State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

Agency of Human Services

[Phone] 802-879-5900

To: House Committee on Health Care

From: Alex McCracken, Director of Communications and Legislative Affairs, Department of Vermont Health Access

Date: February 6, 2024
Re: Audio-Only Telehealth Services Update

Slide 1

Good afternoon. Thank you, Madam Chair, and members of the committee. For the record, my name is Alex McCracken, Director of Communications and Legislative Affairs for the Department of Vermont Health Access (or DVHA). I'm glad to be with you today, and quite excited to be delivering prepared testimony to this committee for the first time.

Slide 2

To start with some background: as a result of Public Health Emergency (PHE), we opened up codes for audio-only/telemedicine in general. Prior to this, telehealth had been allowed but underutilized. We expanded access and allowed telehealth and audio-only for many services, so that Vermonters could continue to access their medical care providers safely and easily. It should be noted that Audio-Only was always meant as an exception for when in-person, or telehealth options are not available.

DVHA made a spreadsheet with all requested codes: each time a code was requested as audio-only we recorded it and consulted this list, and eventually a very wide variety of services were allowed to be audio-only.

Slide 3

Then the PHE ended and disallowed many of the services that had been permitted as audio-only. In our work on this matter, we have been going through the codes to determine which audio-only services we can continue to cover. In this process, we first verify if there were coding errors, and if Medicare allowed it, and then affirm a decision from there. Our decisions never went against correct coding.

Concurrently, Sandi Hoffman, Deputy Commissioner for DVHA, convened a stakeholder group to talk about audio-only services that included VT Care Partners, Vermont Association of Hospitals and Health Systems, Bi-State Primary Care, Vermont Medical Society, and Vermont Health First. In gathering this group together we discussed limitations (correct coding) and fiscal concerns.

Slide 4
On 7/1 we posted all the codes that would be allowed. This was based on all requested services for 4 years – every code that was requested for audio-only, and telemedicine was reviewed and determined whether it was acceptable. After the flood, we were very generous with our allowance for audio-only. DVHA's Special Investigations Unit (SIU) conducted monthly reviews of audio-only codes and exercised some flexibility in response to flooding. For example, if a code was not allowed for audio-only, providers are required to maintain documentation to show why it was necessary and why it was the exception required, should the Department request that information.

Through this process the stakeholder group, along with the Clinical Utilization Review Board (CURB), and the Medicaid and Exchange Advisory Committee (MEAC) reviewed and weighed in. The Department spoke to each group in November on seemingly excessive audio-only billing. DVHA asked providers to reach out to their networks to ensure the issue was being looked at. Ultimately, we determined that it originated with a small number of around five providers, and it turned out to be a billing error that has since been resolved. So, we're back on track.

On our website, there is a telehealth page with a list of codes that are audio-only. If it's not on that list, there may be several reasons. There may be a more appropriate code, or it could be that the service is incorrect to code as telehealth. It's also possible that it may not have come up yet as a question for review. The current list is about half of what the maximum allowable codes were during PHE. We did analyze how often they were used; if it was only used once and not allowed by Medicare, and/or not correct coding, then we wouldn't allow it.

Slide 5
Currently, these codes are allowed through 12/31/24. We are continuing to gather data on utilization. We have seen a decrease in utilization overall for telehealth and audio-only since the height of the PHE. Utilization is decreasing steadily; some codes remain stable at an increased level, and we don't know what that level-off point is overall or for specific services. There are so many variables to consider on this, such as overall member caseload for Medicaid, and the expansion of broadband access that would theoretically decrease the need for audio-only. Again, we should note here that audio-only is supposed to be the exception for care, and that prior to the PHE providers could not bill for audio only.

Slide 6
Our main concern is this: if we see an increase in the number of office visits, a decrease in number of enrolled members, and an increase in number of audio-only services, then we can reasonably believe that the audio-only services are being billed in addition to other visits, ending up with DVHA paying for both. We see this as a potentially significant cost driver. So, if a member and provider speak over the phone and in office, covering the same information each time, Medicaid can be on the hook for both. This

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

also means if a provider calls a Medicaid member, with test results for example, that exchange could be billed under audio-only..

Slide 7
At the end of the day, we want to ensure members have access, but we also want to ensure that it is clinically appropriate. In this, we are trusting providers to communicate with members, and we have asked SIU and DVHA's Business Office to monitor utilization. Should there be a pattern for inappropriate code use for audio only, SIU may investigate, with the assumption providers will have the required documentation explaining why they used audio only.

The Department would like to take a moment to thank our aforementioned partners in this project: VT Care Partners, Vermont Association of Hospitals and Health Systems, Bi-State Primary Care, and Vermont Health First – as well as the CURB, and MEAC. We have heard some very supportive feedback, and we are glad to be engaging with the provider community on this. DVHA greatly appreciates this work, stretching back to 2022, to review decisions, provide input, and collaborate on monitoring providers.

Looking forward, we will continue to conduct our analysis. DVHA is monitoring developing research through a clinical lens, considering utilization, and working with our partners to set policy on audio-only services. We appreciate hearing what VPQHC and DFR had to say in their testimony, and we will continue to look to them on this in the future.

Slide 8
Thank you again, Madam Chair, and members of the committee. That brings me to the end of my prepared remarks, and I am happy to answer any questions that I'm able to at this time.