Act 6 of 2021
Audio-Only Analysis

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VERMONT
DEPARTMENT OF FINANCIAL REGULATION

The Green Mountain Care Board (GMCB) is the owner and steward of the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) which was the source of data in this presentation.

The analyses, conclusions, and recommendations from these data are solely those of the authors. The GMCB had no input into the study design, implementation, or interpretation of the findings. The analyses, conclusions, and recommendations are those of the authors alone and are not necessarily those of the GMCB. No official endorsement by the GMCB is intended or should be inferred.

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Regulation of Audio-Only Telephone Services

Act 6 of 2021 added 8 V.S.A. § 4100l, which requires health insurers to provide coverage for all medically necessary, clinically appropriate health care services delivered by audio-only telephone to the same extent that the plan would cover the services if they were provided through in-person consultation.

- Health insurers may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered by audio-only telephone;
- Health insurers may not require a health care provider to have an existing relationship with a patient in order to be reimbursed for health care services delivered by audio-only telephone.

Requirements for Providers

Under 18 V.S.A. § 9362, providers may deliver health care services to a patient using audio-only telephone if the patient elects to receive the services in this manner and it is clinically appropriate to do so.

- Providers must comply with any training requirements imposed by the provider's licensing board on the appropriate use of audio-only telephone in health care delivery;
- Providers must also document in the patient's record:
  - The patient's informed consent for receiving services using audio-only telephone;
  - The reason that the provider determined that it was clinically appropriate to deliver health care services to the patient by audio-only telephone;
- Patients receiving audio-only telephone services must be advised of their rights right to refuse to receive audio-only telephone services and to request services in an alternative format;
- Providers may not create or cause to be created a recording of a provider's audio-only telephone consultation with a patient;
- Audio-only telephone services cannot be used for:
  - The second certification of an emergency examination determining whether an individual is a person in need of psychiatric treatment;
  - a psychiatrist's examination to determine whether an individual is in need of inpatient hospitalization.

DFR Audio-Only Telephone Order

Act 6 of 2021 requires the Department, working in consultation with DVHA and the GMCB to determine reimbursement for audio-only telephone services.

- The Department solicited proposals from interested parties as to coding and reimbursement for audio-only telephone services;
- The Department received proposals from DVHA, Cigna, MVP Health Care, Blue Cross Blue Shield of Vermont, and the Coalition of Health Care Associations.

On June 29, 2021, the Department ordered that beginning January 1, 2022:

- Health insurers provide reimbursement for audio-only telephone services billed using accepted CPT language and definitions including both CPT codes for in-person services and telephone-specific E/M codes and a V3 or V4 modifier;
- Reimburse for audio-only telephone services at a rate no less than 75% of the rate for equivalent in-person or audio/visual telemedicine covered service.

Act 6 of 2021 Requirements

The Department of Financial Regulation, the Vermont Program for Quality in Health Care, and, to the extent VHCURES data are available, the Green Mountain Care Board shall present information to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding the use of audio-only telephone services in Vermont during calendar year 2022, including:

1. Information on utilization of audio-only telephone services
2. Quality of care
3. Patient satisfaction with receiving health care services by audio-only telephone,
4. The impacts of coverage of audio-only telephone services on health care costs and on access to health care services, and
5. How best to incorporate audio-only telephone services into value-based payments.

https://legislature.vermont.gov/Documents/2022/Docs/ACTS/ACT006/ACT006%20As%20Enacted.pdf

VPQHC Report & Stakeholder Engagement

- Under 18 V.S.A. § 9416, the Vermont Department of Health (VDH) contracted with the Vermont Program for Quality in Health Care, Inc. (VPQHC) and Policy Integrity, LLC to produce a report outlining population-level trends in telehealth use in Vermont, utilizing the Vermont Healthcare Uniform Reporting & Evaluation System (VHCURES).
- In alignment with Act 6 of 2021, dated March 29, 2021, VDH also contracted with VPQHC and Policy Integrity, LLC to track and stay current on the research related to healthcare quality, and audio-only telehealth.
- In October 2023, VPQHC, along with Policy Integrity, Department of Financial Regulation (DFR), and Green Mountain Care Board (GMCB), convened meetings with providers and payers to collaborate on this analysis.

VHCURES: Sources & Limitations

VHCURES is Vermont's all-payer claims database. VHCURES contains claim and eligibility information for Medicare and Medicaid beneficiaries and for most Vermonters covered by private insurance.

VHCURES does not contain complete data on the Vermont health care market because of its specific scope and the exclusion of certain payers, including:

- ERISA self-insured plans (a few may opt-in),
- Federal employee plans,
- VA & TRICARE,
- Self-pay (uninsured), and
- Payers with an average Vermont resident enrollment of fewer than 200.

