



# Impact of Audio-only Telephone in Delivering Health Services During COVID-19

## and Prospects for Future Payment Policies & Medical Board Regulations

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## INTRODUCTION

### **The COVID-19 pandemic and resulting public health emergency (PHE) has severely impacted every aspect of life, including healthcare.**

As a result of the stay-at-home orders, telehealth has been pushed into the center of the healthcare delivery system. Over the last year, many Americans have been introduced to and become familiar with telehealth as an effective and safe tool to access healthcare. However, not all patients have been so lucky. The necessity to utilize telehealth in healthcare delivery has brought to light the digital divide in America, specifically for older, low-income and minority populations. For example, more than one in three US households headed by a person age 65 or older do not have a desktop or laptop, and more than half do not have a smartphone. Additionally, these groups are also less likely to be digitally literate.<sup>1</sup> Preliminary studies have found that these groups are also at higher risk for COVID-19, and suffer serious illness at a higher rate.<sup>2</sup> To address this digital divide, policymakers have temporarily allowed audio-only telephone to be used to deliver certain services in Medicare and many Medicaid programs. The Federation of State Medical Boards Foundation (FSMB Foundation) provided funding to the Center for Connected Health Policy (CCHP) to conduct a study that examined the use of audio-only as a modality to provide services from a federally qualified health center (FQHC) to patients in the Medicaid program.

FQHCs provide primary care as well as mental health and other health services to underserved areas and populations. FQHCs are in a unique position to help fill the need for at-risk patients. However, historically FQHCs have faced a complex matrix of state and federal policies that govern the use of telehealth at their centers. Although they have been temporarily allowed to deliver care via telehealth and telephone in Medicare and in most state Medicaid programs, questions regarding the longevity of the temporary policies remain. Telephone itself has not traditionally been thought of as telehealth, with many states excluding it from their definitions, and policy makers initially were skeptical of its use. This study will examine the Medicaid policies that have been implemented to allow telephone to be utilized to deliver care during the COVID-19 pandemic in FQHCs in ten states selected due to their high volume of COVID-19 patients compared to population. The impacts these temporary audio-only changes have had on how FQHCs can deliver care, the effect on their patients and the potential impacts if the policies are not made permanent will be examined.

1) Velasquez, David, Mehrotra, Ateev. Ensuring the Growth of Telehealth During COVID-19 Does Not Exacerbate Disparities in Care, Health Affairs Blog, May 8, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200505.591306/full/>. Accessed July 15, 2021.

2) Koma, Wyatt, Neuman, Tricia, Claxton, Gary, Rae, Matthew, Kates, Jennifer, Michaud, Josh. How Many Adults are at Risk of Serious Illness if Infected with Coronavirus? Updated Data. Kaiser Family Foundation, April 23, 2020. <https://www.kff.org/coronavirus-covid-19/issue-brief/how-many-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/>. Accessed July 15, 2021.

## METHODOLOGY

To select the states, CCHP examined the Centers for Disease Control and Prevention (CDC) website to select the top ten states with the most COVID cases per 100,000 residents as of April 1, 2021.

The states selected were:

- Arizona
- Arkansas
- Iowa
- North Dakota
- Oklahoma
- South Dakota
- Rhode Island
- Tennessee
- Utah
- Wisconsin

Next, CCHP examined telehealth Medicaid policies for these states as they related to delivering services by an FQHC; policies that existed prior to the pandemic, temporary policies issued in response to COVID-19 and any audio-only policies that had been made permanent by April 2021. CCHP also examined any pending legislation related to audio-only delivered services in Medicaid.

From the above list, CCHP selected five states for further examination based upon states that had a specific audio-only policy for FQHCs. With that criteria, the states were narrowed down to a selection of five:

- Arizona
- Arkansas
- Iowa
- North Dakota
- South Dakota

With these states selected, CCHP began outreach to set up interviews with FQHCs, Primary Care Associations, Medical Boards and on the advice of several states, state medical associations.

Interviewees were asked a set of prepared questions depending on what category of interviewee they fell into (FQHC, Medical Board/Medical Association, or Primary Care Association). The questions can be found in Appendix 1.

