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California Medi-Cal Program: The need for progressive policies of Telehealth to meet
COVID-19 pandemic and the future of healthcare

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Abstract

California Medi-Cal Program: The Need for Progressive Policies of Telehealth to Meet COVID-19 Pandemic and the Future of Healthcare

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Before COVID-19, Telehealth was an unattractive model to healthcare providers. Once they realized its benefits and incentives, the anxiety levels decreased, and healthcare providers envisioned an improved healthcare system for clinics and hospitals. Telehealth is the antidote for patients who could not otherwise access quick in-person healthcare services; nevertheless, many states may revert to scheduling in-person doctor visits post-COVID-19. The U.S. government relaxed telehealth regulations to support the healthcare system and improve healthcare services provided to millions of Americans during the pandemic but not without challenges. Though telehealth is easy and convenient for patients and providers, it is costly to maintain technologically, and compensations to providers are meager. This qualitative research reviewed the literature and policies that supported the effectiveness of telehealth and the need for permanent reimbursement policies for telehealth within California. The Cares Act created policies that promptly solved these issues healthcare providers faced during Covid-19. Recently,

California proposed Assembly Bill 32 that ceased the instability with telehealth policies and built a solid reimbursement plan to surpass the public health emergency. Furthermore, this literature reviewed and analyzed the influence telehealth had among patients with different health needs and the many benefits offered through this model. Covid-19 exposed the benefits of telehealth, an incentive for healthcare providers and the community to adopt it, and the need for additional reimbursement policies. The future of healthcare technology looks promising, especially with the support of a structured government-sponsored program. To improve the financial reimbursement system, legislators, in concert with healthcare professionals and insurance payers, hone in on what opportunities enhance and meet the community's needs and ensure direct payments for those needs. Last, to reinforce the support framework of telehealth, a better team-based strategy for treatments and continuity of care is paramount.

Introduction

The Medicaid program in California is called Medi-Cal. It is the most extensive Medicaid program across the nation, covering nearly 12.5 million Californians as of March 2020 (Norris, 2020). The program covers healthcare and provides health insurance. It has grown since 1966, expanding coverage and implementing new policies. In 1973 Medi-Cal introduced managed care plans. By 1982 hospitals implemented selective contracting strategies with hospitals. Family planning services became accessible by extending coverage to families at 100% of the federal poverty level (FPL) in 2000, and by 2010 insurance coverage to uninsured adults (Norris, 2020). These modifications to the program resulted in the ever-changing community's needs and external matters.

In March of 2020, the World Health Organization (WHO) recognized COVID-19 as a pandemic that infected the world (who.org, 2020). California was no exception, and it forced Medi-Cal to modify its policy due to the environment it faced. These modifications included an increase in the providers' ability to use Telehealth services for Medi-Cal recipients. The California Department of Health Care Services (CDHS) lifted restrictions on which services could be provided through telehealth clinicians and gave the authority to determine clinical appropriateness and established billing codes and payment rates for specialists providing electronic consultations (The State of Telehealth in Medi-Cal Managed Care, 2020). California law defines telehealth as "a 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 health care provider is at the distant site" (Telehealth Frequently Asked

Questions, 2020). At the current state, the Medi-Cal reimbursement rate for telehealth is the same as the professional medical services provided in-person.

The expansion of this program forced providers and patients to change their viewpoint on virtual visits. However, like other clinical practices, it faced barriers widely unaccepted. The success of telehealth rests on resolving technical, regulatory, and financial issues and managing human and organizational change (Kho, 2020). First, clinical providers and organizations have reevaluated what the appropriateness of care is through these visits. Second, the stress of the pandemic demanded organizations to restructure their policies and procedures on telehealth. Finally, political changes continued to create uncertainty about the future of telehealth and its reimbursement rates. This paper will explain why the Covid-19 telehealth expansion should continue its support as part of the California Medi-Cal program post-Covid-19.

Literature Review

The pressure of a pandemic forced the government to restructure its policies of reimbursement on telehealth. However, political changes continue to create ambiguity that threatens the future state of telehealth reimbursement. According to a study conducted by Harvard University, Phreesia and the Commonwealth Fund analyzed data on changes in visit volume for the more than 50,000 providers - Phreesia clients (Ateev,2020). Data collected during the Covid-19 pandemic in 2020 reflected that the number of visits to ambulatory practices fell 60% by early April before rebounding through mid-June. From then through the end of July, weekly visits plateaued at 10% below the pre-pandemic baseline. The cumulative number of lost visits since mid-March 2020 remains substantial and continues to grow (Ateev,2020). If the government did not alter the reimbursement rate, healthcare providers would not be financially stable to conduct care as needed for patients facing chronic conditions and risk healthcare workers' health. The data proves that patients discontinued seeking care when they were most vulnerable. They needed access to their providers. An audio-only visit was a lifeline for them to get essential services because COVID-19 restricted in-person visits. For example, medication refill, easy diagnosis, or educational follow-up regarding diabetes care was provided using the audio-only services.

