Telehealth Advisory Workgroup Meeting #2

October 6, 2021

DHCS

Agenda

- Review and discuss Medi-Cal's current telehealth policy and commitments (45min)
- Reaffirm Workgroup charge (10min)
- Seek Workgroup advisement on potential policy approaches (85min)
- Review latest DHCS telehealth data and identify areas for further research and evaluation (20min)
- Public comment (15min)
- Next steps / adjourn (5 min)

Medi-Cal's Current Telehealth Policy and Commitments

Current and Planned Medi-Cal Telehealth Coverage

The following Medi-Cal telehealth policies are approved in state law through December 31, 2022. The Department intends for these policies to be continued on a permanent basis after 2022 and expanded as specified below:

Baseline coverage of synchronous telehealth

- Synchronous video and audio-only telehealth is covered by Medi-Cal across many services and delivery systems, including physical health, dental, specialty mental health, Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (ODS).
- DHCS intends to continue this policy after 2022 and add baseline coverage of synchronous telehealth coverage to State Plan DMC, 1915(c) waivers, Targeted Case Management (TCM) Program, and Local Educational Agency Medi-Cal Billing Option Program (LEA-BOP).

Baseline coverage of asynchronous telehealth

- Asynchronous telehealth (e.g., store and forward and e-consults) is covered by Medi-Cal across many services and delivery systems, including physical health, dental, and DMC-ODS (e-consults only).
- DHCS intends to continue this policy after 2022 and expand baseline coverage of asynchronous telehealth to 1915(c) waivers, TCM, and LEA-BOP.

Current and Planned Medi-Cal Telehealth Coverage

The following Medi-Cal telehealth policies are approved in state law through December 31, 2022. The Department intends for these policies to be continued on a permanent basis after 2022 and expanded as specified below:

Payment Parity

- DHCS has implemented parity in reimbursement levels between in-person services and telehealth modalities (synchronous video, synchronous audio-only, or asynchronous store and forward, as applicable), as long as those services meet billing code requirements.
- DHCS intends to continue this policy after 2022 and continue the use of cost-based reimbursement for TCM and LEA-BOP telehealth services. Payment parity excludes virtual communications.
- All behavioral health (BH) reimbursements will be cost-based until BH payment reform via CalAIM is implemented.

Current and Planned Medi-Cal Telehealth Coverage

The following Medi-Cal telehealth policies are approved in state law through December 31, 2022. The Department intends for these policies to be continued on a permanent basis after 2022 and expanded as specified below:

Virtual Communications / Check-Ins

- Brief virtual communications are covered by Medi-Cal for physical health.
- DHCS intends to continue this policy after 2022 and expand coverage of virtual communications to 1915(c) waivers, TCM and LEA-BOP.

Telehealth in FQHCs / RHCs

- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are reimbursed at the prospective payment system (PPS) rate for synchronous video, synchronous audio-only, and store and forward, and are not subject to site limitations for either the beneficiary or provider.
- DHCS intends to continue these flexibilities after 2022.

Policies Already Implemented or In Process

✓ Remote Patient Monitoring

Remote patient monitoring is covered by Medi-Cal for dates of service on or after July 1, 2021. DHCS' request for federal approval is under development.

✓ Telephonic Enrollment for Minor Consent

Telephonic enrollment for minor consent will continue after the COVID-19 public health emergency (PHE). This will be done through the Medi-Cal Eligibility Procedures Manual updates as permanent policy, as reflected in MEDIL I21-09.

Workgroup Charge

Workgroup Charge

The charge of the workgroup is to advise DHCS on how to refine its telehealth policies to ensure the policies are designed optimally for a post-PHE world.

- **Billing and coding protocols:** What codes and modifiers should be used to delineate when services are delivered by telehealth, and whether services are video or audio-only.
- **Ongoing monitoring and evaluation:** How DHCS should measure and review telehealth utilization to facilitate consumer protection and Medi-Cal program stewardship.
- **Utilization management:** What standards and protections should be in place to ensure expanded telehealth coverage increases access, supports high-quality care, and reduces health disparities, among other goals.

