

 California
Health Benefits
Review Program



What is the Current State of the Evidence on Telehealth?

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM (CHBRP)

- Independent analytic resource located in the University of California
- Multi-disciplinary
- Provides rapid, evidence-based information to the Legislature
- Neutral analysis of introduced bills at the **request** of the Legislature

CHBRP'S PRIOR WORK ON TELEHEALTH

- AB 744 (2019) Commercial Payment Parity (Chaptered)
- AB 2507 (2016) Defines telehealth and specifies modalities: store and forward; video communication, and telephone communication. Payment.
- SB 289 (2015). DMHC-regulated plans (includes Medi-Cal managed care plans) and CDI-regulated policies. Bill died in Senate.
- AB 1771 (2014) Requires coverage of telephone visits in DMHC-regulated Plans (incl Medi-Cal and CDI). Died in Senate.

SIGNIFICANT CHAPTERED CA TELEHEALTH LEGISLATION:

- Telehealth Development Act of 1996 (SB 1665, Thompson, 1996)
- AB 354 (Cogdill, 2005) – Reimbursement for use of store-and-forward for teleophthalmology and teledermatology.
- Telehealth Advancement Act of 2011 (AB 415, Logue)
- AB 744 (Aguilar-Curry, 2019) – Private payer service & payment parity.
- AB 1494 (Aguilar-Curry, 2019) – Neither face-to-face contact nor the patient’s physical presence is necessary at an enrolled community clinic for purposes of Medi-Cal reimbursement during or immediately following a state of emergency. Allows for reimbursement during or immediately following a state of emergency.

SIGNIFICANT CHAPTERED CA TELEHEALTH LEGISLATION:

- For an excellent compilation of chaptered California state legislation related to telehealth, please see the Center for Connected Health Policy list at <https://www.cchpca.org/telehealth-policy/telehealth-advancement-act>.

ASSEMBLY HEALTH REQUESTED THAT CHBRP SUMMARIZE:

- Whether health care services delivered via telehealth are *equivalent* to in-person services;
- Whether use of telehealth services *affects* the use of other services;
- How utilization of and type of telehealth has *changed over time* and *during* the COVID-19 pandemic;
- Whether providing telehealth services *are cost-effective*; and
- Information about existing *disparities* in access to and use of telehealth.

RESEARCH APPROACH AND CONSIDERATIONS

CHBRP reviewed the best available evidence from peer-reviewed and grey literature to answer these two **Key Questions**

- Does the evidence indicate whether services delivered via telehealth (and specifically telephone) are equivalent to in-person services?
- Does the evidence indicate whether the use of telehealth services (and specifically telephone services) affects the use of other services?



LIMITATION OF MEDICAL EVIDENCE

- A major limitation of the literature is that the pace at which studies of telehealth are published **does not keep pace with the rate of change in telehealth technology.**
- Another important limitation of the studies is the inability to disaggregate the **telehealth** services from other interventions, such as an integrated web portal that includes e-mails as well as information about self-care, access to test results, and ability to refill prescriptions.

OUTCOMES ASSESSED

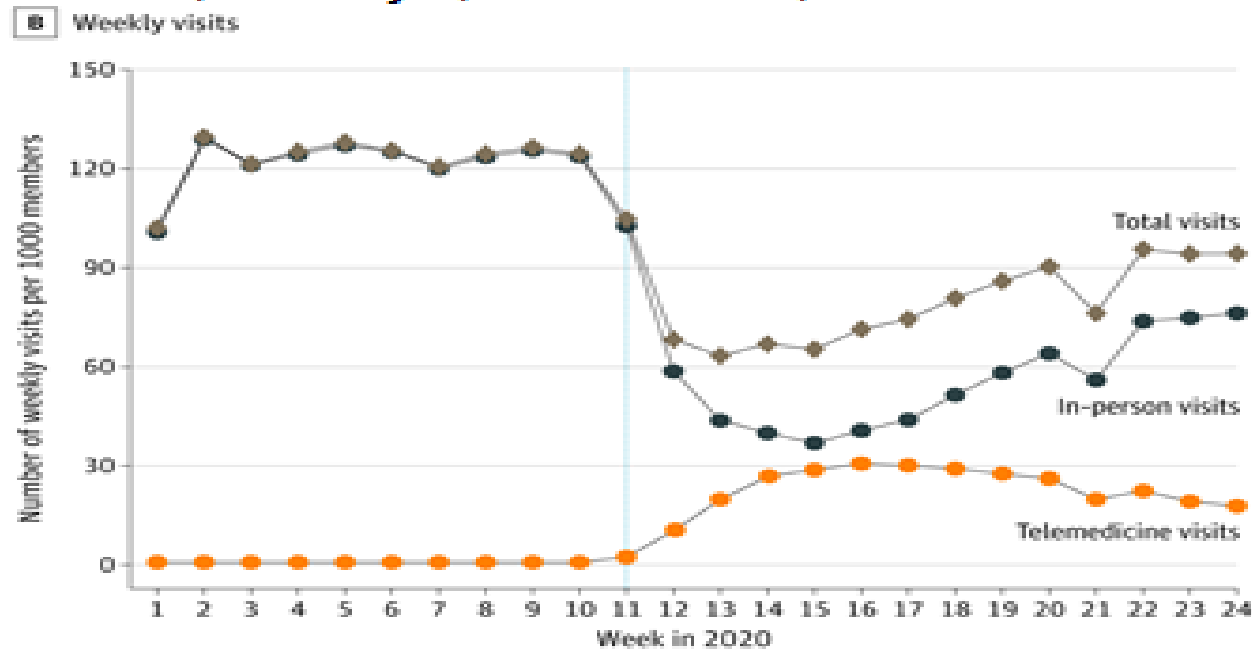
- In order to determine whether telehealth services are **equivalent to in-person services**, CHBRP examined:
 - **(1) health outcomes**, including both physiological measures and patient-reported outcomes and
 - **(2) process of care outcomes**, including treatment adherence, accuracy of diagnoses, and alignment of treatment plans with clinical practice guidelines.
- CHBRP examined effects of telehealth on the **use of other health care services**, such as wait time for specialty care, or number of outpatient visits, ER visits and hospitalizations.

