



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
Sen. Virginia "Ginny" Lyons, Chair, Senate Committee on Health and Welfare
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 Senators Cummings and Lyons, and Representative Lippert:

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 stakeholder questions.

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 7-8;
- VPQHC Final Report on Audio-Only Telemedicine and Clinical Quality Recommendations (Oct. 2020)—pages 9-17;
- National Committee for Quality Assurance (NCQA) Taskforce on Telehealth Policy Report (Sep. 2020)—pages 18-55;
- Working group member comments—pages 56-77; and
- Selected presenter materials—pages 78-114;

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,

/s/ Michael S. Pieciak

Michael S. Pieciak
Commissioner of Financial Regulation



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
Sen. Virginia "Ginny" Lyons, Chair, Senate Committee on Health and Welfare
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 Senators Cummings and Lyons, 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 units² 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

280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
<http://dvha.vermont.gov>

[Phone] 802-879-5900

Agency of Human Services

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>



REPORT-OUT

AUDIO-ONLY TELEMEDICINE & CLINICAL QUALITY RECOMMENDATIONS

October 20, 2020



EXECUTIVE SUMMARY

Audio-only telemedicine has provided Vermonters access to their healthcare under COVID-19, and outside of a pandemic response, has the ability to support the continuity of care for individuals that face barriers to accessing their healthcare through traditional telemedicine and in-person visits. In this report, audio-only telemedicine refers to synchronous, telephone-based visits with a provider that replace an equivalent in person-visit; it does not refer to other telephone-based services such as brief telecommunications, or those associated with remote patient monitoring. The workgroup recognizes that audio-only telemedicine is not a silver bullet for achieving equitable access to health care, but does recognize it as a step in the right direction under the current conditions of our healthcare delivery system of fee-for-service payments, and in a world where the digital divide exists. It is imperative we use every tool available to ensure patients get a measure of care where they need it, when they need it, as we simultaneously bridge from where we are currently as a delivery system, to where we want to be. The workgroup recognizes that missteps in care delivery can occur with any type of encounter, and there is currently a lack of research surrounding the sensitivity of utilization, appropriateness, outcomes, and cost, stratified by clinical condition, health care setting, and telehealth modality.¹ Our proposed framework for ensuring quality care is delivered by audio-only telemedicine, and patient safety is safeguarded, aligns with the basic tenants of continuous quality improvement. This is with the caveat that continuous quality improvement is an iterative process, and adaptations will need to be made, and tested, as new research is carried out and best practices are identified.

¹ Cutter, Christina, et al. "Establishing a 'New Normal' for Value-Based Telehealth." *Health Affairs Blog*, 8 Oct. 2020, doi:10.1377/hblog20201006.638022.



The workgroup recommendations are as follows:

Healthcare Quality Measurement, Monitoring & Evaluation

- Establish a subgroup of the Statewide Telehealth Workgroup to identify how to utilize existing data to monitor the quality, utilization, and cost of care delivered via audio-only telemedicine (which can be embedded in a more comprehensive Vermont telehealth analysis)
- Ensure current peer review processes are applied to audio-only telemedicine
- Provide guidance on nationally-recognized healthcare quality metrics for monitoring and evaluating healthcare delivered by audio-only telemedicine; metrics that are agnostic to encounter type (ex. appropriate antibiotic use; patient and provider satisfaction)
- Apply associated benchmarks, where available, for comparative performance purposes; stratify by modality type, include qualitative and quantitative data
- Ensure providers and organizations are aware of nationally-recognized telehealth systems measure frameworks, and those in development, and support them with implementing those frameworks as needed

Provider Education and Training

- Ensure providers receive the ongoing access and support they need to deliver high-quality telehealth
- If opportunities for improvement are identified through routine monitoring and evaluation of audio-only telemedicine, work as a coordinated group to identify whether trainings exist that can address those needs, and if they do not, leverage resources to develop those trainings
- Vermont law, under 18 V.S.A. §9361, includes a robust informed consent policy for telemedicine. Continue training providers to discuss the modality options for receiving care, the risk and benefits associated with each, and any cost for the visit.



Patient Engagement & Empowerment

- Ensure patients are at the center of the healthcare decision making, and are engaged in their care plan. The Institute of Medicine defines person-centered care as: “Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”² The World Health Organization defines people-centered health services as health services that put “people and communities, not diseases, at the center of health systems, and empower people to take charge of their own health rather than be passive recipients of services.”³
- Explore whether additional means for patient voices to be heard need be established to support continuous quality improvement
- Support patient education by disseminating tools and resources such as to how to prepare for an audio-only visit, types of questions to ask their provider, and how to advocate for their preferences

BACKGROUND

VPQHC reconvened the Vermont Statewide Telehealth Workgroup in an intensive series of weekly meetings between July 31, 2020, and October 6, 2020, to explore the intersection of audio-only telemedicine and clinical quality. The purpose of reconvening the workgroup was to be able to provide insight into key clinical quality considerations related to audio-only telemedicine, under three main categories: identifying best practice related to provider education and training, monitoring and evaluation, and identifying relevant healthcare quality measures. VPQHC arranged for a series of local, regional, national, and global, leaders in telehealth and

² IOM. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press; 2001.

³ “What Are Integrated People-Centered Health Services?” World Health Organization, World Health Organization, 20 Sept. 2018, www.who.int/servicedeliversafety/areas/people-centred-care/ipchs-what/en/.



healthcare quality to speak to the workgroup on the topic; details on the meeting series, including the speaker line up, can be found on the [VPQHC website](#).

During our workgroup discussions, many of the benefits related to audio-only telemedicine and quality of care were raised. It was recognized that many Vermonters face barriers to accessing in-person care, due to things such as transportation, child care, and scheduling issues. Likewise, many face barriers to accessing a remote visit that includes an audio-visual component, as they may not have sufficient access to broadband, the equipment needed to connect, and/or the digital literacy skills that are needed. In a recent study published in *JAMA*, it was found that nationally “26.3% of Medicare beneficiaries lacked digital access at home, making it unlikely that they could have telemedicine video visits with clinicians.”⁴ In addition to that, “the proportion of beneficiaries who lacked digital access was higher among those with low socioeconomic status, those 85 years or older, and in communities of color.”⁵ For these vulnerable individuals, if care over the phone was not an option, this could lead to no care, or delayed care. Audio-only telemedicine visits were identified as an important tool for providers and patients, and a valid means for collecting actionable information that could help inform a patient’s course of care. The audio-only component provides the means to evaluate and move the patient to the next appropriate level of care or action, including recommendation for an in-person evaluation. Other benefits raised primarily surrounded that of the preference of patients and providers, with the recognition that audio-only telemedicine is not something for everyone, but a preferred tool for some if deemed clinically appropriate.

The main quality concerns related to audio-only telemedicine raised by workgroup members during our discussions included fear that clinicians will be unable to reach the appropriate

⁴ 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

⁵ 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



standard of care using audio-only tools, and that the lack of training in this modality could exacerbate this problem, leading to adverse health outcomes, and that there is a lack of evidence-based best practice related to audio-only telemedicine to guide clinical decision-making, training, and evaluation.

Consensus was that in an ideal world, Vermonters would have access to the care modality of their choice. All Vermonters would have access to broadband, equipment, and digital literacy skills they need to navigate remote visits. Providers would be well-versed in how to deliver remote care, and all organizations would have fully functioning telehealth systems. Further, barriers to accessing in-person visits would likewise not exist, and we would no longer live under a fee-for-service reimbursement structure, but under global budgets and capitated payments. However, as we do not have these structures currently in place, audio-only telemedicine is seen as an important tool for supporting access to healthcare for all Vermonters, in the interim, as we bridge from where we are currently, to where we want to be. Furthermore, patient preference for audio-only, as a modality of care on its own, should be available to patients who prefer it, and for whom it is deemed clinically appropriate. The following section outlines our clinical quality findings and recommendations for consideration related to audio-only telemedicine, and accompanying recommendations for establishing a system that works towards addressing patient and provider concerns as well as supporting continuous quality improvement.

RATIONALE FOR RECOMMENDATIONS

Healthcare Quality Measurement & Evaluation

Healthcare quality measurement is an integral component to ensuring a system of continuous quality improvement. 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 over audio-only telemedicine. As Judd Hollander, a national leader in telehealth, and one of our featured guests, stated: “quality care is quality care, whether it is delivered on the 4th floor of a building or the



5th.⁶ For audio-only telemedicine, the same, nationally recognized, healthcare quality measures should be applied to assess the quality of care delivered. Examples of these metrics include: appropriate antibiotic prescribing in pediatric visits, and measures of patient and provider satisfaction. These measures are agnostic to modality type.

Given these national measures exist, and in recognition of administrative burden and the need to avoid duplicative quality reporting, the workgroup would be wary of supporting the development of a Vermont-specific measure set to assess the quality of care delivered over audio-only telemedicine. However, we do support exploring how we can use existing data to monitor and evaluate the quality of care delivered by audio-only telemedicine. We also support ensuring providers and healthcare organizations are aware of nationally-recognized frameworks for assessing their telehealth systems, and have the support they need to implement those systems. We do anticipate that given the ever-evolving world of healthcare quality measurement that changes will be made, and new nationally recognized frameworks will be developed. It is our recommendation that a subgroup of the statewide telehealth workgroup be convened to explore how we can leverage existing data to monitor and evaluate the quality of care delivered by audio-only telemedicine, and stay current on nationally recommended frameworks for telehealth quality measurement. This subgroup can provide updates to the broader Statewide Telehealth Workgroup.

Provider Training & Education

Providers must be supported with the training they need to deliver quality healthcare. While we were unable to identify trainings specific to audio-only telemedicine, we did identify several trainings and resources for developing telehealth skills more broadly. It is the workgroup's recommendation that as monitoring and evaluation of the quality of care delivered by audio-only telemedicine continues, and opportunities for improvement are identified, gap analyses are

⁶ Hollander, Judd. VPQHC Statewide Telehealth Workgroup. 28 Sept. 2020, Zoom.



conducted to identify what trainings already exist to address areas of opportunity for improvement. If it is found that needed trainings are not available, it is our recommendation that the Vermont Statewide Telehealth Workgroup work together as a coordinated entity to leverage resources to ensure those trainings are developed and made available to Vermont providers. In addition, we anticipate additional educational opportunities will be developed as more research is published based on findings during the pandemic response. The Vermont Statewide Telehealth Workgroup is positioned well to act as a means through which this information can be disseminated as appropriate, across the continuum of care. In addition, Vermont law, under 18 V.S.A. §9361, includes a robust informed consent policy for telemedicine. We must continue to train providers to discuss the modality options for receiving care, the risk and benefits associated with each, and any cost for the visit.

Patient Engagement & Empowerment

Patients should be at the center of any healthcare decision-making, regardless of modality type, including audio-only telemedicine. It is important to note that during the COVID-19 emergency, many more patients felt that the risk of infection required them to use remote care than would normally have *preferred* remote care, which will in turn affect perception of cost and value. Patients must be educated regarding their options for receiving care – whether it be audio-only, a video visit, or in-person – and provided a means to voice their preference, and have that taken into account, when there is an option (i.e. outside of heightened pandemic response). We recognize that audio-only telemedicine is not for everyone, both on the patient receiving end, and the provider delivery end. This will necessarily lead to much-needed, and natural, conversations between patients and providers to determine the best course of care and the co-creation of a care plan. A concern that was voiced in the workgroup discussions was that patients may not have a reliable outlet through which they can voice their opinions related to the quality of care delivered; patient satisfaction survey results typically have low return rates, and some patients may not feel comfortable addressing their provider directly out of concern for the impact it could have on their relationship. We recommend that the Statewide Telehealth Workgroup discuss



whether additional avenues should be explored and cultivated to establish an open, and protected, outlet for patients to voice their opinions about the quality of care received. In addition, members of the Statewide Telehealth Workgroup should share tools and resources that can be disseminated to patients, describing what to expect from an audio-only telemedicine visit, how to advocate for their preferences, and how to properly prepare for a visit.



Taskforce on Telehealth Policy (TTP) Findings and Recommendations

Latest Evidence: September 2020



ALLIANCE for
CONNECTED CARE



Table of Contents

Executive Summary	3
Introduction	7
Findings and Recommendations	9
Patient Safety and Program Integrity	9
Data Flow, Care Coordination and Quality Measurement	14
Telehealth Effect on Total Cost of Care	19
Overarching Issues.....	26
Conclusion	30

Appendices:

Temporary Telehealth Policy Changes Made in Response to COVID-19	31
Taskforce on Telehealth Policy Subgroup and Overarching Questions	35
Taskforce on Telehealth Policy Members	37

Executive Summary

Telehealth use rapidly expanded this year in response to the COVID-19 pandemic, meeting the urgent need to ensure access while limiting in-person encounters. Temporary telehealth and remote patient monitoring (RPM) policy changes at the state and federal levels have generated new evidence, practices and adaptations that question the need for many of the restrictions that had been in place prior to the pandemic. Six months in, patients, policymakers, caregivers, clinicians and other providers are generally supportive of maintaining the expanded availability of telehealth services and see it as a critical tool in advancing a well-coordinated, patient-centered and value-optimized health care system.

The Taskforce on Telehealth Policy (TTP) formed to assess early findings and experiences under the flexibilities granted by Congress and CMS during the public health emergency and build a consensus among diverse stakeholders on recommendations that will help realize telehealth's potential to drive well-coordinated, patient-centered and value-optimized care. These recommendations were also informed by more than 300 written public comments and a virtual townhall attended by nearly 1,000 stakeholders. In the end, the TTP found substantial agreement for keeping most—but not all—of the COVID-19 policy changes and exploring new ways to harness the rapidly evolving possibilities of telehealth.

Policymakers put in place extensive restrictions on the use of telehealth at a time when technology was less mature and use cases for it were more limited than today. Prior to the pandemic, assumptions about patient safety, program integrity (fraud, waste and abuse), quality and cost were cited as reasons for these restrictions. The TTP believes that data collected during the COVID period should help inform a reevaluation of telehealth policy and utilization, particularly in fee-for-service (FFS) Medicare. The TTP also finds that the move to value-based payment models with shared financial risk and responsibility for improving the health of a population should alleviate many of the previous concerns, as they allow clinicians and patients to choose the care modalities most appropriate to their needs and preferences.

The TTP acknowledges there are many ways telehealth is used by medical practitioners and accessed by patients. Telehealth as part of an integrated approach with in-person primary care and chronic disease management is different from telehealth used for urgent care or triage, which is different from telehealth used by hospitals for post-discharge follow-up. These are only some examples of the variation of telehealth usage. For purposes of this report, we discuss telehealth in a way that can apply to all of these practices.

The TTP broke into three subgroups: Patient Safety and Program Integrity; Data Flow, Care Coordination and Quality Measurement; and Effect on Total Cost of Care. Below is a summary of each group's findings and the overall recommendations of the TTP, which are delineated more deeply in the pages to follow.



Patient Safety: Telehealth can enhance patient safety by preventing care delays, reducing exposure to pathogens and minimizing travel needed for in-person care. Policymakers should fund research on telehealth best practices for patient safety and update existing patient safety event reporting structures to incorporate telehealth.

Program Integrity: Fraud occurs in all health care programs, but emerging artificial intelligence tools to audit claims and other data may have potential to make it easier to detect aberrations quickly. In the case of telehealth, investigators can uncover Internet Protocol (IP) addresses and other digital signatures (e.g., date/time stamps) to identify bad actors. Integrating these tools into existing enforcement mechanisms may eventually reduce telehealth program integrity risks below those involved with in-person care.

Quality: Telehealth is essentially a setting or modality of care, rather than a type of care. This means that it should be held to the same standards and quality measures as in-person care where possible and appropriate. In cases where the unique characteristics of telehealth dictate a change in a given measure, it should be adapted rather than reinvented or developed from scratch. Where evidence and standards of care allow, measure stewards should do so without altering standards and outcomes expected for services provided via telehealth.

Rules and protocols for data sharing and care coordination between telehealth and other care sites, and their implementation in the form of telehealth certification requirements, should be developed in alignment with standards for other settings and implemented in the form of telehealth platform certification requirements, with the goal of preventing telehealth from adding to the fragmentation and data silos that plague our health care ecosystem and maximizing the integration of virtual care.

As telehealth usage and digital connection continue to expand, patients and the entire health care ecosystem could benefit from tools that enhance care coordination and improve patient experience. "Virtual medical homes" emphasizing remote care, closer patient monitoring and integration of telehealth with in-person care is one potential example, as electronic access to care is a facet of successful patient-centered medical homes. Advancing the concept of a living digital document populated by all members of a patient's care team that integrates information into a hub to support all care—virtual and otherwise—could also drive

higher quality and better outcomes. Policymakers should prioritize pilot testing these concepts.

Telehealth is well suited to improving the measurement of patients' experience of care. The current mail-based surveys suffer from low response rates, the inability to reach specific patient populations and slow feedback loops. Policymakers should leverage telehealth's uniquely digital aspects to improve timeliness, targeting and engagement in assessing patient experience, which is an essential aspect of quality.

Effect on Total Cost of Care: Prior to the pandemic, there was little data available to assess or project the cost effect of widespread access to telehealth in a FFS environment, particularly in Medicare. The temporary lifting of previous restrictions during the public health emergency allows an opportunity to begin doing so, albeit under extraordinary circumstances. A fuller picture will require understanding the effect on costs of COVID-induced care avoidance—among other factors unique to the current situation—and how those interact with greater utilization of telehealth during the pandemic. However, data collected to date indicate that the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded.

Behavioral health has been an exception. The TTP found anecdotal and data-driven evidence of significant increases in uptake of tele-behavioral health under the public health emergency. In part, the increase in demand may be related to the stresses and dislocation brought on by the pandemic, the lessening of social stigma some may attach to visiting in-person sites for this type of care or the reduction in regulatory barriers. Increased utilization of behavioral health services has the potential to decrease net costs and improve outcomes, as untreated behavioral conditions can contribute to greater physical health needs and overall spending. Again, additional evaluation is needed to better understand the impact on outcomes.

Early evidence also suggests that the expansion of telehealth has helped drive a reduction in the rates at which patients missed appointments (no-shows), which has been demonstrated to increase care plan adherence, improve chronic disease management and yield downstream cost savings. It has also increased the use of transitional care management services that improve outcomes and reduce readmissions, mortality rates and costs. Finally, some skilled nursing facilities (SNF) have deployed telehealth to resolve residents' health issues that would otherwise have prompted much more costly ambulance trips to hospitals and emergency departments (ED).

These data, while collected at a time of immense change and uncertainty, have not shown the large increases in net costs that some predicted broader access to telehealth services would bring. We won't know the true effect until the pandemic is over or until care has been adapted to the new reality post-COVID. Future permanent telehealth policy for public payers should be made on the basis of such available data and findings. As the volume of value-based payments increases across public programs, access to telehealth across payers should also increase toward the level currently seen in the commercial market if these tools prove effective in providing high-quality care that meets patient and payer goals.

