Elevance Health | Public Policy Institute

Telehealth Utilization in Florida Medicaid: 2019–2021

August 2022

Contents

Key Takeaways

- In April 2020, telehealth visits among Florida Medicaid members increased to 24.2% of PCP visits and 4.6% of non-PCP visits, then declined to 6.4% of PCP visits and 1.1% of non-PCP visits by December 2021.
- Though telehealth utilization across Florida's Medicaid plans declined after peaking in the early months of COVID-19, it remained higher in 2021 compared to the pre-pandemic period.
- Rates of telehealth visits were higher in rural areas and among older members (ages 65+) and members whose primary spoken language is Spanish.

Background

Medicaid programs have reimbursed for healthcare services via telehealth for decades with some state Medicaid agencies acting as early adopters of telehealth.

As COVID-19 emerged in the United States and federal, state, and local officials implemented public health emergencies (PHEs), telehealth became a necessary tool for Medicaid members to continue to access much-needed services and supports during the pandemic.[1]

To support member and provider needs equitably it is important to understand telehealth—its use and its future.

Multiple studies have examined the extent to which telehealth services increased during the federal and separate state PHEs with the literature demonstrating the significant increases in telehealth utilization during stay-at-home orders in 2020 and as COVID-19 variants surged.[2] However, as the Department of Health and Human Services (HHS) and state Medicaid agencies consider the future of telehealth flexibilities in their programs, it is important to understand not just the increases in telehealth use observed during the peaks of the pandemic, but how those increases persisted over time, the continued utilization of telehealth, and the future of telehealth to support member and provider needs equitably and thoughtfully.

To better understand how Medicaid managed care members accessed telehealth over the course of the pandemic and beyond, Simply Healthcare conducted an analysis of medical encounters to examine members' use of telehealth services from January 2019 through December 2021, which included the early months of Florida's PHE and stay-at-home order. This analysis compares the use of telehealth services before, during, and after the PHE in Florida overall and by member demographics and Medicaid program type.

Optional Federal Telehealth PHE Flexibilities

- Allow providers to conduct telehealth with patients located in their homes and outside of designated rural areas
- Practice remote care, even across state lines, through telehealth
- Deliver care to both established and new patients through telehealth
- Bill for telehealth services (both video and audio-only) at the same rate as if they were provided in person

Landscape: Florida Medicaid Telehealth

Florida traditionally defines "telemedicine" as the practice of healthcare delivery by a practitioner who is in a site other than the site where a recipient is located, using interactive telecommunications equipment that minimally includes real time, two-way interactive communication between a recipient and a practitioner using audio and video equipment.[3]

In response to workforce shortages and meeting the needs of home-bound members due to the COVID-19 pandemic, the Agency for Health Care Administration (AHCA), which administers Florida's Medicaid programs, issued guidance in March 2020 allowing their Medicaid managed care plans to exercise broad flexibility in covering telemedicine services under a broader "telehealth" umbrella.[3] This included, for the first time, allowing remote patient monitoring and store-and-forward services defined as the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email transmission. Simply Healthcare implemented these flexibilities to cover telehealth services, when appropriate, in alignment with how these services would be covered if provided through an in-person encounter with a Medicaid provider, including the same reimbursement for these services.

Overview: Florida Simply Medicaid Programs

Simply Healthcare serves members statewide in Florida's:

- Medicaid Managed Care program (SHP)
- Long-Term Care (LTC) plans, and
- Clear Health Alliance (CHA), which is a health plan for people with Medicaid coverage who are living with HIV/AIDS

Simply Healthcare primarily serves:

- Low-income families and adults
- Adults and individuals with disabilities

For this brief, the information is aggregated to include all three programs unless specifically noted otherwise. As of January of 2022, Simply Healthcare's membership totaled approximately 676,000 people. Figure 1 displays the counties that each Medicaid program serves.

Figure 1

Simply Medicaid Footprint

Simply Medicaid Regions:
1, 2, 4, 5, 7, 9, 10, 11

Simply Long-Term Care:
5, 6, 7, 10, 11

Clear Health Alliance:
Statewide

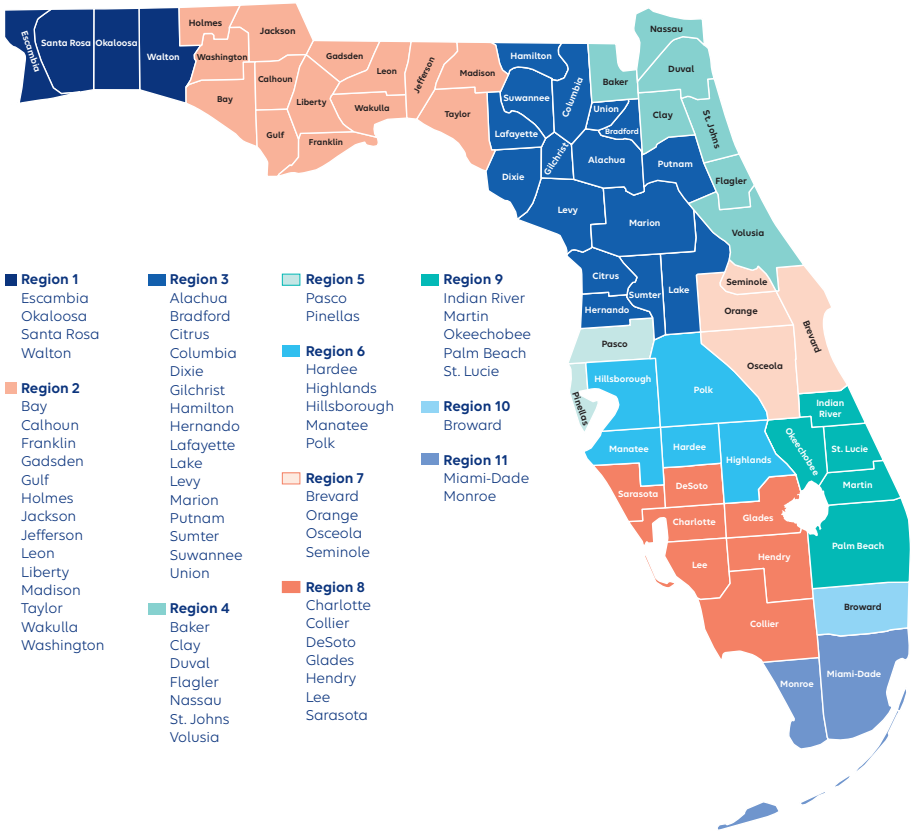
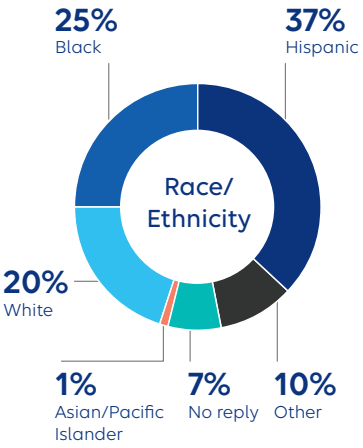
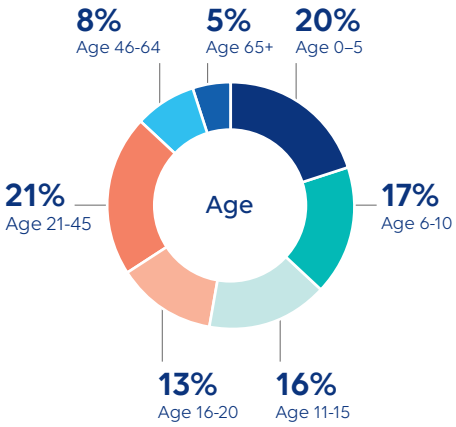


