LAO

The 2021-22 Budget:
Analysis of the Governor's Medi-Cal Telehealth Proposal

MAY 2021

This budget series post provides (1) an overview of the Governor's January budget proposal for an ongoing, post-pandemic Medi-Cal telehealth policy; (2) an assessment of the Governor's proposal; and (3) issues for legislative consideration. We note that the Governor's proposal is primarily policy focused and would largely be implemented through budget-related legislation. With the exception of one discrete related budget item involving the establishment of a new Medi-Cal benefit, the proposal is not accompanied by budget requests for additional funding. (The administration assumes the implementation of the package of policy changes would be cost neutral.) In addition to the Governor's statutory proposal, there are legislative proposals in this subject area that currently are being considered in the policy process. We intend for this post to assist the Legislature in its deliberations on the broader, continuing issue of what ongoing Medi-Cal telehealth policy should be going forward (after the temporary telehealth-related flexibilities granted during the course of the coronavirus disease 2019 [COVID-19] come to an end).

Background

Medi-Cal Is the State's Medicaid Program. Medi-Cal is the state's Medicaid program. As a joint state-federal program, Medi-Cal costs are shared between the state and federal governments, usually with each paying 50 percent of costs. While states have significant flexibility to set their own policies around eligibility, benefits, and provider payment methodologies and rules, state policies generally must be consistent with federal Medicaid rules for federal funding to be made available. However, federal law allows states to waive certain federal Medicaid rules without having to forego federal funding, provided states meet special conditions. For example, in response to the onset of the COVID-19 pandemic, the federal government waived certain Medicaid requirements to allow states to adopt temporary health care flexibilities in their Medicaid programs.

Medi-Cal Provider Reimbursement

Medi-Cal reimburses providers for the services they provide to program beneficiaries in a variety of ways. How Medi-Cal reimburses providers can vary by the type of provider and by the delivery system through which services are provided. (There are two main Medi-Cal delivery systems, which we discuss later.) This section describes several ways providers are reimbursed in Medi-Cal.

Clinicians Typically Are Paid on Fee-for-Service or Capitated Basis. Clinicians include physicians, mental health counselors, nurse practitioners, and many other health care provider types. Clinicians who serve Medi-Cal patients generally are reimbursed in one of two ways. The first is fee-for-service, whereby Medi-Cal pays clinicians a predetermined fee for each service they deliver. When multiple billable services are provided during a patient visit, the clinician can bill individually for each of the services. Another common reimbursement methodology is capitation, whereby clinicians (usually as a member of a provider group) receive a monthly payment for each patient whose care they oversee. This "capitated" payment does not vary directly with the costs of treating each patient, but instead is intended to cover the average cost of all the provider group's patients.

Health Centers Are Subject to a Unique Medi-Cal Reimbursement Methodology. Health centers—commonly known as Federally Qualified Health Centers—are nonprofit health care clinics that provide primary care and other health care services in medically underserved areas or to medically underserved populations regardless of their patients' ability to pay. With over 1,400 locations in California and having served roughly 4 million Medi-Cal beneficiaries in 2019, health centers make up a significant portion of Medi-Cal's primary care provider network. Under federal law, health centers are entitled to a unique Medicaid reimbursement methodology known as the prospective payment system (PPS). Under PPS, health centers receive an all-inclusive payment for each patient visit, generally regardless of what individual services were provided during that visit. Medi-Cal payment rates for health centers range from as low as $64 per visit to as high as $719 per visit, depending on the health center and their services. Statewide, the average Medi-Cal health center payment rate is $215 per visit. By contrast, the average physician clinic payment in Medi-Cal fee-for-service is $84 per visit. States are allowed to waive federal PPS requirements and instead reimburse health centers for services delivered to Medicaid beneficiaries according to an alternative payment methodology. However, the alternative payment methodology must guarantee that health centers receive as much funding as they would have under PPS.

Medi-Cal Provider Reimbursement Methodologies Can Vary Depending on Delivery System. Around 80 percent of Medi-Cal beneficiaries receive care through Medi-Cal's managed care delivery system. In this system, managed care plans are responsible for arranging and paying for most Medi-Cal services, like primary care and hospital inpatient services, utilized by their members. Managed care plans generally are responsible for establishing their own provider reimbursement levels and methodologies (with fee-for-service and provider capitation being the most common methodologies). Medi-Cal beneficiaries not enrolled in managed care receive services through the fee-for-service delivery system. In Medi-Cal's fee-for-service system, providers are paid on a fee-for-service basis at reimbursement levels determined by the state.

Telehealth Modalities

A Variety of Telehealth Modalities Exist. Telehealth is not a distinct health care service, but rather a method through which health care is provided to patients. Telehealth services can be delivered through a variety of "modalities," which are the mechanisms through which telehealth services can be delivered. We describe the various telehealth modalities below.

