An Independent Licensee of the Blue Cross and Blue Shield Association

March 16, 2022

The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair
Senate Committee on Health

Re: HB 1980 HD2 – Relating to Telephonic Services

Dear Chair Keohokalole, Vice Chair Baker, and Committee Members:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify in strong support of HB 1980, HD2, which permits, but does not require or prohibit, Medicaid, health insurers, mutual benefit societies, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances. Clarifies that telephonic services do not constitute telehealth. Effective 1/1/2060.

HMSA strongly supports this measure to increase access to behavioral health care services in Hawaii. We believe that access to behavioral health care, especially in rural areas, poses a challenge for the entire health care community and that this bill will aid in addressing that issue.

Thank you for the opportunity to testify in strong support of HB 1980 HD2.

Sincerely,

Matthew W. Sasaki
Assistant Vice President
Government & External Relations

DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. BOX 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committee on Health
Wednesday, March 16, 2022
1:05 p.m.
Room 225 and Via Videoconference

On the following measure:
H.B.1980, H.D. 2, RELATING TO TELEPHONIC SERVICES

Chair Keohokalole and Members of the Committee:

My name is Colin M. Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to permit, but not require, Medicaid, insurance providers, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances and to clarify that telephonic services do not constitute telehealth.

Initially, we point out that our State insurance laws ***do not*** currently prohibit health plans from voluntarily providing coverage for health services delivered via standard telephone contacts.

This bill, in part, amends Hawaii Revised Statutes (HRS) §§ 431:10A-116.3, 432:1-601.5, and 432D-23.5, by adding a new subsection (g). H.D. 2 of this bill has revised this subsection so that it would not prohibit health plans from voluntarily covering services.

The term “medically necessary" is used on p. 7, lines 15-16; p.12, lines 11-12; and p.17, lines 4-5 of this bill. We note that “medical necessity” is addressed in HRS § 432E-1.4.

Thank you for the opportunity to testify on this bill.

+DAVID Y. IGE
GOVERNOR

CATHY BETTS
DIRECTOR

JOSEPH CAMPOS II
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 15, 2022

TO: The Honorable Senator Jarrett Keohokalole, Chair
Senate Committee on Health

FROM: Cathy Betts, Director

SUBJECT: **HB 1980 HD2– RELATING TO TELEPHONIC SERVICES.**

Hearing: Wednesday, March 16, 2022, 1:05 p.m.
Via Videoconference, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports the intent of this bill and offers comments.

PURPOSE: The purpose of the bill permits, but does not require or prohibit, Medicaid, health insurers, mutual benefit societies, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances. Clarifies that telephonic services do not constitute telehealth. Effective 1/1/2060. (HD2)

The SD1 amended the measure by:

(1) Specifying that telephonic behavioral health services may be covered if in-person behavioral health services have been provided to a patient within twelve, rather than six months prior to the telephonic service;
(2) Clarifying that coverage of telephonic services by an insurer, mutual benefit society, or health maintenance organization is neither required nor prohibited;
(3) Changing the effective date to July 1, 2060, to encourage further discussion; and
(4) Making technical, nonsubstantive amendments for the purposes of clarity, consistency, and style.

The SD2 made further amendments by:

(1) Removing an inconsistency to clarify that telephonic behavioral health services may be covered by Medicaid, health insurers, mutual benefit societies, and health maintenance organizations; and
(2) Making technical, nonsubstantive amendments for the purposes of clarity, consistency, and style.

The Department supports the measure's intent to permit the use of telephonic behavioral health care with conditions and clarifies that telephonic care is not the same as an in-person visit or a real-time video-conference telehealth visit.

During the pandemic, the use of telehealth for many services increased; this is particularly the case for behavioral health services. Also, during the pandemic, the Med-QUEST Division (MQD) increased flexibility to use telephonic modality for all types of clinical services, including behavioral health services. The increased flexibility has been helpful during the pandemic when access to in-person care was limited. Flexible telephonic service also acknowledges and seeks to remedy digital health disparities for individuals without access to audio-visual technology needed for telehealth, such as populations in rural communities or geographic areas that lack internet access or infrastructure and those without "smart" devices.

As the pandemic has worn on, both nationally and locally, Medicaid programs, payers, and healthcare providers have been monitoring and evaluating the use of telehealth and the use of the telephone for healthcare services' clinical outcomes, quality costs, and program integrity. Thus far, the area of behavioral health has shown to have relative equivalency in outcomes for in-person, telehealth, and telephonic visits. Additionally, under some conditions, other health care services for some individuals have proven to be effective, particularly when a patient's real-time audio-visual healthcare visit is not feasible or not preferred.

Thank you for the opportunity to testify on this measure.

UNIVERSITY OF HAWAIʻI SYSTEM
Legislative Testimony

Testimony Presented Before the
Senate Committee on Health
March 16, 2022 at 1:05 p.m.
By
Jerris Hedges, MD, Dean and
Lee Buenconsejo-Lum, MD, FAAFP
Associate Dean for Academic Affairs & DIO
John A. Burns School of Medicine
And
Michael Bruno, PhD
Provost
University of Hawaiʻi at Mānoa

HB 1980 HD2 – RELATING TO TELEPHONIC SERVICES

Chair Keohokalole, Vice Chair Baker, and members of the committee:

Thank you for the opportunity to present testimony today. The John A. Burns School of Medicine (JABSOM) supports HB 1980 HD2 which permits, but does not require, Medicaid, insurance providers and health maintenance organizations to cover telephonic behavioral health services under certain circumstances.

Since 1999, the use and expansion of telehealth services and technology in Hawaii has been recognized as a way to increase access and reduce delays to health care, particularly in rural areas of the state. Many of the highest-risk patients reside in Medically Underserved Areas (MUA), are part of Medically Underserved Populations (MUP), or reside in federally-designated health professional shortage areas. Telehealth via telephonic communication benefits many in these communities. Elderly, as well as medically- and socially-complex patients often face transportation barriers and difficulty navigating our collective system of health care. Patients with behavioral health issues are especially vulnerable and frequently require immediate attention. The inability of behavioral health and other patients to access the internet presents an even greater barrier to much needed health care.

We note that Medicare and Medicaid pay equally for telephonic and telehealth services, recognizing the importance of telephonic services. 42 CFR § 410.78 defining telehealth services provides as follows:

> "(3) Interactive telecommunications system means, except as otherwise provided in this paragraph, multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. For services furnished for purposes of diagnosis, evaluation, or treatment of a mental

health disorder to a patient in their home, **interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology.** A modifier designated by CMS must be appended to the claim for services described in this paragraph to verify that these conditions have been met." Emphasis added.

One of the realities for Hawai'i is that many of those most in need of telephonic care (limited means to travel, poor or absent internet coverage, residence remote from care providers, infirm with limited mobility, immune compromise in the age of COVID, etc.) suffer the most from a lack of provider reimbursement for telephonic coverage. Without telephonic coverage, these at-risk individuals must travel from their residence to clinics and emergency departments at great personal expense or choose to do without care guidance altogether. This measure is a positive step toward recognizing the value of telephonic health care services.

Thank you for the opportunity to provide testimony on this bill.

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the Senate Committee on Health
Wednesday, March 16, 2022; 1:05 p.m.
State Capitol, Conference Room 225
Via Videoconference

RE: HOUSE BILL NO. 1980, HOUSE DRAFT 2, RELATING TO TELEPHONIC SERVICES.

Chair Keohokalole, Vice Chair Baker, and Members of the Committee:

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS THE INTENT** of House Bill No. 1980, House Draft 2, RELATING TO TELEHEALTH., and offer **PROPOSED AMENDMENTS** for your consideration.

By way of background, the HPCA represents Hawaii's Federally Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines to over 150,000 patients each year who live in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

This bill, as received by your Committee, would allow insurance reimbursement for telephonic behavioral health services This bill would apply to Medicaid (Chapter 346, Hawaii Revised Statutes (HRS)), accident an health or sickness insurance contracts (Article 10A of Chapter 431:10A, HRS), benefit societies (Article 1 of Chapter 432, HRS), and health maintenance organizations (Chapter 432D, HRS).

This bill would take effect on January 1, 2060.

For people with adequate broadband access, telehealth was intended to be a lifeline for the provision of essential primary health care services. Yet, because rural and underprivileged communities lack adequate broadband access, they are effectively cut off from primary care. Many are forced to bear their maladies until it became necessary to go to the emergency room.

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

During the COVID pandemic, we learned how effective the use of standard telephone contact in telehealth was. For many in very isolated communities, the poor, and especially for our kupuna who are not as technologically advanced as their keiki, the landline telephone was a lifeline to primary health care providers.

Our member FQHCs can attest to how effective standard telephonic contact was in the provision of primary care and behavioral health to their patients, especially when the State and counties issued restrictions on the number of patients who could enter waiting areas and examination rooms. As we stated in our testimony in 2020 and 2021, telephonic telehealth has always been used as the option of last resort for primary care, and I'm sure that the MedQUEST Division can confirm this through its actuarial data of loss costs. HPCA's concern has always been and continues to be the accessibility of primary care for ALL patients.

The HPCA also notes that recent developments in Medicare might provide an alternative approach that might be less problematic from both a policy and a drafting perspective.

On November 2, 2021, the Centers for Medicare and Medicaid Services (CMS) released its 2022 Medicare Physician Fee Schedule Final Rule. This regulation added certain services to the Medicare telehealth services list through December 31, 2022. "Category 3" services that were added to the Medicare services list for the duration of the federal public health emergency (PHE), which would have otherwise been removed after the PHE ended, will remain on the telehealth service list through the end of calendar year 2023.

Beyond the expanded service list, CMS amended the definition of "interactive telecommunications system" to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes under certain circumstances. Generally, however, other services on the Medicare telehealth services list, unless specifically excepted, must still be furnished using audio and video equipment permitting two-way, real-time interaction communication.

This Committee may wish to consider the inclusion of a definition for "interactive telecommunications system" that provides the basic requirements applicable for audio-only communications, and then allow MedQUEST to amend the specifics pertaining to health care providers, as they deem it necessary, and subject to inclusion into the State Medicaid Plan and approval by CMS.

Ultimately any change to the benefits provided through Medicaid in the State of Hawaii must be approved by the federal government.

If similar language was applied to accident an health or sickness insurance contracts (Article 10A of Chapter 431:10A, HRS), benefit societies (Article 1 of Chapter 432, HRS), and health maintenance organizations (Chapter 432D, HRS), the same benefit would be applicable to ALL consumers. Specific concerns could also be addressed through rulemaking by the Insurance Commission for these chapters.

If it is good enough for Medicare and Medicaid why not private insurance as well?

For your consideration, attached please find proposed amendments that would integrate the definition of "interactive telecommunications system" from the 2022 Medicare Fee Schedule Final Rule into Hawaii's Telehealth Law. These amendments would allow audio-only telecommunications for the diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home if the patient is not capable of, or does not consent to, the use of video technology.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

attachment

THE HOUSE OF REPRESENTATIVES
THIRTY-FIRST LEGISLATURE, 2022
STATE OF HAWAII

H.B. NO. 1980 H.D. 2 S.D. 1 DRAFT

A BILL FOR AN ACT

RELATING TO TELEPHONIC SERVICES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Section 346-59.1, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Reimbursement for services provided through telehealth by way of an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary."

SECTION 2. Section 346-59.1, Hawaii Revised Statutes, is amended by amending subsection (g) to read as follows:

"(g) For the purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Interactive telecommunications system" means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and distant site physician or practitioner; provided that for services furnished for purposes of diagnosis, evaluation, or tratment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only

communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology; and provided further that the term shall have the same meaning as the term is defined in Title 42, Code of Federal Regulations Section 410.78, as amended.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based

communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. [~~Standard~~] Except as otherwise provided for in this section, standard telephone contacts, facsimile transmissions[,] or e-mail text, in combination or by itself, does not constitute a telehealth service [~~for the purposes of this section~~]."

SECTION 3. Section 431:10A-116.3, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Reimbursement for services provided through telehealth by way of an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an

originating site unless a health care provider at the distant site deems it necessary."

SECTION 4. Section 431:10A-116.3, Hawaii Revised Statutes, is amended by amending subsection (g) to read as follows:

"(g) For the purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Interactive telecommunications system" means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and distant site physician or practitioner; provided that for services furnished for purposes of diagnosis, evaluation, or tratment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology; and provided further that the term shall have the same meaning as the term is defined in Title 42, Code of Federal Regulations Section 410.78, as amended.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other nonmedical environments such as school-based

health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. [~~Standard~~] Except as otherwise provided for in this section, standard telephone contacts, facsimile transmissions[,] or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter."

SECTION 5. Section 432:1-601.5, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Reimbursement for services provided through telehealth by way of an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary."

SECTION 6. Section 432:1-601.5, Hawaii Revised Statutes, is amended by amending subsection (g) to read as follows:

"(g) For the purposes of this section:

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter

453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Interactive telecommunications system" means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and distant site physician or practitioner; provided that for services furnished for purposes of diagnosis, evaluation, or tratment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology; and provided further that the term shall have the same meaning as the term is defined in Title 42, Code of Federal Regulations Section 410.78, as amended.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider

through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. [~~Standard~~] Except as otherwise provided for in this section, standard telephone contacts, facsimile

transmissions[,] or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter."

SECTION 7. Section 432D-23.5, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Reimbursement for services provided through telehealth by way of an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary."

SECTION 8. Section 432D-23.5, Hawaii Revised Statutes, is amended by amending subsection (g) to read as follows:

"(g) For the purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a

provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Interactive telecommunications system" means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and distant site physician or practitioner; provided that for services furnished for purposes of diagnosis, evaluation, or tratment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive

telecommunications system but the patient is not capable of, or does not consent to, the use of video technology; and provided further that the term shall have the same meaning as the term is defined in Title 42, Code of Federal Regulations Section 410.78, as amended.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-

quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. [~~Standard~~] Except as otherwise provided for in this section, standard telephone contacts, facsimile transmissions[,] or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter."

SECTION 9. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 10. This Act shall take effect upon its approval.

Report Title:
Medicaid; Accident and Sickness Insurance; Mutual Benefit Societies; Health Maintenance Organizations

Description:
Conforms Hawaii's Telehealth Law to Medicare standards by clarifying that telehealth services be reimbursed for telehealth services provided by way of an "interactive telecommunications system"

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Wednesday, March 16, 2022 at 1:05 PM
Via Video Conference

Senate Committee on Health

To: Senator Jarrett Keohokalole, Chair
Senator Rosalyn Baker, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: HB 1980, HD2 – Comments
Relating to Telephonic Services

My name is Michael Robinson, Vice President of Government Relations & Community Affairs at Hawaiʻi Pacific Health. Hawaiʻi Pacific Health is a not-for-profit health care system comprised of its four medical centers – Kapiʻolani, Pali Momi, Straub and Wilcox and over seventy locations statewide with a mission of creating a healthier Hawaiʻi.

I am writing to provide comments on HB 1980, HD2 which permits, but does not require, Medicaid, insurance providers and health maintenance organizations to cover telephonic behavioral health services under certain circumstances.

Since 1999, the use and expansion of telehealth services and technology in Hawaii has been recognized as a strategy to increase patient access to healthcare by overcoming the geographic challenges across our state. Many of Hawaii's geographically access challenged patients reside in Medically Underserved Areas (MUA), are part of Medically Underserved Populations (MUP), or reside in federally designated health professional shortage areas. Elderly, as well as medically- and socially complex patients often face transportation barriers, limited broadband access and personal difficulty navigating the technological requirements of accessing traditional video telehealth care services. In these instances, telephonic communication becomes a viable alternative for many in these communities to overcome barriers enabling them to access healthcare remotely.

HPH supports the development of a provider reimbursement system that also incorporates reimbursement for telephonic services. The same barriers that pose challenges for patients to access behavioral health are often similar to the challenges we have experienced with our patients accessing acute care services (limited means to travel, poor or absent internet coverage, residence remote from care providers, infirm with limited mobility, immune compromise in the age of COVID, etc.). As a related example,

within HPH charges for telephonic services represent 12-15% of total charges for remote physician to patient acute care service charges indicating a need for telephonic services as an alternative care modality. In the absence of telephonic services being provided or available, these at-risk individuals would have had to resort to travel from their residence to clinics and emergency departments at great personal expense or choose to do without care guidance altogether.

