April 30th, 2021

Re: Act 6 Stakeholder Memo – comments by the coalition of health care associations

To: Sebastian Arduengo, Department of Financial Regulation

Thank you for the opportunity to comment on appropriate billing codes and reimbursement rates for audio-only health care services provided through January 1, 2025.

As previously expressed in testimony, the coalition representing health care providers in our state emphatically supports parity reimbursement for audio-only telephone services. We support the current extension of Regulation H-2020-06-E, and support continuing the reimbursement rates established in that regulation through the end of the 2024 plan year.

The experience of our providers is that audio-only connections offer critical access to care for patients who face barriers that might otherwise cause them to delay, defer, or cut short medical treatment. These barriers exist outside of the pandemic. However, the pandemic highlighted the number of patients for whom technological barriers (broadband access, affordability, computer equipment, and/or comfort with technology) make an audio-visual connection impractical. It has also pushed to the fore our understanding for the appropriate clinical circumstances for different telehealth modalities. Through supporting audio-only services, we have the opportunity to offer care that was previously inaccessible, and we need to keep that pathway open.

Our members are not experiencing a cost savings as part of implementing audio-only. In fact, many report that it takes more time. The additional time costs come from working with patients to determine if audio-only is appropriate; helping patients get situated in a new way of connecting with their providers, including talking through their different options; more time spent by the clinician in the appointment talking through each patient concern and checking that nothing has been missed; more time spent documenting the encounter. The patients who require audio-only access are by definition weighted towards those who are caught on the wrong side of the digital divide and who face barriers to reaching in-person care. For this reason, staff also spend more time working with patients on options to address these barriers – our goal is to make sure the first connection happens *and also* that all appropriate follow-up care takes place. We are creating a critical pathway to care that didn't exist before, and that takes considerable work.

Some of the above cost elements will fade as new systems become standard practice. We can also anticipate that more effective use of telehealth tools will allow for more patients to be seen in a given health care site, reducing per patient overhead costs. However, it will take multiple years before those savings are realized. They are currently just theoretical. It is reasonable to expect that parity will be needed at least through 2024.

Health care organizations and their associations continue to work to make implementation of audio-only services as smooth as possible for practices and patients. We are providing technical assistance for immediate implementation of updated patient informed consent rules. We are participating in statewide conversations around how to address the digital divide, and supporting members in applying for grants and equipment to directly serve their patients who have difficulty connecting to traditional telemedicine. We are partnering with VPQHC and the Northeast Telehealth Resource Center on training opportunities and technical assistance. We are setting the

foundation for health care providers in Vermont to flourish in a value-based telehealth reimbursement system in 2025, but we cannot lose the momentum by reducing reimbursement for virtual care today – such a move would send a clear signal to our providers that they should not invest in this future mode of health care.

We want to strike a correct balance of a reimbursement level that signals to practices to continue offering virtual services and make those services available to all patients, without reimbursing so much that we incentivize practices to *over*utilize telehealth. Looking at basic utilization data over the last year, we see no sign of over-use. We have attached details from Bi-State Primary Care Association, University of Vermont Health Network and Dartmouth-Hitchcock Health. In general, the trends have been as follows:

- Significant drop off in overall visit volume in the first wave of shut-downs, and significant increase in telehealth as a percent of visits that do occur.
- Over the summer, a rebound in overall volume (although not to 100%) and significant decrease in telehealth as a percentage of visits.
- With the second COVID-19 wave in late fall of 2020, an uptick in telehealth use, but nothing as dramatic as in spring of 2020.
- A steady decrease in audio-only as a percent of telehealth services following the spring of 2020. Overlaid on a general reduction in telehealth use, this means a small number of appointments using audio-only services.
- Organizations with multiple services lines see a need for audio-only across their practice. We want to emphasize that even if audio-only drops to a very small absolute number of visits for some providers, those connections are critical for the patients who use them.

These trends are what we would predict for appropriate telehealth use. We also see these general trends reflected in national Medicare claims. We see no evidence that audio-only parity reimbursement will become a driver for increasing remote services beyond what is appropriate for allowing patients to access care in the way that best meets their needs.

Collecting better data on telehealth modalities will allow Vermont to monitor trends and to design future payment systems. We believe that the update to CPT terminology in 2021 clarifies the applicability of those codes to remote services. We recommend that claims for audio-only telephone services use the relevant service code, with a modifier to indicate services delivered remotely and that they were delivered via an audio-only platform. We strongly encourage alignment between Medicaid and commercial payer modifiers if possible in their respective systems. This coding recommendation applies to audio-only services delivered as equivalent to in-person services, not to telephone-specific codes, such as G2012.

See additional attachments:

Bi-State Primary Care Association 2020 & 2021 Telehealth Data
Dartmouth-Hitchcock Health 2020 & 2021 Telehealth Data
UVM Health Network 2020 & 2021 Telehealth Data
Medicare Telehealth Trends – AMA Graphic

Thank you for considering this input as you make your next reimbursement and coding decisions.

Sincerely,

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