The approval of reimbursement for audio-only telehealth was a pivotal move that alleviated the sudden demand healthcare centers faced. Consequently, the growth outcome would allow obtaining research data around telehealth that would be more beneficial for policy making and practice if the data and studies were improved (Welkinhealth, 2021). Telehealth allows patients to have better access to the necessary services they need for their well-being. Medicare primary care visits conducted virtually increased 350-fold to 43.5% from a pre-pandemic level of

just over 0.1% (ASPE, 2020). The access helps patients to seek services throughout the pandemic. The CARES Act passed by Congress on March 25, 2020, and signed into law on March 27, 2020, implemented fast and direct economic assistance for American workers, families, small businesses, and industries. In addition, the policy implemented a variety of programs to address issues related to the onset of the COVID-19 pandemic. (U.S. Department of the Treasury, 2020).

On March 30, as part of the CARES Act, the Center of Medicaid Services published new policies to help physicians and hospitals during the COVID-19 pandemic, including coverage for audio-only telephone visits. The toolkit for telehealth includes several topics- patient populations eligible for telehealth, coverage and reimbursement policies, providers and practitioners qualified to provide telehealth, technology requirements, and pediatric considerations (American Medical Association, 2020). Politicians implementing permeant policies around audio-only visits allow telehealth to grow and care more accessible to patients with issues visiting a provider. Consequently, the growth outcome would allow obtaining research evidence about telehealth that would be more useful for practice and policy decisions if the data and studies were better (Welkinhealth, 2021).

Telehealth Benefits for Outpatient Services

In the article, "The hidden economics of telemedicine," Dr. David Asch states that telehealth technology is set to provide the services face-to-face and open the doors to new options that providers only saw available through an in-person visit (Asch, 2015). As a result, telehealth can change the care model and expand access and enhance health results in cost-effective alternatives (California Telehealth Network, 2020).

Underserved communities tend to have poor health, which is caused by many determinants such as transportation barriers, uninsured, and access to healthcare providers, to name a few (Syed, 2013). In a study published by the Journal of Community Health, impoverished communities' most significant challenge was transportation. In multiple studies 10 to 51% of patients reported transportation issues that constrained their healthcare access (Syed, 2013). The negative impact of no access to transportation resulted in missed opportunities to see a healthcare provider reduce further complications of their disease, failure to treat the diseases promptly, or review treatment plans as often as needed (Syed, 2013).

For underserved communities, time is also an added factor due to the distance. The Journal of General Internal Medicine published a study that identified barriers individuals meet when receiving care from a healthcare facility. It found that patient health status, functional impairment, travel cost, and work or family obligations were barriers (Buzza, 2011). The same study also stated that healthcare employees mentioned distance to provide healthcare (Buzza, 2011). The study concluded that time and distance were the most critical barriers to rural populations seeking healthcare (Buzza, 2011).

A randomized controlled trial published by The Gerontologist measured if telehealth supported immobile, older patients with respiratory failure and heart diseases. The trial studied two groups- receiving telehealth support and receiving regular in-person care (Zvi, 2012). The group that utilized the telehealth service had better general health outcomes and social functioning. The group that was not using telehealth utilized the emergency room. In addition, there was an observed trend toward fewer hospital days for telehealth participants, and telehealth benefited the adults who were immobile and could not access health facilities due to transportation or disability (Zvi, 2012).

The PROMOTE study, conducted for the Madrilian Telehealth Project for COPD, assessed the efficacy and effectiveness of a home telehealth program for COPD patients with severe airflow obstruction. The study measured the number of emergency room visits, hospitalizations, length of hospital stay, and mortality (Segrelles, 2013). Sixty participants in the survey identified if telehealth helped improve COPD patients' health. Half the participants received care through telehealth (TH), and the other half through conventional care (CC). All participants had a prior diagnosis of COPD and were monitored for seven months. The study found that there was a "significant reduction in ER visits (20 in HT vs. 57 in CC), hospitalizations (12 vs. 33), length of hospital stay in (105 vs. 276 days), and need for non-invasive mechanical ventilation (0 vs. 8)" (Segrelles, 2013). In addition, the study proved that telehealth in older, severe COPD patients with several health issues is safe and efficient in decreasing healthcare resource usage (Segrelles, 2013). Both studies concluded that the use of telehealth services reduced the number of ER visits and hospitalizations.

