DEPARTMENT OF HEALTH CARE SERVICES
Telehealth Advisory Workgroup
October 20, 2021
9:30am-12:30pm PT

MEETING SUMMARY

Telehealth Advisory Workgroup Members Attending (alphabetical): Leticia Alejandrez, California Emerging Technology Fund; Sarah Bridge, Association of California Healthcare Districts; Fabiola Carrion, National Health Law Program; David Ford, California Medical Association; Anne Frunk, Shasta Community Health Center; Leticia Galyean, Seneca Family of Agencies; Paul Glassman, California Northstate University College of Dental Medicine; Anna Gorman, County of Los Angeles Department of Health Services; Farid Hassanpour, CenCal Health; Flora Haus, American Association of Retired Persons, California; Katie Heidorn, Insure the Uninsured Project; Sarah Hesketh, California Association of Public Hospitals and Health Systems; Tiffany Huyenh-Cho, Justice in Aging; Linnea Koopmans, Local Health Plans of California; Mei Wa Kwong, Center for Connected Health Policy; Anna Leach-Proffer, Disability Rights of California; Matt Lege, Service Employees International Union, California State Council; Anthony Magit, Rady Children's Hospital & Children's Specialty Care Coalition; Beth Malinowski, California Primary Care Association; James Marcin, University of California, Davis Health; Lisa Matsubara, Planned Parenthood Affiliates of California; Lisa Moore, University of California Health; Amy Moy, Essential Health Access; Mandi Najera, Promesa Behavioral Health; Nancy Netherland, Kids and Caregivers; Claudia Page, California Children's Trust; Rajiv Pramanik, Contra Costa Health Plan; Jen Raymond, Children's Hospital Los Angeles; Cary Sanders, California Pan-Ethnic Health Network; Sylvia Trujillo, Oregon Community Health Information Network; Reynaldo Vargas-Carbajal Jr., Downey Unified School District; Yvette Willock, Los Angeles County Department of Mental Health; Carol Yarbrough, University of California San Francisco Medical Center.

Telehealth Advisory Members Not Attending (alphabetical): Lisa Harris, Indian Health Council; Rebecca Picasso, Blue Shield of California.

California Department of Health Care Services (DHCS) Staff Attending (alphabetical): Palav Babaria, Carolyn Brookins, Mayra Cano, Bambi Cisneros, Jim Elliott, Carol Gallegos, Catherine Hicks, Jacob Lam, Muree Larson-Bright, Linh Le, Karen Mark, Rene Mollow, Christina Moreno, Lisa Murawski, Bill Otterbeck, Kelly Pfeifer, Susan Philip, Raul Ramirez, Michael Rowe, Linette Scott, Sristi Sharma, Erika Sky, Timothy Van Natta, Rachelle Weiss

Manatt Staff Attending (alphabetical): Jared Augenstein, Nathan Donnelly, Anne Fox, Seth Halpern, Alice Lam, Jacqueline Marks Smith

Public Attending: 65 individuals from the public attended by Zoom.

Welcome
Rene Mollow, Deputy Director, Health Care Benefits & Eligibility
Deputy Director Mollow welcomed members.

Telehealth Advisory Workgroup Meeting Presentation and Discussion
Slides: https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Advisory-Workgroup-Meeting-3.pdf

Mollow opened discussion, thanking members for their thoughtful contributions to the first and second workgroup. Mollow noted that while this meeting was the last of the three workgroup sessions, she encouraged workgroup members and the public to continue providing their perspectives throughout the budgetary process.

Mollow outlined the workgroup's agenda, noting that the DHCS and Manatt Health teams would review the policy approaches discussed in the previous workgroup, discuss newly proposed policies, review a proposed research agenda, and confirm next steps.

Alice Lam thanked workgroup members for their feedback during and after the second workgroup. She explained that the goal for the first section of the session was to review the key considerations raised in response to the potential policy approaches outlined in the second workgroup and reminded members that DHCS would circulate an additional survey for members to complete after the final workgroup session.

Lam reviewed the first policy approach: "Use specific modifiers to delineate video visits versus audio-only visits". Lam explained that claims data regarding audio-only vs. video visits is currently limited because there is no audio-only modifier required today in Medi-Cal. She shared that a new audio-only modifier is expected to be announced by the American Medical Association's (AMA's) Common Procedural Terminology (CPT) editorial panel in the coming weeks.

