



# Reimbursing FQHCs for Telehealth Post-COVID-19 Pandemic: Medi-Cal's Options

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# Introduction

The COVID-19 pandemic unleashed extraordinary burdens on Californians in low-income communities, including making it difficult to access health care services in a safe and timely way. Among those especially hard hit by COVID-19 were those enrolled in Medi-Cal, California's Medicaid program, which provides health care coverage to 14 million people in low-income households including children, parents, working adults, seniors, and persons with disabilities. California policymakers rapidly secured temporary flexibilities from the federal government and established policies to enable health care providers to deliver covered services to Medi-Cal enrollees via telehealth during the public health emergency, including video and telephone visits. While the pandemic created enormous burdens for communities and health care service providers, it has also accelerated adoption of telehealth services at rates previously unthinkable and elevated discussions in California and around the country about the long-term possibilities for telehealth to maximize use of our health care workforce and meaningfully improve access for underserved populations.

**Federal data show that telehealth use spiked in the early months of the pandemic, accounting for over 80% of FQHC visits nationally; as of December 2020, telehealth visits accounted for 47% of FQHC visits.**

Federally Qualified Health Centers (FQHCs), which provide comprehensive care to millions of Medi-Cal patients in California, have been on the front lines of rapidly developing and deploying telehealth services to patients during the pandemic. Federal data show that telehealth use spiked in the early months of the pandemic, accounting for over 80% of FQHC visits nationally; as of December 2020, telehealth visits accounted for 47% of FQHC visits.<sup>1</sup>

California policymakers face important choices about whether and how best to permanently extend Medi-Cal coverage for telehealth beyond the temporary federal flexibilities provided during the pandemic. Foremost among these questions is the extent to which video and telephone visits between patients and providers for medical, behavioral health, and dental will be incorporated into the Medi-Cal program. How California decides to approach coverage and reimbursement specifically for FQHCs will significantly impact the degree to which telehealth services are available to and used by Medi-Cal enrollees.

This paper examines the choices and considerations for California policymakers to expand Medi-Cal coverage and reimbursement for telehealth provided by FQHCs by addressing the following questions:

- ▶ What independent authority and flexibility does the California Department of Health Care Services have to extend Medi-Cal coverage for telehealth and to determine reimbursement levels for FQHCs?
- ▶ What are the different reimbursement options and considerations for FQHCs, and what other levers does the Medi-Cal program have to manage appropriate telehealth use?
- ▶ How have other states approached permanent expansion of Medicaid coverage for telehealth, including coverage and reimbursement for FQHCs? What lessons can be learned and applied in California?

This report explores California's authorities to extend telehealth coverage and define reimbursement methodologies, and it examines activities in other states to define permanent Medicaid telehealth coverage and reimbursement policies for FQHCs. This includes six case studies developed from examination of activities in 10 other locations (9 states and the District of Columbia) and an overview of what services, modalities, and reimbursement methodologies they have permanently extended.

## Key Findings

An examination of telehealth policy options and state-level experience defining telehealth policy for FQHCs beyond the public health emergency highlight a few key themes and considerations:

**Temporary flexibilities that enable Medi-Cal enrollees to reach their primary care and behavioral health providers through telehealth from home have catapulted the use of telehealth by Medi-Cal enrollees and highlighted the transformative possibilities of telehealth within Medi-Cal.** Despite comparatively progressive telehealth policies before the pandemic, use of telehealth modalities within Medi-Cal remained relatively muted and limited to a few specific specialties before the pandemic. Sparked by the necessity of the pandemic, the option for Medi-Cal enrollees to utilize telehealth for visits from home directly with their providers for primary care and behavioral health services has spawned dramatic growth in the use of telehealth, patient interest in telehealth, and excitement about the future possibilities of telehealth among Medi-Cal providers.

**California has the power to decide what role telehealth has in the Medi-Cal program and how FQHCs are reimbursed.** Federal guidance makes clear that states, including California, have significant flexibility to decide which telehealth modalities are covered for different services within Medicaid and to determine how FQHCs are reimbursed. Ultimately, it is up to California to decide how aggressively to expand the use of telehealth in the Medi-Cal program.

**As FQHCs go, so goes the Medi-Cal program.** FQHCs serve millions of Medi-Cal patients annually and represent a major segment of the Medi-Cal primary care network in most California communities. The extent to which Medi-Cal adopts telehealth coverage and reimbursement policies that meaningfully incentivize FQHCs to deliver telehealth services will significantly impact if and how expanded telehealth is successfully utilized and leveraged within the Medi-Cal program.

**Value-based payment may be the long-term goal, but interim reimbursement policy is urgently needed to maintain advances in access to care through telehealth.** An alternative payment methodology (APM) in which FQHCs are paid a monthly amount per patient (capitation) may well be the long-term reimbursement solution. However, given the multiyear time frame for implementing APM statewide, decisions made now about if and how to reimburse FQHCs for telehealth services will determine if the recent advances in access to care through telehealth are maintained or will fade away. This will shape whether disparities in health and access to health care for Californians with low incomes, who are disproportionately people of color, begin to shrink or widen.

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**Many states are taking interim steps as a bridge to long-term telehealth policy.** Many state Medicaid programs expect to extend emergency flexibilities beyond the public health emergency while establishing parallel processes (e.g., convening statewide telehealth commissions) to determine which modalities are clinically appropriate for different services, develop accurate projections of telehealth impact on total utilization and program cost, and define

long-term reimbursement policy, particularly as it relates to telephone visits. In some instances, this includes establishing sunset periods for interim policies and explicitly aligning them with time frames to develop value-based payment methodologies. In addition to allowing the state to develop thoughtful long-term policy, such steps provide predictability for providers to strengthen telehealth services and capabilities. Since doors closed are often difficult to open again, a key question for California policymakers is how best to bridge the gap between emergency flexibilities and a more permanent telehealth policy without losing recent advances.