Marshfield Clinic Telehealth conducted a study to demonstrate the effectiveness and cost-benefit of telehealth for patients undergoing postoperative care after having a parathyroidectomy surgery (Urquhart, 2011). It was designed around 39 patients experiencing postoperative care after parathyroidectomy surgery through telehealth at several sites at different distances from the original surgical facility. The study recorded age, gender, distance from the patient's home, surgical center, and the telehealth site. The visits were determined effective and cost-saving. No patients encountered any postoperative surgical complications. Telehealth saved an average round-distance traveled of 119 miles. The travel distance saved an average savings of \$357.00 per patient, including calculations of transportation costs and work hours missed. It

proved that telehealth provided notable convenience and financial benefits for patients and the healthcare system (Urquhart, 2011).

Telehealth for Prevention and Education

A study published by the Science of Diabetes Self-Management and care analyzed diabetes-related behavioral, psychosocial results, and patient satisfaction with the Telemedicine for Reach, Education, Access, and Treatment (TREAT) model (Siminerio, 2014). TREAT enlisted a team of diabetes educators to partner with an endocrinologist to conduct care-based approach that will offer telehealth visits in rural areas. The essential advantage of this model is that it makes it possible to deliver specialized diabetes care services to rural communities where those services would otherwise be unavailable. The study observed thirty-five patients that suffer from type 2 diabetes who were provided with telehealth services. A diabetes educator video conferenced with the patient to review the plan prescribed by the endocrinologist, conducted assessments and presented self-management training. The survey recorded diabetes distress, self-management, consistency to monitoring, and patient satisfaction (Siminerio, 2014). The TREAT model resulted in a significant improvement in adherence to diet, monitoring, and a reduction in distress caused by diabetes. In addition, satisfaction rate amongst the patients was high. Thus, the TREAT model is an alternative for rural communities that suffer from a shortage of team-based diabetes specialists and self-management support services (Siminerio, 2014).

A similar model accentuated the value of telehealth amongst interventional programs. An article published by BMC Geriatrics highlighted the need to increase telehealth intervention to overcome obesity among Medicare recipients (Batsis, 2017). Obesity creates an bigger risk of functional deficiency, a challenge in finding a nursing home, and premature mortality (Batsis, 2017). The Centers for Medicare and Medicaid acknowledged value of addressing obesity and

established a profit in primary care sites to support intensive behavioral therapy in recipients by primary care providers. This benefit pays for regular, quick encounters intended to treat older adult obesity. The article outlines the difficulties in implementing the intervention program because of rural locations with the fastest-growing elderly population, high obesity rates, workforce shortages, and lack of specialized services (Batsis, 2017). To successfully implement the model, these steps are paramount:

- Organizations must recognize that telehealth is needed to increase access to the patients (Batsis, 2017).
- A plan is required to estimate the overhead costs of the telehealth infrastructure, including initial set-up and upgrades, at the delivering and receiving ends (Batsis, 2017).
- The organization needs to secure appropriate billing and capturing of visits. Low reimbursement remains a problem for the long-term sustainability of telehealth systems within a fee-for-service model (Batsis, 2017).

Their recommendation is to extend the benefit's coverage to be more inclusive of non-physician team members through telehealth and improve reimbursement for the services for older adults with obesity (Batsis, 2017). Figure 4 below outlines the barriers and recommendations providers can follow to address the obesity problem. If met, telehealth can address rural disparities with the engagement of non-physician staff in performing this service remotely.

Practice management challenges & proposed recommendations for coverage for medicare obesity benefit in rural areas

	Current state	Barrier	Recommendation
Personnel	Physician, Associate Provider, Clinical Nurse Specialist	Decreased supply of PCPs creating a gap in service coverage	Allowing other healthcare providers or peer-health coaching to deliver service
		Lack of Specialized Services Available	Permit allied health providers in delivering service from larger, specialized centers
Frequency of Visits	22 visits provided by above personnel	Creation of an access issue in practices already overworked and overwhelmed	Maintain visit numbers Delegate visits to allied health providers to off-set visits
Clinical Site	Face-to-face or Telemedicine-based office setting	Transportation issues create a barrier to providing health care services	Advocate for Telemedicine in rural areas
		Individuals must resident and receive care in designated service areas	Eliminate requirement of service area
		Home-based care is not covered	Permit home-based care
Reimbursement	G0477 Code - \$27/visit	Reduced reimbursement to providers	Increase reimbursements or transition to value-based care model

Figure 4: Practice Management Challenge and Proposed Recommendations (Batsis, 2017).