We therefore hope to foster a telehealth environment in Hawaii that allows both patients today the ability to access behavioral health services remotely without unnecessarily foreclosing future opportunities to develop alternative reimbursement structures for other remote access modalities to flourish.

Thank you for the opportunity to testify.

Hawai‘i Psychological Association

For a Healthy Hawai‘i

P.O. Box 833
Honolulu, HI 96808
www.hawaiipsychology.org
Phone: (808) 521 -8995

COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair
DATE: March 16, 2022 1:05 PM. - VIA VIDEO CONFERENCE – Room 225

The Hawai‘i Psychological Association (HPA) offers these comments <u>supporting the intent of HB1980 HD2 to expand access to behavioral health, with important clarifications.</u>

HB1980 HD2 revises four sections of Hawaii's health insurance code for Medicaid; Private Insurance Plans; Benefit Societies; and Health Maintenance Organizations, by providing that telephonic behavioral health services may be provided when:

> (1) Telehealth services are technologic[1]ally unavailable at the time the patient is scheduled to receive a behavioral health service;
> (2) The behavioral health service is a medically necessary, covered health care service; and
> (3) The health care provider has provided the patient with an in-person behavioral health service no longer than twelve months prior to the telephonic service;

According to the committee report accompanying the HD1 of this bill, "**<u>[t|his measure expands access</u>** to remote behavioral health care services." HPA believes that to better comport with the spirit and intent of this bill – amendments to clarify the conditions for coverage are needed.

First, it is very important that access to and health equity in mental health care be actually *expanded* by this proposal, as recent research indicates strong disparities between those who use audio versus video services – particularly along racial, ethnic, linguistic, financial, and age-specific lines. On February 2, 2022, the United States Department of Health and Human Services (DHHS) issued a policy brief entitled "<u>National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services</u>"[2] which reported:

> *"[O]ur study findings are consistent with research studies that show **disparities in audio-only vs. video- enabled telehealth modalities by race/ethnicity, age, education, income, and health insurance coverage**. In a recent survey study, patients with a household income of $50,000 or more were 34 percent more likely to choose a telehealth visit than those making less than $50,000. . . . Although research shows that video visits offer some additional benefits compared with telephone visits, they require more complex setup, video-enabled devices, and broadband internet access, which may present **barriers for older adults, lower income households, and those with limited English proficiency.** In addition to these factors, patients with lower incomes may be more likely to use audio-only services because they are at work during appointments or lack privacy at home. Consistent with these concerns, **we also found lower use of video-enabled telehealth services among adults with low-incomes and those without a high school degree**."*

[1] https://www.capitol.hawaii.gov/session2022/CommReports/HB1980_HD1_HSCR154-22_.htm
[2] <u>https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf</u>

Second, expanding access to audio-only mental health therapy actually promises to improve patient outcomes. It is well-established in the research that behavioral health services administered over the telephone is not only as effective, but **sometimes more effective than face-to-face therapy**. For example, in one study published in Clinical Psychology: Science and Practice (v15 n3, September 2008), researchers concluded that: "**telephone-administered psychotherapy can produce significant reductions in depressive symptoms. Attrition rates were considerably lower than rates reported in face-to-face psychotherapy."**

Third, to best achieve the intent of this bill, and optimize clinical mental health outcomes, we urge this committee to address certain ambiguities in this bill.

For example, it is not clear what might constitute "**technologically unavailable".** Would it be possible for an elderly patient with poor eyesight and declining manual dexterity to refuse to use telehealth video-conferencing and talk with their therapist on the phone instead? What about the patient with social anxiety who prefers audio-only treatment? Will there be coverage if that patient turns off the video in a Zoom call, but not if they decide to connect using the telephone? What type of paperwork and authorization process would be needed to monitor this requirement, and will it hinder timely, life-saving care? If the internet connection is poor and/or spotty, will the patient and practitioner be required to maintain the video if they both agree phone would be better? Our membership has experienced multiple glitches and connection issues through video-conferencing during the pandemic. If interpreted too broadly, "technologically unavailable" can lead to dangerous and life-threatening situations if a patient cannot communicate with their therapist in a time of need.

Another ambiguity relates to the requirement that "**the behavioral health service is a medically necessary, covered health care service."** This language may not be necessary given the implicit nature of health insurance plans. If a service is not covered, it would not be outlined in the plan and there would be no need to address this in statute.

Furthermore, the requirement that the "**provider has provided the enrollee with an in-person behavioral health service no longer than twelve months prior to the telephonic service**" unnecessarily constrains the clinical judgment of the mental health provider. While a time-specific in-person visit may be vital for the proper treatment for many physical ailments and conditions, such as Cancer, Parkinson's Disease, Epilepsy, etc., such regimen and structure may not be necessary in many or most mental health contexts. Particularly concerning would be situations where a patient and his or her mental health provider are unable to meet in person during an extended period, or perhaps it was determined that such a meeting was unnecessary, or the patient is not able-bodied, and has difficulty using transportation. We don't want logistical barriers, health conditions, or other irrelevant barrier to cause a patient to forego treatment, and subsequently relapse or decompensate due to triggering circumstances. We don't want this language to be an unnecessary barrier to life-saving communication.

Fourth, as for policy developments on the national level, we note that **the Centers for Medicare and Medicaid Services (CMS) expressly includes telephone and audio-only communications technology in its definition of "interactive telecommunications system" when administering**

"telehealth" for mental disorders. We encourage this committee to consider capitalizing on the trailblazing work in the telehealth policy of our publicly funded health insurance plans, and adopt similar language that seeks to balance access, care, equity, utilization, and costs.

If telephone contact counts as "telehealth" for Medicare, why can't our private plans do the same?

Finally, we would like to respond to any resistance against "parity" for reimbursements for telephone contacts vis-à-vis video contacts as potentially creating unsustainable cost and coverage conditions for insurers and consumers. HPA believes that any unsubstantiated fear of fraud or unnecessary loss costs should not justify depriving access to many vulnerable populations, nor should it warrant a failure to provide reimbursement that is on par (and in some cases exceed) the level of and effectiveness of care provided by video-based telehealth.

The pandemic has had devastating effects not only to our public health system and economies, but to our collective mental health. The disruptions, anxieties, depression, substance abuse, and chronic stress that COVID has created in our lives - prolonged now for over two years – have brought many in our community to the brink of emotional collapse. The need for mental health services could not be more apparent or pressing; and we must all do what is necessary to address this burgeoning need. We all deserve access to quality mental health services.

We believe with important clarifications, ensuring audio-only treatment, as telehealth or otherwise, as a covered expense in the administration of mental health services is crucial to improving patient outcomes, expediting timely service, and ultimately reducing costs and unnecessary administrative functions. HPA thus supports such an effort and greatly appreciates legislative action to ensure old tools, like the standard telephone, are available to assure adequate lines of communication stay open; and that necessary treatment is available to those who are: not comfortable with video-conferencing platforms; not equipped with the necessary technology or equipment due to expense; or those who live on the more remote neighbor islands or in rural areas - out of reach of necessary broadband network capabilities.

Thank you for the opportunity to provide input on this important bill.

Sincerely,

Alex Lichton, Ph.D.

Alex Lichton, Ph.D.
Chair, HPA Legislative Action Committee

March 16, 2022 at 1:05 pm
Via Videoconference

Senate Committee on Health

To: Chair Jarrett Keohokalole
Vice Chair Rosalyn H. Baker

From: Paige Heckathorn Choy
Associate Vice President, Government Affairs
Healthcare Association of Hawaii

Re: Submitting Comments
HB 1980 HD 2, Relating to Telephonic Services

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

We write today with **comments** on this measure, which seeks to allow reimbursement for telephonic behavioral health services in certain circumstances. Hawaii has been at the forefront of telehealth adoption, which has increased access and shown the merits of this modality of providing care. The pandemic accelerated adoption of telehealth by more patients and providers here in Hawaii and the entire country, prompting key policy-makers—including Medicare—to change rules around use and reimbursement of telehealth to make it more accessible than ever before.

One of the ways in which telehealth has been expanded both in Hawaii and across the country is by allowing telephonic or audio-only services to be used for services in which a patient may not have reliable access to critical internet services or would sincerely prefer to use telephonic services. This flexibility has been especially meaningful for seniors, residents in areas with difficulty accessing internet services, and individuals seeking mental health services because it has made it easier to access very limited professional help.

The legislature has for years recognized the great promise of telehealth and supported policies that would put Hawaii at the forefront of innovation in this policy space. We believe that there are discussions that need to be continued to ensure that patients receive the highest level of care while ensuring proper use of the technology and that this measure offers a step in that direction. Thank you for your consideration of our comments.

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Government Relations

Testimony of
Jonathan Ching
Government Relations Director

Before:
Senate Committee on Health
The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair

March 16, 2022
1:05 p.m.
Via Videoconference

Re: HB 1980, HD2, Relating to Telephonic Services

Chair Keohokalole, Vice Chair Baker, and committee members, thank you for this opportunity to provide testimony on HB 1980, HD2, which permits, but does not require, Medicaid, insurance providers, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances.

Kaiser Permanente Hawai‘i provides the following COMMENTS on HB 1980, HD2.

Kaiser Permanente Hawai‘i is Hawai‘i’s largest integrated health system that provides care and coverage for approximately 265,000 members. Each day, more than 4,400 dedicated employees and more than 650 Hawai‘i Permanente Medical Group physicians and providers come to work at Kaiser Permanente Hawai‘i to care for our members at our 20 medical facilities, including Moanalua Medical Center, providing high-quality care for our members and delivering on our commitment to improve the health of the 1.4 million people living in the communities we serve.

Since the COVID-19 pandemic began in 2020, the use of telehealth in Hawai‘i has dramatically increased as telehealth has been critical to limit the risk of person-to-person transmission while helping to avoid overwhelming our healthcare facilities. While Kaiser Permanente Hawai‘i was already providing high-quality care through telehealth modalities, we saw a dramatic increase in the use of telehealth visits between 2019 and 2020. In 2019, approximately 1,000 of our outpatient visits were done as video visits and 458,000 as telephone visits. In stark contrast, in 2020, approximately 67,000 video visits were performed and 777,000 telephone visits. In 2021, approximately 84,000 video visits were performed and 700,000 telephone visits. We expect this number to continue to increase in 2022 in response to the ongoing pandemic and surges fueled by variants such as Omicron.

Kaiser Permanente Hawaii utilizes audio-only telephone visits as a modality to provide access to high-quality care as part of our integrated approach to care delivery, and we believe this modality

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

is important to offer for individuals who do not have access to, or may not be comfortable using, video conferencing technology. Therefore, we support the inclusion of audio-only telephone visits as part of the definition of "telehealth." We appreciate the amendments made to HB1980, HD2 to clarify that telephonic service are not required to be reimbursed at parity with in-person visits. We recognize that costs associated with different types of visits can vary substantially and we urge the legislature to take an equity approach to reimbursement rather than requiring all audio-only telephone visits to be paid at parity with in-person visits. This approach accounts for the provider's time and resources as well as the relative equivalency to in-person care and allows us to continue to leverage telemedicine as a strategy to make health care more affordable.

We believe telephonic behavioral health services should be covered if clinically appropriate and desired by the patient or provider. **We caution against requirements that impose rigid in-person visit parameters or fail to account for patient and provider needs and preferences.** Instead, we urge the legislature to take a broad approach in determining when audio-only telephone visits are reimbursable to ensure that individuals have equitable access to the modality that best meets their needs.

Mahalo for the opportunity to testify on this important measure.

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

NASW HAWAI'I CHAPTER
National Association of Social Workers

COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

DATE: March 16, 2022 1:05 PM. - VIA VIDEO CONFERENCE – Room 225

Testimony with Comments on HB1980 HD2 HEALTH

The National Association of Social Workers – Hawai'i (NASW- HI) supports amendments to this measure to help clarify the application and effect of HB1980 HD2, which currently suggests, in statute, that insurance plans provide reimbursement for telephonic behavioral services in limited, but vague circumstances. NASW-HI nevertheless appreciates this proposal as it purports to "expand" access to quality mental health care.

As we pivoted to a socially distant way of life over the last few years, we've come to appreciate the breadth and utility of telehealth services. However, several members of our community are unable to avail themselves of these services because they may not live in an area equipped with broadband coverage; or they may lack the resources to purchase a smartphone, tablet, or computer; or they are elderly or disabled and cannot operate equipment that require technological know-how or manual dexterity.

We respectfully ask this committee to address the ambiguity in the proposed language, as well as language that prohibits coverage unless digital access is "technologically unavailable." It is also unclear as to what is "medically necessary". We are concerned that such requirements will result in onerous administrative oversight and present unnecessary and avoidable burdens, costs, and delays that are clinically unrelated to the care being administered.

Also concerning is the requirement that an in-person meeting occur every twelve months. This may not be advisable, clinically, in the behavioral health context; nor may it even be possible in so many circumstances - as social-distance protocols continue to be imposed.

Finally, we note that the Centers for Medicare and Medicaid Services (CMS) considers telephonic services a modality of "telehealth" in Medicare. We encourage the committee to consider amending this bill with language that follows the lead taken by CMS. If publicly-funded Medicare provides parity for telephonic treatment, private insurance should too.

We believe these clarifications are necessary because access to quality mental health services should be streamlined, and not constrained - as seems possible under the current language. Allowing telephonic behavioral health treatment, whether qualifying as "telehealth" or otherwise, is critical to our collective recovery from the chronic stressors presented by the pandemic. Limiting insurance reimbursement for such services effectively functions as a state-sanctioned barrier to access for so many disenfranchised members of our society who do not use the video technology required for telehealth.

677 Ala Moana Boulevard, Suite 904, Honolulu, HI 96813
808.489.9549 • info@naswhi.org • www.naswhi.org

Recent studies have indicated that several vulnerable populations prefer audio-only treatments; and that expanding coverage in this way will the meet the needs of the elderly, disabled, low-income, disenfranchised racial, ethnic, and linguistic groups, and many others who may simply utilize and respond better to telephonic treatment. On this access matter, the Dept. of Health and Human Services recently issued policy brief (entitled "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services"**,** reporting that:

> "[O]ur study findings are consistent with research studies that show **disparities in audio-only vs. video- enabled telehealth modalities by race/ethnicity, age, education, income, and health insurance coverage**. In a recent survey study, patients with a household income of $50,000 or more were 34 percent more likely to choose a telehealth visit than those making less than $50,000. . . . Although research shows that video visits offer some additional benefits compared with telephone visits, they require more complex setup, video-enabled devices, and broadband internet access, which may present **barriers for older adults, lower income households, and those with limited English proficiency.** In addition to these factors, patients with lower incomes may be more likely to use audio-only services because they are at work during appointments or lack privacy at home. Consistent with these concerns, **we also found lower use of video-enabled telehealth services among adults with low-incomes and those without a high school degree**."

There is such great demand and such a limited supply of providers, we want to enable and bolster all the methods that can be employed in addressing Hawaii's mental health needs. We thus support this proposal to the extent that it improves access to quality mental health services – especially to our vulnerable populations. If they prefer and respond most favorably to treatment administered via the telephone, we should be removing barriers to such care.

Thank you for the opportunity to provide this testimony in support

Sincerely,

Sonja Bigalke-Bannan, MSW, LCSW

Sonja Bigalke-Bannan, MSW, LCSW
Executive Director,
National Association of Social Workers- Hawai'i Chapter

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn Baker, Vice Chair
Members, Senate Committee on Health

From: Jacce Mikulanec, Director, Government Relations, The Queen's Health Systems

Date: March 16, 2022

Re: Comments on HB 1980 HD2: Relating to Telephonic Services

The Queen's Health Systems (Queen's) is a nonprofit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, and more than 1,500 affiliated physicians and providers statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to provide comments on HB 1980 HD2, which would permit Medicaid, insurance providers, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances and clarifies that telephonic services do not constitute telehealth. Throughout the COVID19 pandemic Queen's has relied increasingly on various modes of telehealth to deliver critical medical services to our patients – including those delivered through telephonic means. This is particularly beneficial to patients who may have limited mobility, reside in rural areas, or otherwise cannot access services in an office setting.