There is also a variety of data that is not included in VHCURES such as capitation payments or other non-claims payments, clinical information necessary for calculating certain quality measures, financial performance information, and services not covered by insurance.

Data Selection Methodology

Identification of audio-visual and audio-only telehealth claims is challenging for several reasons:

- Each payer has different rules for submission of claims, including acceptable procedure codes, procedure code modifiers, and place of service codes.
- Payer requirements have changed frequently over the last four years, particularly in what procedure codes are covered.
- DFR adopted separate audio-only coverage and coding rules for commercial insurers to align with Vermont Medicaid.

The analytic approach used, therefore, demanded a balance between specificity (e.g., time-period specific identification of claims) and simplicity. For this report, identification was based on:

- procedure code modifier *(telehealth provided in other than in patient's home, in patient's home, or other place of service),* and
- place of service code (synchronous telemedicine service rendered via audio or via audio and video, or mental health telehealth service via audio)

The code list may be found in Appendix 1 of the forthcoming VPQHC Report. The analysis is limited to paid *professional* service claims (e.g., excluding facility claims) and claims that fall under a capitation agreement.

High Level Findings

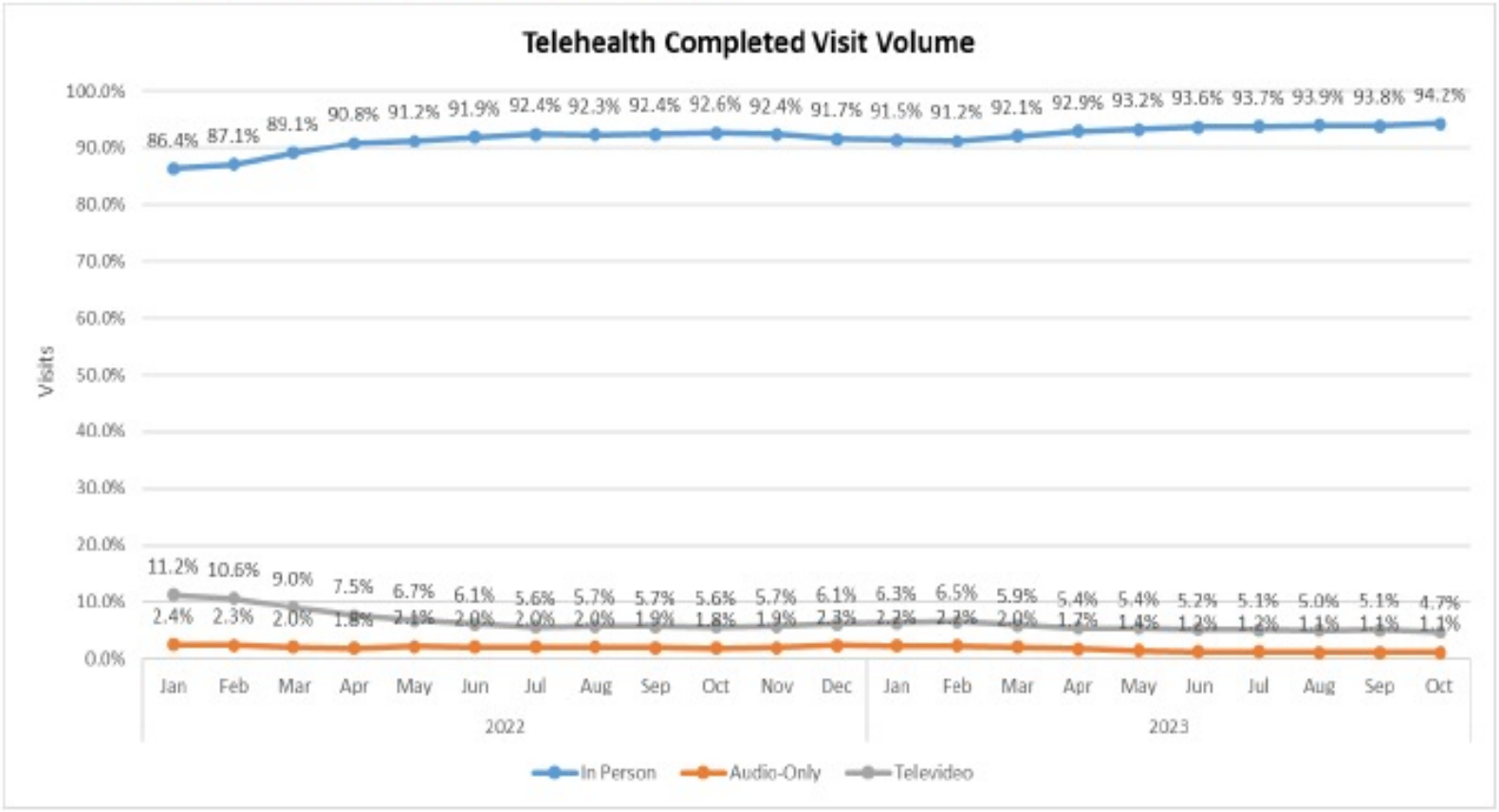
- A small number of telehealth services were being provided to Vermonters in the years before the COVID-19 Pandemic.
- The total number of professional services, including both in-person and telehealth, dropped sharply in 2020, and returned to a level comparable to the pre-COVID period in 2021.
- Telehealth (including audio/video and audio-only) services between 2020 and 2022 represented about 11 percent of all services.
- During the COVID-19 Pandemic, audio-only services represented about six percent of telehealth services and about 0.5% of all services.
- The use of telehealth services during the COVID-19 Pandemic varied somewhat among the private payers and Medicaid, typically between 10 and 20 percent of all professional services. Use by Medicare beneficiaries was substantially lower in each year, between four and eight percent.

