California Policy Needs During COVID: Telehealth

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I. Introduction

The COVID-19 pandemic has highlighted the importance of telehealth in delivering critical care when individuals are not able to receive health care services and supplies in person. During the Public Health Emergency (PHE), California has implemented various policy changes to ensure that Medi-Cal beneficiaries are receiving the health care they need, including through telehealth services. Studies are already showing that these measures have benefited Californians during the pandemic.[1] Many of the state's policy changes should be continued after the pandemic ends so that telehealth services can continue to improve access to health care.

Telehealth is not a distinct service, but another way that providers deliver health care to their patients. California has a robust set of policies that guaranteed telehealth services for Medi-Cal beneficiaries, such as the 2019 update to the Medi-Cal Manual on Telehealth.[2] Many of the policies other states are implementing as a result of COVID-19 were already in place in California. Some of those include permitting the patient's originating site to be anywhere, including, but not exclusive to, a hospital, medical office, community clinic or the person's

[1] *See, e.g.*, Elizabeth Morrison & Elizabeth Horevitz, *Clinicians Call for Making COVID-19 Emergency Telehealth Benefits Permanent*, California Health Care Found.(Aug. 21, 2020), https://www.chcf.org/blog/clinicians-call-making-covid-19-emergency-telehealth-benefits-permanent/?_cldee=bGV3aXNAaGVhbHRobGF3Lm9yZw%3d%3d&recipientid=contact-9696896f5e19e61180e85065f38b3281-fb5c99d6f8ac457e93657a2c8dbae31d&utm_source=ClickDimensions&utm_medium=email&utm_campaign=Behavioral%20Health_2020_Q3&esid=fc858e19-0ff9-ea11-a815-000d3a9bf0b7. *See also*, Yohualli Balderas-Medina Anaya et. al, *Telehealth & COVID-19: Policy Considerations to Improve Access to Care*, UCLA Center for the Study of Latino Health & Culture (2020); https://latino.ucla.edu/wp-content/uploads/2020/05/Telehealth-COVID-19-Report.pdf.

[2] *See* Cal. Dep't Health Care Servs., *Revised Medi-Cal Telehealth Manual* (Jan. 2020) (hereinafter Telehealth Manual).

home.[3] Medi-Cal also already authorized providers to determine if a particular service or benefit was clinically appropriate to be delivered via telehealth.[4]

Although California's existing policies already enabled the use of telehealth among Medi-Cal beneficiaries, the state (along with the federal government) instituted various flexibilities during the PHE in order to expand telehealth access. This issue brief describes what flexibilities should or should not remain after the pandemic and what other changes are needed that are not currently in place.

II. Flexibilities that should be continued

A. Reimburse for audio-only telephone calls

One of the most significant changes made during the pandemic is the ability to reimburse for services provided via telephone without video, both in Medi-Cal Fee-for-Service as well as in Managed Care Plans (virtual or telephonic communication also includes brief communications).[5] During the PHE, the Department of Health Care Services (DHCS) and Managed Care Plans must provide the same reimbursement rate for a service rendered via telephone or virtual communication, as they would if the service was rendered via video or another form of communication, as long as it is medically appropriate for the beneficiary.[6] This change should remain after the PHE ends since many low-income individuals have limited access to devices that enable live video-conferencing interactions, like computers or tablets, and/or do not have broadband access at home.[7]

B. Allow enrollment online and over the phone

DHCS should also continue to allow online enrollment for services and permanently lift requirements for wet signatures. For example, although the Family PACT program had already offered family planning services through telehealth, one key change that took place during the pandemic was permitting Family PACT enrollment and recertification via telehealth or other virtual and telephonic communications modalities. This was a change that advocates sought during the Medi-Cal Telehealth Policy comment process, which was not adopted, and that

[3] *Id.*
[4] *Id.*
[5] *Id.* Before the public health emergency, Medi-Cal only covered two main telehealth modalities: (1) audio-visual, two-way, real time communication (synchronous) or (2) "asynchronous store-forward communication," including e-consults.
[6] *See* Cal. Dep't Health Care Servs., *Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)* (June 23, 2020), https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications-6-19.pdf.
[7] *See* Pew Res. Center., *Internet/Broadband Fact Sheet* (June 12, 2019), https://www.pewresearch.org/internet/fact-sheet/internet-broadband/.

hopefully will continue after the pandemic. Requiring family planning patients to enroll in person to then receive a one-time or time-sensitive service via telehealth defeats the purpose of these flexibilities.

C. Clarify that a patient-provider relationship can be established via a telehealth interaction

Although the Medi-Cal Provider Manual permits a provider to offer telehealth services whenever the provider determines telehealth is clinically appropriate, DHCS and DMHC should also adopt a policy to clarify that an in-person visit is not required in order to establish a patient-provider relationship. During the PHE, the establishment of an in-person relationship through telehealth is allowed. Yet this has not been made clear in the Medi-Cal Telehealth Manual; it only states that a telehealth service is allowed when the provider deems it appropriate. It is important to have a clear policy that allows for a new patient-provider relationship to be established via telehealth and not require a patient to have an in-person visit before doing a telehealth visit with that provider. An update to the Manual should include such a policy as long as it meets appropriate standards of care. Beneficiaries should not be required to first have an in-person visit with a provider before they seek telehealth services through that same provider even after the PHE ends.

III. Protections that should be restored

The Medi-Cal Provider Manual on Telehealth already allows oral or written consent by the Medi-Cal beneficiary.[8] While this policy should continue, confidentiality protections such as HIPAA and other state privacy laws should resume when the public health emergency ends. It is important to safeguard the privacy rights of all health patients, including Medi-Cal beneficiaries, since loosening these protections would mean that confidential and sensitive information of low-income populations would be at risk.