- ***Live Video.*** Services delivered through live video are provided by a health care provider to a patient in real-time through a video system. Services delivered through live video can include both (1) services intended to replace an in-person health care visit and (2) services that are not intended to replace an in-person health care visit (such as a brief check-in with a health care provider that lasts for a short period of time).
- ***Telephone.*** Services delivered by telephone are also provided in real-time. Under this modality, the patient and health care provider cannot see each other while services are being delivered. Services delivered by telephone are often referred to as "audio-only" telehealth, and can also include both (1) services intended to replace an in-person visit and (2) services that are not intended to replace in-person visits. Generally, health care providers deliver services by telephone for a similar set of services as those delivered through live video.
- ***Non-Real-Time Exchange.*** We define non-real-time exchange as the delivery of health information through an electronic messaging system (such as secure email). Services delivered through non-real-time exchange are often referred to as "asynchronous" or "store and forward" telehealth. Non-real-time exchange usually refers to services delivered by a health care provider to a patient. (For example, a dermatologist assessing a patient based on a photograph of their skin.) However, non-real-time exchange may also refer to remote consultations between providers (such as between primary care and specialist providers), known as "eConsult."

- ***Remote Patient Monitoring.*** Remote patient monitoring refers to the tracking—by a health care provider through use of a medical device—of a patient's vital signs or other health information from a distance. Remote patient monitoring is often provided for (1) high-risk patients, such as those with heart conditions or who have been recently discharged from a hospital, and (2) patients with chronic conditions. For example, remote patient monitoring can be used to track glucose levels for patients with diabetes.

Research Findings on Telehealth

There is broad academic literature on the various aspects of telehealth service delivery. (Notably, the academic literature generally pre-dates the onset of the COVID-19 pandemic. The pandemic has changed how telehealth is used in health care delivery substantially. As such, the pre-pandemic research on telehealth may not entirely apply to the post-pandemic world.) This literature explores the clinical effectiveness of telehealth, the patient characteristics of its users, and the impact telehealth expansions have had on health care utilization (a proxy for access) and costs. This section summarizes several of the major research findings. However, in our assessment, the research on telehealth leaves open major questions. While telehealth expansions likely do increase access to care, their impacts on the quality of care (clinical effectiveness) and their fiscal impacts are less consistent and clear.

Telehealth Expansions Have Been Shown to Improve Access to Health Care, but It Is Difficult to Generalize Research Findings. Since expansions of telehealth services generally increase the convenience of seeking out health care, they have potential to improve access to health care. For example, telehealth services can help reduce the burden associated with traveling long distances for in-person health care visits, which may dissuade certain patients from accessing health care. In addition, telehealth services also can result in fewer cancelled health care appointments. Most studies examining the impact of telehealth services on access to care generally focus on specific health care service types and telehealth modalities. (For example, there are studies that examine the impact of live video mental health services and dermatology eConsults on access, respectively.) As a result, generalizing findings on telehealth's impact on access in available literature to telehealth services in general is difficult. Nevertheless, there is some research that indicates that telehealth may improve access to care in particular circumstances. For example, a recent study found that non-real-time exchange among health care providers was associated with an increase in specialist referrals to endocrinologists. Another study of a health care provider network found that a telehealth expansion resulted in an increase in total service utilization (including both in-person and telehealth services) within that network of 80 percent.

Telehealth Payment Rates May Affect Use. How providers are paid for telehealth services may affect the extent to which those services are offered and, by extension, customer utilization. The concept of covering telehealth services at the same payment rate as health care services provided in-person is known as "payment parity." A number of states have in place telehealth payment parity policies. California has a payment parity law, though it does not apply to Medi-Cal. Available research (which predates the onset of the COVID-19 pandemic) suggests that residents of states with payment parity laws utilize telehealth services to a greater extent than residents of states without such laws.

Clinical Effectiveness of Telehealth Tends to Vary by Modality and Service. Clinical effectiveness of telehealth services often is defined as the quality of outcomes after receiving telehealth services relative to the quality of outcomes after receiving the same services in-person. Studies assessing the clinical effectiveness of telehealth services have measured the quality of outcomes across several different dimensions. For example, some studies have measured the quality of outcomes through self-reported patient health information, and others have focused on measures of the processes of health care such as accuracy of treatment diagnoses. In our review of available literature, we find that the clinical effectiveness of telehealth services tends to vary depending on two main factors, which we discuss below.