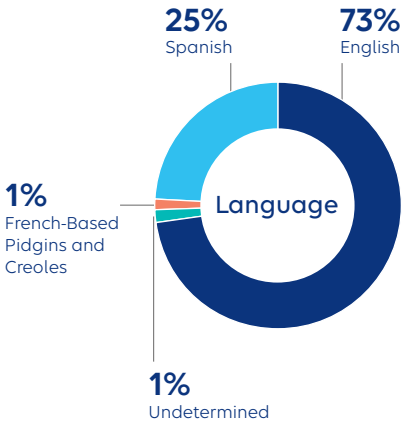
Figure 2

Medicaid Demographics

More than one third of Simply Healthcare's Medicaid members identify as Hispanic, are under the age of 46, and consider English as their primary language.







Methodology

This brief examines changes in the use of telehealth visits among members enrolled in one of Simply Healthcare's Medicaid plans.

This includes SHP, LTC, and CHA and excludes members enrolled in Florida Healthy Kids (Florida Children's Health Insurance Program). This analysis uses encounter data from January 2019 to December 2021 for all medical visits rendered using the date of service and excludes claims for emergency rooms, prescriptions, durable medical equipment, and labs.

In-person visits are the count of unique encounters for an in-office visit rendered within the reporting period.

Telehealth visits are the count of unique encounters for visits rendered within the reporting period by physician, physician extenders (advanced practice registered nurses and physician assistants), and clinic providers (county health departments, federally qualified health centers, and rural health clinics).

The telehealth data includes encounters with any of the following information:

1. A place of service code "02" (Telehealth Provided Other than in Patient's Home); or
2. One of the following CPT codes: 98966-98972; 99091; 99421-99423; 99441-99444; 99453-99454; 99457-99458; 99473-99474; G2010; G2012; G2061-G2063; or
3. Procedures codes with modifiers CR, GQ, GT, or 95.

The data includes synchronous and asynchronous telehealth encounters, however asynchronous encounters only accounted for approximately 1 percent of all telehealth visits in 2020 and 2021. The analysis included paid and unpaid claims to capture total member utilization; claims were de-duplicated using the claim ID to ensure an encounter was counted only once. The proportion of unpaid claims is similar for in-person and telehealth visits.

The analysis used member enrollment files to determine the members' demographics and location by county and examined variations in rural and urban regions based on a member's county. Florida's public health agency defines a rural county based on the 2010 census definition of 100 persons or less per square mile.[4]

The analysis also examined differences between primary care provider (PCP) telehealth visits and non-PCP visits. A single member may only have one assigned PCP at any given time and therefore the analysis defines PCP visits as claims that include services rendered under each member's assigned PCP at the time of service and classifies all other claims as non-PCP visits. In addition, the analysis examined the different provider types delivering services via telehealth to members using the provider's primary specialty type listed in provider enrollment files.

Asynchronous. An exchange of information regarding a patient that does not occur in real time, including the secure collection and transmission of a patient's medical information, clinical data, clinical images, laboratory results, or a self-reported medical history.

Synchronous. An exchange of information regarding a patient occurring in real time.

Source: American Telemedicine Association

Limitations

There are several limitations for consideration for this analysis.

1. When comparing the changes for in-person visits during the years examined, this included all in-person visits, not just those that would have qualified for telehealth visits.

2. Less than one percent of members have an "unknown" location listed on enrollment files for various reasons such as a member having an incorrect or unverified address. This brief includes these members in the analysis at large but excludes members with an unknown county from the county-level and geographic location data.

3. This analysis does not include comprehensive behavioral health services provided by Simply Healthcare's behavioral health partner. This includes mental health targeted case management, specialized therapeutic services, community behavioral health services, and behavioral health interventions. However, behavioral health providers delivering these services may sometimes inaccurately submit claims to Simply Healthcare instead of their behavioral health partner; therefore, these unpaid claims may be in this data as the analysis includes all rendered services regardless of payment status.

4. As coding errors and inconsistencies continue to exist for telehealth visits, there is a possibility that providers underreported telehealth visits. In addition to this, there may be providers in Simply Healthcare's network that offered telehealth, but zero members utilized telehealth with these providers during the reporting period. And finally, Florida's state Medicaid agency, per federal rules, does not require self-reporting of race, ethnicity, and language (REL) which limits opportunities to gain complete data.[5] However, as health equity is of extreme importance, it was still imperative to analyze any REL data available for Medicaid members despite the challenges in interpreting this data.

