

# California Health Benefits Review Program

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## 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

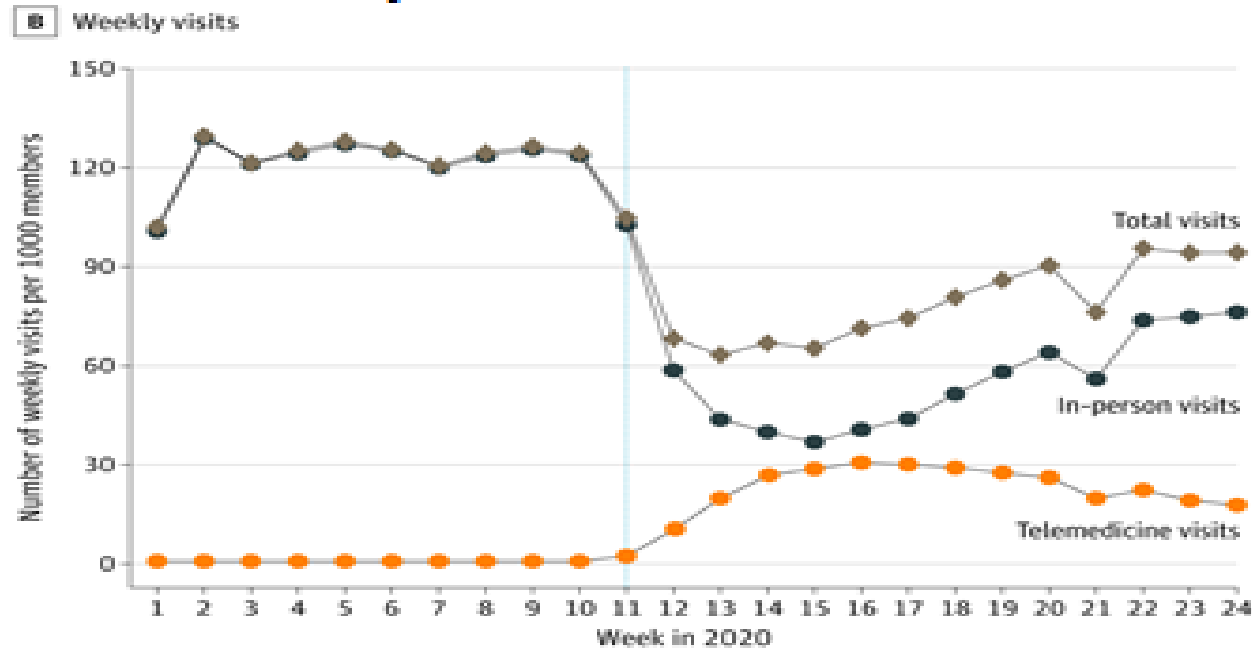
- In order to determine whether telehealth services are **equivalent to in-person services**, CHBRP examined:
  - **(1) health outcomes**, including both physiological measures and patient-reported outcomes and
  - **(2) process of care outcomes**, including treatment adherence, accuracy of diagnoses, 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
<b>Live Video</b>	Clear and Convincing - Yes	Clear and Convincing – Yes	Preponderance - No
<b>Telephone</b>	Preponderance - Yes	Inconclusive	Inconclusive
<b>eConsult</b>	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 costs 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, 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?

[www.chbrp.org](http://www.chbrp.org)

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