Overarching Telehealth Issues: Policymakers should take additional steps to support safe, effective and equitable integration of telehealth into our health care ecosystem. This includes establishing a uniform taxonomy describing the full range of telehealth services and modalities that would aid in aligning standards, quality measurement, payment principles and program integrity guidelines. Policymakers must also promptly expand efforts to address deficiencies in broadband access and technology infrastructure, as well as trust and digital literacy. These gaps can increase health disparities and limit the dispersion of telehealth's benefits. Finally, while the potential of telehealth to improve care and outcomes abounds, policymakers should not expect telehealth to singlehandedly resolve longstanding issues that exist throughout our health care system.

Policymakers should make permanent the following specific COVID-19 policy changes:

- Lifting geographic restrictions and limitations on originating sites.
- Allowing telehealth for various types of clinicians and conditions.
- Acknowledging, as many states now do, that telehealth visits can meet requirements for establishing a clinician/patient relationship if the encounter meets appropriate care standards or unless careful analysis demonstrates that, in specific situations, a previous in-person relationship is necessary.
- Eliminating unnecessary restrictions on telehealth across state lines.

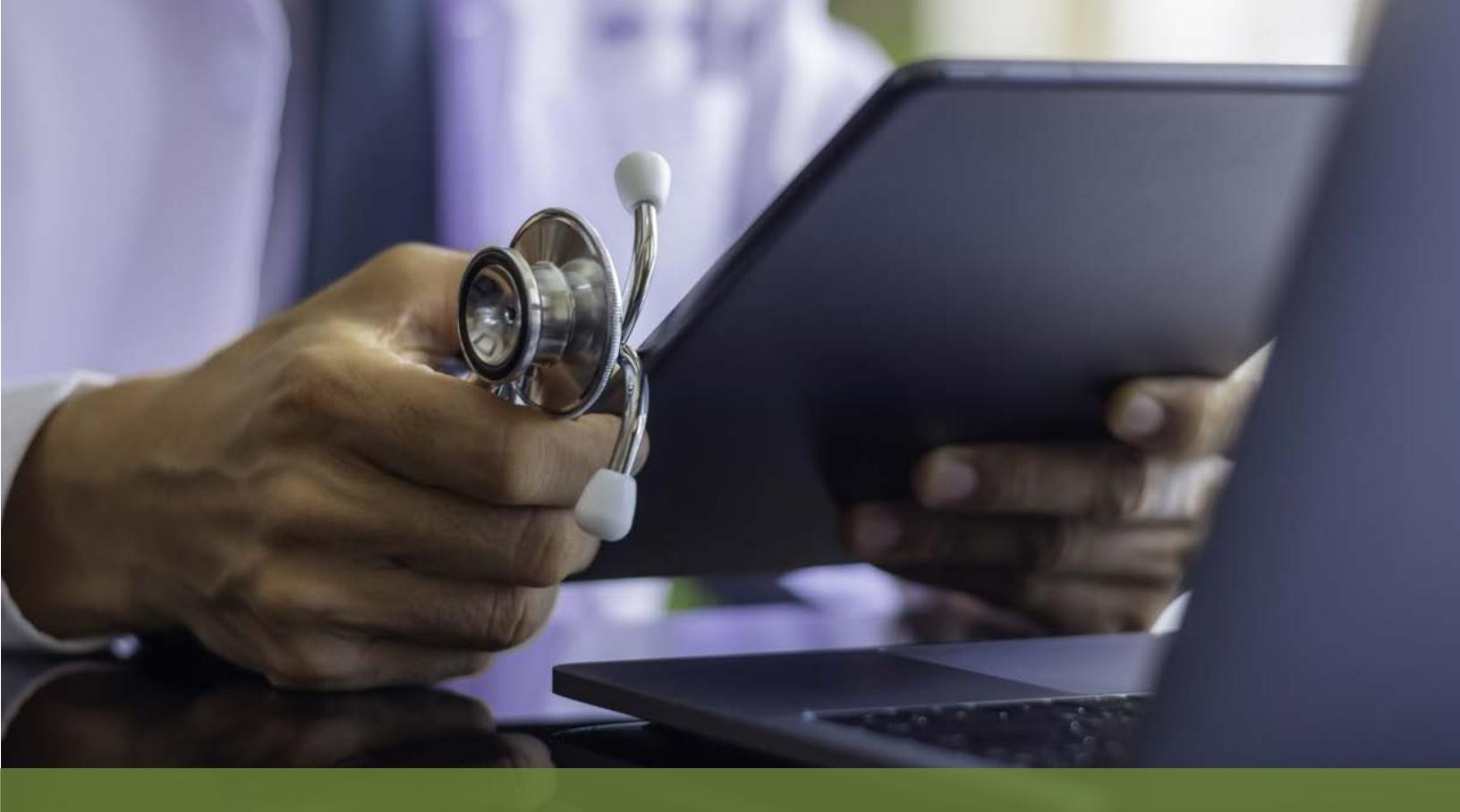
Policymakers should look closely at the effect of expanding prescribing authority to telehealth, as authorized by the public health emergency. They should evaluate what policies and guidelines could be applied, to virtual prescribing to ensure patient safety and avoid adverse outcomes.

Policymakers should fully reinstate enforcement of Health Insurance Portability and Accountability Act (HIPAA) patient privacy protections that were suspended at the start of the public health emergency.



THANK
YOU

The TTP thanks everyone who helped us gather information and data and shared comments to aid our work. We hope these findings and recommendations guide policymakers and other stakeholders to a future where we see telehealth as the natural evolution of health care into the digital age.



Introduction

When COVID-19 emerged as a once-in-a-century threat to public health, the use of telehealth became indispensable to maintaining a functioning health care system. Federal regulatory and legislative actions, and those taken by private insurers expanded access to telehealth, and relaxed regulations to balance health care access with the need to avoid unnecessary physical contact.¹ Early data suggest telehealth also relieved travel burdens, reduced missed appointment rates, increased access to behavioral care, reduced skilled nursing facilities transfers to hospitals, boosted transitional care management and enabled patients to choose virtual visits across a much broader range of services. Consensus quickly emerged among many stakeholders, including some members of Congress and the Administration, that many telehealth policy changes should remain in place after the crisis.

"It's taken this crisis to push us to a new frontier, but there's absolutely no going back," said

**REPRESENTATIVE
MIKE THOMPSON (D-CA)**

"Telehealth is a proven and cost-effective way to get care out to patients, particularly during a crisis....We know telehealth can be an essential bridge in delivering care, particularly during a crisis and today we are working to ensure telehealth continues in a post-Coronavirus world."

Thompson, Welch, Johnson, Schweikert, Matsui Introduce the Protecting Access to Post-COVID-19 Telehealth Act, United States Congressman Mike Thompson, July 16, 2020.

¹ Refer to *Telehealth Policy Changes Made in Response to COVID-19*, page 25.

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma to *The Wall Street Journal*.² "I think we need to do everything we can to support the health care system, make health care more accessible, make it more affordable—and telehealth is one powerful tool that can solve a lot of the problems that we have."³

"We're now aggressively looking at how to make the telehealth revolution a permanent part of American medicine," wrote Health and Human Services (HHS) Secretary Alex Azar. "In many cases, well-meaning anti-fraud and privacy measures make it more difficult than it needs to be. There's a reluctance to let Medicare pay for more telehealth on the grounds that this will drive up health care utilization, straining our health care system and the program's budget. That kind of static thinking is one of the biggest problems in American health care. We shouldn't stand in the way of delivering necessary health care services in the most convenient way possible—especially as our health care system shifts toward paying for outcomes rather than procedures."⁴

Nevertheless, prior concerns about efficacy, appropriateness, fraud, waste and abuse and privacy that fostered previous policy restrictions still linger.

The Taskforce on Telehealth Policy (TTP) was formed to assess the changes occasioned by the pandemic and find agreement on recommendations that would maximize the availability of safe, high-quality and cost-effective telehealth services. Convened by the Alliance for Connected Care, the National Committee for Quality Assurance and the American Telemedicine Association, the TTP represents the perspectives of consumers, physicians, hospitals and health systems, insurers, telehealth platforms, quality measurement experts and federal government liaisons.⁵ The TTP divided into subgroups to address specific, often overlapping questions on:⁶

- Patient Safety and Program Integrity.
- Data Flow, Care Coordination and Quality Measurement.
- Telehealth Effect on Total Cost of Care.

Finally, this report was aided immensely by input from hundreds of health care stakeholders who shared their valuable insights on these and other topics through written comments, virtual meetings and our online Public Comment Town Hall. We hope the findings and recommendations we are sharing help guide policymakers as they chart the future for telehealth.

² *The Doctor Will Zoom You Now*, Wall Street Journal, April 26, 2020.

³ *The New Normal of Care Delivery*, Health IT Leadership Roundtable, July 2020.

⁴ *Trump Administration Aims to Keep Telehealth Revolution Here to Stay*, Azar, USA Today, July 31, 2020.

⁵ Refer to Taskforce on Telehealth Policy Members, page 34.

⁶ Refer to Taskforce on Telehealth Policy Subgroup and Overarching Questions, page 29.

Taskforce on Telehealth Policy Findings and Recommendations



Patient Safety and Program Integrity

PATIENT SAFETY FINDINGS

The goal for patient safety in a telehealth or in-person care encounter is the same. Care provided must not result in preventable patient harm or mortality. Telehealth patient safety includes ensuring access for patients with technology or digital literacy gaps. When a patient safety metric already exists for in-person care and is applicable to telehealth, apply it rather than create additional telehealth-specific metrics.

The Agency for Healthcare Research and Quality (AHRQ) recently released an issue brief that cited studies on telehealth and patient safety.⁷ Among the findings were:

- The evidence-base for telehealth is strong, especially for the remote management of chronic health conditions.⁸
- Systematic reviews confirm that telehealth improves health outcomes, utilization and cost of care for a host of chronic diseases, including heart failure, diabetes, depression, obesity, asthma and mental health conditions.^{9,10,11}
- For nonurgent complaints in primary care settings, diagnostic accuracy and the likelihood of diagnostic error appear to be roughly comparable in tele-diagnosis vs. face-to-face encounters.^{12,13}

The TTP did not achieve full consensus on all recommendations. For example, we found strong, but not unanimous, support for permanently lifting all controlled substance prescribing restrictions in telehealth. The public comments we received, in particular, provided anecdotal feedback suggesting that telehealth improved access, uptake and, potentially, outcomes for behavioral health for which controlled substances are often prescribed, such as medication assisted therapy for substance use disorder. This is reflected in the related recommendations below.

⁷ *Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis*, AHRQ, August 2020.

⁸ *The Impact of Telehealth care on the Quality and Safety of Care: A Systematic Review*, McLean et al., *PLoS One*, 2013.

⁹ *Telehealth for Acute and Chronic Care Consultations*, AHRQ, Totten et al., April 2019.

¹⁰ *Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews*, AHRQ, June 2016.

¹¹ *Improving Diagnosis in Health Care*, National Academies Press, 2015

¹² *How Accurate are First Visit Diagnoses using Synchronous Video Visits with Physicians?*, Ohta et al, *Telemed e-Health* 2017.

¹³ *Diagnostic Accuracy in Primary Care e-visits: Evaluation of a Large Integrated Health Care Delivery System's Experience*, Herzog et al, *Mayo Clinical Proceedings*, 2019.



PATIENT SAFETY RECOMMENDATIONS

1. Policymakers, in partnership with clinical subject matter experts, should identify and recommend minimum standards for assessing and ensuring patient safety via telehealth care delivery and integrate them into existing safety standards.
2. Policymakers should integrate patient safety standards for in-person and telehealth care across health policy, adapting and supplementing existing safety standards, if needed. Policymakers should not layer new telehealth policies on top of existing in-person care regulations.
 - a. For example, there may be a need for standards to alert a telehealth patient that they need to seek in-person care, or to help a patient or their caregiver self-administer tests or perform other medical tasks.
 - b. Integrated patient safety standards should align with quality standards across health care policies, given the close relationship between safety and quality.
3. Congress should continue funding the research efforts of AHRQ and other organizations to identify what works—or what does not—in advancing telehealth patient safety, and should support development of best practices for telehealth as it does for other care sites.
 - a. AHRQ should clarify how to aggregate and analyze patient safety data to better identify improvement opportunities and publish research on telehealth encounter safety. For example, AHRQ could develop best practices and guidelines on optimizing patient safety in a telehealth encounter, as well as guidelines on safely transitioning to an in-person visit or a higher level of care.
4. Policymakers should update existing policy for in-person-care-related adverse patient safety events to incorporate telehealth, including collecting necessary information and data, as well as leveraging existing patient safety event reporting structures and the work of Patient Safety Organizations (PSO).
 - a. Integration of PSO patient safety event reporting could ensure the collection of standardized data on patient safety events in a telehealth encounter that result in serious injury or death.
5. Policymakers should carefully evaluate the experience of allowing prescription of controlled substances via telehealth during the pandemic, particularly for medication-assisted treatment of substance abuse disorders, and how continuing this policy can be done in a manner that protects patient safety and prevents overprescribing or abuse. This should include consideration of:



- a. How prescribing controlled substances in a telehealth encounter can comply with regulations and enforcement currently applied to in-person prescribing.
- b. The burden for compliance should be no greater than compliance with the same rules for in-person care.
- c. How policies should align with SUPPORT for Patients and Communities Act requirements for Medicare Advantage plans to use e-prescribing for controlled substances starting in January 2021.¹⁴
- d. How existing and emerging technologies, such as artificial intelligence and machine learning, may have potential to help detect and mitigate fraud and abuse.

PROGRAM INTEGRITY FINDINGS

While it is undoubtably important to vigorously protect against fraud, waste and abuse (FWA) throughout health care, including in telehealth, arbitrary telehealth restrictions are not a justifiable or viable program integrity strategy. Arbitrary restrictions will not deter unscrupulous actors who will continue to engage in long-standing fraud schemes associated with medical equipment, opioids, compounding pharmacies and other areas.

The most effective approach to aggressively fighting FWA for both in-person and telehealth care is to leverage sophisticated technology tools that can enhance existing program integrity enforcement efforts, and also to drive better collaboration with health care stakeholders.

In crafting our recommendations, we considered common types of FWA that can occur during an in-person patient visit, including claims for medically unnecessary care, billing for services that were never delivered, illegal kickbacks and inappropriately coded claims. Policymakers can aggressively mitigate FWA risk in all these common types through adoption of TTP recommendations regardless of modality.

¹⁴ SUPPORT for Patients and Communities Act, United States Congress, 2018.

**KATE BERRY,
SENIOR VICE PRESIDENT
OF CLINICAL INNOVATION,
AMERICA'S HEALTH INSURANCE PLANS**



"When we're thinking about program integrity, we need to be thinking about patient safety, it's not just fraud and abuse. It's also the patient at the core and we want to make sure that what we're doing is safe and has value."



PROGRAM INTEGRITY RECOMMENDATIONS

1. Congress should direct and fund enforcement agencies to harness available and emerging technologies. As part of their anti-fraud efforts, federal and state governments should foster the development of strategies that can help prevent abuse by using sophisticated analytic and artificial intelligence tools that can detect fraudulent behavior, and audit claims on the back end to uncover aberrations, for example. Telehealth enables payers to monitor IP addresses, date/time and other digital signatures to help identify bad actors. This may facilitate fraud detection and eliminate the need to physically check in-person locations and patients.
 - a. Under the Health Care Fraud and Abuse Control (HCFAC) program, the HHS Inspector General (IG) and CMS have extensive program integrity policies and procedures in place to address FWA and improper payments. HHS should invest in innovative enforcement strategies, employ private sector best practices and leverage predictive analytic methods and emerging artificial intelligence and predictive analytics to fight FWA in telehealth.
 - b. The agencies tasked with protecting Medicare, other health programs, and ultimately, patients and taxpayers, must be appropriately resourced to maximize and incorporate technologies and strategies to uncover aberrations through claims audits and enhance investigations with digital forensics tools.
 - c. These actions may have potential to improve the ability to detect fraud, waste and abuse, and could potentially lower telehealth program integrity risks below the amount seen with in-person care.
 - d. Policymakers must protect patient privacy in every telehealth FWA mitigation effort.



2. Congress does not currently need to create new programs to address telehealth FWA, but instead should require HHS to integrate telehealth into existing FWA efforts.
 - a. HHS should ensure coordinated, efficient and effective enforcement within and across HCFAC, the IG, the CMS Center for Program Integrity, CMS contractors such as Zone Program Integrity Contractors, Medicaid Fraud Control Units and the Federal Bureau of Investigations.
 - b. HHS should ensure that these groups continue to develop and enhance telehealth FWA detection and mitigation strategies beyond telemarketing-oriented durable medical equipment fraud, and integrate such efforts with in-person and existing HCFAC workstreams.
 - c. HHS should provide guidance on the application of newly integrated policies to help payers, clinicians and other providers understand and comply. HHS should partner with the Medicare Learning Network and private sector stakeholders to maximize the effectiveness of this education.
3. Since previous IG fraud reports related to telehealth make it easier to commit traditional fraud, HHS should closely monitor this and examine further ways to deter traditional fraud if there is evidence telehealth accelerates it, especially in light of known experience with issues like durable medical equipment.



Data Flow, Care Coordination and Quality Measurement

DATA FLOW AND CARE COORDINATION FINDINGS

By virtue of its digital, direct-to-patient and portable nature—and its use across a wide range of specialties and sites—telehealth is well positioned to help accelerate the move to a more coordinated, interoperable experience for patients, clinicians and other providers. To do so, the health care community needs standards, guidance and best practices on care management, data flow and documentation that will establish a degree of consistency across all care sites. Done right, these guidelines will encourage telehealth “mobility” and maximize its potential, while also smoothing the path for adoption by clinicians and other providers.

Delivering high quality, well-coordinated care to patients at home through telehealth is an important goal. Older adults and people with complex care needs want to live as independently as they can for as long as they can. Telehealth has the potential to improve access to and quality of care, while reducing strain on family caregivers.

Remote patient monitoring (RPM) is a multi-faceted, rapidly evolving subset of telehealth that brings unique data flow and care coordination challenges and opportunities. RPM, unlike most other forms of telehealth, is primarily asynchronous and may require evaluation of inbound data by a clinician. In some instances, RPM involves sharing of discrete services and expertise from one location to another, enhancing system capacity and performance and bridging care gaps. In others, it is part of a holistic treatment plan, enabling more frequent, accurate monitoring and consultation between patients and providers without requiring individuals to leave the safety of their homes. This is particularly important for vulnerable populations.