Queen's provides a number of telemedicine specialties in areas such as, but not limited to, stroke and neurology, psychiatry, wound care, and critical care; approximately 11.5% of physician-patient acute telehealth services are classified as telephonic. Telehealth modalities assist with connecting our four hospitals statewide and allow our health care professionals to provide care to patients in their local communities who may not access critical care otherwise. Since the start of the COVID19 pandemic, Queen's has made substantial investments in shifting to telehealth as a modality for providing quality care for our patients – including those requiring behavioral health services.

Furthermore, we strongly support efforts to ensure Hawai'i's telehealth statute remains nimble and able to adapt to new, diverse, and safe ways of delivering care to those with behavioral health needs and other chronic conditions.

Thank you for the opportunity to provide comments on HB 1980 HD2.

The Hawaiian Islands Association
for Marriage and Family Therapy
(HIAMFT)
We know systems.
We know relationships.
We know FAMILY MATTERS.

COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

DATE: March 16, 2022 1:05 PM. - VIA VIDEO CONFERENCE – Room 225

Testimony with Comments on HB1980 HD2 RELATING TO TELEPHONIC SERVICES

The Hawaiian Islands Association for Marriage and Family Therapy (HIAMFT) supports the intent and purpose of HB1980 HD2 to the extent its net effect is an overall improvement and increased access to quality mental health services. HB1980 HD2 adds language to the insurance codes that permit the costs of treatment administered via telephone to be reimbursed by health insurance plans operating in Hawaii under certain circumstances. Mental health treatment through talk therapy, such as provided by Marriage and Family Therapists, fits squarely into the type of service covered by this proposal.

Proposal and Draft History

In this draft, HB1980 HD2 provides that: "*Telephonic behavioral health services may be covered, including when: (1) Telehealth services are technologically unavailable at the time the enrollee is scheduled to receive a behavioral health service; (2) The behavioral health service is a medically necessary, covered health care service; and (3) The health care provider has provided the enrollee with an in-person behavioral health service no longer than twelve months prior to the telephonic service*." (Underlining added.) This language is a strong improvement from the HD1 where telephonic services were only allowed ***if*** these conditions were met –thus perhaps inadvertently undermining the expressed purpose of this bill because some plans were already providing coverage for such services *without* such conditions. The HD1 would require existing plans to scale back and ultimately reduce access and patient utilization of necessary tools; so we appreciate the CPC committee for this change.

While we strongly support efforts to encourage insurance plans to explicitly cover behavioral health therapies over the telephone, we do not think the current language in HB1980 HD2 adds any material change to our laws. We favor the language in SB2645 SD1 (SD2 draft currently pending) which amends the definition of "telehealth" to include "standard telephone contacts" – which has been allowed pursuant to public health emergency proclamations. **Healthcare and insurance plans have operated successfully in this way for the two-plus years we've been in the pandemic; therefore, this proposal adds nothing new. We know it is effective without any reported negative consequences.**

Phone: (808) 291-5321 **Email:** hawaiianislandsmfts@gmail.com **Address:** PO Box 698 Honolulu, HI 96709 **Website:** www.hawaiimft.org **Social Media:** FB - @mfthawaii, IG - @hawaiimft

Telephone Contacts as "Telehealth" is Recognized by CMS

We also want to bring to the committee's attention the language on page 20, lines 17-19: "A telephonic service, as defined in section 431:10A-116.3, does not constitute telehealth." As the DCCA Commissioner noted in his testimony on the HD1, this added language is redundant to the definition of telehealth which excludes "telephone contacts." Ultimately, we would like to see the parity in insurance reimbursement that would result if telephone contact qualified as telehealth for behavioral health – as it dues under the emergency orders, because treatment provided by telephone is just as effective, or in some cases, *more* effective in treating mental health conditions. Moreover, such care requires the same degree of time, resources, note-taking, analysis, and treatment methods. This is the approach taken in SB2645 SD1.

It's our understanding that the **Centers for Medicare and Medicaid Services (CMS) has adopted language tailored to mental health contexts to allow telephonic services as "telehealth".** We recommend this committee follow the lead of CMS and the pioneering work they are doing in this area to assure there are no gaps in access and coverage due to economics, age, disability, residence, and/or patient and provider preference. The Hawaii Primary Care Association has recommended language to this effect.

As a matter of policy, if telephonic behavioral health treatment is covered as "telehealth" by government-funded health insurance plans like Medicare, why shouldn't private plans offer the same?

"Telehealth" Innovation Should Not Forfeit Access to Those Incapable of Using this Technology

While devasting to public health and our economy, the COVID 19 Pandemic has spurred revolutionary developments in telehealth. However, as much as we need to embrace change, we should not turn our back on old reliable tools to meeting our most vulnerable. It is estimated that telehealth utilization had increased by over 300% to comply with social distancing protocols. The United States Department of Health and Human Services (DHHS) Assistant Secretary of Planning and Evaluation issued a policy brief[1] on February 2, 2022 highlighting the increased use of telehealth from 1% of visits to 80% in some high-prevalence areas during the initial outbreak peak from March – April 2020; and that Medicare telehealth utilization increased 63-fold between 2019 and 2020.

The wisdom of "necessity is the mother of invention" couldn't be truer than with telehealth services. The efficiencies and improvements in patient health outcomes credited to remote treatment are unprecedented – and likely here to stay. Across the country multiple jurisdictions are making permanent many of the pandemic-prompted changes to the way health care is provided. However, certain measures have been necessary to assure access and connection to those who are otherwise out-of-reach from this quickly-advancing technology.

As is confirmed by recent research, telephonic service is critical to improving access to several **vulnerable groups of patients: (1) the elderly; (2) low-income; (3) mobility- challenged; (4) limited English proficient; and (5) rural residents.** The disparities evident between the patients who use audio-only/telephone calls vs. the video-conferencing technologies of telehealth – during the pandemic - has been thoroughly researched and recognized by DHHS. The DHHS policy brief (entitled "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services" reported:

> "[O]ur study findings are consistent with research studies that show **disparities in audio-only vs. video-enabled telehealth modalities by race/ethnicity, age, education, income, and health insurance coverage**. In a recent survey study, patients with a household income of $50,000 or more were 34 percent more likely to choose a telehealth visit than those making less than $50,000. . . . Although research shows that video visits

[1] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf

> offer some additional benefits compared with telephone visits, they require more complex setup, video-enabled devices, and broadband internet access, which may present **barriers for older adults, lower income households, and those with limited English proficiency.** In addition to these factors, patients with lower incomes may be more likely to use audio-only services because they are at work during appointments or lack privacy at home. Consistent with these concerns, **we also found lower use of video-enabled telehealth services among adults with low-incomes and those without a high school degree**."

We believe audio-only treatment is a critical measure in reaching vulnerable groups who do not have access to digital telehealth, either because they: lack of the financial means to obtain the necessary equipment or broad band service; live in rural and remote areas; do not have an adequate command of the English language to navigate the online platforms; or maybe because they are uncomfortable using high technology.

Vague Language in this Bill

To ensure adequate access and best patient outcomes, HIAMFT recommends important clarifying amendments to ensure that clinically appropriate treatment is not barred from coverage by vague language, like "technologically unavailable" and "medically necessary" are not defined in this bill.

Also, HIAMFT would like to stress that a 12-month in-person meeting, in the behavioral health context, may be unnecessary. We would like to see appropriate latitude and discretion be afforded to mental health practitioners to determine what is clinically advisable for their patient under the circumstances. For example, requiring a long-term long-distance patient with a mild disorder or anxiety to meet with their therapist in person may present an artificial, even harmful barrier. A patient who is otherwise functioning and adapting well to stressors, would not need an in-person meet-up. Asking patients with a severe disability, or terminal condition (as is contemplated in the Our Care Our Choice proposals) to physically come to an office when such effort is unnecessary, and perhaps dangerous - would only seem to set them back. We don't want such a requirement – which in many cases would seem arbitrary - to dissuade patients from seeking treatment.

From a personal standpoint, language requiring an in-person meeting would shut down my entire practice – as all my patients are remote.

Summary

We believe with important clarifications, ensuring audio-only treatment, as telehealth or otherwise, as a covered expense in the administration of mental health services is crucial to improving patient outcomes, expediting timely service, and ultimately reducing costs and unnecessary administrative functions.

HIAMFT supports legislative action to ensure that time-tested modalities, like standard telephone conversations – equal in content, duration, and clinical outcomes as in-person or telehealth treatments, are available to patients; and not precluded from insurance reimbursement. HIAMFT also supports efforts to ensure that insurance laws and regulations do not create unnecessary barriers to the provision of appropriate treatment within the clinical judgment of providers.

Thank you for the opportunity to provide this testimony on this critical access to care legislation.

Sincerely,

Dr. John Souza, Jr., LMFT, DMFT, President
The Hawaiian Islands Association for Marriage and Family Therapy

DISABILITY AND COMMUNICATION ACCESS BOARD

1010 Richards Street, Room 118 • Honolulu, Hawaii 96813
Ph. (808) 586-8121 (V) • Fax (808) 586-8129

March 16, 2022

TESTIMONY TO THE SENATE COMMITTEE ON HEALTH

House Bill 1980, House Draft 2 – Relating to Telephonic Services

The Disability and Communication Access Board (DCAB) supports House Bill 1980, House Draft 2 Relating to Telephonic Services. This bill allows for telephonic behavioral health services to be covered in certain circumstances.

When telehealth services for a behavioral health appointment is not available for people with disabilities, it is important to proceed via telephone to complete the appointment.

Please note that telephonic services for persons with hearing or speech disabilities requires use of the telecommunications relay service (TRS) to communicate with health care providers. Health care providers should place and receive telephone calls through the TRS with patients who have hearing or speech disabilities to receive behavioral health services.

Thank you for the opportunity to provide testimony.

Respectfully submitted,

KIRBY L. SHAW
Executive Director

DAVID Y. IGE
GOVERNOR OF HAWAII

ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAIʻI
STATE COUNCIL
ON DEVELOPMENTAL DISABILITIES
PRINCESS VICTORIA KAMĀMALU BUILDING
1010 RICHARDS STREET, Room 122
HONOLULU, HAWAIʻI 96813
TELEPHONE: (808) 586-8100 FAX: (808) 586-7543

March 16, 2022

The Honorable Senator Jarrett Keohokalole, Chair
Senate Committee on Health
The Thirty-First Legislature
State Capitol
State of Hawaiʻi
Honolulu, Hawaiʻi 96813

Dear Senator Keohokalole and Committee members:

SUBJECT: HB1980 HD2 Relating to Telephonic Services

The Hawaii State Council on Developmental Disabilities **SUPPORTS HB1980 HD2,** which permits, but does not require, Medicaid, insurance providers, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances. Clarifies that telephonic services do not constitute telehealth.

COVID has shown that our intellectual and or developmental disability (I/DD) community members must turn more and more to internet-based supports. Some of these supports come in the form of telehealth appointments and Zoom based communication. COVID proved that many individuals within our I/DD community are part of a high-risk group that needed to rely on staying at home and using telehealth services more so than the average citizen. Many of our I/DD community members live in rural areas of our state and do not have easy access to highspeed broadband. These individuals found themselves without internet and many times without any form of support during the pandemic.

Permitting telephonic services as an option would help increase the capacity to take care of our I/DD community via telephonic health appointments. Telehealth is the preferred option; however, our community members can find themselves at times unable to connect via telehealth as it requires a high-speed internet connection to access video. There are instances in which our individuals only have access to their cell phone and would not be able to access video capability. Having telephonic services as an option could help alleviate these issues and increase the coverage of care for our individuals.

Thank you for the opportunity to submit testimony in **support of HB1980 HD2.**

Sincerely,

Daintry Bartoldus
Executive Administrator

Hawaii Association of Health Plans

March 16, 2022

The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair
Senate Committee on Health

House Bill 1980 HD2 – Relating to Telephonic Services

Dear Chair Keohokalole, Vice Chair Baker, and Members of the Committee:

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to provide testimony on HB 1980 HD2. HAHP is a statewide partnership of Hawaii's health plans and affiliated organizations to improve the health of Hawaii's communities together. The vast majority of Hawaii residents receive their health coverage through a health plan associated with one of our organizations.

HAHP supports the intent of this measure to increase access to health care in Hawaii. Greater access to behavioral health services is needed throughout the state and especially in rural areas where the shortages of health care providers are most severe.

Thank you for allowing us to submit testimony in **support** of HB 1980 HD2.

Sincerely,

HAHP Public Policy Committee

cc: HAHP Board Members

Testimony to the Senate Committee on Health
Wednesday, March 16, 2022
1:05 p. m.
Via videoconference

Re: HB 1980 HD 2, RELATING TO TELEPHONIC SERVICES

Dear Chair Keohokalole, Vice Chair Baker, and Honorable Members of the Senate Committee on Health:

I am Gary Simon, immediate past president and a current board member of the Hawai'i Family Caregiver Coalition. The mission of the Hawai'i Family Caregiver Coalition (HFCC) is to improve the quality of life of those who give and receive care by increasing community awareness of caregiver issues through continuing advocacy, education, and training.

HFCC supports HB 1980 HD 2, RELATING TO TELEPHONIC SERVICES, which would permit, but would not require or prohibit, Medicaid, health insurers, mutual benefit societies, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances.

Telephonic care is especially valuable for those with limited mobility and for those who live in rural areas, hours away from the nearest specialist.

If telephonic care is good enough for Medicare and Medicaid, why not private insurance?

We urge you to support HB 1980 HD 2, and we urge you to recommend its passage.

On behalf of HFCC, I thank you for seriously considering the bill.

Very sincerely,

Gary Simon
Hawai'i Family Caregiver Coalition
Email garysimon@hawaii.rr.com

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376
www.hawaiimedicalassociation.org

SENATE COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

Date: March 16th, 2022
From: Hawaii Medical Association
Elizabeth England MD, Vice Chair, HMA Legislative Committee
William Scruggs MD, Member, HMA Legislative Committee
Elizabeth Ann Ignacio MD, Chair, HMA Legislative Committee

Re: HB1980 HD2, Relating to Telephonic Services
Position: Support with comments

To allow for safer and easier patient-provider interactions during COVID-19, there was a dramatic increase in telehealth. Patients who are elderly, have public insurance, are of Asian, African-American, or Hispanic heritage, and/or of a lower socioeconomic status were more likely to use audio-only communication for medical appointments[1]. Audio-only services provide an invaluable means for marginalized populations that may not have access to internet to receive the healthcare they need.

Reducing barriers to care enables patients to continue to see their providers, even in times of hardship. A large review study of federally qualified health centers (FQHC) during the outbreak of the pandemic found that the number of patient visits for behavioral health appointments, which used a larger proportion of audio-only visits, remained unchanged, while specialties using a higher percentage of video appointments had a 6.5% decrease in visits[2]. This indicates that telephone-based visits allowed more patients to continue their care. Audio-only telemedicine visits are also associated with a reduced time to follow-up visits[3].

While it is imperative that we work to address the complex socioeconomic factors that lead to health disparities, providing an accessible means for disadvantaged populations to receive care is a step in the right direction. This need has been recognized on the federal level; the Center for Medicare and Medicaid Services (CMS) recently updated the definition of telehealth to include audio-only services for established patients receiving mental health or substance abuse disorder treatment[4]. Hawaii should hold all of our insurers to this same expectation. Therefore, HMA respectfully requests that the bill be amended to reflect CMS standards.

Physicians have rapidly adopted telemedicine technologies to better serve our population. Payment parity for audio-only telemedicine care is fair and appropriate. This will increase access to care, improve health, and in doing so, reduce long-term costs.

Thank you for allowing Hawaii Medical Association to testify in support of this measure.

