VERMONT ACADEMY OF FAMILY PHYSICIANS

Vermont Medical Society

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

To: House Health Care Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: February 6, 2024
RE: Support for Pay-Parity for Audio-Only Telehealth Services

The Vermont Medical Society, Vermont Academy of Family Physicians and American Academy of Pediatrics Vermont Chapter submit these comments in support of payment parity with in-person and telehealth services for audio-only telephone services.

We appreciate the work that the Vermont Program for Quality in Health Care has dedicated to analyzing use of audio-only services. You have heard concerns from both the commercial payers and DVHA regarding whether paying for audio-only services will increase cost or lead to duplicative medical appointments. However, that is not what the data is showing based on VPQ's analysis. Instead, it shows that audio-only services are a substitute for in-person services, not provided in addition – and that they are only a very small proportion of all services provided.

I would like to remind the committee that statute already restricts the circumstances when audio only services can be provided:

- There must be patient consent (18 V.S.A § 9362)
- Payers can determine which services are "medically necessary and clinically appropriate" for audio-only telehealth (8 V.S.A. § 4100k(d) – and they only cover a limited list. See the policies here:
    - https://www.bluecrossvt.org/documents/cpp24-temporary-telephone-policy-final
    - https://www.mvphealthcare.com/-/media/project/mvp/healthcare/documents/provider-policies-and-payment-policies/2024/january/mvp-payment-policies-effective-january-1-2024 (page 23)
    - https://dvha.vermont.gov/document/audio-only-telehealth-services

- 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. 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. 2022 data from UVM Health Network shows that the most common reasons for an audio-only visits in the Network were: follow-up (29%), chronic kidney disease (5%), routine prenatal visit (4%), nutrition counseling (3%), anxiety (3%) and pain (3%). They are being used in both the primary care and specialty care setting. The UVM Health Network data showed the specialties using audio-only visits ranged from Family Medicine (15%) and Clinical Laboratory (10%), to Orthopedic Surgery (7%) and Cardiology (3%). At Dartmouth Health, the specialty service lines with the most frequent use of audio-only among their telehealth services included oncology, orthopedic surgery, and the heart and vascular center.

- There are many patients for whom technological barriers make an audio-visual connection impractical including broadband access, affordability, computer equipment, comfort with technology and patient preference. Dartmouth Health 2022 data indicates 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.[1] 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. We are particularly concerned with the impact on access to care for Medicaid patients, given the overlap with lower socioeconomic status and resource challenges accessing the transportation, time off of work, and childcare needed to attend an in-person visit and the technology requirements of an audio-visual visit.

- A Vermont Medical Society member survey 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. See Attachment 1 for physician and PA comments regarding the importance of coverage for audio-only visits.

- In response to the DFR order requiring reimbursement of "at least" 75% for audio-only services, both MVP and BCBSVT are paying at 75% for many audio-only services, forcing some practices to stop offering this service. Many small practices are also responding by limiting audio-only visits to only the most urgent patient needs.

For these reasons, we ask for a requirement that payers reimburse at parity for all "medically necessary, clinically appropriate" health care services delivered by telephone.

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[1] 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 a 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