Center for Connected Health Policy

The National Telehealth Policy Resource Center

EXECUTIVE SUMMARY

Community Health Centers have historically played a vitally important role in providing health care to underserved and uninsured communities. In California, these community health centers, (CHC) which include federally qualified health centers (FQHCs) and rural health centers (RHCs), serve as the safety-net for the most vulnerable populations in the state. In 2013, there were 129 FQHCs in California, many with multiple sites. With resources already stretched to meet current demands, CHCs in California are now facing unprecedented challenges as a result of the passage of the Affordable Care Act (ACA) and Medi-Cal expansion (California's state Medicaid program).

Telehealth technologies could potentially offer valuable solutions for meeting these new demands, yet these tools are significantly under-utilized across the state for a number of reasons, and the clinical and financial benefits are still not well understood by the CHC community. With the support of a grant from the Blue Shield of California Foundation (BSCF), the Center for Connected Health Policy (CCHP) undertook a study to better understand the true costs and potential revenue sources for telehealth care. For this study, five CHCs across the state with demonstrated experience in the use of telehealth for their client population were selected. To design and conduct the financial analysis of these CHCs, CCHP engaged the services of Milliman, Inc., one of the nation's leading actuarial firms. CCHP's policy brief summarizes the actuarial study as well as other barriers that impede CHCs from achieving sustainable telehealth programs.

The financial analysis conducted by Milliman revealed that the telehealth programs are not self-sustaining as they are currently operated. The telehealth programs examined in this study were being subsidized with grants or other CHC resources. The study found that several factors existed that contributed to this unsustainability including:

- The complexity of the billing and reimbursement rules applicable to telehealth delivered services and FQHCs/RHCs present ongoing challenges to sustainability.

- Telehealth programs cannot be sustained as an isolated cost center especially if the program is low volume.

- Shortages of providers and low Medi-Cal reimbursement rates lead to difficulty in securing services and/or lead to contractual arrangements that are not favorable to the CHCs.

- Data systems, including interoperability, EHR transition, and moving to managed care encounter data reporting are barriers to tracking telehealth-related services and costs.

- Inconsistent use of modifiers for coding telehealth-related claims and encounters can cause difficulties in tracking use.

The issue brief provides a series of recommendations to CHCs to help telehealth programs achieve sustainability and to policymakers who can help create an environment that will assist these entities in this goal.

Recommendations for CHCs

- New models of delivery need to be created. Telehealth programs cannot be sustained as an isolated cost center and service, but must be fully integrated into the delivery system of health care.

- CHCs should develop a "learning network" to share information and knowledge regarding common problems associated with telehealth delivery and reimbursement.

- CHCs should consider pooling together their telehealth patient volumes to obtain reasonable rates from distant providers who seek a predictable workload, or look at other alternative means.

- Institute changes to billing systems and the EHR to better track telehealth encounters.

About CCHP

The Center for Connected Health Policy (CCHP) is a nonpartisan public interest organization working to maximize telehealth's ability to improve health outcomes, care delivery, and cost effectiveness. CCHP was established in 2008 with funding from the California HealthCare Foundation (CHCF), and is a program of the Public Health Institute, an independent, non-profit organization dedicated to promoting health, well-being, and improving the quality of life for people throughout California, across the nation, and around the world.

CCHP is a resource for California and other state and national health care decision makers providing technical support that can lead to a more receptive policy environment for provision of telehealth services. CCHP conducts objective policy analysis and research, makes non-partisan policy recommendations, and manages innovative telehealth demonstration projects.

In 2012, CCHP became the federally-designated National Telehealth Policy Resource Center, providing technical assistance to twelve Regional Telehealth Resource Centers (TRCs) nationwide, and serves as a national resource on telehealth policy issues. The NTRC-P project is made possible by Grant #G22RH24746 from the Office of the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services.

Recommendations for Policymakers

Several major policy barriers have been identified that impede these entities from fully utilizing telehealth modalities to improve access and quality of care, and impact the program's long-term sustainability. The following policy-related recommendations include proposed legislative and administrative solutions, all of which will assist the CHCs to take full advantage of digital technologies to improve care and create greater efficiencies.

- Change current federal laws regarding the reimbursement of telehealth delivered services under the Medicare program including geographic, facility, services and provider restrictions.

- Eliminate the current requirement of "face-to-face" in the definition of a "visit" for a CHC on both the federal and state level.

- Change both Medicare and Medi-Cal policy of multiple visits in one day.

- The Department of Health Care Services is encouraged to provide policy leadership to Medi-Cal Managed Care Plans to allow CHCs to take full advantage of the full flexibility the law allows for reimbursing telehealth delivered services.

- Ensure telehealth options in California's 1115 Waiver, "Medi-Cal 2020," remain and are strengthened.

- Medi-Cal should make more billing codes eligible for reimbursement when the service is delivered via telehealth.

