearly 1/3 of all telemedicine occurring during the first months of the pandemic were audio-only.[1]
    - Studies suggest the rate of audio-only as compared to video visits to be even higher among patients receiving care at FQHCs,[2] and that FQHCs indicated audio-only care as critical to reaching vulnerable populations.[3] Data shared with the SCTA from partner FQHCs show similarly high-utilization of audio-only services.
    - Other studies point toward reduced likelihood of a full audio-video visit (as compared to audio-only visits) those who are older, Black, and from urban areas.[4]
    - At MUSC, audio-only makes up between 5-10% of telehealth visits across specialties, demonstrating that video is preferred but that audio-only has a significant role in maintaining continuity with patients receiving care from an academic medical center.
- Various provisions can be instituted to prevent fraud and abuse of audio-only visits. As indicated by proposed provisions outlined in the Medicare CY 2022 Proposed Physician Fee schedule, measures can be put in place to avoid misuse of telephonic codes. These include: requiring the person to be at home (to ensure the issue is a matter of connection, not convenience), requiring patients to have established relationships with existing providers, placing limits on number of telephonic visits between in-person visits, etc.
- Virtual check-ins have the potential to prevent unnecessary in-person care and improve patient outcomes.
    - Virtual check-ins have the potential to reduce unnecessary visits to the providers office, presenting cost-saving to both the patient and payer alike.
    - Health systems have begun to innovatively use virtual check-ins to support the care of patients with chronic diseases, in efforts to achieve the quadruple aim of enhancing patient experience, improving population health, reducing costs, and improving clinician experience.[5]
    - MUSC has begun to test the use of virtual check-ins to support care among patients with hypertension, diabetes, and ADHD, but lack of reimbursement limits the ability for these programs to scale.

Resources

- Medicare Telemedicine Health Care Provider Fact Sheet (March 17, 2020) (CMS)
- Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19 (Health Affairs)
- A virtual visit algorithm: How to differentiate and code telehealth visits, e-visits, and virtual check-ins (American Academy of Family Physicians)

SOUTH CAROLINA
Telehealth
ALLIANCE

References

1. Verma, S. (2020, July 15). *Early impact of cms expansion of medicare telehealth during covid-19*. Health Affairs. Retrieved from: https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.
2. Uscher-Pines, L., Sousa, J., Jones, M., Whaley, C., Perrone, C., McCullough, C., & Ober, A. J. (2021). Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. *JAMA, 325*(11), 1106-1107. doi:10.1001/jama.2021.0282
3. *Telehealth During COVID-19 Ensured Patients Were Not Left Behind*. National Association of Community Health Centers. (n.d.). Retrieved from: https://www.nachc.org/wp-content/uploads/2021/07/Audio-Only-Report-Final.pdf.
4. Pierce, R. P., & Stevermer, J. J. (2020). Disparities in use of telehealth at the onset of the COVID-19 public health emergency. *Journal of telemedicine and telecare*, 1357633X20963893. Advance online publication. https://doi.org/10.1177/1357633X20963893
5. Tai-Seale M, Downing NL, Jones VG, et al. Technology-Enabled Consumer Engagement: Promising Practices At Four Health Care Delivery Organizations. *Health Aff (Millwood)*. 2019;38(3):383-390. doi:10.1377/hlthaff.2018.05027

SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Cover chronic care remote patient monitoring codes currently covered by CMS

Codes: 99091, 99453, 99454, 99457, 99458

Code	Description
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), plus initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment included; do not report 99453 for monitoring of less than 16 days.)
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient.)
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
99458	Each additional 20 minutes (List separately in addition to code for primary procedure.)

Description

- Remote patient monitoring (RPM) is the collection of a wide range of health data from the point of care, such as vital signs, weight, and blood pressure.
- The data are transmitted to health professionals for monitoring and potential intervention as needed (e.g., medication adjustment, health coaching, triaging to in-person care).
- RPM can support acute and chronic disease management for patients with certain conditions.
- In 2019, Medicare began reimbursing the provision of these services as outlined above, and a little over half of state Medicaid agencies cover RPM to one degree or another.