Lam reviewed key considerations raised by workgroup members in response to this policy, including: general support for adding an audio-only modifier to track audio-only visits and a suggestion to use modality-specific modifiers based on the modality used to initiate a visit. Lam underscored that workgroup members shared clear guidance is essential for changes to modifier requirements so providers can appropriately use modifiers and DHCS can appropriately track utilization. Lam noted that workgroup members highlighted the unique workflow and billing/coding requirements of FQHCs. Finally, Lam observed that, overall, workgroup members generally agree that the use of modifiers is a viable option for tracking audio-only visits, but that education of providers and alignment on usage across delivery systems would be critical.

Lam opened the discussion for comments and questions from members, asking specifically for any key considerations not already summarized in her comments or in the materials provided.

Member Comments

Members representing Provider Organizations

- One member noted that it will be important to consider what audio-only services will be covered after the federal public health emergency (PHE) ends for dual Medicare-Medicaid members. Right now, Medicare is covering a broader range of audio-only telehealth services but that coverage will likely be more limited post-PHE.
- One member encouraged DHCS to include specific modifiers for all modalities, including asynchronous modalities which are of particular use in tele-dentistry.

Lam continued reviewing policy approaches discussed in the second workgroup, outlining the policy approach: "Obtain and document in the patient record: (1) consent for the use of specific telehealth modalities; and (2) reason for use of the modality selected". Lam explained that the policy approach as presented was slightly adjusted from that discussed in the second workgroup to reflect that discussion and workgroup member comments.

Lam outlined key considerations raised in regard to this policy. Lam reviewed the general agreement across workgroup members that data collection is critical, while also acknowledging concerns as to whether the consent process is the best way to capture this information. Lam underscored the workgroup's broad consensus on the importance of patient consent, while also acknowledging that workgroup members differed in their perspectives on when and how often consent should be given. Lam noted that the importance of translation services and technology support have been recurring themes throughout workgroup discussions as a means of ensuring consent is fully and appropriately conveyed to the patient. Finally, Lam commented that workgroup members highlighted how patient modality preferences may change throughout the visit and thus policies should be mindful of how to account for those preferences.

Lam opened the discussion for comments and questions from members, asking specifically for any key considerations not already covered in her comments or in the materials provided.

Member Comments

Members representing Consumers/Consumer Organizations

- Members emphasized the importance of consent and the need for consent processes to be in the appropriate language and format that a patient can understand.
- Members opined that documenting patient preferences on audio vs. video visits, and why patients chose one over the other, would be helpful in better tracking access and equity metrics. Specifically, one member recommended that

providers ask patients – and document their responses – about connectivity (e.g., "Do you have broadband? Do you have a device that permits you to engage in telehealth?") as a means of illuminating whether patients are choosing a modality because of personal preference of technological barriers. Another member noted that there are potential ways beyond patient consent that connectivity information could be collected.

- Members commented that consistently asking patients for consent is important, and the consent process could – and should – likely take several different forms, including asking patients for consent during initial intake as well as throughout their clinical experience.
- One member requested that DHCS keep in mind the importance of clear communication to consumer advocates and consumers about consent policies.

Members representing Payer Organizations

- One member questioned whether a provider asking a patient for consent and/or repeatedly inquiring into a patient's connectivity is the best way of capturing patient connectivity data. This member highlighted the importance of patient-centric policies, remarking that repeatedly asking patients for consent to telehealth may not be beneficial to clinical outcomes or patient-centric in its approach. This member compared asking for telehealth consent to asking patients if they would like to switch providers as a means of demonstrating that some important questions (e.g., if a patient would like to switch providers) are not typically repeatedly asked.

Members representing Provider Organizations

- One member further reiterated the importance for patient-centric consent processes, noting that asking why a patient choses one modality over another may infringe upon that patient's right to privacy.

Jared Augenstein introduced the subsequent policy approach: "Activate Common Procedural Terminology (CPT) codes for capturing telephonic evaluation and management and assessment visits in fee-for-service (FFS) Medi-Cal". Augenstein noted that this is a new proposed policy relative to what was discussed in the second workgroup. Augenstein explained that this policy would activate 99441, 99442, and 99443 codes as well as 98966, 98967, and 98968 codes, none of which are currently covered in fee-for-service Medi-Cal. Furthermore, given a significant number of telephonic evaluation and management (99441-3) and assessment and management (98966-8) claims in managed care, it appears that some Medi-Cal managed care plans may be covering these codes.

