89 Main Street, Montpelier, VT 05620 - 3101
(p) 802-828-3301 | http://www.dfr.vermont.gov/

TO: Sen. Anne Cummings, Chair, Senate Committee on Finance
Rep. William J. Lippert, Chair, House Committee on Health Care
FROM: Michael S. Pieciak, Commissioner of Financial Regulation
SUBJECT: Recommendations Required by Act 140 of 2020
DATE: December 1, 2020

Dear Senator Cummings and Representative Lippert:

Thank you for your ongoing work on this important issue. As you know, Act 140 of 2020 required the Department of Financial Regulation to convene a working group to develop recommendations for health insurance and Medicaid coverage of health care services delivered by telephone after the COVID-19 state of emergency ends.

The working group grew to include over 80 members representing providers, health insurers, the Department of Vermont Health Access (DVHA), the Green Mountain Care Board, the Vermont Medical Society, Bi-State Primary Care Association, the VNAs of Vermont, the Vermont Association of Hospitals and Health Systems, Vermont Program for Quality in Health Care (VPQHC), and the Office of the Health Care Advocate.

Beginning in June 2020, the working group heard presentations from an array of experts, academics, and providers with experience providing telehealth service in Vermont and across the country. Presenters included, among others:

- Donald M. Berwick, M.D., Lecturer of Health Care Policy, Department of Health Care Policy, Harvard Medical School;
- Sabrina Corlette, Professor of Law and co-director of the Center on Health Insurance Reforms (CHIR), Georgetown University McCourt School of Public Policy;
- Judd Hollander M.D., Associate Dean for Strategic Health Initiatives at Sidney Kimmel Medical College at Thomas Jefferson University;
- Ateev Mehrotra, M.D., M.P.H., Associate Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School;
- Mark Schmoll, LMHC, Washington County Mental Health;
- Kerry L. Stout, LICSW, Howard Center;
- Claudia Duck Tucker, Vice President of Government Affairs, Teladoc Health;
- Norman Ward, M.D., Chief Medical Officer, OneCare Vermont; and
- Natasha Withers, D.O., FAAFP, Primary Care Provider, Porter Medical Center;

The working group reserved time at the end of each presentation for discussion and questions from members of the group.

In October 2020, the Department asked working group members for proposed recommendations. Over a dozen working group members, ranging from Blue Cross Blue Shield of Vermont and the AARP to individual providers, responded with thoughtful proposals and comments reflecting their unique points of view. Based on these responses, the Department crafted recommendations for the continuation of audio-only health care services after the COVID-19 state of emergency representing the working group's consensus.

In brief, the working group recommended continuing commercial insurance and Medicaid coverage of audio-only health care services after the COVID-19 state of emergency ends utilizing value-based reimbursement where appropriate for provider type and size. However, the working group could not reach consensus on whether audio-only health care services should be reimbursed at parity with in-person services or at some other rate.

This report also includes:

- DVHA Final Recommendations for Continuation of Audio-Only Health Care Services Specific to Vermont Medicaid (Nov. 2020)—pages XX-XX;
- VPQHC Final Report on Audio-Only Telemedicine and Clinical Quality Recommendations (Oct. 2020)—pages XX-XX;
- National Committee for Quality Assurance (NCQA) Taskforce on Telehealth Policy Report (Sep. 2020)—pages XX-XX;
- Working group member comments—pages XX-XX; and
- Selected presenter materials—pages XX-XX;

The Department would like to extend its gratitude to all those who participated in and presented to the working group, especially providers who took time out of their schedules during an unprecedented public health emergency to share their knowledge and experience. This report would not have been possible without their input.

Please do not hesitate to contact me, Sebastian Arduengo (DFR Assistant General Counsel), or Jill Rickard (DFR Director of Policy), with any questions or comments about the recommendations.

Sincerely,

____

Michael S. Pieciak
Commissioner of Financial Regulation

![VERMONT logo]

State of Vermont
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101

For consumer assistance:
[Banking] 888-568-4547
[Insurance] 800-964- 1784
[Securities] 877-550-3907
www.dfr.vermont.gov

TO: Sen. Anne Cummings, Chair, Senate Committee on Finance
Rep. William J. Lippert, Chair, House Committee on Health Care
FROM: Michael S. Pieciak, Commissioner of Financial Regulation
SUBJECT: Recommendations for Continued Coverage of Audio-only Telephone Services after the COVID-19 Pandemic
DATE: December 1, 2020

Dear Senator Cummings and Representative Lippert:

Please find below recommendations developed by the working group for continued health insurance and Medicaid coverage of health care services delivered by telephone after the COVID-19 public health emergency as required by Act 140 of 2020:

Recommendation #1—Address the Digital Health Divide

The workgroup recommends that the state promptly address broadband, technology, and digital literacy gaps to ensure that Vermont's digital divide does not become a health divide.