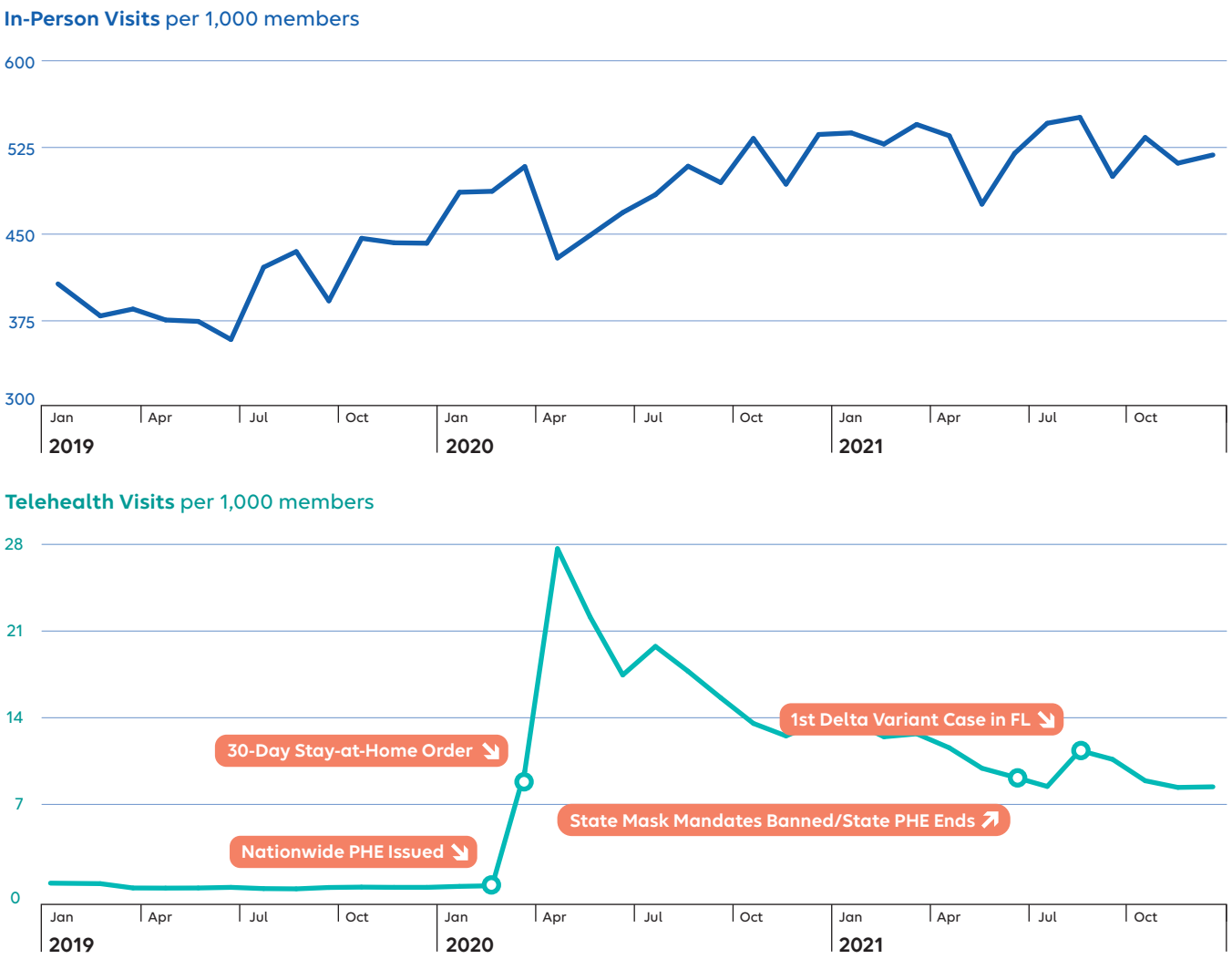
Results

Consistent with the existing literature, Florida Medicaid members did not widely access telehealth prior to the COVID-19 pandemic.[6]

In January 2020, HHS declared a PHE due to COVID-19, and Florida's Governor subsequently enacted a stay-at-home order at the end of March, lasting until the end of April 2020. The sharp decrease for in-person visits and increase in telehealth visits reflect these national and statewide public health policies to slow the spread of COVID-19. Figure 3 displays the changes for in-person and telehealth visits, alongside relevant public health policies, taking place during that time period.