HAWAII MEDICAL ASSOCIATION
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Phone (808) 536-7702 Fax (808) 528-2376
www.hawaiimedicalassociation.org

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TESTIMONY ON BEHALF OF HAWAII PSYCHIATRIC MEDICAL ASSOCIATION

To: Chair Jarrett Keohokalole, Vice Chair Rosalyn Baker
Members of the Senate Committee on Health

From: Dr. Denis Mee-Lee, Legislative Committee Co-Chair
Hawaii Psychiatric Medical Association

Time: 1:05 p.m., March 16, 2022

Re: HB 1980 HD 2, RELATING TO TELEPHONIC SERVICES.

Position: **SUPPORT**

Dear Chair Keohokalole , Vice-Chair Baker and Members of the Senate Committee on Health:

The Hawaii Psychiatric Medical Association (HPMA) appreciates this opportunity to testify in support of HB 1980 HD 2, Relating to Telephonic Services. This bill permits, but does not require or prohibit, Medicaid, health insurers, mutual benefit societies, and health maintenance organizations to cover telephonic behavioral health services under certain circumstances and clarifies that telephonic services do not constitute Telehealth.

HPMA represents between 100 and 200 Physicians, who, after four years of medical school, receive a minimum of four (4) additional years of specialty training in Psychiatry.

Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. The American Psychiatric Association and the Hawaii Psychiatric Medical Association support the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is for the benefit of the patient, protects patient autonomy, confidentiality, and privacy; and when used consistent with APA policies on medical ethics and applicable governing law.

Thank you for allowing HPMA the opportunity to testify on this important measure.

HB-1980-HD-2
Submitted on: 3/14/2022 6:46:54 PM
Testimony for HTH on 3/16/2022 1:05:00 PM

Submitted By	Organization	Testifier Position	Testify
Judith White	Individual	Support	Written Testimony Only

Comments:

Aloha. As a clinical psychologist who has been providing hundreds of hours of telehealth over the past several years, I understand first hand how important this resource is for many individuals to receive mental health treatment. Telephonic services are particularly vital for individuals who may not have access to reliable or any internet service. Insurance coverage for this group of of clients is critical for continuity of quality mental health care.

Mahalo,

Judith C. White, Psy.D.

Kapaa

LATE

HB1980 HD2 Hearing March 16, 2022

As heath care worker, UHMC nursing school student, wife, and mom, I am a strong supporter of HB1980 HD2 for the state's Medicaid managed care plans to not deny service coverage for behavior health though telephonic appointments under certain circumstances. During this entire time that we have globally been in a pandemic, tiredly fighting covid 19, depression and suicide has increased to a 32.8 percent and affecting 1 in every 3 American adults. This pandemic has left many individuals facing challenges that are extremely stressful. Struggling not only to care and support themselves but their family as well.

The need for behavioral health services is more than ever needed. The public stigma of mental health involves negative feelings internalized with shame. Which leads the public to go untreated resulting in self harm, depression and other mental disorders that can affect the entire family. Since this pandemic health care providers have had to get creative in find other way to treat the ill or dying. Successfully, telephonic appointments have made its way to be the new "office visit" however, now, some insurances including Medicaid and Medicare are denying these claims if coded for behavioral health leaving the patient to pay out of pocket which can be expensive. With jobs lost, housing and gas inflation this puts a burden on a family to decide what is more important with their family and what is a priority. This should not be choice an individual or family should have to make.

We have an opportunity to be a voice in this decision and help the state of Hawaii pass this bill allowing any person been seen over telephonic services and get the help they need despite the reason for the visit. A telephonic appointment for behavioral health should be just as important as a face-to-face visit with a physician. Now, more the ever we need to know that we are supported by our medical coverage in event that unforeseen circumstances can occur and are were not suspected. I feel for the future of the younger generations to come it is vital that we continue to make this an option for patients.

Mahalo,

Brandy Perry

HB-1980-HD-2
Submitted on: 3/15/2022 8:37:28 PM
Testimony for HTH on 3/16/2022 1:05:00 PM

LATE

Submitted By	Organization	Testifier Position	Testify
Shelley Wong	Individual	Support	Written Testimony Only

Comments:

Dear Chair Jarrett Keohokalole, Vice Chair Baker, and Members of the Committee,

My name is Shelley Wong and I am a psychiatry resident physician at the University of Hawaii General Psychiatry Residency Program. I am writing on behalf of myself in **support** of HB 1980, HD2.

Medical services, including behavioral health services, during the COVID pandemic were made possible through the expansion of telehealth services. For those without a video conferencing device, reliable internet access, and/or the understanding of how to navigate the technologic requirements of a telemedicine visit, telephone visits allowed the provision of critical care. In order to continue expanding healthcare access to meet the needs of our community, we need to support alternative means of providing care. It is imperative this includes audio-only telemedicine services so as not to worsen the already expanding health inequities amongst our community.

Thank you for the opportunity to provide this testimony in support.

Sincerely,

Shelley Wong, MD

LATE

ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF

February 1, 2022

HP-2022-04

National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services

Madjid Karimi, Euny C. Lee, Sara J. Couture, Aldren Gonzales, Violanda Grigorescu, Scott R. Smith, Nancy De Lew, and Benjamin D. Sommers

KEY POINTS

- Telehealth use increased dramatically during the COVID-19 pandemic, but research suggests that access to telehealth was not equitable across different population subgroups.
- This report analyzes data regarding telehealth use from the Census Bureau's Household Pulse Survey from April to October 2021.
- Overall during the study period, we found that one in four respondents (23.1%) reported use of telehealth services in the previous four weeks.
- Telehealth use rates were similar (21.1-26.8%) among most demographic subgroups but were much lower among those who were uninsured (9.4%) and young adults ages 18 to 24 (17.6%).
- The highest rates of telehealth visits were among those with Medicaid (29.3%) and Medicare (27.4%), Black individuals (26.8%), and those earning less than $25,000 (26.7%).
- There were significant disparities among subgroups in terms of audio versus video telehealth use. Among telehealth users, the highest share of visits that utilized video services occurred among young adults ages 18 to 24 (72.5%), those earning at least $100,000 (68.8%), those with private insurance (65.9%), and White individuals (61.9%). 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%).
- Policy efforts to ensure equitable access to telehealth, in particular video-enabled telehealth, are needed to ensure that disparities that emerged during the pandemic do not become permanent.

BACKGROUND

The use of telehealth services surged during the COVID-19 pandemic. A 2020 study found that telehealth use during the initial COVID-19 peak (March to April 2020) increased from less than 1 percent of visits[1] to as much as 80 percent in places where the pandemic prevalence was high,[2] and a recent ASPE report found that Medicare telehealth utilization increased 63-fold between 2019 and 2020.[3]

The Health Resources and Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.[4] Telehealth is comprised of two forms: 1) two-way, synchronous, interactive client-provider communication through audio

JAMA Network Open.

Research Letter | Diversity, Equity, and Inclusion

Disparities in Use of Video Telemedicine Among Patients With Limited English Proficiency During the COVID-19 Pandemic

Loretta Hsueh, PhD; Jie Huang, PhD; Andrea K. Millman, MA; Anjali Gopalan, MD; Rahul K. Parikh, MD; Silvia Teran, MD; Mary E. Reed, DrPH

Author affiliations and article information are listed at the end of this article.

Introduction

Telemedicine expands health care access for patients facing barriers to in-person care,[1] but may also inadvertently widen existing care disparities[2,3] for the 25 million people living in the US with limited English proficiency (LEP)[4] because of overlapping low digital literacy and health literacy.[5] Data on differential video vs telephone visit use by patients with LEP are needed to inform telemedicine equity strategies. In patients self-scheduling a primary care visit during the COVID-19 pandemic, we hypothesized that LEP would be associated with lower video use compared with telephone, especially among patients without prior video visit experience.

Methods

The retrospective cross-sectional study received institutional review board approval at Kaiser Permanente Northern California (KPNC) and waived informed consent because this was a data-only study with no participant contact. We followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

This study included all patient portal self-scheduled primary care telemedicine visits within KPNC from March 16 to October 31, 2020. In-person visits were only available by clinician recommendation after an initial telemedicine visit. Visits were accessible via any internet-enabled device. We extracted patient sociodemographics, technology access factors, and whether the patient visited their own primary care physician from automated data sources. Multivariate analyses examined the association between scheduling a video visit (vs telephone) and LEP, which was defined as needing an interpreter. An LEP × prior video visit interaction term was added to the multivariate regression to examine whether barriers to the initial video visit can potentially explain video visit use differences by LEP (ie, no video visit use differences by LEP among those with prior video visit use experience would suggest patients with LEP were not dissuaded by their initial video visit experiences).

We report adjusted video visit use frequencies generated from model coefficients for comparisons using Stata, version 14.2 (StataCorp LLC). Two-sided χ^2 tests were used to calculate P values for patient sociodemographics, technology access, and provider factors for interpreter need (**Table 1**). Two-sided logistics regressions were used to calculate P values for odds ratios from multivariable model of the association between the patient's need for a language interpreter and video vs telephone telemedicine visit. Statistical significance was set at $P < .05$. Data were analyzed between February and April 2021.

Results

Among 955 352 primary care telemedicine visits (video: 379 002 [39.6%]; telephone: 576 350 [60.3%]) scheduled by 642 370 patients. There were 22 476 (2.4%) with EHR-documented interpreter need, 454 741 (47.6%) White patients, 216 788 (22.7%) Asian patients, and 196 483 (20.6%) Hispanic patients; 720 338 (74.5%) patients aged 18 to 64 years, 409 632 (42.4%) men, and

Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic

Julia Chen, M.D.[1,2,3,4], Kathleen Y. Li, M.D., M.S.[1,5,6], Juan Andino, M.D., M.B.A.[1,7], Chloe E. Hill, M.D., M.S.[1,8], Sophia Ng, Ph.D.[1], Emma Steppe, M.P.H.[1], and Chad Ellimoottil, M.D., M.S.[1,7]

[1]Institute for Healthcare Policy and Innovation, University of Michigan, Ann Arbor, USA; [2]Michigan Medicine Virtual Care Team, University of Michigan, Ann Arbor, USA; [3]Department of Internal Medicine, University of Michigan, Ann Arbor, USA; [4]East Ann Arbor Health Ctr, University of Michigan, 4260 Plymouth Rd, Ann Arbor, MI, USA; [5]Department of Emergency Medicine, University of Michigan, Ann Arbor, USA; [6]Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, Ann Arbor, USA; [7]Department of Urology, University of Michigan, Ann Arbor, USA; [8]Department of Neurology, University of Michigan, Ann Arbor, USA.

BACKGROUND: Most health insurance organizations reimbursed both video and audio-only (i.e., phone) visits during the COVID-19 pandemic, but may discontinue phone visit coverage after the pandemic. The impact of discontinuing phone visit coverage on various patient subgroups is uncertain.

OBJECTIVE: Identify patient subgroups that are more probable to access telehealth through phone versus video.

DESIGN: Retrospective cohort.

PATIENTS: All patients at a U.S. academic medical center who had an outpatient visit that was eligible for telehealth from April through June 2020.

MAIN MEASURES: The marginal and cumulative effect of patient demographic, socioeconomic, and geographic characteristics on the probability of using video versus phone visits.

KEY RESULTS: A total of 104,204 patients had at least one telehealth visit and 45.4% received care through phone visits only. Patient characteristics associated with lower probability of using video visits included age (average marginal effect [AME] −6.9% for every 10 years of age increase, 95%CI −7.8, −4.5), African-American (AME −10.2%, 95%CI −11.4, −7.6), need an interpreter (AME −19.3%, 95%CI −21.8, −14.4), Medicaid as primary insurance (AME −12.1%, 95%CI −13.7, −9.0), and live in a zip code with low broadband access (AME −7.2%, 95%CI −8.1, −4.8). Most patients had more than one factor which further reduced their probability of using video visits.

CONCLUSIONS: Patients who are older, are African-American, require an interpreter, use Medicaid, and live in areas with low broadband access are less likely to use video visits as compared to phone. Post-pandemic policies that eliminate insurance coverage for phone visits may decrease telehealth access for patients who have one or more of these characteristics.

KEY WORDS: telehealth; video visits; COVID-19.

Prior presentations: *None.*
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INTRODUCTION

Telehealth is the use of telecommunications technology (e.g., video visits, telephone visits) to diagnose, treat, and manage health. During the COVID-19 pandemic, telehealth use surged as a result of the need for social distancing and the introduction of federal and state regulatory and insurance changes.[1] As a result, approximately 1.3 million Medicare patients received care via telehealth in April 2020, compared to 11,000 just over 1 month prior.[2] One key change was that audio-only telehealth (referred to as "phone visit" in this paper) was permitted. Prior to the COVID-19 pandemic, most insurance organizations required providers to perform telehealth using both real-time video and audio. Medicare and many commercial insurance programs temporarily waived the requirement for video so that patients without video-enabled devices, sufficient data to complete a video session, or adequate Internet access could receive medical care while reducing their COVID-19 exposure risk. While most stakeholders agree that video visit coverage should remain after the COVID-19 pandemic, there is disagreement on whether phone visit coverage should continue.[3–5] In fact, the Medicare program announced that they will discontinue coverage for phone visits after the COVID-19 pandemic.[6] On one hand, opponents of continuing phone visit coverage argue that phone visits limit the ability of a clinician to deliver high-quality care. On the other hand, proponents of continuing phone visit coverage argue that phone visits are an essential option for patients who lack access to video-enabled devices.

Because telehealth was not routinely used prior to the COVID-19 pandemic, little is known about the characteristics of patients who rely on phone visits versus those who can use video visits. Given the widespread prevalence of smartphones, it is plausible that most patients, or their caregivers, can

in limited conditions.[2] Nevertheless, the pandemic caused the use of telehealth to skyrocket. One study found a 3,806 percent increase in the volume of telehealth claims from private payers from July 2019 to July 2020, largely due to the increased flexibility that the temporary regulatory suspensions allowed.[3] Further, the Centers for Disease Control and Prevention (CDC) found that 95 percent of health centers funded by Health Resources and Services Administration (HRSA) used telehealth for services, whereas previously 43 percent of HRSA-supported health centers were capable of using telehealth in 2019.[4] In addition to an increase in use, satisfaction with telehealth services increased. One survey found that the percentage of consumers who said they would continue to use telehealth services going forward increased from 11 percent pre-pandemic to 40 percent.[5]

However, these surges in telehealth use were a result of temporary guidelines. As these allowances expire, the telehealth market is forced to comply with pre-pandemic restrictions on its use, and patient satisfaction and convenience will suffer.[6] For telehealth to remain a healthcare mainstay post-pandemic, the changes made to temporarily increase telehealth access must be seriously considered as permanent reforms to continue giving patients better autonomy and flexibility with their healthcare decisions.

TEMPORARY TELEHEALTH CHANGES DURING THE PANDEMIC: AN OVERVIEW

Audio-only Telehealth

Prior to COVID-19, most states did not allow audio-only telehealth, which does not employ video. In fact, only two states allowed audio-only telehealth, and only in specific cases. In 2019, Maine declared that insurance carriers must cover telephone-only services if video technology was unavailable to an existing patient, and if the medical service requested was appropriate for audio-only telehealth.[7] Additionally, Alaska regulations effective in 2020 allowed for some audio-only psychiatric and psychological services if video communication was unavailable.[8]

During the pandemic, audio-only telehealth became crucial to health care access. In March 2020, the Centers for Medicare and Medicaid Services (CMS) announced that Medicare would temporarily allow "virtual check-ins" via telephone.[9] States quickly followed suit, with some pointing to CMS guidance and some issuing more specific guidelines.[10] In 2021, with executive orders related to telehealth expiring, 18 states have made permanent changes that allow for some forms of audio-only telehealth.[11]

For this analysis of audio-only telehealth, we focus on five categories of medical services: evaluation and management (E/M) services; telepsychiatry and behavioral health services; substance use disorder services; teledentistry; and physical, occupational and speech therapies.