Recommendation # 2—Continue Coverage of Audio-Only Services

The workgroup recommends extending 8 V.S.A. § 4100k to require commercial health insurers continue coverage of audio-only telephone services after the COVID-19 public health emergency when medically necessary and clinically appropriate.

- Both experts and providers in the field reported that audio-only telephone services improved health and health outcomes by increasing access to care and expanded options for how patients seek care;
- Many Vermonters would not be able to access care at all without the option of audio-only telephone services because they do not have access to video services due to lack of quality internet or suitable hardware;
- Providers reported that patients were more able and willing to seek mental health and substance use disorder treatment telephonically than by in-person or audio/visual modalities;
- Audio-only telephone services reduce missed appointments due to childcare, weather, or transportation issues;

- Although there is a greater potential for fraud associated with audio-only service delivery, experts who spoke to the workgroup stated that most fraud would be readily discoverable in the claims adjudication process. A provider, for instance, could not perform "hands-on" services over the telephone, and such claims could be flagged for review.

Recommendation #3—Require Informed Patient Consent for Audio-Only Services

The workgroup recommends extending 18 V.S.A. § 9361(c) to require informed patient consent for delivery of audio-only telephone services.

- Members of health insurance plans should have the option to choose between audio-only telephone, in-person, or audio-visual service delivery without risking loss or withdrawal of benefits to which the member is otherwise entitled;
- Patients should continue to have the right to receive in-person care from their provider in a timely manner, via an adequate network of in-person care providers;
- While audio-only telephone services may sometimes be equivalent or superior to in-person or audio-video care for some services, they may be inferior for other services. Thus, informed consent is a crucial protection to ensure that people in rural and economically disadvantaged communities are given an opportunity to make a fully informed choice between audio-only and other modalities;
- Informed consent is important to set patient expectations and ensure that patients understand that they will be billed for audio-only telephone services.

Recommendation #4—Apply the Same Standard of Appropriate Practice Across all Treatment Modalities

The workgroup recommends extending 18 V.S.A. § 9361(b) to hold audio-only telephone services to the same standard of appropriate practice applicable in traditional provider-patient settings.

- Providers should be held to the same standard of care, regardless of whether a visit is held in person, remotely with an audio-visual component, or via audio-only telemedicine;
- Because there are few nationally recognized frameworks for assessing the quality of care delivered over audio-only telephone, the VPQHC Statewide Telehealth Workgroup should continue to explore how Vermont can monitor and evaluate the quality of care delivered by audio-only telemedicine and stay current on nationally recommended frameworks for telehealth quality measurement.

Recommendation #5—Require Provider Training as Appropriate

The workgroup recommends that providers offering audio-only telephone services complete training as appropriate to ensure the standard of appropriate practice is met.

- Although training is not strictly necessary for audio-only service delivery, large practices with large telehealth components, such as Jefferson Health and Teladoc, reported that training was beneficial both in helping providers determine when telehealth services are clinically appropriate and managing patient expectations;
- The VPQHC Statewide Telehealth Workgroup should work to leverage existing resources and identify new research to ensure trainings are developed and made easily and conveniently available to providers.

Recommendation #6—Standardize Definitions

The workgroup recommends standardizing definitions of "telehealth" and "telemedicine" to the extent feasible between Medicaid and commercial health insurance to reduce terminology-related confusion. According to the New England Journal of Medicine:[1]

- "Telemedicine" specifically refers to the practice of medicine via remote means. For example, an urgent care consultation delivered via video.
- "Telehealth" is a broader term referring to all components and activities of healthcare and the healthcare system conducted through telecommunications technology. Examples include remote patient monitoring and provider-to-provider remote communication.

Recommendation #7—Utilize Value-Based Reimbursement

The workgroup recommends that, as part of Vermont's ongoing health reform efforts, audio-only services should be reimbursed through a value-based, prospective, or capitated payment system where appropriate for provider type and size no later than January 1, 2024 following a transition period of not less than two years during which audio-only and telehealth services are reimbursed on a fee-for-service basis with appropriate CPT coding reflecting the modality of service.

