Emerging Opportunities for Telemedicine Research in Rhode Island

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In the past few years, Rhode Island has made substantial strides towards advancing the coverage of telemedicine services.[1] Despite the state's more supportive policy environment, considerable caveats to coverage and barriers to telemedicine provision and use remain. For instance, the RI Medicaid program reimburses providers for certain telemedicine services, including live video telepsychiatry services, but does not reimburse providers for asynchronous telemedicine nor remote patient monitoring.[1-3] On the private payer side, RI joined the ranks of other states with private payer laws, with the passing of the Rhode Island Telemedicine Coverage Act in 2016.[4] This policy, implemented in 2018, represents a significant step towards supporting the growth of telemedicine services by requiring commercial insurers to provide the same coverage for telemedicine services as they do for in-person services.[4] However, certain aspects of the law have yet to be clarified.[4-6]

For instance, the Telemedicine Coverage Act does not offer specific guidelines about whether health plans may enable limits on coverage for certain telemedicine services.[6] Additionally, the law does not explicitly state that telemedicine services need to be paid at parity with in-person services.[6] Among other states with telemedicine coverage laws, some states, including Minnesota, mandate that Medicaid and private payers must reimburse telemedicine services at the same rates as in-person services.[7,8] This measure to ensure payment parity between telemedicine and in-person services may directly affect whether providers are willing to supply telemedicine visits as well as invest in resources related to telemedicine provision.[9,10]

In addition to these limits to the Telemedicine Coverage Act, there are restrictions for whether RI providers may practice medicine across borders. Currently, RI providers cannot deliver telemedicine services across state borders.[11] If patients are traveling or have moved out of state for instance, then they cannot continue seeing their existing provider via telemedicine. The Interstate Medical Licensure Compact (IMLC) is an agreement between 24 states and one territory that allows licensed physicians to practice medicine across state lines within states that are participants.[12] While several other New England states are part of the IMLC, it is unclear whether RI will join the compact.[11] In 2017, RI lawmakers established a legislative commission to advise on whether RI should be a part of the IMLC.[13] Previously, RI was a member of the Nurse Licensure Compact (NLC), allowing licensed registered nurses to see patients in other states.[11,14] However, as of 2018, RI is not a part of the NLC, and nurses in the state can no longer practice telemedicine across state borders.[11,14]

Whether these policies surrounding telemedicine in RI have impacted its use across different patient populations is unclear. In Minnesota, the Minnesota All-Payer Claims Database (MN APCD) has been used to examine the population-level patterns of telemedicine use across coverage populations.[15] Over the period 2010 to 2015, the volume of telemedicine visits increased sharply, from 11,113 to 86,238 visits, and 26 users per 10,000 enrollees to 113 users per 10,000 enrollees.[15] Nevertheless, only a small minority of the population used any telemedicine, and the majority of this growth is attributed to the increase of direct-to-consumer visits among the commercially insured population in metropolitan areas.[15] Within nonmetropolitan areas, most telemedicine visits were real-time services for mental health care, suggesting that in nonmetropolitan areas, telemedicine may have improved access for specialty care.[15]

Using the newly available HealthFacts RI Database, Rhode Island's All-Payer Claims Database, researchers may begin to track telemedicine use in the state.[16] HealthFacts RI, as a collaboration between the Rhode Island Department of Health, the Office of the Health Insurance Commissioner, the Health Benefits Exchange, and the Executive Office of Health and Human Services, collects de-identified healthcare claims from public and private payers.[16] While RI contains a relatively larger proportion of individuals living in urban areas compared to MN, telemedicine still has the capacity to improve access to care in the state.[17] According to the U.S. Census Bureau, the poverty rate in RI is 11.6%, and 9.3% of the population lives in rural region.[16,18] Additionally, the RI Department of Health reported in 2016 that transportation remains one of the biggest barriers to receiving care for rural residents.[18,19] Local RI organizations determined that 22 percent of individuals had forgone care due to transportation barriers, and for low-income individuals, transportation fares are prohibitively expensive.[19]

Similar to the analyses on the patterns of telemedicine use across privately and publicly insured patient populations completed in Minnesota, there are important questions about how different patient coverage populations use telemedicine in RI that may be explored using the HealthFacts RI. In 2017, the Medicaid program in RI served 32% of the under 65 population, and as of 2011, around 57% of all individuals are covered by private insurance.[20,21] Understanding the underlying trends in telemedicine use across these coverage populations may provide insight into whether the Telemedicine Coverage Act and other policies surrounding telemedicine in RI expanded access to care, particularly in underserved areas. Currently, the evidence in the literature about whether state telemedicine coverage policies drive the provision of telemedicine services is mixed. While several studies in the past few years have found that states with parity legislation have more telemedicine visits, others have found no associations between telemedicine use overall and statewide telemedicine policies.[9,10,22-24] In Minnesota, the Minnesota Telemedicine Act (MTA) mandated reimbursement parity for all healthcare services provided via telemedicine for Medicaid enrollees in 2016, and for commercial beneficiaries in 2017.[25] The MN APCD is being leveraged to compare the volume and breadth of telemedicine utilization across multiple payers before and after the expansion of the telemedicine parity policy.

In addition to understanding how policy changes have impacted telemedicine use in RI, there is a need for researchers to examine how telemedicine can be integrated with in-person care. For instance, the rise of the RI Accountable Entity (AE) Program in the previous few years, forming new Medicaid Accountable Care Organizations (ACO) in the state, introduces opportunities to study telemedicine within the context of a value-based care setting.[26] These ACOs, which are accountable for the quality, utilization and total cost of care for its attributed population, may use telemedicine to maintain continuity of care for high need and high cost populations.[26] Future work should examine if ACOs are increasing their use of telemedicine, and whether integrated telemedicine visits can promote the goals of AEs, including care coordination, addressing the social determinants of health, and reducing medical spending.

Telemedicine also has the potential to address the shortage of mental health providers and complement in-person mental health services, particularly for conditions such as substance use disorders (SUDs). In RI, substance use results in an age-adjusted rate of 26.9 deaths per 100,000 persons, compared to a national average rate of 14.6 deaths per 100,000 persons.[27] There may be a role, therefore, for telemedicine visits for SUD treatment, or tele-SUD, to bridge gaps in care within the state. In a recently published paper using commercial claims data, Huskamp and colleagues found that tele-SUD visits are still very low, but are currently being used to complement in-person SUD care, and have experienced rapid growth in the past decade, increasing from 0.62 visits per 1,000 people diagnosed with SUD in 2010 to 3.05 visits per 1,000 people in 2017.[28] The researchers concluded that the overall low use of tele-SUD visits may be too low given its capacity to improve patient outcomes, and more studies are needed to study the use of tele-SUD in various patient populations in order to guide future legislation surrounding tele-SUD.[28]

To date, the evidence on the use of telemedicine visits across patient populations, its impact on follow-up outcomes, and overall access to care is still limited. There are new opportunities in RI however, to examine the patterns of telemedicine use, and to achieve a better understanding of how telemedicine can support the provision of appropriate, timely, and high-quality care. Leveraging new sources of data in the state and evaluating recent advances in policies such as the RI Telemedicine Coverage Act, will be crucial for informing future legislation that aims to improve the delivery of health care services in the state.

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