The process of transforming CHCs into the 21st Century to be able to take full advantage of the rapidly growing field of technology-enabled care and monitoring will be challenging but necessary. With Alternative Payment Models on the horizon and resources becoming more scarce, it will be critically important for public policymakers, CHC state and regional leadership, health center operations and management, and clinical care providers to be prepared and willing to embrace these new technologies to more effectively meet the growing demand for access to health care and support for the most vulnerable Californians.

INTRODUCTION

Community Health Centers have historically played a vitally important role in providing health care to underserved and uninsured communities. In California, these community health centers, (CHC) which include federally qualified health centers (FQHCs) and rural health centers (RHCs), serve as the safety-net for the most vulnerable populations in the state. In 2013, there were 129 FQHCs in California, many with multiple sites.[1] With resources already stretched to meet current demands, CHCs in California are now facing unprecedented challenges as a result of the passage of the Affordable Care Act (ACA) and Medi-Cal expansion (California's state Medicaid program). Nearly 1.4 million individuals have been enrolled into Qualified Health Plans through Covered California as of February 2015,[2] and total Medi-Cal enrollment for 2015-16 is projected to be 12.4 million, a third of the population of the state;[3] and, an estimated 2.6 million undocumented individuals in the state are excluded from health coverage and remain uninsured.[4]

To meet this increased demand for primary care and chronic disease management, CHCs throughout the state are having to re-assess how to best use their resources, and are beginning to explore how to take advantage of new technologies for improving access and quality of care. Further, CHCs are seeking to become better prepared for the possibility of new alternative payment systems that will emphasize value over volume of services provided.

Telehealth technologies could potentially offer valuable solutions for meeting these new demands, yet these tools are significantly under-utilized across the state for a number of reasons, and the clinical and financial benefits are still not well understood by the CHC community. With the support of a grant from the Blue Shield of California Foundation (BSCF), the Center for Connected Health Policy (CCHP) undertook a study to better understand the true costs and potential revenue sources for telehealth care. For this study, five CHCs across the state with demonstrated experience in the use of telehealth for their client population were selected. To design and conduct the financial analysis of these CHCs,

CCHP engaged the services of Milliman, Inc., one of the nation's leading actuarial firms. This policy brief provides a summary of the findings of the actuarial study, and a series of policy and operational recommendations to encourage more effective and efficient use of telehealth to assist in sustainability of a telehealth program within a CHC.

The paper is divided into three distinct parts:

- Background – to set the stage and understand the issues CHCs face in utilizing and being reimbursed for telehealth-delivered services.

- Financial Analysis – a summary of the financial analysis conducted by Milliman of the five participating CHCs. (The full actuarial report is available on CCHP's website, cchpca.org).

- Recommendations – recommendations for both CHCs in how to make their telehealth programs more sustainable and policy recommendations that will help improve the environment for CHCs.

BACKGROUND

Definition of Telehealth

The definition of telehealth used for this brief is the one that appears in California Business and Professions Code Section 2290.5(a)(6). Telehealth:

"means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers."

The legal definition encompasses all current modalities of telehealth which are live video (synchronous), store-and-forward (asynchronous), remote patient monitoring (RPM), and mHealth (for more information on these modalities, see cchpca.org). Clinics may utilize one or a combination of the modalities though they may not receive reimbursement for the services they provide. While the definition of telehealth in California law is broad and encompassing, the payers', both public and private, policies still dictate what is reimbursed and what is not.

Current California Telehealth Payment Policies

Projected to cover one third of California's population in FY 2015-2016,[5] Medi-Cal's fee-for-service policies play a major role in influencing the future of telehealth expansion in the state. The Telehealth Advancement Act of 2011 reshaped California's policies governing the use and reimbursement for telehealth. However, four years later Medi-Cal policies and regulations governing fee-for-service reimbursement for telehealth remains limited. For example, while the list of eligible providers for the use of live video was expanded to include any licensed health professional, Medi-Cal reimbursement policy restricts what is billable for these providers under the program if the service is provided via telehealth. Additionally, while any licensed health provider may provide telehealth services via the four modalities, only dermatology and ophthalmology, and more recently tele-dentistry, are reimbursed if provided

via this modality. No reimbursement is available for remote monitoring.

Medi-Cal managed care plans however have greater discretion for coverage of telehealth delivered services through their provider networks. A comprehensive analysis of private payers' policies and practices related to telehealth coverage has proven to be difficult, but anecdotal information gleaned from some plans, and examination of some provider manuals indicate that private payers also roughly follow the reimbursement policies of Medi-Cal fee-for-service. Thus, private plans generally pay for live video, some limited store-and-forward services and likely do not cover any RPM. Covered California encourages, but does not mandate, plans participating in the Exchange to provide services via telehealth.

This limited reimbursement environment, despite the flexibility allowed by California law, creates a challenging situation for CHCs to design and implement a sustainable telehealth model. Additionally, CHCs face other regulatory hurdles unique to them that create barriers to sustainability.