**Extending prospective payment system (PPS) reimbursement to FQHCs for video and telephone visits provides an immediate, direct, and administratively straightforward mechanism to extend telehealth use by Medi-Cal patients and to expand access in the interim.** California can extend PPS reimbursement to FQHCs for video and telephone visits conducted directly between providers and patients quickly and with relative ease. Such a step would incentivize continued delivery and development of telehealth by FQHCs in primary care and ensure that the expanded access and reduced barriers to care are maintained. While reimbursement policies may evolve over time, particularly for modalities like telephone visits, PPS provides an immediate mechanism to maintain advances in access. Other pathways, such as defining unique payment rates for telehealth modalities, present challenges, such as the difficulty of developing rates in a timely manner, the lack of reliable information to inform rate setting, and the risk that new rates will not incentivize continued use of telehealth by FQHCs.

**Other state Medicaid programs appear most comfortable with extending PPS reimbursement to FQHCs for primary care video visits and behavioral health telephone visits.** While uncertainty persists about some telehealth expansions, including whether FQHCs should receive PPS payment for all telephone visits, there appears to be an emerging consensus among many state Medicaid programs to move forward quickly on others. Among the 10 locations

(9 states and the District of Columbia) examined for this paper, 5 have already extended coverage of video visits with the PPS reimbursement for FQHCs beyond the public health emergency, and most others shared the expectation that this modality will be extended. Additionally, there appears to be broad support for and fewer concerns about the efficacy of telephone visits for behavioral health services.

## The California Telehealth Context

### Background

With enactment of the Telehealth Development Act of 1996 and the Telehealth Advancement Act of 2011, California was considered an innovator in state telehealth policy. For numerous reasons, however, telehealth did not flourish within the Medi-Cal program. Use was not widespread among Medi-Cal providers and their patients and was largely limited to a small set of specialties. Providing telehealth to Medi-Cal enrollees often required great effort and financial investment by managed care plans and clinics that were committed to improving access to care to their patients using telehealth.

Just months before the pandemic, in September 2019, the California Department of Health Care Services (DHCS) expanded and clarified Medi-Cal coverage, eligibility, and reimbursement rates for telehealth.<sup>2</sup> These changes were expected to have a positive, but not necessarily transformational, impact on telehealth access and use. Specific restrictions and limitations were applied to coverage and reimbursement for telehealth services provided by FQHCs.

Temporary Medi-Cal telehealth flexibilities due to COVID-19, however, have spawned a significant and widespread increase in telehealth use by enabling patients to access video and telephone telehealth visits directly with their providers for primary care and behavioral health services from their home.

## FQHC Telehealth Coverage in Medi-Cal Before the Pandemic

Before the pandemic, the Medi-Cal program explicitly covered and reimbursed at the PPS rate *live (synchronous) video visits* delivered by FQHCs for all covered services, provided certain requirements were met. This included requiring that a billable provider be present with the patient, that services occur within the “four walls” of an approved FQHC site, and that services be limited to “established” patients. In its most common form, a Medi-Cal enrollee would go to their FQHC to have a video visit with a specialist at another location, often at another FQHC site, at an academic medical center, or on contract with a third-party vendor. *Store-and-forward telehealth (asynchronous)*, such as when a picture of a patient’s dermatological condition is taken and sent securely to a specialist who examines it later and provides a diagnosis, was also covered within a small set of specialties. Provided that these conditions

were met *and* that the service delivered was part of an FQHC’s federally approved scope of service, FQHCs would be reimbursed at the PPS rate for both live video visits and store-and-forward telehealth.

Practically speaking, Medi-Cal rules restricted all Medi-Cal enrollees from initiating a telehealth visit directly with their primary care or behavioral health provider from their home. The “four walls” requirement further prevented FQHCs from generating PPS reimbursement for telehealth visits unless both the provider and patient were present in an approved FQHC site.

**Exclusions.** Telephone visits, remote patient monitoring, and email were not covered telehealth modalities in Medi-Cal before the pandemic. Additionally, while the September 2019 coverage changes enabled Medi-Cal coverage for provider-to-provider electronic consults between primary care and specialist providers, FQHCs were explicitly excluded.

**Table 1. Medi-Cal Telehealth Coverage for FQHC Service Providers**

	PRE-COVID-19 PANDEMIC	DURING COVID-19 PANDEMIC
<b>Live Video</b> (synchronous)	Reimbursed at PPS rate under following conditions: <ul style="list-style-type: none"> <li>▶ Service is covered by Medi-Cal and within the FQHC’s “scope of services”</li> <li>▶ Provider deems modality appropriate</li> <li>▶ Service must be rendered within clinic’s “four walls”</li> <li>▶ Established patient*</li> </ul>	Waived requirements: <ul style="list-style-type: none"> <li>▶ Established patient*</li> <li>▶ Originating site is a clinical setting</li> <li>▶ FQHC’s billable provider be within the FQHC’s “four walls”</li> </ul>
<b>Store and Forward</b> (asynchronous)	Reimbursed at PPS for 3 specialties: dentistry, dermatology, and ophthalmology	No change
<b>Telephone Visits</b>	Not allowed due to telephone not being an acceptable modality and “four walls” requirement	<ul style="list-style-type: none"> <li>▶ Telephone an accepted modality</li> <li>▶ Waived “four walls” requirement for FQHCs</li> <li>▶ Reimbursed at PPS rate</li> </ul>
<b>Provider-to-Provider Electronic Consultations</b> (e-consults)	FQHCs explicitly prohibited from reimbursement for e-consults	No change
<b>Remote Patient Monitoring</b>	Not covered	Not covered (but proposed as new benefit in Governor Newsom’s 2021–22 budget proposal)

\*An *established patient* has an active health record and has visited within 3 years or assigned by Medi-Cal managed care plan.

## Pandemic Flexibilities

In March 2020, California received approval from the Centers for Medicare & Medicaid Services for temporary telehealth flexibilities tied to the president's COVID-19 national emergency declaration. Most impactfully, the temporary Medi-Cal flexibilities enabled FQHCs to bill at their PPS rate for video and telephone visits that originate outside the clinic setting and to bill for new patients whose care was provided via telehealth.<sup>3</sup> Additionally, the Office of Civil Rights temporarily waived penalties for HIPAA (Health Insurance Portability and Accountability Act) violations for health care providers to deliver telehealth services with certain noncompliant video chats.