Augenstein posed several questions for the workgroup, including how this policy might support DHCS's expansive coverage of the delivery of services via audio only; whether there is a reason DHCS should not cover these codes; and whether there are other considerations for using telephonic codes versus regular E&M codes with an audio modifier.

Palav Babaria, Deputy Director and Chief Quality Officer, Quality and Population Health Management, acknowledged the challenge of communicating billing and modifier changes across the system, noting the beneficial role of standardization across modifiers at the state and national level.

Augenstein opened the discussion for comments and questions from members, asking specifically for any key considerations not already covered in his comments or in the materials provided.

Member Comments

Members representing Provider Organizations

- Members raised that the telephonic Evaluation and Management (E&M) CPT codes (99441-3) can be challenging for FQHCs to utilize because of the definitional requirements for eligible billing provider types and other definition requirements (e.g., that they cannot be billed in the 24 hours preceding or 7 days following an in-person visit) that do not always align with FQHC workflows or patient population needs.
- One member stated that their managed care plans do not use the codes described, highlighting that not all managed care plans are currently in alignment on code definitions and usage.
- One member commented that providers believe Medicare currently values these codes at a low relative value unit (RVU) level and thus if DHCS does decide to leverage these code definitions, it would be worthwhile to set reimbursement at a level at which providers would be incentivized to use them.
- One member noted that the 99441-3 codes are not on the list of E&M codes eligible for Proposition 56 Supplemental Payments through Family Planning Access Care Treatment (Family PACT, FPACT). This member also shared that electronic claims systems can occasionally have limits on the number of modifiers they accept.

Augenstein continued to the subsequent policy approach discussed in the previous workgroup: “Providers who offer telehealth must be located in California (with some exceptions for specialty care)” and “‘Telehealth-only providers’ or ‘third-party telehealth providers’ without a physical location would be required to register with DCHS and submit annual data reports showing utilization and encounters among Medi-Cal beneficiaries”.

Augenstein reviewed AB 457, which addresses third party telehealth providers and mandates patient consent and notification requirements and health plan reporting on services delivered by third-party telehealth providers. Medi-Cal is currently exempt from AB 457 regulations, but the statute directs DHCS to consider whether it is appropriate to adopt AB 457 requirements.

Augenstein reviewed key considerations raised by workgroup members in previous discussions: members noted that out-of-state and third-party telehealth providers may help ease current and potential workforce shortages. Additionally, members raised

concerns about third-party telehealth providers targeting low-acuity services and potentially not connecting in local in-person services thereby resulting in fragmented information sharing and disjointed care.

Augenstein opened the discussion for comments and questions from members, asking specifically for any key considerations not already covered in his comments or in the materials provided.

Member Comments

Members representing Provider Organizations

- One member questioned whether the policy as written would bar California providers from providing telehealth services to a patient in California when that provider is out of state (e.g., for an academic conference).

Members representing Consumers/Consumer Organizations

- One member emphasized the importance of ensuring that telehealth providers providing services to California communities have an anchor in the local community. Another member commented that for out-of-state providers who are contracted with in-state purchasers, it is the role of the purchaser to ensure that out-of-state providers are making the appropriate referrals and providing the appropriate data.

Members representing Research and Policy Organizations

- One member observed that the intent of this policy is to ensure meaningful consent and choice to see a provider in-person or through virtual care. Thus, all payers – including DHCS – should ensure that policies do not calcify the currently-existing silos of in-person care. This member noted that, if payers are working to drive telehealth adoption and create care coordination, whether providers are located in California or outside of California, it would be important for the department to embrace hybrid models that connect telehealth providers with local community providers. This member explained that, without connections to local community providers, telehealth providers may refer patients to urgent care centers or the emergency room, thereby increasing costs and fragmentation.

Augenstein continued to the final policy approach discussed in the second workgroup: "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: (1) time (providers whose telehealth time exceeds hours in a week or month; (2) volume (providers who bill a higher ratio of telehealth vs. in-person visits relative to others in their specialty); (3) time and volume (unexplained increase in volume; shorter appointment times that do not meet standard of care); (4) standard of care (providers billing for services that cannot be accessed by patients without being physically present); (5) consumer complaints (patients who are limited English proficient or with disabilities being turned away due to providers' lack of accessibility/assistive tools)."