Increasingly, RPM can entail receipt of data from wearables and other devices that may not be related to a specific diagnosis or care plan but may be helpful in assessing and addressing health concerns. RPM has the potential to fill gaps between patients’ visits with their doctors and to leverage the rapidly expanding array of tools that augment patient-generated health data.

There are also new opportunities for telehealth to support improved care coordination and data flow. One is through the development of “virtual medical homes” that provide patient navigators to coordinate care and follow-up for patients receiving remote services, while ensuring integration



into the larger health system. Virtual medical homes could decrease transportation costs and burdens, increase access to care (particularly for those who are in rural settings or mobility challenged) and drive down no-show rates.

Another is to begin moving toward a standard by which all members of a patient's care team—not just those delivering care via telehealth—update and share a living, virtual, care coordination document. While interoperability is a long-standing goal that faces many challenges, there may be ways in which telehealth can uniquely contribute to addressing some of these challenges and drive adoption of a more patient-centered approach to coordinating individuals' treatment across their care team. If nothing else, many telehealth visits involve the two-way, digital exchange of data and information in a fashion that can reasonably be expected to contain opportunities to share data and records more interoperably.

DATA FLOW AND CARE INTEGRATION RECOMMENDATIONS

1. Policymakers and stakeholders should develop and document clear data sharing standards and guidelines that send a signal to clinicians, other providers and vendors about data transmission and interoperability expectations. These standards and guidelines should become the basis for telehealth platform certification requirements that are aligned with data sharing and documentation guidelines for other care settings.
 - a. These should include provisions that encourage integration of telehealth-related data and care records with all other patient information and strong patient privacy and security criteria to ensure compliance with HIPAA and a requirement to ensure patients have access to their data and that platforms share patients' data promptly at their request. The goals should be to facilitate interoperability, lower the barriers to telehealth integration and facilitate outcomes analyses that leverage telemedicine data registries.
 - b. The work should build on existing standards and 21st Century Cures Act data sharing and anti-data blocking legislation¹⁵ and regulations.¹⁶ While the standards and guidelines should serve as a floor of minimum expectations, policymakers should also describe an optimum level of capabilities in these areas.
 - c. Policymakers should immediately convene relevant third-party entities such as (but not exclusive to) the Interoperability Standards Advisory, Health Level 7, CARIN Alliance, NCQA and radiology's Digital Imaging and Communications in Medicine (DICOM) to develop the above, with input from vendors, patients, payers, clinicians and other providers, quality measurement entities and other relevant stakeholders.

¹⁵ The 21st Century Cures Act, December 13, 2016.

¹⁶ Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers, Centers for Medicare and Medicaid Services, May 1, 2020.



2. CMS should develop and pilot a program that empowers and supports patients receiving care remotely. Patients opting to partake in this virtual medical home model would have access to designated patient navigators and other tools to maximize data sharing, care coordination, patient experience and outcomes. The program should be designed to complement and enhance any existing care coordination or patient-centered medical home services in place and to fully integrate remote care into the health care system. These wrap-around services could have the most impact in publicly subsidized managed care arrangements, such as Medicare Advantage, managed Medicaid and Exchange plans.
 - a. Community health workers or community-based organizations with particular knowledge and expertise in a given region or population could be enlisted to provide this function.
 - b. Higher levels of services would be available to those with more complex needs or challenges.
 - c. To make such a model feasible, policymakers must align payments, care management protocols, penalties and other incentives across programs and payers, and clearly enumerate responsibilities of each party.
3. The recent CMS Interoperability Rule moves payers toward adopting FHIR-based standards. In coordination with this effort, funding should be allocated to efforts that promote a shared, living, virtual, patient-centric care plan among all members of a patient's team—such as the FHIR CarePlan—and away from siloed, encounter-based documentation. Of course, the shared care plan will require numerous patient consent considerations that must remain at the forefront, especially when it comes to protected health care information like behavioral health, substance use disorder information or HIV, for example. A pilot test should be conducted to refine and advance the concept.
 - a. Based on past experience, strong accountability models are essential to driving this kind of coordination.
 - b. The virtual plan should not restrict an individual provider's ability to maintain a plan for their portion of the patient's care, but encourage the use across providers of a dynamic master care plan that accounts for all of the patient's medical interactions.



QUALITY MEASUREMENT FINDINGS

The quality enterprise should prioritize the use of existing standards and measures when evaluating the quality of care provided by telehealth. Where this is not feasible, measures should be adapted according to clinical guidelines, rather than reinvented to conform to the methods unique to telehealth. For example, telehealth encounters can require getting labs before a visit, ensuring that patients can use and are comfortable with the technology during the visit, and helping patients navigate needed follow-up remotely after the visit. To this end, NCQA responded to the lifting of telehealth restrictions during the COVID-19 pandemic by updating 40 HEDIS® measures to deem services provided by telehealth as equivalent to in-person care for purposes of measure compliance.¹⁷

Policymakers should carefully consider the capabilities, limitations and requirements of telehealth as a site of care when measuring the quality of a telehealth encounter, as would be done with any other site. Measurement should focus on whether a telehealth encounter delivers what the patient needs, improves health outcomes, provides an experience the patient can interact with appropriately and integrates with the patients' overall health care. Moreover, stakeholders should view telehealth as part of a continuum of encounters between patients and clinicians that are coordinated among varying sites, not stand-alone events.

Early findings from COVID-era experience suggest that telehealth may reduce missed appointment (no-show) rates in comparison with in-person visits. In addition, telehealth may have a positive impact in supporting family caregivers, as they often play a critical role in patients' health and well-being. Measure stewards and policymakers should work to quantify each of these potential benefits, where possible, as quality measures are adapted for telehealth, consistent with the goal of improving the patient and family caregivers' experiences, integrating health and social supports and understanding patients' goals and preferences.

Measuring quality provided via RPM is another area that requires attention. Any standards and measures related to RPM should be designed to capture the tangible impact of this modality's effectiveness, efficiency and closer monitoring of chronic conditions that can prompt earlier interventions to reduce costly exacerbations, improve outcomes and patient and family caregiver experience and ensure data flow in a way that maximizes its impact.

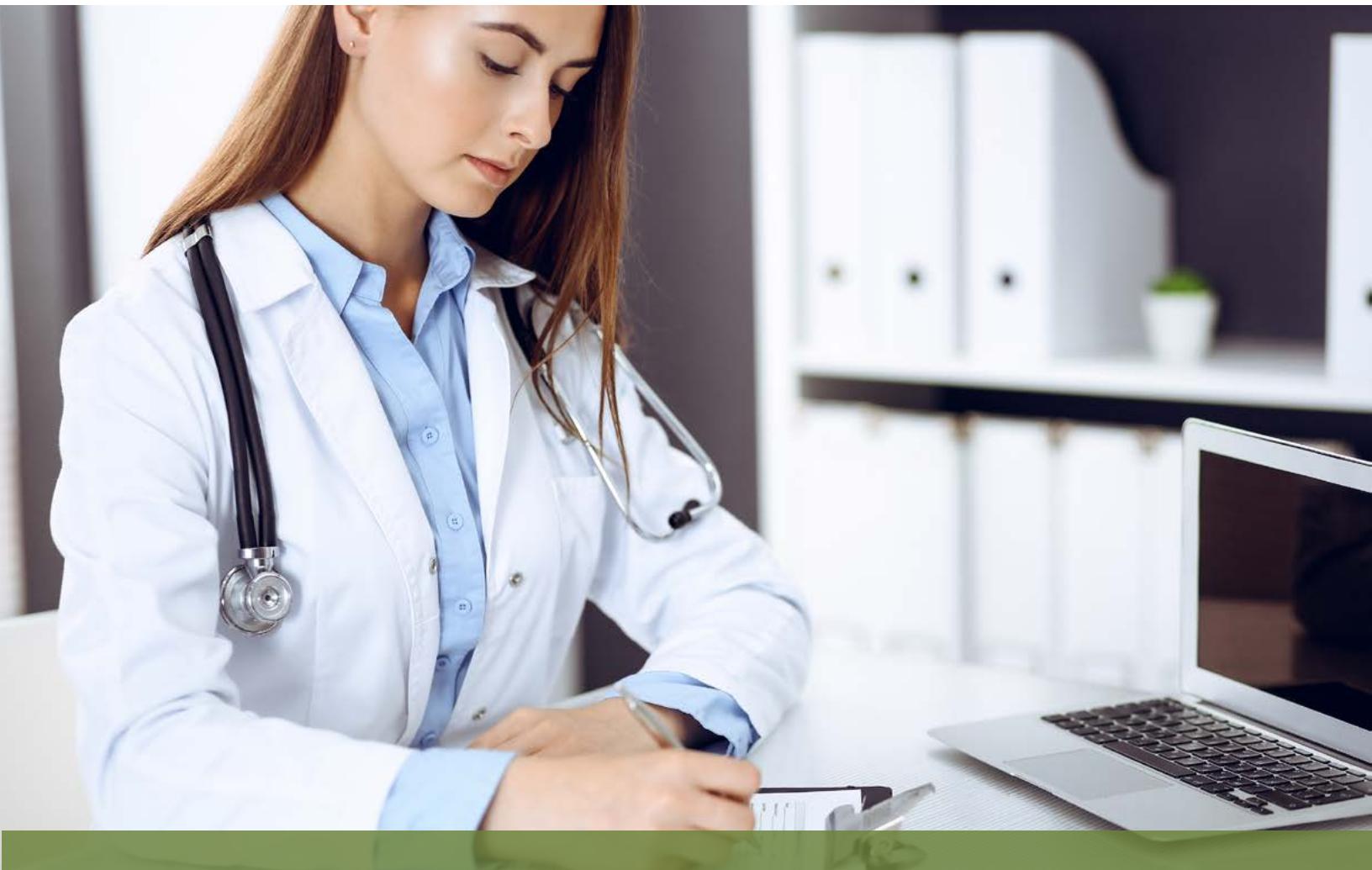
Telehealth also offers a "leap forward" opportunity for patient experience measurement. Because the initiation, completion and follow-up for a telehealth visit often occur digitally, there exists the possibility of assessing patient experience in a more real-time, clinician and other provider-specific fashion that improves response rates and provides faster, more meaningful feedback than current mailed paper surveys. While some existing patient experience metrics may apply equally to telehealth, others will not. This should be a factor in developing and implementing patient experience measures for remote encounters.

¹⁷ HEDIS, the Healthcare Effectiveness Data and Information Set, is a registered trademark of NCQA.



QUALITY MEASUREMENT RECOMMENDATIONS

1. Measure stewards should carefully and thoughtfully review all measures individually to determine the need for telehealth adaptations.
 - a. Review should consider how quality measurement could account for telehealth's unique impact on quality, safety, cost effectiveness, access and outcomes.
2. CMS should pilot a patient experience survey linked to telehealth encounters for all types of care, leveraging telehealth's uniquely digital aspects to improve timeliness, targeting and engagement.
 - a. Lessons learned should help update patient experience measurement across settings to improve response rates and provide faster, more targeted feedback.





Telehealth's Effect on Total Cost of Care Findings

Among the greatest barriers to broader telehealth adoption are assumptions among policymakers that allowing greater telehealth access will lead to higher utilization and costs. This opinion is especially prevalent for FFS Medicare. Recent data provided to the TTP challenge some of these assumptions.

A small silver lining of the pandemic has been the generation of first-ever Medicare FFS data that allows budget analysts, including the Congressional Budget Office (CBO), the Office of Management and Budget and the CMS Actuary, to begin to assess telehealth's impact on Medicare more accurately.

Policymakers will, of course, want further analysis of how much COVID-induced care avoidance may have contributed to telehealth's impact on utilization during the pandemic. However, data generated from provider organizations and the federal government to date show that total health care utilization remained steady during telehealth's expansion and did not substantiate concerns about supply-induced demand.

CONGRESSIONAL BUDGET OFFICE TELEHEALTH ESTIMATES

Traditional Medicare stands out from other major insurers and value-based payment models that use telehealth for patient care and savings. This is largely because the CBO says that telehealth dramatically increases utilization and costs. CBO does not count potential savings, for example from avoided SNF transfers, reduced readmissions, better chronic disease management and avoided urgent care visits. Because Congress often requires offsetting new spending, CBO has great influence. However, CBO's assumptions have led to substantially overestimated telehealth costs. In 2001, after Congress introduced telehealth into Medicare, CBO projected the cost to be \$150 million in the first 5 years, or \$30 million a year.¹ In fact, over the first 14 years, Medicare spent only \$57 million—a third less in almost triple the time.² CBO explained its hesitancy in 2015, saying, "Because Medicare coverage of telemedicine is limited, CBO does not have extensive data that would help project how expanding such coverage would affect federal spending."³ CBO does not use Veterans Administration and Department of Defense data, both of which use telehealth extensively, because they are "closed systems."

¹ H.R. 5661 Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, CBO, September 2001.

² Telemedicine Fans Point to CBO's History of Cost Overestimates, Politico, December 2014.

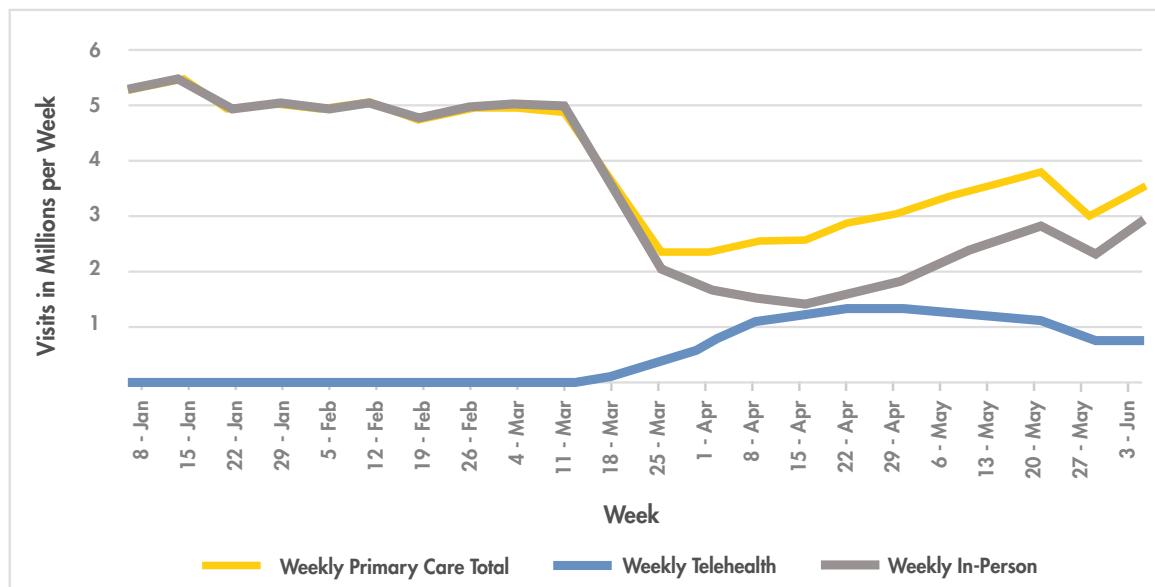
³ Telemedicine, CBO, July 2015.



For example, an HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicare FFS telehealth report found that from mid-March through early July more than 10.1 million traditional Medicare beneficiaries used telehealth.¹⁸ That includes nearly 50% of primary care visits conducted via telehealth in April vs. less than 1% before COVID-19.

However, the net number of Medicare FFS primary care in-person and telehealth visits combined remained below pre-pandemic levels. As in-person care began to resume in May, telehealth visits dropped to 30% but there was still no net visit increase. The effects of the COVID-19 pandemic on patients seeking or avoiding care still need further analysis, but these data suggest that telehealth substituted for in-person care without increasing utilization.

Figure 1. Primary Care Visits for FFS Medicare Beneficiaries (visits in millions per week)



Source: Medicare claims data up to June 3rd, available as of June 16.

Other sources mirror ASPE's findings. The U.S. Department of Veterans Affairs researchers found that, from March to May 2020, a 56% decline in in-person visits was partly offset by a two-fold increase in telephone and video visits.¹⁹ At least during that period of the pandemic, telehealth replaced in-person visits but did not increase overall utilization.

The TTP obtained initial findings from health systems and independent practices across the country, including Johns Hopkins, Stanford Health Care, Ascension, Intermountain Healthcare, Nemours Children's Health System, University of Rochester, Northwestern and Aledade. The TTP also received input from the American Academy of Actuaries' Telehealth Subcommittee, an advisor to the HHS Secretary, a former Medicare leader and a former Congressional Committee staffer who dealt regularly with the CBO. Using these data, we narrowed our focus to five key topics that can impact costs.

¹⁸ Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the Covid-19 Pandemic, HHS Assistant Secretary for Planning and Evaluation, July 2020

¹⁹ Reduced In-Person and Increased Telehealth Outpatient Visits During the COVID-19 Pandemic, Annals of Internal Medicine, August 2020.



1. Substitution of in-person care.
2. Preventing more costly care.
3. Lower no-show rates.
4. Greater transitional care management.
5. Lowering skilled nursing facility transfers.

Substitution Effects. It is essential to distinguish between the extent to which telehealth serves as a substitute for in-person care as opposed to an add-on. One study estimates that virtual care could substitute for up to \$250 billion of current U.S. health care spending,²⁰ and the emerging data from the pandemic shows this could be correct. It is still too soon for large-scale, academically rigorous analysis of what is happening that properly discount pandemic effects, but the evidence from March to July is promising for telehealth.

Data gathered by the TTP indicate that telehealth largely substituted for in-person care and did not increase the total number of visits. Again, policymakers will want further analysis of the separate phenomena of cost related to COVID-induced care avoidance and cost related to widespread access to telehealth. However, as with ASPE, health systems surveyed by the TTP found that telehealth simply represented a change in care delivery modality with steady overall utilization. Total visits, including in-person and video, never went above pre-pandemic levels, even as clinics reopened to in-person care broadly across the health system.

Preventing More Costly Care: Telehealth facilitates access to health care for individuals who might otherwise skip or avoid important services. It also allows care delivery more quickly and efficiently in lower cost settings. The TTP found evidence that telehealth can help reduce more costly urgent and ED care, as well as use of costly and often overused services such as imaging.

- Ascension Health found that, from March to May of this year, nearly 70% of patients would have gone to either urgent care or the ED had they not had access to virtual care. These patients would have used more costly options without access to telehealth.²¹
- Nemours found that 67% of parents who used its 24/7 on-demand virtual care service before COVID-19 reported they otherwise would have visited an ED, urgent-care center or retail health clinic had telehealth not been available.²²

²⁰ *Telehealth: A quarter-trillion-dollar post-COVID-19 reality?*, McKinsey and Company, May 2020.

²¹ *Ascension Task Force on Telehealth Policy*, March-May 2020.

²² *Analysis of a Pediatric Telemedicine Program*, Vyas et al, December 2018.



