California Initiative for Health Equity & Action (Cal-IHEA)
HEALTH POLICY REPORT

Evaluating Medi-Cal Telehealth Policy for Audio-Only Visits Post-Pandemic

Pablo Cuadros, MPH
UC Berkeley School of Public Health

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EXECUTIVE SUMMARY

The COVID-19 pandemic accelerated the adoption of telehealth services for many California health care providers and systems. While many of the flexibilities to telehealth service delivery may remain permanent, the California Department of Health Care Services (DHCS) proposed removing payment parity for telephone/audio-only services after the public health emergency ends. This could have a negative impact on access to health care services for underserved populations with limited internet access, access to live video technology, or transportation or employment flexibility for an in-person visit. This policy analysis examines the impact of regulations that allow for an incremental transition from payment parity for audio-only visits to a reimbursement schedule that promotes live video visits. This approach can help to safeguard the reimbursement and availability of audio-only services for Medi-Cal providers while allowing for adequate investment in technological infrastructure that would allow safety net providers and systems to adopt and tailor accessible live video services for their populations. As more research is being conducted on the effectiveness of telehealth services through audio-only modalities, it is critical to maintain equitable access to telehealth services for all Medi-Cal patients. California's DHCS must synthesize information from critical stakeholders to guide current telehealth policy proposals with the goal of lowering barriers to access to telehealth for Medi-Cal patients while providing high-quality services.