Medicare

Medicare's telehealth policies create another significant layer of complication for CHCs. Medicare limits reimbursement for telehealth delivered services to enrollees who are located in:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract;
- A county outside of a MSA; OR
- A federal telehealth demonstration program in Hawaii or Alaska.[6]

These restrictions eliminate nearly all of California from qualifying as an eligible originating site for a telehealth service under the program. Should a CHC qualify to be an eligible site under Medicare, they are further restricted by the services that may be reimbursed, the types of providers that may perform such services, and the need for the patient to be in a medical facility (thereby eliminating the home, which is an eligible site for an RHC or FQHC visit, and other non-traditional locations such as a school or church).

Health Care Financing for Community Health Centers

CHCs are reimbursed based on a complex federal and state funding structure that rewards volume over value. CHCs with the FQHC or RHC designation receive enhanced reimbursement from Medicare and Medi-Cal that is intended to support the essential services they provide their communities. FQHCs and RHCs are required to submit cost reports to the California Department of Health Care Services (DHCS) and the U.S. Health Resources and Services Administration. Cost reports are used to reconcile and verify payments for allowable costs and determine future reimbursement rates. In the Medi-Cal fee-for-service system, FQHC's are paid a per-visit payment known as the prospective payment system (PPS). The PPS rate is based on a baseline rate that reflects the health center's costs to provide services in 1999-2000, adjusted for inflation. When a Medi-Cal beneficiary in the managed care system receives care from an FQHC, the managed care plan makes a per-visit payment to the center. If the rates paid by managed care plans are below the PPS rate, the state makes a supplemental "wrap-around" payment to the federally qualified health center to bring the total payment up to the PPS rate.

CHCs that seek to expand their services to include specialty care services (with or without telehealth) face significant regulatory barriers. In California there is no dedicated funding for specialty care services for the uninsured, Medi-Cal rates for specialty care are inadequate, and CHCs that seek to use enhanced Medi-Cal funding for this purpose face many uncertainties. Medi-Cal is the predominant payer for CHCs, followed by Medicare. Legislation is currently being considered (SB147 (Hernandez)) that would require DHCS to authorize a three year alternative payment model (APM) pilot project for FQHCs. If enacted, this law would serve to facilitate the transition away from a payment system that rewards volume with a flexible alternative that recognizes the value added when Medi-Cal beneficiaries are able to more easily access the care they need and when providers are able to deliver care in the most appropriate manner to patients.

Commercial payers represent a relatively small proportion of total payments to CHCs. However, this proportion may grow, especially for those CHCs that are part of the essential community provider networks offered by Covered California health plans.

In addition to the reimbursement and related policy issues, which are significant, CHCs face a number of operational barriers to support the expansion of telehealth in their facility. CCHP, with approximately $2M in grant support from the California HealthCare Foundation (CHCF), partnered with the five University of California (UC) Medical Schools, to test to what extent CHCs would utilize specialty care services if they were provided at no cost through the UC medical centers. The 43 CHCs that participated were each provided with $10,000 in grant support, assistance with obtaining telehealth equipment and training, and coordination of scheduling of the virtual visits. From the evaluation of this demonstration program ten key programmatic recommendations were produced to help guide CHCs interested in incorporating telehealth into their health center operations. These recommendations are described in greater detail in CCHP's *Specialty Care Satety Net Inititiave (SCSNI): Integrating Telehealth in the Priary are Setting,* but in essence it was clear that much planning, coordination, and organization-wide commitment is essential to be successful as these technologies, by their very nature are disruptive, and transformative.

A recent survey and assessment of some of the leading CHC executive directors and CHC regional association directors commissioned by the California Telehealth Network (CTN) substantiates these findings with reimbursement policies rising to the top as the biggest barrier to telehealth deployement in their opinion.

> "Should a CHC qualify to be an eligible site under Medicare, they are further restricted by the services that may be reimbursed, the types of providers that may perform such services, and the need for the patient to be in a medical facility."

The Community Health Centers

Five CHCs were selected to participate in this study. Each had experience in utilizing telehealth within their Community Health Centers through their telehealth programs that ranged from established programs of over ten years and provision of multiple specialties via telehealth to newer ones with only a few years' experience and a narrower list of services. Three of the CHCs were FQHCs and the other two were RHCs. As an FQHC or RHC, these clinics are faced with other provisions that impact their reimbursement for telehealth delivered services.

FQHCs & RHCs

An FQHC is an organization that receives a grant under Section 330 of the Public Health Service Act. An FQHC qualifies for enhanced reimbursement from Medicare and Medicaid. FQHCs must meet certain qualifications in order to receive such a designation.[7] Some of these qualifications include:

- Location in a medically underserved area or serve a special medically underserved population (MUP).

- Be a public or private nonprofit entity.

