August 21, 2020

HSD 410 Rules Coordinator
Oregon Health Authority, Health Systems Division
500 Summer St. NE, B-87
Salem, OR 97301

Submitted electronically via email to: HSD.Rules@dhsoha.state.or.us

RE: OARs 410-146-0085, 410-147-0120 Rule Language to Clarify Telemedicine Encounters for IHS/FQHC/RHC Providers; OARs 410-141-3566 Coordinated Care Organization (CCO) Telemedicine/Telehealth Payment Parity Requirements for Providers; and OARs 410-130-0610 Adopt Telemedicine Rule as Permanent to Assure Access to Services During Emergency

On the behalf of OCHIN, we appreciate the opportunity to comment on the recently released rules to address telehealth and payment parity as a consequence of COVID-19. We commend the Oregon Health Authority for its swift action to support patients and providers during this pandemic, as well as to continue many of the flexibilities afforded to them permanently.

OCHIN is a 501(c)(3) nonprofit community-based health information technology (HIT) collaborative. Our mission is to pioneer the use of health information technology (HIT) in caring for the medically underserved, touching over 500 clinics across the U.S. In Oregon, OCHIN works with 34 unique health center members and has helped them deploy telehealth platforms, workflows, and equipment, that have enabled 793,000 virtual encounters YTD, comprising 26.2% of all encounters within these centers. OCHIN serves community health centers (CHCs), including Federally Qualified Health Centers (FQHCs), rural and school-based health centers, safety-net providers and public health and corrections facilities across the nation. As the last to join the telehealth movement because of coverage inequality, we are excited to learn the true impact of telehealth as a modality of care delivery to this chronically underserved and medically complex population.

OCHIN’s extensive experience in health IT provides a clear picture of what is required to close the care gap using technology. When a health center seeks to expand their care delivery methods or innovate technologically, challenges arise in re-establishing workflow, ensuring proper training, and overcoming a patient’s lack of access to technology and broadband connectivity, as well as technological facilitation. These gaps drive health disparities and stand as obstacles to achieving truly equitable access to care. To reach this goal, we must start with payment and ensure health centers aren’t forced to engage with patients face-to-face to receive the highest reimbursement rate. We overcome this by providing payment parity between face-to-
face and virtual services to help health centers keep their doors open. Then, it is critical that we enable health centers to deliver the same quality of care as commercial care systems by providing them with the innovative technology necessary to reach their patients where they are. Equity begins within the health delivery system, and then translates to the patient. We must take these steps to keep health centers viable and accessible; then, continue to improve care delivery by overcoming obstacles, such as technology, connectivity, and language and cultural differences.

The changes facilitated during COVID-19 to improve access to care have been long-awaited for those serving patients in community health centers. Once we emerge from this public health emergency, as the pandemic slows down, we must continue to allow federally qualified health centers and rural health clinics to furnish telehealth services. This requires permanent telehealth payment parity, removal of obsolete restrictions on the location of the patient, and permanently allowing audio-only care delivery when appropriate.

I) OARs 410-147-0120 FQHC and RHC Services

OCHIN strongly supports the permanent inclusion of synchronous two-way audiovisual care delivery to a patient as a face-to-face encounter for FQHCs and RHCs. This is a critical step toward achieving health equity, especially for patients in underserved or geographically isolated areas. However, many of these areas are also facing inequities in broadband access. This lack of connectivity places more importance on the availability and coverage of telephonic evaluation management services, assessment and management services, and psychotherapy when we are not in a public health emergency. When these methods of care remain uncovered, it results in an unreasonable amount of uncompensated care, adding to clinics’ financial burden and resulting in provider burnout.

