NCQA© HEDIS® MEASURES & MENTAL HEALTH: THE CURRENT LANDSCAPE & FUTURE DEVELOPMENTS

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**Position:** Dr. Liu is a behavioral health researcher joined the National Committee for Quality Assurance in 2012 as a research scientist. Dr. Liu serves as a project director and researcher on several federally funded child and adult behavioral health measurement projects at NCQA. As the measure lead of NCQA’s behavioral health measures, Dr. Liu guides the re-evaluation and updates of HEDIS behavioral health measures. Dr. Liu’s research focuses on access to mental health services, evidence-based treatment for behavioral health problems, and child welfare services. Prior to joining NCQA, Dr. Liu was a research assistant professor at University of Maryland School of Social Work and conducted the evaluation of a federally funded research project on the implementation of evidence-based practices in child welfare systems in six states.

**Education:** Dr. Liu holds a Ph.D. and a Master in Social Work from University at Albany, State University of New York. She received her undergraduate degree from China Youth University for Political Sciences.

Emily C. Morden, M.S.W.

**Position:** Ms. Morden is a Senior Research Associate in the Performance Measurement Department at the National Committee for Quality Assurance. Ms. Morden works on the development and maintenance of health care performance measures primarily addressing geriatric and behavioral health care. She works in collaboration and consultation with internal and external advisory panels in order to inform measure development. Prior to working at NCQA, Ms. Morden was an Associate Program Officer with the Board on the Health of Select Populations at the Institute of Medicine (IOM). While at the IOM, Ms. Morden worked on several studies examining the quality of health care services for military service members and veterans, contributing her research and report writing skills to several IOM reports. Before moving to Washington D.C. to work in the field of health care quality, Ms. Morden resided in Oregon and worked as a medical social worker for hospice programs. She also has several years of experience working as a counselor in both adult and adolescent mental health treatment facilities. In these clinical roles, Ms. Morden gained expertise in the delivery and integration of behavioral health care services. Ms. Morden has interest and proficiency in many subjects including medical social work services, palliative and end of life care, medical ethics and decision-making, behavioral health treatment modalities, and care for vulnerable older adults.

**Education:** Ms. Morden holds an M.S.W. degree from Portland State University and a B.A. in sociology from the University of Oregon.
Babette S. Edgar, Pharm.D., MBA, BCPS

**Position:** Babette S. Edgar, Pharm.D., MBA, FAMCP is a Principal at BluePeak Advisors (BPA), and is President-Elect of the Academy of Managed Care Pharmacy.

Babette has been in the managed care industry for 23 years and advises health plans, pharmacy benefit management companies and pharmaceutical companies on Medicare and managed care strategies, operational and compliance issues.

Prior to starting her own firm, Babette worked at CatalystRx, where she was President, Government Services and ran the Medicare business for the fourth largest PBM. Babette was the Director of the Division of Finance and Operations for the Medicare Drug Benefit Group at the Centers for Medicare and Medicaid (CMS), where she directed building and implementing the formulary and benefit design review processes for the Part D drug benefit. She oversaw the CMS Part D team that developed the agency's marketing guidelines and marketing models, and conducted oversight of the marketing review process. Babette also directed CMS operations for reviewing and monitoring the licensure and solvency of Part D plan sponsors, assisted in developing transition guidance for Part D plans with patients migrating from Medicaid or other benefits; and provided input into the Part D regulations and other subregulatory guidance from a managed care pharmacy perspective.

Previous to her term at CMS, Babette was Vice President, Clinical Business Development at Caremark/AdvancePCS, where she directed sales for a multimillion dollar disease management product line, and directed account management for 16 premier accounts, including Blue Cross plans, managed health plans, Medicare/Medicaid, third party administrators and large and small employers. Babette previously served as Director of Clinical Services for Advance Paradigm, where she ran the P and T process, performed academic detailing, and managed the clinical team responsible for developing clinical content and clinical strategy.

Babette has authored many articles in peer-reviewed journals, and has been a speaker at many national meetings, conferences and symposia.
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Otsuka Pharmaceutical Development and Commercialization, Inc. (OPDC) and Lundbeck, LLC. have entered into collaboration with Open Minds, LLC. to explore new ways of bringing/increasing awareness around serious mental illness.