Behavioral Health through Telehealth

Telehealth allows behavioral health providers to deliver care in an effective method. Earlier technologies, such as telephonic communication and email, provide efficient ways to administer care for mental health issues. For example, a randomized trial conducted by the National Institute of Mental Health Research found that telephone-delivered psychotherapy did not change its effectiveness compared to face-to-face therapy, in addition to an advantage for telephonic treatment in completion rates (Mohr, 2012).

As the COVID-19 pandemic continues, state Medicaid programs should include a broader scope of behavioral health care services through telehealth for beneficiaries, including audio-only and text-only services, while taking steps to ensure that these delivery models provide adequate protections for patient privacy (Coursolle, 2020).

Changes in Telehealth Policies Due to Covid-19

The Covid-19 pandemic has caused both the medical and healthcare system to change their approach to telehealth. Still, it continues to see barriers within its policy and practice due to the ever-changing political and public health environment. Before the pandemic, the Centers for Medicare and Medicaid Services (CMS) imposed strict Medicare reimbursement restrictions based on geographic location, type of care providers, and telehealth delivery method (Zhai, 2021). Under President Trump's leadership, the CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wide range of services from their doctors without having to travel to a healthcare facility (CMS, 2020). However, the federal and state government continue to eliminate or adjust reimbursement waivers or benefits providers are currently receiving. On March 6, 2020, there was an expansion of telehealth with the 1135 waiver. Under this new waiver, Medicare can pay for office, hospital, and other telehealth visits across the country and include patients' residence places (CMS, 2020).

The Center for Disease Control and Prevention has identified various categories under the Telehealth Modalities:

- Synchronous: The use of live telephone or video communication with a patient using a smartphone, tablet, or computer.

- **Asynchronous:** This includes a service in which a provider can store and forward technology where messages, images, or data are collected, and the provider replies to them later. This method usually applies to a patient portal that offers secure messaging to their healthcare provider.
- **Remote Patient Monitoring:** permits direct transmission of a patient's clinical measurements remotely (Center for Disease Control and Prevention, 2020).

This enables providers to treat the patient and get reimbursement for encounters that are not necessarily in person. Figure 1 below demonstrates various methods of telehealth.

Telemedicine Can Facilitate a Broad Range of Interactions Using Different Devices and Modalities

Interactions	Devices	Modalities	Patient Location
<ul style="list-style-type: none"> • Patient to provider • Provider to provider 	<ul style="list-style-type: none"> • Smartphone • Computer/tablet • Monitoring device 	<ul style="list-style-type: none"> • Videoconference • Remote patient monitoring • Phone* • Secure messaging* 	<ul style="list-style-type: none"> • Home (or location of choice) • Clinic/Office • Hospital

Figure 1: Telemedicine Can Facilitate a Broad Range of Interactions Using Different Devices and Modalities (KFF, 2020).

The United States Government falls short of defining telehealth with technology; policymakers must adopt the integration of technology and healthcare model to improve access and create an effective system that supports patient care (Kumar, 2005). Methods like patient portals can alleviate the health systems' pressure because they can fulfill simple requests, such as medication refills, scheduling an appointment, and connecting with a provider for non-urgent

issues without scheduling an appointment (Byron, 2017). Auditing audio-only communication addresses the ability to access video technology and literacy barriers encountered by low income patients (Ortega, 2020). Technical factors have recently been less problematic in recent years as various applications have evolved with high-quality video transmission and necessary confidentiality and security (Wright, 2020). Some of these platforms that offer secure medical application options include Zoom, Bluejeans, Doxy.me, thera-LINK, TheraNest, SimplePractice, and Vsee (Wright, 2020).

Covid-19 has forced the federal government to open the door to future expansions of telehealth services. The expiration of these modifications were set with some dates already determined and other pending further review; telehealth advocates support these policies' continuation (Ortega, 2020). "This includes extending Medicare coverage for all modes of health care (video, audio-only, store-and-transfer and remote-patient monitoring), for all geographic and originating sites and both synchronous and asynchronous care (Ortega, 2020)." Figure 2 below demonstrates the fundamental changes made to cover restrictions for Medicare fees for service during the Covid-19 pandemic.