- Provide certain "required primary health services" made up of "basic health services" related to traditionally defined primary care services, diagnostic laboratory and radiology services, preventative health treatment, immunization and screen services, emergency medical services, appropriate pharmaceutical services, referrals to providers of medical services, including "specialty referral when medically indicated" and for other health-related services.

- May also provide such "additional health services" as may be appropriate for particular centers where they are "necessary for the adequate support of the 'required primary health services.'"[8]

Participating Clinics:

- Shasta Community Health Center (SCHC)
- Community Health Alliance of Pasadena (ChapCare)
- Barton Community Health Center (Barton)
- West County Health Centers (West County)
- Southern Inyo Healthcare District (Southern Inyo)

A RHC is a FQHC certified to receive special Medicare and Medicaid reimbursement which is meant to increase rural patients' access to primary care services.[9] Both entities are similar to each other. "Figure 1" is a comparison chart of the two.[10]

FQHCs and RHCs serve a disproportionate share of low-income, indigent and uninsured populations. FQHCs must accept all patients regardless of a person's ability to pay. Due to the ACA, some may also be covered by private payers, but most CHC clients are covered through public payers such as Medi-Cal or Medicare that pay low rates or the clients must pay out of pocket, if at all. These factors already create financial challenges for these entities without the added complication of finding ways to pay for telehealth delivered services that are not reimbursed fully by all payers.

As noted above, CHCs are paid a PPS rate that is based upon a baseline of costs and adjusted for inflation. The PPS rate covers all services that are provided in an encounter. Because FQHCs and RHCs do not all provide the same services or have the same costs, rates can vary. The rates can range from $85 to $280 per encounter. For fee-for-service encounters, CHCs will receive their PPS rate for each encounter. As stated earlier, Medi-Cal managed care plans (MCPs) pay rates that are comparable to what they pay other providers for the same service. Should that rate be below the PPS rate, the state pays what is called a "wrap around" that makes up the shortfall that makes it equal to that CHC's PPS rate. Under Medicare Advantage Plans, FQHCs receive a wrap around rate, RHCs do not.

In addition to the reimbursement issues, other policies and regulations impact the ability of FQHCs and RHCs to utilize telehealth.

Figure 1: FQHCs & RHCs Overview

	RHC	FQHC
Location	Non-urban MUA or HPSA	MUA or MUP
Organizational Type	For profit, nonprofit, or public entity	Nonprofit or public entity
Governance Requirement	None	Majority user board of directors
Services Provided	Basic Primary Care	Comprehensive primary care, mental and dental health
Other services required	Basic lab	Pharmacy, lab enabling services
Mid-level provider required	Yes, 50%	No
Enhancement Medicaid/ Medicare reimbursements	Yes	Yes
Federal funds to offset uninsured costs	No	Yes
Medicare Payment	Prospective Payment System (PPS) methodology	PPS methodology
Medicaid Payment	PPS methodology	PPS methodology
Geographical Location	• Non-urban area determined by US Census Bureau AND • Geographic Primary Care HPSA or • Population-group Primary Care HPSA or • MUA • Governor-Designated/ Secretary-Certified Shortage Area	Can be located in urban or rural areas

FQHCs & RHCs Cannot Serve As A Distant Site Provider

The Center for Medicare and Medicaid Services (CMS) issued a recent clarification effective January 1, 2015 which states that, "RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract."[11] This prohibition prevents both a RHC and FQHC from acting as a distant site provider which may impact sustainability. For example, if an FQHC has multiple sites, and a specialist is located at one site and the patient at another, that patient cannot see that specialist via telehealth if the FQHC wishes to be reimbursed. CMS' reasoning for this prohibition is because Medicare only reimburses for a few types of providers to act as a the distant site practitioner, which is noted in statute.[12] That list does not include an RHC or FQHC.

Such language does not exist in California law or Medi-Cal policy. Therefore, CHCs may act as a distant site provider for Medicaid.

FQHCs Cannot Bill Multiple Visits In One Day

FQHCs may not bill for two or more visits in the same day which creates a loss to the clinic if a patient has an appointment for one condition and during the examination another issue is discovered. "This would include situations where a RHC or FQHC patient has a medically-necessary face-to-face visit with a RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner (including a specialist) for evaluation of a different condition on the same day."[13] Should the clinic be able to arrange for that patient to see a specialist via telehealth that day, the costs associated with that, staff time to set up the appointment and brief the specialist, time spent with the patient during the appointment, transmission costs, etc., are not reimbursed. The only two options available to the clinic would be to have the patient return another day, which creates a burden on the patient, or the clinic absorbs the costs.

This restriction appears to be a Medicare and Medi-Cal policy restriction and not necessarily a statutory limitation as is the previous issue. Therefore, a change to such a policy can be made administratively.

