University of California
Office of the President

1111 Franklin St.
Oakland, CA 94607

www.chbrp.org

July 30, 2014

Senator Kevin de Leon
Chair, Senate Appropriations Committee
State Capitol, Room 2206
Sacramento, CA 95814

Via email only: brendan.mccarthy@sen.ca.gov

Dear Senator de Leon:

The California Health Benefits Review Program (CHBRP)[1] is pleased to provide the Senate Appropriations Committee with an updated analysis of AB 1771 (Perez): Telephone Visits. This update reflects the most recent language – as of June 24, 2014 – for AB 1771, which requires reimbursement and coverage for patient-initiated telephone evaluation and management visits with providers. Since CHBRP's original report, submitted April 25, 2014, new language in AB 1771:

- Delays implementation to January 1, 2016;
- Narrows the scope to require coverage of only telephone visits (previous versions included electronic communications such as e-mail, live videoconferencing, store-and-forward,[2] and potentially other electronic methods, which CHBRP had previously excluded from analysis);
- No longer requires reimbursement "at the same level and amount" for telephonic visits of similar time and complexity to in-person visits; and
- Expands coverage to include patient-initiated telephone visits provided[3] by both physicians and licensed non-physicians, as defined in the Business and Professions Code, Division 2.

[1]CHBRP, established by the California Health and Safety Code, Section 127660-127665, at the University of California, responds to requests from the State Legislature to provide independent analyses of the medical effectiveness, financial impacts, and public health impacts of proposed health insurance benefit mandates and repeals.
[2] Technology, which is explicitly defined in the state's telehealth law, that involves the capture and storage of medical information (such as an x-ray or sound recording) that is then forwarded to a physician for evaluation.
[3] For services to be reimbursed, medical providers must be licensed and entitled to collecting reimbursement via health insurance carriers and other payers. Typically, this means that registered nurses and other support staff are not able to bill for services despite the change in benefits.

Medical Effectiveness

Many health professionals are regulated under the California Business and Professions Code, Division 2. Those to whom AB 1771 would likely apply are listed in Table 1.

Table 1. Health Professionals Likely Affected by AB 1771

Health professionals regulated under California Business and Professions Code, Division 2	
• Registered nurses • Advanced practice nurses • Licensed vocational nurses • Acupuncturists • Audiologists • Chiropractors • Clinical laboratory scientists • Dieticians • Licensed clinical social workers • Licensed counselors • Licensed midwives • Marriage and Family Therapists	• Occupational therapists • Perfusionists • Pharmacists • Physical therapists • Physicians • Physician assistants • Podiatrists • Psychiatric technicians • Psychologists • Respiratory therapists • Speech language pathologists

Note: This is not a comprehensive list of regulated health professionals. CHBRP excludes non-physicians such as dentists, dental hygienists, dental assistants, optometrists, and opticians, who are not typically covered under health insurance medical benefits. For most Californians, dentists' and optometrists' services are covered under separate dental and vision plans.

Telephone use by health professionals. The extent of patient-initiated telephone calls varies across these health professions, depending on the nature of their roles, the setting in which they practice, and whether evaluation and management requires physical contact. For instance:

- Registered nurses, advanced practice nurses, and physician assistants who practice in outpatient settings often interact with patients over the telephone. In some physician offices and clinics, registered nurses respond to calls from patients and use protocols to evaluate patients, provide advice on self-care, and, if necessary, schedule an appointment with the patient's physician or another clinician in the practice. Some advanced practice nurses, physician assistants, and midwives have their own panels of patients and respond to calls from them;
- Pharmacists respond to calls from patients who have questions about their medications; and
- Clinical psychologists, licensed clinical social workers, licensed counselors, and marriage and family therapists respond to calls from patients who are experiencing mental health problems and may also provide individual or group psychotherapy visits via telephone.