Temporary pandemic flexibilities are tied to the declaration of a national public health emergency. In January 2021, the acting Health and Human Services director signaled in a letter to governors that the public health emergency will likely remain in place until the end of 2021, indicating that FQHC telehealth flexibilities will remain in place through the end of the year.

Similarly, Governor Newsom released his 2021–22 state budget proposal in January 2021, which proposes adding remote patient monitoring (RPM) as a covered benefit and includes \$94 million to “maintain and expand telehealth flexibilities authorized during COVID-19 for Medi-Cal providers.” A more detailed proposal outlining which flexibilities are proposed to be extended and how reimbursement will be structured is expected from DHCS in early February. These actions provide a starting place for policy discussions and negotiations.

## Why FQHC Telehealth Policy Matters

In most California communities, FQHCs represent a major, if not the largest, segment of the Medi-Cal primary care network. As of 2015, safety-net clinics were the primary care provider for 41% of Medi-Cal enrollees in managed care plans.<sup>4</sup> The choices that California makes on FQHC reimbursement in Medi-Cal will likely have a significant impact on if and how telehealth is successfully utilized and leveraged within the Medi-Cal program. Additionally, expanded telehealth in Medi-Cal may prove an essential tool to maximizing limited primary care and behavioral health service capacity, reducing long-standing access barriers in Medi-Cal and tackling long-standing access and quality inequities faced by the most vulnerable Californians.

Given that FQHCs are governed by federal statute, federal agency oversight, and statewide policy, the Medi-Cal program faces a different set of policy choices and limitations around how it establishes telehealth coverage and reimbursement policy for FQHC providers. Central questions about state authorities include:

- ▶ What are the authorities of DHCS relative to federal statute and federal agencies to establish permanent telehealth coverage and reimbursement rules for the Medi-Cal program broadly and for FQHCs specifically?
- ▶ Given that federal statute requires that FQHCs be reimbursed on a per-visit prospective payment system basis for covered services, what choices and considerations does California have to set FQHC reimbursement levels and methodologies for different telehealth modalities?
- ▶ Do coverage and reimbursement options vary by telehealth service modality?
- ▶ Are there other FQHC-specific rules or levers that California can use to manage delivery and utilization of telehealth services within FQHCs?

Beyond considerations of what the state can and cannot do, California must consider on balance a number of other priorities, such as expanding access, ensuring an appropriate standard of clinical quality, adding value without introducing unnecessary utilization, and responsibly managing the cost to the Medi-Cal program. The state scan provides lessons on how other states have navigated the transition from temporary to longer-term telehealth coverage and reimbursement for FQHCs, including which telehealth modalities have been extended, how these modalities are reimbursed, and how the states expect to move forward from here.

## What Authorities Does California Have?

Overall, Medicaid payment and services for FQHCs is an area where most of the day-to-day policies are determined at the state level. However, states are bound by federal Medicaid statute, as well as federal agency guidance when it comes to determining both which services are covered and how FQHCs are reimbursed. In other words, whereas federal statute and federal agency guidance may establish the “rules of the road,” California has substantial flexibility to make decisions about FQHC reimbursement, services, and modalities within Medi-Cal.

Findings related to California’s authority and options to define Medi-Cal telehealth policy include the following:

### **California has a lot of flexibility to decide what telehealth to cover and reimburse in Medi-Cal.**

The Centers for Medicare & Medicaid Services (CMS) clarified that states have significant flexibility in determining which Medicaid services to cover and reimburse via telehealth.<sup>5</sup> Key guidance included the following:

- ▶ States can determine whether or not to utilize telehealth, which types of services to cover, which geographic areas to cover, which provider

types may deliver and bill for care, and which reimbursement codes and modifiers to use.

- ▶ For services within the scope of the FQHC benefit (defined in federal statute), states must pay FQHCs at the same rate as face-to-face visits (e.g., PPS rate) for covered telehealth services, unless they seek a State Plan Amendment (SPA) for a unique payment rate and methodology.
- ▶ For services otherwise covered by Medicaid but not covered as part of the FQHC benefit (e.g., remote monitoring, provider-to-provider e-consult), states may pay FQHCs at lower fee-for-service rates.
- ▶ States are required to submit a SPA if they intend to define a unique payment rate and methodology for specific telehealth services for FQHCs.
- ▶ States are generally not required to submit a SPA to pay providers for telehealth services, including telephone visits, at the same rate they would have received for a face-to-face service, unless the current SPA specifically defines eligible visits as face-to-face.

Although California has allowed live video and limited store-and-forward telehealth to be reimbursed at the PPS rate, the SPA does include “face-to-face” as part of the FQHC visit definition. DHCS determined a need to submit a waiver of this requirement to enable telephone visits as a part of its March 2020 SPA.<sup>6</sup> Although California already allowed PPS for some live video visits, this does suggest that the state would feel compelled to submit a new SPA as part of any new telephone visit policies. However, CMS has made clear that California retains the authority to extend telehealth coverage and reimbursement to the Medi-Cal program and indicated an openness to approve extension of the PPS rate to FQHC providers for telephone visits. Three states examined for this brief already reimburse FQHCs for telephone visits at the PPS rate.



There are administrative and legislative pathways to codify changes in Medi-Cal telehealth coverage. States also have flexibility to define Medi-Cal telehealth policy changes through legislation or administrative rulemaking. Each pathway presents a series of trade-offs. Whereas administrative rule changes provide flexibility to the Medicaid agency to adapt future telehealth coverage policies and can avoid contentious legislative exercises, enacting legislation can lock in desirable policies and incorporate broader public and stakeholder engagement. Of the states examined for this paper that have enacted new telehealth policies, two pursued administrative rule changes and three passed legislation.

California has multiple options for Medi-Cal reimbursement to FQHCs for telehealth (TABLE 2). States may elect to pay FQHCs for Medicaid telehealth

modalities that constitute visits at the same rate they would otherwise pay for a face-to-face (e.g., PPS rate). However, if a state determines that the per-visit PPS rate is not appropriate or desired for a modality, it has other reimbursement options, including developing an alternative payment methodology (APM), defining the telehealth modality as a “carve out” to the FQHC scope of services or developing a service-specific PPS rate.