Payer Coverage Considerations

- RPM has been shown to clinical outcomes by supporting chronic disease management. Research has demonstrated its utility across multiple conditions including diabetes,[1] weight management,[2] cardiovascular disease,[3,4] and COPD.[4]
    - One example of this is MUSC's technology assisted case management program (TACM-2), which focuses on low-income patients with diabetes and hypertension.
        - The program has monitored over 1,500 patients to date, with an average reduction of 1.4% in A1C among enrolled patients.
        - Lack of reimbursement for these services is one of the biggest barriers to growing this program.
- RPM can also be used prevent hospital admissions and readmissions. Research has demonstrated this for various chronic and acute conditions including various cardiac and pulmonary conditions,[5,6] including more recently COVID-19. [7,8,9]
    - During the COVID-19 pandemic, MUSC RPM nurses monitored 1,234 COVID positive patients between March 30 and December 31, 2020, many of whom were older and in underserved populations. The purpose of the program was to provide appropriate triage to patients, keeping at home when possible and referring to PCP/ED in the case of symptom exacerbation.
        - In aggregate, 89% of the 916 patients at moderate or high risk of severe complications were managed solely at home.

  - The program is currently being adapted to the needs of the most recent wave of infections. To free hospital beds, recovering patients will be monitored post-discharge in order to wean home oxygen with the use of transmitted pulse oximetry, making this a Medicare billable service.
- RPM can be efficient and cost-effective. Numerous studies have demonstrated the cost effectiveness of RPM for chronic conditions like diabetes.[10,11] Moreover, current CMS codes encourage a team-based approach to RPM services, allowing efficient use of nursing and other team members functioning at the highest level of their license, while ensuring physician oversight for the highest quality care.
- Cost containment mechanisms:
  - The provisions of the RPM codes themselves, as designed by CMS, have built-in elements to prevent overuse and abuse (e.g., only allowing one practitioner to bill CPT codes 99453 and 99454 during a 30-day period and only when at least 16 days of data have been collected on at least one medical device).
  - Moreover, current programs in SC have demonstrated that clinicians are skilled in reserving RPM resources for patients who are most in need and meet certain program criteria (e.g., A1C of at least 8% or higher for diabetes RPM).

Resources

- 2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule (Foley)
- CMS Revises 2021 Remote Patient Monitoring Rules, Issues Correction (Foley)
- Remote Patient Monitoring in the Safety Net: What Payers and Providers Need to Know (CHCF)