Augenstein reviewed considerations previously raised by workgroup members: members questioned whether existing, in-person monitoring policies can be used for or adapted to telehealth modalities; members opined that tracking whether a patient is offered a full array of services across modalities may serve as an indicator of access and equity; members noted that creating long-term policies requires thinking creatively about the future uses of telehealth beyond its uses today.

Augenstein opened the discussion for comments and questions from members, asking specifically for any key considerations not already covered in his comments or in the materials provided.

Member Comments

Members representing Payer Organizations

- A member noted that the proposed policies are challenging to monitor at the individual provider level. Additionally, this member inquired into whether these policies are being considered more as prospective or retrospective review. Augenstein confirmed that these policies would drive retrospective review.
- One member highlighted the importance of considering monitoring policies in the context of overall policy decisions, citing the fact that a telehealth-only provider would by definition have a high telehealth volume. Additionally, this member underscored the importance of recognizing provider preference in modality delivery, noting that some providers (e.g., behavioral health) are choosing to practice solely through telehealth. This member cautioned the department about thinking through whether any policy would disallow a provider from practicing in his/her preferred modality, as doing so may unintentionally and adversely affect workforce volumes.

Members representing Provider Organizations

- A member commented that policy-makers should be wary of defining time and volume parameters, given that the industry does not yet have insight into the baseline of telehealth volume in a post-PHE environment.
- Additionally, a member observed that variations in time and volume will likely vary by patient population, service type, and specialty needs.

Lam transitioned the discussion to the next section: other policy approaches that will help achieve DHCS's guiding principles for telehealth. Lam emphasized DHCS's goal of ensuring equitable access to the modality type that best fits the needs of a patient and meets standard of care.

Babaria shared there is emerging evidence which will help the country better understand how to leverage different clinical modalities for different clinical needs. Babaria asked the workgroup to discuss what information is currently known in regards to which modalities are best utilized for which clinical use cases; she also encouraged the workgroup to think about how to craft policies that ensures the Department can iterate in the future.

In regards to health equity, Babaria noted that there are clear disparities in broadband and technology access. She asked the workgroup members to consider how policies might be designed so as not to exacerbate existing disparities.

Lam outlined the first proposed policy approach for discussion: “Provide patients the choice of video or audio-only modalities when care is provided via telehealth, if the care can be appropriately delivered via more than one modality”. Lam explained that DHCS’s Medi-Cal telehealth policy does not require Medi-Cal providers offering services via telehealth to offer a specific set of telehealth modalities; patient choice of telehealth modality is limited to those modalities offered by any given Medi-Cal provider.

Augenstein outlined a few questions for workgroup member consideration, including: how DHCS should balance patient choice of telehealth modality with delivery of services via the most clinically appropriate modality; what do we know about patient choice in commercial coverage, and are we creating worsening health disparities if Medi-Cal beneficiaries have less choice; how might this policy approach impact access to care if some providers are unable to offer both modalities; should DHCS consider implementing this policy over time to accommodate providers who haven’t yet adopted video; what other policy approaches should DHCS consider to ensure patient choice in telehealth modalities.

Babaria emphasized that policy makers have an opportunity to reduce clinical access disparities and create uniformed access to telehealth coverage.

Augenstein opened the discussion for comments and questions from members in response to the proposed policy approach.

Member Comments

Members representing Consumers/Consumer Organizations

- One member highlighted the importance of acknowledging that, while telehealth has existed for a long time, it’s current scale is distinctly new. Another member opined that policy makers and providers should trust patients to know what they need, arguing that if patients have resources to access telehealth services and are informed on the different types of services, those patients can make appropriate clinical decisions.

Members representing Provider Organizations

- Members were in general agreement that restricting access to services is disadvantageous to patients. One member noted that what patients or providers deem “clinically advantageous” may differ based on a patients location or other needs. Another member highlighted the importance of gathering information on what is working well in telehealth and that it would be unfortunate to prematurely restrict access to care, especially when the industry does not fully understand the ramifications of telehealth on outcomes. One member reiterated that the Department should include asynchronous telehealth in its policies.

Members representing Payer Organizations

- A member highlighted that access disparities currently exist between commercial and Medi-Cal patients, emphasizing the importance of ensuring that any policies regulating access not increase existing access disparities. This member encouraged the workgroup and the Department not to think about telehealth as a replacement of in-person service, but an extension of that service. Additionally, this member noted that health plans already have regulations in place that allow monitoring of fraud, waste, and abuse and thus this member is unsure if additional, telehealth-specific regulations are warranted.