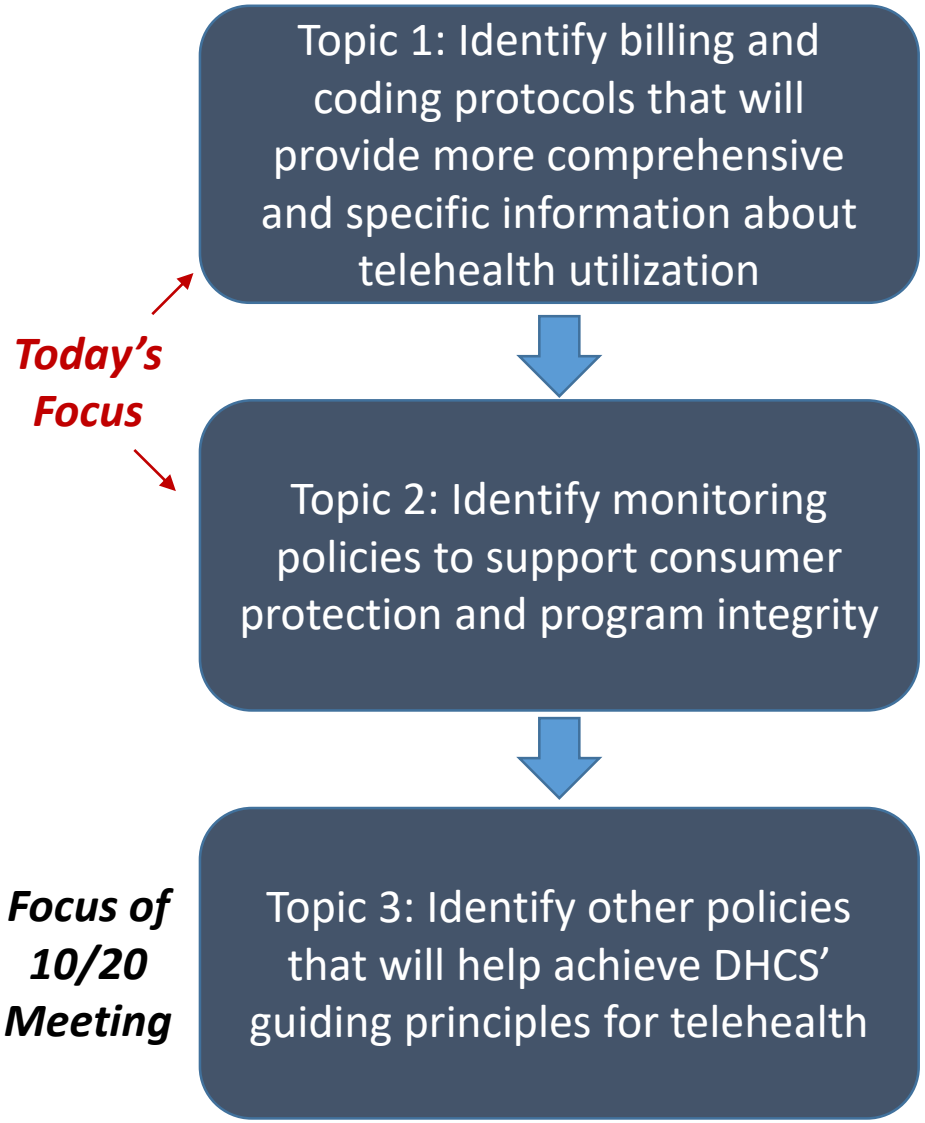
Putting Recommendations and Proposals Into Practice

- 2022-2023 Budget (Governor's budget proposal and assumptions, Trailer Bill Language (TBL))
- State Plan Amendments or waiver amendments
- State policy and operational guidance (e.g., provider manual revisions, plan letters, targeted review and monitoring protocols)
- Research and evaluation agenda

The Workgroup meeting timeline is driven by AB 133 direction that the Workgroup inform proposed 2022-23 Governor's Budget development. Stakeholder engagement will continue after three scheduled Workgroup meetings.

Potential Policy Approaches

Topics for Workgroup Advisement



Issues to be Addressed

- Limitations in understanding current telehealth use and impact due to inconsistent and optional use of telehealth modifiers within certain delivery systems
- Inability to differentiate between video and audio modalities

- Lack of monitoring capabilities to support consumer protections and analyze utilization outliers
- Limited evidence base on the quality of "telehealth-only" or third party telehealth providers and potential impact on coordination of care

- Ensure Medi-Cal beneficiaries have equitable access to in-person care or care via the telehealth modality that best suits their needs and meets standard of care

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach

Utilize specific modifiers to delineate video visit vs. audio-only visits

Current State

Providers who offer physical health services by telehealth are directed to bill for video visits with a unique modifier, but **there is no distinct modifier guidance for audio-only encounters**. (DHCS Provider Manual)

Specialty mental health, DMC, and DMC-ODS counties received separate guidance requiring them to bill for services delivered via audio-only using a specific modifier starting November 1, 2021; the use of the audio-only modifier is currently optional.