## AUDIO-ONLY POLICIES IN RESPONSE TO COVID-19

Like many states during the pandemic, each of the states examined for this paper allowed for audio-only to be used to deliver services. Prior to the pandemic, with only three exceptions in the sample, states generally did not allow audio-only to be a means of delivering health services. The three exceptions, Arizona, Iowa and Utah, only did so in very limited circumstances, mainly for case

management purposes. However, the pandemic quickly altered the situation and all ten states issued some temporary measure that allowed for audio-only to be used to deliver services to Medicaid enrollees. The details of those policies varied.

### Services Covered

The states were split regarding what services could be provided via audio-only during the pandemic with one group having a specific list of service codes where audio-only could be used and the other having a more vague, but on the face, broader policy with language such as, the audio-only service is functionally equivalent to face-to-face services.<sup>3</sup> How some of the states approached what services should be covered via audio-only in some cases was similar to its pre-COVID-19 approach to telehealth in general. For example, some state Medicaid programs before COVID-19 would have a specific list of services that could be covered via telehealth, and pursued that same list-based approach in relation to audio-only services during COVID-19.

Another facet is that some of the states allowed audio-only to be used as a means of delivering services for all of the services that could be provided via telehealth. In other words, while there was a specific list of services that could be provided via telehealth technology, the state made no distinction or did not create a subset of eligible services if delivered via audio-only. For example, no distinction was made between live video or audio-only as the delivery means for eligible services, either could be used.

Therefore, for this study, “limited services covered” means a subset of services existed within the eligible telehealth services that were also eligible to be provided via audio-only. If the state allowed all of their telehealth eligible services to be covered via audio-only, but still had a specific list for those eligible services for telehealth, those states were placed in the “Did not specify/Broad coverage of services” category.

**TABLE 1. COVID-19 POLICIES ON SERVICES COVERED IF PROVIDED BY AUDIO-ONLY**

STATE	LIMITED SERVICES COVERED IF AUDIO-ONLY USED	DID NOT SPECIFY/ BROAD COVERAGE OF SERVICES
AR		Included in delivery of telehealth-eligible services.
AZ	Provided specific code to use	
IA	Provided specific codes to use	
ND	Provided specific codes to use	
OK	Provided specific codes to use	
SD	Allowed specific services to use audio-only	
RI		Included in delivery of telehealth-eligible services.
TN	Provided specific codes to use	
UT		Allowed use of telephone “when clinically appropriate”
WI		Allowed audio-only when “functional equivalency to the face-to-face service.”

3) Wisconsin Department of Health Services. Additional Services to be Provided Via Telehealth. ForwardHealth Update, March 2020, No. 2020-15. <https://www.forwardhealth.wi.gov/kw/pdf/2020-15.pdf> Accessed August 1, 2021.

Even with the designation of “limited services” allowed with audio-only, the states varied in what they would allow to be covered. Arizona, while providing a specific set of service codes that would be allowed with audio-only, provided a good-sized number of codes compared to North Dakota. South Dakota took a hybrid approach by listing specific codes for audio-only, but also services for specific conditions, such as treatment for behavioral health for substance use disorders. Oklahoma noted that audio-only could be used for members who could not access telehealth equipment, the service was necessary for health and safety of the member and the service could be effectively provided via audio-only, but it still limited eligibility to specific codes.<sup>4</sup> And Tennessee which is a managed care state, had plans with different policies for audio-only.

The most common codes allowed though were 99441, 99442, and 99443 which is no surprise as these are specific telephone evaluation and management (E/M) codes:

- **99441** – Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **99442** – 11-20 minutes of medical discussion
- **99443** – 21-30 minutes of medical discussion

Of the states with the “limited” audio-only, the codes allowed were:

**TABLE 2. STATES WITH LIMITED AUDIO-ONLY**

STATE	CODES ALLOWED
AZ <sup>5</sup>	90791, 09792, 09832-90834, 90836-90840, 90845-90849, 90853, 92507, 92508, 92521-92524, 92526, 96116, 96121, 96127, 96130-96133, 96136-96139, 96156, 96158-96161, 96164, 96165, 96167-96168, 96170, 96171, 97110, 97129, 97130, 97150, 97156, 97158, 97530, 97535, 97802-97804, 99202-99205, 99211-99215, 99231-99235, 99241-99245, 99341-99344, 99347-99349, 99354-99359, 99411-99412, 99417, 99421-99423, 99497, 99498, H0001, H0002, H0004, H0015, H0031, H0034, H2011, H2027, H2033, S5100, S9480, T1002, T1003, T1015, T2016, T2017, T2019, T2020, T2021
IA <sup>6</sup>	99451, 99452, 99441, 99442, 99443

4) Oklahoma Health Care Authority. Expanded use of telehealth and telephonic services during COVID-19 National/State Emergency for COVID-19. <https://oklahoma.gov/ohca/providers/telehealth/state-emergency-for-covid-19.html>. Accessed August 1, 2021.

