CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Telemedicine

Rule Number(s): 5160-1-18

Date: 06/16/2014

Rule Type:

9New

Amended

5-Year Review

Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

The Department is implementing "Telemedicine" as a Medicaid-covered service. This service is the direct delivery of services to a Medicaid eligible patient via synchronous interactive, real-time electronic communication that comprises both audio and video elements.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

ORC 5164.94 (effective 5/20/2014)

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

No.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   N/A

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

This service is being offered under the Ohio Medicaid program in order to assure access to care under circumstances or in locations where access to medical care has been particularly challenging. In medically underserved areas where access to primary and specialty care is especially challenging, telemedicine can provide effective diagnosis and timely treatment of medical conditions.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

Claims records will be used to evaluate the number of consumers who received services delivered through telemedicine and the number of providers involved in the delivery of services through telemedicine. The Department will also track the number of instances where the billing of evaluation and management services in lieu of telemedicine was inappropriate.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

8/12: Internal ODM staff given the rule concepts for a week of review

8/19: Agency Staff from the Ohio Department of Medicaid, the Ohio Department of Mental Health and Addiction Services, and the Ohio Department of Developmental Disabilities met to review concepts and ask for suggestions.

9/6: Phone call with Managed Care Plans to discuss concept. During the call it was made clear that there was concern based off of a policy paper from the Medical Board regarding whether or

not the physician had to have an in-person meeting with the patient before being permitted to have telemedicine visits.

9/12: Phone call with the Medical Board to walk through concept of the rule as well as get clarity on the issue brought up by the managed care plans. They took the rule back for further review and edits.

9/20: Second call with the Medical Board to review their edits and make sure all were in agreement. All parties were satisfied by the end of the call with the rule language and concepts.

At the end of September, ODM had a meeting with the Ohio Hospital Association and the Ohio Children's Hospital Association to walk through the rule, and staff incorporated several of their edits into the rule. The main concern was regarding the distance concept – we have worked extensively on this and are still expecting to get more feedbackon this piece of the policy.

08/22, 10/24, and 12/19: ODM introduced the language at the MCAC and Physician Group meetings for their thoughts and edits.

12/6: ODM staff toured the stroke clinic at Riverside Hospital to better fully understand the dynamics of the telehealth world.

2/24/14: ODM met with Dr. Rasmussen from the Cleveland Clinic to better understand their specific technology platforms and telemedicine/telehealth collaborations.

2/25/14-3/4/14: ODM administered its official clearance process. The public at large was offered the opportunity to submit comments on the proposed rule. As a result of this process, ODM received comments from 16 different groups/individuals.

3/27/14: ODM staff met with the chief legal counsel for the Medical Board to discuss how ODM's proposed telemedicine complies with Medical Board rules.

4/11/14: ODM staff met with Jim Betts and his clients to discuss the advantages of using telemedicine to increase access to speech therapy.

5/2/14: ODM staff held a conference call with the Ohio Association of Community Health Centers to discuss their questions and clarify ODM's proposed policies regarding eligible distant site providers.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

See above.

As a result of feedback received from the stakeholder community, ODM is making numerous changes to the telemedicine rule, 5160-1-18.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

According to the National Council on State Legislatures, for states with large rural populations, telemedicine has become a cost-effective alternative to traditional face-to-face consultations or examinations between provider and patient. Forty-three state Medicaid agencies and the District of Columbia offer telemedicine services. Nineteen states and the District of Columbia currently require private insurance plans in the state to cover telehealth services. See NCSL at:http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx

The Veteran's Health Administration has used telemedicine as part of its standard medical practice since the late 1990's. The VHA attributes telemedicine to fewer bed days of care, reduced hospitalizations and high rates of patient satisfaction. See VHA: Taking Home Telehealth Services to Scale Nationally at: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2013/Jan/1657_Broderick_telehealth_adoption_VHA_case_study.pdf

A Commonwealth Fund Case study shows that remote patient monitoring (telemedicine) reduces hospitalizations and health care costs. Another result is an improvement in patient knowledge of their condition, greater satisfaction with their care and improved clinical outcomes. See Case Studies in Telehealth Adoption at**:** http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2013/Jan/1654_Broderick_telehealth_adoption_synthesis.pdf

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

There are no known alternatives to this service.

11. Did the Agency specifically consider a performance-based regulation? Please explain.

Though performance based requirements are an effective alternative to conventional code based pricing mechanisms, ODM would prefer to have a baseline of service utilization prior to introducing provider incentive options.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

Because telemedicine is not a service currently offered under the Ohio Medicaid State Plan, there are no existing Ohio Medicaid regulations regarding telemedicine. ODM has talked on numerous occasions to the Medical and Nursing Boards about the impact of ODM's proposed telemedicine coverage on current Medical and Nursing Board rules.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

ODM plans to use Current Procedural Terminology (CPT) coding and CMS Health Care Common Procedure Coding Systems (HCPCS) to identify the specific services provided by the licensed professionals approved to render telemedicine services to Medicaid consumers.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The provision of the Telemedicine service will affect specific Medicaid community providers statewide. Licensed practitioners such as MDs, DOs, and psychologists will be able to provide and receive reimbursement for this service.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

This rule imposes no license fees or fines. For the providers mentioned above, the service may involve staff time in order to report clinical information between the distant and originating site.

c. Quantify the expected adverse impact from the regulation.