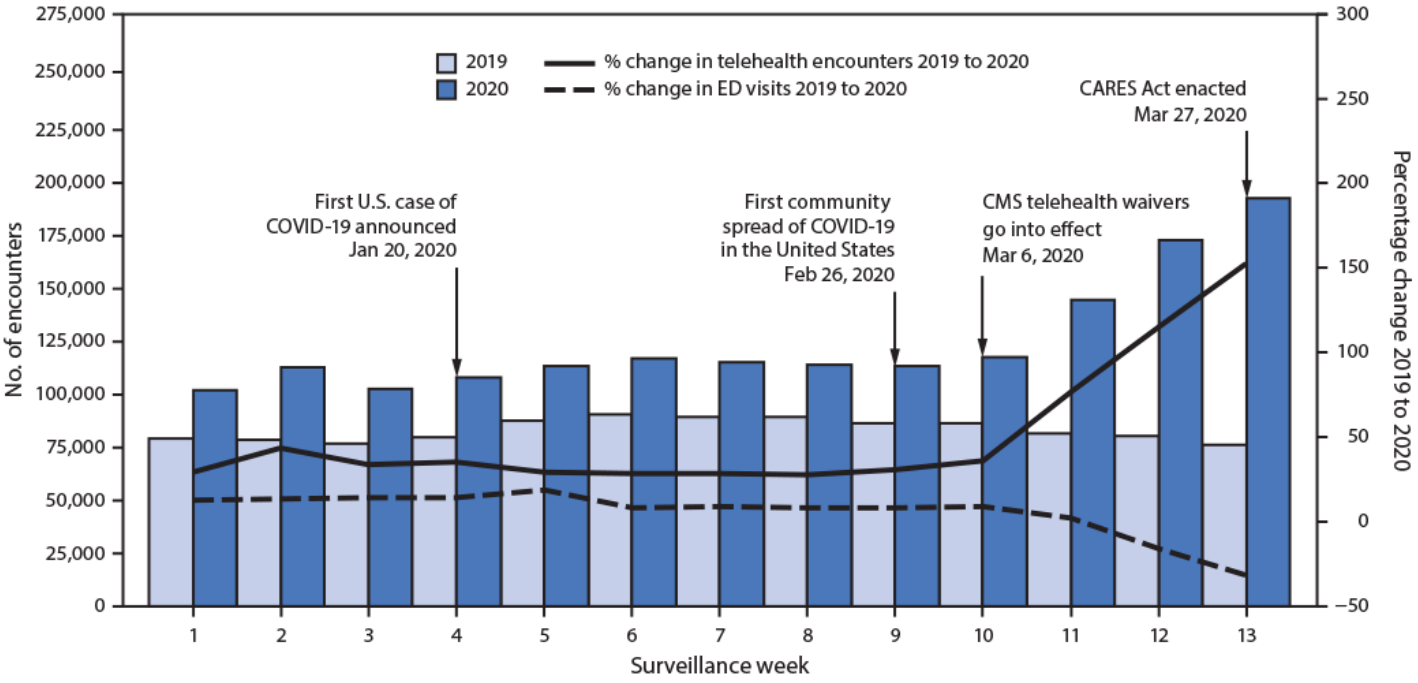
POLICY BACKGROUND

Prior to the pandemic, the Department of Health Care Services (DHCS) had coverage restrictions on telehealth service delivery based on organization, location, patient eligibility and modality. Medi-Cal restricted coverage for live video and asynchronous telehealth services while excluding audio-only services, e-consults, and remote patient monitoring. Providers were reimbursed at parity for both asynchronous and synchronous live visits. Federally Qualified Health Centers (FQHC) & Rural Health Centers (RHC) only offered coverage for telehealth to established patients and limited the services that could be provided through asynchronous modalities to ophthalmology, dermatology and dentistry. Previous regulations also limited the location that patients could receive telehealth services, which excluded them from being able to receive care in their own homes.

After the declaration of a state of emergency, implementation of 1135 waivers led to increased flexibility of telehealth service delivery. DHCS covered audio-only services, lifted location restrictions so patients could communicate with their providers from their home (if medically

appropriate), and increased flexibility so FQHC patients could receive care using various telehealth modalities. Telehealth use allowed health centers to safely care for patients while limiting the spread of COVID-19. Overall, telehealth utilization spiked early in the pandemic but has decreased since April 2020 to slightly above pre pandemic levels.

Figure 1. Trends in the Telehealth Utilization During the Emergence of the Covid-19 Pandemic



Koonin, L. M. (2020). Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic—United States, January–March 2020. *MMWR. Morbidity and Mortality Weekly Report*, *69*.

Even though DHCS has continued to reimbursement parity for all modalities, there is considerable uncertainty around the future of telehealth policy. DHCS has proposed a delineated approach to reimbursement for each modality. The department plans to permanently lift location requirements and maintain payment parity for live video visits. However, they also plan to create separate reimbursement schedules for asynchronous services and live audio visits. DHCS's proposal would not allow clinics to establish new patients through audio-only visits and FQHCs, RHCs, Tribal Health clinic providers would not be able to bill for audio-only visits at the predetermined prospective rate determined by Medicare (PPS rate). In its Post Public Health Emergency (PHE) proposal, the department noted it "does not believe it is appropriate to pay FQHC/RHC and/or non-clinic providers for less involved and less costly modalities, such as a telephonic/audio-only visits, e-consults, or e-visits, at the same rate as a visit conducted in-person or through synchronous telehealth modalities"[2].

DHCS's proposed restrictions may be detrimental for historically underserved populations in California. Even though this proposal has been made public, DHCS said they are willing to engage key stakeholders in ongoing discussions regarding the future of telehealth policy for Medi-Cal patients. California Legislature has recently released the Budget Trailer Bill (AB 133)

that maintains COVID-19 telehealth policies through December 31, 2022.[3] In the meantime, DHCS plans to consult with an advisory group to establish policies that increase access and equity amongst Medi-Cal patients before the January 2022 budget is released. The objective of this policy analysis is to identify strategies to remove barriers to telehealth access among marginalized communities in California and ensure access to quality telehealth services. This analysis entails a review of the literature surrounding the utilization and quality of telehealth services offered during the pandemic and a synthesis of information presented in grey-literature, webinars and California state informational hearings. We provide recommendations for DHCS's post-PHE telemedicine policy proposal that would facilitate equitable access to telehealth services while maintaining high levels of quality and efficiency.

EVIDENCE ASSESMENT

The central argument supporting the elimination of payment parity for telephone/audio-only services is that DHCS leadership believes the state should not provide equal payment for modalities that are less costly and less involved. However, this justification does not take into consideration the value of having certain telehealth services provided through telephone or audio-only. It is critical to examine available evidence and identify research gaps regarding the overall effectiveness and accessibility of audio-based care for the Medi-Cal population.

