

To: Sebastian Arduengo, Department of Financial Regulation

**From: Matthew Houde, Dartmouth Health
Mary-Kate Mohlman, Bi-State Primary Care Association
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Date: June 10, 2022

RE: Audio-Only Coding and Reimbursement Revisions for PY 2023

Thank you for inviting comments on revising [the Audio-Only Coding and Reimbursement Order](#) for Plan Year 2023. We submit these comments on behalf of a number of Vermont's provider organizations, representing physicians, Federally Qualified Health Centers and hospitals:

- **Dartmouth Health**
- **Bi-State Primary Care Association**
- **The University of Vermont Health Network**
- **The Vermont Medical Society**
- **The Vermont Association of Hospitals and Health Systems**

Our organizations urge DFR to update the PY2023 order to require 100% parity with in-person and telehealth services for audio-only telephone services.

Providing parity for audio-only telephone services is the only way to accomplish the goals of Vermont patients having equitable access to services in their medical home, and achieving useful outcomes for studying the use of audio-only services over the next year.

- Audio-only connections offer critical access to healthcare services for patients who face barriers that might otherwise cause them to delay, defer, or cut short medical treatment.¹ Since 2020, practices have been using audio-only visits for a number of situations, including medication management, follow-up appointments for chronic conditions, post-discharge or post-procedure follow-up, making health treatment plans, and discussing imaging and labs. See Attachment 1 from the UVM Health Network showing that the most common reasons for an audio-only visits in the Network are: follow-up (50%), chronic kidney disease (9%), routine prenatal visit (7%), nutrition counseling (6%), anxiety (5%) and pain (5%). They are being used in both the primary care and specialty care setting. See the attached data from UVM Health Network showing the specialties using audio-only visits range from Family Medicine (15%) and Clinical Laboratory (10%), to Orthopedics (7%) and Cardiology (3%). At Dartmouth Health, the specialty service lines with the most frequent use of audio-only among their telehealth services include oncology, orthopedic surgery, and the heart and vascular center - see Attachment 2.

¹ Vermont Program for Quality in Health Care, Report: Audio-Only Telemedicine & Clinical Quality Recommendations, October 20, 2020; available at <https://legislature.vermont.gov/assets/Legislative-Reports/Audio-Only-Telephone-Services-Working-Group-Report-v2.pdf>

- We still do not know how long Vermont will be dealing with waves of COVID-19 and how other infectious diseases could play out with reduced mitigation strategies, for example a significant winter 2023 flu and respiratory illness season, so continued flexibility in the 2023 plan year is critical to supporting both patient care and public health needs.
- There are many of patients for whom technological barriers make an audio-visual connection impractical including broadband access, affordability, computer equipment, comfort with technology and patient preference. See Attachment 2 from Dartmouth Health indicating why audio-only was the scheduled modality instead of video visits. The data show the reason for 70% of audio-only visits was patient preference, 22% was for known technology issues (lack of technology/broadband), and 8% were for other reasons.
- Audio-only reimbursement addresses equity issues: research shows that rates of those who lack digital access are higher among those with low socioeconomic status, those 85 years or older, and in communities of color.² Dartmouth Health’s data show there are several Hospital Service Areas (HSAs) in Vermont with failed video visits. A failed video visit is an appointment that was scheduled to be conducted as video however, they ended up being conducted as audio-only due to technology & broadband issues. The Vermont HSAs with the highest failure rate include St. Johnsbury, Rutland, Bennington, Newport, Springfield, Windsor and Randolph. Failed video visits were also highest in patients over the age of 65.
- Under 8 VSA § 4100I, plans must only provide coverage for services that are determined by the plans to be “medically necessary, clinically appropriate” health care services to be delivered remotely and plans are limiting coverage to services they have determined can be provided without an in-person visit. See for example BlueCross BlueShield’s policy, which lists only 40 services that are reimbursable using telephone: <https://www.bluecrossvt.org/documents/telephone-policy-effective-april-2022>
- A Vermont Medical Society member survey in November 2021 revealed that Vermont health care practices are not experiencing a cost savings as part of implementing audio-only services and many practices report that providing services over the phone requires more time including: working with patients to determine if audio-only is appropriate, helping patients get situated in a new way of connecting with their clinicians, longer appointment times talking through each patient concern and checking that nothing has been missed, more time spent documenting the encounter and more follow-up time by staff to call patients separately to coordinate prescriptions, referrals or other follow-up care.
- Audio-only services comprise a small subset of visits and are being used responsibly. Data from the UVM Health Network show that audio-only visits account for between 2.68% and 2.13% of all visits and approximately 22-25% of telehealth visits in 2022. The percent has been holding steady for the past year and is a decrease from close to 6%