Lam moved to the subsequent potential policy approach: "Ensure patients have the opportunity to access in-person services", outlining DHCS's current telehealth policy, which gives providers the flexibility to use telehealth as a modality for delivering medically necessary services to their patients. DHCS does not require providers to offer in-person services if they also offer services via telehealth.

Lam outlined a few questions for member consideration, including: should providers be required to offer in-person services or refer to in-person services; are there some clinical areas or specialties that should be exempt from such requirements; how would this policy be implemented by providers and plans; what is the optimal way for patients to be notified of the opportunity for in-person access; how might this policy approach impact access to care and health disparities.

Babaria asked the workgroup to reflect on whether this policy should be adjusted based on certain specialties or populations.

Augenstein furthered Babaria's comment, posing the question of what it means to offer a referral (i.e., is a referral connecting a patient to his/her typical source of care, or is a referral simply connecting that patient to any in-person provider). Augenstein opened the discussion for comments and questions from members in response to the proposed policy approach.

Member Comments

Members representing Consumers/Consumer Organizations

- One member shared that they would encourage in-person visits because in-person visits help identify certain aspects of a patients history and current health status (e.g., human trafficking and abuse).
- Another member commented that, while annual notices are helpful in reiterating to patients their right to in-person services, annual notices should not be the sole basis of highlighting beneficiary choice. This member recommended notification at the time of scheduling or through an online patient portal.

Members representing Payer Organizations

- A member reiterated the importance of provider education to knowing what types of questions to ask patients who may be at-risk of human trafficking so that they can identify those patients over different modalities.

Members representing Provider Organizations

- Members agreed that the availability of in-person visits is important, and that the necessity of in-person care can vary by specialty and patient need.
- One member noted the importance of timeline in the consideration of this policy approach, rhetorically asking the workgroup whether an in-person visit that is booked 4 or more months out would qualify as appropriate access to in-person care. Additionally, this member opined that being offered an in-person visit with a provider he/she has never seen before should not be considered access to in-person services.
- A member agreed with a previous comment, noting that annual notifications on patient rights to in-person care are helpful but insufficient, indicating that notice of in-person options should be repeated in multiple ways so patients are aware of their modality choices.
- Members generally agreed that the need for in-person services varies by specialty; mental and behavioral health was cited as an example of a specialty that will likely permanently shift to increased telehealth post-PHE.
- One member emphasized the dramatic provider shortage across specialties, noting that wait times for in-person visits, even in the commercial context, are long, and thus it is important to optimize the choices patients have for timely and clinically appropriate care.

Lam continued the conversation, transitioning to another potential policy approach: "Allow new patients to be established via telehealth (video or audio-only) subject to certain protections". Lam reviewed DHCS's current telehealth policy, which does not discuss the establishment of new patients via telehealth.

Augenstein posed a few questions to the workgroup, including: how might this policy approach impact access to care; what protections or criteria should be met in order to establish a new patient via telehealth; are there clinical areas or specialties where it would be clinically inappropriate to establish a new patient via a video visit or audio-only visit; how might this approach impact certain quality or outcome measures that require in-person care and are there policy modifications to guard against that.

Babaria offered additional context for this policy, asking the workgroup whether there are criteria for when patients need to be seen in person after an initial telehealth visit, how children should be considered in this policy, and whether there should be a requirement on when an in-person follow-up should or needs to occur.

Augenstein opened the discussion for comments and questions from members in response to the proposed policy approach.

Member Comments

Members representing Consumers/Consumer Organizations

- Members raised the importance of thinking about this policy from the patient perspective. A member commented that home health and rural health patients

have a hard time accessing the healthcare system and that while CalAIM is working to support unhoused populations, unhoused populations have a hard time accessing clinical care.
- One member noted that it may not be clinically appropriate to establish a new patient via telehealth, encouraging the Department to consider the impact of these policies on youths, schools, and youth initiatives.

Members representing Provider Organizations
- Members were in agreement that access barriers that existed prior to the PHE continue to exist and thus policies should be sure to not exacerbate existing barriers to care.
- Members commented that while not every service is appropriate for telehealth, clinical teams have established that they are capable of making decisions on what is clinically appropriate and which modality best-fits the needs of patients. Members referenced that, during the PHE, patients who historically were not able to access services (due to transportation issues, childcare issues, challenge getting time off work, etc.) were able to do so, and thus it's essential for policy makers to not put up barriers to accessing care.
- Additionally, members noted that in-person services are sometimes inaccessible to patients (e.g., they have to travel very far, long wait times), and thus any policy that restricts access to telehealth must ensure that access to in-person services can be provided, including transportation that would help access that care.

