August 7, 2020

Secretary Mandy Cohen, MD
NC Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2000

RE: Telehealth, Virtual Patient Communication, and Remote Patient Monitoring

Dear Secretary Cohen:

On behalf of the NC Pediatric Society, thank you for the opportunity to review and comment on Telehealth, Virtual Patient Communication, and Remote Patient Monitoring. The NC Pediatric Society (NCPeds) represents 2,300 pediatricians and other child health professionals across North Carolina. We share your deep concern for strong health access and outcomes.

First, we commend NCDHHS for quickly turning to telehealth for Medicaid at the beginning of the COVID-19 pandemic. This has been an important way for patients to receive needed care. The thoughtfulness and speed at which NCDHHS pivoted is truly remarkable.

Second, we also applaud NCDHHS for seeking to make many of these telehealth codes permanent. We appreciate the close attention to using the best available data to make changes. In general we support the package, although we have some suggestions for further improvement as well.

We particularly appreciate the following:


Paying at parity for in-person visits (H, page 16): Telehealth visits can take as long or longer for the physician and staff. Paying at parity is an important way to support this service. We also understand your rationale for paying a lesser percentage for phone calls, although we have concerns about broadband access at the community and patient level.
We particularly appreciate the following (con’d)
Assuring the medical record goes to the medical home (8.3): It is important that the medical home have a complete record of care for the patient. We appreciate that the default is that the medical home receive the record unless the patient proactively seeks to limit access.

Paying facility fees (7.0): This is an important support for three-way consultations and otherwise helping to ensure that a family can connect with a specialists a long-drive away in a medically appropriate environment when needed. This is especially important for children who are medically fragile or complex for whom travel can be particularly difficult or expensive (e.g., if an ambulance is required for transportation).

Allowing care in a variety of settings, including CDSAs and schools (8.2)

Permitting use of a range of HIPAA compliant devices (5.1)

We offer the following concerns and suggestions for improvement:

Format Table C-1 to include the modifier: While the narrative on page 11 and beyond clearly states the need for a GT modifier, it would be quicker for the end user if the need to include the modifier were included as part of the table, perhaps as a heading “C.1. Telehealth Services When Billed with a GT Modifier” or in the table itself (99201-GT; 00202-GT, etc.).

Consider including the CR modifier in the narrative or as a footnote: Including the CR modifier in the permanent policy may allow for immediate use of telehealth during emergencies and crises, including localized conditions (e.g., an explosion).

Clarify flexibility on originating sites (1.4) This flexibility has been critical during the pandemic as pediatricians and others may need to stay at home or families may face challenges coming into the office for a variety of reasons. Even not during a pandemic, doctors can be immune-compromised during flu season and parents with multiple children may struggle to get all the kids bundled up and into the office, or a child may be visiting/sheltering with another relative. It would be helpful if the policy continued to specifically allow the provider to be at locations other than the office and was clear that appropriate telehealth services could be provided to any established patient, regardless of their location/originating site.

Align CHIP and Medicaid: While such a policy change may be beyond the purview of this particular policy document, it does offer another example of how aligning the programs would result in administration simplification. Almost 3 of the 16 pages of this document cover how to handle the differences in Medicaid and Health Choice. ¹

Continue disaggregating data and let providers know that is happening: NCDHHS has done an outstanding job collecting and analyzing telehealth (and other) data during the pandemic. It is our understanding that preliminary results suggest that there may be some differences by age, race, geography and/or eligibility status (such as children in foster care). We encourage the Department to continue this level of analysis and report it back to providers at least at a macro-level to help inform improvement strategies. Noting the importance of this kind of data within the policy itself may promote more careful attention to equity by providers.

Thank you again for all of your work to promote child health, including through telehealth.

Sincerely,

Susan Mims, MD, MPH, FAAP

President,
North Carolina Pediatric Society

Cc: Dr. Shannon Dowler