Payer Service Counts

Payer	Service Type	2018	2019	2020	2021	2022
Blue Cross Blue Shield	Audio-Only	*	*	1,517	1,352	7,580
	All Other Telehealth	1,993	4,135	348,430	344,426	229,655
	All Other Professional	2,249,349	2,278,697	1,549,580	1,741,802	1,479,426
	Total			1,899,527	2,087,580	1,716,661
	Percent Audio-Only			*0.1%*	*0.1%*	*0.4%*
CIGNA	Audio-Only	25	31	2,266	1,168	541
	All Other Telehealth	39	60	14,643	15,696	12,787
	All Other Professional	103,489	120,695	123,603	142,302	144,183
	Total	103,553	120,786	140,512	159,166	157,511
	Percent Audio-Only	*0.0%*	*0.0%*	*1.6%*	*0.7%*	*0.3%*
Medicaid	Audio-Only	*	*	39,130	29,068	25,707
	All Other Telehealth	6,036	8,591	332,554	375,023	310,734
	All Other Professional	3,636,060	3,229,661	2,307,361	2,612,186	2,562,738
	Total			2,679,045	3,016,277	2,899,179
	Percent Audio-Only			*1.5%*	*1.0%*	*0.9%*
Medicare	Audio-Only	*	*	37,871	14,956	8,313
	All Other Telehealth	4,904	6,706	172,129	142,848	107,089
	All Other Professional	2,957,271	2,934,886	2,447,929	2,646,430	2,492,567
	Total			2,657,929	2,804,234	2,607,969
	Percent Audio-Only			*1.4%*	*0.5%*	*0.3%*
MVP	Audio-Only	*	*	1,998	1,134	2,418
	All Other Telehealth	263	595	66,596	72,387	53,936
	All Other Professional	335,675	406,466	408,010	500,308	517,352
	Total			476,604	573,829	573,706
	Percent Audio-Only			*0.4%*	*0.2%*	*0.4%*

* Cell count is less than 11

UVM Health Network Visits 2022-2023



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Service Quality

The metric for quality was articulated in a 2020 VPQHC Report: https://www.vpqhc.org/s/Final-Report-Out-Statewide-Telehealth-Workgroup-Clinical-Quality-Audio-Only-Telemedicine.pdf

> *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.*

Hailu et al. (2022), however found that conducting quality assessments based on service modality is difficult. For instance, does the digital divide limit uptake of audio/video telemedicine even if that modality is preferable?

As noted above: VHCURES does not include clinical information

Patient Satisfaction: National Studies

- Danila, et al. (2022) found that among a group of diverse, established older or underserved patients, the satisfaction rate for audio-only services was not less than audio/video telemedicine.
- Peltz, et al. (2022) found that audio-only visits had great value for specialized populations, such as older adults and homeless populations, where access to video enabled devices is lower. Audio-only visits also had value for individuals who could not communicate in English because of the difficulty of accommodating interpreters on audio/video telemedicine platforms.
- Li, et al. (2023) found that older adults depended on audio-only visits to access care when in-person care was limited. Additionally, even after adjusting for many socioeconomic factors, comfort with video chat technology is a strong predictor of satisfaction with telehealth visits over audio-only.