OPDC/Lundbeck’s interaction with Open Minds is through PsychU, an online, non-branded portal dedicated to providing information and resources on important disease state and care delivery topics related to mental illness. One of the methods employed for the sharing of information will be the hosting of virtual fora. Virtual fora conducted by OPDC/Lundbeck are based on the following parameters:

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OPDC and Lundbeck operate in a highly regulated and scrutinized industry. Therefore, we may not be able to discuss every issue or topic that you are interested in, but we will do our best to communicate openly and directly. The lack of response to certain questions or comments should not be taken as an agreement with the view posed or an admission of any kind.
Why Do We Care About Behavioral Health?

- Patients and society suffer
- Higher occurrence of physical illness
- Disproportionately high contribution to health care cost
Strategic Issues In Behavioral Health

• More insured people and expansion of covered services
• Integration of behavioral health care into primary care and of primary care into behavioral health care settings
• Quality of behavioral health is not improving
## NCQA Measures: Behavioral Health

<table>
<thead>
<tr>
<th>Topic</th>
<th>Measure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>Depression screening &amp; follow up</td>
<td>Under development</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Depression monitoring</td>
<td>In HEDIS®</td>
</tr>
<tr>
<td>Medication management</td>
<td>Adherence to antipsychotic medications</td>
<td>In HEDIS</td>
</tr>
<tr>
<td></td>
<td>Antidepressant medication management</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Psychosocial care</td>
<td>Use of first-line psychosocial care for children on antipsychotics</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Coordination</td>
<td>Follow-up after ED visit for mental illness</td>
<td>Proposed for 2017</td>
</tr>
<tr>
<td></td>
<td>Follow-up after hospitalization for mental illness</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Overuse/ Appropriateness</td>
<td>Use of multiple antipsychotics in children</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Integration of medical needs</td>
<td>Diabetes screening/monitoring for people with schizophrenia</td>
<td>In HEDIS</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular monitoring for people with cardiovascular disease and schizophrenia</td>
<td>In HEDIS</td>
</tr>
<tr>
<td></td>
<td>Metabolic monitoring for children on antipsychotics</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Utilization</td>
<td>Mental Health Service Utilization</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Depression remission/response</td>
<td>Proposed for 2017</td>
</tr>
</tbody>
</table>

NCQA: National Committee for Quality Assurance  
HEDIS: Healthcare Effectiveness Data and Information Set  
ED: Emergency Department  

Source for proposed measures: Internal data from National Committee for Quality Assurance. Information also available on NCQA’s website.
# NCQA Measures: Substance Use

<table>
<thead>
<tr>
<th>Topic</th>
<th>Measure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>Alcohol screening &amp; brief intervention</td>
<td>Under development</td>
</tr>
<tr>
<td>Overuse/Appropriateness</td>
<td>Opioid overuse</td>
<td>Under development</td>
</tr>
<tr>
<td></td>
<td>• Opioid high dosage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multiple prescribers or pharmacies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multi-provider, high dosage</td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td>Follow-up after ED visit for Alcohol and Other Drug Dependence (AOD)</td>
<td>Proposed for 2017</td>
</tr>
<tr>
<td>Access to care</td>
<td>Initiation and Engagement of AOD treatment</td>
<td>In HEDIS</td>
</tr>
<tr>
<td>Utilization</td>
<td>Identification of AOD Services</td>
<td>In HEDIS</td>
</tr>
</tbody>
</table>

ED: Emergency Department  
AOD: Alcohol and Other Drug Dependence  
HEDIS: Healthcare Effectiveness Data and Information Set  
Source: Internal data from National Committee for Quality Assurance
Initiation Of Substance Use Treatment Is Declining¹

HEDIS: Healthcare Effectiveness Data and Information Set
AOD: Alcohol and Other Drug Dependence

Follow-Up After Hospitalization For Mental Illness¹

Follow-up within 30 days post-discharge

Serious Mental Illness (SMI)

Prevalence of Serious Mental Illness Among U.S. Adults (2014)