Discussion Questions:

- How should DHCS address visits with mixed modalities (e.g., starts via video and ends as audio-only)?
- Should video visit and audio-only modifiers be consistent across delivery systems?
- What other policy approaches should DHCS consider to differentiate between video and audio modalities?

Potential Policy Approach

Document reasons for using audio-only instead of video in the patient record

Current State

During COVID-19, providers are required to document in the patient's medical record circumstances for audio-only visits and that the visit is intended to replace a face-to-face visit (DHCS bulletin).

In addition, for all telehealth modalities, providers are required to document verbal/written consent and provide appropriate documentation to substantiate that the appropriate service code was billed (DHCS Provider Manual).

Discussion Questions:

- How can DHCS ensure patient choice and decision-making is informed with respect to available modalities?
- What detail should be captured in the patient's record related to the rationale for audio-only?
- How specific should patient consent for telehealth be as it relates to selected modalities?
- What other policy approaches should DHCS consider to gain a more comprehensive understanding of reasons for the use of audio-only?

Additional Discussion Questions: Topic 1

- What other billing and coding protocols are important to consider?
- What factors should DHCS consider when weighing the implementation of billing and coding protocols?

Potential Policy Approach

Providers who offer telehealth must be located in California (with some exceptions for specialty care)

Current State

Out-of-state providers who offer telehealth to Medi-Cal beneficiaries must be:

- Licensed in California;
- Enrolled as a Medi-Cal rendering provider or non-physician medical practitioner; and,
- Affiliated with an enrolled Medi-Cal provider group that is located in California or a border community and meet all Medi-Cal program enrollment requirements.

Exception: A person who is licensed as a health care practitioner in another state and is employed by a tribal health program does not need to be licensed in California to perform services for the tribal health program.
(DHCS' Telehealth FAQs)

Discussion Questions:

- How might this potential policy approach impact access to care and continuity of care?
- What principles or considerations should drive exceptions to this policy approach?
- What other policy approaches should DHCS consider putting in place for out-of-state providers?

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach

"Telehealth-only providers" or "third party telehealth providers" without a physical location must register with DHCS and submit annual data reports showing utilization and encounters among Medi-Cal beneficiaries

Current State

Telehealth-only providers or third party telehealth providers without a physical location in California are not required to register with DHCS (beyond typical state licensure requirements) or submit annual data on telehealth utilization among Medi-Cal beneficiaries. DHCS does not have information available to delineate telehealth-only or third party telehealth providers from other providers.

Discussion Questions:

- How might this potential policy approach impact access to care and continuity of care? Patient choice for in-person visits?
- How do telehealth-only and third party telehealth providers add value to, and integrate with, existing Medi-Cal delivery systems? What potential policy approaches would encourage integration and coordination?
- Does this put undue administrative burden on telehealth-only and third party telehealth providers?
- What other policy approaches should DHCS consider to monitor telehealth utilization among telehealth-only and third party telehealth providers?

Potential Policy Approach

Adopt utilization review procedures for telehealth services similar to those used for in-person services. This may include conducting targeted review of outliers, based on such criteria as:

- **Time: Providers whose telehealth time exceeds hours in a week or month.**
- **Volume: Providers who bill a higher ratio of telehealth vs. in-person visits relative to others in their specialty.**
- **Time + Volume: Unexplained increase in volume and shorter appointment times that do not meet standard of care**
- **Standard of Care: Providers billing for services that cannot be accessed by patient without being physically present**
- **Consumer Complaints: Patients who are limited English proficient or with disabilities being turned away due to providers' lack of accessibility/assistive tools**

Current State

DHCS currently conducts reviews based on fraud complaints, statutorily required reviews, and other reviews as needed to ensure Medi-Cal program integrity.

Discussion Questions:

- What are the right parameters that should be used for conducting outlier analyses?
- What other monitoring protocols or policy approaches should DHCS consider to facilitate oversight of telehealth services?

Additional Discussion Questions: Topic 2

- What other monitoring approaches are important to consider?
- What factors should DHCS consider when weighing implementation of monitoring approaches?