Key Changes to Coverage Restrictions for Medicare Fee-for-Service During the COVID-19 Emergency

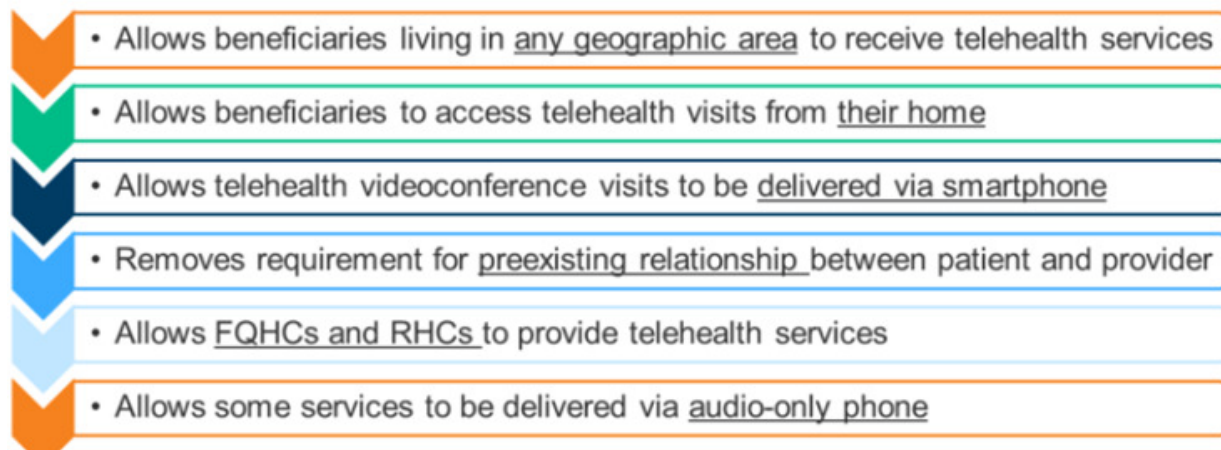
- 
- Allows beneficiaries living in any geographic area to receive telehealth services
 - Allows beneficiaries to access telehealth visits from their home
 - Allows telehealth videoconference visits to be delivered via smartphone
 - Removes requirement for preexisting relationship between patient and provider
 - Allows FQHCs and RHCs to provide telehealth services
 - Allows some services to be delivered via audio-only phone

Figure 2: Key Changes to Coverage Restrictions for Medicare Fee-for-Service During the COVID-19 Emergency (KFF, 2020)

Before the pandemic, telehealth for routine care was low amongst several healthcare systems (Harvey, 2019). Due to the pandemic, health systems with fewer than 100 visits via video now have higher than 600 patients per day through video visits (Jedreck, 2020). This shows a sharp incline in need for the service and how it is readily available if needed. The pandemic forced health care systems to switch to telehealth services to continue offering adequate care (Jedreck, 2020).

Telehealth Policies in California

During the Covid-19 pandemic, Medi-cal healthcare providers must explore how to deliver value-based care while still staying aligned with Medi-Cal policies. Telehealth is a beneficial service in many ways, and the Covid-19 pandemic has highlighted the demand for it to be an available service even after the pandemic is over. However, before the pandemic, the California Medi-Cal program was not reimbursing for most telemedicine services; the government's support and quick action to aid patients changed this (California Policy, 2020). As a result, many providers were constrained to only scheduling in-person visits, which would cause access issues for patients.

On January 1, 2012, the Telehealth Advancement Act of 2011 was enacted; it updated legal definitions of telehealth, streamlined Medi-Cal's approval processes for telehealth-delivered services, and broadened the types of allowed telehealth-delivered services (California Policy, 2020). This law replaces the outdated legal term of telemedicine with the term telehealth. Telemedicine under the old law's terminology was defined as the practice of medicine via live video connections between patients and providers in separate locations or via data communications. As technological advances resulted in new telehealth treatment options, this

legal definition grew obsolete and became a barrier to implementing these advancements (California Policy, 2020). This law expanded the services delivered through technology and removed obstacles that the visit needed to be held in a medical facility to anywhere appropriate.

For California, the attempt to revert policies in place as a response to Covid-19 has begun, which causes hardships for patients and providers. As of July 1, 2021, Medi-cal will change the current fee schedule for services provided via telephonic services. Currently, Medi-cal will reimburse a visit if administered by telephone/audio-only. Medi-cal plans to "expand the use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients. These modalities would be subject to a separate fee schedule and not be billable by Federally Qualified Health Center /Rural Health Centers" (DHHS, 2021). No law or policy enforces that similar coverage will stand even after the pandemic. The expansion of health insurance coverage for telehealth in both national and state-level with a target towards susceptible population is a crucial stride in improving telehealth adaptation (Ortega, 2021).