Evaluation and Management (E/M) Services

E/M services cover many types of health care appointments, but are most generally thought of as office visits and preventive services.[12] Prior to the pandemic, only Maine allowed for audio-only telehealth visits for E/M services.[13] However, in 2020, all 50 states and Washington, D.C. temporarily expanded telehealth coverage to include audio-only communications for general E/M services. States issued short-term billing codes that physicians and other qualified health professionals could use to conduct audio-only check-ins with

2. See, e.g., "A Multilayered Analysis of Telehealth: How This Emerging Venue of Care Is Affecting the Healthcare Landscape," FAIR Health, July 2019. https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/A%20Multilayered%20Analysis%20of%20Telehealth%20-%20A%20FAIR%20Health%20White%20Paper.pdf; Thiru M. Annaswamy et al., "Telemedicine barriers and challenges for persons with disabilities: COVID-19 and beyond," Disability and Health Journal 13:4(October 2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7346769.

3. "Monthly Telehealth Regional Tracker, July 2020," FAIR Health, July 2020. https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/july-2020-national-telehealth.pdf.

4. Hanna B. Demeke et al., "Trends in Use of Telehealth Among Health Centers During the COVID-19 Pandemic—United States, June 26 - November 6, 2020," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Feb. 19, 2021. https://www.cdc.gov/mmwr/volumes/70/wr/mm7007a3.htm.

5. Oleg Bestsennyy et al., "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" McKinsey & Company, July 9, 2021. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

6. See, e.g., Frances Stead Sellers, "Patients and doctors who embraced telehealth during the pandemic fear it will become harder to access," The Washington Post Sept. 15, 2021. https://www.washingtonpost.com/national/telehealth-doctors-waivers/2021/09/10/fb6619a0-f6e1-11eb-9738-8395ec2a44e7_story.html; Larissa Scott, "Patients frustrated over changes to telehealth services after state executive order expires," ABC Action News, July 9, 2021. https://www.abcactionnews.com/news/state/patient-frustrated-over-changes-to-telehealth-services-after-state-executive-order-expires.

7. "S.P. 383- L.D. 1263, An Act Regarding Telehealth," State of Maine Legislature, June 13, 2019. http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0383&item=3&snum=129;%20https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs_doc/COVID-19/MaineCare-Telehealth-Summary-New-Codes-and-Info-041620.pdf.

8. "Behavioral Health Services," Alaska Medicaid, Aug. 13, 2020. http://manuals.medicaidalaska.com/FQHC_RHC/fqhc_rhc/behavioral_health_services.htm.

9. "Medicare Telemedicine Health Care Provider Fact Sheet," Centers for Medicare & Medicaid Services, March 17, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

10. "COVID-19 Audio-Only Delivery," Center for Connected Health Policy, last accessed Sept. 25, 2021. https://www.cchpca.org/topic/audio-only-delivery-covid-19.

11. "Telephone Medicaid Reimbursement," Center for Connected Health Policy, last accessed Sept. 25, 2021. https://www.cchpca.org/policy-trends.

12. "What Are E/M Codes?" American Association of Professional Coders," last accessed Oct. 4, 2021. https://www.aapc.com/evaluation-management/em-coding.aspx#EMCodeCategories.

13. "S.P. 383- L.D. 1263, An Act Regarding Telehealth." http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0383&item=3&snum=129;%20https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs_doc/COVID-19/MaineCare-Telehealth-Summary-New-Codes-and-Info-041620.pdf.

patients.[14] Guidance on audio-only E/M services typically allowed providers to hold visits with established patients via telephone. Indiana explicitly mentioned that providers could also consult new patients via telephone.[15] Otherwise, state guidance on E/M services via telephone was uniform and allowed all qualified providers to use audio-only telehealth.[16]

Telepsychiatry and Behavioral Health Services

E/M services cover a lot of ground for health services, but many states made specific allowances for behavioral health professionals to consult patients via audio-only telehealth. Prior to the pandemic, only Alaska allowed audio-only delivery of some behavioral health services if video telehealth was unavailable to patients.[17] However, all states made temporary audio-only allowances for behavioral health professionals and their patients once CMS issued guidance allowing audio-only behavioral telehealth.[18] States provided their own guidance on a spectrum of detail; for example, Arizona advised that "all services that are clinically able to be furnished via telehealth modalities (including telephone) will be covered."[19]

Other states gave more pointed guidance on which behavioral health professionals could temporarily use audio-only telehealth. For example, Mississippi enabled psychiatrists, psychologists, licensed professional counselors and licensed certified social workers to use audio-only telehealth.[20] Finally, New Hampshire explicitly named Clinical Psychologists and School Psychologists licensed by the Board of Psychologists, Clinical Social Workers, master's level psychiatric nurses, Pastoral psychotherapists, marriage and family therapists and clinical mental health counselors as able to use audio-only.[21] This represented a dramatic increase in the use of telehealth for behavioral health services.

Substance Use Disorder Services

Substance use disorder (SUD) services faced particular setbacks with the pandemic. Programs for SUDs are usually based on group treatments, regular face-to-face visits, frequent monitoring and developing interpersonal relationships, which were all inaccessible due to stay-at-home orders.[22] However, the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidelines allowing flexibility for providers to prescribe and dispense controlled substances, as well as provide consultations via audio-only telehealth.[23]

Services for SUDs did go audio-only, usually with explicit guidance from states for SUDs, but some under the umbrella of behavioral health guidelines that states issued. Since the two are often regulated under the same state agency, audio-only telehealth for behavioral health services extended to SUD treatment. One notable distinction was found in Kentucky, in which the state's Medicaid program did not allow residential SUD treatment services or residential crisis services to use telehealth.[24] Otherwise, every state permitted audio-only telehealth for SUDs relatively openly.

Teledentistry

Teledentistry is an innovative component of traditional dental care. While teledentistry was part of the industry prior to the pandemic, many states did not explicitly include teledentistry in existing telehealth regulations, making its use challenging. However, due to the pandemic 28 states made specific mention of teledentistry allowances when it came to audio-only telehealth expansion in state-level executive orders.[25] Illustrated in Map 1, this change allowed dentists, and in some cases hygienists, to consult with patients over the phone regarding their oral health.

14. See, e.g., "Oregon Health Plan coverage of telephone/telemedicine/telehealth services," Oregon Health Authority, March 20, 2020. https://www.oregon.gov/oha/HSD/OHP/Announcements/Oregon%20Health%20Plan%20coverage%20of%20telemedicine%20services.pdf.

15. Courtney Joslin and Chung Yi See, "Audio-Only Subcategories," R Street Institute, last accessed October 24, 2021. https://www.rstreet.org/2021/10/24/telehealth-database.

Note: This database is intended to be a living document. Information included in this paper is reflective of the data available as of Nov. 12, 2021.

16. Ibid.

17. "Behavioral Health Services." http://manuals.medicaidalaska.com/FQHC_RHC/fqhc_rhc/behavioral_health_services.htm.

18. Joslin and See, "Audio-Only Subcategories." https://www.rstreet.org/2021/10/24/telehealth-database.

19. "Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19)," Arizona Health Care Cost Containment System, last accessed Sept 24, 2021. https://www.azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#telehealth.

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Telemedicine implementation and use in community health centers during COVID-19: Clinic personnel and patient perspectives

Denise D. Payán [a,*], Jennifer L. Frehn [a], Lorena Garcia [b], Aaron A. Tierney [c], Hector P. Rodriguez [c]

[a] Department of Public Health, School of Social Sciences, Humanities and Arts, University of California, Merced, 5200 N Lake Road, Merced, CA, 95343, USA
[b] Department of Public Health Sciences, School of Medicine, University of California, Davis, One Shields Avenue, Davis, CA, 95616, USA
[c] Division of Health Policy and Management, School of Public Health, University of California, Berkeley, 2121 Berkeley Way, Berkeley, CA, 94720, USA

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ABSTRACT

In March 2020, federal and state telehealth policy changes catalyzed telemedicine adoption and use in community health centers. There is a dearth of evidence on telemedicine implementation and use in these safety net settings and a lack of information reflecting the perspectives of patients with limited English proficiency. We conducted in-depth interviews with clinic personnel and patients during the pandemic in two federally qualified health centers that primarily serve Chinese and Latino immigrants. Twenty-four interviews (clinic personnel = 15; patients who primarily speak a language other than English = 9) were completed remotely between December 2020 and April 2021. Interview scripts included questions about their telemedicine experiences, technology, resources and needs, barriers, facilitators, language access, and continued use, with a brief socio-demographic survey. Data analyses involved a primarily deductive approach and thematic analysis of transcript content. Both FQHCs adopted telemedicine in a few weeks and transitioned primarily to video and audio-only visits within two months. Findings reveal third-party language interpretation services were challenging to integrate into telemedicine video visits. Bilingual personnel who provided language concordant care were seen as essential for efficient and high-quality patient telemedicine experiences. Audio-only visits were of particular benefit to reach patients of older age, with limited English proficiency, and with limited digital literacy. Continued use of telemedicine is contingent on reimbursement policy decisions and interventions to increase patient digital literacy and technological resources. Results highlight the importance of reimbursing audio-only visits post-pandemic and investing in efforts to improve the quality of language services in telemedicine encounters.

1. Background & significance

The coronavirus disease 2019 (COVID-19) pandemic catalyzed rapid adoption and implementation of telemedicine beginning March 2020 (Eberly et al., 2020; Koonin et al., 2020). The pandemic drastically shifted health care from in-person to remote to mitigate risk of infection. Federal and state telehealth policy changes were adopted as temporary measures, including financial incentives (i.e., changes to reimbursement like payment parity between in-person and telemedicine visits), licensing modifications, and relaxed privacy standards, to increase utilization (Keesara, Jonas, & Schulman, 2020; Shachar, Engel, & Elwyn, 2020).

Steep telehealth increases during COVID-19 presents a unique opportunity to investigate factors that influence telemedicine use in safety net settings. Pre-pandemic, there was limited adoption and use of telemedicine live video communication (and other modalities) among low-income and marginalized populations and safety net healthcare organizations (Anthony, Campos-Castillo, & Lim, 2018; Park, Erikson, Han, & Iyer, 2018; Rodriguez, Saadi, Schwamm, Bates, & Samal, 2021). Community health centers like Federally Qualified Health Centers (FQHCs), who predominantly serve patients who are uninsured or are Medicaid recipients, have historically lagged in adoption and use due to reimbursement and licensing issues. In 2016, only 37.6% of community health centers reported using telehealth (Shin, Sharac, & Jacobs, 2014).

Telemedicine can improve healthcare access and health outcomes in medically underserved communities by addressing structural barriers like transportation, excess wait times, childcare responsibilities, inconvenient appointment times, and regional medical provider shortages (Bashshur et al., 2016; Donelan et al., 2019; Gordon, Solanki, Bokhour, &

* Corresponding author.
E-mail addresses: dpayan@ucmerced.edu (D.D. Payán), jfrehn@ucmerced.edu (J.L. Frehn), lgarcia@ucdavis.edu (L. Garcia), aat2143@berkeley.edu (A.A. Tierney), hrod@berkeley.edu (H.P. Rodriguez).

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Association of Race and Neighborhood Disadvantage with Patient Engagement in a Home-Based COVID-19 Remote Monitoring Program

Bradley A. Fritz, MD, MSc[1,2], Brett Ramsey, MBA[1], Dick Taylor, MD[3], John Paul Shoup, MD[4], Jennifer M. Schmidt, MD[5], Megan Guinn, MBA, BSN, RN[4], and Thomas M. Maddox, MD, MSc[1,6]

[1]Healthcare Innovation Lab, BJC HealthCare/Washington University School of Medicine, St. Louis, MO, USA; [2]Department of Anesthesiology, Washington University School of Medicine, St. Louis, MO, USA; [3]Epic 1, BJC HealthCare/Washington University School of Medicine, St. Louis, MO, USA; [4]BJC Medical Group, St. Louis, MO, USA; [5]Division of General Internal Medicine, Department of Medicine, Washington University School of Medicine, St. Louis, MO, USA; [6]Division of Cardiology, Department of Medicine, Washington University School of Medicine, St. Louis, MO, USA.

BACKGROUND: COVID-positive outpatients may benefit from remote monitoring, but such a program often relies on smartphone apps. This may introduce racial and socio-economic barriers to participation. Offering multiple methods for participation may address these barriers.
OBJECTIVES: (1) To examine associations of race and neighborhood disadvantage with patient retention in a monitoring program offering two participation methods. (2) To measure the association of the program with emergency department visits and hospital admissions.
DESIGN: Retrospective propensity-matched cohort study.
PARTICIPANTS: COVID-positive outpatients at a single university-affiliated healthcare system and propensity-matched controls.
INTERVENTIONS: A home monitoring program providing daily symptom tracking via patient portal app or telephone calls.
MAIN MEASURES: Among program enrollees, retention (until 14 days, symptom resolution, or hospital admission) by race and neighborhood disadvantage, with stratification by program arm. In enrollees versus matched controls, emergency department utilization and hospital admission within 30 days.
KEY RESULTS: There were 7592 enrolled patients and 9710 matched controls. Black enrollees chose the telephone arm more frequently than White enrollees (68% versus 44%, $p = 0.009$), as did those from more versus less disadvantaged neighborhoods (59% versus 43%, $p = 0.02$). Retention was similar in Black enrollees and White enrollees (63% versus 62%, $p = 0.76$) and in more versus less disadvantaged neighborhoods (63% versus 62%, $p = 0.44$). When stratified by program arm, Black enrollees had lower retention than White enrollees in the app arm (49% versus 55%, $p = 0.01$), but not in the telephone arm (69% versus 71%, $p = 0.12$). Compared to controls, enrollees more frequently visited the emergency department (HR 1.71 [95% CI 1.56–1.87]) and were admitted to the hospital (HR 1.16 [95% CI 1.02–1.31]).
CONCLUSIONS: In a COVID-19 remote patient monitoring program, Black enrollees preferentially selected, and had higher retention in, telephone- over app-based monitoring. As a result, overall retention was similar between races. Remote monitoring programs with multiple modes may reduce barriers to participation.

KEY WORDS: ambulatory monitoring; COVID-19; race factors; facilities and services utilization.

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INTRODUCTION

Infections caused by SARS-CoV-2 have caused a pandemic that has pushed healthcare systems worldwide to their limits. Fortunately, most patients present with mild symptoms that can be managed via home quarantine.[1,2] Patients require careful monitoring during their quarantine, because deterioration requiring hospitalization may occur after a period of apparent stability.[3,4] Remote monitoring at home is an attractive management strategy because it reduces transmission risks associated with in-person follow-up[5,6] and because it eliminates transportation barriers for economically disadvantaged or geographically distant patients.[7–9] Traditional home monitoring programs are labor-intensive, requiring nurses to call patients daily to assess symptoms.[10] Emerging technologies have enabled automation of this process via smartphone apps, engaging staff only when medical intervention might be warranted.[11,12]

Although automated home monitoring programs are attractive due to their scalability, these programs may create barriers to patient engagement. Patients must have access to a smart device and a reliable internet connection to participate. The well-described "digital divide" may prevent Black, economically disadvantaged, or older patients from participating in an app-based remote monitoring program.[13–16] Accordingly, we designed a program that allowed for either app-based or

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The Internet: Barrier to Health Care for Older Adults?

Charles M. Lepkowsky
Solvang, California

Stephan Arndt
University of Iowa and Iowa Consortium for Substance Abuse Research and Evaluation/University of Iowa

Insurers, institutional and independent providers of health care have made increasing use of websites for patient communication, in the absence of data indicating that patients, especially older adults, utilize information technology (IT). The current study was designed to determine patient frequency of Internet and IT utilization across age groups. It was hypothesized that use of websites for patient communication might represent a barrier to health care for older adults. Data from 423 preexisting deidentified clinical records were used to determine whether there are differences between age groups in frequency of Internet and other IT utilization across 5 functional domains including health care. Internet and other IT utilization declined significantly with increasing age beyond 60 years. The findings indicate that people over age 65 are not a homogenous population regarding IT use. The decline in frequency using IT also advanced differently for each of 5 functional domains, suggesting that IT use is not a homogenous category. Decreasing frequency of Internet use to access health care showed the strongest association with increasing age. Findings support the hypothesis that use of websites for communicating with older adult populations might create a barrier to access to health care. It is suggested that health care protocols for working with older adults should include Internet and IT utilization as a specific area of assessment or treatment.