5) Arizona Health Care Cost Containment System. AHCCCS Telehealth Code Set With Place of Service. [https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/TelehealthCodeSet\\_COVID.xlsx](https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/TelehealthCodeSet_COVID.xlsx). Accessed August 1, 2021.

6) Iowa Department of Human Services. Informational Letter No. 2115-MC-FFS, March 11, 2020. [https://dhs.iowa.gov/sites/default/files/2115-MC-FFS\\_Billing\\_related\\_to\\_COVID-19.pdf?070720201307](https://dhs.iowa.gov/sites/default/files/2115-MC-FFS_Billing_related_to_COVID-19.pdf?070720201307). Accessed August 1, 2021.

**TABLE 2. STATES WITH LIMITED AUDIO-ONLY**

STATE	CODES ALLOWED
ND <sup>7</sup>	99441-99443
OK <sup>8</sup>	9941, 99442, 99443 (E&M Billing) Other providers use 98966, 98967, 98968
SD <sup>9</sup>	<ul style="list-style-type: none"> <li>Behavioral health services delivered by a substance use disorder agency, a community mental health center or independent mental health practitioner</li> <li>Well child check-ups</li> <li>Optometrists – 98966, 98667, 98968</li> <li>Physician services for recipients actively experiencing symptoms consistent with COVID-19</li> </ul>
TN <sup>10</sup>	<p><b>Blue Shield</b></p> <ul style="list-style-type: none"> <li>99441, 99442, 99443,</li> <li>E&amp;M Codes: 99201-99215</li> <li>Behavioral Health – 90791, 90792, 90832, 90834, 90837</li> <li>G2012*</li> </ul> <p><b>Amerigroup</b> Use the same E&amp;M Code as would have for an in-person visit.</p>

## Federally Qualified Health Centers & Audio-Only Pandemic Policies

As was found with pre-pandemic FQHC telehealth Medicaid policies, the audio-only COVID-19 policies varied and some were not as specific compared to other states. For example, there may not have been an explicit mention of FQHCs being allowed to use audio-only to deliver services, but audio-only was placed under the state’s telehealth policies and FQHCs could utilize telehealth to provide audio-only services. Additionally, the policies that did exist related to FQHCs and audio-only did not necessarily mirror those for other providers. For example, while South Dakota Medicaid did allow FQHCs to utilize

audio-only to deliver services, they did not receive their typical rates that they would have had the service taken place in-person. This rate, known as the Prospective Payment Service (PPS) rate is based on a calculation that takes into the consideration various factors unique to the FQHC and amounts vary from clinic to clinic. Instead, the South Dakota Medicaid policy for audio-only for an FQHC would be based on fee schedule rates of 75% of the FQHC’s PPS rate.<sup>11</sup> In contrast, Arizona would give the FQHC its PPS rate if it was within that clinic’s scope to provide that service. If not, the rate will be a contracted amount.<sup>12</sup>

7) North Dakota Human Services. North Dakota (ND) Medicaid\*: COVID-19 Temporary Telehealth Polich (March 25, 2020).

<https://www.nd.gov/dhs/info/covid-19/docs/policy-medicare-temporary-telehealth.pdf>. Accessed August 1, 2021.

8) Oklahoma Health Care Authority. Expanded use of telehealth and telephonic services during COVID-19 National/State Emergency for COVID-19.

<https://oklahoma.gov/ohca/providers/telehealth/state-emergency-for-covid-19.html>. Accessed August 1, 2021.

9) South Dakota Department of Social Services. Coronavirus (COVID-19) Frequently Asked Questions. April 6, 2020.

<https://sdaho.org/wp-content/uploads/2020/04/COVID-19-DSS-FAQ-4.6.20.pdf>. Accessed August 1, 2021.