CMS Definition of a "Visit"

The Medicare billing manual defines a "visit" for both an FQHC and RHC as, "a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a *__face-to-face__* (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP or a CSW during which one or more RHC or FQHC services are rendered."[14] This definition would presumably prevent reimbursement to an FQHC or RHC utilizing other forms of telehealth such as store-and-forward and remote monitoring which does not require the immediate presence of the patient with the provider.

While this definition of a "visit" appears to be a Medicare administrative policy and not in federal law, California, as have other states, have replicated this definition in statute. Under California Welfare and Institutions Code Section 14132.100(g)(1), a "visit" for FQHCs and RHCs is defined as a "face-to-face."

FINANCIAL ANALYSIS

Methodology of Financial Study

To conduct the financial analysis, Milliman worked with both CCHP and the California Telehealth Resource Center (CTRC) who provided technical assistance. Milliman took the following steps to conduct this study:

Established a sample of CHCs interested in participation. After contacting several CHCs that currently have telehealth programs, five agreed to participate in this study. These CHCs demonstrated their commitment to participate throughout the project by providing necessary data as available, and hosting a site visit for individuals from CCHP, CTRC, and Milliman. In return, each CHC that participated received a detailed financial analysis of their telehealth program from Milliman.

Milliman developed a two-part data collection tool to collect data on each CHCs' telehealth program. The data collection tool was split into the following parts:

- **Part I:** Claims experience from billing/encounter data. This included submitted claims data (patient data, demographics, diagnoses, telehealth service, cost, dates, etc.).

- **Part II:** Administrative and programmatic costs of telehealth services. Milliman collected ongoing costs for the telehealth program, which included costs for maintenance, staff salary, technical support, and inventory. Additionally, Milliman collected data on revenue sources for each CHC such as grants and donations.

Milliman reviewed the data it received from each CHC for reasonableness. They identified missing, incomplete, or mislabeled/miscoded data. This step revealed that data related to telehealth services are not systematically maintained or complete. Milliman worked closely with each of the five CHCs to understand data challenges and received data in various formats and states of completeness.

Milliman conducted community health center site visits with CCHP and CTRC representatives. The purpose of these site visits was to obtain an in-depth understanding of each CHCs' telehealth programs and services, and its current methods for collecting relevant data. A financial analysis was provided to each CHC. Each participant reviewed and provided comments.

Summation of Financial Analysis

The financial analysis conducted by MIlliman revealed that the telehealth programs are not self-sustaining as they are currently operated. The telehealth programs examined in this study were being subsidized with grants or other CHC resources. The study found that several factors existed that contributed to this unsustainability.

The complexity of the billing and reimbursement rules present ongoing challenges to sustainability. The rules related to telehealth billing and what telehealth services are eligible for reimbursement can be quite complex. The myriad of rules and payment amounts also change on a regular basis. CHCs report that some smaller health plans routinely reject claims. Based on these anecdotes it is difficult to ascertain whether the claims rejections are appropriate.

Additionally, the restrictions and regulations upon FQHCs and RHCs limit their ability to fully utilize telehealth modalities and the potential models that they may employ for sustainability. For example, under the Medicare program, FQHCs and RHCs are not authorized to serve as distant site providers.[15]

Telehealth programs cannot be sustained as an isolated cost center. To succeed and be sustainable, telehealth must be seen as a _modality_ of delivering care, and be seamlessly integrated into the overall healthcare delivery system. Core to the problem of sustainability is the low volume of telehealth encounters for a typical CHC. Telehealth programs, especially those with such low volume, cannot be sustained by traditional reimbursement models. Several of the CHCs in this study are utilizing grants to pay for parts of their telehealth program. Continuing to seek grants from both public and private sources is a useful short term strategy but does not lead to a self-sustaining program at scale.

Provider contracting has its own set of challenges. The shortage of specialists available is compounded by the rates that CHCs can afford to pay the distant provider. For Medi-Cal patients, the issue would be solved if the distant provider accepted Medi-Cal payments, but CHCs report that most of the distant providers associated with their telehealth program either do not have the ability to bill Medi-Cal directly or find Medi-Cal reimbursement rates too low. For CHCs that use telehealth to serve the uninsured population, finding affordable specialist rates is especially a challenge since they receive no revenue on a per-encounter basis.

Contracting structures are also an issue. Contracting specialists may require payment for a minimum number of visits each month even if the monthly visit volume is not met. A predictable volume of telehealth services cannot necessarily be guaranteed to contracted providers. Other specialists require "block time," a set-aside time period, usually two to four hours completely devoted to the specialist. Under this arrangement, patient no-shows, cancellations, or low monthly volume can lead to unnecessary program costs.

Data systems, including interoperability, EHR transition, and moving to managed care encounter data reporting are barriers to tracking telehealth-related services and costs. Tracking and data collection systems varied across the five CHCs studied for this project. With other demands thrust upon the CHCs, tracking telehealth encounters proved to be difficult and cumbersome. For example, one CHC is currently working with two different electronic health records systems: one for mental health providers and one for medical providers. Certain contracted distant providers do not use either system. Therefore, to develop a complete picture of the telehealth program, the telehealth coordinator must manually track every encounter on a telehealth log.