Figure 3

Florida Medicaid Plans Telehealth vs. In-Person Encounters, 2019—2021



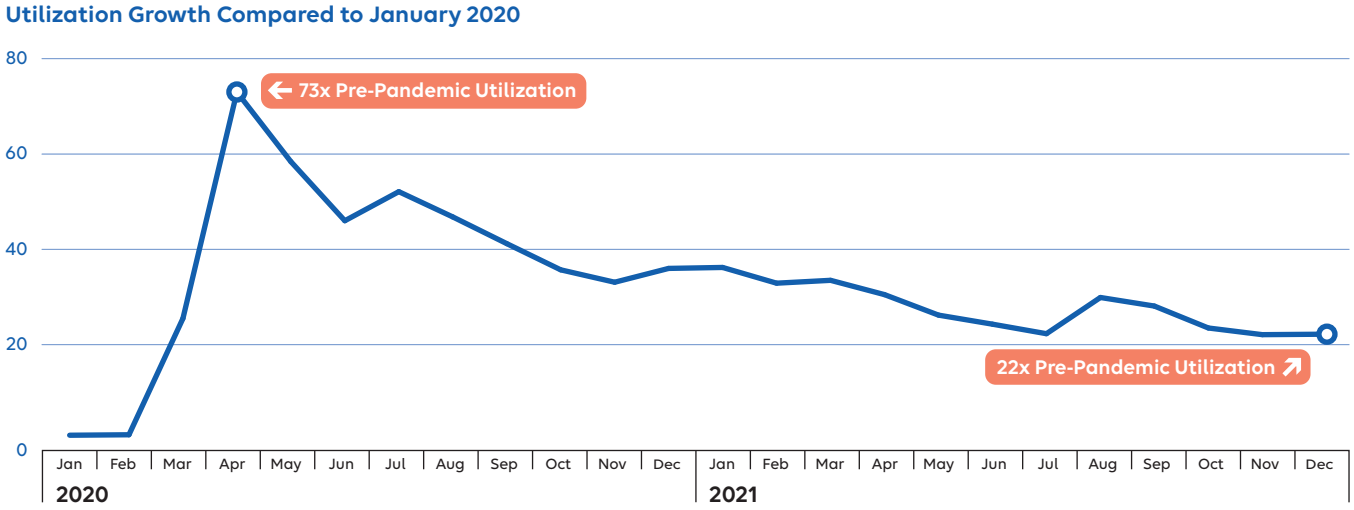
Overall Trends

As noted, telehealth utilization was minimal throughout 2019, peaked in 2020, and levelled off in 2021 (Figure 4). This trend was consistent across all of Simply Healthcare's Medicaid plans.

Although telehealth utilization slowly declined after April 2020, compared to the pre-pandemic time period, telehealth utilization remained exponentially higher in 2021. During the stay-at-home order in the month of April, telehealth utilization was 73 times higher than its use in January 2020 and although the rate of telehealth utilization decreased, utilization remained 22 times higher in December 2021 as compared to January 2020.

Figure 4

Monthly Variation in Telehealth Utilization, 2020-2021



Program Variations

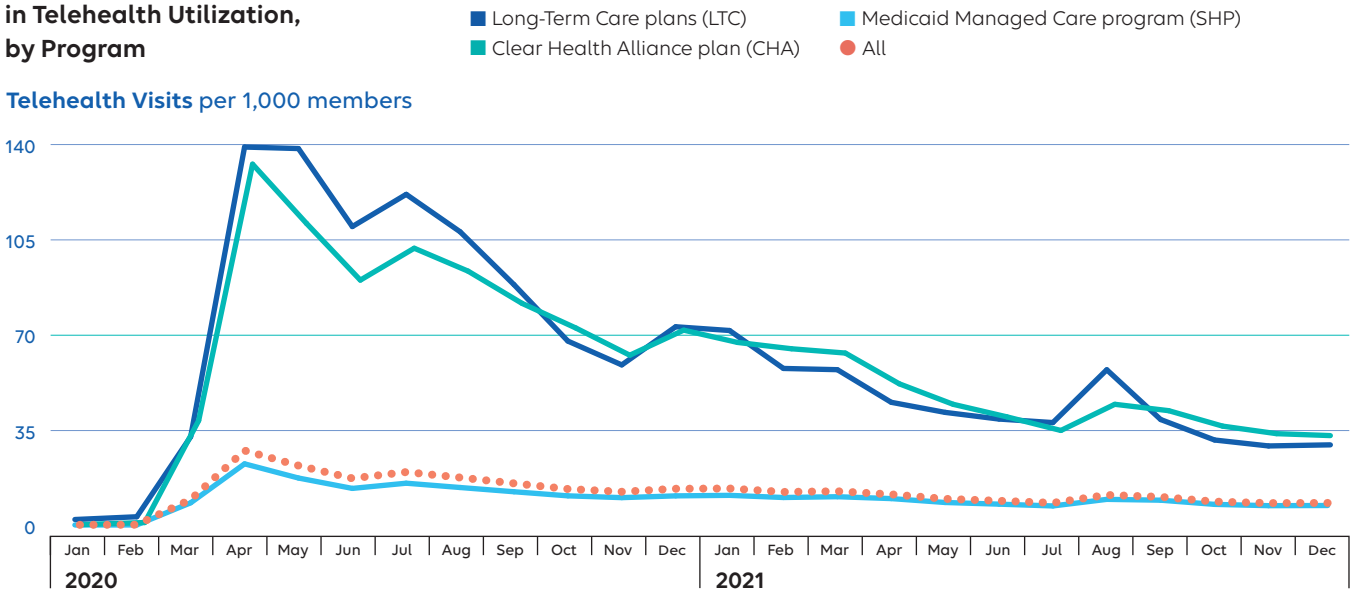
Members in the LTC plan were the primary users of telehealth prior to the pandemic with a telehealth rate of 2.34 visits/1,000 members in January 2020 versus less than 1 visit/1,000 members in CHA and SHP in January 2020. (Figure 5)

However, during and after the state's PHE, the highest users of telehealth varied between members in CHA and LTC, with CHA members having higher utilization in December of 2021 of 33.15 visits/1,000 compared to 29.75 visits/1,000 members and 7.48 visits/1,000 members in LTC and SHP, respectively.

Consistent with other studies, telehealth was vital to the immuno-compromised individuals comprising the CHA plan to reduce exposure to COVID-19 while continuing to be engaged in their care and manage their conditions.[7] As LTC and CHA members drove telehealth utilization, there is an opportunity to improve and increase telehealth access among SHP members and providers.

Figure 5

Monthly Variation in Telehealth Utilization, by Program



Member Location

Prior to the pandemic in 2019, members living in rural areas utilized telehealth at higher rates than members living in urban areas with an average of 13.8 visits/1,000 members in 2019 in rural areas compared to 0.36 visits/1,000 members in urban areas.

Most members accessing these services in rural areas were in the CHA and LTC programs.