Medi-cal California Medicaid Insurance

To qualify for the Medi-Cal program in the state of California, one of these requirements must be met: 65 or older, blind, disabled, under 21, pregnant, in a skilled nursing or intermediate care home, refugee status for a limited time, and have breast and cervical cancer (DHHS, 2019).

The recipients must be between 19 and 64 years old, and the family's income is at or below 138% of the Federal Poverty Level (DHHS, 2019). An enrollment to either, CalFresh, Social Security Income, CalWorks, Refugee Assistance, and Foster Care or Adoption Assistance Program will make one eligible for Medi-Cal (DHHS, 2019). California has an extensive Medi-Cal program compared to the rest of the nations (DHHS, 2019).

In 2016, Senate Bill 75 passed, and it expanded Medi-Cal coverage to all children regardless of immigration status if they met the other requirements (DHHS, 2019). Medi-Cal continues to expand on its services to meet the community's needs. However, finding cost-controlling or even cost-cutting strategies that will be acceptable to Medicaid beneficiaries poses severe challenges (Danis, 2006). In a study published by Johns Hopkins University Press, a study was designed to determine the priorities of disabled adults enrolled in the Medi-Cal program to inform state legislators to make budgetary decisions. The participants, who were non-institutionalized disabled adults under age 65, receiving primary health care coverage from Medi-Cal, were asked questions to identify what covered services were their priorities and find cost-saving opportunities by removing some services. The findings revealed that disabled adult beneficiaries in the California Medicaid program needed to maintain the full range of services even if this requires more significant restrictions on how services are used or higher out-of-pocket costs for those who can afford them (Danis, 2006). These services continue to be a lifeline for poverty-stricken individuals in California.

Telehealth Benefits in Emergency Rooms

Covid-19 has threatened to overwhelm health facilities and create a shortage of personal protective equipment (PPE). Telehealth became one of the most crucial tools that allowed providers to continue providing care when patients and healthcare systems were most vulnerable. It protects providers from an increased risk of infection, resulting in staffing shortages, patient safety, and a stressful environment (Ribeira, 2020). Providers in both inpatient and outpatient settings used telehealth to sustain their services. Table 3 explains various scenarios telehealth is utilized to treat patients throughout the Covid-19 pandemic.

Telemedicine Is Being Used in Many Scenarios during the COVID-19 Pandemic:

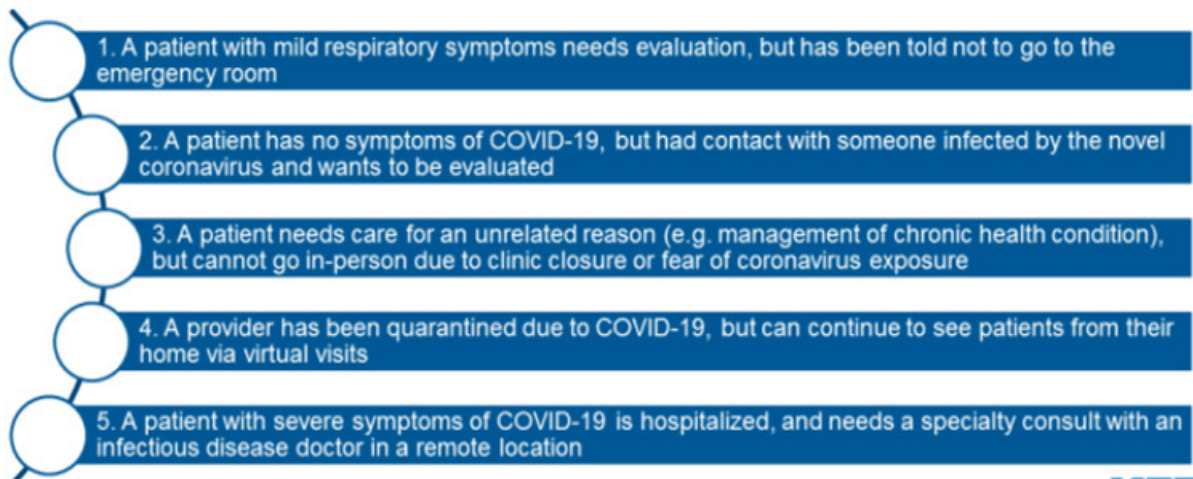


Figure 3: Telemedicine Can Facilitate a Broad Range of Interactions Using Different Devices and Modalities (KFF, 2020).