II) OARs 410-141-3566 Telemedicine Payment Parity Requirements

OCHIN strongly agrees with the decision to permanently adopt payment parity for expanded telemedicine and telehealth services at parity with in-person visits, and including synchronous audio/video visits, electronic/telephonic visits, and eConsults (electronic clinician to clinician consultations). However, we would like to clarify that PPS rates should be paid whether the care is delivered face-to-face, virtually, or via audio-only, as care is care regardless of modality. The lack of payment parity has hindered the adoption of true telehealth for those serving primarily Medicaid patients because of the disproportionately low payment in comparison to the time and education required to deliver care using this methodology. Acquisition of costly telehealth technology becomes less practical when appointments pay less, which in turn reduces ease of access for patients and increases burden for providers.
Even during the pandemic, many providers did not take the leap because of their uncertainty about what the end of the public health emergency would bring, or because complex billing methodology created more administrative burden than the appointments themselves were worth. It is critical that this expansion applies to community health centers, including FQHCs and RHCs which are often left out of regulatory changes. To achieve health care equity, these health centers with rapidly expanding patient populations must be fully compensated for the care they are delivering. It is expected that the growth in uninsured patients caused by the pandemic will increase patient volume and demand at these health centers, stretching their slim budgets even thinner and threatening their existence.

While large commercial systems have been innovating to expand their care modalities for years, community health centers are only now being given this opportunity, and are expected to catch up when they need time to grow into this new capability and learn how to increase efficiency. Some have not yet participated due to the expectation that this expanded opportunity will be short-lived and they will be left holding the bill for technology they can no longer benefit from. Without permanent certainty around payment, providers cannot continue to offer these services, as it strains health center budgets and, in turn, lowers quality of care for patients, many of whom are served regardless of their ability to pay. Oregon’s expanded payment parity for telehealth law, properly applied and expanded, will truly provide an opportunity to level the playing field, allowing all patients and providers to utilize cutting-edge technology to improve access to care.

### III) OARs 410-130-0610 Telemedicine

**a. Permanent telehealth expansion**

OCHIN strongly supports permanently adopting the permanent expansion of telehealth to include synchronous audio/visual visits, electronic/telephonic patient to clinician services, and eConsults. However, we do recommend the inclusion of “asynchronous” methods of care where they may be appropriate. Although it could be discerned that electronic/telephonic could cover asynchronous care methods, we urge for this to be called out specifically to provide greater clarity and align more closely with standard terminology. We are also strongly supportive of the permanent inclusion of a patient’s home as an alternate site, but suggest further expanding this requirement to simply the location of the patient, as it could inadvertently restrict care for those who are unhoused or between stable living situations.

**b. Interpreter requirement**

We are also strongly in favor of the requirement for providers to ensure that limited English proficient (LEP) and deaf or hard of hearing patients and their families are provided with a qualified and certified health care interpreter when needed. As an organization whose patients speak many languages, ensuring LEP patients can have meaningful and culturally-sensitive interactions with their providers helps overcome yet another persistent inequity in health care.
We urge that a provider code is established for health centers to be reimbursed for this service, and that CCOs are required to comply with this rule. Further, providers require technical assistance to integrate the right tools to account for language and reading ability and patients require technological support on their end, as a language barrier and unfamiliarity with technology can impact access or deter the use of this technology. To achieve equity in care, we must account for all individual barriers that may reduce or obstruct access to culturally competent care.

c. Establishing a patient via telehealth

Although the ability to establish a patient remotely was especially important during COVID-19, it remains critical for Oregonians even when the public health emergency comes to an end. With such a large population that remains underserved, and so many that must travel extensive distances to get to a provider, having the ability to become established as a patient via telehealth does not threaten the health or safety of a patient—in fact, it directly expands access. Archaic restrictions that reduce the ability for a health center to deliver care virtually harms communities, especially where the health center is the only access point. When these centers are in primarily rural areas, requiring a patient to endure an extensive commute to establish care can deter utilization of primary care and result in patients foregoing treatment or relying on emergency department visits when their symptoms reach a critical point. This drives up costs and reduces the effectiveness of a robust primary care system, which is necessary to serve these communities.

We greatly appreciate OHA’s efforts to update rules with the learning that has resulted from this unfortunate pandemic, and use this experience to better serve our population. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll
EVP, Government Relations and Public Affairs