- ***Modality.*** Available research indicates that there are differences in the clinical effectiveness of telehealth services based on whether services are provided through live video or through telephone. (Available research on the clinical effectiveness of telehealth services provided through non-real-time exchange or remote patient monitoring is limited.) In general, the literature indicates that telehealth services delivered through live video likely are more clinically effective than telehealth services delivered through telephone. However, whether there is a difference in clinical effectiveness based on telehealth modality also depends on the specific health care service type examined. For example, available research indicates that behavioral health services provided through telephone likely are as clinically effective as those provided through live video.
- ***Service.*** Studies examining the clinical effectiveness of telehealth generally focus on specific health care service types. (For example, one study we reviewed examined the impact of infectious disease consultations through telehealth on hospital lengths of stay.) Accordingly, extrapolating the findings in the literature to telehealth services in general is difficult. However, the available literature does indicate that there likely are differences in the clinical effectiveness of telehealth services based on health care service type. For example, available research indicates that telehealth services are particularly clinically effective for behavioral health treatment. In a 2020 survey, University of California, Los Angeles (UCLA) primary care providers reported that treatment for mental health conditions was particularly appropriate for telehealth. In the same survey, providers reported that treatment for upper respiratory infections, diabetes, and skin conditions also were appropriate for telehealth. However, in the same survey, providers reported that treatment for chest pain, shortness of breath, ear or hearing issues, and abdominal pain were not appropriate for telehealth.

Fiscal Impact of Telehealth Expansions Are Not Fully Understood. Telehealth expansions appear to have the potential to increase or decrease health care costs, likely depending on a number of factors, including the relative reimbursement rates for in-person and telehealth services (under a fee-for-service reimbursement method) and the type of health care being provided through telehealth. Our review of the literature finds that data on the fiscal impact of telehealth expansions are more limited than that available with respect to the clinical effectiveness of these expansions. Below, we highlight several outstanding questions we have about the fiscal impact of telehealth expansions.

- ***How Do Provider Expenses for Delivering Telehealth Services Differ From In-Person Services?*** In our review of the academic literature, we found little information around the extent to which the expense of delivering telehealth services from a provider perspective differs from the expense of delivering in-person health care services. While provider labor costs might be similar between the two, other expenses likely differ. For example, the delivery of telehealth services generally requires the purchase of communication technology platforms and could involve changes to providers' electronic health record systems. In-person health care services, on the other hand, require the purchasing or leasing and maintenance of a facility of the size needed to accommodate in-person visits. Providing hybrid telehealth and in-person services generally could involve incurring all the above expenses, though certain in-person expenses, such as cleaning exam rooms between each patient visit, could go down to the extent telehealth visits substitute for in-person visits. Even if the provider expenses that come with delivering telehealth and in-person services might not differ markedly in the short run, the expanded use of telehealth potentially could lower the long-run expense of delivering care if providers adapt to providing fewer in-person visits. However, as noted above, data in the academic literature that would allow us to assess the likelihood of this potential are limited.

- ***At What Level Should Telehealth Reimbursement Rates Be Set Relative to In-Person Services to Encourage Widespread Provider Participation?*** As noted earlier, research suggests that residents of states with payment parity laws utilize telehealth services to a greater extent than residents of states without such laws. However, how high reimbursement rates for telehealth services need to be to encourage widespread provider adoption of telehealth modalities remains uncertain—particularly going forward following the expansion of telehealth services that occurred during COVID-19. (We discuss the expansion that took place in California later in this post.)
- ***Do Telehealth Expansions Increase or Decrease Net Health Care Costs Overall?*** Overall, research on how telehealth expansions affect utilization suggests that they have the potential to increase net costs, however, some studies do point to potential cost savings. For instance, one study found that state mandates requiring that health insurers cover telehealth services led to reductions in hospitalizations in nonmetropolitan areas (though not in metropolitan areas). Another study found that telehealth services could lower health care costs to the extent they serve as a lower-cost substitute for in-person care. Other studies, however, show that telehealth expansions lead to increases in health care utilization overall. As discussed earlier, one study of a health care provider network found that a telehealth expansion increased overall service utilization (including both in-person and telehealth services) within that network by 80 percent. With significant increases in overall service utilization, reimbursement rates for telehealth services would have to be significantly less than those for in-person services for net health care costs to go down as a result of a telehealth expansion. On balance, telehealth expansions appear more likely to increase, rather than decrease, net health care costs unless their reimbursement rates are set at relatively lower levels compared to in-person visits.

Telehealth Impacts on Health Equity

Telehealth Expansions Have Potential to Promote Health Equity… As discussed earlier, expansions of telehealth services have potential to broadly improve access to health care (through increasing the convenience of seeking out health care). Certain population groups may especially benefit from this improved access to health care. For example, individuals who live in rural areas are especially likely to need to travel long distances for in-person health care visits. In addition, individuals with complex care needs also may have difficulty traveling to health care appointments, and individuals who face difficulties with taking time off work—who are especially likely to be low income—may not seek out in-person health care visits despite needing medical care. Accordingly, the increased convenience of telehealth services may particularly benefit these population groups, which available research has shown experience disparities in their health outcomes. To the extent that telehealth services lead to additional necessary health care services being provided to these populations, they have potential to reduce health disparities and promote health equity.

