To: Senate Finance Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: March 19, 2024
RE: Support for H. 861 – 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 H. 861, related to payment for telehealth services.

Our organizations collectively represent approximately three thousand physicians and physician assistants in Vermont. Our members provide primary care and specialty health care services in hospital-based practices, Federally Qualified Health Centers, and independent practices and are here today to urge you to support H. 861 as a way to support practices in providing equitable access to health care services for patients. **Please see Attachment 1** with comments from our members about the importance of ongoing coverage for audio-only services in order to provide access to care for patients.

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

Without this bill, the current floors for telehealth reimbursement, including audio-only services, would be removed and payers could set the rate at any level, down to no reimbursement. H. 861 removes a statutory 2026 sunset on payment parity for audio-visual services and moves the floor to pay for audio-only services, which is currently set by DFR at 75% of in-person rates, to 100%. **Without these protections, small providers in particular – who do not negotiate individual fee schedules with payers but rely on one community fee schedule – do not believe reimbursement rates will be reasonable or account for the costs of providing services, and therefore may have to limit access to these modalities for patients.**

Statute and coding guidance provide a number of patient protections when telehealth services are provided, and these will continue:

- 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 or relaying lab results is not, and has never been, a billable service. Most telephone-only services cannot originate from a related office visit that occurred within the past seven days and cannot lead to an office visit service or procedure within the next 24 hours.[1]
- There must be patient choice and consent (18 V.S.A § 9362). Patient concerns early in the pandemic regarding unexpected copays may have been before consent policies were

[1] See descriptions of CPT codes 99441-99443, available at: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/coding-telehealth-audio-virtual-digital-visits.html

clearly in place, which require informing the patient that audio-only is a choice and whether insurance will be billed and any potential copay/coinsurance.

- 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.[2]

This bill will not raise health care costs or premiums:

Many of the concerns payers have voiced in previous discussions regarding audio-only telehealth services – 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. However, now we have the data from VPQHC's recent Telehealth Utilization Report showing how many services are performed using audio-only. The report finds that it is a small fraction of overall services – approximately six percent of telehealth services and about 0.5% of all services - and appear to have been a substitute for not additive to in-person services. The small number of services and stable trends of visits do not show any signs of abuse or overuse. DFR testified regarding the report to the House Health Care Committee stating that:

> ***Even if all telemedicine services were reimbursed at parity with in-person services, the overall cost of care would have only increased with medical trend, as with all other healthcare services***

This bill insures equitable access to critical health care services:

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 of the report, 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).

This is consistent with data available to us from the health records of larger local health care systems. 2022 data from UVM Health Network shows that the most common reasons for an audio-only visits in the Network were: follow-up (29%), chronic kidney disease (5%), routine prenatal visit (4%), nutrition counseling (3%), anxiety (3%) and pain (3%). At Dartmouth Health, the specialty service lines with the most frequent use of audio-only among their telehealth services included oncology, orthopedic surgery, and the heart and vascular center.

There are many patients for whom technological barriers make an audio-visual connection impractical including broadband access, affordability, computer equipment,

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[2] 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

comfort with technology and patient preference. Dartmouth Health 2022 data indicates why audio-only was the scheduled modality instead of video visits. The data show the reason for 70% of audio-only visits was patient preference, 22% was for known technology issues (lack of technology/broadband), and 8% were for other reasons.

Audio-only reimbursement addresses equity issues: research shows that rates of those who lack digital access are higher among those with low socioeconomic status, those 85 years or older, and in communities of color.[3] Dartmouth Health's data show there are several Hospital Service Areas (HSAs) in Vermont with failed video visits. A failed video visit is an appointment that was scheduled to be conducted as video however, they ended up being conducted as audio-only due to technology & broadband issues. The Vermont HSAs with the highest failure rate include St. Johnsbury, Rutland, Bennington, Newport, Springfield, Windsor and Randolph. Failed video visits were also highest in patients over the age of 65. We are particularly concerned with the impact on access to care patients with lower socioeconomic status and resource challenges accessing the transportation, time off of work, and childcare needed to attend an in-person visit and the technology requirements of an audio-visual visit. See the testimony from BiState Primary Care Association in the House, explaining the importance of access to telehealth services for patients of Federally Qualified Health Centers, and that according to a 2023 national survey of health center patients 87.7% of respondents were satisfied with the telehealth services they received, including those who received audio-only services.

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

- 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.

In response to the DFR order requiring reimbursement of "at least" 75% for audio-only services, both MVP and BCBSVT are paying at 75% for many audio-only services, forcing some practices to stop offering this service. Many small practices are also responding by limiting audio-only visits to only the most urgent patient needs.

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[3] Roberts ET, Mehrotra A. Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. JAMA Intern Med. 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666; see also a HHS data brief finding that video telehealth rates were lowest among those without a high school diploma (38.1%), adults ages 65 and older (43.5%), and Latino (50.7%), Asian (51.3%) and Black individuals (53.6%): https://aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021

The majority of states require payment parity and Medicaid and Medicare pay at parity:

- 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)[4]
- 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.

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