Data courtesy of SAMHSA

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Male</th>
<th>Female</th>
<th>18-25</th>
<th>26-49</th>
<th>50+</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>NH/OPI*</th>
<th>AI/AN**</th>
<th>2 or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>4.1</td>
<td>5.0</td>
<td>3.1</td>
<td>4.8</td>
<td>4.9</td>
<td>3.1</td>
<td>3.5</td>
<td>4.4</td>
<td>3.1</td>
<td>2.9</td>
<td>2.4</td>
<td>4.0</td>
<td>8.9</td>
</tr>
</tbody>
</table>

SMI: Serious Mental Illness


*NH/OPI = Native Hawaiian/Other Pacific Islander
**AI/AN = American Indian/Alaska Native
Disparities In Care

• Individuals with SMI are less likely to receive adequate treatment for hypertension or diabetes \(^1,2\)
• Early mortality: people with SMI die 25 years earlier than the general population \(^3\)


SMI: Serious Mental Illness
NASMHPD: National Association of State Mental Health Program Directors
Schizophrenia & Bipolar Disorder Measure Set

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

~ Reported by Medicaid plans since 2013 ~
~ Claims-based measures ~

Source: Internal data from National Committee for Quality Assurance
# Adherence To Antipsychotic Medications For Individuals With Schizophrenia

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Members 19-64 years of age during the measurement year with schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Members dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period</td>
</tr>
<tr>
<td>Performance Rate (2014)</td>
<td>60%</td>
</tr>
</tbody>
</table>

Diabetes Screening For People With Schizophrenia Or Bipolar Disorder Who Are Using Antipsychotic Medications

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Members 18-64 years of age with schizophrenia or bipolar disorder and dispensed an antipsychotic medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Members had a glucose test or HbA1c test during the measurement year</td>
</tr>
<tr>
<td>Performance Rate (2014)</td>
<td>80%</td>
</tr>
</tbody>
</table>

## Diabetes Monitoring For People With Diabetes & Schizophrenia

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Members 18-64 years of age with schizophrenia and diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Members had both an LDL-C test and an HbA1c test during the measurement year</td>
</tr>
<tr>
<td>Performance Rate (2014)</td>
<td>69%</td>
</tr>
</tbody>
</table>

LDL-C: low-density lipoprotein cholesterol

Cardiovascular Monitoring For People With Cardiovascular Disease & Schizophrenia

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Members 18-64 years of age with schizophrenia and cardiovascular disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Members had an LDL-C test during the measurement year</td>
</tr>
<tr>
<td>Performance Rate (2014)</td>
<td>76%</td>
</tr>
</tbody>
</table>

LDL-C: low-density lipoprotein cholesterol

Additional Preventive Care & Outcome Measures For SMI

Background

• NCQA and Mathematica Policy Research contracted with ASPE and SAMHSA (2010-2014) to develop measures that
  – Address preventive care, continuity of care, and outcomes for people with SMI and/or alcohol or other drug use disorders (AOD)¹
• Measures recommended for endorsement by the National Quality Forum (NQF) in 2015²

SMI: Serious Mental Illness
NQF: National Quality Forum
ASPE: Assistant Secretary for Planning and Evaluation
SAMHSA: Substance Abuse and Mental Health Services Administration
NCQA: National Committee for Quality Assurance
AOD: Alcohol and Other Drug Dependence

### Screening, Continuity Of Care, & Outcome Measures For SMI & AOD¹

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Mass Index Screening and Follow-up for People with Serious Mental Illness</td>
<td>2601</td>
</tr>
<tr>
<td>Alcohol Screening and Follow-up for People with Serious Mental Illness</td>
<td>2599</td>
</tr>
<tr>
<td>Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol and Other Drug Dependence</td>
<td>2600</td>
</tr>
<tr>
<td>Follow-Up After Emergency Department Use for Mental Health Conditions or Alcohol and Other Drug Dependence</td>
<td>2605</td>
</tr>
<tr>
<td>Controlling High Blood Pressure for People with Serious Mental Illness</td>
<td>2602</td>
</tr>
</tbody>
</table>

SMI: Serious Mental Illness; AOD: Alcohol and Other Drug Dependence; NQF: National Quality Forum

# Diabetes Care Measures For People With SMI¹

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c testing</td>
<td>2603</td>
</tr>
<tr>
<td>HbA1c poor control (&gt;9%)</td>
<td>2607</td>
</tr>
<tr>
<td>HbA1c control (&lt;8%)</td>
<td>2608</td>
</tr>
<tr>
<td>Eye exam</td>
<td>2609</td>
</tr>
<tr>
<td>Medical attention for nephropathy</td>
<td>2604</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>2606</td>
</tr>
</tbody>
</table>

SMI: Serious Mental Illness  
NQF: National Quality Forum  

New Measures Under Development

• Suite of substance use measures will cover alcohol screening, treatment, opioid overuse, and follow-up care
• Depression screening, monitoring and outcome measures
• Evaluating telehealth for HEDIS behavioral health measures

HEDIS: Healthcare Effectiveness Data and Information Set

Source: Internal data from National Committee for Quality Assurance
SBIRT, Identification, & Treatment

Screening & Brief Intervention
Identification of AOD
Initiation of treatment among people with diagnosis
Engagement in treatment among people with diagnosis

SBIRT: Screening, Brief Intervention, and Referral to Treatment
SAMHSA: Substance Abuse and Mental Health Services Administration

## Specifications Of SBIRT, Identification & IET

<table>
<thead>
<tr>
<th>Screening &amp; Brief Intervention</th>
<th>Identification of AOD</th>
<th>Initiation and Engagement of AOD Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Development</td>
<td>In HEDIS</td>
<td>In HEDIS</td>
</tr>
</tbody>
</table>

**Denominator**

- Members ≥18 years of age
- All members
- Members ≥13 years with new AOD abuse or dependence diagnosis

**Numerator**

- Screening, brief intervention
- Inpatient, outpatient and ED visit with an AOD diagnosis
- Inpatient, outpatient, visit with an AOD diagnosis within 14 and 44 days of the index visit

**Data source**

- ECDS/hybrid
- Administrative claims

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**Specifications Of SBIRT, Identification & IET**

**Source:** Internal data from National Committee for Quality Assurance
Polling Question

What would be the most relevant setting of care for alcohol screening and brief intervention measure?

A. Primary care
B. Behavioral health care
C. Emergency department for everyone
D. Emergency department for patients who had alcohol use related complications (e.g., injury from a car accident, intoxication)
Polling Question

What do you see as the biggest challenge in introducing an SBIRT (Screening Brief Intervention and Referral for Treatment) alcohol screening and brief intervention measure for HEDIS?

A. Lack of use of claims codes on alcohol screening brief intervention that are available
B. Lack of providers who are trained to provide SBIRT services
C. Variation of the quality of SBIRT services
D. Defining what counts as brief intervention
E. Lack of documentation of alcohol screening and brief intervention in structured fields in the EHR
# Opioid Overuse

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Members 19 years of age and older receiving prescription opioids for &gt; 15 days during the measurement year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate 1: Opioid high dosage</td>
<td>Received a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer</td>
</tr>
<tr>
<td>Rate 2: Multiple prescribers and multiple pharmacies</td>
<td>Received prescriptions for opioids from four or more prescribers AND four or more pharmacies</td>
</tr>
<tr>
<td>Rate 3: Multi-provider, high dosage</td>
<td>Met both rate 1 AND rate 2</td>
</tr>
</tbody>
</table>
| Exclusions                               | • A diagnosis of cancer  
                                             • Had only one opioid medication dispensing event  
                                             • Hospice |

Source: Internal data from National Committee for Quality Assurance
Measures: Balancing Pain Management

• Purpose:
  – Avoid potential unintended consequence of monitoring opioid overuse
  – Provide appropriate pain management

• Existing pain measure examples:
  – Process measures: Pain Assessment & Follow-Up (NQF #0420)
  – Outcome measures: Health Outcomes Survey (HOS)

• Question:
  – What pain management topics should be considered for measure development?

NQF: National Quality Forum; HOS: Health Outcomes Survey;
Source: Internal data from National Committee for Quality Assurance
Polling Question

What is the most important pain management measure concept to develop in order to minimize the unintended consequences of opioid overuse monitoring?