All research cited is available on VPQHC's website at: https://www.vpqhc.org/audioonly-telemedicine

Patient Satisfaction: Provider Responses

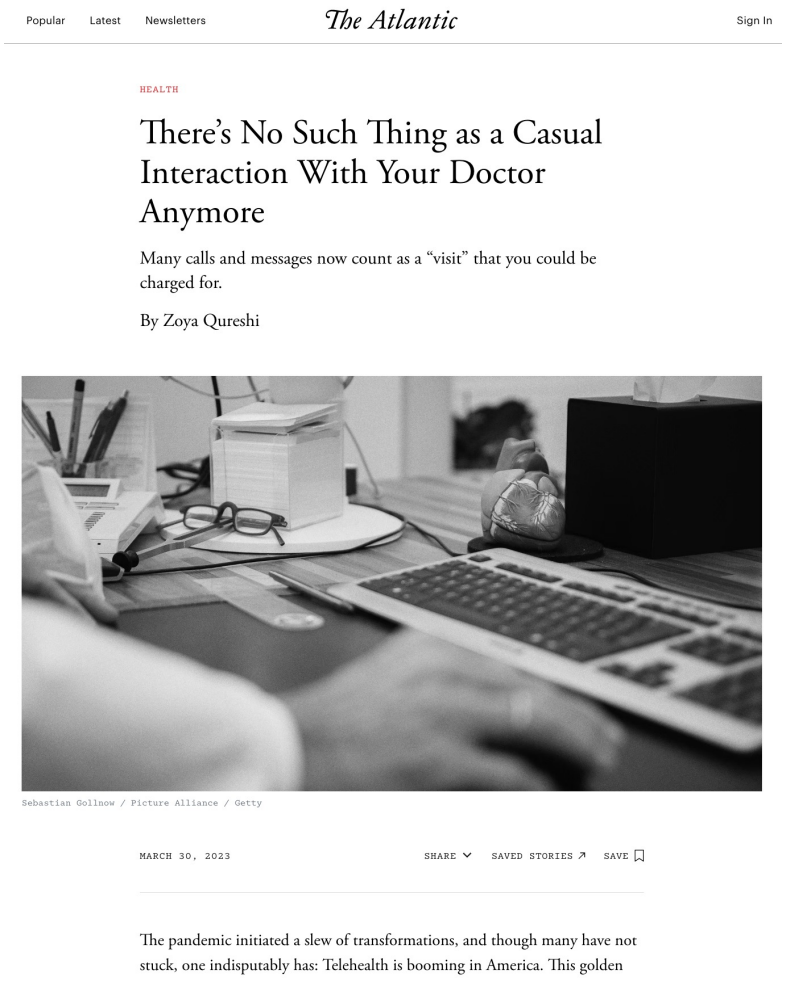
- *I have many elderly patients who avoid seeking care from October to May because they don't drive in the dark or inclement weather.*
- [audio-only] *is very important for our sick, elderly patients, with poor transportation in rural areas, some of whom are homebound, to contact us, and to develop ongoing healthcare plans and supervision.*
- *This type of appointment is usually requested by the patient.*
- *In my experience* [audio-only] *particularly served the elderly, less internet savvy and more rural, internet access challenged populations.*
- *There is no reason a clinician's time and skill are less valuable on the phone than on a screen or in person. In fact, it takes more skill and effort to provide this service. Many patients do not have good internet but almost all have phone access.*

Written comments from the Vermont Medical Society's Physician and PA Member Survey.

Patient Satisfaction: Insurer Responses

"When Jed Jacobsohn got COVID for the first time in May, he began gathering information. How long should he quarantine for? How could his two young children stay healthy? He decided to give his doctor a quick call, and after five minutes, he hung up satisfied, he told me. Next thing he knew, he had a $180 bill. His satisfaction evaporated."

- BCBSVT routinely receives customer complaints related to billing and copayments for telephone visits.



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HEALTH

There's No Such Thing as a Casual Interaction With Your Doctor Anymore

Many calls and messages now count as a "visit" that you could be charged for.

By Zoya Qureshi

Sebastian Gollnow / Picture Alliance / Getty

MARCH 30, 2023 SHARE SAVED STORIES SAVE

The pandemic initiated a slew of transformations, and though many have not stuck, one indisputably has: Telehealth is booming in America. This golden

Commercial Insurer Cost Impact

The total number of professional services claims in VHCURES, while comparable to pre-COVID levels, has not exceeded 2018 levels:

- All commercial health insurers reimburse mental health/substance use disorder (MH/SUD) services provided through audio-only at parity with in-person services.
- MVP Health Care and BCBSVT reimburse less for non-MH/SUD services
- Even if all telemedicine services were reimbursed at parity with in-person services, the overall cost of care would have only increased with medical trend, as with all other healthcare services.
- However, independent providers have reported that they do not provide audio-only services due to low reimbursement.

Holmgren, et al. (2023) found that telemedicine use is associated with greater time spent in electronic health record (EHR) systems and suggested that health systems and policymakers may need to alter productivity expectations and reimbursement policies.

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Next Steps/Questions