10) Division of TennCare. Novel COVID-19 Testing and Telehealth Services for TennCare Enrollees, March 17, 2020.

<https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareMCOCOVID19TelehealthDxTestingUpdate.pdf>. Accessed August 1, 2021.

**TABLE 3. SUMMARY OF STATES' MEDICAID AUDIO-ONLY POLICIES**

STATE	AUDIO-ONLY POLICY ALLOWED BEFORE COVID-19	AUDIO-ONLY POLICY FOR COVID-19	ALLOWED ONLY SPECIFIC CODES	ALLOWED SIMILAR TO SERVICES PROVIDED VIA LIVE VIDEO	FQHC-SPECIFIC TELEHEALTH POLICY EXISTED PRE-COVID-19	FQHC AUDIO-ONLY POLICY EXISTS	MADE AUDIO-ONLY POLICY PERMANENT
AR	✓*	✓		✓		✓	
AZ		✓	✓	✓	✓	✓	
IA	✓*	✓	✓		✓	✓	
ND		✓	✓			✓	
OK		✓	✓				
SD		✓	✓		✓	✓	
RI		✓		✓			
TN		✓	✓				✓
UT	✓*	✓		✓			✓
WI		✓		✓	✓	✓	

\* Limited services

Last, CCHP looked at what policies, if any, had been made permanent by April 2021 in the selected states. Very few had been and what was made permanent may have been limited. For example, Tennessee's policy was to allow audio-only when other modalities

were unavailable and only for behavioral health services.<sup>13</sup> Some states such as South Dakota, have discontinued their temporary audio-only policies.<sup>14</sup> Table 3 provides a summary of these findings.

11) South Dakota Department of Social Services. Coronavirus (COVID-19) Frequently Asked Questions. April 6, 2020.

<https://sdaho.org/wp-content/uploads/2020/04/COVID-19-DSS-FAQ-4.6.20.pdf>. Accessed August 1, 2021.

12) Arizona Health Care Cost Containment System. Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19).

<https://www.azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#telehealth>

13) HB 620. <https://www.capitol.tn.gov/Bills/112/Bill/HB0620.pdf>. Accessed August 1, 2021.

14) South Dakota Department of Social Services. [https://dss.sd.gov/docs/medicaid/providers/ProviderBulletins/COVID-19/COVID19\\_FAQ\\_Providers.pdf](https://dss.sd.gov/docs/medicaid/providers/ProviderBulletins/COVID-19/COVID19_FAQ_Providers.pdf). Accessed August 1, 2021.



## KEY INFORMANT INTERVIEWS

Arizona, Arkansas, Iowa, North Dakota and South Dakota were selected for more in-depth examination with key informant interviews with FQHCs, primary care associations (PCAs), medical boards and on the suggestion of interviewees, state medical associations. The decision was based upon selecting five states that had an existing written Medicaid FQHC-specific audio-only policy. At the time of the research, of the five states, only South Dakota had ended the temporary telehealth waivers. Given the on-going demands of the pandemic on these institutions, CCHP was able to only find willing interviewees in Iowa, North Dakota and South Dakota for the time this research was taking place.

### FQHC Interviews

Interviews began with general demographic questions to get a sense of the population being served by the FQHCs. Given the states selected, the patient population served by FQHCs in these states was made up in the majority of those who identified as white which reflected the population in general for the three states, though one FQHC in South Dakota did note they had a significant Native American population they were serving.

In addition, general information regarding age and payer type that patients were covered by was solicited. Similar information was found across the three states with the majority of patients being in the adult (18-64 years of age) category. A significant portion of the patients served by the interviewed FQHCs were covered by Medicaid, though one FQHC noted a large portion of their patients were covered by commercial/private payers. This FQHC attributed it to the communities some of its clinics were located in.

The FQHCs were then asked if they had an established telehealth program prior to COVID-19. The FQHCs' experiences were split, with half noting that they had to stand up a brand new telehealth program at the beginning of COVID-19, which was primarily done within 1-2 weeks, and one noting that it had a mature telehealth program. Interestingly, the one with a mature program noted that its past experience did not necessarily benefit them at the beginning of the pandemic. Due to the policies that existed pre-COVID-19, FQHCs were more likely to act as originating site providers and had built their telehealth programs around this model. For COVID-19, the FQHCs became the telehealth providers or distant site providers, and thus had to change their workflows and mindset to provide their services via telehealth and not simply be the link for patients to access the services from another provider.