References

1. H. Tchero, P. Kangambega, C. Briatte, S. Brunet-Houdard, G.R. Retali, E. Rusch. Clinical effectiveness of telemedicine in diabetes mellitus: a meta-analysis of 42 randomized controlled trials Telemed. J. E Health, 25 (7) (2019), pp. 569-583
2. Vegesna, A., Tran, M., Angelaccio, M., & Arcona, S. (2017). Remote Patient Monitoring via Non-Invasive Digital Technologies: A Systematic Review. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, *23*(1), 3–17.
3. Bashi, N., Karunanithi, M., Fatehi, F., Ding, H., & Walters, D. (2017). Remote Monitoring of Patients With Heart Failure: An Overview of Systematic Reviews. *Journal of medical Internet research*, *19*(1), e18. https://doi.org/10.2196/jmir.6571
4. Taylor, M. L., Thomas, E. E., Snoswell, C. L., Smith, A. C., & Caffery, L. J. (2021). Does remote patient monitoring reduce acute care use? A systematic review. *BMJ open*, *11*(3), e040232. https://doi.org/10.1136/bmjopen-2020-040232
5. Hale, T. M., Jethwani, K., Kandola, M. S., Saldana, F., & Kvedar, J. C. (2016). A Remote Medication Monitoring System for Chronic Heart Failure Patients to Reduce Readmissions: A Two-Arm Randomized Pilot Study. *Journal of medical Internet research*, *18*(5), e91. https://doi.org/10.2196/jmir.5256
6. Abraham, W. T., Adamson, P. B., Bourge, R. C., Aaron, M. F., Costanzo, M. R., Stevenson, L. W., Strickland, W., Neelagaru, S., Raval, N., Krueger, S., Weiner, S., Shavelle, D., Jeffries, B., Yadav, J. S., & CHAMPION Trial Study Group (2011). Wireless pulmonary artery haemodynamic monitoring in chronic heart failure: a randomised controlled trial. *Lancet (London, England)*, *377*(9766), 658–666. https://doi.org/10.1016/S0140-6736(11)60101-3
7. Gordon, W. J., Henderson, D., DeSharone, A., Fisher, H. N., Judge, J., Levine, D. M., MacLean, L., Sousa, D., Su, M. Y., & Boxer, R. (2020). Remote Patient Monitoring Program for Hospital Discharged COVID-19 Patients. *Applied clinical informatics*, *11*(5), 792–801. https://doi.org/10.1055/s-0040-1721039
8. Annis, T., Pleasants, S., Hultman, G., Lindemann, E., Thompson, J. A., Billecke, S., Badlani, S., & Melton, G. B. (2020). Rapid implementation of a COVID-19 remote patient monitoring program. *Journal of the American Medical Informatics Association : JAMIA*, *27*(8), 1326–1330. https://doi.org/10.1093/jamia/ocaa097
9. Ford, D., Harvey, J. B., McElligott, J., King, K., Simpson, K. N., Valenta, S., Warr, E. H., Walsh, T., Debenham, E., Teasdale, C., Meystre, S., Obeid, J. S., Metts, C., & Lenert, L. A. (2020). Leveraging health system telehealth and informatics infrastructure to create a continuum of services for COVID-19 screening, testing, and treatment. *Journal of the American Medical Informatics Association : JAMIA*, *27*(12), 1871–1877. https://doi.org/10.1093/jamia/ocaa157
10. R. Warren, K. Carlisle, G. Mihala, et al. Effects of telemonitoring on glycaemic control and healthcare costs in type 2 diabetes: a randomised controlled trial J. Telemed. Telecare, 24 (2018), pp. 586-595
11. J.Y. Lee, S.W.H. Lee Telemedicine cost-effectiveness for diabetes management: a systematic review Diabetes Technol. Ther., 20 (2018), pp. 492-500

SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Cover interprofessional internet consultation (e-Consult) codes covered by CMS

Codes: 99446, 99447, 99448, 99449, 99451, 99452

Code	Description	Provider Time
99446	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	5-10 minutes medical consultative discussion and review
99447	11-20 minutes of medical consultative discussion and review	11-20 minutes medical consultative discussion and review
99448	21-30 minutes or more of medical consultative discussion and review	21-30 minutes or more of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review	31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes of medical consultative discussion and review	5 minutes of medical consultative discussion and review
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/ requesting physician or other qualified health care professional, 30 minutes	30 minutes

Description of Services:

- Interprofessional Internet Consultation (eConsult) codes provide reimbursement of provider-to-provider interactions regarding a patient's care. Using these codes, a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician with specific specialty expertise.
- The consulting provider is able to assist the treating provider with diagnosis and/or management of the patient's problem, decreasing the need for an in-person referral.
- Code detail:[1]
    - 99446-99449 include both real-time discussion and a written report between the two providers *(more than 50% of time must be medical consultative verbal or internet discussion)*
    - 99451 is used for asynchronous consultation including a written report
    - 99452 is used by the requesting/treating provider or other qualified healthcare provider to gather the information needed to request the consult
- Medicare adopted and began reimbursing for these codes in 2018.