Members representing Payer Organizations
- A member commented that establishing a patient via telehealth should be allowed as long as the telehealth modality is appropriate for the type of service being delivered, noting that it would likely be advisable for the patient to be later seen in-person, depending on the condition.

Lam transitioned the conversation to the final potential policy approach for consideration: "Allow the use of synchronous telehealth to meet patient access to care standards ("network adequacy")".

Lam outlined that currently, if managed care plans are unable to meet time or distance requirements for patient access to care in their provider networks, they can request an Alternative Access Standard for greater distance or travel time than the access to care standard. DHCS is considering allowing certain providers/services to utilize telehealth as a means to account for patient access to care standards rather than having to utilize an Alternative Access Standard.

Augenstein posed several questions for the workgroup, including: how should access to services via telehealth be accounted for in meeting patient access standards; how might this potential policy approach impact access to care and health disparities, particularly in medically underserved communities; are there potential unintended consequences of this policy approach; should this policy approach be limited to specific telehealth modalities.

Augenstein opened the discussion for comments and questions from members in response to the proposed policy approach.

Member Comments

Members representing Consumers/Consumer Organizations

- Members were in agreement that workforce shortages are extremely relevant for network adequacy considerations, noting that the intent of telehealth is not to replace in-person providers. One member suggested that speaking with the Department of Managed Health Care about their use of telehealth and network adequacy may be helpful in better understanding the role of telehealth and network adequacy.
- Two members flagged their concerns about network adequacy and telehealth. One member shared that they would like to see how this policy would be implemented, suggesting further study into telehealth meeting network adequacy needs in conjunction with closely tracking federal reforms.
- Another member highlighted the importance of alternative payment mechanisms, citing the importance of billing for patient and provider education. Furthermore, this member noted incorporating incentives for providers who may not be a part of large health systems to continue adapting to new technologies, including tablets and interpreter services.

Members representing Payer Organizations

- Members commented that access to services via telehealth should not be a replacement of in-person visits. Members noted that the network adequacy parameters for telehealth may vary by provider or specialty type.
- One member reflected on the importance of crafting this policy with the future of Medi-Cal beneficiaries in mind, acknowledging that younger generations have grown up in the digital space and thus are more likely to seek out their services through digital platforms. Thus, in crafting network adequacy standards, it is important to acknowledge that limiting telehealth would potentially not meet the preferences of certain subgroups or populations.

Linette Scott, Deputy Director and Chief Data Officer, Enterprise Data and Information Management, introduced herself and thanked the workgroup for a thoughtful discussion. She noted that her team had worked to present data that the workgroup had requested in previous meetings. She explained that the utilization analysis consisted of paid claims for the 20 most commonly-used CPT codes for outpatient telehealth visits from April 2020 through March 2021, that the claims included both fee-for-service and managed care, that the outpatient visits included outpatient medical and non-specialty mental health services and did not include specialty mental health services.

Scott walked through several graphs that illustrated the following:

- Of Medi-Cal members with three or fewer total claims, about half were office-only utilizers; at all levels of utilization, it was much more common to have office-only utilizers than telehealth-only utilizers

- About one in five of new patient E&M claims were via telehealth across age groups
- For established patient E&M claims, telehealth represented one-third or more of all claims for each age group; older patients were more likely to have telehealth claims
- Fewer than one in five new patients E&M claims were via telehealth for both sexes
- Just over one-third of established patients E&M claims for both female and male members were via telehealth
- Across all race/ethnicity groups, new patient E&M claims via telehealth were around 20% or less of all claims
- Asian/Pacific Islander established patients had the highest percent of telehealth E&M claims; American Indian/Alaska Native patients had the lowest; all racial/ethnic groups had about 33% or higher telehealth claims
- For new patient E&M claims, telehealth represented around 20% of visits across aid codes; pregnant and presumptive eligibility aid codes had the lowest percent of telehealth claims;
- Pregnant members had the lowest percent of telehealth visits for establish patient E&M claims; for most aid codes, telehealth claims were about one-third of claims
- As utilization increases, adult age groups represent an increasing share of utilization; a trend that holds across modalities (in-person-only, mixed, and telehealth-only)
- Individuals who are Hispanic represent 50% of Medi-Cal members, 52% of members with at least 1 E&M claim, and 43% of members with 4+ telehealth only claims
- Females represent 50% of Medi-Cal members, 60% of members with at least 1 E&M claim, and 58-66% of members with 4+ claims across service modalities
- Chinese-speaking members had the highest percent of telehealth-only claims; Hmong-speaking members had the highest percent of office-only claims

Scott opened the discussion for comments and questions from members in response to the data presented.