Latest Telehealth Data and Areas for Further Research

Telehealth Claims Utilization Analysis

- DHCS analyzed paid claims for the 20 most commonly-used Current Procedural Terminology (CPT) codes for outpatient telehealth visits from April 2020 through March 2021
- The claims include fee-for-service and managed care
- These outpatient visits include outpatient medical and non-specialty mental health services. These data do not include specialty mental health services
- These analyses of data from the DHCS Medi-Cal Data Warehouse are preliminary

Most commonly used procedure codes for telehealth services are primarily evaluation and management (E&M) services and psychiatric and mental health services

CPT Code	% Telehealth	Area	Detail	Procedure Description
99203	14%	Evaluation and Management Services	New Patient Office or Other Outpatient Services	Low level of medical decision making and/or the provider spends 30–44 minutes of total time
99204	14%			Moderate level of medical decision making and/or the provider spends 45–59 minutes of total time
99211	36%		Established Patient Office or Other Outpatient Services	May not require the presence of a physician or other qualified health care professional.
99212	43%			Straightforward level of medical decision making and/or the provider spends 10–19 minutes of total time
99213	33%			Low level of medical decision making and/or the provider spends 20–29 minutes of total time
99214	27%			Moderate level of medical decision making and/or the provider spends 30–39 minutes of total time
99215	29%			High level of medical decision making and/or the provider spends 40–54 minutes of total time

Preliminary analyses

Most commonly used procedure codes for telehealth services are primarily evaluation and management (E&M) services and psychiatric and mental health services

CPT Code	% Telehealth	Area	Detail	Procedure Description
90791	51%	Psychiatric Diagnostic Procedures	Psychotherapy Services and Procedures	Psychiatric evaluation of the patient with the aim of making a diagnosis
90832	57%			Psychotherapy, a series of techniques for treating the psychiatric disorders of the patient. The treatment session with the patient typically lasts between 16 to 37 minutes.
90834	48%			Psychotherapy, a series of techniques for treating the psychiatric disorders of the patient. The treatment session with the patient typically lasts between 38 to 52 minutes.
90837	60%			Psychotherapy, a series of technique for treating the psychiatric disorders of the patient. The treatment session typically lasts for a minimum of 53 minutes or more

Preliminary analyses

Most commonly used procedure codes for telehealth services are primarily evaluation and management (E&M) services and psychiatric and mental health services

CPT Code	% Telehealth	Area	Detail	Procedure Description
92507	60%	Special Otolaryngologic Services and Procedures	Treatment of Auditory Processing Disorder	The provider treats a patient with communication and hearing difficulties by directly interacting with the patient. They assess the patient with impairment in their ability to make sounds, along with significant receptive and expressive deficit, to identify if the sound signals reach the brain through the ears
92508	53%			The provider treats a group of two or more individuals with communication and hearing difficulties by directly interacting with them. They assess the patients with impairment in their ability to make sounds, along with significant receptive and expressive deficits, to identify if the sound signals reach the brain through the ears.
H2019	26%	Other Mental Health and Community Support Services		Therapeutic behavioral services, per 15 minutes
G9008	35%			Coordinated care fee, physician coordinated care oversight services

Preliminary analyses

Most commonly used procedure codes for telehealth services are primarily evaluation and management (E&M) services and psychiatric and mental health services

CPT Code	% Telehealth	Area	Detail	Procedure Description
H0032	45%	Mental Health Programs and Medication Administration Training		Mental health service plan development by non-physician

Preliminary analyses

Most commonly used procedure codes for telehealth services are primarily evaluation and management (E&M) services and psychiatric and mental health services

CPT Code	% Telehealth	Area	Detail	Procedure Description
G2012	These codes specifically refer to types of telehealth	Other Evaluation and Management Services		Virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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
Q3014		Telehealth Originating Site Facility Fee		Telehealth originating site facility fee
T1014		Other Services		Telehealth transmission, per minute, professional services bill separately
99442		Non-Face-to-Face Evaluation and Management Services	Non-Face-to-Face Telephone Services	The provider performs an E&M service for an established patient through a telephone conversation lasting 11 to 20 minutes.