Another common issue is that typically a CHC's billing system and EHR system are separate, with different user access points. This lack of interoperability between systems and user access points creates administrative burdens for billing staff and telehealth staff interested in tracking the total charges, revenue, and payments to the distant provider associated with the same telehealth encounter. Interoperable systems cannot be developed or implemented overnight.

Inconsistent use of modifiers for coding telehealth-related claims and encounters can cause difficulties. When submitting a reimbursement claim to a payer, to signify that the encounter took place via telehealth, a modifier is placed before the billing code, either "GT" for a live video encounter or "GQ" for a store-and-forward encounter. CHCs rarely use the modifiers because they are (1) usually acting as an originating site, or (2) in cases when they are billing for the telehealth encounter provided by a distant provider, they are billing a PPS rate. CHCs also report that use of the modifiers sometimes results in a rejected claim so they have been reluctant to use the telehealth modifier. While these are legitimate reasons for not using the modifiers, it is difficult to identify, and track over time, telehealth related claims and encounters without these modifiers.

RECOMMENDATIONS

Community Health Centers

New models of delivery need to be created. Telehealth programs cannot be sustained as an isolated cost center and service, but must be fully integrated into the delivery system of health care. Additionally, a low volume of telehealth encounters cannot sustain the costs of the programs. However, creating new models of delivery that allow for seamless integration of telehealth modalities is essential for long-term sustainability and improved access to quality care. These models should consider using telehealth to expand the reach of primary care physicans with advanced practice nurses and other mid-level staff, and consider the client being served at the center of the care system, regardless of his or her location.

CHCs should develop a "learning network" to share information and knowledge regarding common problems associated with telehealth delivery and reimbursement. Developing a "learning network" with telehealth coordinators, billing staff, and telehealth clinical staff who meet on a regular basis, can provide an opportunity to discuss and share common issues, approaches, and solutions to advance the field. These can be convened by existing associations or coalitions.

CHCs should consider pooling together their telehealth patient volumes to obtain reasonable rates from distant providers who seek a predictable workload, or look at other alternative means. Currently, some CHCs must contract with providers who's rates and terms are unsustainable for their telehealth program. CHCs should consider banding together to secure more reasonable rates from specialists, and expand the pool of competitive contract telehealth providers.

Institute changes to billing systems and the EHR to better track telehealth encounters. CHCs are encouraged to produce routine, standardized reports that track telehealth encounters through the EHR and billing systems to get a clearer picture of telehealth encounter volume(s). These two reports can be used to reconcile patient demographics, clinical information, and financial information while interoperable systems are developed and implemented. In an effort to accurately track telehealth encounters, CHCs should consider creating an identifier in the EHR and billing systems so telehealth-related encounters are easily tracked and identified.

Policymakers

Several major policy barriers have been identified that impede these entities from fully utilizing telehealth modalities to improve access and quality of care, and impact the program's long-term sustainability. The following policy-related recommendations include proposed legislative and administrative solutions, all of which will assist the CHCs to take full advantage of digital technologies to improve care and create greater efficiencies.

Change current federal laws regarding the reimbursement of telehealth delivered services under the Medicare program. Currently, federal law limits the use of telehealth in the Medicare program only to strictly defined rural-based beneficiaries, as well as other onerous restrictions on type of provider, location of care, and type of service provided. These limitations restrict CHCs in their ability to serve vulnerable populations through telehealth, in particular the geographic limitations. Additionally, limited Medicare policy has the unintended effect of being replicated by private payers or state Medicaid policies. While this recommendation is not exclusive to the barriers faced by CHCs, it is critically important to paving the way for more supportive reimbursement policies for them.

Eliminate the current requirement of "face-to-face" in the CMS definition and California law of a "visit". Even if the previous recommendation should take place, a CHC would still be limited in what telehealth modality to use as RPM and store-and-forward would still not qualify as a "visit" as defined by CMS for reimbursement under Medicare and California statute for Medi-Cal. Medicare should change their definition and legislation will be required to alter the California definition.

Change both Medicare and Medi-Cal policy of multiple visits in one day. Currently, both Medicare and Medi-Cal policy will not allow for multiple visits in one day to be billed, outside of very limited exceptions. Such a limitation puts a CHC at a disadvantage when using telehealth as the encounter with the specialist would not be paid. The CHC would either face a loss of payment or require the patient to return another day, which places a burden on the client. This change can be made administratively within each program.