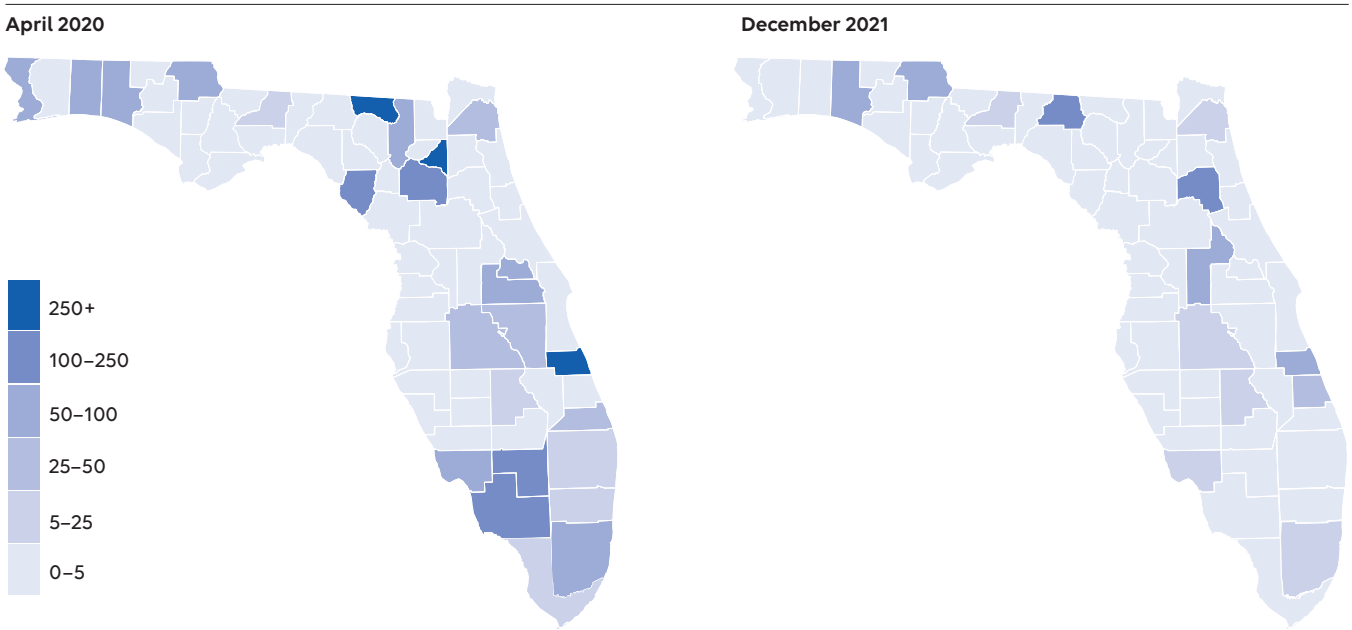
During the peak of the pandemic in April 2020, telehealth utilization among rural members was almost double that of urban members (53.8 visits/1,000 members vs. 27.1 visits/1,000 members). Rural members consistently used telehealth at a higher rate than urban members during the PHE and by December 2021, individuals residing in rural areas were accessing telehealth services at a rate of 1.4 times higher than urban members. The higher utilization among rural members may be a result of rural members finding it more appealing to participate in telehealth versus driving a considerable distance or this population becoming more familiar and comfortable with telehealth over time.

Across Florida's 67 counties, there was wide variation in telehealth use in both April 2020 and December 2021. (Figure 6)

Figure 6

Telehealth Utilization by County

Telehealth Visits per 1,000 members



Age

Prior to the pandemic, telehealth utilization was similar between children, (0-18 years), adults (19-64 years), and older adults (≥ 65 years).

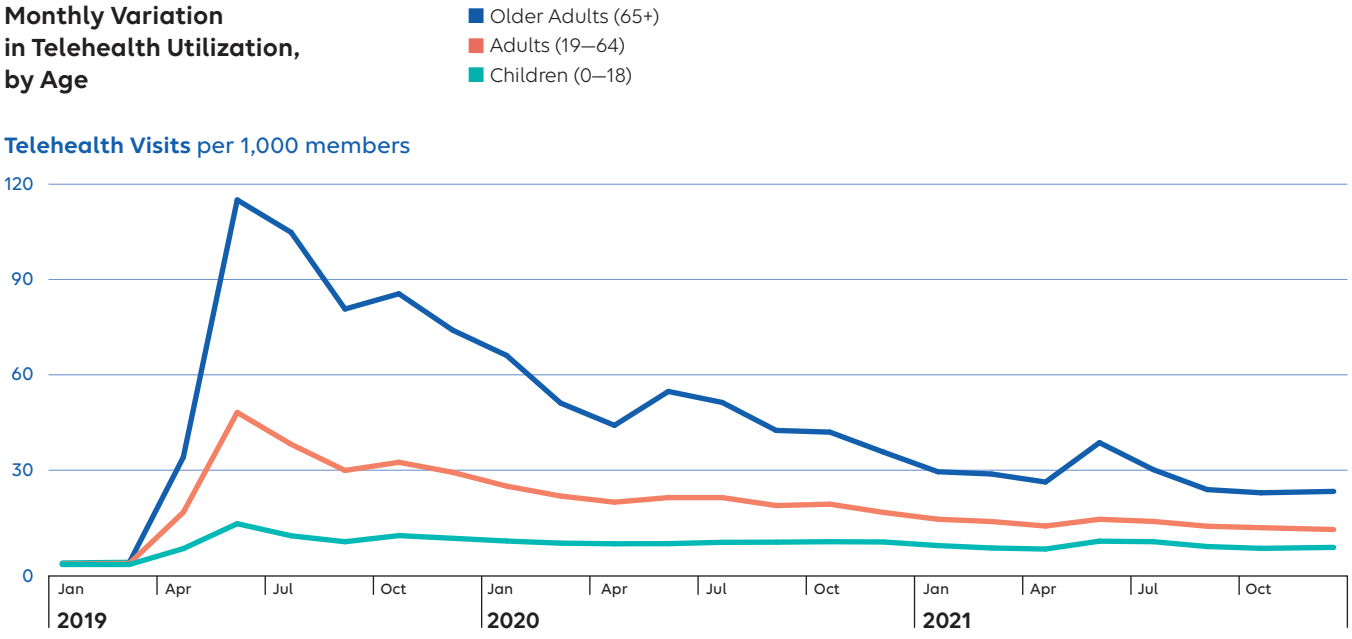
Older adults' utilization of telehealth services was consistently higher during and after Florida's COVID-19 PHE (with a peak of 115 visits/ 1,000 members in April 2020) compared to use by members under the age of 65 and remained higher through December 2021.