…However, Health Equity Is Not Necessarily Improved for All Populations. To the extent that telehealth expansions lead to fewer available in-person visits for services that are not appropriate to provide through telehealth—some of which we discussed earlier—they could have harmful effects on promoting health equity. In addition, telehealth expansions may not reach populations that could benefit most. For example, although low-income individuals and individuals with complex conditions are especially likely to benefit from the increased convenience that available telehealth services offer, research has shown that telehealth services are used more widely by higher-income and healthier people. In addition, available research also has found that individuals who do not speak English are substantially less likely to receive telehealth services. In the 2020 UCLA survey discussed earlier, primary care providers reported that it was easiest to provide telehealth services to individuals with higher levels of education (who are typically higher income), and difficult to provide telehealth services to people for whom English was not their

preferred language. Notably, available research also indicates that the particular modality through which telehealth services are provided also is relevant to whether telehealth expansions benefit populations that experience health disparities. For example, reflecting disparities in broadband access, receiving telehealth services through live video is more prevalent among higher-income individuals. Conversely, low-income individuals are more likely to receive telehealth services through telephone.

Telehealth in Medi-Cal Before and During COVID-19

In early 2020, the federal government declared a national public health emergency in response to the onset of the COVID-19 pandemic and waived certain Medicaid health care delivery requirements for the duration of the emergency. In California, the Department of Health Care Services (DHCS) used this authority to adopt several temporary flexibilities in the Medi-Cal program related to the delivery of telehealth services. In this section, we summarize both (1) the state's Medi-Cal telehealth policy as it existed prior to the COVID-19 pandemic and (2) the state's current temporary Medi-Cal telehealth policy (which is authorized by the federal government to continue until the end of the declared national public health emergency).

Prior to COVID-19, Medi-Cal Covered Certain Services Delivered Through Telehealth. In 2019, DHCS adopted a permanent Medi-Cal telehealth policy after a process of stakeholder engagement and public comment. This Medi-Cal telehealth policy, which was in effect until the onset of the COVID-19 pandemic (specifically at the time the national public health emergency declaration was made), allowed for the coverage of certain Medi-Cal services delivered through certain telehealth modalities. Notably, under this telehealth policy, the Medi-Cal program covered (1) telehealth services provided through live video and (2) telehealth services provided through non-real-time exchange, if a health care provider determined the service to be clinically appropriate. With the exception of eConsult, the Medi-Cal program covered these services at the same payment rate as services provided in-person. In addition, under this telehealth policy, the Medi-Cal program also covered brief patient check-ins with health care providers over the phone. These services were not covered at payment parity. The above coverage requirements applied to both fee-for-service health care provider reimbursement and reimbursement to health care providers through capitation.

Outside of the fee-for-service and capitated reimbursement models, under this Medi-Cal telehealth policy there were specific exceptions for certain health care provider types. For example, counties generally were able to be reimbursed at payment parity for behavioral health services delivered through telephone. (In California, counties generally are responsible for providing both mental health services for severe mental illness and substance use disorder services through Medi-Cal, and receive reimbursement for these services through a separate reimbursement model.) In addition, while Medi-Cal covered live video and certain non-real-time exchange services at health centers at payment parity, health center patients generally could only receive telehealth services on location at the health center (with the provider attending remotely). Health centers also were not allowed to establish new patients through telehealth modalities. **Figure 1** on the next page contains a description of the state's Medi-Cal telehealth policy as it existed just prior to the COVID-19 pandemic, and compares it to the state's policy during the pandemic and as proposed by the Governor to continue after the pandemic on an ongoing basis. The latter two sets of policies are discussed below and later in this post, respectively.

During the COVID-19 Pandemic, the State Temporarily Expanded Telehealth Flexibilities to Ensure Continued Access to Health Care. As discussed earlier, in response to the onset of the COVID-19 pandemic, the state has implemented temporary COVID-19 telehealth flexibilities in Medi-Cal, which expire at the end of the national public health emergency. Notably, these temporary flexibilities include coverage of telehealth services provided through telephone at payment parity (including at health centers through PPS). Furthermore, several of the state's temporary Medi-Cal telehealth flexibilities pertain specifically to health centers. These include (1) removing the requirement for a patient to be present at the health

Figure 1

Medi-Cal Telehealth Policy Before, During, and Proposed for After COVID-19 Pandemic