To minimize the possibility of exposure while preserving the quality of care, hospitals used telehealth to provide a protective barrier between patients and staff to limit the COVID-19 spread in the emergency department (ED) (Chou 2020). Telehealth was created to overcome the obstacles between patients and providers, but now it has proven to protect and provide efficiency in the ED (Chou 2020). The White House Coronavirus Task Force advised medical centers to implement a patient assessment strategy through telehealth. Baylor Scott & White All Saints Medical Center in Texas executed a process that allowed ED providers to screen a patient through telehealth for Covid-19. If they did not seem at substantial risk, they would then enter the patient room with a commonly used surgical mask. If the patient seems high risk and appears ill or unstable, the physician will evaluate the patient by entering the room while donning full PPE. (Chou 2020). If the patient seems stable, the physician will conduct a visual, physical exam through videoconference over iPad, which allowed them to avoid any risk during the visit (Chou

2020). This strategy significantly reduces PPE utilization; it is economical and avoids physicians' wasting time donning and doffing PPE, improving department flow, and prioritizing gravely ill patients more resourcefully while increasing patient capacity (Chou, 2020). Telehealth preserves PPE by saving one to two interactions per patient that would otherwise be required (Ribeira, 2020).

According to Mayo Clinic Health System, after implementing virtual, they found that virtual care models have firmly met the needs of people with possible COVID-19 and those with positive COVID-19 test results (Crane,2020). "Virtual visits have been widely accepted by patients and represent a key component of providing timely and safe health care during this pandemic" (Crane, 2020).

Methodology

This study is a qualitative analysis of archival data from peer-reviewed journal articles. Several academic databases, California State University Northridge Library and US National Library of Medicine National Institutes of Health, were searched to identify relevant literature. In addition, information from the California Medical website was used to research current policies. The search keyword was "Telehealth AND California Medical AND Covid-19 AND FQHC AND Telemedicine AND Medicare AND outpatient and Policy". In addition, there were filters added to find more aligned results. Search filter criteria were peer-reviewed and published between 2010 and 2021. For the California State University Northridge Library database only, the filter "Available online at CSUN" was added because of logistic purposes. California State University Northridge Library initially returned 2,241 search results, and the US National Library of Medicine National Institutes of Health returned 42 search results.

The articles were reviewed based on title relevance. Reports based on Covid-19 were prioritized because they aligned with the paper. Based on the title review, the excluded articles did not have key phrases about telehealth, primary care, prevention, behavioral health, or emergency department utilization. The article title review resulted in the exclusion of 16 articles from the US National Library of Medicine National Institutes of Health. The qualitative analysis process reviewed the keywords and the abstract of the study. The keywords were telehealth, Medicaid, and Medicare. If the article passed the initial review, the further reviews looked for commonalities within the study context. Findings and conclusions were considered in a later review.

Telehealth factors such as modalities, audio-only visits, or video visits were the main subject of 5 of the articles. Primary care factors such as access barriers, prevention programs,

and outpatient services were the main subjects of an additional 13 articles. Finally, policy and state insurance programs such as Medi-cal, policies, substance use disorders, people experiencing homelessness, and people with HIV/AIDS was the main subject of 7 articles.

Findings/Analysis

Telehealth Improves Access to Care

Before the Covid-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) did not give healthcare providers the flexibility to utilize Telehealth services to treat patients. CMS declared that Medicare would reimburse visits carried through telehealth, including video, network portal, and audio communications (Ortega, 2020). The use of telehealth services provided support to providers and the healthcare system to respond to the state's public health emergency during Covid-19. Telehealth services allow providers to manage access and continuity of care while decreasing the potential further spread of the virus. Telehealth reduced the number of providers needed to enter the patient room in the emergency room at Stanford Hospital (Ribeira, 2020). The implementation of telehealth entails modifications in both clinicians and patients. The goal of the quick adoption of telehealth was to decrease the proportion of in-person care, offer in-person clinic visits only for patients who cannot access telehealth technology or have urgent concerns requiring complete in-person physical examination (Jedrick, 2020).

The incorporation of audio usage addressed underserved patients' technology accessibility and literacy barriers (Ortega, 2020). As a result, patients who historically had difficulties obtaining medical care were given the option to receive care within the convenience of their homes. "In our current environment, inequitable access to telehealth is caused by three major factors:

Disparities in access to broadband internet and related technology

Financial barriers to the reimbursement of telehealth

Lack of institutional commitment to equity in telehealth (Ortega, 2020)."