Preliminary analyses

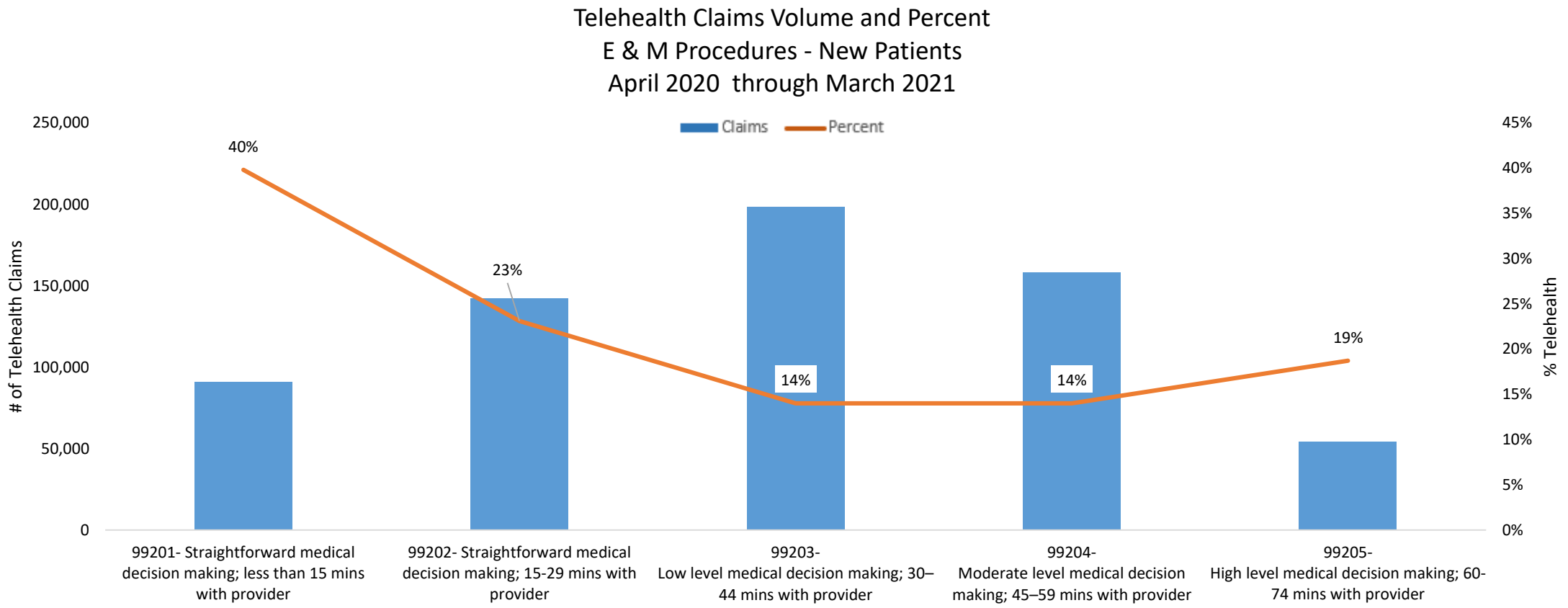
Established patient visits had twice the telehealth utilization of new patient visits

CPT Code	Group	Telehealth	Total Count	Percent Telehealth	Most Common Reason for Visit (for Telehealth Visits)
99201*	New	90,679	227,922	40%	Contact with and (suspected) exposure to other viral communicable diseases
99202		142,131	614,107	23%	
99203		198,373	1,374,535	14%	
99204		157,927	1,091,789	15%	Encounter for screening for malignant neoplasm of colon
99205		54,157	290,164	19%	Major depressive disorder, recurrent, moderate
Total New Patient E&M		**643,267**	**3,598,517**	**18%**	
99211	Established	505,474	1,415,910	36%	Contact with and (suspected) exposure to other viral communicable diseases
99212		2,539,922	5,886,092	43%	Essential (primary) hypertension
99213		6,221,562	19,088,157	33%	
99214		2,235,338	8,227,654	27%	
99215		321,849	1,091,050	30%	
Total Established Patient E&M		**11,824,145**	**35,708,863**	**33%**	