MEDICAL EFFECTIVENESS FINDINGS

	Equivalent to In-Person Services		Use of Other Services
	Health Outcomes	Process of Care	Access and Utilization
Live Video	Clear and Convincing - Yes	Clear and Convincing – Yes	Preponderance - No
Telephone	Preponderance - Yes	Inconclusive	Inconclusive
eConsult	Insufficient	Insufficient	Preponderance - Yes

UTILIZATION OF TELEHEALTH

Figure 1. Trends in In-Person, Telehealth, and Total Visits per Week, January 1, 2020–June 16, 2020



Source: Patel, et al. 2020.

Note: The dotted vertical line indicates the week of March 17, 2020 (week 11), when Medicare expanded reimbursement for telemedicine visits due to the COVID-19 pandemic. Week 21 (May 20–May 26, 2020) includes Memorial Day, a federal holiday in the US. The work week was likely 4 days for many practices resulting in a decrease in visit volume.

UTILIZATION OF TELEHEALTH

- During the COVID-19 pandemic, **use of telephone** increased dramatically in March and April of 2020. As restrictions around telehealth technology loosened, **video** use increased and overtook telephone.
- Telehealth use is highest among behavioral health providers, radiologists, pathologists, and emergency medicine physicians. While telehealth use among all provider types increased during the COVID-19 pandemic, these trends have held.



COST-EFFECTIVENESS OF TELEHEALTH

- Generally, telehealth was associated with overall cost savings or was cost neutral.
- Except for a direct-to-consumer telehealth study (discussed in our Brief), no recent studies were identified that found increased overall costs with telehealth services.

COST-EFFECTIVENESS OF TELEHEALTH DURING COVID-19

- CHBRP was unable to locate any recent analyses that reported data on telehealth's effects on cost during the COVID-19 pandemic; the major changes in the behavior of health systems and consumers associated with the pandemic *may* have led to overall cost increases rather than the cost savings that were identified in earlier studies.

DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH

- Telehealth may improve **access** to health care services, but **disparities** in telehealth utilization persist.
- In the context of the current COVID-19 pandemic, researchers have noted that individuals with poorer health are most likely to benefit from telehealth services but these individuals are also less likely to use telehealth than healthier individuals.
- The disparities in rural telehealth utilization may be partially explained by disparities in infrastructure and technology access.

DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH

- Telehealth access and utilization varies across population groups, with non-English speakers, people of color, older Americans, and lower-income households all reporting greater technology barriers, lower telehealth utilization, and higher likelihood of using telephone/audio-only rather than video telehealth.
- Telehealth disparities likely persist but may have narrowed as a result of COVID-19 pandemic-facilitated health system changes.

CONCLUSION

- Use of telehealth has changed substantially in the last year, both in terms of volume and in delivery.
- More literature evaluating the effectiveness is forthcoming.
- Although utilization of telehealth has decreased from the peak in April 2020, although utilization of telehealth has decreased from the peak in April 2020, it is likely that utilization of telehealth will remain higher than pre-pandemic levels, although the magnitude of increase is unclear.
- Studies of telehealth have not been able to keep pace with the very rapid rate of change in telehealth technology and changes in use.

Questions on Telehealth Brief?

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