Clinical Impact Statement
This study adds to the literature by demonstrating specifically that use of the Internet for communicating with insurers and health care providers creates a potential barrier to health care for older adults. This finding has broad implications for Medicare, private insurers, and health care organizations, as well as clinicians in independent and small-group practices, using websites for patient access and communication.

Keywords: digital inequality, Internet, older adults, access to health care

Significant disparities in Internet and information technology (IT) utilization have been associated with numerous variables, including ethnicity, age, and socioeconomic status (SES; Hunsaker & Hargittai, 2018; U.S. Census Bureau, 2016).

Internet and IT utilization for people with intellectual and developmental disabilities is also much lower than that of the general population (Dobransky & Hargittai, 2006), despite efforts to engage young adults with intellectual disability with social media and other IT (Davies et al., 2015). The disparities in Internet use and access to IT have been variously described as the digital divide (Hoffman & Novak, 2000)

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Charles M. Lepkowsky, Independent Practice, Solvang, California; Stephan Arndt, Carver College of Medicine, University of Iowa, and Iowa Consortium for Substance Abuse Research and Evaluation/University of Iowa.

Correspondence concerning this article should be addressed to Charles M. Lepkowsky, 1143 Deer Trail Lane, Solvang, CA 93463. E-mail: clepkowsky@gmail.com

Chapter

COVID-19, Telehealth and Access to Care

Charles M. Lepkowsky

Abstract

Telehealth has become increasingly prominent during the COVID-19 pandemic, highlighting limitations in access to care for older adults less fluent in information technology (IT). Although the 20 percent disparity in IT use between younger and older adult cohorts remains unchanged over several decades, insurers, institutional and independent providers of health care have made increasing use of IT for patient communication. Data demonstrate an age-related decline in the frequency of IT use for accessing health care. Restrictions on reimbursement for the use of the telephone for accessing health care during the COVID-19 pandemic are discussed as a barrier to access to care. Recommendations are made for assessment of media most available to older adults for accessing health care, as well as providing funding to support increased access to care.

Keywords: COVID-19, older adults, access to health care, information technology (IT), FACETS

1. Introduction

The COVID-19 virus (SARS-CoV-2) was first identified in December of 2019 [1]. COVID-19 spread rapidly, and by the end of January 2020, the World Health Organization (WHO) had officially labeled the COVID-19 outbreak a pandemic [2]. At risk populations were soon identified, including older adults [3–6]. In an effort to contain the growth of the contagion, in early 2020 shelter in place practices were adopted in many countries, forcing the closure of routine businesses including schools, restaurants, and outpatient healthcare facilities [7–11]. Patient care rapidly shifted to virtual contact using telehealth platforms including internet-based videoconferencing software [12]. In the United States (US), the Center for Medicare and Medicaid Services (CMS) made changes liberalizing standards allowing reimbursement for videoconferencing telehealth, increasing access to care [13, 14]. However, the rapid shift to telehealth brought to the forefront an access to care issue that had been simmering for some time: compared with younger age cohorts, most adults over the age of 65 make limited use of information technology (IT) [15–18]. The intersection of the rapid growth of telehealth, age-related declines in IT utilization, and access to care is a growing area of concern for the health care systems with strong implications for the future of healthcare delivery.

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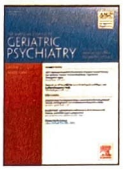

Letter to the Editor

Telehealth Reimbursement Allows Access to Mental Health Care During COVID-19

Dear Editor,

Older adults belong to the cohort most at risk for serious illness reactions to COVID-19, for whom shelter in place is most strongly recommended.[1] In order to make remote services more accessible, the Center for Medicare and Medicaid Services (CMS) announced nonenforcement of some telehealth policies, e.g., those limiting the patient's location to approved rural facilities, or requiring HIPAA compliance of audio-visual platforms used for telehealth.[2] While these measures increased access to care to Medicare subscribers with IT fluency, they failed to address access to care for Medicare subscribers who lack IT fluency. Around 93% of people over the age of 70 and 98% of people over the age of 80 (an average of 95.5% of people over the age of 70) do not use the internet to communicate with health care providers, and instead rely entirely on face-to-face or telephone interactions with health care providers.[3]

The American Psychological Association has made repeated appeals to CMS to allow reimbursement for the use of telephonic psychotherapy services during shelter in place. On April 30, 2020, CMS responded by allowing reimbursement for telephonic contact with patients using CPT codes for routine psychotherapy.[4] This important change in Medicare policy makes health care temporarily accessible to 95.5% of Medicare subscribers over the age of 70. However, the change is only temporary and will expire when the COVID-19 crisis has been resolved.

Valid and reliable instruments are available for assessing the media people use for accessing health care.[5] Such instruments might be employed with older adults, in order to determine the most effective means through which they can access health care. Hospitals, community health clinics, government-funded health agencies and private practices might gather additional data that a) inform health care providers about the most effective media for communicating with older adult patients, and b) provide a more broad-based sample to contribute to the existing data demonstrating patterns of IT use by older adults for communicating with health care providers, as well as accessing social contact, financial management, and other business functions.

CMS's decision to reimburse telephonic psychotherapy[4] is an important acknowledgement of the potential barriers to health care IT represents for older adults. Reimbursing providers for telephonic delivery of ongoing psychotherapy and other services make health care accessible to an average of 95.5% of Medicare subscribers over the age of 70.[3] Although the duration of shelter in place and the future trajectory of COVID-19 remain uncertain, the data suggest that substantial and permanent CMS policy changes allowing reimbursement for telephonic access to health care for older adults will be increasingly important in the near future.

AUTHOR CONTRIBUTION

The author warrants that he has reviewed and approved the manuscript prior to its submission, and assumes responsibility for the contents of the manuscript.

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Audio-Only Telehealth Now Approved Permanently for Mental Health/Substance Use Services

MARK MORAN

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Experts say the expansion of telehealth to include audio-only services for mental health and substance use disorders will improve access for underserved communities.

The Centers for Medicare and Medicaid Services (CMS) has expanded the definition of telehealth services that are permanently eligible for reimbursement under the Medicare program to include audio-only services for established patients with mental illness/substance use disorders (SUDs) who are unable or unwilling to use video technology.

The final rule on telehealth services for mental illness/SUDs is part of the 2022 Medicare Physician Fee Schedule, which covers updates to physician payment and other regulations regarding Medicare's Merit-Based Incentive Payment System (MIPS) each year. It was published in the *Federal Register* on November 19, 2021, and went into effect on January 1.

The expansion of telehealth to include audio-only services applies only to mental illness/SUDs. These services had been temporarily reimbursed as part of the government's response to the COVID-19 public health emergency, beginning with the presidential emergency declaration in March 2020 (*Psychiatric News*). In December 2020, Congress approved the Consolidated Appropriations Act (CAA) of 2021, a $1.4 trillion dollar package that—among many other provisions—permanently expanded mental health services provided via telehealth by easing geographic and site-of-service restrictions under the Medicare program (*Psychiatric News*).

The rule is an enormous victory for patients and psychiatrists for which APA had advocated unceasingly for months.

"I am delighted at the inclusion of audio-only telehealth reimbursement," said Peter Yellowlees, M.D., a member of the APA Committee on Telepsychiatry and a past president of the American Telemedicine Association. "This is likely to be especially important for patients who are already underserved, homeless, and from racial and ethnic minorities and may be one approach to reducing the inherent longstanding institutional racism and bias that we now acknowledge has existed in our health systems for many years."

Grayson Norquist, M.D., a member of the APA Council on Quality Care, also underscored the importance of audio-only services for advancing equitable access to care. "The ability to use audio-only is critical for providing access to mental health services for people who lack resources or the skills to use video technology," he said. "This increases our capacity to engage and treat those who have been underserved in the past in both rural and urban environments."

Norquist is also vice chair of psychiatry and behavioral sciences at Emory University and chief of the Grady Behavioral Health Service in Atlanta.

In July 2021, CMS proposed that in-person visits take place every six months for all patients—whether new or established patients—after the initial telehealth encounter; in the final rule, the administration extended this provision to every 12 months for established patients, with exceptions at the discretion of the treating psychiatrist. As mandated by the CAA, there is no exception for new patients. They must be seen by physicians or other practitioners in an in-person visit within six months prior to initiation of mental health services via telehealth.

POLICY NEWS

Examining the Benefits and Challenges of Audio-Only Telehealth

The recent debate over audio-only telehealth coverage centers on the value of the phone call. Is it a proper method for healthcare delivery, and should doctors be reimbursed for it?

By Eric Wicklund

July 27, 2021 - With the pandemic limiting access to in-person healthcare, audio-only telehealth has surfaced as a popular platform for care delivery. But it's not good for all (or even many) services, and that's forcing providers and lawmakers to take a close look at what can and can't be done by phone.

COVID-19 pushed the modality – basically defined as telehealth without the video - into the spotlight, but the debate over its value has been going on for much longer. And it's tied to a long-standing barrier to telehealth expansion and one of the oft-mentioned social determinants of health: broadband.

Advocates have long argued that telehealth will struggle in parts of the country where broadband is either unreliable or unavailable, because patients won't be able to access an audio-visual platform and providers won't want to spend the money creating one. But in those areas – often rural, with their own challenges to accessing care – they will and do connect by phone.

And in that context, a landline telephone might be the only way for someone to get in touch with a care provider.

That said, a telephone conversation isn't always the best format for healthcare. Opponents argue that a provider should be able to see the patient to establish a basic doctor-patient relationship, and that many diagnoses and treatments rely on visual observations and cues. On the other hand, providers can and do gain valuable information from a phone call, and there are certain instances where that may be enough to push a care plan forward.

SETTING MEDICARE COVERAGE FOR A PHONE CALL

READ MORE: New Letter Urges Congress to Establish a Post-Pandemic Telehealth Policy

Among those wrestling with guidelines is the Centers for Medicare & Medicaid Services, which has proposed covering audio-only telehealth services for mental healthcare in its 2022 Physician Fee Index. The agency had announced temporary coverage for audio-only telehealth during the pandemic and even issued a list of services for which audio-only could replace audio-visual telehealth.

Taking a cue from providers who took advantage of COVID-19 emergency waivers to use the modality during the pandemic, CMS included permanent audio-only telehealth coverage in the proposed 2022 PFS under the following conditions:

- The services are limited to diagnosis, evaluation or treatment of mental health disorders;
- They involve established patients;
- They're preceded by an in-person visit within the six months prior to using telehealth;
- They take place in the patient's home;
- The care provider has the technical capability at the time of service to use an audio-visual telehealth platform with the patient;
- The patient can't access the resources for an audio-visual telehealth visit or doesn't want to use that modality; and
- The care provider documents the claim as an audio-only telehealth service.

CMS has historically been slow to embrace telehealth, often saying it needs more proof that these care pathways improve clinical outcomes, reduce costs and improve provider workflows, as well as proof that providers wouldn't overuse the platform to collect reimbursements. The agency had in fact all but banned audio-only telehealth services until the pandemic, when the modality was included in a batch of waivers aimed at boosting access and coverage.

What CMS and many others found, however, was that audio-only telehealth was among the most popular services during the pandemic, **with an estimated one in three telehealth encounters being conducted by phone**. And many of those encounters were for mental health or substance abuse care.

This prompted the decision to propose permanent coverage for specific services.

READ MORE: As State Emergencies End, Providers Look for New Telehealth Limits

"Clinically, mental health services often differ from most other Medicare telehealth services in that mental health care often involves verbal conversation, where visualization between the patient and practitioner may be less critical," Nathaniel Lacktman, a partner with the Foley & Lardner law firm and chair of the firm's Telemedicine & Digital Health Industry Team, **wrote in a recent blog explaining the proposed CMS coverage**. "Considering the social determinants that affect an individual's ability to receive mental health care, assessing clinical safety, and recognizing that patients may have come to rely upon the use of audio-only technology to receive mental health care, CMS opined that terminating the audio-only flexibility at the end of the PHE could harm access to care."

SUPPORTERS: AUDIO-ONLY TELEHEALTH HAS VALUE

Among those supporting audio-only telehealth coverage is the American Medical Association, which **weighed in on the matter in an April 2021 letter to CMS**.

"Many of the same patients who cannot access audio-video telehealth services also face barriers to accessing timely in-person services," AMA Executive Vice President and CEO James Madara, MD, pointed out. "The decision about whether an in-person office visit is needed is very different for a patient in a rural area who may have to travel for hours to reach their physician's office than for patients who are located close to the medical practice and do not face barriers such as functional limitations. Similarly, the decision about whether a patient should continue to try and stabilize an acute problem at home or travel to a distant emergency department is a more complicated decision without access to timely in-person care or audio-video telehealth services. The availability of timely audio-only services has made a huge difference to these patients and their physicians."

The Medicare Payment Advisory Commission (MedPAC) **also supports permanent coverage for audio-only telehealth** "if there is potential for clinical benefit." But it also notes that researchers haven't studied the value of audio-only telehealth against audio-visual telehealth or in-person care, so the benefits so far are anecdotal rather than proven.

There have been a handful of studies on the matter. The RAND Corporation, for instance, **studied telehealth traffic at federally qualified health centers during the pandemic** and found a majority of the visits were conducted by phone.

READ MORE: Congress to Debate Medicare Coverage for Audio-Only Telehealth Services

"While there are important concerns about the quality of audio-only visits, eliminating coverage for telephone visits could disproportionately affect underserved populations and threaten the ability of clinics to meet patient needs," Lori Uscher-Price, a senior policy researcher at RAND, said in a press release accompanying the study.

"Lower-income patients may face unique barriers to accessing video visits, while federally qualified health centers may lack resources to develop the necessary infrastructure to conduct video telehealth," she added. "These are important considerations for policymakers if telehealth continues to be widely embraced in the future."

IS A PHONE CALL THE SAME AS A VISIT?

Aside from allowing providers to deliver healthcare via telephone, there's the question of how much they should be reimbursed for using it. Opponents argue that a simple phone call doesn't have the same value as an in-person or audio-visual exam, while proponents point out that it may be the only way for a patient and provider to connect.

This taps into the argument about payment parity. Some worry that providers will stay away from using a telehealth service that's reimbursed at less than an in-person service, even if there are other reasons to use that service.

In California, that's what prompted the California Medical Association **to oppose a plan by Governor Gavin Newsom** to establish Medicaid reimbursement for audio-only telehealth services at 65 percent of in-person care.

"Overwhelmingly, Medi-Cal patients opt to utilize audio-only telehealth over audio-visual telehealth," the organization said in a May 2021 press release. "This could be due to a lack of good broadband connectivity, a need to take those

telehealth visits on their mobile phones that have data limits, or for privacy reasons. Whatever the reasons, it makes little sense to eliminate an option for access to care, for those individuals who already lack it the most, further exacerbating existing inequities."

Among the states that are supporting audio-only telehealth is New York, where S8416, passed in the summer of 2020, ensured permanent coverage for the modality. That state is one of more than 20 to expand telehealth coverage after the pandemic to cover the modality, **according to a recent survey by the Commonwealth Fund**.

But that survey also noted the challenges faced by lawmakers in regulating coverage.

"Regulators observed that some providers have begun to charge for short, three- to four-minute phone calls (for example, to answer a brief question of convey test results) that previously would not have required an in-person visit and thus would not have been billed," researchers wrote. "Regulators noted that these short calls can leave patients with unexpected cost sharing."

Lawmakers in Arkansas and **New Hampshire**, meanwhile, have pushed back against expanding coverage, saying the phone isn't a good modality for treatment. They envision instances in which providers bill Medicaid or Medicare for every little phone call or make incorrect diagnoses based on what they hear from a patient.