IV. Changes Needed That Are Not Currently in Place

A. Adopt policies that "bridge the digital divide" and close other gaps that impede access to telehealth

Low-income households, rural communities, as well as Black and Latinx populations lack access to broadband that enable telehealth utilization.[9] Policymakers should expand efforts to ensure access to these technology devices and infrastructure, as well as to digital literacy that will improve equity and reduce health care disparities. California should work aggressively and

[8] *See supra* note 2. Telehealth Manual.
[9] *See* Pew Research Center, *Internet/Broadband Fact Sheet* (June 12, 2019), https://www.pewresearch.org/internet/fact-sheet/internet-broadband/.

promptly expand access to broadband (high-speed internet), making it available and affordable to low-income, rural, and other underserved populations on Medi-Cal.

Additionally, Medi-Cal beneficiaries should have access to devices that enable a telehealth interaction. Both DHCS and the Department of Managed Health Care should offer telehealth technologies, like smartphones and tablets, as supplemental benefits for Medi-Cal beneficiaries. Additionally, certain individuals with access to computers do not always know how to use them properly, particularly those who are older, less educated, Black or Latinx.[10] Digital literacy is also critical for Medi-Cal providers and their staff who work with these patients. The state and managed care plans should conduct extensive public outreach, including trainings targeted to Medi-Cal beneficiaries and low-income communities, as well as Medi-Cal providers and their staff.

In addition to covering audio-only telephone calls, Medi-Cal should also cover text messaging as well as other email-based communications for a number of reasons. First, text-based communications for behavioral health services has proven to be an effective way of keeping providers in constant contact with patients. Second, more low-income patients are more likely to have access to a telephone that allows text-messages rather than video-conferencing. Third, text-messaging services offers patients added privacy if they live in a household with other people or are survivors of intimate partner and domestic violence.[11] Washington and Colorado are already covering text-based services under Medicaid.[12]

B. Reimburse for Remote Patient Monitoring

Medi-Cal still does not reimburse for services delivered via remote patient monitoring (RPM), which at least twenty-two states already allow.[13] RPM involves the use of telehealth technologies to collect medical data, such as vital signs and blood pressure, from patients in one location in order to electronically transmit that information to health care providers in a different location. This modality enables more frequent monitoring and consultation between patients and providers without requiring the former to leave the safety of their homes. A study

[10] *See* U.S. Dep't of Education, *A Description of U.S. Adults Who Are Not Digitally Literate*, Statistics In Brief (May 2018), https://nces.ed.gov/pubs2018/2018161.pdf.
[11] *See* Abigail Coursolle & Allison Smith, Nat'l Health L. Program, *Medicaid Beneficiaries Need Better Access to Behavioral Telehealth Services* (Aug. 19, 2020), https://healthlaw.org/medicaid-beneficiaries-need-better-access-to-behavioral-telehealth-services/.
[12] *Id.*
[13] *See* Center for Connected Health Pol'y, *State Telehealth Medicaid Fee-For-Service Policy: A Historical Analysis of Telehealth: 2013-2019* (2020), https://www.cchpca.org/sites/default/files/2020-01/Historical%20State%20Telehealth%20Medicaid%20Fee%20For%20Service%20Policy%20Report%20FINAL.pdf?utm_source=Telehealth+Enthusiasts&utm_campaign=9f1c503f72-EMAIL_CAMPAIGN_2020_01_17_11_12&utm_medium=email&utm_term=0_ae00b0e89a-9f1c503f72-353227725.

conducted by UCLA showed that California Latinxs have responded very well to RPM monitoring of blood pressure during the pandemic.[14]

C. Measure Telehealth Outcomes

The pandemic offers us with an opportunity to study the outcomes of those who are and should be benefiting from telehealth. The evidence is clear: Latinxs, Black, and other communities of color in California are at increased risk of, and are experiencing higher rates of serious illness and death from COVID-19.[15] California policymakers and researchers should analyze the health outcomes among low-income Medi-Cal beneficiaries. State and local entities should also fund research on telehealth best practices for patient safety and effectiveness.

Conclusion

The COVID-19 pandemic and PHE has demonstrated that telehealth is critical to further guarantee health care access for Medi-Cal beneficiaries. California has been prepared to meet the challenge in many instances, but there is more work to be done and the need for it will continue well after the PHE ends.

List of Recommendations

- Medi-Cal should reimburse for audio-only telephone calls if the provider deems the service to be appropriate through this modality.
- Medi-Cal should continue to allow online enrollment for services and permanently lift requirements for wet signatures.
- The Department of Health Care Services and the Department of Managed Health Care should clarify that a first-time patient-provider relationship can be established via a telehealth interaction.
- Confidentiality protections such as HIPAA and other state privacy laws should be restored when the public health emergency ends.
- The state should adopt policies that bridge the digital divide and close other gaps that impede access to telehealth.
- Medi-Cal should reimburse for text-based services.
- Medi-Cal should reimburse for remote patient monitoring.

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[14] *See* Yohualli Balderas-Medina Anaya et. al, *Telehealth & COVID-19: Policy Considerations to Improve Access to Care*, UCLA Center for the Study of Latino Health & Culture (2020); https://latino.ucla.edu/wp-content/uploads/2020/05/Telehealth-COVID-19-Report.pdf.

[15] *See* Rong-Gong Iin II, *California Latino, Black residents hit even harder by coronavirus as white people see less danger*, LOS ANGELES TIMES (June 27, 2020), https://www.latimes.com/california/story/2020-06-27/california-latinos-black-people-hit-even-harder-by-coronavirus.

- The state should study the outcomes of those who are and should be benefiting from telehealth, particularly Medi-Cal beneficiaries.