In contrast, much of the care provided by some health professionals cannot be delivered over the telephone because it requires in-person contact between the health professional and the patient. For example, a physical therapist may need to have in-person visits with a patient for certain knee injuries to teach the patient how to perform exercises necessary for rehabilitation and to monitor the patient's progress. Similarly, an audiologist needs to have an in-person visit with a

patient to evaluate hearing loss. Finally, some health professionals, most notably clinical laboratory scientists, seldom interact directly with patients.

Effectiveness of telephone visits by non-physicians. A large body of literature has been published regarding the effectiveness of telephone interventions provided by non-physician clinicians. Assessing the implications of this literature for AB 1771 is challenging because AB 1771 would only require health plans to reimburse telephone calls that are initiated by an established patient within a certain time interval (as specified in Current Procedural Terminology codes) regarding new or acute concerns unrelated to recent office visits and for which an in-person visit is not required.

Most of the literature on telephone interventions provided by non-physician clinicians has assessed disease management programs for patients with chronic conditions, such as diabetes and congestive heart failure. Although details vary widely across disease management programs, in most cases the majority of telephone calls are initiated by non-physician clinicians for purposes of monitoring patients' conditions and teaching patients how to manage their conditions. Findings regarding the effectiveness of telephone calls initiated by health professionals cannot be extrapolated to calls initiated by patients because the content of the conversations may differ. In addition, some disease management programs combine telephone calls with remote monitoring of patients' vital signs by non-physician clinicians (e.g., electronic transmission of data on lung function for patients with chronic obstructive pulmonary disease). For such interventions, the effects of the telephone calls cannot be separated from the effects of remote monitoring.

Therefore, CHBRP finds insufficient evidence[4] to determine whether care provided by non-physicians solely via telephone is effective when initiated by patients.

Benefit Coverage, Utilization, and Cost

Change in Utilization: It is important to note that patients are currently using the telephone to communicate with their medical providers, and have been for decades. While some health insurers may reimburse for these encounters, coverage is not required.

As in the original report, CHBRP assumes the AB 1771–related telephone visits would fall into two categories:

- Substitute (or replace) current in-person visits with patient-initiated evaluation and management telephone encounters; and
- Supplement current in-person visits with net additional services via telephone that (1) previously would not have been delivered in person due to distance, inconvenience, and time, and (2) services that physicians have already been providing via telephone, but were previously not billed or reimbursed because they were not covered.

[4] The absence of evidence is not evidence of no effect. It is an indication that the impact of the intervention on the outcome in question is unknown.

To allow for direct comparisons between the previous and current analyses, CHBRP made the following alterations to the original CHBRP analysis to estimate the impact of the amended language:

- New data on non-physician provider claims were analyzed to capture premandate use of in-person and telephonic evaluation and management services. The same criteria used in the original analysis to estimate physician provider utilization from claims data were used to estimate non-physician provider utilization.
- CHBRP assumes that both physician and non-physician use would increase based on previous evidence published in *Health Affairs*, reflecting Kaiser Permanente's experience with covering telephone and e-mail (Pearl 2014). Because e-mail is no longer a component of the bill, CHBRP uses a simplifying assumption that telephone visits would replace e-mail visits due to the reimbursement available for telephone under this amendment to AB 1771.
- The unit costs (i.e., estimated price) of supplemental and substitute visits delivered via telephone were reduced from approximately $100 per visit – the reimbursement for in-person visits – to $50 per visit – the average reimbursement for telephonic visits.[5] In addition, the patient cost-sharing amounts were reduced from $20 per visit to $5 per visit.

The difference in reimbursement between in-person visits at approximately $100 and telephone visits at $50 could create resistance to substitution of telephonic evaluation and management by providers because delivering the same evaluation and management visit telephonically would reduce their reimbursement rate by 50%. Given that response by providers is unknown, CHBRP created four new scenarios to test different assumptions about the increase in telephone services and the amount of substitute and supplemental services (Tables 2 and 3) using the new baseline utilization and reimbursement levels per amended language. The scenarios use the same basic assumptions employed in the original CHBRP report to evaluate the potential impact of the amended language.