Any impact on staff time will be dependent upon on whether or not the two sites have electronic health records (EHR) and, if so, whether or not the sites are using the same EHR technology. The staff time involved at sites with no EHR will be more than the staff time involved at sites with EHR. Providers who don't have EHR capacity still have the ability to share clinical information telephonically through facsimiles. Ohio Medicaid is currently involved with programs that encourage the adoption of EHR and connectivity across sites.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Telemedicine has the potential to improve program outcomes and lower costs. Any adverse impacts on providers reporting information from one to another has the potential to be offset by provider productivity gains and increased revenue. Providers currently share information in a referrer/referee situation. The medical board considers the reporting of information between referrer/referee to be a condition of the "continuum of care." The provider community is generally supportive of ODM's adoption of telemedicine.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

For this rule, there is no justifiable reason to provide any exceptions based on business size. Regardless of the size of the business, compliance is required for all providers who choose to offer services through telemedicine. No provider enrolled in Medicaid is required to offer services through telemedicine, therefore small businesses who are also providers enrolled in Medicaid are not required to meet any additional compliance requirements as a result of this rule.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This rule imposes no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

5160-1-18 **Telemedicine.**

Unless stated otherwise in rule 4731-11-09 or elsewhere in the Administrative Code, the following rule applies to health care services covered by the medicaid program and delivered using telemedicine.

(A) For purposes of this rule, the following definitions apply:

(1) "Telemedicine" is the direct delivery of services to a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. The following activities are not telemedicine:

(a) The delivery of service by electronic mail, telephone, or facsimile transmission;

(b) Conversations between practitioners regarding the patient without the patient present either physically or via synchronous, interactive, real-time electronic communication; and

(c) Audio-video communication related to the delivery of service in an intensive care unit.

(2) "Distant site" is the physical location of the consulting practitioner at the time when a health care service delivered through the use of telemedicine is provided.

(3) "Originating site" is the physical location of the patient at the time a health care service is provided through the use of telemedicine. The originating site may be one of five places:

(a) The office of a medical doctor, doctor of osteopathic medicine, optometerist, or podiatrist;

(b) A federally qualified health center, as defined in chapter 5160-28 of the Administrative Code, rural health center, or primary care clinic;

(c) An outpatient hospital;

(d) An inpatient hospital; or

(e) For services not included in the nursing facility per diem payment, a nursing facility.

(B) Requirements and responsibilities.

(1) The originating site is responsible for documenting the medical necessity of the health care service provided through the use of telemedicine, for securing the informed consent of the patient, and for developing and maintaining progress

notes.

(2) The rendering practitioner at the distant site must be a medical doctor, doctor of osteopathic medicine or licensed psychologist or a federally qualified health center, as defined in chapter 5160-28. When the rendering provider is a federally qualified health center the rendering practitioner must be a medical doctor, doctor of osteopathic medicine or licensed psychologist.

(3) The distant site is responsible for maintaining documentation of the health care service delivered through the use of telemedicine and for sending progress notes to the originating site for incorporation into the patient's records.

(C) Coverage.

(1) Payment may be made for the following health care services delivered at the distant site:

(a) Evaluation and management services characterized as "office or other outpatient services";

(b) Evaluation and management services characterized as either "office or other outpatient consultations" or "inpatient consultations"; or

(c) Psychiatry services characterized as "psychiatric diagnostic procedures", "psychotherapy," "pharmacologic management," or "interactive complexity."

(2) Except for medical emergencies, no payment is made for a health care service delivered through the use of telemedicine if the originating site is located within a five mile radius from the distant site.

(D) Claim payment.

(1) The distant site provider may submit a professional claim for the health care service delivered through the use of telemedicine. No institutional (facility) claim may be submitted. All appropriate codes and modifiers must be reported.

(2) An originating site provider that is neither an inpatient hospital nor a nursing facility may submit a claim for a telemedicine originating fee. If such an originating site provider renders a separately identifiable evaluation and management service to the patient on the same date as the health care service delivered through the use of telemedicine, then the provider may instead submit a claim for the evaluation and management service with the appropriate originating site modifier. No originating site provider may receive both a telemedicine originating fee and payment for an evaluation and management service provided to a patient on the same day.

(3) The payment amount for a health care service delivered through the use of telemedicine, a telemedicine originating fee, or an evaluation and management service is the lesser of the submitted charge or the maximum amount shown in Appendix DD to rule 5160-1-60 of the Administrative Code for the date of service.