► **Prospective Payment System (PPS).** For those modalities construed as a visit, such as video visits directly between a patient and provider, telephone visits, traditional synchronous telehealth, and store-and-forward asynchronous visits, states may pay providers the same amount as they would pay for an in-person face-to-face visit. This includes paying FQHCs at the PPS rate for these visits. In

Table 2. FQHC Reimbursement Rate Pathways for Medi-Cal

CONSIDERATIONS AND TRADE-OFFS	
<b>Prospective Payment System (PPS) Rate</b>	<ul style="list-style-type: none"> <li>► Is a viable option for video visits, telephone visits, and store-and-forward telehealth</li> <li>► Is likely not applicable to provider-to-provider e-consults and remote patient monitoring, which do not constitute billable visits</li> <li>► Administratively straightforward to administer</li> <li>► Potential state concerns about fiscal impacts</li> <li>► Open questions about alignment between PPS rate and FQHC costs to provide care through these modalities</li> </ul>
<b>Alternative Payment Methodology (APM)</b>	<ul style="list-style-type: none"> <li>► Enables incorporation of multiple modalities into a global rate</li> <li>► Avoids multiple rates and rules for different modalities</li> <li>► Takes multiple years to develop, does not resolve the immediate question of how telehealth services should be reimbursed in the interim — after the public health emergency has ended but before an APM is implemented statewide</li> <li>► State would need to decide how telehealth visits would factor into APM base calculation</li> </ul>
<b>PPS Carve Out</b>	<ul style="list-style-type: none"> <li>► Might be a promising alternative for nonvisit telehealth services (e-consult, remote patient monitoring)</li> <li>► Uncertain applicability to video and telephone visits that otherwise meet the requirements of face-to-face visits</li> <li>► Simpler option to develop and administer than APM or service-specific PPS, though more complex than PPS</li> <li>► Allows for FQHC payment at same rate as other providers</li> <li>► Rates may not be sufficient to incentivize meaningful level of utilization by FQHCs, thereby restricting access to care through telehealth for Medi-Cal enrollees who are FQHC patients</li> </ul>
<b>Service-Specific PPS Rate</b>	<ul style="list-style-type: none"> <li>► Allows for a cost-based reimbursement level likely below the full PPS rate</li> <li>► Likely a significant ongoing administrative burden to design and administer</li> <li>► Untested option in telehealth</li> </ul>

some instances, such as telephone visits, California may determine the need to submit a State Plan Amendment. PPS as a reimbursement pathway, however, likely does not extend to nonvisit services such as provider-to-provider e-consults or remote patient monitoring. This option is the easiest to enact for video and telephone visits.

- ▶ **Alternative Payment Methodology (APM).** Under federal statute, states have the option of defining an APM to experiment with alternatives to the PPS payment structure. A number of states have used the APM pathway to pursue a “value-based” reimbursement methodology that does not rely on a per-visit methodology for reimbursement. Under this system, states can elect not to cover telehealth visits separately and instead seek to encompass them in a global APM payment. Under federal statute any FQHC APM must reimburse FQHCs at least what they would have otherwise been reimbursed via PPS (number of Medicaid visits × PPS rate per visit) and must garner the approval of both the state and any FQHCs in question. This suggests that state decisions about recognizing or not recognizing telehealth modalities as “visits” could change the minimum payment required to FQHCs. As a matter of course, any effort to encompass telehealth reimbursement into a newly formed APM in California would likely take multiple years to complete and would not resolve questions about telehealth reimbursement for FQHCs in the interim years.
- ▶ **Carve out.** “Carving out” a service from a bundled payment like the FQHC PPS means that payments for that service are calculated and made separately from the global rate. In this way, FQHCs can be reimbursed at the same rates as other Medicaid providers for a specific service without that revenue being counted against their reconciled PPS/APM reimbursement. There are multiple examples of states carving out distinct services from the global rate / PPS calculation, typically because the cost of delivering that service is meaningfully different than the global rate (either higher or lower). One common example from multiple states is long-acting reversible contraception (LARC), a valuable but

also costly service to provide. A range of examples from other states include x-rays, inpatient hospital services, remote patient monitoring, pharmacy, and injections for substance use disorder, among others. This approach, which requires a State Plan Amendment, would provide a relatively straightforward mechanism to ensure that FQHCs are paid for telehealth modalities without wrestling with program cost uncertainty or the development of unique FQHC rates. It would, however, present new cost tracking and management by both DHCS and individual FQHCs. It is unclear if fee-for-service rates would be sufficient to incentivize use of some modalities (e.g., telephone or video visits) by FQHCs when there are wide differences between fee-for-service rates and PPS rates. Additionally, whereas e-consults or remote patient monitoring represent distinct nonvisit services, telephone or video visits are clinical visits delivered through different telehealth modalities. FQHCs may object to differential payment for telehealth visits that otherwise meet requirements for services rendered in person. Therefore, a carve-out approach may be most appropriate for nonvisit services, such as remote patient monitoring or provider-to-provider e-consult.

- ▶ **Service-specific PPS rates.** In California, FQHCs are reimbursed at one site-specific PPS rate for all covered services, meaning that they are reimbursed at the same visit rate for medical, behavioral health, or dental services. Some states have established separate PPS rates for different services, such as a separate rate for medical versus dental visits. Certain other states have gone further in establishing these “category” PPS rates for additional services. States appear to have the option of defining separate cost-related/PPS reimbursement rates for FQHCs for specific telehealth modalities, including telephone visits or remote patient monitoring, among others. The difference between this approach and the “carve-out” approach outlined above is that rather than basing payment on the state Medicaid program fee-for-service rate, the rate would be calculated according to the costs of providing that particular category of service (PPS

methodology). This approach does require a State Plan Amendment. While a separate FQHC cost-based mechanism may be appropriate, defining a service-specific PPS rate for a narrow service would require significant effort, such as developing and maintaining a separate PPS structure, that could far outweigh the potential benefit. In the context of telehealth as a category of services, it is also an untested approach that has not been enacted in other states.

