Senate Committee on Finance
Room 6 and Zoom
March 19, 2024
1:30 PM | H. 861 - An act relating to reimbursement parity for health care services delivered in person, by telemedicine, and by audio-only telephone

Title Slide

Good afternoon, Chair Cummings and Members of the Senate Committee on Finance.

My name is Ali Johnson, and I am a Quality Improvement Specialist at Vermont Program for Quality in Health Care.

Today, I will share the results of a study that looked at telehealth *use* in Vermont before and during COVID.

2. Outline

I will go over the purpose of the report, information used, questions asked, findings gleaned from the data, and a few thoughts about the intersection between clinical quality and audio-only telemedicine.

3-4. Purpose of Report

The Department of Health contracted with VPQHC and Policy Integrity to examine Vermont population-level telehealth trends based on claims data for 2018-2022.

Cost analysis was outside the scope of our report.

5. Acknowledgement ~ VDH

I would like to thank the Department of Health for financially supporting the study and helping us access the data used.

6. Special Thanks

A very special thanks to Steve Kappel of Policy Integrity for analyzing the claims data and drafting much of the report.

7-8. Information Used

This study used data from VHCURES, Vermont's All-Payer claims database. We focused on the health care utilization data that health insurers and healthcare providers must report by law.

There are a couple of caveats:

- VHCURES does not contain information about uninsured people or those covered by self-insured payers, federal employee plans, Veterans' Affairs, TRICARE, or payers with an average enrollment of fewer than 200 Vermont residents.

- Claims are not clinical records. This is why the report focuses on healthcare *utilization* rather than *quality*.

9. Acknowledgement ~ GMCB

I would like to thank the Green Mountain Care Board for allowing us to access the VHCURES dataset and for being so responsive to our requests to review the analysis and findings.

Please note that the analyses, conclusions, and recommendations shared today are those of VPQHC and not necessarily those of the GMCB.

10. Information Used ~ Claims

I would like to touch on what was – and wasn't – included in the study.

(animation) We started with services that generated a paid claim. Services that were not billed or paid for, such as correspondence in patient portals like MyChart, were not included.

(animation) We limited the scope to professional services provided by individual providers; hospital and nursing home services were not analyzed.

(animation) We included information from Medicare, Medicaid, and the three largest private payers: BlueCross BlueShield of Vermont, Cigna, and MVP. Information about smaller private payers could not be included because of differences in coding and reimbursement rules among private payers.

(animation) If a patient's service was paid for by more than one payer, we used the primary claim. This way, we could avoid duplication.

(animation) Finally, the study looked at the two years before the Public Health Emergency and the three years during the pandemic.

11. CAUTION

Our biggest challenge in analyzing telehealth use was defining 'telehealth.' There was no universal sign on each telehealth claim for us to be able to identify it. Before COVID, telehealth was not as common, and during the pandemic, healthcare providers and payers were all adapting to changing rules and requirements.

12.-13. How We Defined 'Telehealth' Claims

We were very fortunate to have support from payers, who could help us understand those changes in reimbursable codes. With their help, we decided on an approach of identifying audio-visual and audio-only telehealth claims based on procedure codes, procedure code modifiers, and place of service codes. I'm skipping through this quickly because I want to get to the findings, and these methods are laid out in an appendix in the report.

14.-15. Key Questions

We asked three main questions:

- How has telehealth impacted utilization of professional services?
- What are patterns of audio-visual and audio-only use?
- And has the pattern of the telehealth provider location changed?

16.-17. Findings

Our full report may be accessed at www.vpqhc.org.

18. Professional Services Overall

Looking at in-person and telehealth professional services combined, the dotted linear trend line shows that, overall, services decreased from 2018 to 2022. The number of services dropped in 2020, then rebounded with the continuation of a general decline.

This might be due to changes in the market share of the five payers we selected or to the number of people included in VHCURES over those five years.

19. Professional Services by Modality

This chart shows what is underneath the overall trend line in the previous slide. Here, we see the major portion of in-person services in gray, the audio-visual services in orange, and the relatively tiny number of audio-only services in blue.

Telehealth services appear to have been used as a substitute for in-person services. In other words, the increased use of telehealth during the pandemic does not seem to have increased the total number of provider visits.