Some groups have suggested even stricter regulations on coverage for audio-only telehealth. In May 2020, **America's Physician Groups t told CMS** that diagnoses obtained from the modality should be eligible for risk assessment if they met certain conditions:

- They are restricted to established patients;
- They are limited to pre-existing conditions previously submitted for risk assessment purposes;
- They are limited to visits initiated by the patient, unless a provider or health plan had requested the visit to share specific lab results;
- Diagnoses must be captured by two care providers from different practices;
- They're supported by additional documentation in the medical record beyond the diagnosis;
- Any diagnoses should be tied to specific lab test results;
- All audio-only telehealth visits must be self-audited using an independent auditor and reported back to CMS; and
- CMS should impose a cap on how much the diagnoses can affect average risk scores from the previous year.

Regardless of the arguments, most agree that there's enough value in the phone call – and there are enough people in the country for whom the telephone is the only modality to access care – to merit some sort of coverage. The challenge lies in identifying which specific services can be delivered and how they can be reimbursed.

The Effect of Telephone-Administered Psychotherapy on Symptoms of Depression and Attrition: A Meta-Analysis

David C. Mohr, Northwestern University, Hines Veterans Administration Hospital
Lea Vella, San Diego State University
Stacey Hart, Ryerson University
Timothy Heckman, Ohio University
Gregory Simon, Group Health Cooperative

Increasingly, the telephone is being used to deliver psychotherapy for depression, in part as a means to reduce barriers to treatment. Twelve trials of telephone-administered psychotherapies, in which depressive symptoms were assessed, were included. There was a significant reduction in depressive symptoms for patients enrolled in telephone-administered psychotherapy as compared to control conditions ($d = 0.26$, 95% confidence interval [CI] = 0.14–0.39, $p < .0001$). There was also a significant reduction in depressive symptoms in analyses of pretreatment to posttreatment change ($d = 0.81$, 95% CI = 0.50–1.13, $p < .0001$). The mean attrition rate was 7.56% (95% CI = 4.23–10.90). These findings suggest that telephone-administered psychotherapy can produce significant reductions in depressive symptoms. Attrition rates were considerably lower than rates reported in face-to-face psychotherapy.

Key words: **depression, meta-analysis, psychotherapy, telemental health.** ***[Clin Psychol Sci Prac 15: 243–253, 2008]***

Address correspondence to David C. Mohr, Department of Preventive Medicine, Northwestern University, Feinberg School of Medicine, 680 North Lakeshore Drive, Suite 1220, Chicago, IL 60611. E-mail: d-mohr@northwestern.edu.
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The telephone was invented by Alexander Graham Bell in 1876. The first report of telemedicine in a major medical journal, which described the use of the telephone to diagnose a child's cough, occurred three years later in 1879 ("The Telephone as a Medium of Consultation and Medical Diagnosis," 1879). The telephone quickly became a widely used tool in the practice of primary-care medicine. In contrast, providers of psychotherapy were slow to adopt the telephone to deliver mental health–related services. To the best of our knowledge, the first report of the use of the telephone in the administration of psychotherapy was published in 1949, 70 years after the first telemedicine report (Berger & Glueck, 1949). In 1996, a report developed by an American Psychological Association task force found that empirical evidence concerning telephone-administered psychotherapy was scant to nonexistent (Haas, Benedict, & Kobos, 1996). In the last decade, this has changed considerably.

Most of the work in telephone-administered psychotherapy has focused on treating depressive symptoms. Depression is common and is a significant cause of disability (Murray & Lopez, 1997). Psychotherapy is an attractive treatment option for many patients, as evidenced by the finding that approximately two-thirds of depressed patients prefer psychotherapy over antidepressant medication (Bedi et al., 2000; Brody, Khaliq, & Thompson, 1997; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Priest, Vize, Roberts, Roberts, & Tylee, 1996). However, only 20% of all patients referred for psychotherapy ever enter treatment (Brody et al., 1997; Weddington, 1983) and, of

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Telephone and In-Person Cognitive Behavioral Therapy for Major Depression after Traumatic Brain Injury: A Randomized Controlled Trial

Jesse R. Fann,[1] Charles H. Bombardier,[2] Steven Vannoy,[3] Joshua Dyer,[2] Evette Ludman,[4] Sureyya Dikmen,[2] Kenneth Marshall,[1] Jason Barber,[5] and Nancy Temkin[5]

Abstract

Major depressive disorder (MDD) is prevalent after traumatic brain injury (TBI); however, there is a lack of evidence regarding effective treatment approaches. We conducted a choice-stratified randomized controlled trial in 100 adults with MDD within 10 years of complicated mild to severe TBI to test the effectiveness of brief cognitive behavioral therapy administered over the telephone (CBT-T) ($n=40$) or in-person (CBT-IP) ($n=18$), compared with usual care (UC) ($n=42$). Participants were recruited from clinical and community settings throughout the United States. The main outcomes were change in depression severity on the clinician-rated 17 item Hamilton Depression Rating Scale (HAMD-17) and the patient-reported Symptom Checklist-20 (SCL-20) over 16 weeks. There was no significant difference between the combined CBT and UC groups over 16 weeks on the HAMD-17 (treatment effect=1.2, 95% CI: −1.5–4.0; $p=0.37$) and a nonsignificant trend favoring CBT on the SCL-20 (treatment effect=0.28, 95% CI: −0.03–0.59; $p=0.074$). In follow-up comparisons, the CBT-T group had significantly more improvement on the SCL-20 than the UC group (treatment effect=0.36, 95% CI: 0.01–0.70; $p=0.043$) and completers of eight or more CBT sessions had significantly improved SCL-20 scores compared with the UC group (treatment effect=0.43, 95% CI: 0.10–0.76; $p=0.011$). CBT participants reported significantly more symptom improvement ($p=0.010$) and greater satisfaction with depression care ($p<0.001$), than did the UC group. In-person and telephone-administered CBT are acceptable and feasible in persons with TBI. Although further research is warranted, telephone CBT holds particular promise for enhancing access and adherence to effective depression treatment.

Key words: behavior; clinical trial; head trauma; rehabilitation; TBI

Introduction

TRAUMATIC BRAIN INJURY (TBI) occurs in >3,500,000 people in the United States, and 10,000,000 people worldwide annually.[1,2] With TBI being the "signature injury" of the conflicts in Iraq and Afghanistan, the need for effective treatments for the sequelae of TBI is increasing significantly.[3,4] Rehabilitation aims to help TBI survivors resume their roles in work or school, with family or friends, and in the larger community. However, mental health problems such as depression, anxiety, and substance abuse are common, and may interfere with successful recovery.[5–9] Psychosocial problems are often more predictive of poor outcomes than the physical sequelae of TBI in both civilian[10] and military[4] populations. Major depressive disorder (MDD) is the most prevalent psychiatric disorder accompanying TBI[7,8] and is associated with poorer health status,[11–13] including physical complaints,[11] cognitive[14–18] and social[14,19,20] problems, and increased costs[21] among persons with TBI.

Despite the prevalence and adverse impact of depression after TBI, the science and practice of treating depression in this population lack a solid evidence base. Depression is undertreated in this population, with only 20% of those with MDD receiving counseling, and 41% receiving antidepressants during the 1st year after injury.[22] In order to decrease morbidity and improve functional outcomes after TBI, effective treatments for MDD must be developed, tested, and disseminated. Recent reviews of depression treatment literature in people with TBI conclude that serotonergic antidepressants and cognitive behavioral therapy (CBT) appear to be the most promising approaches to treating depression following TBI; however, there is an absence of high quality depression

Departments of [1]Psychiatry and Behavioral Sciences, [2]Rehabilitation Medicine, [5]Neurological Surgery, University of Washington, Seattle, Washington.
[3]Department of Counseling and School Psychology, University of Massachusetts, Boston, Massachusetts.
[4]Group Health Research Institute, Seattle, Washington.

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Research

BMJ

Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomised controlled non-inferiority trial

Karina Lovell, Debbie Cox, Gillian Haddock, Christopher Jones, David Raines, Rachel Garvey, Chris Roberts, Sarah Hadley

Abstract

Objectives To compare the effectiveness of cognitive behaviour therapy delivered by telephone with the same therapy given face to face in the treatment of obsessive compulsive disorder.
Design Randomised controlled non-inferiority trial.
Setting Two psychology outpatient departments in the United Kingdom.
Participants 72 patients with obsessive compulsive disorder.
Intervention 10 weekly sessions of exposure therapy and response prevention delivered by telephone or face to face.
Main outcome measures Yale Brown obsessive compulsive disorder scale, Beck depression inventory, and client satisfaction questionnaire.
Results Difference in the Yale Brown obsessive compulsive disorder checklist score between the two treatments at six months was −0.55 (95% confidence interval −4.26 to 3.15). Patient satisfaction was high for both forms of treatment.
Conclusion The clinical outcome of cognitive behaviour therapy delivered by telephone was equivalent to treatment delivered face to face and similar levels of satisfaction were reported.
Trial registration Current Controlled Trials ISRCTN500103984.

Introduction

Obsessive compulsive disorder is a disabling mental health illness that tends to be chronic unless adequately treated.[1] The economic burden of this disorder is high—the estimated direct and indirect costs are $8.4m (£4.5m, €6.6m) in the United States each year.[2] Cognitive behaviour therapy, particularly graded exposure and response prevention, is effective in treating obsessive compulsive disorder.[3] The current mode of delivery is a 45-60 minute face to face session with the therapist each week, during the hours of 9 am and 5 pm. Such a mode of delivery results in long waiting lists and precludes access to treatment. Recent mental health policy in the United Kingdom demands more accessible and effective treatments. Thus, alternative models of delivery have been proposed that aim to reduce contact with therapists and make services more accessible.[4] Innovations such as computerised cognitive behaviour therapy and facilitated self help still often require patients to attend scheduled clinic appointments.[5 6] Although useful, these systems increase throughput and access only for patients who can attend the clinic. Providing treatment over the telephone could increase access to patients who cannot attend clinic appointments for geographical, social, medical, or economic reasons. Telephone delivery of cognitive behaviour therapy is growing.[7-9] A pilot study of telephone delivery of such treatment in obsessive compulsive disorder showed potential with regard to effectiveness and reduced therapist time, and a larger open study found a good outcome.[10 11]

Methods

Design, objectives, and randomisation

We carried out a randomised controlled non-inferiority trial that compared exposure therapy and response prevention delivered either face to face during traditional 60 minute appointments or by telephone with reduced contact with the therapist. We hypothesised that exposure therapy and response prevention delivered by either of these methods will have similar clinical outcomes in the treatment of obsessive cognitive disorder.

Participants

We recruited patients during 2001 and 2002 from two psychology outpatient treatment units in greater Manchester. All patients were assessed at screening clinics, and patients whose main problem was obsessive compulsive disorder were invited to take part. Inclusion criteria were diagnosis of obsessive compulsive disorder; obsessive compulsive disorder as the main presenting problem; score of 16 or more on the Yale Brown obsessive compulsive checklist; and age 16-65. We excluded patients who had obsessional slowness (a variant of obsessive compulsive disorder), organic brain disease, a diagnosis of substance misuse, or severe depression with suicidal intent, and patients who had been on a stable dose of antidepressants or anxiolytics for less than three months.

Outcomes

Primary outcome measure was the Yale Brown obsessive compulsive checklist (self report version).[12] This is a 10 item questionnaire, and each question is scored between 0 and 4 (0 no symptoms, 4 severe symptoms). The total score range is 0-7 very mild, 8-15 mild, 16-23 moderate, 24-31 marked, and 32-40 severe. A secondary outcome measure was the Beck depression inventory.[13] Satisfaction with treatment was measured using the client satisfaction questionnaire at the initial follow-up visit.[14]

Procedure

To establish baseline data we assessed patients twice, with four weeks in between. We used permuted blocks with a block size of

A Randomized Controlled Trial of Telephone-Delivered Cognitive-Behavioral Therapy for Late-Life Anxiety Disorders

Gretchen A. Brenes, Ph.D., Michael E. Miller, Ph.D., Jeff D. Williamson, M.D., W. Vaughn McCall, M.D., Mark Knudson, M.D., Melinda A. Stanley, Ph.D.

Objectives: *Older adults face a number of barriers to receiving psychotherapy, such as a lack of transportation and access to providers. One way to overcome such barriers is to provide treatment by telephone. The purpose of this study was to examine the effects of cognitive behavioral therapy delivered by telephone (CBT-T) to older adults diagnosed with an anxiety disorder.* **Design:** *Randomized controlled trial.* **Setting:** *Participants' homes.* **Participants:** *Sixty participants age 60 and older with a diagnosis of generalized anxiety disorder, panic disorder, or anxiety disorder not otherwise specified.* **Intervention:** *CBT-T versus information-only comparison.* **Measurements:** *Coprimary outcomes included worry (Penn State Worry Questionnaire) and general anxiety (State Trait Anxiety Inventory). Secondary outcomes included clinician-rated anxiety (Hamilton Anxiety Rating Scale), anxiety sensitivity (Anxiety Sensitivity Index), depressive symptoms (Beck Depression Inventory), quality of life (SF-36), and sleep (Insomnia Severity Index). Assessments were completed prior to randomization, immediately upon completion of treatment, and 6 months after completing treatment.* **Results:** *CBT-T was superior to information-only in reducing general anxiety (ES = 0.71), worry (ES = 0.61), anxiety sensitivity (ES = 0.85), and insomnia (ES = 0.82) at the posttreatment assessment; however, only the reductions in worry were maintained by the 6-month follow-up assessment (ES = 0.80).* **Conclusions:** *These results suggest that CBT-T may be efficacious in reducing anxiety and worry in older adults, but additional sessions may be needed to maintain these effects.* (Am J Geriatr Psychiatry 2012; 20:707–716)

Key Words: Anxiety, cognitive-behavioral therapy, elderly, generalized anxiety disorder, panic disorder, telephone-delivered psychotherapy

Received August 10, 2010; accepted March 29, 2011. From the Department of Psychiatry and Behavioral Medicine (GAB, WVM); Department of Biostatistical Sciences (MEM); Department of Internal Medicine Section on Gerontology and Geriatric Medicine (JDW); Department of Family and Community Medicine (MK), Wake Forest University School of Medicine, Winston-Salem, NC; and Menninger Department of Psychiatry and Behavioral Sciences, Michael E. DeBakey Veterans Affairs Medical Center, Houston Center for Quality of Care and Utilization Studies (MAS), Houston, TX. Send correspondence and reprint requests to Gretchen A. Brenes, Ph.D., Department of Psychiatry and Behavioral Medicine, Wake Forest University School of Medicine, Medical Center Blvd., Winston-Salem, NC 27157. e-mail: gbrenes@wfubmc.edu

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BMC Research Notes

RESEARCH ARTICLE Open Access

Randomized trial of telephone versus in-person delivery of a brief psychosocial intervention in post-stroke depression

Catherine J. Kirkness[1], Kevin C. Cain[2], Kyra J. Becker[3], David L. Tirschwell[3], Ann M. Buzaitis[4], Pamela L. Weisman[1], Sylvia McKenzie[5], Linda Teri[6], Ruth Kohen[7], Richard C. Veith[7] and Pamela H. Mitchell[1,8*]

Abstract

Background: A psychosocial behavioral intervention delivered in-person by advanced practice nurses has been shown effective in substantially reducing post-stroke depression (PSD). This follow-up trial compared the effectiveness of a shortened intervention delivered by either telephone or in-person to usual care. To our knowledge, this is the first of current behavioral therapy trials to expand the protocol in a new clinical sample. 100 people with Geriatric Depression Scores ≥ 11 were randomized within 4 months of stroke to usual care (N = 28), telephone intervention (N = 37), or in-person intervention (N = 35). Primary outcome was response [percent reduction in the Hamilton Depression Rating Scale (HDRS)] and remission (HDRS score < 10) at 8 weeks and 12 months post treatment.

Results: Intervention groups were combined for the primary analysis (pre-planned). The mean response in HDRS scores was 39% reduction for the combined intervention group (40% in-person; 38% telephone groups) versus 33% for the usual care group at 8 weeks (p = 0.3). Remission occurred in 37% in the combined intervention groups at 8 weeks versus 27% in the control group (p = 0.3) and 44% intervention versus 36% control at 12 months (p = 0.5). While favouring the intervention, these differences were not statistically significant.