Medi-Cal has other levers to manage appropriate telehealth use at FQHCs. Beyond covered services and reimbursement, states have a number of tools they can use to manage utilization and cost of telehealth modalities among Medicaid providers and with FQHC providers specifically. Some examples include the following:

- ▶ Placing limits on how many encounters an FQHC can bill from multiple services per patient in a day (already in place in California)
- ▶ Setting conditions for telehealth reimbursement (e.g., must be an established patient, must have an in-person visit before a telehealth visit, must have at least one in-person visit annually, limits on number of reimbursable visits, provider may not instigate a telehealth visit, prior authorization requirements)
- ▶ Establishing audit and monitoring practices to guard against fraud and abuse
- ▶ Restricting location of the provider and patient at the time of service (e.g., office, home)
- ▶ Restricting which providers are eligible for reimbursement

## What Can Be Learned from Other States?

A scan of activity in other states highlights in real time how they are advancing changes in Medicaid telehealth beyond the public health emergency, their approaches and perspectives toward FQHCs, and expected directions for the future. The 10 Medicaid programs examined for this research are Arizona; Colorado; Michigan; New Hampshire; Ohio; Pennsylvania; Texas; Vermont; Wisconsin; and Washington, DC. Themes from the state scan are outlined below.

**Total FQHC service utilization has followed a consistent pattern during the pandemic.** States have followed several common FQHC utilization patterns during the pandemic. After initial dips in total medical visits at FQHCs, utilization has recovered and hovered either at or slightly below prepandemic levels (including telehealth visits). In contrast, most states have experienced behavioral health utilization above pre-pandemic levels driven by increased need and the success of telehealth modalities. While the proportion of FQHC visits delivered via telehealth differ widely by state, anecdotal perceptions are that telephone visits account for the vast majority of telehealth visits.

**Several states have extended reimbursement for video visits at the PPS rate for FQHCs beyond the public health emergency** (TABLE 3, PAGE 12). Colorado, Michigan, New Hampshire, Ohio, and Vermont have all extended PPS reimbursement for video visits in their Medicaid programs (including those initiated from the patient home) beyond the public health emergency through administrative rules or legislation. Even among those states that have not extended these policies, there is widespread expectation by health center primary care associations that PPS reimbursement for video visits for primary care and behavioral health therapy will be extended without controversy.

**Table 3. Examples of States That Have Adopted Medicaid Policies for Telehealth That Extend Beyond the Public Health Emergency**

✓ Covered, reimbursed at PPS rate  
 ✓ Covered, not reimbursed at PPS rate

	OHIO	COLORADO	NEW HAMPSHIRE	VERMONT	MICHIGAN
<b>Live Video</b> (synchronous)*	✓	✓	✓	✓	✓
<b>Store and Forward</b> (asynchronous)	✓	✓	✓	✓	
<b>Provider-to-Patient Video Visit</b>	✓	✓	✓	✓	✓
<b>Provider-to-Patient Telephone Visit</b>	✓	✓	✓		
<b>Teledentistry</b>	✓	✓	✓	✓	
<b>Email/Text</b>	✓				
<b>Remote Monitoring</b>	✓†			✓‡	
<b>Mechanism</b>	Administrative	Legislation	Legislation	Legislation	Administrative

\*Includes video visits initiated from the patient home

† “Carved out” of PPS, reimbursed at Medicare rate

‡ Limited to chronic heart failure through home health

**Three of 10 locations (9 states and the District of Columbia) examined have extended reimbursement for telephone visits at PPS.** Colorado, New Hampshire, and Ohio have all extended PPS reimbursement for telephone visits at FQHCs beyond the public health emergency. These states have generally determined that telephone visits thus far have substituted, rather than added to, total visits and have elected to start with more expansive reimbursement policies with the expectation that policies will be refined over time. In most states, including those that have extended telephone visit reimbursement, there is ongoing discussion about a number of issues related to clinical efficacy, short- and long-term costs, reimbursement rates, and access considerations. FQHC advocates and Medicaid agency representatives all recognize that telephone visits may not be appropriate for all services or in all instances but note that more experience is needed to define permanent guidelines and policies. Medicaid agencies are watchful of the impact of expanded modalities on cost relative to improved access and health outcomes but are struggling to confidently project if telehealth use will be substitutive or additive. In regards to access, there appears to be agreement that although video visits can be more

optimal in specific situations, practical limitations, such as unstable broadband, cell phone data limitations (and cost to patients), ease of use of data platforms, and patient resistance, meaningfully prevent the use of video by patients at present. Telephone visits, which can deliver equivalent clinical benefit for certain visits/situations, present significantly fewer barriers to use for patients and generate other benefits, such as reduced no-show rates, elimination of transportation barriers, and increased accessibility for working patients, among others.

**More time and experience is needed to establish long-term telehealth policy.** Even among those states that have taken early action to pass rules/legislation to liberally expand telehealth coverage, there is notable uncertainty about what appropriate long-term policy should be. Most state officials indicated they need for more time and experience to determine which services are clinically appropriate for different modalities, to define the appropriate distribution of telehealth visits versus in-person visits, or to make realistic estimates of utilization and cost. Those states that have been most active have extended temporary policies with the expectation that long-term policies will be

refined over time in coordination with stakeholders. As examples, New Hampshire and Vermont legislation both included mandated creation of working groups or commissions to examine permanent telephone coverage and reimbursement policies. Other states, such as Pennsylvania and Michigan, anticipate interim policies to be enacted between the end of the public health emergency and when any state legislation or permanent administrative rules are enacted.

*“We know we are fixing the bicycle as we ride it.”*

— State Medicaid agency representative

*“It is terrible to be figuring out how to finance these [telehealth modalities] long-term while we are still figuring out what is clinically appropriate.”*

— State primary care association representative

*“The big takeaway is that we need more time, and so we are asking for flexibility.”*

— State Medicaid agency representative

Very few states have yet established cost or utilization projections. The Ohio Department of Medicaid, which extended telephone and video visit reimbursement for FQHCs, has projected a two-year increase in visits and costs followed by long-term savings to the Medicaid program. The Colorado Department of Health Care Policy and Financing (HCPF) projected for the June 2020 legislation a 4.4% increase in primary care costs, but has since reported a normalization of visit volume after a spike in volume during the early pandemic period. They have also emphasized the need for more experience to make reliable projections.