Payer Coverage Considerations

- <u>eConsults are cost effective.</u> eConsults are associated with cost savings to payers, as concluded from a randomized study of eConsults versus face-to-face consultations in a statewide federally qualified health center.[2]

- Reduced unnecessary in-person referrals. Primary care providers ask targeted clinical questions and are empowered to treat and manage low-acuity issues.
- Improved communication and coordination increases efficiency. Improved PCP/specialist coordination through eConsults frees up specialist time to focus on more high acuity and complex cases.[3]
- Increases timely access to care. eConsults increase access to specialty care through improved timeliness and decreased appointment wait times.[4] This is especially beneficial in rural and underserved communities which disproportionately experience travel and resource burdens.
- Increased quality and improved health outcomes. With increased access to specialists through eConsults, patients receive quality care in a timely manner, and are less likely to experience negative health outcomes associated with care delays.
- Built-in provisions to prevent fraud and abuse.
    - The patient must consent and agree to cost-sharing.
    - Certain time constraints exist around in-person visits and billing frequency.

Resources

- AAMC Project Core information
- Cost Effectiveness Analysis of Cardiology eConsults for Medicaid Patients
- Center for Connected Health Policy Issue in Focus: New eConsult RCT Shows Significant Savings for Medicaid (paper linked above)
- eConsult Workgroup Resources
- Center for Connected Health Policy Issue Brief: eConsult – A Valuable Telehealth Tool for Increasing Access to Specialty Care
- eConsult Infographic
- North Carolina Medicaid coverage of Provider-to-Provider Store and Forward Telehealth (Virtual Communications)

References

1. Nicoletti, B. (2021, March 18). *Interprofessional internet Consultations*. CodingIntel. Retrieved from: https://codingintel.com/interprofessional-internet-consultations/.
2. Anderson, D., Victoria Villagra, Coman, E., Zlateva, I., Hutchinson, A., Villagra, J., & Olayiwola, N. (2018). A Cost-Effectiveness Analysis of Cardiology eConsults for Medicaid Patients. *The American Journal of Managed Care*, *24*(1).
3. Mann, S. (2017). eConsults Reduce Need for Specialty Referrals. *Association of American Medical Colleges*. https://www.aamc.org/news-insights/econsults-reduce-need-specialty-referrals.
4. Gaye, M., Mehrotra, A., Byrnes-Enoch, H., Chokshi, D., Wallach, A., Rodriguez, L., & Barnett, M. L. (2021). Association of econsult implementation with access to specialist care in a large urban safety-net system. *JAMA Health Forum*, *2*(5). https://doi.org/10.1001/jamahealthforum.2021.0456

SOUTH CAROLINA Telehealth ALLIANCE

Recommendation: Cover behavioral health integration codes (including CoCM) covered by CMS

Codes: 99494, 99492, 99493, 99484, HCPCS code G2214

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
Add-On CoCM (Any month) (CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)†	N/A	Usual work for the visit code
CoCM First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months (CPT code 99493)**	60 minutes per calendar month	26 minutes
General BHI (CPT code 99484)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

**CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

The Behavioral Health Integrated Care Model

- Integrating behavioral health into primary care has been widely accepted as an effective strategy for addressing the growing behavioral and mental health care needs of patients, leading to new behavioral health integration (BHI) payment models.
- BHI models leverage trained behavioral health care managers to provide care management services to a panel of patients under the supervision of the treating medical provider.
- Psychiatric Collaborative Care Services (CoCM), is a specific BHI model involving a psychiatrist that provides consultative support to the behavioral healthcare manager.
- Strategic use of integrated behavioral health can improve health and patient experience, while reducing unnecessary costs in time, money, and delays in care.
- Medicare began covering BHI services in 2017, with an increasing number of private payers and 19 state Medicaid agencies now covering as well.
- Telehealth can be used to deliver care management services and/or to provide the psychiatric consultative support to behavioral healthcare manager, adding efficiency to this already effective care model.