		Before COVID-19	During COVID-19	Proposed for After COVID-19[a]
Fee-for-Service and Managed Care Network Clinicians[b]				
Live Video	**Covered benefit?**	Yes, for new and established patients.	Yes, for new and established patients.	Yes, for new and established patients.
	Reimbursement policy	Parity with in-person services.	Parity with in-person services.	Parity with in-person services.
Telephone	**Covered benefit?**	Yes, but generally limited to brief check-ins, for established patients.	Yes, for new and established patients.	Yes, for established patients.
	Reimbursement policy	Brief check-in reimbursement rates.	Parity with in-person services.	Separate fee schedule developed by DHCS.[c]
Non-Real-Time Exchange	**Covered benefit?**	Yes, for new and established patients.	Yes, for new and established patients.	Yes, for established patients.
	Reimbursement policy	Store and forward at parity with in-person services, eConsult at separate rate.	Store and forward at parity with in-person services, eConsult at separate rate.	Separate fee schedule developed by DHCS.[c]
Remote Patient Monitoring	**Covered benefit?**	No	No	Yes, for established patients.
	Reimbursement policy	N/A	N/A	Separate fee schedule developed by DHCS.[c]
Health Centers				
Live Video	**Covered benefit?**	No with exceptions.[d]	Yes, for new and established patients.	Yes, for new patients who live in service area, and established patients.
	Reimbursement policy	N/A	Parity with in-person services (at PPS rates).	Parity with in-person services (at PPS rates).
Telephone	**Covered benefit?**	No	Yes, for new and established patients.	No
	Reimbursement policy	N/A	Parity with in-person services (at PPS rates).	N/A
Non-Real-Time Exchange	**Covered benefit?**	No with exceptions.[d]	Yes, for opthalmology, dermatology, and dentistry for new and established patients.	No
	Reimbursement policy	N/A	Parity with in-person services (at PPS rates).	N/A
Remote Patient Monitoring	**Covered benefit?**	No	No	No
	Reimbursement policy	N/A	N/A	N/A

[a] As proposed in the Governor's 2021-22 budget through budget-related statutory language.

[b] This section describes policy for clinicians that provide care through Medi-Cal's managed care and fee-for-service delivery systems. Clinicians working within Medi-Cal's other delivery systems, such as school-based care and behavioral health providers, are subject to their own pre-COVID-19 telehealth policies. The Governor's proposed payment parity policy would allow managed care plans to reimburse their network providers for telehealth services at rates other than parity when mutually agreed between the plan and provider.

[c] The proposed budget-related statutory changes would authorize but not require DHCS to develop and use a separate fee schedule. Accordingly, DHCS would have authority to reimburse for some or all of these services at parity with in-person services.

[d] While live video and certain non-real-time exchange telehealth services are covered at health centers (and reimbursed at parity with in-person services), a patient generally can only receive the telehealth services on location at the health center. Given this requirement, these services at health centers generally involve a telehealth visit with a specialist attending from a distant site.

COVID-19 = coronavirus disease 2019; DHCS = Department of Health Care Services; and PPS = prospective payment system.

center to receive telehealth services (allowing beneficiaries to receive telehealth services at home) and (2) allowing health centers to provide telehealth services to both new and established patients. Figure 1 contains a description of the state's temporary Medi-Cal telehealth flexibilities.

Expanded Telehealth Flexibilities Likely Have Helped Sustain Service Utilization in Medi-Cal During Pandemic. During the COVID-19 pandemic (and especially in the initial months), utilization of in-person care plummeted. To ensure continued access to care, health care providers began to increase availability of telehealth services. (A 2020 study found that among commercially insured enrollees, the number of telehealth visits increased from 17 visits per 10,000 enrollees enrollees in March 2019 to 650 visits per 10,000 enrollees in April 2020.) The state's temporary Medi-Cal telehealth flexibilities likely have helped sustain access to health care for Medi-Cal beneficiaries during the pandemic. For example, DHCS data indicate that telehealth visits in the Medi-Cal program rose to a high of over 11,000 per 100,000 beneficiaries in April 2020 (compared to just 285 per 100,000 beneficiaries in April 2019).

Governor's Proposal

The Governor proposes budget-related legislation to change Medi-Cal telehealth policies on a permanent basis. With the exception of the remote patient monitoring benefit discussed below, these changes are expected by the administration to be cost neutral and generally would take effect once the COVID-19-related national public health emergency ends. Many components of the proposal may need to receive federal approval in order for there to be federal financial participation in the expanded telehealth services.

Governor Proposes to Make Permanent Some Medi-Cal Telehealth Flexibilities Adopted in Response to Pandemic… As shown in Figure 1, the Governor proposes to extend and make permanent some, but not all, of the Medi-Cal telehealth flexibilities that were temporarily adopted during the COVID-19 pandemic. Major telehealth flexibilities proposed to be made permanent include, for example, (1) coverage of telehealth services through telephone for providers other than health centers (2) removal of the requirement for beneficiaries to be on location at health centers to access telehealth services, and (3) allowing health centers to provide live video services to both new and established patients.