Preliminary analyses

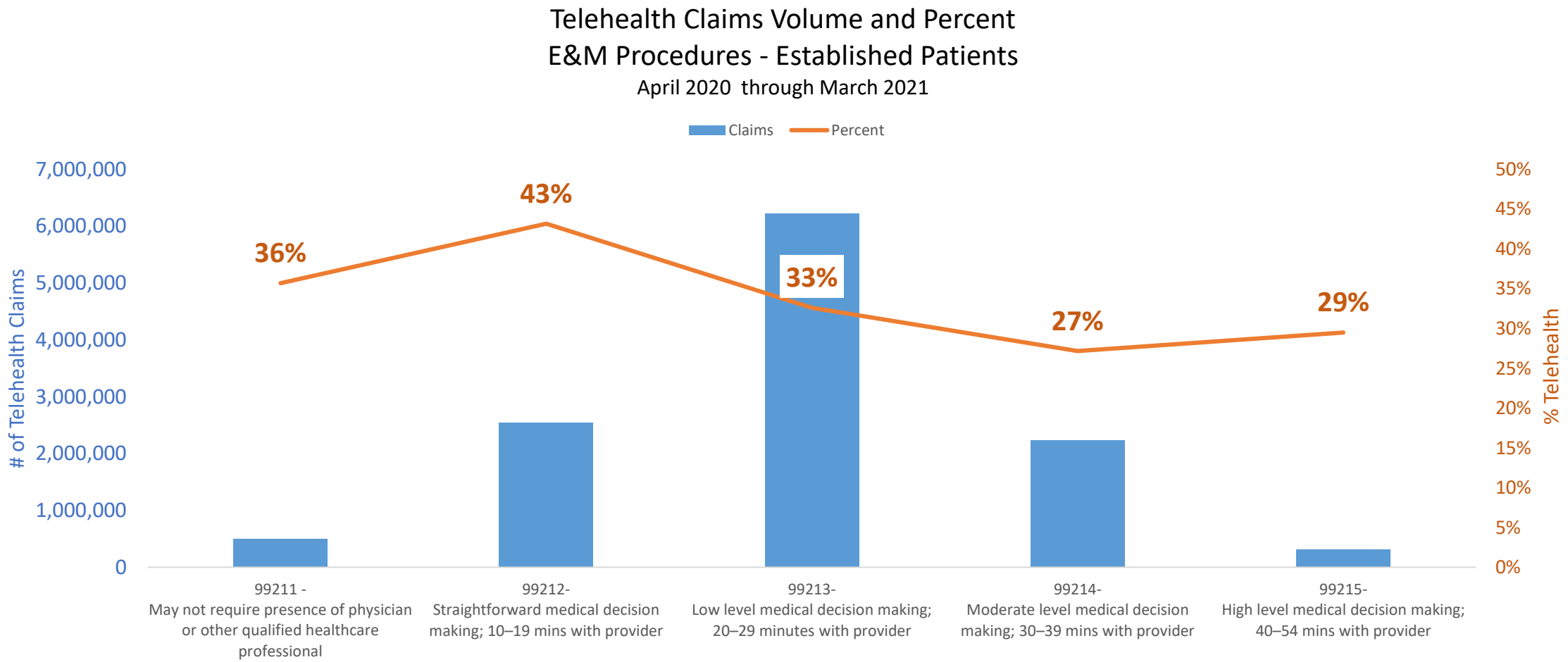
* CPT code 99201 was removed in January 2021