Generally, the use of telehealth among children remained relatively low during the pandemic and after the end of Florida's PHE (with the peak being in April 2020) with rates staying below 14 visits/1,000 members during the entire time period studied whereas adults' use of telehealth peaked at 48 visits/1,000 members in April 2020.

However, by December 2021, telehealth utilization among children and adults was approximately 5.7 and 11.3 visits per 1,000 members, respectively. (Figure 7) Lower rates among children may present an opportunity to improve access through strategies such as supporting the use of telehealth within the pediatric medical home and among pediatric specialists or increasing parental education regarding telehealth options and resources.[8]

Figure 7

Monthly Variation in Telehealth Utilization, by Age



Race, Ethnicity, and Language (REL)

The average annual utilization of telehealth was lower in 2021 compared to 2020 for all members, regardless of their race or ethnicity.

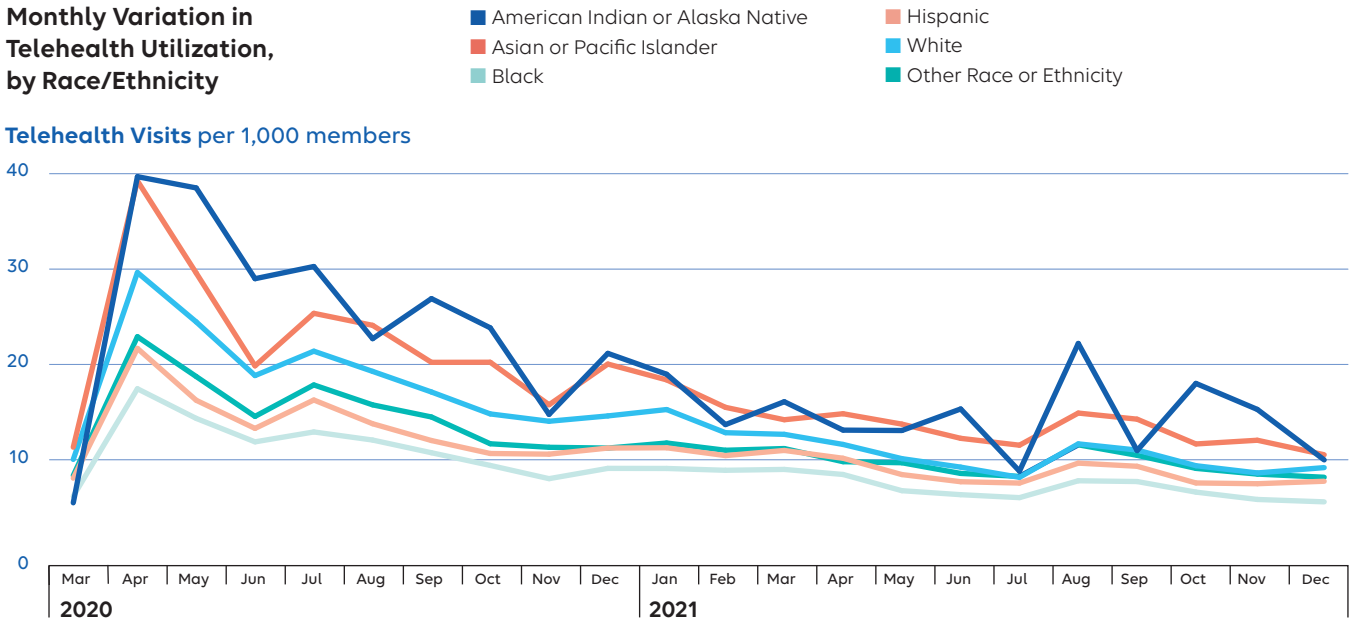
Members who did not report race/ethnicity comprise about 7 percent of the total membership and those members utilized telehealth 2.5 times more than those who reported races and ethnicities. Members identifying as American Indian/Alaska Native and Asian/Pacific Islander consistently utilized telehealth at higher rates than other reported ethnicities. Figure 8 displays telehealth use for all reported races/ethnicities between March 2020 and December 2021 to remove the outlier from February of 2020.*

Spanish speaking members tended to have slightly higher telehealth utilization than members with other known primary languages. Similar to the race/ethnicity data, members with an undetermined primary language utilized telehealth approximately 3 times higher in 2020 and 2021 than those reporting a primary language. Figure 9 displays telehealth utilization by members reporting a primary language.

When looking at specific points in time, telehealth utilization by REL was not always proportional to the share of the total Medicaid membership by REL. (Table 1) For instance, in April 2020, 16.7 percent of members utilizing telehealth were black and yet members identifying as black

Figure 8

Monthly Variation in Telehealth Utilization, by Race/Ethnicity



*American Indian/Alaska Native members displayed a high telehealth utilization rate in February 2020 of over 100 visits/1,000 members however this is due to low member count exclusively from the LTC program.

comprised 25.2 percent of total Medicaid membership. Although there was some under-representation based on race/ethnicity, in other instances, the proportion aligns with the composition of total membership. Interestingly, however, Spanish speaking members seemed to access telehealth more widely after the allowance of telehealth flexibilities compared to membership representation. This could be attributed to the disparities in COVID infection among the Hispanic and Latino populations in Florida, leading these members to opt for telehealth versus in-person visits.[9]