20. Professional Services by Modality and Payer

This table breaks down the previous slide of in-person vs. audio-visual vs. audio-only further by payer. We limited the analysis to the three years of the pandemic, when telehealth was more widely used. Let's take these three findings one at a time.

(animation - orange) Looking at all provider services combined, the rate of services used by Medicare and Medicaid members was higher than private payers.

(animation - green) Audio-visual telehealth services were most used by BlueCross BlueShield and Medicaid beneficiaries.

(animation - yellow) Rates of audio-only telehealth services were highest among people covered by Medicare, Medicaid, and Cigna.

21. Telehealth Services by Modality and Diagnosis

Thinking about one of our key questions, "What are patterns of audio-visual and audio-only use," we understood that mental healthcare was being provided via telehealth, and we wanted to know how much of that was audio-visual vs. audio-only.

This table shows counts of telehealth services for different diagnostic categories, separated out by audio-visual and audio-only. The information is limited to 2022, when the use and reimbursement for telehealth codes was getting more stable.

There are two main takeaways:

(animation – green) First, people with mental health diagnoses used nearly 80% of all telehealth services.

(animation – gold) However, the portion of all telehealth that was audio-only was lower for mental health than any other diagnostic category.

22. Telehealth Services by Modality and Diagnosis (Focus on Physical Health)

Here we see Table 4 from the report again.

The middle pair of columns shows audio-only and audio-visual services in each diagnostic category as a percentage of all services.

(animation - green) For example, for Category C Neoplasms (cancer), there were 1,079 audio-only services, representing 2.4% of 44,554 audio-only services given for all diagnostic categories combined.

The final column shows the percentage of telehealth services for a particular diagnostic category that were audio-only.

(animation - yellow) For example, for Category C Neoplasms, there were 1,079 audio-only services compared to 4,859 telehealth services (1,079 audio-only plus 3,380 audio-visual); so 22.2% of neoplasm-related telehealth services were audio-only.

(animation - blue) The types of diagnoses with the highest percentage of telehealth services being audio-only 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).

23. Telehealth Services by Modality, Diagnosis, and Age

Since mental health services represented such a large part of telehealth services in 2022, what did that look like broken down by age?

This chart has four lines:

- The orange line is the rate of audio-visual services for claims that were for 'Category F' or 'Mental Health' diagnoses.
- The gold line is for audio-visual services for all other diagnoses.
- The blue line is the rate of audio-only services for mental health diagnoses.
- And the gray line is the rate of audio-only services for all other diagnoses.

Services for people with mental health diagnoses accounted for over 90% of all telehealth use in ages 10-34 and declined as age increased. (The orange and blue lines.)

In older age groups, use of telehealth for physical health diagnoses becomes more common. (The gray and gold lines.)

(animation – red) For physical health, the highest audio-only service utilization rates were in people aged 55+.

24. Telehealth Services by Provider State

The final finding that I will highlight today is related to the states from which providers are delivering telehealth services.

This chart shows the number of telehealth services (audio-visual and audio-only combined) that were experienced by Vermonters or occurred in Vermont.

For the two years before COVID, I've included a callout so that you can see the detail because the counts are so low compared to the other years.

- Data for Vermont providers are in blue;
- for New Hampshire, in orange;
- for Massachusetts, in purple;
- for New York, in yellow;
- with missing information, in gray; and
- for all other states combined, in green.

Telehealth services shifted from mostly being given by other states' providers to being given by VT providers.

One explanation may be patients' continuing to use local providers but shifting from in-person to telehealth services.

25.-26. A Note on Quality

The study I just shared focused on *utilization* of telehealth services. But what can we say about clinical *quality* of telehealth services?

As I mentioned earlier, claims are not clinical records. This makes it difficult to use VHCURES data to assess quality of care.

More research is needed on the quality of care delivered through telehealth, including audio-only telemedicine.

VPQHC has been tracking research related to clinical quality and audio-only telemedicine.

27. Audio-Only Telemedicine and Clinical Quality Tracking Sheet

Every six months, we research the literature and update our summary, shown here. This tracking sheet is available at www.vpqhc.org.

28. Thanks to Our Collaborators

In closing, I would like to thank the many individuals who met with my colleagues and me to better understand the data and what would be meaningful to study.

29. Contact

Thank you for your time and attention. I will be happy to answer any questions you may have.