A. Pain assessment and follow up
B. Use of non-pharmacologic therapy (i.e. multidisciplinary approach) and non-opioid pharmacologic therapy as a first-line treatment for chronic pain
C. Avoid the prescription of opioids for acute pain at high dosage or for a long period of time
D. Use of psychotherapy and multi-disciplinary approach for chronic low back pain
E. New users of opioids: patients signing consent form for receiving opioid treatment, screening for risk of substance abuse
F. Chronic users of opioids: patients receiving an urine drug test in the past 6 or 12 months, monitoring of functional status
G. Other
# New Measures Address Follow-Up After ED Visit

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td><strong>Members 6 years of age and older who had a visit to the ED with a primary diagnosis of mental illness</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td><strong>Members 13 years of age and older who had a visit to the ED with a diagnosis of Alcohol and other Drug Dependence (AOD)</strong></td>
</tr>
<tr>
<td><strong>Members who had a follow up visit with a primary diagnosis of mental illness within 7- and 30-days after an ED visit</strong></td>
<td><strong>Members who had a follow up visit with a primary diagnosis of AOD within 7- and 30-days after an ED visit</strong></td>
</tr>
</tbody>
</table>

**Data Source**: Administrative Claims

ED: Emergency Department; AOD: Alcohol and Other Drug Dependence

Source: Internal data from National Committee for Quality Assurance
## Depression Measures Are Introduced In Stages

<table>
<thead>
<tr>
<th>Depression Monitoring</th>
<th>Percentage of individuals age ≥12 with a diagnosis of major depression or dysthymia who had a PHQ-9 tool administered at least once during a four-month period</th>
<th>HEDIS 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Remission or Response</td>
<td>Percentage of individuals age ≥12 with a diagnosis of major depression or dysthymia and an elevated PHQ-9 score, who had evidence of response or remission within 5–7 months of the elevated PHQ-9 score</td>
<td>Proposed for HEDIS 2017</td>
</tr>
<tr>
<td>Depression Screening and Follow-Up</td>
<td>Percentage of individuals age ≥12 who were screened for clinical depression using a standardized tool and, if screened positive, received appropriate follow-up care</td>
<td>Under development: Planned for HEDIS 2018</td>
</tr>
</tbody>
</table>

HEDIS: Healthcare Effectiveness Data and Information Set; PHQ-9: Patient Health Questionnaire 9

New Data Reporting Method: Electronic Clinical Data Sources (ECDS)¹

- Patient care across settings in a structured, electronic format
- Maintained over time
- Includes some or all key clinical data relevant to care
- Bidirectional, automated access to information
- Accessible by the healthcare team at the point of care

ECDS: Electronic Clinical Data Sources

HEDIS Learning Collaborative Supports Implementation

• Voluntary collaborative of 13 health plans interested in reporting using ECDS\(^1\)
• Focused on three depression care measures\(^2\)
• Components of the collaborative:\(^1\)
  – Education and technical assistance
  – Bidirectional learning
• Learning will inform development of guidelines for new HEDIS ECDS data collection method\(^1\)

ECDS: Electronic Clinical Data Sources; HEDIS: Healthcare Effectiveness Data and Information Set

What Is Telehealth?

“Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.”

Telehealth Coding & HEDIS Measures

- Usually same CPT codes with modifier (GT)
- Evaluating telehealth for HEDIS measures
  - Prioritizing behavioral health measures
  - Evidence on effectiveness of telehealth
  - Modality and type of telehealth activities that should count
  - Pros and cons to counting telehealth
    - Improve access
    - Assessments of quality of telehealth to avoid poor care
  - Impact on measure denominator and performance rate
  - Implications on HEDIS reporting and auditing guidelines


Source: Internal data from National Committee for Quality Assurance

The information provided by PsychU is intended for your educational benefit only. It is not intended as, nor is it a substitute for medical care or advice or professional diagnosis. Users seeking medical advice should consult with their physician or other healthcare professional.
Polling Question

What do you see as the biggest challenge of including telehealth in HEDIS measures?

A. Lack of available coding to identify telehealth visits
B. Lack of use of telehealth claims codes that are available
C. Ensuring quality care is being delivered by trained providers
D. Defining what type(s) of telehealth visits that should count
E. Variability of use and quality of telehealth across different health systems and health plans
F. Lack of incentives to document telehealth in claims or medical records
G. Other
CLOSING