The Department of Health Care Services is encouraged to provide policy leadership to Medi-Cal Managed Care Plans to allow CHCs to take full advantage of the full flexibility the law allows for reimbursing telehealth delivered services. Currently, Medi-Cal only reimburses for a limited set of services and providers, and does not reimburse for RPM and only a few specialties for store-and-forward delivered services. Clear guidelines from DHCS and the Department of Managed Care are needed to encourage, if not *require,* managed care plans to cover all forms of telehealth. Such an action can take place administratively, and does not require additional legislative action. This would provide CHCs with considerably more options for coverage.

Ensure telehealth options in California's 1115 Waiver, "Medi-Cal 2020," remain and are strengthened. California's Section 1115 Waiver Renewal, called "Medi-Cal 2020," was submitted to CMS on March 27, 2015. It promotes a Medi-Cal payment reform strategy that includes: (1) an alternative payment methodology, which restructures the PPS rate into a flexible capitation payment; (2) payments to promote care coordination and care management; and (3) a pay-for-performance/shared savings model. The waiver specifically states, "Under the Waiver, the state will expand access to specialty services by providing incentives for telehealth. Priority would first be given to geographic areas or certain specialists where access is more limited. Under the Waiver, the state will pilot-test incentive payments to encourage use of telehealth and require corresponding reporting of outcome data." [16] However, several months remain until the waiver is finalized and implementation begins to take place. If approved, DHCS has a golden opportunity to ensure that technology enabled health care becomes a valuable component of the services provided by CHCs to advance the triple aim of better care, improved outcomes and increased efficiencies resulting in reduced costs.

Medi-Cal should make more billing codes eligible for reimbursement when the service is delivered via telehealth. Currently in Medi-Cal, only a limited set of service codes are eligible for reimbursement if telehealth is used. Specialists that have their own specific codes are not able to bill for them and are forced to either forgo reimbursement or bill at a lower rate with a general consultation code. This change can be made administratively.

CONCLUSION

The process of transforming Federally Qualified Health Centers and Rural Health Clinics in California into the 21st Century to be able to take full advantage of the rapidly growing field of technology-enabled care and monitoring will be challenging but necessary. With Alternative Payment Models on the horizon and resources becoming more scarce, it will be critically important for public policymakers, CHC state and regional leadership, health center operations and management, and clinical care providers to be prepared and willing to embrace these new technologies to more effectively meet the growing demand for access to health care and support for the most vulnerable Californians.

ABOUT THE COMMUNITY HEALTH CENTERS

Barton Community Health Center

Barton Health's mission is to deliver safe, high-quality care and engage the community in the improvement of health and wellness. The area served by Barton Health has approximately 100,000 residents and includes eastern El Dorado County, the south shore area of Lake Tahoe, the Stateline area joining El Dorado and Douglas counties, and down both western and eastern slopes of the Tahoe basin. These areas are predominantly rural, isolated from major urban centers in California and Nevada. Access to care can be especially challenging during six months of the year when severe winters further limit travel over high mountain passes on the few major roadways. The economy in the region is seasonal, driven by the ski industry. Many full-time residents (i.e., those that live in the area throughout the year) are primarily in low-income service jobs at the ski resorts and in tourism and construction, and may be underinsured or uninsured.

Barton launched its telehealth program in 2009 in response to a gap analysis that revealed lack of access to key specialty services for area residents. Through various grants, Barton was able to build necessary infrastructure and make investments in telehealth equipment. Barton's telehealth program offers access to numerous specialists. Barton acts as the originating site for cardiology, dermatology, endocrinology, infectious diseases, neurology, oncology, and psychiatry telehealth services. Barton hosts between 150 and 200 telehealth visits each month.

ChapCare

ChapCare is a FQHC with five health center locations. It provides care for an area that covers 432 square miles and 34 independent cities in the San Gabriel Valley. Barriers to access in non-rural communities such as the San Gabriel Valley include lack of reliable timely public transportation and a shortage of specialists. For populations that are uninsured or underinsured, these access barriers may be exacerbated, as providers who are willing to see uninsured patients are further limited. While the ACA, through Covered California and the Medicaid expansion, has reduced the number of total uninsured among ChapCare's patient population, ChapCare is still the safety net clinic for the remaining uninsured, including unauthorized immigrants who are not eligible for insurance coverage.

ChapCare's telehealth program was implemented in 2011 to help address problems of access to specialty care services for the uninsured population in the San Gabriel Valley. ChapCare's telehealth program began with providing store-and-forward services for optometry, radiology, dermatology, and orthopedics.

Shasta Community Health Center

Shasta Community Health Center (SCHC) is a nonprofit FQHC based in Redding, California. SCHC has served Shasta and surrounding counties and communities since 1988. SCHC's mission is to provide quality healthcare services to the medically underserved populations. Many of the patients served by SCHC live in remote, underserved areas. SCHC serves a low-income population: 64% of SCHC's patients are at or below 100% of FPL and 95% are at or below 200% of FPL. Transportation costs and travel time can be real barriers to regular healthcare services, especially for individuals with chronic conditions and/or mental health conditions.