In the original CHBRP analysis, scenarios were developed to understand the likely behavioral response to telehealth (all four modalities of original bill language) reimbursement using different levels of phase-in ("Low" scenario = 25% of potentially billable services under full implementation that would be delivered *and reimbursed*; "High" scenario = 100% of potentially billable services under full implementation that would be delivered *and reimbursed*) during the first year, and also to understand the impact of cost-sharing. CHBRP used the same approach to estimate the impact of the amendments, but adjusted the analysis to reflect changes in providers and services now covered by AB 1771, expected reimbursement levels, and the range of potential provider responses to AB 1771.

Change in expenditures: The "60:40, Medium-high substitution to supplemental" scenarios presented above in both the high and low scenarios represent the equivalent assumptions to the

[5] Milliman analysis of 2012 MarketScan data. These price reductions reflect the amended bill language that eliminates the visit equivalency requirement – "same level and amount" – and assumes the telephone calls are of lesser urgency/complexity than those accounted for in CHBRP's original analysis. CHBRP used the same average "unit cost" for physician and non-physician visits.

original analysis. Based on these assumptions, AB 1771 would result in a decrease in overall expenditures due to the benefit mandate displacing more expensive in-person office visits and replacing them with less expensive telephone visits for the same services.

However, due to provider incentives to earn more revenue per encounter when delivering equivalent services, it cannot be assumed that CHBRP's original assumptions related to 60% substitution and 40% supplement would be adopted systemwide, except in areas with very high existing volume, provider shortages and stretched capacity. Instead, the range of expenditure estimates provides insight into the possible behavioral response from the health care delivery system, given various levels of telephone visits that are delivered and billed, ranging from:

- ***Reductions in total expenditures*** if providers agree to accept less money per encounter by substituting telephone visits for in-person visits.
- ***Increase in total expenditures*** if providers add capacity, either by working longer hours and/or adding non-physicians, to respond to patient-initiated telephone calls, while maintaining in-person visits.

Table 2. High-end Scenario – 100% of Eligible Services Are Delivered and Reimbursed

Ratio of telephone visits that substitute for in-person visits to supplemental(a) visits				
	90:10 High substitution: low supplemental visits	60:40(b) Medium-high substitution to supplemental	30:70 Medium-low substitution to supplemental	10: 90 Low substitution: high supplemental visits
Change in Utilization				
Increase in telephone visits	124% 4,965,478	129% 5,203,885	136% 5,477,732	141% 5,684,091
Change in Expenditures				
Change in total premiums	-0.1412% -$163,188,000	-0.0235% -$27,204,000	0.1116% $128,996,000	0.2135% $246,701,000
Change in total expenditures	-0.1769% -$227,222,000	-0.0502% -$64,524,000	0.0953% $122,361,000	0.2049% $263,190,000

Source: California Health Benefits Review Program, 2014
Notes: (a) Supplemental visits are defined as visits that either: (1) are currently not provided due to time, distance, or inconvenience; or (2) are currently provided, but not reimbursed.
(b) 60:40 scenario mirrors assumptions from CHBRP's original report, published April 25, 2014. Additional scenarios (90:10, 30:70, and 10:90) reflect the percentage of all telephone visits that will substitute for existing in-person services in comparison to those that represent supplemental (new) visits if telephone visits were now covered.

Table 3. Low-end Scenario – 25% of Eligible Services Are Delivered and Reimbursed

Ratio of telephonic visits that substitute for in-person visits to supplemental(a) visits				
	90:10 High substitution: low supplemental visits	60:40(b) Medium-high substitution to supplemental	30:70 Medium-low substitution to supplemental	10:90 Low substitution: high supplemental visits
Change in Utilization				
Increase in telephone visits	30% 1,221,608	30% 1,216,788	30% 1,211,810	30% 1,208,399
Change in Expenditures				
Change in total premiums	-0.0347% -$40,148,000	-0.0055% -$6,361,000	0.0247% $28,537,000	0.0454% $52,447,000
Change in total expenditures	-0.0435% -$55,901,000	-0.0117% -$15,086,000	0.0211% $27,069,000	0.0435% $55,953,000