Utilization of Audio-only Services

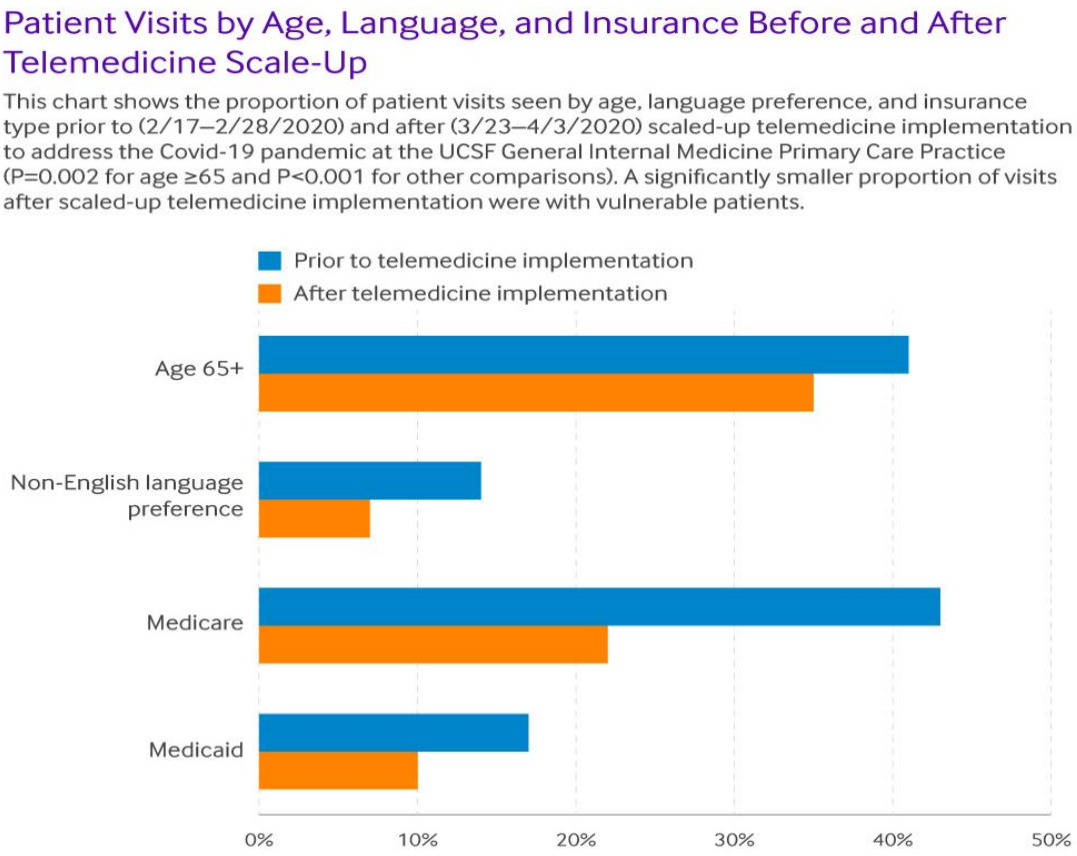
Early investigation at the start of the pandemic showed that telephone-based visits were the most commonly used mode of communication between patients and providers. As state governments added reimbursement flexibility for telehealth services, the rate of live video visits increased past the rate of phone calls. Despite the rapid growth in live video services, a significant portion of certain subgroups continued to rely on audio-only/telephone care during this time.[4] A survey administered by the California Health Care Foundation (CHCF) showed that of the 62% of respondents who received telehealth care during the start of the lockdown, approximately half of them utilized video while the other half utilized telephone services. Individuals who were <200% the federal poverty limit were more likely to utilize phone visits than those above that income level. [5] Another study that examined telephone and live video service usage amongst FQHCs showed that, during the first six months of the public health emergency, 48.5% of primary care visits were delivered via audio-only modalities while only 3.4% of visits were delivered via live video. Early evaluations of telehealth utilization among FQHC patients during the public health emergency indicate that FQHC patients continue to be reliant on audio-only modalities.[6] This suggests that placing policy restrictions on telephone-based services for Medi-Cal patients may reduce access to care for low-income Californians.

Access to Technology

Policymakers should take into consideration which populations have limited technological access or digital literacy skills that make it difficult for them to use live video visits. A study conducted at a UCSF primary care practice showed that the proportion of visits by patients aged 65 years or older, non-English speaking, or enrolled in Medicare or Medicaid decreased significantly when telemedicine was scaled-up, suggesting that these patient segments may be less equipped to

utilize telehealth when it is scaled-up.[7] A survey distributed by the California Primary Care Association to Bay Area community health care organizations examined patients' access to specific communication technologies and preferred modality to communicate with healthcare specialists. More than 65% of patients surveyed had access to a cell phone while less than 30% of respondents had access to a digital device (laptop, tablet, or computer).[8] Respondents were significantly more likely to communicate with healthcare professionals over the phone and reported access to quality video cameras was the primary barrier to using live video visits.

Figure 2. Patient Visits after Telehealth Implementation in USCF Primary Care Practice



Nouri Sarah, C, K., R, L., & KarlinerLeah. (2020). Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic. *NEJM Catalyst Innovations in Care Delivery*.