² 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; see also the recent HHS data brief finding that video telehealth rates were lowest among those without a high school diploma (38.1%), adults ages 65 and older (43.5%), and Latino (50.7%), Asian (51.3%) and Black individuals (53.6%): <https://aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021>

of all visits in January and February of 2021. Data from Dartmouth Health shows at the start of the pandemic (March 2020) audio-only visits comprised approximately 75% of Dartmouth Health's telehealth visits. There was a consistent decrease over the next 6 months, which lead us to an average of 30% audio-only use in December of 2020. Since December of 2020, it has remained relatively stable at less than 25% of telemedicine visits being delivered as audio-only. A similar trend of decreasing audio-only visits from 2021 to a small but steady number has been reported from other provider types, as well, such as independent practice and FQHCs.

- In response to the July 2021 order issued by DFR requiring reimbursement of “at least” 75% for audio-only services, both MVP and BCBSVT are paying at 75% for the majority of audio-only services, forcing some practices to stop offering this service. All but the largest health facilities in Vermont are unable to negotiate contracts and fee schedules with commercial payers and must decide on a case-by-case basis if they are able to cover their costs with 75% reimbursement. Many small practices are also responding by limiting audio-only visits to only the most urgent patient needs.

For these reasons, we ask that DFR update the 2023 order to require reimbursement at parity for all “medically necessary, clinically appropriate” health care services delivered by telephone.

In response to the specific questions posed at the Audio-Only Work Group meeting on May 30th:

- 1. Absent parity for all phone visits, we support that the order be updated to reflect that payers cannot distinguish between provider type if implementing differential reimbursement rates.**

In response to the July 2021 order issued by DFR, both MVP and BCBSVT issued policies stating that they will reimburse at 100% for services provided by mental health providers but at 75% even when the same services are offered by primary care providers.³ (The BCBSVT policy has since been revised). At a time when primary care clinicians are providing a large percentage of mental health and substance abuse care and when the state is working to encourage treatment of MH/SUD in the mental home through Hub and Spoke and other efforts, this is counterproductive. Primary care practices surveyed have indicated that 50% or more of their visits are now mental health-related. See for example: <https://vtdigger.org/2022/03/21/dr-ashley-miller-mental-health-crisis-is-overwhelming-our-primary-care-system/>. One group of independent primary care practices queried last week indicated that mental health visits comprise 90% of their audio-only visits. At a minimum, when a payer determines that a service is “worth” 100% payment, this should be implemented regardless of provider type providing that service. **Importantly, all visits related to mental health and primary care services should be reimbursed at 100% of in-person rates, rather than simply having payers respond to a “parity” requirement by reverting to paying all providers equally at 75%.**

³ <https://www.bluecrossvt.org/documents/telephone-policy-publication-12422> (accessed in spring 2022, no longer available on website)
[2021-64-telehealth-coding-and-reimbursement-updates-for-vermont-providers.pdf \(mvphealthcare.com\)](https://www.mvphealthcare.com/2021-64-telehealth-coding-and-reimbursement-updates-for-vermont-providers.pdf)

2. We support the order being updated to reflect that payers must reimburse at 100% of in-person rates for the most common audio-only visits. We do have concerns that such differentiation will only add a layer of complexity into an already complex and confusing reimbursement scheme. Further, there are services outside those listed below that provide important access for patients, and we don't want frequency to be confused for need or importance – for example, BCBSVT reimburses for a number of important mental and behavioral health codes that do not fall in the list below. For this reason, we strongly support 100% reimbursement for all audio-only services. That said, the most common codes our practices are using for audio-only services at this time appear to be:

- Office or other outpatient visit for the evaluation and management of a new patient (99202-99205)
- Office or other outpatient visit for the evaluation and management of an established patient (99211-99215)
- Telephone evaluation and management service by a physician or other qualified health care professional (99441-99443)

Thank you for seeking input from the Working Group and provider organizations on updates to the PY2023 order. Please don't hesitate to reach out to any of us for further information or clarification.

Attachments:

- UVM Health Network Audio-Only Visits 2021-2022
- Dartmouth Health Data for Vermont Audio-Only 5/31/22