Testimony on Audio-Only Telehealth
Senate Health and Welfare; February 18th, 2021

Thank you for the opportunity to provide testimony on the audio-only telehealth legislation currently being considered by the Senate Health and Welfare committee.

We appreciate the considerable work done by the Department of Financial Regulation Working Group and House Health Care on this topic. It is important to note that while these groups considered the eventual framework for a permanent audio-only solution, the language being considered today is *not* that solution, it exists as a temporary bridge while we put together the pieces for that solution. A second important note is that those pieces should include both options for audio-only telehealth and also steps to resolve the digital divide created by limitations in telecommunications infrastructure, cost, equipment access, and digital comfort. While this testimony does not address digital divide concerns, these concerns are a dominating context to this conversation and we strongly support addressing this gap in Vermont.

As is discussed in the Department of Financial Regulation Working Group report on audio-only telehealth, the fee-for-service and equivalency-based format currently being used is not a long-term solution. Ideally the final reimbursement model for audio-only would:

- Account for telephone-based services that are not office visit equivalents but are emerging as clinical best practices - remote patient monitoring and chronic care management are examples of these tools.
- Facilitate the use of the full care teams at health care practices, including appropriate use of staff with different license levels and non-clinical staff.
- Provide a mechanism to realize future savings as health care practices increase efficiency, particularly as regards physical space requirements - health care practices are not going to sell their current buildings, but in the future they may be able to expand patient access without expanding a physical footprint.

We see these advantages captured in fully mature value-based payment systems - we want to learn from those systems to design a structure that works for all Vermont providers. That goal requires time, data, and a transition period for implementation. For this reason we need a temporary solution to address the cliff in audio-only access at the end of current DFR flexibilities.

The language developed in the House Health Care Committee for audio-only telehealth builds that temporary bridge and achieves the following objectives:

- Maintains access for patients who rely on an audio-only modality - we do not want to move backwards in access, and more importantly, our *patients* do not want to move backwards. Patients are receiving high quality care through all types of visits, including audio-only, and limiting access would disrupt their care.
- Sets up a structure for collecting the data needed to develop future payment models.
- Offers clear guidance on informed consent for patients, which is a critical element for clarity in both treatment and billing. We recognize that there has been considerable confusion over the last year and we want to minimize that confusion.

- Maintains “triage call” codes so that health care practices can determine appropriate next steps for patients *without* requiring a full office visit - note that there is not a patient cost share associated with these codes for Medicaid and Commercial insurance, and they cannot be billed in connection with other services (for example, if a patient has an office visit, this code does not add on additional check-in costs).
- Provides stability to health care practices who went through a very disruptive - literally catastrophic - transition to remote care in March of 2020 and are seeking equilibrium while continuing to address COVID-19 related disruptions.

The reimbursement guidance considered here *does not* replace the other guardrails that currently exist for medical practice. Practitioners still must reach the same standard of care for serving patients, they are not held to a lesser standard by using the audio-only modality. Patients must be informed about the treatment and its modality and consent to the treatment plan, including consent to billing. Billing still begins with the service type, as described by common coding, the proposed parity language does not invent a new class of service. An episode of care remains a single episode of care - for example, calling a nurse for clarification on instructions is still the same process it always was, not a new service because a telephone is used. Regulations on prescribing controlled substances remain in effect. Medical malpractice rules and codes of ethics similarly remain in effect.

Below are a few examples of the types of guardrails in place outside of this telehealth statute. In the interest of length this illustrates with detail some of the examples cited in the committee hearing but does not include exhaustive examples:

Rule Governing the Prescribing of Opioids for Pain
https://www.healthvermont.gov/sites/default/files/documents/pdf/Opioid%20Prescribing%20Rule%202.1.19.pdf

6.0 Prescribing Opioids for Chronic Pain
The following section outlines requirements for prescribing Schedule II, III or IV opioids for chronic pain (pain lasting longer than 90 days). If the provider is prescribing to the patient for the first time during a course of treatment, the Universal Precautions in Section 4.0 also apply.
The requirements in this section apply to patients who are receiving an opioid for the treatment of chronic pain.
6.1 Screening, Evaluation, and Risk Assessment
6.1.1 The prescriber shall conduct and document a thorough medical evaluation and physical examination as part of the patient’s medical record when prescribing opioids for chronic pain.

From the Board of Medical Practice - Prescribing (general)
https://www.healthvermont.gov/sites/default/files/documents/2016/12/BMP_Policies_Vermont%20Telemedicine%20Policy_05062015%20.pdf

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. . . The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. . . .

From the Board of Medical Practice - Patient Relationship
https://www.healthvermont.gov/sites/default/files/documents/2016/12/BMP_Policies_Vermont%20Telemedicine%20Policy_05062015%20.pdf

For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation, and as required by Vermont law. 26 V.S.A. § 1354(a)(33). As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.
…
. Use of electronic means to provide medical care does not diminish the obligations that arise upon formation of the physician-patient relationship. Vermont law makes it unprofessional conduct to prescribe or dispense medication, furnish medical services or to provide prescription-only devices without taking necessary steps to verify the patient's identity, establish a documented diagnosis through the use of accepted medical practices, and maintain an appropriate record. 26 V.S.A. § 1354(a)(33).

Example of a CPT Code for a New Patient:
99387 - Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient. [Additional guidance and diagnosis codes cover what is included in the examination depending on patient - for example gynecological exams and relevant normal or abnormal findings].

Other Service Code Examples:
Coding protocols can be difficult. Coding for a mammogram is complicated and has entire manuals dedicated to it. Similarly, there is detailed, and expanding, guidance around the range of options for delivering test and laboratory results in a timely fashion to patients. The clearest answer to Sen. Hardy's question is the one delivered in the

spoken testimony, that the parity system for audio-only does not create new charges for patient-practice interactions that are connected to a single episode of care.

Below is a simple example of how, when there is a gray area, a code can include guidance on when it becomes applicable. This example is one of the brief virtual communications codes that we refer to as the “triage” calls:

G2012 - Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Finally, it may be useful to indicate what we hope to see in audio-only telehealth as we move further from the COVID-19 disruptions and as we collect better data:

- Dramatic reduction in telehealth use overall, which we already see, and a recalibration of audio-only as a much smaller percentage of that use.
- Increase in audio-only use in instances where patients previously experienced barriers to care. Indicators of removing barriers would include reduced “no-show” rates and increased completion of treatment.
- Continued utilization of audio-only services designed to increase efficiency - for example the triage call codes.
- Pilot programs in telephone-based services that do not currently have fee-based reimbursement in Vermont - for example there is a planned pilot in self monitored blood pressure for hypertension management and Bi-State is supporting FQHCs in greater adoption of the Medicare Chronic Care Management program.

We are excited to be on the path towards strategic deployment of telehealth in Vermont to reach the aims of increasing health care access, improving quality of care, and supporting our rural workforce. Thank you for your consideration of extending audio-only reimbursement as we work towards these objectives.

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