- A pre-COVID-19 Anthem study of Medicare Advantage claims data for acute and non-urgent care utilization found savings of 6%, or \$242 per episode of care costs, by diverting members to telehealth visits who would have otherwise gone to an ED. The study also found less use of imaging, lab tests and antibiotics.²³
- In a pre-COVID-19 study of 40,000 Cigna beneficiaries, the 20,000 beneficiaries who used the MDLive telehealth platform had 17% lower costs when compared with non-virtual care. Virtual care users also experienced a 36% net reduction in ED use per 1,000 people compared to non-virtual care users.²⁴

No-Show Rates: Policymakers need to consider telehealth's impact on no-show rates. Missed appointments decrease care plan compliance, which can lead to more expensive care needs. In 2012, CBO determined that prescription drug legislation cost estimates must account for the offsetting effects of medication adherence.²⁵ Telehealth's similar offsetting effects on no-show rates and better care plan adherence contribute to downstream cost savings and are thus important cost factors. For example, in diabetes care management, routine visits can help prevent long-term, costly effects.

Health systems and clinician practices consistently report lower no-show rates with telehealth, especially in behavioral care, where telehealth removes the stigma of visiting a behavioral clinic. For example, the baseline no-show rate for psychiatry services is between 19% and 22% of appointments—while MDLive reports no-show rates of only 4.4% – 7.26% for its behavioral health telehealth visits.²⁶ Dr. E. Ray Dorsey, MD, MBA, professor of neurology and director of the Center for Health and Technology at the University of Rochester Medical Center, commented that patients are more likely to show up to virtual appointments—with no-show rates down about 10% during the pandemic. For the Marshfield Clinic, office visit no-show rates pre-COVID-19 were roughly 5%; they dropped to 3.8% with telehealth during COVID-19.

Improved no-show rates are likely due to telehealth's convenience, especially its impact on travel burdens that create barriers to care in accessing transportation, taking time off from work and finding childcare. In 2018, CMS estimated that telemedicine saves Medicare patients \$60 million on travel, with a projected estimate of \$100 million by 2024 and \$170 million by 2029.²⁷ CMS also noted that estimates tend to underestimate telemedicine's impact. Higher projections estimate \$540 million in savings by 2029.

**CHRIS MEYER,
DIRECTOR OF VIRTUAL CARE,
MARSHFIELD CLINIC:**



"We saw many more farmers getting behavioral health services during COVID that didn't before. When we talked to them, they were brutally honest, "There's no way in heck I'm going into a building that says behavioral health, but if I can do it on my iPad at home, I'm okay doing it."

²³ Telehealth Eliminates Time and Distance to Save Money, *Healthcare Finance*, October 2019.

²⁴ At Cigna, Telehealth Reduces Patient Costs and ER Visits, and Boosts Use of Generic Rx, *Healthcare IT News*, November 2019.

²⁵ Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services, CBO, November 2012.

²⁶ Research Reveals Reasons Underlying Patient No-shows, *ACP Internist*, February 2009.

²⁷ Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, Centers for Medicare and Medicaid Services, November 2018.



Transitional Care Management (TCM): While the TTP did not have time to collect enough data to fully analyze TCM, we received anecdotal evidence that TCM code billing increased during COVID-19. This suggests that clinicians, other providers and patients are more robustly utilizing TCM services. Previous analysis has suggested that increased TCM usage can lower readmissions, thereby reducing health care costs.

TCM service use increased from roughly 300,000 claims during 2013, the first year of TCM services, to nearly 1.3 million claims in 2018. This resulted in significantly lower readmission rates, significantly lower mortality, and significantly decreased health care costs.²⁸ The analysis also found that TCM use is low when accounting for the number of Medicare beneficiaries with eligible discharges. CMS cited this study in its 2020 physician fee schedule rule, noting that increasing medically necessary TCM utilization could positively affect patient outcomes.²⁹ Readmissions are particularly detrimental for patients and hugely costly to providers and payers—in 2019 roughly 83% of hospitals incurred readmission penalties.

Lowering Skilled Nursing Facility (SNF) Transfers. SNF patient hospital readmissions cost Medicare over \$4 billion each year. The TTP received data from Third Eye Health, a platform that triages patients via telehealth who may need to be transferred to the hospital, showing that their consultations from March–July successfully treated patients in SNFs at an overall rate of 91%, including for high-cost falls with injury (84.79%), shortness of breath (66.67%) and acute or chronic pain (95.96%). While much more evidence needs to be collected, the TTP believes telehealth in SNFs may decrease readmissions, as well as hospitalizations and ED visits, yielding significant savings.³⁰

Telehealth and RPM's impact on reducing strain on the estimated 41 million family caregivers also merits consideration. In 2017, family caregivers furnished \$470 billion worth of care, more than total out-of-pocket spending on health care that year (\$366 billion) or the total spending for all sources of paid long-term services and supports, including post-acute care in 2016 (also \$366 billion).³¹

Telehealth and RPM also create opportunities for additional communication and information sharing between patients, caregivers and clinicians. Accelerating adoption of value-based payment models, which have shared financial risk to incentivize prevention, chronic disease management and efficiency, can integrate telehealth.

²⁸ *Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries*, Bindman et al, September 2018.

²⁹ *Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies*, Centers for Medicare and Medicaid Services, November 2019.

³⁰ *Use Of Telemedicine Can Reduce Hospitalizations Of Nursing Home Residents And Generate Savings For Medicare*

³¹ *Valuing the Invaluable*, AARP, 2019.



Finally, debate will continue over appropriate telehealth payment amounts, but key principles can help focus these discussions. Telehealth should be seen as neither inherently driving nor reducing costs. Similarly, payers should have flexibility in rates and sites, based on different markets and different situations, and should retain the ability to innovate with product offerings that reward value-based providers. It is in everyone's interest to ensure that telehealth services are reimbursed at a rate that reflects the cost of providing these services and the value that they bring as part of the overall care experience. Appropriate reimbursement and access to telehealth services will allow patients to utilize these services where they and their care team feel it is both clinically appropriate and the best possible way of receiving care.

**RICARDO MUÑOZ, MD,
CHIEF, DIVISION OF CARDIAC
CRITICAL CARE MEDICINE &
EXECUTIVE DIRECTOR, TELEMEDICINE,
CHILDREN'S NATIONAL HEALTH SYSTEM:**

"On the fee-for-service side, the technical fees paid to in-person and telehealth visits should be commensurate with the cost and benefit of providing the service. Otherwise, institutions may favor physical visits over telehealth for reimbursement purposes."





Cost Recommendations

1. Telehealth services should be reimbursed based on a thoughtful consideration of the value provided and the cost of delivery—as is done with in-person care. Flexibility on the use and reimbursement of these services is essential to maximizing the benefit to patients and the system at large.
2. When analyzing and discussing telehealth costs, policymakers should take a wider view and incorporate costs to patients and family caregivers, clinicians and other providers, and payers. These costs could—and should—include avoided transportation costs, time spent scheduling, preparing for or waiting for a visit, missed work, child/elder care, missed appointments, and technology/infrastructure costs. Although a change in care modality may create new costs, policymakers should not examine these costs without considering “baked in” in-person costs.
3. Accurately assessing the true value – including the cost and quality – of telehealth utilization will require that policymakers focus on evidence of its effectiveness and its ability to meaningfully increase access to care, not previously-held assumptions. Data from the current public health emergency are a first look at the effect on Medicare costs of lifting telehealth restrictions and it does not, at this writing, reflect excessive or unnecessary utilization. However, long-term conclusions and policies based on costs and outcomes in Medicare can only be drawn from data derived during the relatively normal conditions that follow the pandemic. Increased behavioral health utilization during the pandemic may provide a good example of meaningful increased access that has potential to improve outcomes and avoid future unnecessary and costly utilization. This will require further investigation.

**MARGARET E. O'KANE,
PRESIDENT, NCQA**



“Value-based arrangements with providers and plans at risk create the flexibility to design models that utilize telehealth where and when it can help improve care and outcomes.”



Overarching Issues

OVERARCHING ISSUES FINDINGS

Telehealth demonstrated during the COVID-19 public health emergency that it can improve access, safety, convenience, efficacy and patients experience of care. Telehealth is the natural evolution of health care into the digital age—it is not a different type of care, but a different site of care. As such, we should not hold telehealth to higher standards than other care sites, and we should trust clinicians providing telehealth services to triage patients needing a higher level of care or in-patient care, as we do in other care settings. As is done in other care settings, patients' preference for obtaining care in-person vs. telehealth should be respected

This raises important questions about many previous telehealth restrictions, such as prohibiting reimbursement for visits originating in patients' homes and allowing limited types of conditions and providers to utilize telehealth under traditional Medicare, such as behavioral clinicians and physical therapists. Many—but not all—policy changes that temporarily lifted restrictions during the pandemic should become permanent. There are better ways to address FWA concerns and telehealth's appropriateness in various situations that drove the previous restrictions.

For example, requiring clinicians and other providers to have a previous, in-person relationship with patients can inhibit needed access to care and is not consistent with most state-level or value-based payment policies. Similarly, blanket bans on audio-only can exacerbate disparities for patients lacking video technology or broadband access. Asynchronous modalities such as RPM may also be appropriate for services that do not require real-time interaction.

Strict limits on providing telehealth across state lines that were waived during the pandemic also do not appear warranted. States have a patchwork of requirements for obtaining and maintaining a medical license that burdens physician and other health professionals and make it difficult for clinicians to practice telehealth in multiple states—even when those states are contiguous or share a metropolitan area.

Waiver of these restrictions, allowed for additional surge capacity, dramatically lessened wait times for telehealth visits and helped triage many conditions that might otherwise have resulted in unnecessary in-person care that put patients at risk. Outside of a pandemic, care across state lines can ensure access to care in places with clinician shortages, allow residents who travel for work or seasonally to maintain consistent doctor-patient relationships and allow specialized care and expert consultations for those with serious conditions.

There are currently different definitions of telehealth, telemedicine and RPM. A widely agreed upon taxonomy of the various telehealth modalities can help clarify policy.

Finally, policymakers should not expect telehealth to resolve long-standing issues, such as care coordination and the move from FFS to value-based payment, but instead leverage telehealth-related policy development to help address these issues.



OVERARCHING ISSUE POLICY RECOMMENDATIONS

1. Policymakers should make permanent the following telehealth policy changes enacted during COVID-19 to improve access, patient safety and outcomes:
 - a. Removal of strict limits on sites where telehealth visits may originate, conditions clinicians may treat and which clinicians and providers may use telehealth.
 - b. Acknowledging that telehealth visits can establish clinician/patient relationships as long as they meet appropriate standards of care or unless careful analysis demonstrates that, in specific situations, ensuring patient safety, program integrity or appropriate high-quality care requires a previous in-person relationship.
 - c. Allowing audio-only telehealth where evidence demonstrates it to be effective, safe and appropriate, or where it is likely to be so and offers access to care that would otherwise be unavailable to a patient.
 - d. Allowing asynchronous telehealth (e.g., remote patient monitoring) when it is the preference or need of the patient on a limited basis as more clinical evidence is generated on best practices for ensuring quality, safety and program integrity.

AMERICAN TELEMEDICINE ASSOCIATION TELEHEALTH TAXONOMY

The most commonly used approaches in telehealth include:

- Virtual Visits: Live, synchronous, interactive encounters between a patient and a health care provider via video, telephone or live chat.
- Chat-based Interactions: Asynchronous online or mobile app communications to transmit a patient's personal health data, vital signs and other physiologic data or diagnostic images to a health care provider to review and deliver a consultation, diagnosis or treatment plan at a later time.
- Remote Patient Monitoring: The collection, transmission, evaluation and communication of individual health data from a patient to their health care provider from outside a hospital or clinical office (i.e., the patient's home) using personal health devices including wearable sensors, implanted health monitors, smartphones and mobile apps. Remote patient monitoring supports ongoing condition monitoring and chronic disease management and can be synchronous or asynchronous, depending upon the patient's needs. The application of emerging technologies, including artificial intelligence and machine learning, can enable better disease surveillance and early detection, allow for improved diagnosis and support personalized medicine.
- Technology-Enabled Modalities: Telehealth and virtual care solutions also provide for physician-to-physician consultation, patient education, data transmission, data interpretation, digital diagnostics (algorithm-enabled diagnostic support) and digital therapeutics (the use of personal health devices and sensors, either alone or in combination with conventional drug therapies, for disease prevention and management).



- e. Identifying and implementing policies related to use of these modalities that is based on the evidence of their effectiveness, safety and ability to meaningfully impact access to care.
- f. Allowing insurers to provide telehealth technology, such as smartphones and tablets, as supplemental benefits.
- g. Allowing telehealth across state lines by considering strategies to expedite licensure reciprocity between states, while maintaining important patient protections and disciplinary tools for bad actors.

2. Stakeholders, including policymakers, should agree on a taxonomy of telehealth care that fully describes the range of services and modalities—including types of audio-only encounters—that appropriately aligns standards, quality, payment (as appropriate) and program integrity. Within that taxonomy, policymakers should view “virtual visits” as another site of care rather than as a different type of care.
3. Broadband and technology greatly facilitate telehealth and contribute to telehealth’s patient safety benefits, but they are not available to or affordable for all patients, particularly rural and underserved populations. Policymakers must promptly expand efforts to ensure universal access to broadband and other needed telehealth technology to bridge these gaps and avoid exacerbating disparities as health care moves into the digital age.
 - a. Policymakers should assess how to best address patients with specific telehealth challenges, such as those with translation needs or limited visual or auditory capacity, and who lack broadband access.
 - b. There also must be contingencies in place to address technology failures.

**REGINA BENJAMIN, MD,
FOUNDER, BAYOUCLINIC/GULF
STATES HEALTH POLICY CENTER,
FORMER U.S. SURGEON GENERAL**



“Part of the infrastructure that needs to be put in place is the capability to work with ethnic communities and other demographic groups, on both sides of the Patient-Clinician relationship, to identify digital literacy and trust gaps that inhibit successful adoption of telehealth.”



4. Policymakers should develop and prioritize initiatives aimed at addressing the lack of trust and digital literacy gaps that inhibit successful telehealth adoption for patients, clinicians and other providers—with particular focus on populations that have struggled in the transition to telehealth during the pandemic. Policymakers need to identify groups at highest risk for low digital literacy and partner with patient and consumer groups to implement initiatives to increase digital literacy rates.
5. Policymakers should reinstate full enforcement of HIPAA patient privacy protections.

Conclusion

Telehealth has become an important part of the modern health care system. Lessons learned and data generated during the COVID-19 pandemic, as described in this report, can help policymakers maximize its benefits and address previous concerns about safety, program integrity, quality and costs. The broad consensus identified by the TTP on how to move forward should send a clear signal to policymakers that telehealth is a widely accepted, valued and expected care delivery option.

Consensus is emerging that telehealth is the natural evolution of health care into the digital age, not another type of care or new benefit. New technologies provide tools to address concerns about program integrity, care coordination and quality, and new data generated during the pandemic challenge previous assumptions about increased costs.

Policymakers will, of course, want to continue to assess the impact of telehealth as part of the new normal, but it is abundantly clear that telehealth should be here to stay.

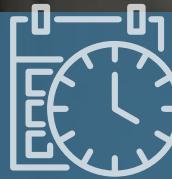


THANK
YOU

The TTP thanks everyone who helped us gather data and shared thoughtful and well-informed comments to aid our work. The TTP convenors want to thank the members who took time from their busy schedules to help work through the deliberations needed to build our consensus. It is because of this incredibly generous insight and assistance that the TTP learned and accomplished so much in a short time.



Timeline of Temporary Telehealth Policy Changes



March 6: Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act

- First COVID-19 supplemental funding bill lets HHS temporarily waive Medicare telehealth restrictions.
- Adds “telehealth service” to what HHS can temporarily waive or modify.
- Applies to rural and originating site restrictions.
- Authority only exists during declared COVID-19 public health emergency.
- Limited to providers with a previous relationship with a patient:
 - Furnished services to the patient in previous three years.
 - The provider is in same TIN as someone with an established relationship through Medicare.

March 10: CMS Medicare Advantage Guidance

- May waive/reduce cost-pays for COVID-19 tests, telehealth and other services if done for all enrollees.
- May provide Part B services via telehealth in any area and from many places, including homes.
- May waive prior authorization that otherwise applies to COVID-19 tests or services at any time.
- May provide smartphone/tablet as supplemental benefit.

March 17: CMS FFS Guidance

- Medicare covers office, hospital and other telehealth visits nationwide and in homes as of March 6.
- Telehealth waiver applies to all treatment during the Public Health Emergency, not just COVID-19.
- Providers already authorized in statute (1834(m)) get telemedicine pay, including NPs, MDs, PAs.



- Interactive audio-visual telecommunications system that permits real-time communication.
- Allows the use of telephones with audio and visual capabilities—smart phones permissible.
- HHS is waiving HIPAA enforcement for provision of services in good faith via FaceTime and Skype.
- CMS not enforcing statute's Established Relationship language.
- The IG grants flexibility for providers to waive co-pays.
- Did not change e-visit codes.
- Controlled substance prescribing rules waived.

March 17: CMS Medicaid Guidance

- Flexibility to incent greater use of telehealth through 1135 waivers.
- Allows providers to use non-HIPAA compliant telehealth modes from platforms.
- Flexibility to make it easier for providers to care for people at home:
 - a. To allow telehealth and virtual/telephonic communications for covered State plan benefits.
 - b. Waiver of face-to-face encounters for FQHCs and Rural Health Clinics.
 - c. Reimbursement of virtual communication and e-consults for certain providers.
- Flexibility so Medicaid and Managed care enrollees could use telephones to receive care.
- Flexibility to let Medicaid pay for the same telehealth services Medicare now can.

March 17: Department of Health and Human Services, Office of Civil Rights

- Announces enforcement discretion to waive HIPAA penalties for good faith telehealth during COVID.
- Drug Enforcement Administration—Effective March 31.
- Allows controlled substance prescribing by telehealth if:
 - a. For legitimate medical purpose by practitioner acting in the usual course of professional practice.
 - b. Done via an audio-visual, real-time, two-way interactive communication system.
 - c. In accordance with applicable federal and state law.



March 27: Congressional Action: 3rd Package—Coronavirus Aid, Relief and Economic Security Act

- Amends Telehealth Network and Telehealth Resource Centers grant program to support evidence-based projects, extend grant period funding from 4 years to 5 years and ensures that 50% of funds go to rural projects (\$29M for each of FY21-25).
- Allows plans or employers to provide pre-deductible telehealth coverage for people with HSA-eligible HDPs, either discounted or fully covered. Amends Safe Harbor language and Disregard list.
- Eliminates requirement that clinicians must have treated patients in the past three years.
- Allows FQHCs and Rural Health Clinics to furnish telehealth in home or other setting, with composite reimbursement similar to comparable Medicare Physician Fee Schedule for telehealth.
- Eliminates the requirement that nephrologists conduct periodic home dialysis evaluations face-to-face.
- Allows hospice providers to use telehealth for face-to-face eligibility recertification encounter.
- Provides HHS flexibility to consider ways to encourage home health use of telecommunications and other communications or monitoring, consistent with the individual's care plan.