About 18% of new patient E&M claims were telehealth during this time period



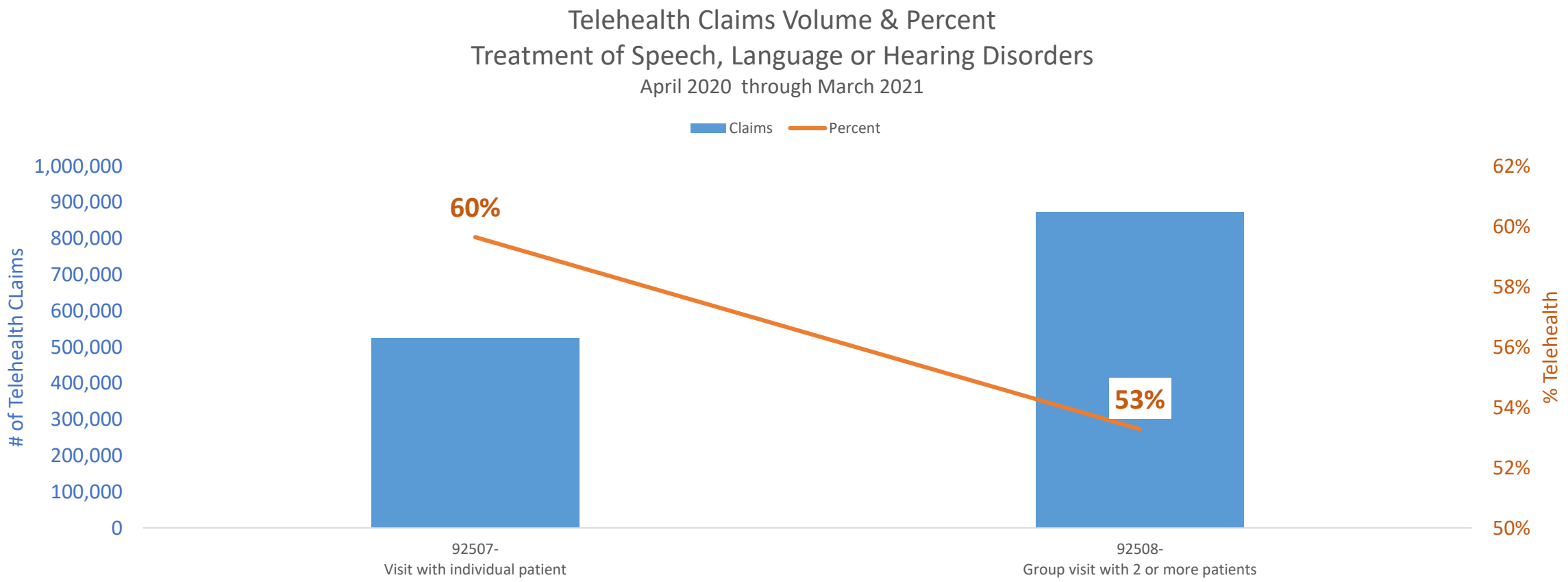
Preliminary analyses

About 33% of established patient E&M claims were telehealth during this time period



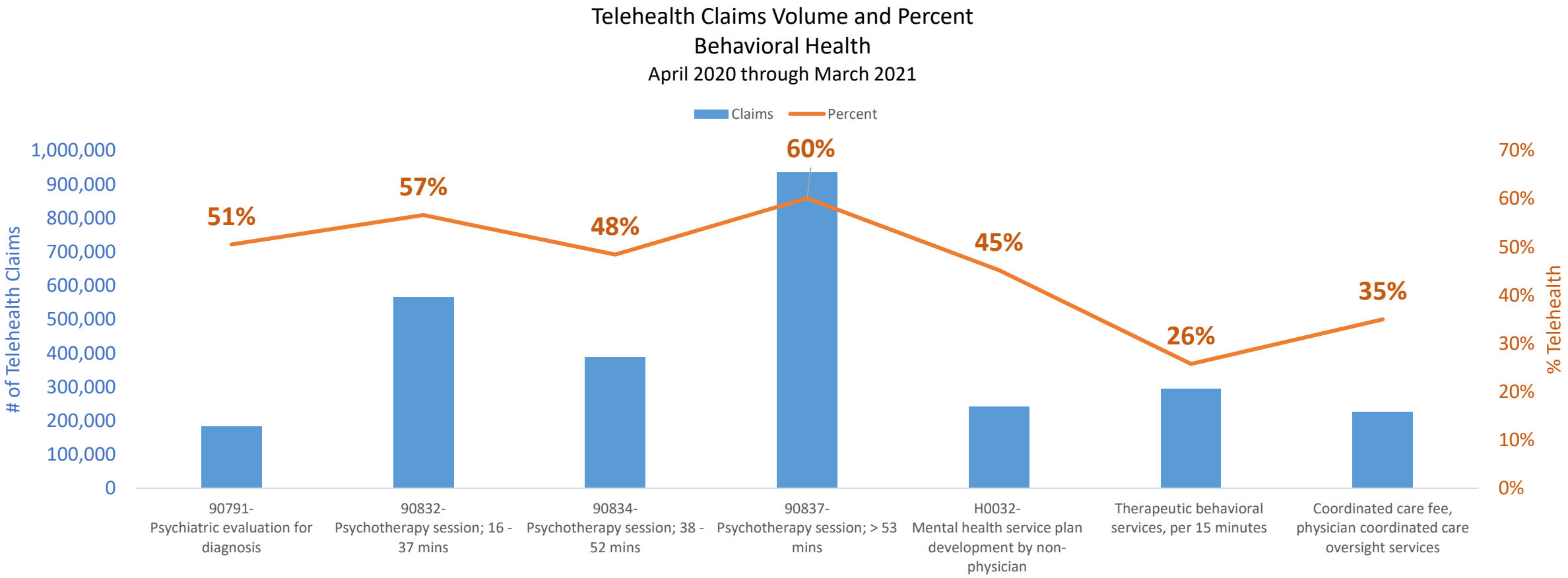
Preliminary analyses

About 50 – 60% of claims for treatment of speech, language, or hearing disorders were telehealth during this time period