Conclusions: A brief psychosocial intervention for PSD delivered by telephone or in-person did not reduce depression significantly more than usual care. However, the comparable effectiveness of telephone and in-person follow-up for treatment of depression found is important given greater accessibility by telephone and mandated post-hospital follow-up for comprehensive stroke centers.

Clinical Trial Registration URL: https://register.clinicaltrials.gov, unique identifier: NCT01133106, Registered 5/26/2010

Keywords: Behavioural therapy, Psychosocial intervention, Depression, Randomized controlled trial, Stroke, Nurse therapist

Background

It is now well established that depression is a significant risk factor for having a stroke and also complicates recovery from stroke [1]. Further, meta-analyses show that roughly 30% of people with strokes suffer from clinical depression [2]. We previously showed that a brief psychosocial behavioural intervention delivered in-person by psychosocial nurse practitioners to community dwelling ischemic stroke survivors is efficacious in reducing depressive symptoms rapidly and sustaining that reduction over time [3]. At the time we began the previous study, Cochrane Database reviews showed few adequately designed studies of psychosocial and non-pharmacologic interventions, with relatively small effects [4, 5]. Our previous study was cited as one of those in progress that might add to support for such interventions [5].

Since the publication of the Cochrane review, our initial study, living well with stroke (LWWS) brief psychosocial

*Correspondence: pmitch@uw.edu
[1] Biobehavioral Nursing and Health Informatics, University of Washington, Box 357266, Seattle, WA 98195-7266, USA
Full list of author information is available at the end of the article

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Benefits and Challenges of Conducting Psychotherapy by Telephone

Gretchen A. Brenes, Cobi W. Ingram, and Suzanne C. Danhauer
Wake Forest School of Medicine

Telephone-delivered psychotherapy has increased utility as a method of service delivery in the current world, where a number of barriers, including economic hardships and limited access to care, may prevent people from receiving the treatment they need. This method of service provision is practical and has the potential to reach large numbers of underserved people in a cost-effective manner. The aim of this article is to review the state-of-the-art of telephone-delivered psychotherapy and to identify improvements and possible solutions to challenges. Results of randomized, controlled trials indicate high client acceptance and positive outcomes with this method of delivering psychotherapy. Nonetheless, psychotherapists wishing to deliver psychotherapy by telephone face a number of challenges, including a lack of control over the environment, potential compromises of privacy and confidentiality, developing therapeutic alliance without face-to-face contact, ethical and legal issues in providing psychotherapy by telephone, handling crisis situations at a distance, and psychotherapist adjustment to conducting psychotherapy in an alternative manner. There remains a need for further research, including direct comparisons of face-to-face psychotherapy with telephone-delivered psychotherapy and feasibility of telephone delivery of psychotherapies other than cognitive–behavioral therapy.

Keywords: telehealth, telephone, psychotherapy, mental health, health care access

Overview of Telehealth

Telehealth refers to "the use of telecommunications and information technologies to provide access to health information and services across a geographical distance" (Glueckauf, Picket, Ketterson, Loomis, & Rozensky, 2003, p. 160). Use of telehealth, especially for mental health care, has increased rapidly because of the desire to provide health care to underserved populations, reduce health care costs, and meet consumers' desires (Glueckauf et al., 2003). A number of barriers to traditional face-to-face psychotherapy may prevent people from obtaining the help they need, including transportation issues, need for childcare, perceived stigma, and difficulty leaving work (Bee, Lovell, Lidbetter, Easton, & Gask, 2010; Mohr et al., 2005). Over two-thirds of depressed patients in a primary care setting reported at least one practical barrier (e.g., transportation difficulties) that hampered their ability to attend psychotherapy regularly (Mohr, Hart, Howard, et al., 2006). Telephone-delivered psychotherapy can minimize such barriers, either as the primary method of delivering psychotherapy or as an adjunct to face-to-face psychotherapy.

Telephone-delivered psychotherapy offers increased client convenience with respect to location and flexible timing of appointments (Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004; Tutty, Ludman, & Simon, 2005; Tutty, Spangler, Poppleton, Ludman, & Simon, 2010). Clients can complete sessions at home in privacy, which may reduce concerns about stigma related to mental health treatment (Mozer, Franklin, & Rose, 2008; Simon et al., 2004) and potentially be less threatening than face-to-face sessions for some clients.

Clients who could benefit from improved access to psychotherapy include older adults, individuals who lack local service pro-

Editor's Note. This is one of 19 accepted articles received in response to an open call for submissions on Telehealth and Technology Innovations in Professional Psychology.—MCR

GRETCHEN A. BRENES received her PhD in clinical psychology from Washington University in St. Louis. She is an associate professor in the Departments of Psychiatry and Behavioral Medicine and Social Sciences and Health Policy at Wake Forest School of Medicine. Her areas of research and practice include late-life anxiety, telephone-delivered psychotherapy, access to mental health services for rural populations, and the effects of anxiety on physical functioning and disability.

COBI W. INGRAM received her MSW from Washington University in St. Louis. She is a Social Worker in the Department of Psychiatry and Behavioral Sciences at Wake Forest School of Medicine. Her areas of professional interest include assessment and treatment of anxiety, therapeutic outcomes, program evaluation, and professional development and training.

SUZANNE C. DANHAUER received her PhD in clinical psychology from the University of Kentucky. She is an associate professor in the Department of Social Sciences and Health Policy in the Division of Public Health Sciences at Wake Forest School of Medicine. Her research interests include behavioral and mind-body interventions for cancer survivors to reduce symptom burden and improve quality of life, psychosocial oncology, and development of various telehealth approaches to intervention delivery, particularly for individuals residing in rural areas.

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CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Gretchen A. Brenes, Department of Psychiatry and Behavioral Medicine, Wake Forest School of Medicine, Winston-Salem, NC 27157. E-mail: gbrenes@wakehealth.edu

DEPRESSION AND ANXIETY 33:415–423 (2016)

Research Article

BEHAVIORAL ACTIVATION AND THERAPEUTIC EXPOSURE FOR POSTTRAUMATIC STRESS DISORDER: A NONINFERIORITY TRIAL OF TREATMENT DELIVERED IN PERSON VERSUS HOME-BASED TELEHEALTH

Ron Acierno, Ph.D.,[1,2]* Daniel F. Gros, Ph.D.,[1,3] Kenneth J. Ruggiero, Ph.D.,[1,2] Melba A. Hernandez-Tejada, DHA,[1,2] Rebecca G. Knapp, Ph.D.,[1,3] Carl W. Lejuez, Ph.D.,[4] Wendy Muzzy, MRA, MLIS,[1,2] Christopher B. Frueh, Ph.D.,[5] Leonard E. Egede, M.D.,[1,3] and Peter W. Tuerk, Ph.D.[1,3]

Objective: *Combat veterans returning to society with impairing mental health conditions such as PTSD and major depression (MD) report significant barriers to care related to aspects of traditional psychotherapy service delivery (e.g., stigma, travel time, and cost). Hence, alternate treatment delivery methods are needed. Home-based telehealth (HBT) is one such option; however, this delivery mode has not been compared to in person, clinic-based care for PTSD in adequately powered trials. The present study was designed to compare relative noninferiority of evidence-based psychotherapies for PTSD and MD, specifically Behavioral Activation and Therapeutic Exposure (BA-TE), when delivered via HBT versus in person, in clinic delivery.* **Method:** *A repeated measures (i.e., baseline, posttreatment, 3-, 6-month follow-up) randomized controlled design powered for noninferiority analyses was used to compare PTSD and MD symptom improvement in response to BA-TE delivered via HBT versus in person, in clinic conditions. Participants were 232 veterans diagnosed with full criteria or predefined subthreshold PTSD.* **Results:** *PTSD and MD symptom improvement following BA-TE delivered by HBT was comparable to that of BA-TE delivered in person at posttreatment and at 3- and 12-month follow-up.* **Conclusion:** *Evidence-based psychotherapy for PTSD and depression can be safely and effectively delivered via HBT with clinical outcomes paralleling those of clinic-based care delivered in person. HBT, thereby, addresses barriers to care related to both logistics and stigma. Depression and Anxiety 33:415–423, 2016.*

[1]Mental Health Service, Ralph H. Johnson Veterans Affairs Medical Center, Charleston, South Carolina
[2]College of Nursing, Medical University of South Carolina, Charleston, South Carolina
[3]Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina
[4]Center for Addictions, Personality, and Emotion Research, University of Maryland, College Park, Maryland
[5]Department of Psychology, University of Hawai'i, Hilo, Hawaii

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Clinical Trial Registration number: NCT01177488.

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*Correspondence to: Ron Acierno, Mental Health Service 116, Ralph H. Johnson VAMC, 109 Bee Street, Charleston, SC 29401. E-mail: acierno@musc.edu
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MARCH 2021

Testimonials from Patients and Providers on the Value of Audio-only Tele-behavioral Health Services

DEBORAH CAGLE (A PATIENT WHO RECEIVES AUDIO-ONLY TELETHERAPY)

"I live on a boat with my husband, but we have very iffy WiFi. I have been taking care of my husband who has had a couple of surgeries. I just had a surgery myself. The reason we did telehealth, besides the coronavirus, is that it was just hard for me to leave my husband while I was going through some of my sessions... (Teletherapy) saved my life and saved my marriage. If I hadn't had this opportunity to do the audio I don't know where I'd be right now or if I'd even be here."

MONICA KRAMER MCCONKEY, LPC (A RURAL MENTAL HEALTH SPECIALIST)

"I work primarily with farmers and their families as well as agricultural industry personnel. I spend several hours each week with clients in an audio-only setting. With COVID came the move to virtually based counseling and therapy sessions. However, this has proved to be challenging to several of the farmers/ranchers I meet with for three reasons. 1) broadband connection is insufficient to provide a clear and uninterrupted session, 2) there is a lack of either technology or training in how to log into and utilize a format such as Zoom, and 3) many farmers call me from mobile locations such as the tractor, barn, yard, vehicle, etc. I always give the option of in-person meetings, Zoom sessions, or phone conversations. Several of my clients prefer phone conversations for the flexibility and accessibility that they afford."

JIM BROYLES, PHD (A PSYCHOLOGIST)

"Audio-only telehealth has really benefited (my patients) tremendously. It has expanded the ability of many of the potential consumers of psychological services to access the help that they need. A lot of people who are Medicare recipients either don't have the access to the technology that allows both audio and video connection to their service provider, or they are not technologically sophisticated enough to really make that an easy or readily available means of accessing that service. For people who are less sophisticated with technology, it's very difficult for them to shorten that time. It also impacts the stress that clients are experiencing. They're already living in very stressful times right now or they wouldn't be reaching out for help."

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Telephone Counseling and Home Telehealth Monitoring to Improve Medication Adherence: Results of a Pilot Trial Among Individuals With Multiple Sclerosis

Aaron P. Turner
VA Puget Sound Health Care System, Seattle, Washington, VA MS Center of Excellence West, Seattle, Washington, VA Center of Excellence in Substance Abuse Treatment and Education, Seattle, Washington, and University of Washington

Alicia P. Sloan
VA Puget Sound Health Care System, Seattle, Washington and VA MS Center of Excellence West, Seattle, Washington

Daniel R. Kivlahan
VA Puget Sound Health Care System, Seattle, Washington, VA Center of Excellence in Substance Abuse Treatment and Education, Seattle, Washington, and University of Washington

Jodie K. Haselkorn
VA Puget Sound Health Care System, Seattle, Washington, VA MS Center of Excellence West, Seattle, Washington, and University of Washington

Objective: To evaluate the impact upon medication adherence of brief telephone-based counseling using principles of motivational interviewing and telehealth home monitoring. ***Design:*** Randomized controlled pilot trial of 19 veterans with multiple sclerosis (MS) currently prescribed disease modifying therapy (DMT) who endorsed missing doses. Follow-up was conducted at 1, 3, and 6 months. ***Results:*** Participants in the intervention condition reported better adherence relative to controls at 6-month follow-up [*M* (*SD*) = 1.3 (2.1) vs. 8.2 (12.3) past month missed doses]. All participants in the intervention condition completed all 3 telephone counseling sessions and 90% or greater rated the program as highly successful. ***Conclusion:*** Brief telephone counseling represents a promising mechanism for improving medication adherence. The primary components, motivational interviewing and home telehealth monitoring, provided complementary mechanisms for initiating and sustaining behavior change over time. The intervention was well tolerated and provided an opportunity to extend access and reduce barriers to care by bringing it into the homes of participants.

Keywords: multiple sclerosis, medication adherence, motivational interviewing, self-management, telehealth

Impact and Implications

- Preliminary evidence suggests that brief telephone counseling based upon motivational interviewing is an effective means of promoting self-management and health behavior change.
- The flexibility of telephone-based counseling has considerable potential to extend the reach of psychological interventions outside of traditional practice settings.
- There is considerable opportunity to incorporate telephone-based counseling and self-management into both chronic illness management and rehabilitation care.

Introduction

Medication adherence represents a significant challenge to the efficacy and cost-effectiveness of health care. Problems with medication adherence are well documented in many common conditions, including hypertension, chronic obstructive pulmonary disease, depression, and diabetes. Existing literature suggests that typical rates of adherence are often as low as 50% (Haynes,

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Aaron P. Turner, VA Puget Sound Health Care System, Seattle, Washington, VA MS Center of Excellence West, Seattle, Washington, VA Center of Excellence in Substance Abuse Treatment and Education, Seattle, Washington, and Department of Rehabilitation Medicine, University of Washington; Alicia P. Sloan, VA Puget Sound Health Care System and VA MS Center of Excellence West; Daniel R. Kivlahan, VA Puget Sound Health Care System, VA Center of Excellence in Substance Abuse Treatment and Education, and Department of Psychiatry and Behavioral Sciences, University of Washington; and Jodie K. Haselkorn, VA Puget Sound Health Care System, VA MS Center of Excellence West, Department of Rehabilitation Medicine and Department of Epidemiology, University of Washington.

This research was supported by Department of Veterans Affairs Rehabilitation Research and Development Service Career Development Awards (B3319VA) and (B4927W) to Aaron P. Turner. Additional support was provided by the VA MS Center of Excellence West and the VA Center of Excellence in Substance Abuse Treatment and Education. Trial Registration clinicaltrials.gov Identifier: NCT00118547.

Correspondence concerning this article should be addressed to Aaron P. Turner, PhD, VA Puget Sound Health Care System, Rehabilitation Care Service, S-117-RCS, 1660 S. Columbian Way, Seattle, WA 98108. E-mail: Aaron.Turner@med.va.gov

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

July, 2021

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

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March 16, 20212

Testimony with Comments on HB1980 HD2

My name is Becky Gardner and I am submitting this testimony on behalf of myself as Owner & Principal of Policy Matters LLC.

As I have been working with multiple organizations to better understand the utility and efficacy of audio-only health care as Telehealth, we have compiled a comprehensive store of research clearly indicating the the need and effectiveness of audio-only healthcare; as well as the disparate discriminatory impact that denying audio-only as a modality of telehealth on many marginalized groups – including the elderly, low-income, limited English proficient, and rural patients.

Please find some of those research findings attached.

I would also like to stress that HB1980 HD2 makes no material change in the effect of our laws. While purporting to expand access, the language is only aspirational, and suggests certain burdensome conditions to both providers and patients; which, if applied, would actually further restrict coverage from what many private insurers already provide.

Perhaps the most problematic language, however, is the amendment to the definition of Telehealth on page 20 lines 17-19 that: " A telephonic service, as defined in section 431:10A-116.3, does **not** constitute telehealth."

This goes against the trend happening in on the federal level with Medicare – which seeks to permanently expand access through audio-only treatment **as "telehealth"**. This proposed language is redundant of existing telehealth law, perhaps for the protection of private insurers. We should be protecting residents and their ability to receive healthcare; and empowering providers to heal. I recommend this committee adopt the language of SB2073 or SB2645, which relate to the same specific matter.

Thank you for the opportunity to provide this testimony.

Sincerely,

Rebecca (Becky) Gardner, Esq.