April 2: Federal Communications Commission

- Establishes the \$200M COVID-19 Telehealth Program to help providers connect to patients per the CARES Act.

Effective April 6: CMS Interim Final Rule

- Adds 80 services that can be furnished via telehealth.
- Adds payment codes for prolonged audio-only E&M services between the practitioner and patient:
 - a. Removes the preexisting relationship requirement on virtual check-ins.
 - b. Additional codes for licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech language pathologists. Distant site restrictions remain for some.
 - c. Allows virtual required physician supervision via real-time audio/video technology.



April 10: Medicare Advantage Memo

- Allows risk adjustment for diagnoses via interactive audio-visual communication.
- Health risk assessment codes—96160 and 96161—are “add-on” codes.

April 30: CMS Second Interim Final Rule

- Along with 1135 waiver, removes remaining limitations on who can furnish telehealth, including physical therapists, occupational therapists and speech language pathologists.
- Along with an 1135 waiver, waives the video requirement for certain telephone E&M services, and adds them to the list of Medicare telehealth services.
- Allows hospitals to bill for services furnished remotely by hospital-based practitioners to registered outpatients, including at home, when it is a temporary, provider-based hospital department.
- Allows hospitals to bill the originating site (facility fees) for telehealth furnished by hospital-based practitioners to registered outpatients, including when the patient is at home.
- Expansion of codes approved for audio-only telehealth visits using the 1135 waiver: E&M, behavioral, SUD, educational services and annual wellness visits at same pay as an office visit.
- Medicare covers telehealth services provided by rural health clinics and FQHCs as per the CARES Act.
- New additions will be made on a sub-regulatory basis to speed the process.

State Actions

- Waived licensure laws to varying extents, to facilitate cross-border care (50).
- Pay at same rate as in-person care (32).
- Expand services (44), providers (32), phone (44), text/email (11), home as originating site (26).



Taskforce on Telehealth Policy (TTP)



Overarching and Subgroup Questions

To help guide the TTPs work, conveners crafted a set of questions, some overarching about telehealth and several specific to its three subgroups:

- Patient Safety and Program Integrity.
- Telehealth's Effect on Total Cost of Care.
- Data Flow, Care Coordination and Quality Measurement.

There naturally is overlap among these topics. Patient safety is essential for quality, as is cost, by avoiding costly patient harm. Program integrity to prevent and fight fraud, waste and abuse is integral to cost, quality and safety, because delivering unnecessary care diminishes quality and can harm patients. Data flow and care integration are necessary to optimize patient safety and prevent costly unnecessary care. Quality measurement to assess whether people get appropriate also affects cost, safety and integrity. The overlap quickly emerged in subgroup discussions and helped bring about consensus in the final recommendations.

OVERARCHING QUESTIONS

- What criteria should be for which emergency regulatory changes to keep vs. default to pre-COVID rules?
- What role can federal and state policy play in giving patients and providers tools and technical assistance to meet telehealth needs?
- What have we learned during the pandemic that can be applied to a policy on access, quality, safety, cost effectiveness and outcomes?



PATIENT SAFETY AND PROGRAM INTEGRITY

Patient safety concerns drove some pre-COVID telehealth restrictions.

- What do data tell us about program integrity with telehealth vs. in-person care?
- How can telehealth/virtual care technologies be used to enhance program integrity?
- How does your organization address program integrity with telehealth/virtual care and how does it differ from in-person care?
- What best practices should payers implement to optimize program integrity to prevent fraud and abuse?
- What do data tell us about patient safety with telehealth vs. in-person care?
- Are there opportunities for greater levels of patient safety in telehealth?
- What controls are needed to prevent diversion of controlled substances prescribed via telehealth?
- How can we best protect patient privacy while ensuring interoperable telehealth access that enables effective payer-provider collaboration?

DATA FLOW, CARE COORDINATION AND QUALITY MEASUREMENT

Telehealth was often seen as separate rather than part of core care.

- How do we fully leverage telehealth capabilities throughout the care and quality ecosystems?
- What are barriers to a more integrated quality measurement system, data sharing and patient-centered care for remote services?
- What are the best ways to assess the impact of telehealth expansion on quality and patient experience?
- How do we adapt the quality infrastructure to incorporate and support telehealth expansion and strengthen its infrastructure?
- What has your experience been with consumer telehealth satisfaction? Would they accept virtual care in an integrated care system?
- How might policies encourage patients and providers to view telehealth as another kind of care vs. a different care modality?

TELEHEALTH EFFECT ON TOTAL COST OF CARE

Before COVID, policymakers often assumed that expanding telehealth would increase costs.

- What have we learned about telehealth utilization during the pandemic?
- How should federal budgeting models adapt to reflect expanded telehealth access?
- What is needed to determine the effect of telehealth expansion on prevention, urgent care, post-acute care and so on?
- What principles should inform telehealth pay vs. in-person care and do these vary by service/mode of telehealth?



Taskforce on Telehealth Policy Members

PETER ANTALL, MD,

Chief Medical Officer and President,
Amwell Medical Group

KATE BERRY,

Senior Vice President of Clinical Innovation, America's
Health Insurance Plans

REGINA BENJAMIN, MD,

Founder, BayouClinic/Gulf States Health Policy Center,
former U.S. Surgeon General

KRISTA DROBAC,

Executive Director, Alliance for Connected Care

YUL EJNES, MD,

Clinical Associate Professor of Medicine, Brown
University, Board of Regents Chair-Emeritus, American
College of Physicians

REBEKAH GEE, MD,

Chief Executive Officer,
Louisiana State University Health System

NANCY GIN, MD,

Executive Vice President of Quality and Chief Quality
Officer, The Permanente Federation, Kaiser Permanente

KATE GOODRICH, MD,

Senior Vice President Trend and Analytics,
Humana

ANN MOND JOHNSON,

Chief Executive Officer, American Telemedicine
Association

CHUCK INGOGLIA,

President & Chief Executive Officer, National Council
for Behavioral Health

MEGAN MAHONEY, MD,

Chief of Staff, Stanford Health Care, Clinical Professor,
Division of Primary Care and Population Health,
Stanford University

CHRIS MEYER,

Director of Virtual Care, Marshfield Clinic

RICARDO MUÑOZ, MD,

Chief, Division of Cardiac Critical Care Medicine,
Executive Director, Telemedicine, Children's National
Health System, Co-director, Children's National Heart
Institute, Professor of Pediatrics, The George
Washington University School of Medicine

PEGGY O'KANE,

President, National Committee for Quality Assurance

KERRY PALAKANIS, DNP, APRN,

Executive Director, Connected Care Operations,
Intermountain Healthcare

MICHELLE SCHREIBER, MD,

Federal Liaison (non-voting), Centers for Medicare &
Medicaid Services

DOROTHY SIEMON, JD,

Senior Vice President for Policy Development, AARP

JULIA SKAPIK, MD, MPH,

Medical Director, Informatics, National Association of
Community Health Centers

JASON TIBBELS, MD,

Chief Quality Officer, Teladoc Health

NICHOLAS UEHLECKE,

Federal Liaison (non-voting), Department of Health &
Human Services

ANDREW WATSON, MD,

MLitt, Surgeon, Vice-President University of
Pennsylvania Medical Center, Past President ATA

CYNTHIA ZELIS, MD, MBA,

Chief Medical Officer, MD Live



ALLIANCE for
CONNECTED CARE



The National Committee for Quality Assurance (NCQA) is a 501(c)(3) not-for-profit that uses measurement, transparency and accountability to improve health care. NCQA creates standards, measures performance and highlights organizations that do well. All this helps drive improvement, save lives, keep people healthy and save money.

1100 13th Street NW | Third Floor | Washington, DC 20005
www.ncqa.org

55 of 114
NCQA1005-0920

Audio-only Telemedicine Work Group Recommendations

October, 2020

Blue Cross and Blue Shield of Vermont (BCBSVT) recognizes that audio-only telephone care bridges a critical gap during the COVID-19 pandemic. In the long term, however, BCBSVT has significant concerns about promoting audio-only care as a substitute for either audio-visual telemedicine or in-person care. Audio-only care can be a valuable addition to the suite of health care options available patients and providers, but it should not be an alternative for in-person care, particularly for individuals that live in rural or “inconvenient” locations and are already at risk for health care inequality.

Widening health disparities

Audio-only care should only supplement, not replace, high-quality in-person or audio-visual health care. Numerous experts agree that audio-only care can have significant negative impacts on social determinants of health and socio-economic disparities, and can lead to inequality in care for rural and economically disadvantaged populations.

- Harvard University’s Dr. Ateev Mehrotra noted that socio-economic disadvantages and increased health disparities can be exacerbated by audio-only telemedicine.
- Blue Cross and Blue Shield of Vermont’s Dr. Kate McIntosh spoke about concerns that audio-only medical care reinforces and perpetuates inequality in health care for poorer and more rural individuals and families.
- World-renowned health care scholar and physician Dr. Donald Berwick noted that the benefits to telemedicine are nuanced. Body language signals are difficult to be picked up telemetrically. The success of the appointment can depend on the patient being a good communicator.

Audio-only care may increase access to providers, and supplement audio-visual telemedicine or in-person care, but it cannot solve—and may ultimately contribute to—the health disparities of disadvantaged populations.

Coding

Audio-only care should only be coded using the telephone care CPT codes. This will ensure that we do not deviate from accepted CPT language and definitions. CPT coding is not an area where Vermont should choose a unique policy path for many reasons. The only objective of non-standard coding appears to be higher payment levels for audio-only care. Deviation from national standards will prevent us from identifying fraud, waste, and abuse; and make tracking for quality purposes impossible. Compliance with unusual single-state CPT usage may be low for large national health care organizations and add cost and complexity to an overwhelmingly complicated system.

Capitation versus global payments

Appropriate fee-for-service payment levels are necessary. There is little, if any disagreement, among stakeholders in the Vermont health care system that fee for service payment does not support high quality, cost effective care and that we must move to a better payment system. Thus, although BCBSVT supports capitation, capitating specific services does not serve the same goal as creating a global payment model where the best mode of treatment can be tailored to the patient's condition, need, and desire among a choice of many treatment options and modalities. BCBSVT has been striving toward a global payment model for years, and while we have had limited success in some areas, we are far from broad implementation of these payment structures. For example, telemedicine including audio-only care, is a better fit within a capitated or global payment when such payment applies to the full breadth of all primary care services. That is, when a primary care physician or practice is accountable for patient care, quality, and outcomes and the payment system reflects that accountability.

Cost

CPT codes for audio-only care should be set at 55% of the CPT for an in-person visit. We must acknowledge the reduced cost that is required to provide audio-only service, as well as the inferior care provided by audio-only mediums. CPT code definitions takes into account both the work involved in the service provided, and the practice's overhead in supplying that service. Per the American Academy of Family Practice, primary care practice overhead is approximately 60% of receivables ([Gordon, 2007](#)). As a result, 40% of the payment of any code reflects the provider work. On par payments for audio-only care many encourage this modality in inappropriate circumstances and undermines our collective efforts to achieve affordability. Furthermore, BCBSVT members have complained that they are being charged the same as an office visit, when they feel the value is not equivalent.

Quality measures

Assessing the quality and value of audio-only health care is uncharted territory. Any recommendation must sunset to allow for reassessment. We strongly caution that there are no accepted quality measures for audio-only care. As Reid Plimpton of the Northeast Telehealth Resource Center noted, audio-only care is not an evidence-based practice yet. The available data on quality measures looks almost exclusively at triage telephone calls. These calls focus on the screening process that assigns a degree of urgency to wounds or illnesses to decide the order of treatment. In other words, these studies focus on deciding whether or not a patient needs to come in to be seen, not on the provision of care over the telephone.

Standards of care

The standards of care cannot be lowered for audio-only care. Instead, not all care can be provided through this modality and any recommendations should reflect the care that is disallowed by the State of Vermont. The quality of care needs to be equivalent across all modalities.

Outcome studies show that the quality of audio-visual and audio-only care is significantly inferior to an in-person visit for certain conditions. For example, Dr. Ateev Mehrotra noted the prescribing rate of antibiotics is significantly higher for ear infections when the doctor does not look in a child's ear. Given this and other evidence, it is essential that the standard of care be maintained through the curation of the proper channel for the assessment of any specific conditions. In this way, we can assure that all pertinent elements of the past medical history, physical exam, vital signs, assessment, and plan can be met at the same level as an in-office visit, as sufficient to meet the standard for care for that specific care episode.

Some have argued that there is a standard of care for audio-only care in that it is no different from the standard of care that is applicable to all medical services. However, this argument fails to acknowledge the lack of research pertaining to audio-only care necessary to meaningfully inform such standards. Blue Cross and Blue Shield of Vermont's telemedicine medical policy language reflects our concerns about vulnerable populations:

*Audio-only telephone care may not be used in place of an in-person visit if the consequence of using telemedicine might reasonably result in **imminent harm** to the beneficiary. The care provided must be able to meet the standard of care as defined above.*

Non-verbal children, developmentally delayed children and adults, incapacitated adults who cannot easily be evaluated over audio-only mediums, and children who are not old enough to interact with the provider over an audio-only connection present a special concern for quality and appropriateness of care. For these individuals especially, it is critical to understand the risks and concerns that third-party reporting may present in the clinical evaluation. Therefore, audio-only telephone care should only be utilized if the standard for care (as defined above) can be met for that care episode, taking into account the critical role that an in-person assessment, the physical examination, and vital signs may play in the care of these vulnerable individuals.

In summary, BCBSVT supports adding audio-only care to the options available for patients and providers, but significant protections and restrictions must be in place to ensure patient safety and recognize appropriate limitations of this type of health care. The experts who presented to the Audio-Only Workgroup unanimously consider telephone care as part of a spectrum—used for triage, for routine follow up check ins, and for non-provider encounters. These experts did not support, nor is any other state considering, audio-only care as an ongoing primary treatment modality.

Subject: FW: Deadline for Proposed Recommendations Reminder

Date: Monday, October 12, 2020 at 10:03:11 AM Eastern Daylight Time

From: Gretkowski, Susan

To: Arduengo, Sebastian

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

MVP feedback.

Classified as Confidential

From: Estey, Jordan <JEstey@mvphealthcare.com>

Sent: Monday, October 12, 2020 10:02 AM

To: Gretkowski, Susan <SGretkowski@mvphealthcare.com>

Subject: RE: Deadline for Proposed Recommendations Reminder

The work group recommends that:

- **When clinically appropriate, coverage should be permitted for audio-only telephone encounters**
Health plans and providers should be given the flexibility to determine coverage based on clinical appropriateness for the service being performed, and the value provided to members. Patient populations are diverse. They have unique clinical needs, may lack access to technology resources, and vary in levels of technological sophistication. To address these needs and gaps, policymakers should promote a broad range of technology solutions as part of the care continuum, such as audio-only telephone services. However, policymakers must also preserve and promote evidence-based decisions on modality use. Not every modality will be appropriate in every clinical setting, for every service, and for every patient's needs. Health plans and providers should be empowered to tailor coverage and interventions based on individual patient needs as well as modality effectiveness, safety, and ability to meaningfully improve patient access to care. To the extent that audio-only coverage is required or mandated across health care services beyond the pandemic, it could unnecessarily increase costs, result in lower quality and value of services (in some instances), and raise concerns about fraud and abuse.

From: Arduengo, Sebastian <Sebastian.Arduengo@vermont.gov>

Sent: Tuesday, October 6, 2020 11:59 AM

Cc: Hillary Wolfley

Subject: Deadline for Proposed Recommendations Reminder

This message is from an **EXTERNAL** email address - Please only click links and



OneCare Vermont

October 12, 2020

Sebastian Arduengo, Esq.
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620 - 3101

Dear Sebastian,

At the start of the pandemic, Centers for Medicare & Medicaid Services acted quickly to expand the use of telehealth by implementing waivers through the CARES Acts. These waivers were crucial to providers in Vermont, many of which are in the OneCare Vermont ACO network. Nationally, the use of telehealth increased within ACOs once the pandemic hit. According to a [National Association of ACOs survey](#), more than half of ACOs replaced between 10 percent and 24 percent of in-person visits with telehealth at one point in early May. The pandemic has required health care providers and payers to reconsider how services are delivered and reimbursed.

While telehealth played a crucial role in providing needed care during the pandemic, its benefits will continue to be utilized well beyond the immediate public health emergency (PHE). Expanded telehealth will increase access to patients who have difficulty leaving their homes or that have underlying health conditions that would preclude this important interaction with their health care provider. Improving access to care and mitigating short and long term impacts on chronic disease are goals of the Vermont All Payer Model and of OneCare.

It's become clear that audio-only services are critical. Its continued use will remain essential once the PHE is lifted as many seniors, lower-income households, and those living in the most remote parts of state will continue to be without access to video-based visits, either because they lack access to technology, broadband connectivity to conduct video-based visits, or technological literacy. For these patients, the choice is not between a video visit and a phone visit — it is the choice between an audio visit or no visit. The digital divide is now listed as a new Social Determinant of Health, and Vermont risks a further widening of health disparities without greater access to audio-only telehealth at a time when the focus on population health and social determinants of health is more important than ever.

OneCare supports the state's move to expand telehealth in ways that are clinically meaningful and improve patient care. While consideration will have to be given to all aspects of telehealth, clinicians can now, more than ever, deliver high-quality exams through modern technology and should be allowed to continue seeing patients following their best clinical judgments and emerging research support for evidence based use guidelines.

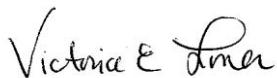
Page Two
October 12, 2020
Sebastian Arduengo, Esq.

Alternative payment models, including ACOs and other types of value-based payment models, are another avenue to expand telehealth coverage. Providers will use telehealth well after the pandemic has concluded in order to continue to expand access and address their patients' needs. OneCare plans to examine the use of telehealth by network providers throughout Vermont during the COVID-19 PHE. Preliminary data suggests we will see an increase in telehealth over certain in-person visits in a way that could contribute to improvements in health.

Nationally, the conversation has shifted to the need to increase access to telemedicine and making it permanent beyond the conclusion of the PHE. For providers participating in Advanced Alternative Payment Models, such as Risk Bearing ACOs, like OneCare, the federal government through the Medicare Payment Advisory Commission (MedPac) has supported the continuation of policies expanding telehealth services.

While it is likely that OneCare Vermont's network of providers will be able to participate with the most liberal offering of telehealth services to patients because of its role in the Vermont All Payer Model, we support broader application of these criteria for all providers in the state. It is imperative as we continue down the path of value based care that we ensure that there are no gaps in access to high quality health care services to Vermonters, especially our most vulnerable.

Sincerely,



Victoria E. Loner, RN.C, MHCDS
CEO, OneCare Vermont

VEL/jh

October 9th, 2020

To: Sebastian Arduengo, Department of Financial Regulation

Re: Audio-Only Telemedicine Working Group, Cover Letter to Recommendations

Act 91 provided reimbursement at parity for the use of live interactive audio and video. The undersigned organizations write to strongly support the Department for Financial Regulation recommending to the Legislature that payers reimburse audio-only telemedicine at parity through January 1, 2026, and reimburse for the full range of telephone-based telehealth service codes. These recommendations are outlined in detail in the joint letter from Bi-State Primary Care, University of Vermont Health Network, Vermont Association of Hospitals and Health Systems and Vermont Medical Society.

Telehealth is a key tool for improving access and health outcomes by providing patients expanded options for how they seek care. Vermont's system of health care providers has been actively building telehealth modalities, with slow but steady increases in capacity and capability over the last several years. In mid-March, in light of the COVID-19 pandemic, we witnessed the rapid transition to caring for a large percentage of patients via telehealth. This was enabled by swift action by Vermont's Legislature and Governor, as well as federal coverage expansion mandates. As our state continues to emphasize a population health, value-based system of care, telehealth is essential for continuing to provide high quality, cost-effective and patient-centered care.

Patients and clinicians have had overwhelmingly positive experiences with the expansion of telehealth options – including audio-only services. Early data from the University of Vermont Medical Center indicate very favorable patient views of telehealth options, and in some cases, services delivered through telehealth outrank services provided in person, particularly when convenience and ease of scheduling are taken into account. With a mandate to maintain social distancing for the foreseeable future, it is evident telehealth, including audio-only, will remain an integral part of patient care in our state. This will be driven not only by patients' demand for these services, but also by a need to protect health care providers and employees by limiting the number of individuals in clinical settings at one time. Reimbursement should incentivize access to care in the safest setting, including via telephone in one's own home. This experience will also inform how we provide safe care beyond COVID-19, as we seek to minimize the risk of other infectious diseases, such as influenza.

It is essential that we not lose the ground we have gained in telehealth expansion this year. Patients have been able to seek care in new and convenient ways, breaking down barriers to access. These barriers are particularly acute for rural patients, low-income patients, patients with mobility or transportation challenges, as well as patients for whom getting to their health care provider in-person is one burden too many. Telehealth is not a universal substitute for in-person care, but it is a critical tool for patients and providers alike.

An important underpinning for our future success in this area is that reimbursement for telemedicine modalities needs to be equivalent to face-to-face reimbursement. While there can be efficiencies gained through telehealth over time, some expenses will go up, particularly during early phases of implementation. We are asking providers to juggle COVID-19 related disruptions, recovery from those disruptions, and making practice changes (not just in telehealth) to maintain patient access in the post-COVID health care world. For providers to continue to successfully integrate telehealth into their clinical practice, it will need to be reimbursed equitably.

Sincerely,

Devon Green
VP, Government Relations
Vermont Association of Hospitals and Health Systems

Laura Pelosi, on behalf of
Vermont Health Care Association
Bayada Home Health and Hospice

Georgia J. Maheras
Vice President of Policy & Strategy
Bi-State Primary Care Association

Susan Ridzon
Executive Director
HealthFirst Independent Practice Association

Matthew Houde
Vice President of Government Relations
Dartmouth Hitchcock-Health

Virginia Renfrew, on behalf of
Vermont Association of Naturopathic Physicians

Jane Catton, BScN, MSOL, RN, NE-BC
Chief Executive Officer
Age Well

Beth Hammond
Executive Director
Heineberg Community Senior Center

Jill Mazza Olson
Executive Director
VNAs of Vermont

Julie Tessler
Executive Director
Vermont Care Partners: VT Council

Jessa Barnard
Executive Director
Vermont Medical Society

Patrick Gallivan
Executive Director
Vermont State Dental Society

Stephanie Winters
Executive Director
Vermont Psychiatric Association
Vermont Academy of Family Physicians
American Academy of Pediatrics - Vermont
Chapter

Jason Williams
Network Director, Government and
Community Relations
The University of Vermont Health Network

Luke McGowan
Director, Community and Economic
Development Office
Resource and Recovery Center
City of Burlington

Recommendations:

Add a Statutory Definition of Telehealth

We recommend inserting a new definition of telehealth as a technical fix for clarity and to avoid incongruities as we add telehealth types. The assumption is that any drafter will review the full telehealth-related titles to clean up the language throughout.

Amend 8 V.S.A. § 4100k (h) (7) as follows:

(7) “Telehealth” means methods for health care service delivery using telecommunications technologies such as audio and video interactive communications, audio-only communications, remote patient monitoring devices, text and image transfers, and other remote communications systems. Telehealth includes telemedicine, store and forward, mHealth, and telemonitoring.

Remove Restrictions on Audio-Only Telemedicine Through January 1, 2026

Removing restrictions on the definition of “telemedicine” will bring reimbursement for audio-only, placed under the sunset clause of January 1, 2026 in 8 V.S.A. § 4100k(a)(2) Act 91. The sunset allows for review of the system in light of quality data collected for a period of time following the end of the Public Health Emergency and the evolution of payment reform.

Amend 8 V.S.A. § 4100k (h) (7) as follows:

(8) (7) “Telemedicine” means the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment through the use of a live interactive remote connection audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104 -191.

Reform Rules to Ensure Consumer Affordability and Expand Remote Monitoring

Vermont does not currently have a separate category of brief telecommunications such as the current “triage calls” (G2012, G0071) reimbursed as part of COVID-19 response. These are used to determine if a full visit is necessary and are not billed if a visit follows. We recommend maintaining these services, without cost share, following the PHE and that they be billed by physicians or other qualified health care professionals including LPNs and RNs (as is current BCBSVT policy) but do not have a statutory change connected to this recommendation.

We recommend reforming Vermont’s telemonitoring rules to allow for more expansive application of this tool. Currently there is no commercial plan requirement for telemonitoring. The Medicaid requirement is found in 33 V.S.A. § 1901g and has been implemented with a narrow scope of provider and diagnosis type. An example of possible language follows:

“Remote patient monitoring services” or “telemonitoring” means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and brief telecommunications between provider and patient or caregiver. It may combine asynchronous and real time services.

A carrier shall provide coverage for telemonitoring if:

- A. The telemonitoring is intended to collect a patient’s health-related data, including, but not limited to, pulse and blood pressure readings, that assist a provider in monitoring and assessing the patient’s medical condition;
- B. The telemonitoring is part of an established plan of treatment designed by a qualified health professional and reviewed with the patient and, where appropriate, with the patient’s caregiver;
- C. The patient is cognitively and physically capable of operating the mobile health devices or has a caregiver willing and able to assist with the mobile health devices; and
- D. The patient has consented to the plan of treatment.

Rationale:

Audio-only telehealth services are a critical tool for patients who face barriers to reaching in-person services (transportation access, child care, paid time off work) and barriers accessing audio-visual services (lack of broadband, lack of affordable broadband, lack of equipment, digital literacy restrictions). For these patients the ability to connect to a provider using the telephone may make the difference in whether they receive care at all. In some instances, the audio-only connection may only be a first stop in accessing care that includes a physical exam or video element, but this bridge is a critical one to build and we believe our reimbursement system should reflect that fact.

There is also a public health imperative to make remote care, when appropriate, easily available. During COVID-19 it is self-evident that we do not want to incentivize unnecessary trips to health care providers. Even outside of this emergency there are public health reasons to reduce exposure to infectious disease, such as influenza, and effectively manage patient traffic through common areas. The same patients who are most vulnerable, our older population, are also those that are most likely to need an audio-only option for telehealth - for example, the Pew Research Center finds that a third of adults over the age of 65 do not use the Internet, and among low-income older adults that number climbs to more than half (2017 usage data).

Additionally, we have a goal of maintaining patient-centered care anchored in the local communities of Vermont. Audio-only telehealth ensures that patients have convenient access to their local providers, who can work with them to build appropriate and individualized care plans. We do not want to incentivize patients to defer to third party telemedicine vendors for their convenient care, then local providers for other needs, and establish a fragmented pattern of

care. We instead want to build a system that fully integrates in-person and remote options in Vermont community practices. Audio-only options are increasingly what patients will expect as part of patient-centered health care access and we should support our practices in meeting those expectations.

We can build a framework for audio-only telemedicine by removing the requirement to use video as part of the telemedicine encounter, as described above. The existing framework for telemedicine reimbursement outside of that clause is largely technology neutral. Clinicians must be able to achieve the appropriate standard of care for any tool they use, those standards do not change by modality. (See 18 V.S.A. § 9361 (b): "...Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider-patient settings.") This requirement will naturally limit many applications of audio-only modes, however we believe that this clinical determination should be made by clinicians on an individual basis - not imposed by statute. We support the work of VPQHC to address the broader issue of clinician education and training in telehealth tools, but view that as outside the scope of reimbursement recommendations, which are the focus of these comments.

As with the standard of care, existing telemedicine statute also provides an appropriate framework for patient informed consent to ensure that patients understand the modality they are choosing to access care (see 18 V.S.A. § 9361 (C)(1)). We support informed consent to audio-only telemedicine, but as this is already covered in existing statute we do not have a recommendation for change. We also recommend maintaining the telephone "triage" call codes, and following the lead of BCBSVT in making those billable by RNs and LPNs, as a way to maximize the tools available to practices in connecting patients with the best form of care.

It is important to have a balanced toolbox of telephone-based care options. One thing that we know from research in both health outcomes and cost savings is that the most effective remote tools fall into the broader category of telehealth, in particular telemonitoring and chronic care management. For example, HHS' Agency for Healthcare Research and Quality wrote about chronic care support and remote patient monitoring that "...there is a large volume of research reporting that clinical outcomes with telehealth are as good as or better than usual care and that telehealth improves intermediate outcomes and satisfaction" (White Paper on The Evidence Base for Telehealth, 5/14/2020). However, reimbursement for these codes, which use telephone in connection with other data collection, is concentrated primarily in Medicare – there is not consistency across payers.

Although the charge of this work group was to consider audio-only telemedicine, not the wider application of telephone-based care, we cannot practically separate the two issues. If we only offer audio-only telemedicine, and not other codes more commonly used in connection with telephone services, then we incentivize practices to find a creative billing solution to be able to offer telemonitoring such as chronic care support. This would distort both the reimbursement levels for services (pushing it into an office visit equivalent) and also which staff provide the

services. Therefore, we recommend taking a more holistic approach that includes audio-only telemedicine, brief telecommunications, and expansion of telemonitoring.

We recognize that many of these complications would be resolved by moving away from fee-for-service payment structures and into a global budget system. However, we need a viable system of telehealth for patients to access care now, at a time when we are far short of having a global budget framework at scale. The sunset clause currently in place for the telemedicine parity payment structure addresses this issue by allowing us to re-evaluate the structure in five years when our payment reform efforts are further developed.

Please see separate cover letter for organizations endorsing this consensus document for audio-only telemedicine recommendations.

October 12, 2020

To: Audio-Only Working Group, Dept of Financial Regulation

From: Dillon Burns, Mental Health Services Director, Vermont Care Partners

Thank you for your request for legislative recommendations on reimbursement for audio-only treatment. We endorse the Oct 9th recommendations submitted by a coalition of Vermont healthcare providers to expand the definition of telehealth in state statute to include audio-only communication, thereby increasing access to quality care for vulnerable Vermonters.

Vermonters who receive mental health and substance use disorder treatment at designated agencies are often the Vermonters most likely to have barriers to transportation, broadband, and effective equipment for telehealth. At the same time, they are most likely to experience financial stress, physical health challenges, isolation, and mental health challenges during the COVID-19 pandemic and beyond. Vermont should support access to as many treatment modalities as possible, including audio-only telehealth, unless we have strong evidence that the quality of care is compromised.

We have not seen evidence that quality of client care is diminished with audio-only mental health and substance use disorder treatment. Expert witnesses testifying to the Department of Financial Regulation's Audio-Only Working Group over the past three months uniformly supported audio-only treatment for psychiatric/behavioral/mental health concerns. A systemic review of literature on the differences between audio-only and face-to-face therapy found "no evidence of mode-related difference in a range of interactional features including therapeutic alliance, disclosure, empathy, attentiveness or participation," and identified that the only substantive difference was the duration of contact.¹

Clinicians in the Vermont Care Partners network, Mark Schmoll of Washington County Mental Health Services and Kerry Stout from Howard Center, testified to the Working Group that while they saw difference in client experience between face-to-face care and audio-only care, they could comfortably say that they are able to meet the standard of care and that they received positive feedback from clients. Because their Eldercare clients are homebound and often without

¹ Irvine A, Drew P, Bower P, et al. Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. *J Affect Disord.* 2020;265:120-131. doi:10.1016/j.jad.2020.01.057

broadband or without technical facility, audio-only telehealth is the only treatment modality they can access safely during the pandemic.

Network agencies have reported throughout the pandemic that no-show rates for regularly scheduled appointments have decreased during the pandemic due to client use of telehealth, including audio-only telehealth. Our agencies have years of experiencing providing community support services via telephone to our Medicaid clients and have found this to be an effective way to support and engage clients in their treatment.

While we are supportive of reimbursement for audio-only telehealth, we are aware of the limitations, challenges, and training needs associated with providing telehealth of any kind. We are committed to ensuring that our clients have the highest quality of care and that they have choice in how this care is delivered. Audio-only telehealth should be one tool in the clinical toolbox of Vermont providers, with clients deciding which modality of care works best for them.



199 Main Street, Suite 225 | Burlington, VT 05401
1-866-227-7451 | Fax: 802-651-9805 | TTY: 1-877-434-7598
aarp.org/vt | [@aarpvt](https://twitter.com/aarpvt) | facebook.com/AARPVermont

Delivered via email

October 12, 2020

Department of Financial Regulation:

AARP Vermont, on behalf of our more than 130,000 members and all older Vermonters, appreciates the work you have undertaken to address the unprecedented public health and economic crisis that we face as a state. We are encouraged by the increase in telehealth across the state as a result of expanded access to and reimbursement for the use of live interactive audio and video as a result of the passage of Act 91.

AARP strongly supports the Department of Financial Regulation recommending to the Legislature that payers reimburse audio-only telemedicine through January 1, 2026, and reimburse for the full range of telephone-based telehealth service codes. Telehealth is a key tool for improving access and health outcomes by providing patients expanded options for how they seek care. Vermont's system of health care providers has been actively building telehealth modalities, with slow but steady increases in capacity and capability over the last several years. In mid-March, in light of the COVID-19 pandemic, we witnessed the rapid transition to caring for a large percentage of patients via telehealth. This was enabled by swift action by Vermont's Legislature and Governor, as well as federal coverage expansion mandates. As our state continues to emphasize a population health, value-based system of care, telehealth is essential for continuing to provide high quality, cost-effective and patient-centered care.

Patients and clinicians have had overwhelmingly positive experiences with the expansion of telehealth options – including audio-only services. Early data from the University of Vermont Medical Center indicate very favorable patient views of telehealth options, and in some cases, services delivered through telehealth outrank services provided in person, particularly when convenience and ease of scheduling are taken into account. With a mandate to maintain social distancing for the foreseeable future, it is evident telehealth, including audio-only, will remain an integral part of patient care in our state. This will be driven not only by patients' demand for these services, but also by a need to protect health care providers and employees by limiting the number of individuals in clinical settings at one time. This experience will also inform how we provide safe care beyond COVID-19, as we seek to minimize the risk of other infectious diseases, such as influenza.

It is essential that we not lose the ground we have gained in telehealth expansion this year. Patients have been able to seek care in new and convenient ways, breaking down barriers to access. These barriers are particularly acute for rural patients, low-income patients, patients with mobility or transportation challenges, as well as patients for whom getting to their health care provider in-

Real Possibilities

70 of 114

person is one burden too many. Telehealth is not a universal substitute for in-person care, but it is a critical tool for patients and providers alike.

We support the changes to the definition of Telehealth as underlined below:

Recommendations:

Add Definition of Telehealth

We recommend inserting a new definition of telehealth as a technical fix for clarity and to avoid incongruities as we add telehealth types. The assumption is that any drafter will review the full telehealth-related titles to clean up the language throughout.

Amend 8 V.S.A. § 4100k (h) (7) as follows:

(7) “Telehealth” means methods for health care service delivery using telecommunications technologies such as audio and video interactive communications, audio-only communications, remote patient monitoring devices, text and image transfers, and other remote communications systems. Telehealth includes telemedicine, store and forward, mHealth, and telemonitoring.

Remove Restrictions on Audio-Only Telemedicine Through January 1, 2026

Removing restrictions on the definition of “telemedicine” will bring reimbursement for audio-only, placed under the sunset clause of January 1, 2026 in 8 V.S.A. § 4100k(a)(2) Act 91. The sunset allows for review of the system in light of quality data collected for a period of time following the end of the Public Health Emergency and the evolution of payment reform.

Amend 8 V.S.A. § 4100k (h) (7) as follows:

(8) (7) “Telemedicine” means the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment through the use of a live interactive remote connection audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104 -191.

We look forward to continuing our mutual work to protect Vermonters, including aged 50 and older.

Sincerely,



Greg Marchildon, AARP Vermont State Director

Subject: RE: Deadline for Proposed Recommendations Reminder
Date: Monday, October 12, 2020 at 4:45:05 PM Eastern Daylight Time
From: Jim Dandeneau
To: 'Arduengo, Sebastian'
Attachments: image001.jpg

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.
Hi Sebastian,

I've got recommendations from the VT Association of Physical Therapists.

The workgroup recommends that telehealth expansions be extended indefinitely for physical therapists, including audio-only to assist patients without video capability. There is strong preliminary outcome data suggesting decreased utilization with telemedicine, and word of mouth from providers confirms the effectiveness of telehealth sessions, particularly on educating patients in self-management.

Please let me know if you have any questions or comments. Thanks!

jim

Jim Dandeneau | Government Relations Specialist

PRIMMER PIPER EGGLESTON & CRAMER PC
30 Main St., Suite 500 | P.O. Box 1489, Burlington, VT 05402
Tel: 802 864 0880 | Cell: 802 489 6681 | Fax: 802 862 0328
jdandeneau@primmer.com | www.primmer.com



**PRIMMER PIPER
EGGLESTON &
CRAMER PC**

From: Arduengo, Sebastian <Sebastian.Arduengo@vermont.gov>
Sent: Monday, October 12, 2020 11:31 AM
Cc: Hillary Wolfley <HillaryW@vpqhc.org>
Subject: Re: Deadline for Proposed Recommendations Reminder

This is another reminder to get any proposed recommendations in to me by close of business today.

I've already received comments and proposed recommendations from:

- The Provider Coalition
- Vermont Care Partners
- VPQHC
- AARP
- David Brown, Ph.D.

Subject: Support for telehealth language
Date: Monday, October 12, 2020 at 3:16:54 PM Eastern Daylight Time
From: Kim Fitzgerald
To: Sebastian.Arduengo@vermont.gov
Attachments: image002.jpg

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Dear Sebastian,

I'm writing today to support Act 91 that provided reimbursement at parity for the use of live interactive audio and video for telehealth services, and specifically that this reimbursement continue, including audio-only telemedicine at parity.

Cathedral Square manages over 1,000 homes/apartments mostly for those 55 and older or disabled. Prior to COVID, we were helping to host telehealth appointments through our SASH program but had limited provider involvement - mostly due to reimbursement. Once COVID hit, telehealth appointments became the only option for our residents but it was also the wisest, and in Vermont winters that remains true outside of COVID. Telehealth services protect frail elders and those with disabilities from having to deal with transportation struggles, going out in inclement weather, and being exposed to infection and disease. But in order to continue in this direction, we need telehealth services to be reimbursed at the same level as an in office visit. As our state continues to emphasize a population health, value-based system of care, telehealth is essential for continuing to provide high quality, cost-effective, patient-centered care.

For many of our low income residents they do not have the technology to have a video appointment. Although we are working to put in place a technology lending library for all SASH locations around the state, the only option for some residents currently is an audio appointment. Many of our residents have had audio appointments throughout the pandemic, and most have gone extremely well. It gives our residents a sense of relief to talk with their provider especially during these difficult times.

Please let this be one of the silver linings in the pandemic, it is essential that we not lose the ground we have gained in telehealth expansion this year.

Sincerely,

Kim Fitzgerald

Chief Executive Officer
Cathedral Square
412 Farrell St, Suite 100
South Burlington, VT 05403
802.859.8808
www.cathedralsquare.org
www.sashvt.org



PRIVACY & CONFIDENTIALITY NOTICE: This message and any attachments are for the designated recipient only and

Subject: FW: Deadline for Proposed Recommendations Reminder

Date: Monday, October 12, 2020 at 2:48:37 PM Eastern Daylight Time

From: Heidi Peterson, LICSW

To: Sebastian.Arduengo@vermont.gov

Priority: High

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Hello.

I am a psychotherapist in private practice and also practice in a hospital-based outpatient clinic. I would like to offer some comments about future commercial insurance coverage of audio-only telephone services.

I recommend that audio-only psychotherapy continue to be covered in the future by commercial insurance (as well as Medicare and Medicaid), based on my experience with 2020 conditions. Within my own practice, I have several individuals who would not be able to receive care without the option of audio-only sessions. These are individuals with no internet, no electronic devices, or unreliable internet coverage. Older Vermonters and people of limited means are often in this group, putting them at risk for being unable to access services if audio-only sessions are not supported. Some of my most vulnerable patients are in this group who risk not being able to access services. In our rural state, there have been many sessions with patients this year where the video coverage or internet connection has been disrupted during the session. Since audio-only sessions are supported, we have been able to switch seamlessly to the telephone to continue and complete the session, preventing disruption of care. My colleagues and I have also noticed that the rate of missed appointments has declined, as the access to remote sessions—audio-only or video—has allowed people to attend without disruption due to problems with transportation or family illness. This means that we are able to make decisions about the frequency and intensity of care based on the clinical needs of the patient rather than on the basis of access issues.

I also recommend that the reimbursement for audio-only services remain equivalent to the in-person and video rates. I, like many of my colleagues, continue to pay full office overhead during the pandemic and have incurred additional costs to be able to provide remote psychotherapy services (HIPPA compliant video meeting platform, secure e-mail, etc., greater bandwidth for internet, etc). There do not appear to be any future scenarios that would reduce overhead and make audio-only services less expensive to provide. When it becomes safe for therapists and patients, many patients will want to return to in-person sessions, requiring the office setting, while some patients will be better served by meeting with the therapist remotely, including by audio-only, resulting in the need to continue to have the capacity for both office-based and remote sessions and the on-going costs associated with this.

Thank you for welcoming comments on this important issue from among the broader group of clinicians practicing in Vermont.

Best,

Heidi Peterson

Heidi Peterson, LICSW
Green Mountain EMDR and Psychotherapy, PLLC
160 Benmont Avenue, Suite 20
Bennington, VT 05201

Subject: Audio-only Mental Health Treatment

Date: Monday, October 12, 2020 at 8:57:55 AM Eastern Daylight Time

From: David Brown

To: Sebastian.Arduengo@vermont.gov

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Dear Mr. Arduengo,

I understand that your workgroup is receptive to input from mental health providers. The following are my thoughts on audio-only telephone services.

The workgroup recommends that coverage of audio-only telephone services be continued through the pandemic and maintained post-pandemic for the following reasons:

- Many people do not have access to video services due to lack of quality internet or suitable hardware. Audio-only services allow this population access to treatment they would otherwise not have.
- Post-pandemic, the option of telephone services will reduce the number of missed sessions due to last-minute scheduling problems due to childcare, weather and transportation.
- Audio-only sessions are effective. This is supported by anecdotal evidence as well as with an outcome measure I use in my practice.

The workgroup recommends that reimbursement for video and audio-only sessions remain equal to in-person sessions for the following reasons:

- Video and audio-only sessions consume as much time but are more cognitively and physically demanding than in-person visits. Clinicians frequently report that they are able to see fewer patients per week in these modes versus face-to-face sessions.
- While many clinicians have been working from home during the pandemic, most of us continue to pay rent for office space we are hoping to return to when it is safe to do so. There are additional procedures and costs associated with telehealth at home which increase the financial overhead and unreimbursed administrative time. Historically, there has never been a reimbursement differential depending on whether the clinician has a home office, or an office in a commercial space. Payment should remain fixed to time and procedure code.

Thank you for your consideration. Please feel free to contact me if you have any questions.

Sincerely,

David Brown, Ph.D.

Subject: Audio Only Mental Health sessions

Date: Friday, October 9, 2020 at 2:17:19 PM Eastern Daylight Time

From: Lisa M. Pezzulich, Psy.D.

To: Sebastian.Arduengo@vermont.gov

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Dear Mr. Arduengo,

I am a doctoral level clinical psychologist in private practice in Bennington, VT. I am writing in regard to feedback about insurance coverage for audio-only mental health treatments.

I am strongly recommending that insurance coverage for audio-only therapy sessions be continued, for the following reasons:

- 1) I have found my sessions with clients in the audio-only format to be equally effective to both video telehealth sessions and live sessions with clients, as evidenced by the depth and breadth of the sessions, direct feedback from my clients as to their perceptions of the treatment, and positive improvement in client symptoms following audio-only treatments.
- 2) Audio-only sessions have been an important part of treatment via telehealth when technological fails (internet outages, Zoom outages, computer issues) have prevented the video format.
- 3) Some of my patients do not have access to video-format technology, based on their skill level (especially older patients), their income (lack of a computer, smart phone, or internet at their houses), or the rural nature of their housing (cannot access the internet, but have a "landline" phone). To deny these patients access to telehealth, which has been approved for several years in Vermont, is discriminatory.
- 4) Post-pandemic, when live sessions will be more feasible, the availability of audio-only sessions (as per above) would also be very helpful in terms of continuation of care when client illness, client lack of transportation to sessions, and/or weather events (snow, ice, etc) prevent clients from being able to come to the office.

In addition, it should be noted that reimbursements for all forms of telehealth should remain equal to in person sessions. As a business owner, my overhead costs for running my business (need for an office, billing company fees, internet/phone costs, liability insurance, etc) will not be reduced by using telehealth.

Thank you for your consideration,

Lisa M. Pezzulich, Psy.D.

--
Lisa M. Pezzulich, Psy.D.

Mindful Solutions, PLLC

160 Benmont Ave, Suite 20

Bennington, VT 05201

(802) 442-3520 X211

fax: (802) 447-3392

PLEASE NOTE email is not intended for emergency communication.

Confidentiality disclaimer: This communication is confidential and privileged. If you are not the intended

Subject: recommendations for future regulations

Date: Tuesday, October 6, 2020 at 7:00:32 PM Eastern Daylight Time

From: Joyce

To: Sebastian.Arduengo@vermont.gov

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Dear Sebastian,

I am a VT licensed psychologist. I have been practicing in private practice for more than 30 years. I accept most health insurances including VT Medicaid. During this pandemic and state of emergency I have continued to see patients and deliver services through telemedicine, solely through video. My recommendation for moving forward, is to continue this coverage of telehealth. I recommend that our reimbursement rates stay as they are. The possibility of transitioning from office visits may change overhead, such as office rental and utilities, but making home offices which are confidential, securing a HIPPA compliant video platform, as well the usual office expenses of telephone, supplies, and WIFI will amount to almost the same overhead.

With regard,

Joyce A. Sullivan, MA, LADC
Licensed Psychologist/VT Masters

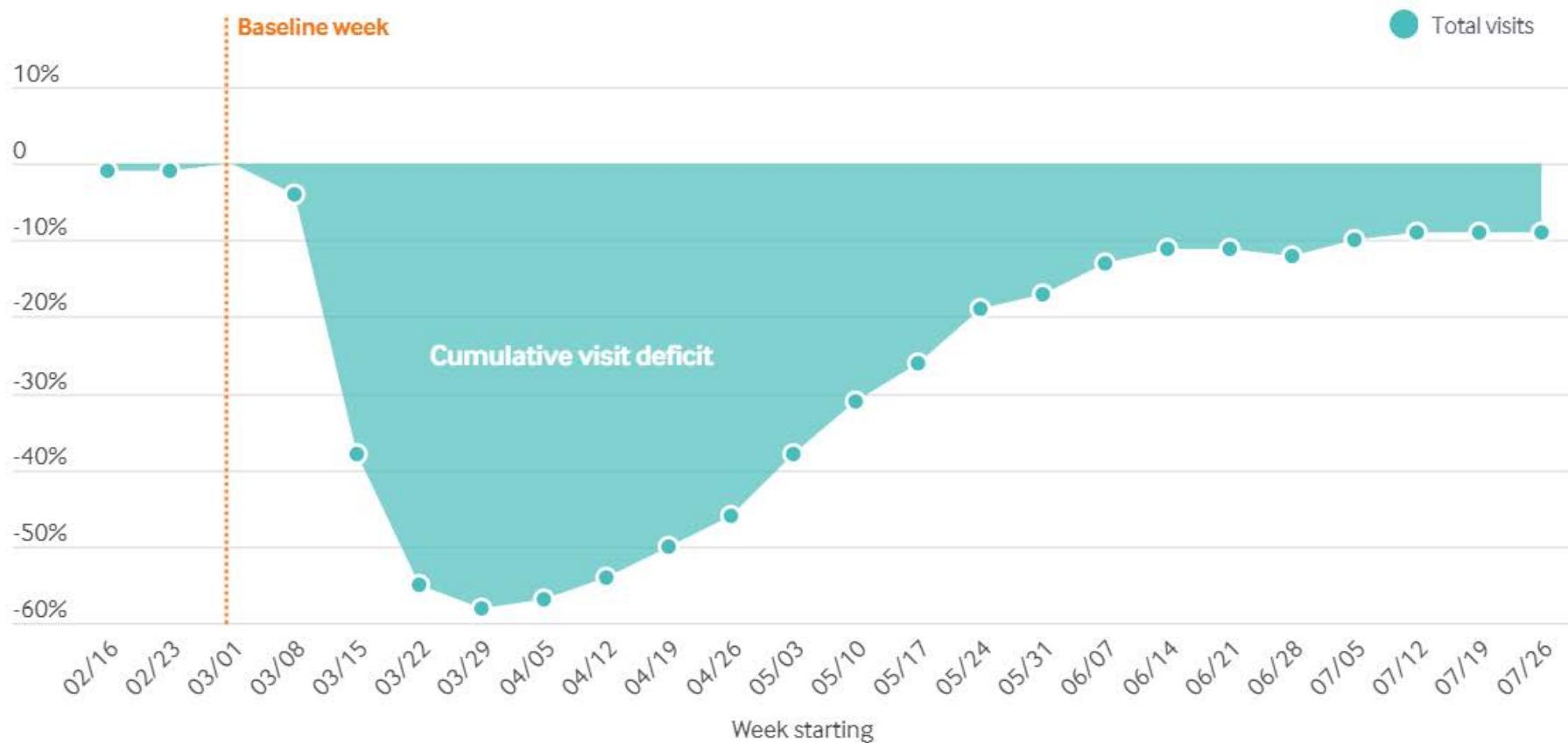
Telemedicine in the Era of COVID-19

Ateev Mehrotra MD



HARVARD
MEDICAL SCHOOL | Department of
Health Care Policy 78 of 114

Volume of visits of any types in outpatient care fell by almost 60% before rebounding

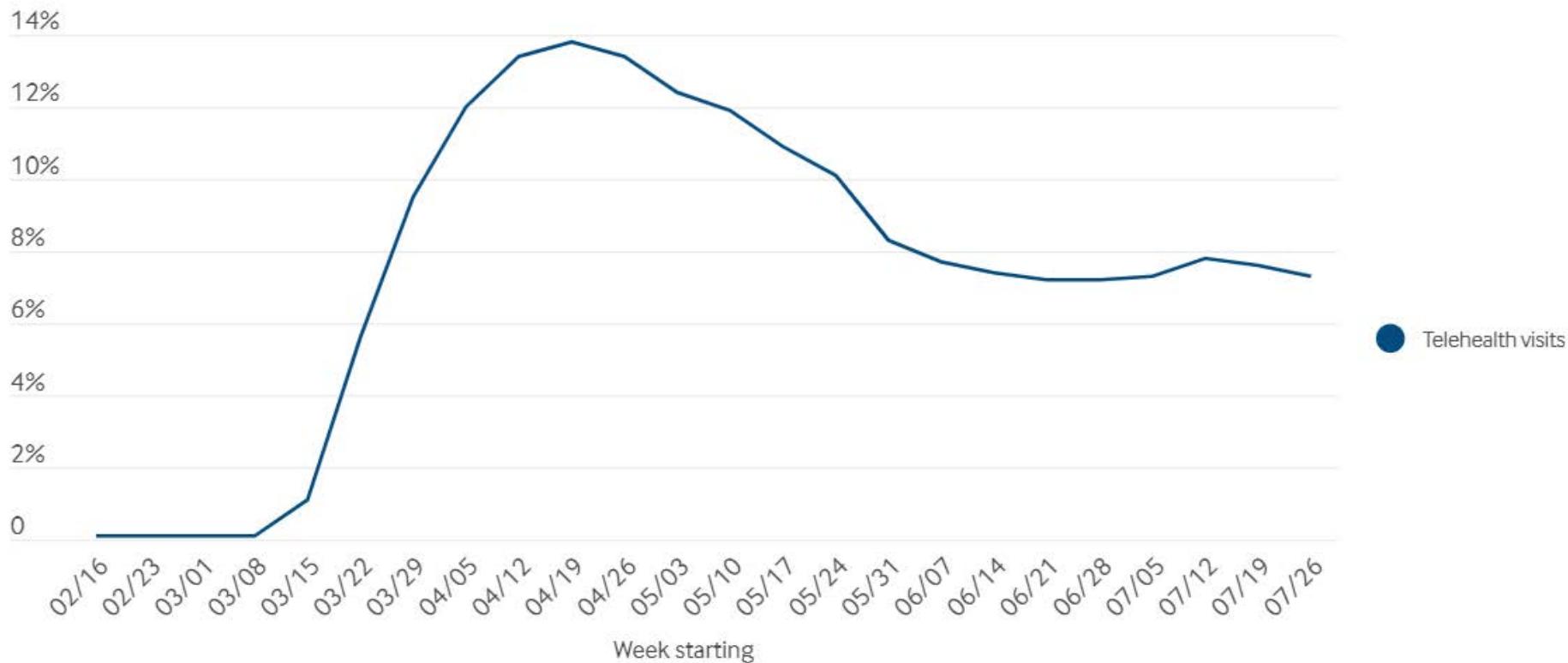


Policymakers implemented many changes to facilitate telemedicine use

- Telemedicine visits can be provided to patients in their homes
- All out-of-pocket costs are waived for telemedicine visits
- Payment is mandated for audio-only telephone communications
- Visits are no longer limited to rural residents
- Licensure requirements waived
- Providers prescribe for opioid use disorder using telemedicine
- Types of providers that can deliver a telemedicine visit expanded

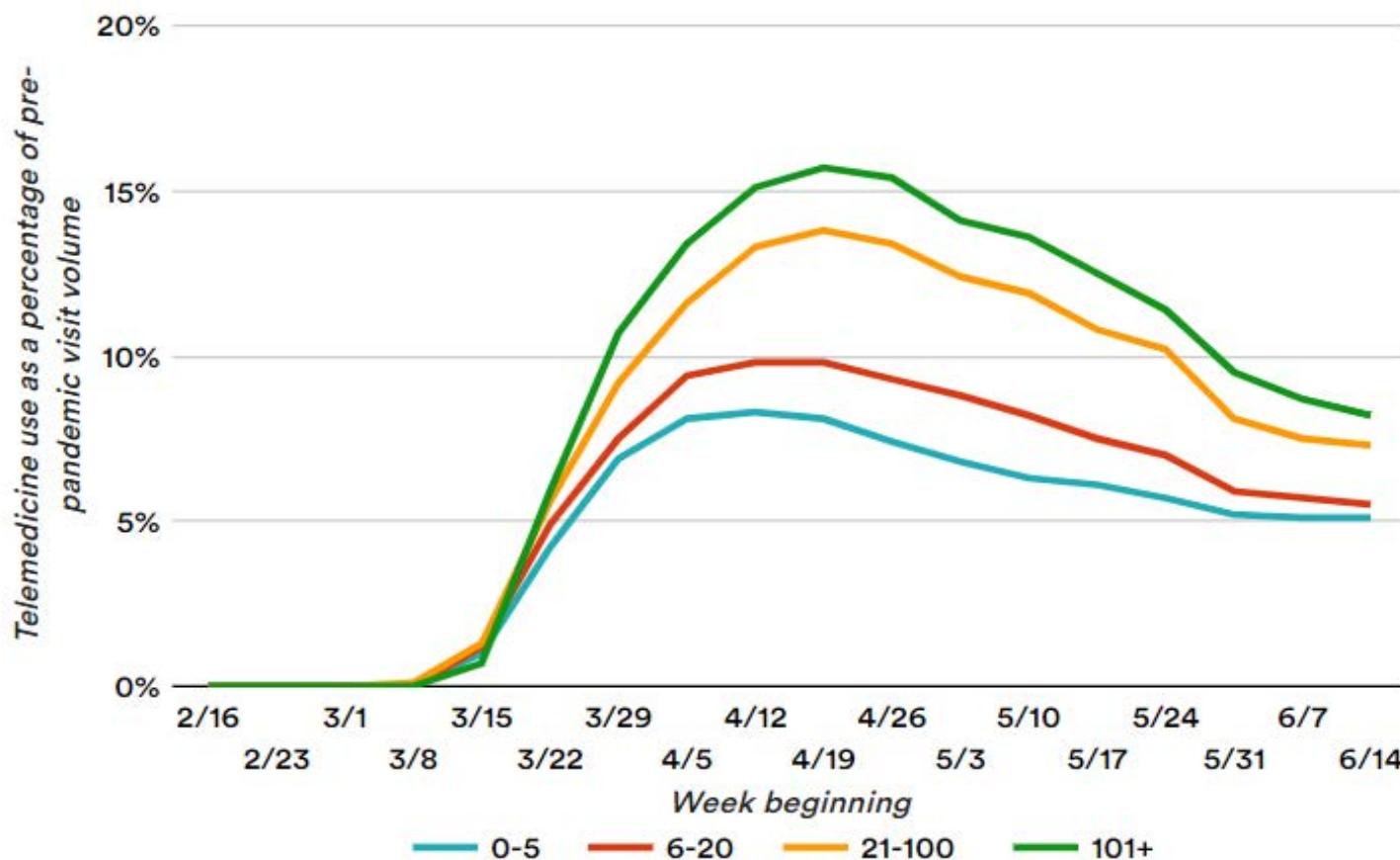
Dramatic rise in use of telemedicine, followed by decline and plateauing

Number of telehealth visits in a given week as a percent of baseline total visits



<https://www.commonwealthfund.org/publications/2020/aug/impact-covid-19-pandemic-outpatient-visits-changing-patterns-care-newest>

Telemedicine uptake greatest among larger organizations



Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?

Ateev Mehrotra

Associate Professor of Health Care Policy
and Medicine
Harvard Medical School

Bill Wang

Research Assistant
Department of Health Care Policy
Harvard Medical School

Gregory Snyder

Senior Medical Director of
Strategy and Clinical Operations
Medically Home

ABSTRACT

ISSUE: In response to the COVID-19 pandemic, many temporary policies were introduced to encourage telemedicine use. There is ongoing debate on what policies should be made permanent.

GOAL: To provide both a framework for how to evaluate telemedicine policies and recommendations on future telemedicine guidelines.

FINDINGS: To encourage higher-value use of telemedicine and discourage overuse of care, we recommend that payments should be limited to services for selected patient populations and health conditions, or to

TOPLINES

► **Insurers and policymakers face a difficult challenge in designing an optimal payment and regulatory policy for telemedicine.**

► **Policies should promote high-value applications of telemedicine but guard against significant overuse.**

Challenges

- Sense of urgency given continued uncertainty about long-term plans has deterred investments by providers
- Government and health plans leery of covering telemedicine visits permanently
- Convenience, the key strength of telemedicine can be viewed as its Achilles heel
- Concern that increased use of telemedicine will result in “overuse” of care

Key policy considerations

- Telemedicine ≠ video/audio visits
- No single telemedicine policy
- Need for simplicity
- How to address overuse?
 - Limitations by patient, condition, provider
- Relative cost difference – should there be parity?
- Should there be coverage of phone calls

Questions

mehrotra@hcp.med.harvard.edu

Understanding Coding for Audio Only Services

Peter Hollmann MD

Disclosures

- Representing myself
- Past CPT Panel Chair
- Current RUC Alternate (AMA seat)
- Member and past Co-Chair AMA Digital Medicine Payment Advisory Group
- Co-Chair E/M Workgroup
- 20 years as BCBSRI Medical Director (part time)
- CMO Brown Medicine (Dept. of Medicine, Brown)

Codes and Nomenclature System

- Need a common terminology system for claims payment
- CPT ® is Current Procedural Terminology and is owned by the AMA
 - Used for reporting professional services and outpatient facility
 - Category 1: recognized clinical services
 - Category 2: quality
 - Category 3: new services, not fully developed as commonly practiced
- HCPCS II are other codes that are managed by CMS
 - Medicare G codes eg Annual Wellness Visits
 - Drug codes for “medical” claims (NDC for pharmacy claims)
 - Medicaid codes
- ICD
 - Inpatient procedures ICD-PCS
 - Diagnoses ICD-CM

CPT Process

- <https://www.ama-assn.org/practice-management/cpt>
- CPT has established criteria for code approval
- Anyone can submit a code change/new code proposal
- Completed proposals are reviewed by Advisors (all medical specialties and healthcare professions) and comments submitted to Editorial Panel
- Panel votes
- Meetings are open
- Interested parties can participate in details of applications and comments
- Public information is more general to avoid copyright issues and erroneous information going public

CPT Editorial Panel

- Appointed by AMA Board
- Independent Experts – The AMA does not tell the Panel how to vote.
- No slotted seats except payer (including CMS) and hospital association
 - 11 Nominated by specialty societies
 - 3 payer
 - 1 Hospital
 - Two seats are for non physicians
- Meets 3 times a year

RBRVS Update Committee

- Convened by AMA to make recommendations to CMS
- Expert Panel
- Specialty specific and rotating seats
- AMA seat
- Level of Interest in recommending values for new and revised codes paid on the Medicare Physician Fee Schedule
 - Specialty will survey for time and intensity and relative value
 - Surveyees compare to a reference service list
 - Specialty will present to RUC
- Open meetings
- Two-thirds majority required for recommendation

Normal Timeframes

- Timeframes largely governed by CMS rulemaking and implementation issues for payers
- October CPT Panel Meeting is last of 2020 (for 2022 cycle)
- Codes go to RUC Jan 2021
- CMS list codes and values in proposed rule July 2021
- Comment period
- CPT Publishes codes August 2021
- Final Rule November 2021
- Codes effective January 1, 2022

Broad Categories of “Telemedicine Services” and Non Face to Face Management in CPT

- In person services done via real time audio-video
- Interprofessional consultations “eConsult”
- On-line digital evaluation and management – portal visit
- Telephone (audio only)
- Remote physiologic monitoring and many other remote/digital services (eg glucose monitoring)
- Non face to face care management services

Modifier 95 RTAV (real time audiovideo)

Appendix P

Appendix P—CPT Codes That May Be Used For Synchronous Telemedicine Services

CPT 2020

Appendix P

CPT Codes That May Be Used For Synchronous Telemedicine Services

This listing is a summary of CPT codes that may be used for reporting synchronous (real-time) telemedicine services when appended by modifier 95. Procedures on this list involve electronic communication using interactive telecommunications equipment that includes, at a minimum, audio and video. The codes listed below are identified in CPT 2020 with the ★ symbol.

90791

96040

99254

E/M Guidelines and Structure

- Three Key Components (each component has levels)
 - History
 - Exam
 - Medical Decision Making
- For 2021 Office Visits are Medical Decision Making or Total Time on the Date of the Encounter
 - CMS adopted the concepts for telehealth code selections during PHE
 - Uses CPT 2020 times and MDM criteria
 - AMA published/educating 2021 guidelines and began Nov. 2019
- E/M is a single date of service (though valuation is based on work before and after the encounter)

Online Digital Evaluation and Management Services

#●99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

#●99422 11-20 minutes

#●99423 21 or more minutes

►(Report 99421, 99422, 99423 once per 7-day period)◀

►(Clinical staff time is not calculated as part of cumulative time for 99421, 99422, 99423)◀

►(Do not report online digital E/M services for cumulative service time less than 5 minutes)◀

►(Do not count 99421, 99422, 99423 time otherwise reported with other services)◀

Telephone Services (Audio Only)

Telephone Services

► Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure. (Do not report 99441-99443, if 99421, 99422, 99423 have been reported by the same provider in the previous seven days for the same problem.)◀

99441

Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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

→ *CPT Changes: An Insider's View 2008, 2013*

→ *CPT Assistant* Mar 08:6, Apr 13:3, Oct 13:11, Nov 13:3, Oct 14:3, Mar 18:7, Jan 19:13, Mar 19:8

99442

11-20 minutes of medical discussion

→ *CPT Changes: An Insider's View 2008, 2013*

→ *CPT Assistant* Mar 08:6, Apr 13:3, Oct 13:11, Mar 18:7, Jan 19:13, Mar 19:8

99443

21-30 minutes of medical discussion

Now compare to [Telehealth] Office/Outpatient E/M

HCPCS CODE	SHORT DESCRIPTION	NATIONAL NF PRICE
99212	Office/outpatient visit est	\$46.19
99213	Office/outpatient visit est	\$76.15
99214	Office/outpatient visit est	\$110.43
99215	Office/outpatient visit est	\$148.33
G2012	Virtual Check-In	\$14.80
99421	E-visit, 5-10 mins.	\$15.52
99422	E-visit, 11-20 mins.	\$31.04
99423	E-visit, 21-30 mins.	\$51.16
99441	Telephone, 5-10 mins.	\$14.44
99442	Telephone, 11-20 mins.	\$28.15
99443	Telephone, 21-30 mins.	\$41.14

CMS Cross-walked payment

99441=99212

99442=99213

99443=99214

Effective 3/1/20

Announced April 30

CMS Telehealth Codes

LIST OF MEDICARE TELEHEALTH SERVICES				
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic		
90785	Psytx complex interactive		Yes	
90791	Psych diagnostic evaluation		Yes	
90792	Psych diag eval w/med svcs		Yes	
90832	Psytx w pt 30 minutes		Yes	
90833	Psytx w pt w e/m 30 min		Yes	
90834	Psytx w pt 45 minutes		Yes	
90836	Psytx w pt w e/m 45 min		Yes	
90837	Psytx w pt 60 minutes		Yes	
90838	Psytx w pt w e/m 60 min		Yes	
90839	Psytx crisis initial 60 min		Yes	
90840	Psytx crisis ea addl 30 min		Yes	
90845	Psychoanalysis		Yes	
90846	Family psytx w/o pt 50 min		Yes	
90847	Family psytx w/pt 50 min		Yes	
90853	Group psychotherapy	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
G0438	Ppps, initial visit		Yes	
G0439	Ppps, subseq visit		Yes	

AWV
may be
Audio only



CMS Telehealth List

LIST OF MEDICARE TELEHEALTH SERVICES				
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
97804	Medical nutrition group		Yes	
99201	Office/outpatient visit new			
99202	Office/outpatient visit new			
99203	Office/outpatient visit new			
99204	Office/outpatient visit new			
99205	Office/outpatient visit new			
99211	Office/outpatient visit est			
99212	Office/outpatient visit est			
99213	Office/outpatient visit est			
99214	Office/outpatient visit est			
99215	Office/outpatient visit est			
99217	Observation care discharge	Temporary Addition for the PHE for the COVID-19 Pandemic		
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99224	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		

Adaptation on an Urgent Basis

- Some payers allow codes approved for RTAV to be audio only
- Payers accept that Hx/PE/MDM rules are not reasonable in telehealth
- Medicare uses telephone but pays as if in person (per time unit)
- New patients allowed
 - Previously only established patients allowed to prevent abuse
- Major variability between payers on codes allowed, modifiers to use, benefits re cost share especially.
- Temporary policies create uncertainty and delay transformation
- Temporary policies allowed patient care and improved practice viability

Telephone Codes

Pros

- Longstanding established utility
- Technology barriers for RTAV
- Patient cost to have equipment can be an issue in RTAV
- A major source of uncompensated care now recognized
- Primary Care essential

Cons

- Inadequate payment per minute
- Once per week
- Concerns about mis-use
- Already paid in the most recent E/M
- Established patients only

Office Visits 2021 Code Selection

- **Written for in person visits**
- Great utility with RTAV as avoids Exam level requirement
- Does not apply to other E/M codes yet (eg home or nursing facility)
- May be reasonable to jump start 2021 on other codes or on office visits for remainder 2020

Clinical Appropriateness

- Longstanding practices
- Not black and white – find the best way possible to care for patients given the circumstances
- Example:
 - 99396 Comprehensive Preventive E/M
 - Requires a physical
 - Allow reporting and expect PE to be done and not billed again next OV

Goals

Short term

- Get patients access
- Keep practices viable
- Make the system work for patients and practices
- Create regional consistency
- Get payers and practices united
- Do not disrupt relationships eg with telemed vendors

Long term

- Use CPT as intended
 - CPT may make changes
- Use RUC valuations
- Help practices develop capacity for greater access and continuity
- Protect consumers

Other Issues

- Surrogates instead of patients or some of each
- Quality measures
- Risk Adjustment - do telemed/audio only claims count?
- Attribution - do telemed/audio only claims count?



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

**Vermont Audio-only
Telephone Working Group**

**Overview of Federal & State Telehealth Policy
During COVID-19**

July 6, 2020
Sabrina Corlette, J.D.

About Georgetown's Center on Health Insurance Reforms (CHIR)

- A team of private health insurance experts
- Conduct research and policy analysis, provide technical assistance to federal and state officials and consumer advocates
- Learn more at <https://chir.georgetown.edu/>
- COVID-19 Resource Center
<https://chir.georgetown.edu/chir-covid-19-resource-center/>
- Subscribe to CHIRblog: <http://chirblog.org/>
- Follow us on Twitter @GtownCHIR, @SabrinaCorlette



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**

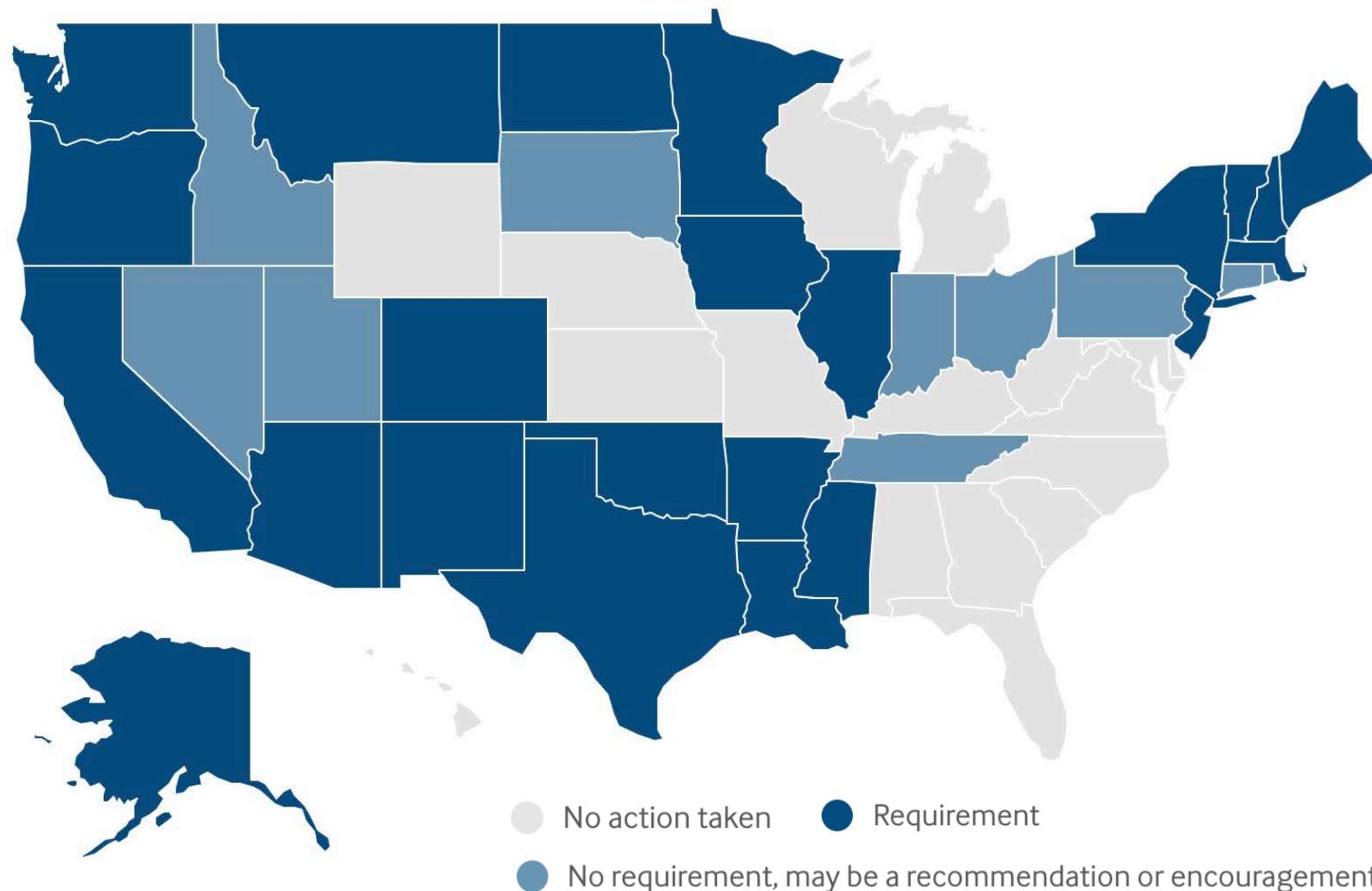
Pre-COVID Policy Landscape

- Several states advancing telehealth legislation, including:
 - Coverage requirements
 - Specifying modalities (i.e., store & forward, audio-only)
 - Expanding list of authorized providers (esp. mental health)
 - Reimbursement parity
 - Ex.: CO, LA, MI, MN, TN, VA, WA

Federal Actions in Response to COVID-19

- Waiver of HIPAA privacy requirements
- Permitting mid-year benefit changes to expand coverage of telehealth
- Allowing pre-deductible coverage in catastrophic plans, HSA-eligible HDHPs
- Mandate to cover screening for COVID-19 tests via telehealth
- Allowing large employers to offer telehealth-only benefit to workers

State Action in Response to COVID-19



Source: Data collection and analysis by researchers at the
Center on Health Insurance Reforms, Georgetown University

Telehealth Coverage in a Post-COVID World: Considerations for States

- Service delivery via telehealth here to stay
- What's the right balance of coverage, reimbursement, and medical management policies?
 - Coverage and/or cost-sharing parity?
 - Audio vs. visual?
 - Reimbursement parity?
 - Relaxing licensing/credentialing requirements?
 - Protection of patient privacy?
- How can states ensure these policies reduce (and do not exacerbate) existing inequities in access to care?

Thank you!

Sabrina Corlette, J.D.

Research Professor

Georgetown University Center on Health
Insurance Reforms

Sabrina.Corlette@georgetown.edu

@SabrinaCorlette

202-687-3003



Georgetown University Health Policy Institute

**CENTER ON HEALTH
INSURANCE REFORMS**