Figure 9

Monthly Variation in Telehealth Utilization, by Primary Language

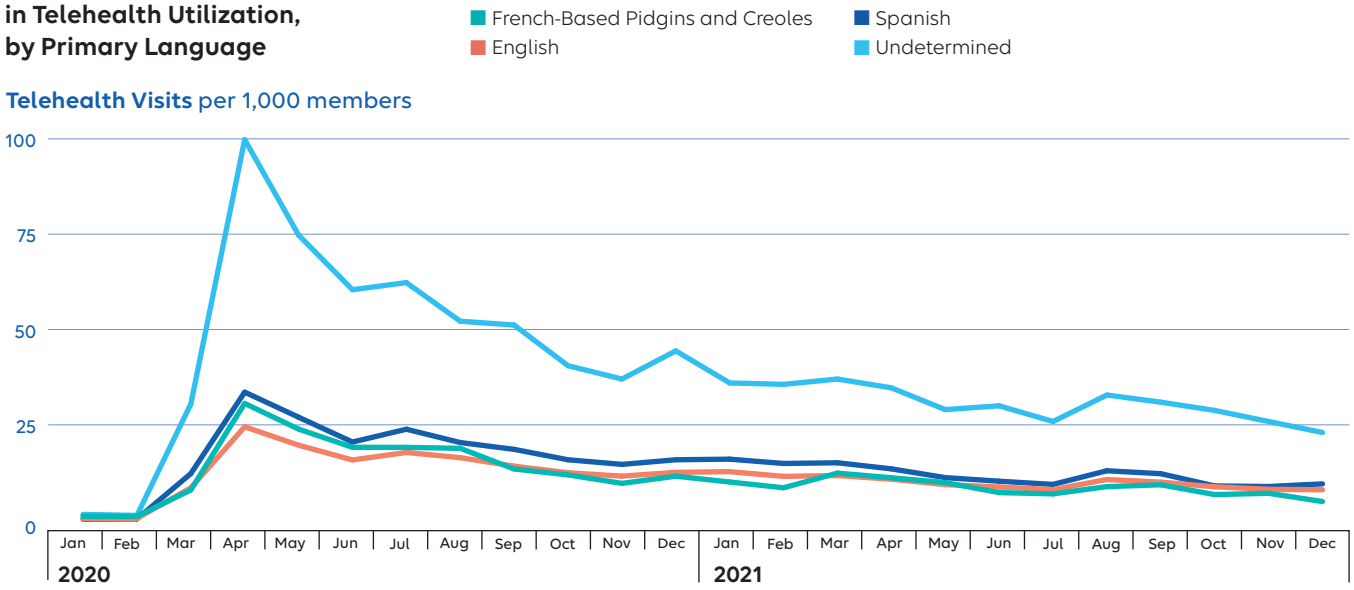


Table 1

Members' Telehealth Utilization by Race/Ethnicity and Primary Language

	% Members with Telehealth Visits			% of Total Population (as of Jan. 2022)
	Jan. 2020	Apr. 2020	Dec. 2021	
Race/Ethnicity				
American Indian or Alaska Native	0.3%	0.3%	0.2%	0.2%
Asian or Pacific Islander	1.8%	1.7%	1.7%	1.2%
Black	16.7%	17.1%	16.8%	25.2%
White	19.8%	19.8%	21.6%	20.4%
Hispanic	32.3%	30.3%	33.6%	36.5%
Not Provided	21.4%	24.0%	16.4%	6.6%
Other Race or Ethnicity	7.8%	6.8%	9.7%	9.9%
Primary Language				
French-Based Pidgins and Creoles	1.9%	1.2%	0.8%	1.2%
English	75.9%	62.6%	68.9%	73.0%
Spanish	18.4%	33.2%	28.7%	25.2%
Undetermined	3.8%	3.1%	1.6%	0.6%

Provider Telehealth Utilization

Primary Care Providers (PCPs) vs Non-PCPs

All members select a PCP or the plan assigns a PCP, and unless they are receiving specialty care, members are required to see their PCP.

Prior to the pandemic, telehealth utilization was almost identical between PCPs and non-PCPs, with an average rate of 0.13 PCP visits per 1,000 members and 0.14 non-PCP visits in 2019.

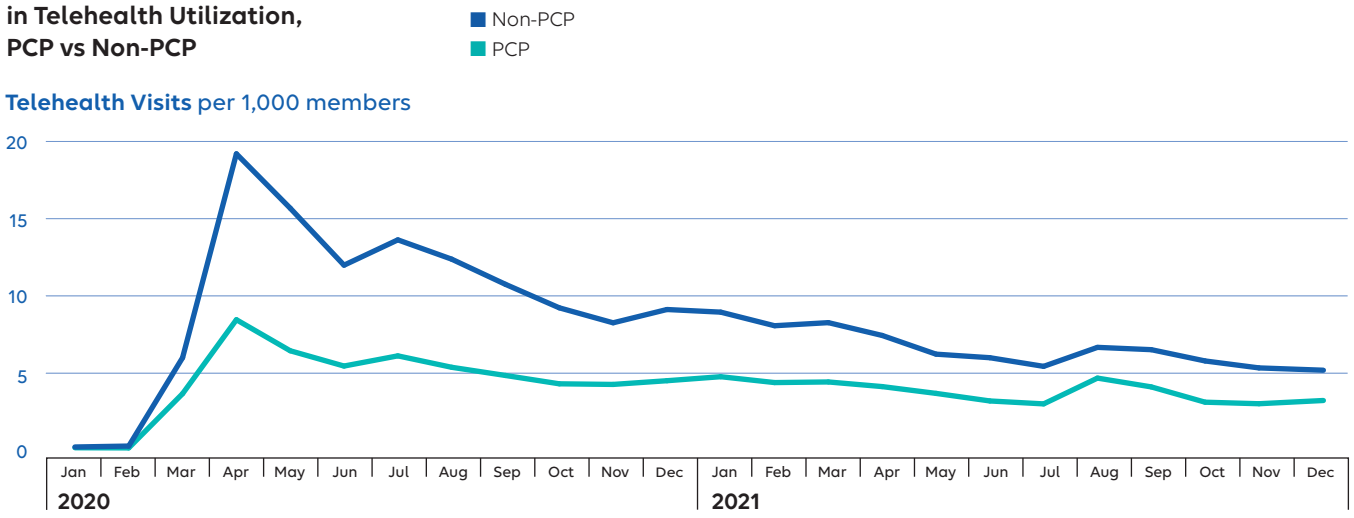
Overall, the volume of non-PCP encounters is higher than PCP encounters regardless of the mode of visit. For instance, members visited non-PCPs approximately 6.8 times more than PCPs in 2020 and 2021. Therefore, it is unsurprising that utilization of telehealth services for non-PCP visits was noticeably higher than use for PCP visits throughout 2020 and 2021. (Figure 10) As displayed, there was a sharper decline in telehealth visits among non-PCPs versus PCPs between April 2020 and June 2020.