Members Questions and Comments Regarding Data

Members collectively thanked Scott for her and her team's efforts to share these data. Several members expressed interest in the root cause of the trends illustrated by the data.

Several members expressed interest in further stratification of the data:

- by geography or health plan, overlaying a broadband connectivity map
- by more discrete age ranges to better understand trends across youth populations
- by county to illustrate trends for rural vs. urban populations.

Babaria reviewed DHCS's telehealth research and evaluation plan. She noted that questions remain on the cost of care and how telehealth can be best utilized to support workforce shortages. Babaria reinforced the workgroup's comments that telehealth can reach historically underserved communities, while simultaneously acknowledging that DHCS needs to better understand how to address the digital divide. Babaria outlined that DHCS will be seeking expert input in the search and evaluation development process, including telehealth researchers and input from workgroup members. She emphasized that the Department is aware of important efforts being done across the states, and highlighted that it is the Departments goal to support and compliment those efforts. She explained that the Department is developing methodologies which will ultimately contribute to a final research and evaluation plan.

Babaria outlined high level research questions that will contribute to DHCS's Evaluation and Research plan, including:

- How is telehealth evolving over time
- How is the mix of service modalities (telehealth, in-person) changing over time
- How does telehealth contribute to access to care
- How does telehealth contribute to the quality of care
- How is the use of telehealth impacting the total cost of care
- What are provider experience with using telehealth
- What are Medi-Cal members experience with using telehealth
- How do these initiatives fit into CalAIM initiatives

Babaria opened the discussion for comments and questions.

Member Comments on Research and Evaluation Plan Development

- One member expressed the importance of leveraging data to identify fraud, waste, and abuse of the system, noting North Carolina's use of dashboards as a generalized way of identifying trends.
- One member noted that, in regards to access, the Department could look at reduced wait times and reduced no show rates; in regards to equity, the Department could look at whether there are differences in certain populations accessing different modalities more easily than others.
- One member commented that quantitative data is essential, but that qualitative data also plays an important role in research and evaluation; this member recommended having conversations with providers to receive feedback on utilization management processes. This member also recommended looking at medical records to see if the services provided demonstrate quality of care.
- One member underscored the importance of establishing a data baseline for telehealth and the challenge of doing so given the increased use of telehealth during the COVID-19 pandemic.

Mollow thanked members for their thoughtful contributions, and outlined ways that workgroup members could continue their engagement with DHCS as the Department looks to make policy recommendations for the Governor's budget. She reviewed events to date, noting that the three Telehealth Advisory Workgroup meetings, post-meeting

surveys, interviews, and input submitted through the DHCS mailbox have all contributed to current understanding. Moving forward, DHCS will draft a workgroup recommendations report that reviews and summarizes workgroup member input. Mollow noted that workgroup members will have the opportunity to provide feedback on this report during an open review period in November. Additionally, throughout the budget process, Mollow encouraged workgroup members to remain engaged, noting that DHCS will host webinars to review the proposed 2022-2023 budget and welcome workgroup member feedback.

Lam opened the discussion to public comment.

Public Comment

- An individual with the American Association of Orthodontists (AAO) emphasized the importance of standard of care, and establishing guardrails that ensure patient safety. This attendee commented that the AAO has been investigating telehealth policies and will look to share more through a submitted letter.

- An individual with Behavioral Health and Recovery Services inquired into how network adequacy standards would apply to telehealth.
    - Lam explained that the potential policy approach discussed during the session was whether to allow the use of synchronous telehealth to meet patient access to care standards.

- An individual with the Program of All-Inclusive Care for the Elderly (PACE) noted the benefit of allowing new patients to be established via telehealth, outlining that their patient populations can be uncomfortable coming into a PACE center due to the COVID-19 pandemic. This individual shared that a new patient can be established via telehealth and once enrolled in PACE, that patient can be seen across a variety of modalities as deemed necessary.

Closing Remarks

Mollow thanked everyone for their attendance and thoughtful discussion. Mollow closed the meeting.