To meet the community needs, SCHC launched its telehealth program in 2001. Currently, SCHC utilizes telehealth for psychiatric and pediatric specialty services. Pediatric specialty telehealth services include endocrinology, neurology, and psychiatry. SCHC serves as a spoke site, which means patients receive services at SCHC and uses telehealth to connect with a provider who is located at a distant site.

Southern Inyo Community Clinic

Southern Inyo Healthcare District serves communities in Inyo County, which covers an area of over 10,000 square miles of diverse country, including low-lying deserts and mountainous terrain. The area encompasses Death Valley National Park, Mount Whitney, and a large part of the Inyo National Forest and Alabama Hills Recreational Area. While the area has a small resident population, it has approximately 1.5 million visitors per year. Southern Inyo Healthcare District provides services to the county's residents and to its tourist population. The closest medical centers are in Ridgecrest and Bishop, which are each about an hour drive away.

The Southern Inyo Community Clinic began its telehealth program in 2001 to provide specialty access services to those who live and work in the community without having to travel long distances. Currently, Southern Inyo offers rheumatology, cardiology, dermatology, psychiatry, and endocrinology telehealth services, and plans on including diabetics and chronic pain management as part of its telehealth offerings. Telehealth services are available via live videoconferencing using two mobile telehealth carts located in the facility.

West County Health Centers

West County Health Centers (West County) is a designated FQHC that operates a network of health centers and clinics in West Sonoma County. West County provides services to an estimated population of 60,000 people living in an area that covers Fort Ross to Valley Ford and from the Pacific coastline into Sebastopol. West County's patient population consists of families and individuals who are low-income and at-risk, such as individuals who are not accepted elsewhere because of HIV/AIDS, homelessness, mental illness, or addiction. Approximately 41% of its total patients are living at or below federal poverty level (FPL) and the service area hosts a homeless population of approximately 300 individuals.

West County launched its telehealth program in 2011 to address its community's needs for specialty services and to reduce access barriers that are due to travel time and distance. West County's health centers and clinics are dispersed throughout West Sonoma County: in Occidental, Guerneville, Sebastopol, and Forestville. West County has "traditional" telehealth programs for specialty services provided to a patient by a remote provider. West County is unique in that it is experimenting with innovative ways to leverage "nontraditional" telehealth technologies to improve care coordination and management.

Endnotes

1. Blue Shield of California Foundation, California Community Health Centers: Financial & Operational Peformance Analysis, 2010-2013, http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/Report-Financial-Operational-Analysis-of-CA-Health-Centers.pdf, p.5. (Accessed July 22, 2015).

2. Covered California, Enrollment by Pricing Region as of February 2015. http://hbex.coveredca.com/data-research/library/OE2-regional-tables.pdf (Accessed July 22, 2015).

3. Governor's May Revise FY 2015-2016, p. 42 http://dof.ca.gov/documents/2015-16_May_Revision.pdf (Accessed July 22, 2015).

4. Public Policy Institute of California, Just the Facts: Undocumented Immigrants, http://www.ppic.org/main/publication_show.asp?i=818 (Accessed July 22, 2015).

5. Governor's May Revise FY 2015-2016, p. 42 http://dof.ca.gov/documents/2015-16_May_Revision.pdf. (Accessed July 22, 2015).

6. Social Security Act Section 1834(m)(4)(c)(i).

7. Human Resources Services Administration. What are federally qualified health centers (FQHCs)? < http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html> (Accessed June 23, 2015).

8. California HealthCare Foundation, Adding Specialty Services to a California: FQHC: Legal and Regulatory Issues, Appendix A, July 2009.

9. Human Resources Services Administration. What are rural health clinics (RHCs)? < http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html>, (Accessed June 23, 2015).

10. Rural Assistance Center. RHC & FQHC Program Comparison. < https://www.raconline.org/pdf/ProgramComparisonChart.pdf> (Accessed June 23, 2015).

11. Center of Medicare and Medicaid Services (CMS), 2015 Update of the Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, MLN Matters. http://www.cms.gov/outreach-and-education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8981.pdf (Accessed June 24, 2015).

12. Social Security Act Section 1834(m)(2)(A).

13. Medicare Benefit Policy Manual, Chapter 13 – Rural Health clinic (RHC) and Federal Qualified Health Center (FQHC) services, Section 40.3, "Multiple Visits on the Same Day." < http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf> (Accessed June 23, 2015).

14. Medicare Benefit Policy Manual, Chapter 13 – Rural Health clinic (RHC) and Federal Qualified Health Center (FQHC) services, Section 40, "RHC and FQHC Vistis". < http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf> (Accessed June 23, 2015).

15. 2015 Update of the Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Servcies. December 2014.

16. California Department of Health Care Services, 1115 Waiver Renewal: Official Submission, Medi-Cal 2020: Key Concepts for Renewal, (Version 3-27-15), p. 24 http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR_032715.pdf. (Accessed July 22, 2015).

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