The initial non-PCP visit spike between March and April was likely an effect similar to the national trend of providers deferring health care visits to decrease the risk of transmitting the virus and members selecting telehealth to reduce risk of exposure.[10] As of December 2021, telehealth utilization continued to be higher among non-PCPs than PCPs with visit rates of 5.2 visits per 1,000 members and 3.2 visits per 1,000 members, respectively.

Finally, when examining utilization differences throughout 2020 and 2021, it is interesting to note that in January 2020 prior to the pandemic, telehealth visits accounted for less than 1 percent of all visits among PCPs and non-PCP visits whereas in April 2020 there was increase in the proportion of telehealth visits among PCPs (24.2 percent of all visits) and non-PCPs (4.6 percent of all visits). By December 2021, 1.1 percent of all non-PCP and 6.4 percent of all PCP visits were conducted via telehealth.

Figure 10

Monthly Variation in Telehealth Utilization, PCP vs Non-PCP



Provider Types

In 2019, there were 55 different provider types delivering services via telehealth throughout the year. In 2020, that number rose to 197 provider types before falling to 176 provider types in 2021.

Table 2 shows the top 10 provider types from 2019 to 2021 and the percent of all telehealth visits each provider type completed.

Children account for the majority of Simply Healthcare's membership and therefore it is not surprising to see that pediatricians completed the most telehealth visits among all provider types in all three years. Total telehealth visits among pediatricians were 18 times higher in 2021 than telehealth visits in 2019. And the fall of 2021 notably had a spike in COVID-19 cases among school-aged children, which could have been a factor in the increases of telehealth among pediatricians.[11]

Although this analysis did not include encounters submitted to Simply Healthcare's behavioral health partner, other data from Simply Healthcare's behavioral health partner suggests that the flexibilities to deliver behavioral health through telehealth during the PHE were critical for members to safely access mental health targeted case management, specialized therapeutic services, community behavioral health services, and behavioral health interventions. Future projects may provide a separate analysis regarding behavioral health utilization during and after Florida's PHE.

Table 2

Top 10 Provider Types Delivering Services via Telehealth, 2019—2021

2019		2020		2021	
Provider Type	**% All Telehealth Visits**	**Provider Type**	**% All Telehealth Visits**	**Provider Type**	**% All Telehealth Visits**
Pediatrics	32.0%	Pediatrics	9.8%	Pediatrics	13.5%
Pediatric NP	13.4%	General Practice	8.5%	Family Medicine	8.2%
Cardiovascular Disease	12.5%	Internal Medicine	8.1%	Internal Medicine	7.4%
Psychiatry	10.1%	Family Medicine	7.9%	Family Practice NP	6.6%
Lic. Professional Counselor	9.4%	Family Practice NP	5.7%	General Practice	6.3%
Family Medicine	3.5%	Certified NP	3.0%	Pediatric NP	4.1%
Physician Assistant	2.6%	Neurology/Spec Qual-Child Neurologist	2.9%	Neurology/Spec Qual-Child Neurologist	3.0%
Internal Medicine	1.6%	Pulmonary Diseases	2.4%	Physician Assistant	2.8%
Family Practice NP	1.5%	Pain Medicine	2.4%	Psychiatry	2.7%
Neurology/Spec Qual-Child Neurologist	1.4%	Physician Assistant	2.4%	Certified NP	2.6%

NP = Nurse Practitioner

Discussion

The COVID-19 pandemic transformed the healthcare delivery system in many ways, including by leading many providers and consumers to depend on telehealth for the first time.

In turn, this rapid shift away from in-person care at the start of the pandemic expanded access to telehealth services. In Medicaid, increased telehealth access was possible through flexibilities allowed by federal and state governments. This analysis demonstrates that telehealth flexibilities implemented via managed care plans were an essential tool during the peak of the COVID-19 pandemic in Florida and continue to be a strategy for expanding access to care for Medicaid members and for supporting providers serving Medicaid managed care members.

As HHS and state Medicaid programs consider the future of telehealth policy after the expiration of PHE flexibilities, the data presented in this paper points to the potential of telehealth to increase and sustain access for a diversity of members across Medicaid programs. For instance, the data show greater rates of telehealth visits among older adults, American Indian/Alaska Native and Asian/Pacific Islander members, and members whose primary spoken language is Spanish. It also shows persistently higher rates of telehealth use in rural vs. urban areas, pointing to an opportunity for telehealth as one tool to continue to equitably deliver care.

As such, policymakers, payors, and advocates should continue examining telehealth policies through an equity lens and consider additional support Medicaid members and providers may need to participate in telehealth. For example, in 2018, 52 million Americans reported not knowing how to use a computer with the majority being older, less educated, and people of color; and broadband dead zones were typically found in rural areas, low-income neighborhoods, and minority communities.[12] Therefore, telehealth policies should continue to consider access to broadband, affordability and types of devices needed to support audio and visual visits, language needs, adaptive equipment for people with disabilities, private space availability, and digital literacy needs.[13] Finally, future state telehealth policy updates should leverage broadband and digital equity policies and programs to address the digital divide.

Conclusion

This data analysis provides new insights regarding how Florida Medicaid providers and members are continuing to utilize telehealth even as the COVID-19 pandemic wanes.

However, to fully take advantage of the momentum of telehealth and to ensure that it meets the diverse needs of Medicaid members, continued efforts are necessary to understand members' and providers' willingness and ability to adopt telehealth and to reduce barriers for access.

Endnotes

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About Us

Elevance Health Public Policy Institute

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Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. The company supports consumers, families, and communities across the entire care journey—connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve more than 118 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions.

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