For the FQHCs interviewed, audio-only visits averaged out to about 15-30% of their total visits. They noted that there was a higher volume in the early days of COVID-19 and the use of telehealth in general started to decrease after the first few months. They have noticed a slight uptick with the current surge due to the Delta Variant. When asked primarily what types of services were delivered via audio-only, the answers were very similar across the board:

- Behavioral Health
- Chronic conditions
- Acute care such as sore throats or flu-like symptoms
- Refills on prescriptions

Some providers also noted that their comfort level using audio-only increased when they were dealing with an established patient whose history they were very familiar with.

When asked what services did not lend themselves to audio-only the FQHCs noted anything that required visuals. All FQHC interviewees stated that their institution did work on internal guidelines on when it was appropriate to use telehealth and audio-only so that their providers had some guidance. One interviewee noted that audio-only in some cases may act as a pre-cursor to an in-person or telehealth visit because adequate or complete information could not be obtained through the modality, but this also meant that when the patient was seen in-person or via live video, that visit went more efficiently as some initial work was taken care of with the audio-visit.

The FQHCs were then asked why audio-only was utilized instead of live video and/or in-person visits. Setting aside the in-person visit possibly being unavailable or unwise due to the infectious nature of COVID-19, the interviewees noted that the most significant reason audio-only was utilized was due to connectivity issues, followed next by access to video equipment.

According to Broadband Now, the states in this sample are ranked:

- Iowa - 45
- North Dakota - 22
- South Dakota - 37

for internet coverage speed and price access; all issues that FQHCs identified as problems for their patients which led to use of audio-only. Even though North Dakota is ranked 22nd, interviewees noted that there were still significant swaths of rural areas where at best connectivity was spotty or non-existent. The providers at FQHCs viewed the use of audio-only as a necessity to ensure patients continued to receive health services.

A portion of the providers also noted that patient's comfort level was also a factor in utilizing audio-only. Some patients, while possibly having live video available to them, were intimidated by the technology and preferred the more familiar audio-only option.

When queried on the providers' views of using audio-only to provide services, the response ranged from initial skepticism to acceptance or surprise at how well it worked for certain services. The providers would like to continue to have audio-only as an option should it be needed. However, all the providers agreed that audio-only was utilized out of necessity as a "back-up" if there was no other way to provide services, if there were technology issues with live video, or patient preference.

When asked about the patient's feelings regarding audio-only, the FQHCs said they could only provide anecdotal information, but overall, it was accepted by the patients, many of whom felt grateful that they did not have to travel into a clinic during a pandemic. Some patients felt as though more time and attention was paid during the audio-only visit compared to an in-person visit. It was noted in some cases that some older patients seemed to have a preference for audio-only over live video.

To conclude the interview, the FQHCs were asked what the impact would be should audio-only cease to be available as an option to provide services. They noted that it would most likely mean the cessation of services to some of their patient population as they may have difficulty utilizing live video or coming into the clinic for an in-person visit. While none of the FQHCs interviewed stated that audio-only was their first choice in delivering services, they noted that it played an important role in ensuring access to services for all their patients and they would like to have it around to ensure no patient was left without.



## Primary Care Associations

Primary Care Associations (PCAs) for all three states were interviewed and much of what they relayed as far as members' use of audio-only and their thoughts surrounding it echoed what was found in the FQHC interviews. Interviewees here noted that audio-only was primarily used as a back-up. It was reiterated that their members' preference was for in-person or live video, but due to connectivity issues, audio-only had to be employed in some cases.

The PCAs did however provide a more detailed picture regarding the legislative landscape. Overall, while there were some sympathetic lawmakers, concerns around over-utilization, quality and fraud were raised regarding audio-only. In both North Dakota and Iowa, legislative attempts to push forward some audio-only policy failed. The PCAs noted that the failure of these efforts made them concerned about access issues patients may face if audio-only were to be scaled back dramatically or completely eliminated.