**There appears to be significant receptivity to telephone visits for behavioral health services.** While medical services use among FQHC patients has remained below prepandemic levels even with the addition of video and telephone visits, several states reported that total behavioral health visits conducted by FQHCs exceed prepandemic levels. There appears to be wide recognition that telephone visits have vastly expanded access and increased use of existing provider capacity (e.g., lower no-show rates), fewer concerns about the efficacy of telephone visits for behavioral health services, and a receptivity to long-term policies that enhance use of behavioral health services.

#### Interim Steps and Time to Learn More

**New Hampshire.** As a part of July 2020 legislation that established payment parity for telehealth services and permanently expanded coverage for telephone visits, the New Hampshire legislature also established the Commission to Study Telehealth Services to provide feedback on the impact and value of telehealth coverage changes, with the expectation to revisit policies during the next legislative session.

**Vermont.** Part of the legislation to permanently expand coverage of video visits at the PPS rate for FQHCs included creation of an Audio Only Telephone Services Working Group. Workgroup recommendations released in November 2020 urged continued telephone reimbursement and articulated key principles to ensure cost-effectiveness, quality, and access. The state has elected to leave the temporary expansion of telephone visits (also at PPS) and other temporary telehealth expansions in place for at least one year rather than advance complicated new legislation during a remote session.

**Colorado.** Following passage of legislation extending PPS reimbursement for video and telephone visits, the Medicaid agency is expected to seek flexibility to allow for non-PPS reimbursement for telephone services even though it has no intention of reducing payment before the next fiscal year.

**States are also exploring nonreimbursement levers to manage telehealth use.** States have multiple levers by which to manage use of different modalities by FQHCs beyond reimbursement or absolute restrictions on which modalities are permitted for different services. States report exploring multiple strategies, such as:

- ▶ Requiring at least one in-person FQHC visit per year for members that utilize a video or telephone visit
- ▶ Prohibiting providers from initiating video or telephone visits (to prevent conversion of triage calls into billable visits)
- ▶ Limiting video or telephone visits to established patients only
- ▶ Restricting video and/or telephone visits to specific evaluation and monitoring codes
- ▶ Requiring documentation of why a video visit is not feasible for telephone visits
- ▶ Suspending the “four walls” requirement and allowing providers to deliver video/telephone visits at home in *limited* circumstances (e.g., snow days, natural disasters, public health emergencies)
- ▶ Instituting utilization limits for telehealth services

**Teledentistry has gained permanent approval in some states.** Despite an absence of teledentistry awareness or services before the pandemic, 4 of the 10 locations (9 states and the District of Columbia) examined have already extended PPS reimbursement for teledentistry services — Colorado, New Hampshire, Ohio, and Vermont. For the most part, reimbursement is limited to oral health evaluation.

**Remote patient monitoring (RPM) appears to be a phase two priority in multiple states.** Although RPM is not yet reimbursed in most states, it appears to be an area of interest for the future. One state, Ohio, reimburses FQHCs for RPM. The service is “carved out” of the FQHC scope of services and reimbursed

at the Medicare rate. Primary care association representatives in Colorado, Michigan, Texas, and Vermont all highlighted RPM as an area of interest for the future. They acknowledged that PPS reimbursement is not likely but expressed interest in the relevance and potential impact of RPM for health center patient populations.

## Conclusion

The emergence of widespread telehealth utilization in Medi-Cal has been a rare bright spot in an otherwise overwhelming and challenging period. Beyond just increased telehealth use, the moment has awakened interest and openness by Medi-Cal enrollees to utilize telehealth, spurred providers to fully implement and understand telehealth, and catalyzed innovation and transformative thinking within the field. FQHCs, which serve as an essential and dominant segment of the Medi-Cal provider network, have been on the front lines of rapidly deploying telehealth in Medi-Cal for primary care, behavioral health, and dental services.

In California, the degree to which recent telehealth advances that expand access to care to vulnerable residents and maximize limited provider capacity are maintained and built upon, or lost, will in large part be determined by how the state defines Medi-Cal telehealth coverage and reimbursement policy specifically for FQHCs. The unpredictability of the pandemic and the experience of other states are reminders that, while “permanent” solutions may seem desirable now, interim steps between the public health emergency and long-term telehealth reimbursement policies are likely needed. Therefore, policymakers may be well-served to consider “bridge” policies for FQHCs that preserve and build upon recent advances and link to a longer-term payment vision, such as:

- ▶ Acting to solidify temporary flexibilities with clear long-term value, such as extending PPS reimbursement to FQHCs for video visits in primary care and behavioral health, as well as for telephone visits for behavioral health

- ▶ Extending PPS reimbursement for telephone visits for medical services at FQHCs for a defined interim period (e.g., two to four years) in parallel with formal commissions or working groups to establish long-term guidelines and reimbursement policies
- ▶ Explicit alignment of interim telehealth policies with the development of a value-based reimbursement structure for FQHCs

The power, and choice, about how to move forward is in California's hands.

## Appendix. State Case Studies

Medicaid telehealth policy activity in nine states and the District of Columbia was examined for this paper. Four locations — Arizona; Pennsylvania; Washington, DC; and Wisconsin — were identified as being in more preliminary stages of policy development. Written case studies were developed only for those states that were further along in policy development (Colorado, Ohio, Vermont, Michigan, New Hampshire, and Texas).

### COLORADO

While the Colorado Medicaid program (Health First Colorado) permitted reimbursement for provider-to-patient video visits and other synchronous telehealth services before the pandemic, the program did not enable any additional reimbursement to FQHCs. Rather, it determined that these services could be subsumed into existing cost-related reimbursement. As a result, few if any Colorado FQHCs actively provided telehealth services.