While broadband access is improving in rural counties in California, significant barriers remain to establishing telehealth services in rural health clinics. A study utilizing responses from a 2018 American Hospital Association survey found that rural hospitals were less likely to have telehealth infrastructure in comparison to urban hospitals.[9] Furthermore, an estimated 33% of rural patients in the U.S. lack access to broadband services required for live video visits—signaling a large divide in broadband internet access between rural and urban populations.[10] The federal government is considering plans to invest $100 billion in initiatives to expand broadband

access to rural communities as part of their overall infrastructure plan.[11] However, while current and future investments to bridge the digital divide (in terms of technological infrastructure) may come to fruition, it remains an important issue preventing certain patients from using video telehealth modalities in the present day.

Quality of Audio-only Communication

Although there are no recent studies available regarding the quality of audio-only services in primary care during the pandemic, a systematic review completed by the California Health Benefits Review Board (CHBRP) on the effectiveness of telephone only services in comparison to in-person visits identified three studies that exhibited the effectiveness of audio-only communication in the treatment in various clinical settings relevant to primary care. While there is limited evidence on the impact of telephone-based health care services relevant for primary care clinics, future research is needed to examine the quality of telephone services and their impact on health outcomes.

DHCS POLICY RECOMMENDATIONS

Based on the available evidence, the following actions are recommended for DHCS to facilitate an equitable transition of telehealth coverage after the public health emergency:

Delayed Sliding Scale Reimbursement Schedule:

This model suggests that DHCS and Medi-Cal facilitate an incremental decrease in payment parity between telephone and synchronous live video services once the public health emergency has ended. This reimbursement model would maintain payment parity between all telehealth service modalities for a set period of time (like a year) once the pandemic is over. Then, the reimbursement amount would decrease at a gradual pace for a subsequent period (i.e., five years). This transition would allow for much needed investments in technological infrastructure for vulnerable health care organizations, like FQHCs, who lagged implementation and interventions to improve digital literacy skills among key patient populations. At a macro-level, expanded access to broadband internet due to federal and state policy could also help to decrease barriers during this time. This model also includes a cap in the differential of reimbursement between audio and video services to ensure that access to audio-only services remains a viable and reimbursed option for Medi-Cal patients, allowing DHCS to create a pathway to its proposed reimbursement schedule for each telehealth modality without disruptive impact to FQHC or RHC patients. Moreover, having a clear and reasonable timeline to transform their care delivery would be critical toward facilitating gradual utilization of high-quality live video services that fit the needs of their patient population.

Standard Utilization Review:

To ensure both quality and equity in access between in-person and telehealth services, principles that guide payers' decision to deny coverage need to be the same for both in person and telehealth services. Modality alone should not impact a payer’s decision to deny coverage. Coverage should primarily be tied to concerns regarding costs and quality of care for each service provided. By standardizing utilization reviews of both in-person and telehealth services,

DHCS would not be inadvertently shutting down avenues for care that are more accessible to certain populations and provide sufficient effectiveness.

RECOMMENDED ACTIONS FOR MAJOR STAKEHOLDERS

The following table summarizes opportunities to maintain an accessible, high quality telehealth services for Medi-CAL patients This table includes with recommended actions for major stakeholders (California state agencies, health foundations and managed care plans):

Recommendation	Responsible Entity	Overview
Equitable Telehealth Policy Change Post Pandemic (Sliding Reimbursement Schedule, Standard Utilization Review)	DHCS, Managed Care Plans	Policy changes selected in this alternative are designed to give the healthcare organizations the ability to transform service delivery to fit the proposed requirements of proposed telehealth policies. Maintaining flexibility in the way health plans can be reimbursed for provided quality services while creating safeguards that limit a payer's ability to deny coverage solely based on modality will be critical.
Telehealth Standardization Initiative	CA Foundations, Non-profits	Centralized guidance and support systems will be critical in maintaining equitable access to telehealth services amongst all health systems. Through important to create infrastructure for these clinics through the creation of a state-wide support call center and supportive learning collaborative for FQHC networks. This will help implement accessible live video services in anticipation of proposed policy changes by DHCS
Filling in Data Gaps	Office of Statewide Health Planning and Development (OSPHD)	OSHPD could lead the charge in collecting and analyzing healthcare usage data that would inform policy decisions. Research should focus on the quality and cost-effectiveness of each telecommunication modality covered in the DHCS proposal. Data can inform reimbursement structure for telemedicine services in the future.

ABOUT THE AUTHOR

Pablo Cuadros, MPH is health policy fellow at the UC Berkeley School of Public Health. He earned a BA in Psychology from Northeastern University and MPH in Health Policy and Management from UC Berkeley. His professional interests include assessing the impact policy has on the adoption of digital health services amongst safety net patients and integrating telehealth systems in community-based organizations.

SUGGESTED CITATION

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