From the foregoing, it is clear that audio-only services played an important role during the COVID-19 pandemic to ensure FQHC patients could still continue to receive health services while minimizing exposure to the virus. The reliance on audio-only in the states selected for this research was primarily based on access issues, particularly connectivity and access to technology that would facilitate a live video interaction. However, while providers saw benefits and that audio-only served to deliver certain services well, it was treated by many as a back-up to when live video or an in-person interaction was not possible.

## Medical Boards and Medical Associations

CCHP requests to state's medical boards for interviews were declined as they did not have a policy regarding audio-only. It was suggested that the state medical association might have more to say on the subject. A search for any guidance regarding audio-only published by either organization during the pandemic yielded no results. When reaching out to the medical associations, only one agreed to be interviewed. The information was very similar to what the PCA had provided in that for policymakers, concerns over costs, quality and fraud made them hesitant to establish a more permanent policy for audio-only at this time.

## DISCUSSION

Should policies that allowed audio-only services to be provided cease to exist, there were concerns that patients would lose access to services. When asked what they thought patients would do, interviewees responded that patients would either come in-person or do without. Given the rise of the Delta Variant, the in-person option may not be as viable of a course for some.



At least in the three states examined, legislative efforts at this time appear to have been unsuccessful. While South Dakota did not have a specific piece of audio-only legislation, it was the only state among the three that has stopped reimbursing the use of audio-only in its Medicaid program as of mid-July. This lack of forward progress may be attributed to concerns over costs, over-utilization and questions around quality if the services are being delivered via audio-only. Although one state did indicate that policymakers believed that they could solve the broadband/connectivity issue and thus eliminate the need for audio-only.

The concerns about over-utilization and quality may be alleviated somewhat by examining the approaches the FQHCs had taken during the pandemic. FQHC interviewees noted that they were very mindful of what services could be provided via audio only. The interviewees did not take a blanket approach towards providing all services via audio-only, but were selective in what they believed could be effectively provided via the modality. Additionally, the interviewees indicated that audio-only was a back-up to when other ways to provide services did not work. Therefore, the clinics have already addressed some of the concerns of policymakers: ensuring that the services provided are of quality and limiting the use of audio-only by treating it as a secondary option.

Two limitations of the information provided in this study should be noted. The sample size is fairly small. While there are likely some findings that could be applied to multiple states, using audio-only because of broadband connectivity issues, for example, other relevant information may have been gleaned from a larger sample size. Second, while CCHP attempted to select states based upon a methodology that would be equitable and showed no geographic or population bias, what did occur with the three states examined resulted in some homogeneity in geography and population. Different information may have been found if other states such as coastal ones were examined.

**“At least in the three states examined, legislative efforts at this time appear to have been unsuccessful. While South Dakota did not have a specific piece of audio-only legislation, it was the only state among the three that has stopped reimbursing the use of audio-only in its Medicaid program as of mid-July.”**

One other item to note was the experience of one FQHC that had pre-pandemic telehealth experience and a fairly mature program. As mentioned earlier, this FQHC said that the experience was not as useful as one may think as they were asked to be the purveyor of telehealth services during the pandemic instead of acting as the facilitator. This was due to pre-existing policies that in some cases would not allow FQHCs to act as distant site providers. Therefore, potentially significant numbers of FQHCs nationally entered the pandemic with limited experience in utilizing telehealth to deliver services themselves and the use of audio-only may also have benefited providers as they became more experienced utilizing telehealth technologies as the direct provider of services.



## RECOMMENDATIONS

Based on the foregoing, CCHP offers these recommendations to policymakers regarding the use of audio-only by an FQHC to deliver services.

- **Continue to make audio-only available as an option for FQHCs to provide services.** The concern that some patients will go without receiving services is a significant issue. Particularly as we are experiencing the Delta Variant surge, FQHCs will need to have as many tools at their disposal as possible to continue delivering services.
- **At a minimum, allow audio-only to continue on a temporary basis.** While policymakers may be hesitant to craft permanent policies, allowing FQHCs to use audio-only for a time beyond the pandemic will allow patients to ease back into in-person visits or provide time to find other solutions to issues such as connectivity or access to technology like smartphones or laptops.