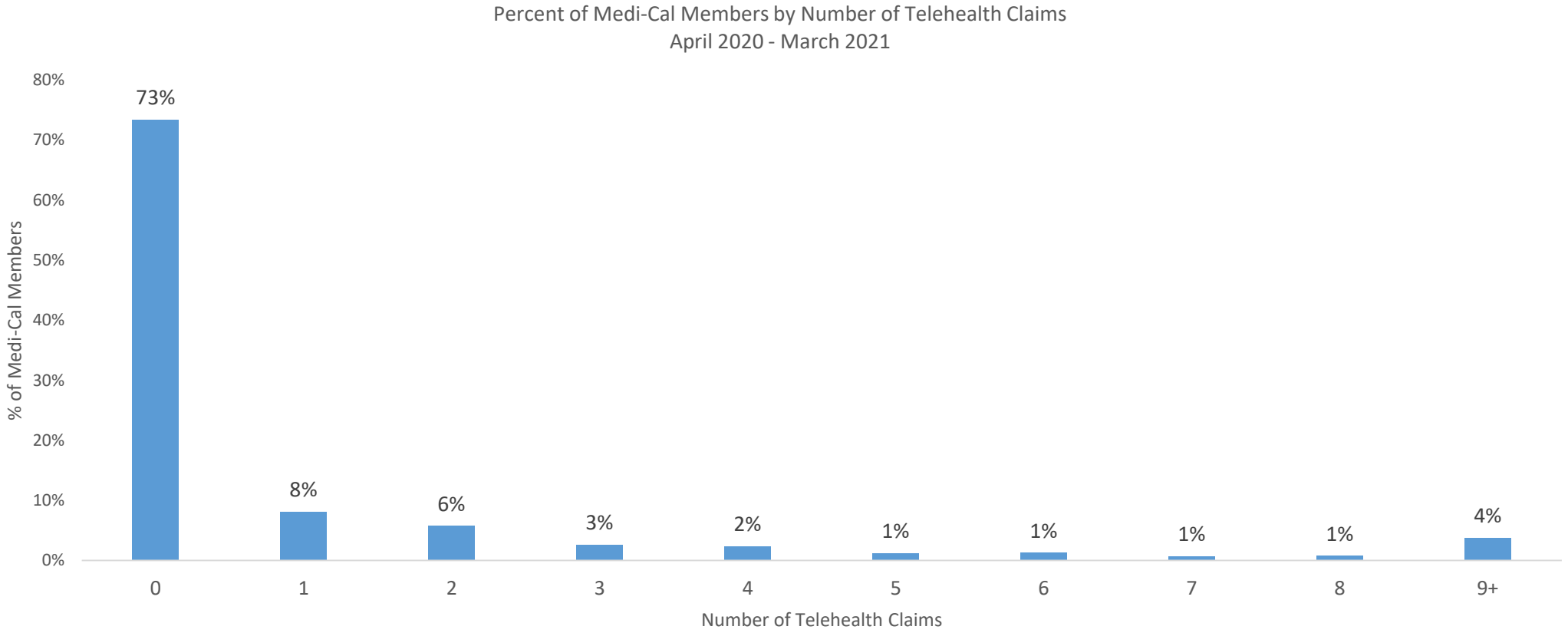
Preliminary analyses

About half of psychotherapy claims were telehealth; about 25 – 45% of mental health-related services claims were telehealth



Preliminary analyses

Nearly 75% of Medi-Cal members had no telehealth claims; 4% of Medi-Cal members had 9-plus telehealth claims during the time period



Preliminary analyses

Areas for Further Data Analysis & Research

- **Potential Areas for Further Data Analysis**
  - Further analyses of broader set of CPT codes
  - Demographics of high telehealth utilizers (5 or more visits)
  - Claims requiring in-person evaluation but with telehealth modifier
  - Outlier telehealth volumes
  - Disaggregate 0-20 age data into smaller age groupings
  - Other data analysis suggestions from workgroup members
- **Developing a Research and Evaluation Agenda**
  - Conduct a more detailed assessment of Medi-Cal telehealth claims/encounter data
  - Consider how billing protocol design will inform future data collection and analytic possibilities
  - Develop short-term (1 year) and longer-term (2-3 years) research agendas to understand the impact of:
    - Telehealth utilization on access, quality of care, and disparities
    - Utilization management and billing protocols
  - Incorporate workgroup feedback into research and evaluation plans

Public Comment

*During this time, should you wish to be unmuted to comment, click "Raise Hand" in the Zoom window. If selected, you'll be asked to unmute your microphone. For those joining by phone-only, you may press *9 to raise your hand. If selected, you will hear an operator say, "The host would like to unmute your microphone." To unmute, press *6. Once unmuted, please state your name and organization. Commenters will be given two minutes to speak.*

Additional Comments and Next Steps

For questions or comments, please email **Medi-Cal_Telehealth@dhcs.ca.gov**.