Following the pandemic surge, the Department of Health Care Policy and Financing (HCPF) pursued temporary flexibilities that included synchronous and asynchronous telehealth, including patient-to-provider video and telephone visits with PPS payment to FQHCs. Following the implementation of temporary flexibilities, the HCPF began drafting permanent reimbursement changes via administrative rulemaking, with input from the Colorado Community Health Network (CCHN) and other stakeholders. However, CCHN eventually attached the temporary public health emergency changes to other telehealth legislation being driven by commercial provider interests. SB2020-212, passed in June 2020, requires the state to pay FQHCs (and all other providers) the same as the established face-to-face encounter rate for video and telephone visits provided these services are HIPAA compliant (Colorado uses an APM methodology).<sup>7</sup>

SB2020-212 included a fiscal analysis that projected a 4.4% increase in telehealth visits over current baseline, as well as a decrease in transportation costs to the Medicaid program. More recently, HCPF indicated that following an initial jump in Medicaid primary care visits per member immediately following the expansion of telehealth flexibilities, utilization rates have now fallen to prepandemic levels.

HCPF has posed some questions about the value and appropriateness of telephone visits, as well as the potential impact on program costs. That said, there appears to be an acknowledgment that without continued reimbursement parity for telephone visits for the foreseeable future, FQHCs will face significant financial challenges. Stated a CCHN representative, “It is terrible to be figuring out how to finance these [modalities] long-term while we’re still figuring out what is clinically appropriate.”

While it has said it does not intend to change payments until after July 2021, HCPF would like the flexibility to eventually establish telehealth-specific rates for FQHC and non-FQHC providers. This may include steps to pursue a new bill in the next legislative session to remove the SB2020-212 parity requirement that direct provider-to-patient telehealth (video and telephone) visits be reimbursed at the same rate as face-to-face encounters to provide the agency with some administrative flexibility.



## OHIO

Before the COVID pandemic, the Ohio Medicaid program limited telehealth reimbursement to synchronous live video telehealth visits (at the PPS rate). With the pandemic, the Medicaid program enacted temporary flexibilities that included reimbursement of medical and behavioral health services for asynchronous telehealth (store and forward), direct provider-to-patient video visits, telephone/email/text/fax visits, and remote monitoring, as well as limited dental evaluation/triage. With the exception of remote monitoring, these services were paid to FQHCs at the PPS rate.

As of November 15, 2020, the Ohio Department of Medicaid (ODM) enacted administrative rules to make permanent the vast majority of temporary flexibilities, including PPS payment for video visits from the patient home, telephone/email/text visits, and oral health evaluation.<sup>8</sup> Fax visits are no longer reimbursed, but technically FQHCs may be reimbursed PPS for email and text visits. Remote monitoring is “carved out” of the PPS rate and paid using Medicare codes (including an initial connection fee and monthly charge). In terms of additional limitations, the ODM requires that members who use telehealth services also have at least one face-to-face visit per year.

Considerations that factored into the above rule changes included acknowledgment of “broadband deserts” in many rural areas, positive impacts of telehealth on patient no-show rates, and transportation barriers and other enrollee access challenges (e.g., taking off work for appointments). While the ODM fiscal analysis anticipates a short-term increase in visits and costs due to expanded connected health reimbursement, it also estimates long-term savings to the Medicaid program. That said, the agency acknowledges that future rules modifications and cost estimates will be informed by experience. Stated an ODM representative, “We know we are fixing the bicycle as we ride it.”

The permanent telehealth coverage and reimbursement rules were developed administratively by the ODM without statewide legislation. Although ODM determined that a State Plan Amendment (SPA) was unnecessary to expand telehealth modalities or pay FQHCs at the PPS rate, it will be filing a SPA.

As of October 2020, about 25% of FQHC billable visits are virtual. Anecdotally, the vast majority of these are telephone. The Ohio Association of Community Health Centers has prioritized support for FQHCs to effectively and appropriately utilize telehealth in an ongoing manner. Of additional focus is serious exploration of enhanced use of remote monitoring, as well as incorporation of telehealth modalities into the calculation of managed care quality calculations (e.g., HEDIS).

Of note, Ohio’s FQHC PPS rate structure has important differences compared to California’s. Ohio FQHCs receive different PPS rates for medical, behavioral health, and dental services, as well as stated caps on how high these rates may be set. A number of discrete services are carved out of the PPS rate, including x-ray, group therapy, acupuncture, dietician, IUD, and remote monitoring services. Lastly, Ohio does not utilize a yearend reconciliation process for FQHCs.

## VERMONT

Initiated before the pandemic, the Vermont legislature finalized and passed Act 091 in March 2020 that ensured payment parity for FQHCs providing Medicaid services via traditional synchronous and asynchronous (store-and-forward) telehealth, teledentistry services, and direct video visits originating from the patient home.<sup>9</sup> This legislation ensured that FQHCs would be paid at the PPS rate for these services. The parity legislation did not include permanent reimbursement for telephone services at the same rate as office visits, but did allow for temporary use of telephone visits during the public health emergency (with payment parity). This legislation also expanded the category of reimbursable telehealth services by opening store-and-forward interprofessional consultations (all specialty types, currently reimbursed as fee-for-service). The legislation sunsets in 2026 in anticipation of a health center global payment model under development.

Act 140 of 2020 required the Department of Financial Regulation to convene a working group to develop recommendations for permanent reimbursement of telephone services in Medicaid (including but not limited to FQHCs). The report, released on December 1, 2020, recommended continued coverage of audio-only services with a number of complementary recommendations, including required patient consent, application of the same standards of care across modalities, required provider training, additional investments to address the digital divide and a recommendation to fold audio-only reimbursement into a broader value-based reimbursement model by 2024.<sup>10</sup> In regards to impact on total cost of care, the working group report concluded that “data generated from provider organizations and the federal government to date show that total health care use remained steady during telehealth’s expansion and did not substantiate concerns about supply-induced demand” but also noted that further cost-based analysis will need to be conducted postpandemic. The working group noted that telehealth use has largely substituted rather than added to total utilization, even following the reopening of in-person services after the initial COVID surge.