…And Discontinue Others, in Particular Policies Related to Coverage for Services Through Telephone. As previously noted, the Governor does not propose to extend and make permanent all the telehealth flexibilities that were adopted during the pandemic. Under the Governor's proposal, flexibilities not extended would expire at the end of the national COVID-19 public health emergency. Most notably, the Governor proposes ending payment parity for services provided through telephone (instead paying for them according to a new fee schedule that would be developed by DHCS) and eliminating Medi-Cal coverage of services through telephone at health centers. The administration has indicated that it is open to re-examining coverage of telehealth services through telephone and other telehealth modalities at health centers within the context of broader reform of the health center payment model (through the alternative payment methodology for health centers discussed earlier).

Governor Also Proposes to Modify Longer-Standing Medi-Cal Telehealth Policies. The Governor's proposal also would modify some longer-standing Medi-Cal telehealth policies (with changes taking effect after the declared national public health emergency ends). For example, while the Governor's proposed permanent Medi-Cal telehealth policy generally would require payment parity for live video services, Medi-Cal managed care plans would not be required to conform to payment parity requirements for live video in cases where they come to an agreement with a provider on an alternative reimbursement rate or methodology. In addition, the Governor's proposal would allow for non-real-time exchange services to

be reimbursed through Medi-Cal at an alternative fee schedule (not at payment parity). (However, we understand that the administration intends to keep reimbursement rates at parity for certain non-real-time exchange services.)

Governor Proposes Adding New Remote Patient Monitoring Benefit. As previously discussed, remote patient monitoring is a telehealth service through which clinicians receive physiological data on their patients that is collected by remote monitoring devices, with the goal of better managing the patients' care. The Governor's budget proposes to make remote patient monitoring a Medi-Cal benefit available beginning in 2021-22 through providers other than health centers, where the benefit would not be reimbursable under Medi-Cal. Unlike the other proposed Medi-Cal telehealth policy changes, the Governor assumes the addition of remote patient monitoring would affect Medi-Cal costs. To fund this new benefit, the Governor proposes spending $34 million General Fund ($94.8 million total funds) in 2021-22 and ongoing.

Assessment

Given Potential for Improved Access, Components of Governor's Proposal Have Merit. As discussed earlier, expansions of telehealth services have potential to increase overall access to health care. Furthermore, Medi-Cal beneficiaries—who generally are low income and who may have complex care needs—may be particularly likely to benefit from the increased convenience that telehealth services offer. Accordingly, the permanent extension of certain telehealth flexibilities could lead to improved access to health care—beyond the end of the declared national public health emergency—for Medi-Cal beneficiaries. Given the potential that expansions of telehealth services have to improve overall access to health care (especially for Medi-Cal beneficiaries), we find that the components of the Governor's proposal that make permanent current flexibilities have merit. These include (1) maintaining coverage of telehealth services through telephone for providers other than health centers and (2) maintaining that Medi-Cal beneficiaries do not need to be on location at health centers to receive telehealth services.

However, Proposed Limits on Health Center Flexibilities to Provide Telehealth Services Going Forward Could Impede Access and Work Against Efforts to Promote Health Equity. As discussed earlier, health centers make up a significant portion of Medi-Cal's primary care provider network. In 2019, roughly one-third of all Medi-Cal beneficiaries accessed health care services through health centers. During the COVID-19 pandemic, the majority of telehealth services delivered through health centers were provided through telephone, rather than through live video or other telehealth modalities. This is consistent with research that shows that differences in broadband access contribute to low-income individuals being less likely to receive telehealth services through live video (and more likely to receive telehealth services through telephone). However, the Governor does not propose to permanently allow for Medi-Cal coverage of telehealth services through telephone at health centers. Not continuing coverage for this modality could substantially impede access to care for the significant number of Medi-Cal beneficiaries receiving services at health centers. Moreover, the Governor's proposed permanent Medi-Cal telehealth policy would create differences in access to health care *among* Medi-Cal beneficiaries depending on which health care provider they receive services from. For example, under the Governor's proposed permanent Medi-Cal telehealth policy, a Medi-Cal beneficiary with a primary care provider based at a health center would not be able to receive services through telephone, while a beneficiary with another primary care provider would be able to. We find that this inconsistency in Medi-Cal coverage among program beneficiaries—which could create inequities within the Medi-Cal beneficiary population—lacks a sufficient policy rationale.

Governor's Proposal Would Implement Different Telehealth Payment Policies Between Medi-Cal and Commercial Insurance, Potentially Affecting Access. Under current law, commercial health plans must reimburse telehealth services (including telehealth services provided through telephone) at parity with in-person services. By contrast, the Governor's Medi-Cal telehealth proposal potentially would set reimbursement levels for certain telehealth services at lower rates than in-person services, creating a difference in telehealth reimbursement policy between Medi-Cal and commercial insurance. Given the role that reimbursement rates can play in encouraging service availability, this difference could create or exacerbate disparities in access to telehealth services between individuals with commercial insurance and Medi-Cal beneficiaries. The proposed limitations in Medi-Cal coverage of telehealth services at health centers may widen these disparities since health centers make up a significant portion of Medi-Cal's primary care network.