Source: California Health Benefits Review Program, 2014
Notes: (a) Supplemental visits are defined as visits that either: (1) are currently not provided due to time, distance, or inconvenience; or (2) are currently provided, but not reimbursed.
(b) 60:40 scenario mirrors assumptions from CHBRP's original report, published April 25, 2014. Additional scenarios (90:10, 30:70, and 10:90) reflect the percentage of all telephone visits that will substitute for existing in-person services in comparison to those that represent supplemental (new) visits if telephone visits were now covered.

Public Health

CHBRP estimates that AB 1771 would increase health care access for those enrollees who initiate telephone visits (supplemental or substitute). Provider willingness to deliver the newly reimbursed care via telephone, when medically appropriate, is also likely to increase patient satisfaction due to increased convenience and reduced wait time for some visits.

However, CHBRP is unable to estimate changes in health outcomes attributable to AB 1771 due to insufficient evidence of the effectiveness of patient-initiated telephone visits to produce equivalent or better morbidity or mortality outcomes when compared to in-person visits. Additionally, CHBRP is unable to find evidence to determine whether patient-initiated telephone encounters would result in harms to patients or a reduction in health disparities. Note that the absence of evidence is not "evidence of no effect." It is possible that an impact – positive or negative – could result, but current evidence is insufficient to inform an estimate.

CHBRP's public health conclusion is based on anticipation that AB 1771 would further increase access to providers for some enrollees, especially those in rural areas, as well as enrollees in urban areas who may experience travel barriers related to cost and/or distance. In turn, some enrollees using telephone services may reduce their lost productivity due to reductions in travel time and waiting time for in-person visits. Furthermore, the current capacity of providers to see additional patients would expand due to the addition of non-physicians and the deletion of the previous requirement for encounters to be of similar complexity and time to that of office visits. Thus, as a result of amendments that require coverage of telephone visits with non-physicians, additional visits per day may be achievable. Postmandate, CHBRP estimates that a portion of

enrollees will continue to receive the same care (no change in utilization, but their providers are now compensated for the care), while other enrollees will have new access to care (increase in net utilization and compensation).

In summary, as AB 1771 is currently written, CHBRP finds:

- Insufficient evidence to determine whether patient-initiated telephone visits with non-physicians are effective.
- Estimates on AB 1771's impact on expenditures vary – from reducing overall expenditures to increasing overall expenditures – depending on providers' behavioral response to the ability to be reimbursed for telephone visits at lower cost than in-person visits.
- Overall impact on the public's health is unknown, though patient experience may change with the increased convenience of telephone and decreased travel and waiting time for in-person visits.

Please feel free to contact CHBRP with further questions.

Sincerely,

Garen L. Corbett, MS
Director, California Health Benefits Review Program
Division of Health Sciences and Services
University of California, Office of the President

References

Inglis SC, Clark RA, McAlister FA, et al. Structured telephone support or telemonitoring programmes for patients with chronic heart failure. *Cochrane Database Systematic Reviews*. 2010(8): CD007228.

McLean S, Chandler D, Nurmatov U, et al. Telehealthcare for asthma. *Cochrane Database of Systematic Reviews*, 2010:(10);CD007717.

Neubeck L, Redfern J, Fernandez R, Briffa T, Bauman A, Freedman SB. Telehealth interventions for the secondary prevention of coronary heart disease: a systematic review. *European Journal of Cardiovascular Prevention and Rehabilitation*. 2009;16:281-289.

Pearl R. Kaiser Permanente Northern California: Current Experiences with Internet, Mobile and Video Technologies. *Health Affairs*. 2014; 33(2): 241-257.

Suksomboon N, Poolsup N, Nge YL. Impact of phone call intervention on glycemic control in diabetes patients: a systematic review and meta-analysis of randomized, controlled trials. *PLoS One*. 2014; 9:e89207.