It further stated that telehealth both prevented more-costly care and reduced patient no-show rates. The working group also articulated a few key principles to guide the evolution of telehealth reimbursement and made specific recommendations related to ongoing quality measurement and monitoring and to patient safety, among other areas. Vermont has elected to maintain pandemic flexibilities for one additional year in order to avoid complicated new legislation during what is expected to be a remote legislative session.

The Bi-State Primary Care Association (PCA) has articulated separately that it is also advocating for an expanded range of telehealth services including remote patient monitoring, chronic care management, medication-assisted treatment services, and additional audio-based telehealth, though not for reimbursement at the PPS rate. While there is a hope to fold future reimbursement into a global payment mechanism, the Bi-State PCA has urged putting initial fee-for-service reimbursement systems in place now until the planned global payment model is finalized in the coming years. Many of these principles are reflected in the working group report.

## MICHIGAN

Although the Michigan Medicaid program had essentially no telehealth policies in place before the COVID-19 pandemic, the state Medicaid agency had been working for about a year to develop administrative rules. As a result of the pandemic, Michigan Medicaid accelerated the release of a base set of permanent telehealth policies in March 2020. These included reimbursement for a defined set of medical and behavioral health services for video visits, including those originating from the patient home, where FQHCs are reimbursed at the PPS rate. A SPA was not completed for these permanent policies.

Soon after, the Department of Health and Human Services (DHHS) submitted a disaster relief SPA for several temporary expansions, including a broader set of services (e.g., oral health evaluation, OT/PT, additional behavioral health codes), PPS reimbursement for telephone visits, and a temporary allowance to enable providers to be at home when delivering services. While these temporary authorizations are in response to the public health emergency, Michigan has clarified that they may be continued for some period beyond the end of the federal public health emergency declaration. This provides some flexibility to bridge temporary and permanent reimbursement policy.

Negotiations and discussions are underway about additional permanent telehealth expansions. It is anticipated that DHHS will allow video visit reimbursement for a broader set of services. The Michigan Primary Care Association would also like to see inclusion of asynchronous store-and-forward telehealth, as well as the allowance of providers to deliver services from home in defined circumstances (e.g., snow days). DHHS, like some other state Medicaid agencies, has expressed concerns that telephone visits are not permanently allowed by CMS. Stakeholders are also exploring additional potential levers that could establish rules for appropriate telephone visit utilization, such as new-patient establishment rules, potential limits to the range of services allowed for telephone visits, or even requirements that providers document why a video visit is not possible.

A secondary area of future discussion is remote patient monitoring. There is the expectation any future FQHC payment for RPM would be carved out of the PPS rate or potentially encompassed in a broader carved-out care management service.

## NEW HAMPSHIRE

Although live video visits originating from the patient home for primary care and behavioral health services were already covered before the pandemic, use of this benefit was extremely limited in New Hampshire. Following additional pandemic flexibilities, the New Hampshire legislature passed HB1623 in July 2020, which mandated that FQHCs be paid the same rate for video and telephone visits as they are for in-person visits (New Hampshire FQHCs use either an APM or PPS rate and are paid in full by their managed care plans).<sup>11</sup>

The state has also established the Commission to Study Telehealth Services to provide feedback on the impact and value of these telehealth changes, with the potential to modify rules during the next legislative session. As with most other states, total FQHC visits were about 15% below prior-year visits overall, and just above 20% of all visits were virtual visits. While medical visits have declined, telehealth has contributed to an absolute increase in behavioral health visits.

## TEXAS

Before the pandemic, Texas health centers had very limited options for utilizing telehealth in Medicaid. Legislation in 2018 allowed FQHCs to serve as both originating and distant site providers for traditional telehealth services, though regulations were not finalized to enable this until June 2020. In March 2020, Texas pursued a temporary waiver that enabled FQHCs to be reimbursed at the PPS rate for live video and telephone visits, including those originating from the patient home. However, it maintained a prohibition on all teledentistry services. In June 2020, the Texas Medicaid and Healthcare Partnership (TMHP) finalized regulations enabling FQHCs as originating/distant site providers for traditional synchronous telehealth services and reimbursed at the PPS rate. Although the Texas Association of Community Health Centers (TACHC) argued that a State Plan Amendment was not necessary for these rule changes, TMHP elected to submit a SPA.

TMHP is in the process of developing permanent rules for telehealth covered services and reimbursement for FQHCs. This includes release of a financial impact report by the Medicaid Commission in November 2020. While total Texas FQHC visits remain low and about 20% of visits are still provided via video or telephone visit, the state of Texas likely faces a large budget deficit. It is uncertain how this will impact decisions on permanent reimbursement to FQHCs.

Looking forward, TACHC has also prioritized exploration of expanding use and reimbursement for remote patient monitoring, though it acknowledges that any reimbursement would not be at the PPS rate.

## Endnotes

1. *Health Center COVID-19 Survey Operational Capacity*, Health Resources and Service Administration, n.d.
2. "Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)" (PDF), in *Medi-Cal Provider Manual*, California Dept. of Health Care Services (DHCS), last updated August 2020.
3. Anne Marie Costello (deputy director, Center for Medicaid & CHIP Services) to Jacey Cooper (chief deputy director, Health Care Programs, DHCS), *California State Plan Amendment Approval Letter 20-0024* (PDF), May 13, 2020.
4. Bobbie Wunsch and Tim Reilly, *Medi-Cal Managed Care Plans and Safety Net Clinics Under the ACA* (PDF), California Health Care Foundation, December 2015.
5. *Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth* (PDF), CMS, March 12, 2020.
6. Approval Letter 20-0024, CMS.
7. "Telemedicine - Provider Information," Colorado Dept. of Policy and Financing, n.d.
8. *Telehealth administrative rules* (PDF), Ohio Dept. of Medicaid, November 5, 2020.
9. *Act 91. An Act Relating to Vermont's Response to COVID-19* (PDF), Vermont Legislature, March 2020.
10. *Report of the audio-only telephone services working group* (PDF), Vermont Dept. of Financial Regulations, December 1, 2020.
11. *H.B. 1623-FN* (PDF), 2020, Reg. Sess. (N.H. 2020).