- **Actively address the connectivity issue & technology divide.** As the interviewees noted, audio-only was primarily used because connectivity was a major issue for patients. While building out adequate connections may take some time, policymakers should address other measures that can bridge the gap until everyone does have broadband access. Such solutions could include subsidies to access the internet, cost of connectivity having been noted as an issue for some, providing hot spots in certain regions, offering training on how to use technology for those who need help with digital literacy, and providing equipment to access live video such as laptops or smartphones.

It is clear audio-only served a vital purpose in ensuring patients were able to access care. It was not necessarily the preferred means of treating a patient, but when circumstances presented patients and providers with limited options, it proved a valuable tool for FQHCs who serve some of the most vulnerable populations. As COVID-19 continues to exist in and impact our lives, it would be premature to simply eliminate this option for FQHCs to use.

## CONCLUSION

As the interviews showed, FQHCs themselves were already cognizant of the limitations of audio-only and have put into place protocols to decide what cases are best served through this modality. Policymakers should not disregard these efforts that FQHCs have made thus far and risk patients losing access to needed services.

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## APPENDIX A



## INTERVIEW QUESTIONS FOR FQHCs

1. **What is your patient mix?** *Medicare, Medicaid, Private Payer*
2. **What is the age mix of your patients?** *Seniors, Adult, Children*
3. **What is the population mix of your patients?** *White, Black, Latino, Asian/Pacific Islander*
4. **Did your FQHC have a telehealth program prior to COVID-19?**
  - *If not, how quickly did you start a telehealth program?*
  - *If so, how quickly did you ramp up?*
5. **Through what modalities did you offer telehealth?** *Live Video, Store-And-Forward, Audio-Only, RPM*
6. **What was the share of patients that used audio-only?**
7. **What was the reason for using audio-only?**
  - *Patient preference*
  - *Connectivity issues (No connectivity or poor connectivity)*
  - *Technology issues (Did not have access to the technology or technology not work)*
  - *Provider preference*
8. **As a provider how did you feel audio-only worked in providing services to your patients?**
9. **Were there services you did not feel comfortable providing via audio-only?**
10. **Were there services you felt lent themselves well to being provided via audio-only?**
11. **Which patients seemed to use audio-only the most?**
12. **If audio-only continued to be allowed as an option to provide services would you want to continue?**
13. **What was your patients' reaction to audio-only?**
14. **Would your patients want to continue using audio-only if it was still allowed as an option or would they prefer live video or in-person services?**
15. **What would happen if you could no longer provide services via audio-only?**



## INTERVIEW QUESTIONS FOR PCAs

1. What has been the impact allowing audio-only to be used to provide health services?
2. Does your organization have a position on the continued use of audio-only to provide services to patients?
3. What percentage of services has audio-only been used to provide?
4. What have you heard from members as the reason why audio-only has been a good/bad thing?
5. Do your members wish to continue to use audio-only to provide health services?
  - *If so why?*
  - *If not, why?*
6. What have you heard from policymakers regarding the continued use of audio-only?

## INTERVIEW QUESTIONS FOR MEDICAL BOARDS/ASSOCIATIONS

1. Did the Board/Association come out with guidance or guidelines for providers regarding the use of telehealth either before or during COVID-19? If it was before, were they updated in any way?
2. Was there any guidance the Board/Association gave to licensees on the use of audio-only to provide services?
3. Do you consider audio-only to be telehealth and if so, do you have general guidance/policy/regulation on telehealth that you feel could already encompass audio-only? Or on the other-hand, do you view them to be different, therefore existing telehealth guidance/policy/regulation is not applicable and audio-only is treated separately?
4. Policymakers now are looking at or have decided on permanent policies related to audio-only, what are the Board/Association's thoughts or reactions? Does the Board/Association take up legislation for discussion/position and if so, have they done either on audio-only and/or telehealth legislation generally?
5. Did the Board/Association consider doing any type of studies on the use of audio-only?





6. Do you have any prescribing guidance and/or concern specific to audio-only and/or telehealth?
7. Is the Board/Association considering any guidance or regulations regarding the provision of services via audio-only?
8. Has the Board/Association worked with any other practitioner licensing boards/associations in their state on the subject as well, and/or are you aware of other boards/associations opining in some way for other licensees on audio-only?
9. Have you received any outreach from licensees/consumers/legislators directly asking questions about audio-only or for guidance, and can you share what people have been concerned about?