Several Outstanding Questions on Proposed Payment Rate Policies. As previously noted, and among other changes, the Governor proposes paying for live-video telehealth services at parity with in-person visits and paying for services delivered through telephone on a separate fee schedule (except at health centers, where these services would not be reimbursable). Setting payment rates at appropriate levels is important for encouraging clinically effective care (the appropriate type of care) and discouraging clinically ineffective care. Additionally, to ensure services are made available, payment rates must at least cover the marginal cost of the service rendered. The Governor's proposed policies for setting payment rates raise a number of outstanding questions, which we explore in the following bullets.

- ***How Would Payment Parity for Live-Video Telehealth Services Affect Access?*** Higher reimbursement rates for a given service encourage health care providers to deliver the service and thereby facilitate access to that service while lower reimbursement rates do the opposite. By setting reimbursement rates for live-video telehealth services equal to those for in-person visits, the Governor's proposed policies generally would encourage providers to make live-video telehealth services available at comparable levels to in-person services (to the extent telehealth is appropriate). Accordingly, this proposed reimbursement rate policy could significantly increase access to live-video services and, in doing so, improve the convenience of obtaining care for patients and delivering care for providers. This improved access to live-video telehealth likely would partially substitute for in-person care—and thereby maintain access while improving patient and provider convenience—while also partially being in addition to in-person care—thereby increasing overall access.
- ***How Would Lower Reimbursement Rates for Services Through Telephone Affect Access?*** The Governor's proposal to set telehealth services provided through telephone at an alternative fee schedule—likely with lower reimbursement rates—could discourage providers from making these visits available at comparable levels to in-person services. However, the added convenience and potentially lower expense of delivering these telehealth services nevertheless could encourage reasonably widespread provider adoption of this modality. At this time, how these reimbursement rates would compare to in-person reimbursement rates is unknown, pending the administration's development of the alternative fee schedule for these services. Ultimately, we likely would not know what reimbursement levels are sufficient for encouraging reasonable access to telehealth services through telephone until after changes to Medi-Cal telehealth policy have been in place for one or more years following the pandemic.
- ***How Would Proposed Reimbursement Rate Policies Affect the Quality of Care?*** As previously discussed, certain telehealth modalities, such as live-video telehealth, have been shown to be clinically effective for treating a variety of conditions. However, evidence of the clinical effectiveness of

other telehealth modalities is less robust and certain health conditions are not amenable to diagnosis and treatment via telehealth and instead require an in-person visit. Providing telehealth services may be more attractive than providing in-person services due to their potentially superior convenience and the possibly lower expense of their delivery. If providers receive high reimbursement rates for telehealth services relative to the services' delivery expense, providers may elect to provide telehealth services even in cases where in-person care would be more appropriate. This could negatively affect the quality of care. The state could consider these incentive effects in setting reimbursement rates for telehealth services.

- ***Is the Current Health Center Reimbursement Model Appropriate for Live-Video Telehealth Services?*** As previously discussed, health centers generally receive an all-inclusive payment rate known as PPS for each Medi-Cal patient visit, rather than being paid for each service delivered during the visit. PPS rates in the state range from $64 to $719 per visit depending the health center, averaging $215 per visit. One reason why PPS rates are higher than a typical visit to a physician clinic is that health center visits often include additional services on top of a standard checkup. Such additional services—which often are reimbursed through health centers' per-visit payment rate—can include dental services, mental health counseling, the dispensing of prescription drugs (including the cost of the drugs themselves), and even transportation. While some of these services can be provided via telehealth (mental health counseling, for example), others cannot (the dispensing of prescription drugs). Nevertheless, under the Governor's proposed reimbursement policy, telehealth reimbursement rates for live-video services provided by health centers still would cover the average cost of providing these additional services, even those not deliverable via telehealth. This raises the question of whether health centers' current payment methodology is appropriate for live-video services.
- ***What Are the State's Options for Reimbursing Telehealth Services at Health Centers?*** Changing how health centers are paid, such as through waiving their federal entitlement to PPS, is a complicated process that is constrained by federal rules. Accordingly, what options the state has for reimbursing health centers at rates other than those dictated by PPS is not entirely clear. While reimbursing health centers for telehealth services at lower rates than PPS may be the most reasonable option, finding a methodology for doing so that conforms with federal rules could prove challenging. Potential policy options include (1) making broad changes to how health centers are reimbursed through waiving PPS and adopting an alternative payment methodology (such as a value-based payment methodology), (2) reimbursing at least certain telehealth services at Medi-Cal fee-for-service rates, and (3) establishing separate PPS rates for in-person and telehealth services.