Description of Use

- The treating (billing) provider directs behavioral healthcare manager or clinical staff in delivery of BHI services to a panel of patients being treated by that provider for any mental, behavioral health, or psychiatric conditions that would benefit from BHI.
- Clinical staff or the behavioral health manager documents time spent delivering BHI services, and codes are billed (incident to the billing provider) on a monthly basis for these services rendered.
- For CoCM, a psychiatric consultant participates in regular review of patients receiving BHI services to advise on diagnosis, medication management, treatment progression, etc.

- CoCM requires additional documentation in a patient registry to support and document review and guidance provided by psychiatric consultant.

Payer Coverage Considerations

- The benefits of BHI Models are well-documented. The effectiveness and value of integration of behavioral healthcare into primary care is well-documented across the literature.
  - Collaborative care improves mental health outcomes.[1, 2, 3]
  - Enhances patient experience.[4]
  - Reduces costs.[3,5]
- Telehealth BHI models significantly improve patient's mental health and use substantially less time, compared to referral-based telepsychiatry.[6]
- Provisions to prevent fraud and abuse are built in. Documentation/registry requirements for BHI and CoCM help avoid potential for fraud and abuse of BHI/CoCM billing. Some state Medicaid agencies—including New York and California—have required an additional step of attestation on behalf of the billing BHI provider to ensure all components of the CoCM model are being met.[7]

Resources

- CMS Medicare Learning Network – Behavioral Health Integration Resource
- Current state Medicaids and private payers covering BHI / CoCM Codes
- American Hospital Association Value Initiative Brief: Integrated Behavioral Health is High-value Care
- Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care
- Advancing Integrated Mental Health Solutions (AIMS) Center: Collaborative Care (University of Washington)

References

1. Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane database of systematic reviews*, *10*, CD006525. https://doi.org/10.1002/14651858.CD006525.pub2
2. Reed, S. J., Shore, K. K., & Tice, J. A. (2016). Effectiveness and Value of Integrating Behavioral Health Into Primary Care. *JAMA internal medicine*, *176*(5), 691–692. https://doi.org/10.1001/jamainternmed.2016.0804
3. Reiss-Brennan, B., Brunisholz, K. D., Dredge, C., Briot, P., Grazier, K., Wilcox, A., Savitz, L., & James, B. (2016). Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. *JAMA*, *316*(8), 826–834. https://doi.org/10.1001/jama.2016.11232
4. Davis, M. M., Gunn, R., Gowen, L. K., Miller, B. F., Green, L. A., & Cohen, D. J. (2018). A qualitative study of patient experiences of care in integrated behavioral health and primary care settings: more similar than different. *Translational Behavioral Medicine*, 8(5), 649-659. doi:10.1093/tbm/ibx001
5. Ross, K. M., Klein, B., Ferro, K., McQueeney, D. A., Gernon, R., & Miller, B. F. (2019). The Cost Effectiveness of Embedding a Behavioral Health Clinician into an Existing Primary Care Practice to Facilitate the Integration of Care: A Prospective, Case-Control Program Evaluation. *Journal of clinical psychology in medical settings*, *26*(1), 59–67. https://doi.org/10.1007/s10880-018-9564-9
6. C, Bauer AM, Cerimele JM, et al. Comparison of Teleintegrated Care and Telereferral Care for Treating Complex Psychiatric Disorders in Primary Care: A Pragmatic Randomized Comparative Effectiveness Trial. *JAMA Psychiatry.* Published online August 25, 2021. doi:10.1001/jamapsychiatry.2021.2318
7. California Health Care Foundation (2020). *Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care.* Retrieved from: https://www.chcf.org/wp-content/uploads/2020/09/CrackingCodesMedicaid ReimbursingPsychiatric CollaborativeCare.pdf