Establishing telehealth reimbursement rates would allow organizations to invest in infrastructures that would expand access to beneficiaries from diverse backgrounds. "The absence of a consistent, comprehensive policy for reimbursement is a serious obstacle to the integration of Telehealth (Batsis, 2017)." In addition, a more stable environment with the reimbursement would further increase the covered services for patients and incentivize healthcare providers to offer this model of care.

Allowing the practice of the audio-only phone for telehealth appointments ensures access for patients who lack video technology (Gabriela, 2020). In addition, the investment in telecommunications infrastructure for less-resourced care sites could initiate an asset to offer internet access to patients in rural areas (Gabriela, 2020). This may commit direct funding for healthcare systems and independent private practices to adopt telehealth (Gabriela, 2020).

Future Health Emergencies

Other health emergencies are emerging that telehealth can continue to support. "The United States growing epidemic of obesity affects over 35% of adults over 65 years (Batsis, 2017)." Providers are discouraged from acquiring more Medicare/Medicaid patients because of reduced reimbursement rates and rising operating costs; this generates access challenges for the at-risk beneficiaries (Batsis, 2017). Distance is a known significant factor in seeking healthcare or completing treatment (Batsis, 2017). The travel cost and time were other collective factors affecting access and distance, causing appointments to become an "all-day affair" (Batsis, 2017). A study conducted in a Columbus, Ohio primary clinic demonstrated that telehealth increases the efficiency of health care resources by significantly reducing patient no-show rates. Between March 16 and May 1, 2020, telehealth appointments had a statistically significant lower no-show rate of 7.5%, compared with the no-show rate of in-office visits during this period of 36.1%

(Drerup, 2021). The telehealth visit no-show rate of 7.5% was also lower than the baseline non-COVID-19 in-office no-show rate of 29.8% (Drerup, 2021). Expansion of current state-level and federal backing for health insurance coverage of telehealth visits focusing on at-risk populations is an essential phase in improving access (Ortega, 2020).

Future of Telehealth Reimbursement

Laws need to be passed to ensure that providers receive the reimbursement needed to continue to offer care through telehealth. Assembly Bill 32 was presented to address telehealth reimbursement in the state of California. It expands the definition of synchronous interaction for telehealth purposes, including audio-video, audio-only, and other virtual communication. It requires health plans and insurers to reimburse for audio-video, audio-only, and other virtual communication at the same rate as in-person services (A.B. 32, 2021). This law would require the Department of Health Care Services to reimburse each federally qualified health center and rural health clinic for health care services furnished through audio-only telehealth, including telephone, at the applicable prospective payment system per-visit rate, consistent with this bill, until the earlier of January 1, 2025 (A.B. 32, 2021). It will provide mental health services reimbursement for audio-only telehealth. The proposal noted that patients had reported high satisfaction with telehealth, citing how easy it is to connect with their providers without the need to take time off work, find childcare, or find transportation to an in-person appointment (A.B. 32, 2021). It was highlighted that audio-only services are imperative because many patients have reported challenges accessing video technology due to limitations with internet access, especially in rural or low-income areas (A.B. 32, 2021). "Primary care and specialty care providers noted that telehealth is a critical access point to address various health care needs, including helping patients manage chronic disease, adjust pain medications, and for follow-up visits after a

procedure, among others (A.B. 32, 2021)." This bill will allow organizations to invest in the telehealth model and provide quality care to patients who probably did not have the accessibility to obtain it previously.

Conclusion

This study shows that telehealth helped providers continue to give patients the care necessary during the Covid-19 pandemic while still limiting the need for in-person interaction. This highlights the value telehealth offers to providers and patients. The quick action to ease telehealth regulation saved medical staff and patients from avoiding a possible infection and helped reduce the burden at hospitals. As the public health emergency is ending, the possibility of reverting to the previous regulations is causing health systems not to invest in expanding their infrastructure to support further expansion. The government can create permanent reimbursement rates to solidify the adoption of telehealth within the communities that need it most. Assembly Bill-32 challenges the reimbursement inability and proposes policies that will prompt providers to continue investing in telehealth. Telehealth expansion will favor underserved communities that do not have access to preventative care or treatment of chronic conditions. Furthermore, there is a notable amount of uncertainty related to cost assessments of expanding telehealth reimbursement even after the health crisis ends. If SB-32 is passed, legislators will have the opportunity to collect data to calculate the impact of telehealth on providers and insurance companies. The information will validate if telehealth is a sustainable model that can continue to remodel healthcare.

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