VERMONT ACADEMY OF FAMILY PHYSICIANS

Vermont Medical Society

Vermont Chapter
INCORPORATED IN VERMONT
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

To: House Health Care Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: February 15, 2024
RE: Support for DR 24-0673 – Continued Reimbursement Policy for Telehealth

The Vermont Medical Society, Vermont Academy of Family Physicians and American Academy of Pediatrics Vermont Chapter testify this morning in strong support of DR 24-0673, related to payment for telehealth services.

I would like to highlight what this bill does and does not do.

Nothing in this bill changes the status quo in place today for coverage for telehealth services – except to move the floor to pay for audio-only services, which is currently at 75% of in-person rates, to 100%.

Otherwise, Vermont statue already requires that payers provide coverage for audio-only and audio-visual telehealth services. In addition:

- What is a billable service now will continue to be a billable service – this requires meeting coding guidelines for an office visit. Simply calling in a prescription renewal is not, and has never been, a billable service.
- There must be patient choice and consent (18 V.S.A § 9362).
- Payers can determine which services are "medically necessary and clinically appropriate" for audio-only telehealth (8 V.S.A. § 4100k(d) – and they only cover a limited list. So, if a payer determines a service is not clinically appropriate to reimburse through audio-only, they do not have to. See current payment policies here:
    - https://www.bluecrossvt.org/documents/cpp24-temporary-telephone-policy-final
    - https://www.mvphealthcare.com/-/media/project/mvp/healthcare/documents/provider-policies-and-payment-policies/2024/january/mvp-payment-policies-effective-january-1-2024 (page 23)
    - https://dvha.vermont.gov/document/audio-only-telehealth-services

Many of the concerns payers voiced at the hearing this morning – that providers would use the telephone to provide a high number of services or provide services when not appropriate are the same concerns we heard voiced early on in the COVID-19 pandemic when discussing audio-only coverage. However, now we have the data from VPQHC's recent Telehealth Utilization Report showing how many services are performed using audio-only and it is a small fraction of overall services, and do not show any signs of abuse or overuse. DFR testified to your committee that even if payers did reimburse for all telemedicine services at parity, costs would only have changed consistent with medical trend.

Testimony this morning also suggested that audio-only telehealth is being used frequently for child sick visits. However, the VPQHC's report also shows that this modality is most used by older people and people with heart disease and cancer:

- See Table 6, showing the highest rates of audio-only services were for people aged 55+.
- See Table 4, showing highest percentage of audio-only telehealth services are Category C, Neoplasms, Category D In Situ Neoplasms & Blood Diseases (e.g., non-invasive cancer and leukemia), and Category I Circulatory System Diseases (including heart attack and stroke).

We hear from our members that using telehealth requires the same amount of work and expense:

- Certain telehealth services actually require more time to deliver care than the equivalent in-person service (e.g., a provider needs to spend more time developing rapport, asking a patient to demonstrate range of motion or describe symptoms)
- Clinicians may need to employ additional technology support staff or digital navigators to ensure that all patients are able to access and use telehealth services.
- Telehealth requires the same clinical decision-making as in-person care.
- Telehealth often utilizes the same or similar clinical and nonclinical staff to prepare a patient for their virtual visit including "rooming patient," obtaining clinical history, making appointments, etc.
- Delivering services via telehealth may increase certain overhead costs, such as additional technical staff, cost of telehealth platforms, or additional costs for data privacy and security.

What are other states requiring?

- As of December 2023, 29 states have passed laws requiring payers to implement payment parity:
    - 21 states have implemented policies requiring payment parity
    - 8 states have payment parity in place with caveats (e.g., for behavioral health services, only; for established patients, only; for a time-limited basis, like Vermont)[1]
- CMS currently pays for Medicare telehealth services at the same rate as the equivalent in-person service, a policy implemented during the PHE, and one which CMS has said it will continue through the end of 2024.

For these reasons, we support continued parity for audio-visual telehealth and parity for all "medically necessary, clinically appropriate" health care services delivered by telephone.

Please reach out if we can provide any additional information.

[1] https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat