THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

House Bill 679
Proponent Testimony
Ohio House of Representatives Insurance Committee

Arick Forrest, MD
Vice Dean for Clinical Affairs
President, The Ohio State University Physicians, Inc.
The Ohio State University Wexner Medical Center
June 3, 2020

Chairman Brinkman, Vice Chair Antani, Ranking Member Boggs, and members of the House Insurance Committee, my name is Dr. Arick Forrest. I am Vice Dean of Clinical Affairs for the Ohio State University College of Medicine and President of the Ohio State University Physicians, Inc. I also am a practicing otolaryngologist. I am pleased to provide proponent testimony on House Bill 679, which would codify coverage for telehealth. I commend Representatives Fraizer and Holmes for introducing legislation to make permanent many of the advances we recently have made in providing service virtually to our patients.

Virtual health, or telehealth, is a cost-effective method for delivering health care services, improving quality and safety and increasing access to care. Ohio State has a long history of using telehealth. In 1995, Ohio State began using telemedicine to increase inmate access to care. We found that there were significant savings from a reduction in inmate trips to the emergency room and doctor's offices as well as unnecessary medical tests. We have provided more than 10,000 telemedicine visits with inmates and are currently offering 14 specialty clinics to 29 prison sites across

the state.

In 2011, the Ohio State University Wexner Medical Center (OSUWMC) Comprehensive Stroke Center began tele-stroke services across the state – offering the highest level of timely, evidenced-based stroke care regardless of where someone lives.

In 2013, Ohio State psychiatrists began providing tele-behavioral health services for emergency department patients. Timely patient evaluation decreases length of stay, prevents escalation of psychiatric issues, and increases the number of patients that can be discharged to home instead of being admitted to a psychiatric facility.

More recently, our primary care physicians (PCPs) started offering follow up video visits for established patients. PCPs also began electronic consultation, keeping them as the coordinator of the patient's care with timely access to subspecialty providers. Specialty areas utilizing telehealth include dermatology, pulmonology, gastroenterology, hepatology, congestive heart failure, and otolaryngology.

Experience with telehealth prepared us well to respond to patients' needs during the COVID-19 pandemic. Telehealth has expanded exponentially, by necessity, to ensure that patients still have access to needed care while in person visits were not possible. Through flexibility provided through Medicaid and Medicaid waivers, and corresponding coverage from private insurers, we quickly shifted our ambulatory care from primarily in-person to care almost exclusively through virtual means – including through our MyChart online application that supports live video visits and email - and through telephone calls.

It will be vital to continue these Medicare and Medicaid waivers and flexibilities beyond the emergency period for which they operate. We appreciate that this bill strives to do that for Ohio Medicaid and recommend that the bill not reduce any of what Ohio Medicaid has implemented. It will also be important for members of the Ohio General

Assembly to encourage Congress and the Trump Administration to continue these waivers for Medicare and Medicaid at the federal level.

Our shift to telehealth was particularly critical to ensure that we could handle routine or acute care for older or at-risk patients, including those with chronic conditions, without risking a visit to a medical office.

OSUWMC jumped from 134 video visits and 39 telephone appointments during January and February 2020 to 30,944 video visits and 35,710 calls from March 19 through April 27, 2020. We now have 1400 providers conducting more than 2500 video visits per day. While many will return to in-person appointments, virtual visits have become part of our standard practice and many patients appreciate the convenience and ease of telehealth visits for their care. Telehealth has quickly become a normal way of providing care to our patients, across types of providers and conditions – from primary care to specialty care and disease management.

Since we have expanded telehealth visits, our no-show and late cancellation rates have dropped among our entire patient populations, but particularly for Medicaid recipients.

Telehealth is clearly increasing access to care, particularly for individuals with barriers to care, including transportation, and can save patients money as compared to coming to an in person visit, as it may save them the cost of gas, parking, lost wages and/or childcare which for some patients is not insignificant.

We are pleased that House Bill 679 as introduced would codify some of the practices that have been put in place on an emergency basis through Medicaid waivers. In particular, we strongly support the bill's expanded list of providers who are eligible to provide care through telehealth. We also support codifying coverage for both Medicaid and private plans, allowing for reimbursement of emails and telephone calls in addition to face-to-face virtual visits, and providing for expanded behavioral health

and substance use disorder services via telehealth.

We do have some recommendations for improvements to the legislation.

We encourage you to add clinical pharmacists to this list of providers who can provide services via telehealth in both the private market and Medicaid. Last General Assembly, Ohio passed legislation to recognize pharmacists as providers. As important parts of the care team, pharmacists provide significant assistance in medication management and chronic disease management through consult agreements with physicians.

In addition, we ask you to add licensed genetic counselors to the list of allowable providers. Genetic counselors actively work with our cancer program patients, maternal/fetal medicine, cardiac care and more. Their patient consultations can be done by remote means and should be permitted to do so.

We also ask the committee to remove a requirement that a patient must first be seen in person before having a virtual visit, or that a patient must be seen in person at least once annually. Telehealth increases access to care for vulnerable populations, as previously noted, including those who are underserved. We appreciate that the bill includes a waiver of this requirement if the practitioner determines that the situation is critical and an in-person visit is not practical. However, we can foresee complications in determining what is considered “critical.” Can the health plan interpret that requirement and deny coverage for services provided? Practitioners are in the best position to determine whether care can be provided appropriately via virtual means, and a virtual visit can provide an important entry to care for patients with barriers to care. I understand there may be an amendment to allow a waiver of the in-person first visit requirement if the provider or plan determines that telehealth services are necessary and an in-person visit is not practical. This would be a beneficial improvement to the bill.

The bill also adds to the list of prohibited fees, including any administrative costs associated with telehealth. We would like to continue dialogue with the sponsors and Committee on this issue, as we prefer that reimbursement be determined in negotiation between the provider and plan. Restrictions should not be included in statute.

H.B. 679 also includes a new methodology for reimbursements for email or telephone services, based on a tally of minutes pent per patient. Health plan issuers would reimburse for a block of time on such services that is equivalent to the standard amount of time spent on a telehealth service. We appreciate the intent of this provision, but seek clarification on its implementation. The language should be clarified to assure that standard claims and CPT coding methodologies are followed and that it does not impose new or different billing requirements on providers and payers. Further, tallying of time for appropriate coding is difficult in our current electronic health record. A pending amendment may alter this methodology and require the Superintendent of Insurance to issue rules determining payment. We look forward to examining the new language more closely.

I believe a potential amendment may remove language that requires a plan to provide coverage for telehealth services on the same terms and the same basis as in-person health care services. We would strongly oppose the remove of this language. It requires coverage parity, but not payment parity, and is vital to ensure all services are covered regardless of the methodology through which they are provided.

Regarding Medicaid coverage, we ask the Committee to allow coverage of all types of patient care, including complex care. The bill limits coverage to evaluation and management with clinical decision making not to exceed moderate complexity. Often the provider does not know the full complexity of care needed until the visit begins, and providers should be reimbursed for the full care provided. Also, it can be safer for our most frail patients to receive care without having to leave their home and risk traveling to an office. Therefore, it is critical that these patients, most with complex

needs, be able to receive appropriate care through telehealth means.

The bill also would cover Medicaid reimbursement for inpatient or office consultation for new or established patient when providing the same quality and timeliness of care to the patient is not possible other than by telehealth. This suggests that this is the only time that inpatient or consultation services could be covered. That seems limiting. Provider and patient choice on how care is delivered should be permitted.

In summary, we support efforts to create greater access to and coverage of telehealth in Ohio. Virtual health improves access to clinical experts and helps mitigate health disparities across communities, and has quickly become the new normal for providing care. We look forward to working with the sponsors and Committee to address these outstanding issues and ensuring that the great progress we have made in telehealth can continue for our patients and communities.

I am happy to answer any questions you may have.