- Research and presentations to the workgroup indicated that clinical outcomes with audio-only telephone services are as good as or better than in-person care and that audio-only telephone services improves intermediate outcomes and satisfaction—especially for patients whose alternative is no care at all;
- Providers generally have fixed costs they must pay regardless of service modality, and report that audio-only service delivery is as administratively and cognitively demanding as in-person services;
- Experts who spoke to the workgroup reported that while use of audio-only telephone services resulted in increased utilization, these services were generally low-cost and the

[1] NEJM Catalyst, *What is Telehealth?* (Feb. 1, 2018), *available at* https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268.

increased utilization was offset by a decrease in relative value units[2] of the services provided;

- There is a need for simplicity in payment policies;
- Along with in-person and other forms of remote care, audio-only telephone services are a component in reaching positive health outcomes.

[2] Relative value units (RVUs) are designed to provide relative economic values for medical care based on the cost of providing services categorized as physician work, practice expense, and professional liability.

State of Vermont
Department of Vermont Health Access [Phone] 802-879-5900
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

BACKGROUND

Pursuant to Act 140 of 2020, the Department of Financial Regulation must provide recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and Finance regarding coverage for health care services delivered by telephone (i.e., audio-only) for commercial health insurance and Medicaid for the period after the public health emergency (PHE) ends (due on/before December 1, 2020).

The Department of Vermont Health Access is required within the legislation to be consulted; as such, the Department of Vermont Health Access has been working with departments within the Agency of Human Services (hereafter, "Agency") to develop a set of recommendations to provide to the Department of Financial Regulation specific to Vermont Medicaid. It is important to note that Agency departments administering specialized programs have the authority to establish and define telephonic (i.e., audio-only) policies for the specialized programs managed by these departments when such policies are medically necessary and/or clinically appropriate.

COVERAGE OF HEALTH CARE SERVICES DELIVERED BY TELEPHONE AFTER THE PUBLIC HEALTH EMERGENCY ENDS: FINAL PROPOSED RECOMMENDATIONS

- Vermont Medicaid supports continued coverage of health care services delivered by telephone (i.e., audio-only) when medically necessary, clinically appropriate, and when access to face-to-face or two-way, real-time, live audio and video interactive communication is unavailable. This coverage, through Medicaid's fee-for-service system, would be for the period after the public health emergency when the temporary COVID-19 policy ends and is in alignment with national support for coverage parity for this modality of delivering health care services;

- Vermont Medicaid models its adopted rules after federal regulations and guidance (e.g., the health care administrative rule on telehealth). As such, any recommendations applicable to Vermont Medicaid should include relevant federal regulations and guidance, including that services are medically necessary and clinically appropriate (e.g., for delivery by telephone [audio-only]) & should consider appropriate reimbursement for health care service delivery by an audio-only modality (i.e., based on Medicare's Physician Fee Schedule methodology for service codes specific to telephonic delivery);

- Definitions should be standardized to the extent feasible to reduce provider, consumer, and stakeholder confusion related to telehealth terminology;

- For example, federal Medicaid programs define **telehealth** as "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance" and includes additional explanation for clarity between the definitions of telehealth and telemedicine that "telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of **telemedicine**, they are often considered under the broad umbrella of telehealth services." [1]

- Consumer choice in health care service delivery method should be supported, incorporating lessons learned from substantial telemedicine (i.e., live audio & video) and telephonic (i.e., audio-only) health care service delivery during the public health emergency into the requirements for appropriate informed consent;
  - "The Medicaid member shall have the option to refuse telehealth services at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Vermont Medicaid benefit to which the Member is entitled."

- Qualified providers offering telehealth services (including audio-only) must:
  - ensure that a telehealth service (including audio-only) is clinically appropriate for the underlying Medicaid-covered service;
  - meet or exceed federal and state requirements for medical and health information privacy, including compliance with HIPAA;
  - take appropriate steps to establish the provider-patient relationship and conduct all appropriate evaluations and history of the Medicaid member consistent with traditional standards of care;
  - maintain medical records for all Medicaid members receiving health care services through telehealth (to include audio-only) that are consistent with established laws and regulations governing patient health care records and documents the telehealth modality utilized for service delivery;
  - establish an emergency protocol when care indicates that acute or emergency treatment is necessary for the safety of the Medicaid member;
  - address needs for continuity of care for Medicaid members (e.g., informing member or designee of how to contact the provider or designee and/or providing member or identified providers timely access to medical records); and
  - if prescriptions are contemplated, follow traditional standards of care to ensure member safety in the absence of a traditional physical examination.

- Qualified providers offering telehealth services (including audio-only) must complete training as necessary for ensuring the standard of care is met when delivering services through telehealth.

[1] https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html