Administration's Assumption That the Proposal Generally Does Not Have a Net Fiscal Impact Warrants Scrutiny. Although the Governor's proposed Medi-Cal telehealth policy likely would generate various costs and savings in Medi-Cal, the administration has not provided a fiscal estimate of its proposal (with the exception of the remote patient monitoring component). Rather, the administration has shared that, on net, it assumes the fiscal impact of the proposal is zero. (The administration assumes that potential increased costs due to increased utilization of telehealth services would be offset by the lower cost of providing telehealth services and reductions in more costly interventions due to increased access to preventative care.) We question the reasonableness of this assumption. In particular, we think that significant net costs could arise over the long term to the extent that telehealth expansion significantly increases overall service utilization, and reductions in costlier interventions do not materialize to the extent necessary to offset these costs. As discussed earlier, research has found that

previous telehealth expansions have increased total service utilization (in-person and telehealth services together) by as much as 80 percent. In deciding on which aspects of the Governor's Medi-Cal telehealth policy to approve, the Legislature could consider the associated fiscal risks and ask the administration for more information on why generally assuming cost neutrality is reasonable.

Consider Deferring the Establishment of Ongoing, Post-Pandemic Medi-Cal Telehealth Policy

The Governor's January budget proposed significant changes to Medi-Cal telehealth policy, which generally would take effect after the end of the COVID-19-related national public health emergency. Changes to the Governor's proposal could be forthcoming in the May Revision. The Legislature also is currently deliberating telehealth-related statutory proposals in the policy process. This post broadly analyzes and raises outstanding questions about what Medi-Cal telehealth policy should be going forward. As we discuss below, setting ongoing Medi-Cal telehealth policy involves a number of important policy considerations, many of which may benefit from more deliberation than this year's budget process has allowed.

Given Outstanding Questions and Concerns, Setting Ongoing Medi-Cal Telehealth Policy Now May Be Premature. As discussed earlier, the Governor proposes to establish a permanent Medi-Cal telehealth policy following the many telehealth policy changes that have been put in place during the COVID-19-related public health emergency. This proposed ongoing telehealth policy would maintain some, but not all, of the temporary COVID-19 Medi-Cal telehealth flexibilities and make other changes to long-standing Medi-Cal telehealth policy. These changes would take place before a number of outstanding questions could be answered related to the clinical effectiveness and fiscal impact of telehealth services, the impact of telehealth services on health equity, and the appropriateness of payment rates for telehealth services.

Consider Extending Current Flexibilities on a Temporary Basis. Given the many outstanding questions about what permanent Medi-Cal telehealth policy should be, the Legislature could consider generally extending the current temporary flexibilities through 2021-22 to allow for greater deliberation over what ongoing Medi-Cal telehealth policy should be. If the COVID-19-related national health public health emergency expires on December 31, 2021 as assumed by the Governor's January budget, an extension through 2021-22 reflects a six-month extension of current Medi-Cal telehealth policy. Extending current Medi-Cal telehealth policy would come with General Fund (and federal fund) costs and likely would require approval from the federal government.

Consider Approving Remote Patient Monitoring Benefit and Extending Its Availability to Health Centers Now. As previously discussed, the Governor proposes adding a new telehealth benefit called remote patient monitoring at an annual General Fund cost of $34 million beginning in 2021-22. We do not have concerns with the proposed addition of this new Medi-Cal benefit. However, we find that the Governor's proposed prohibition on health centers from being reimbursed for this new benefit lacks a policy rationale. Specifically, we find the exclusion of health centers raises equity concerns as a significant portion of Medi-Cal beneficiaries would not be able to access the new benefit through their primary care providers. Accordingly, the Legislature could consider extending the Governor's proposed new remote patient monitoring benefit in Medi-Cal to health centers. Doing so would result in additional costs and likely would require federal approval. In our review of other states' Medicaid telehealth policies, we find that gaining federal approval for health center reimbursement of remote patient monitoring at an alternative fee schedule than PPS (which could potentially reduce the costs of this extension) is possible.

Consider Convening a Workgroup to Develop and Evaluate Options for Longer-Term Medi-Cal Telehealth Policy. The Legislature could consider directing DHCS to convene a workgroup to develop and evaluate the state's options for longer-term Medi-Cal telehealth policy. The workgroup could include representatives from the Legislature, administration, and the Medi-Cal stakeholder community. The workgroup would be tasked with evaluating the benefits and trade-offs of various policy options related to Medi-Cal coverage of and reimbursement for telehealth services. Specifically, the workgroup could evaluate the potential impacts of various telehealth coverage and reimbursement policies on access, the quality of care, health equity, and Medi-Cal program costs. For example, the workgroup could evaluate what is an appropriate and federally permissible telehealth reimbursement methodology for health centers. If consensus could be reached, the workgroup could offer recommendations on what longer-term Medi-Cal telehealth policy should be. The workgroup would report back to the Legislature on its findings during the 2022-23 budget process.

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