# DEPARTMENT OF HEALTH CARE SERVICES
## Telehealth Advisory Workgroup
## October 6, 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; Lisa Harris, Indian Health Council; 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; Rebecca Picasso, Blue Shield of California; 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.

**California Department of Health Care Services (DHCS) Staff Attending (alphabetical):** Palav Babaria, Autumn Boylan, Mayra Cano, Bambi Cisneros, Carol Gallegos, Phillip Heinrich, Catherine Hicks, Yingjia Huang, Jacob Lam, Muree Larson-Bright, Linh Le, Karen Mark, Rene Mollow, Christina Moreno, Lisa Murawski, Bill Otterbeck, Kelly Pfeifer, Susan Philip, Raul Ramirez, Melissa Rolland, Michael Rowe, Linette Scott, 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:** 67 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**

Mollow reviewed the workgroup agenda and noted that DHCS appreciated workgroup members taking the time to submit their surveys after the first workgroup meeting. She emphasized that DHCS heard members' concerns about the speed of the workgroup, and conveyed that stakeholder engagement will continue past the third workgroup on October 20th, 2021, and into the new year during the budget process.

Mollow emphasized DHCS's belief that telehealth played an important role in improving access and reducing barriers to care during the Public Health Emergency (PHE) and noted that DHCS has already significantly expanded telehealth coverage and reimbursement in response to the pandemic and is committed to extending most of those policies on a permanent basis after 2022.

Mollow explained that video and audio-only synchronous telehealth is currently covered by Medi-Cal and that DHCS intends to continue this policy after 2022. Additionally, Mollow explained that DHCS is looking at a continuation of asynchronous telehealth (e.g., store and forward and e-consults) beyond 2022 and intends to expand asynchronous telehealth to 1915(c) waivers, Targeted Case Management (TCM), and Local Education Agency Medi-Cal Billing Option Program (LEA-BOP).

Mollow emphasized that DHCS has already implemented parity in reimbursement levels between in-person services and telehealth modalities (synchronous video, synchronous audio-only, or asynchronous store and forward, as applicable), so long as those services meet billing code requirements. Mollow explained that DHCS intends to continue this policy after 2022 and continue the use of cost-based reimbursement for TCM and LEA BOP telehealth services. She noted that behavioral health reimbursements will be cost-based until behavioral health payment reform via the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

Mollow explained that brief virtual check-ins are covered by Medi-Cal for physical health and DHCS intends to continue this policy after 2022 and expand coverage of virtual community to 1915(c) waivers, TCM, and LEA-BOP.

Mollow also explained that telehealth in Federally Qualified Health Centers and Rural Health Centers (FQHCs/RHCs) will be reimbursed at a Prospective Payment System (PPS) rate for synchronous video, synchronous audio-only, and store and forward, and are not subject to site limitations for either beneficiary or provider. Mollow noted DHCS intends to continue these flexibilities after 2022.

Mollow also discussed policies that have already been implemented or are in process. Specifically, she discussed Remote Patient Monitoring (RPM), noting that RPM is covered by Medi-Cal for dates of service on or after July 1, 2021 and that request for federal approval is under development. She further noted that telephonic enrollment for minor consent will continue after the PHE through the Medi-Cal Eligibility Procedures Manual Updates as permanent policy and MEDIL I12-09 has been issued to reflect this policy.

Mollow opened the discussion for comments and questions from members.

**Member Comments:**

- *Members representing Provider Organizations*

Members noted that previous guidance indicated health centers were not allowed to establish patients using asynchronous modalities, and thus requested more detail on what exclusions would be included under asynchronous telehealth policies.

- *Members representing Payer Organizations*

Members inquired into whether there were any current telehealth policies in place because of the PHE that DHCS did not intend to continue.

Mollow noted that the Telehealth Policy Commitments document that DHCS shared prior to the second workgroup meeting outlined the policies that DHCS is committed to continuing at this time and that these future policies would also be informed by this workgroup and other standard policymaking processes.

- *Members representing Research and Policy Organizations*

A member inquired into whether RPM and e-consults would continue post-PHE.

Mollow noted that e-consults are between two providers and that e-consults are not currently covered by Medi-Cal for FQHCs per Centers for Medicare and Medicaid Services' (CMS) policy. Mollow also noted that there is a dedicated code set for RPM and that DHCS is working to seek the relevant federal approvals for offering this benefit.

- *Members representing Consumers/Consumer Organizations*

One member inquired into whether texting would be included under the modality of a brief encounter. Regarding behavioral health, members inquired into whether group therapy was considered a billable service for telehealth and whether community health workers would be able to bill for their services.

Mollow noted that texting is not included in the scope of the workgroup, but that DHCS is open to continuing the discussion after January.

Kelly Pfeifer, Deputy Director, Behavioral Health, noted that group therapy can be done by telehealth during PHE flexibilities, but noted that there are open concerns about the quality of group therapy over audio-only modalities. Pfeifer also noted that community

health workers are not eligible billing professionals for E/M codes but there are other codes which allow a broad range of provider types, including CHWs.

Palav Babaria, Deputy Director and Chief Quality Officer, Quality and Population Health Management, introduced herself to the workgroup. Babaria noted quality and health equity are central to DHCS's agenda, and encouraged all workgroup members to anchor their thinking in quality and equity.

Babaria emphasized the importance of telehealth while also acknowledging the operational challenge of telehealth implementation. She noted that certain forms of telehealth have shown improvements in equity and quality, and help close gaps in disparities, but also noted how much the industry has to learn in regards to telehealth clinical care. She posed a few key considerations to the workgroup, asking members to think about:

- Potential unintended consequences of DHCS recommendations that might worsen quality or disparities;
- How to promote a consistent telehealth experience across the state;
- Whether certain forms of telehealth have been shown to improve equity and quality more than others.

Mollow reviewed the workgroup's charge, noting that the workgroup is charged with advising DHCS on how to refine its telehealth policies to ensure the policies are designed optimally for a post-PHE world. She discussed several topic areas of focus that DHCS was hoping the workgroup could help define. Specially, in regards to 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. In regards to ongoing monitoring and evaluation, how DHCS should measure and review telehealth utilization to facilitate consumer protection and Medi-Cal program stewardship. In regards to 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.

Mollow noted that DHCS recognizes telehealth utilization is significantly higher than it has been in the past and is expected to remain high.

Mollow outlined that policies and proposal recommendations from this workgroup will be put into practice via DHCS's development of budget proposals and Trailer Bill Language (TBL), State Plan Amendments or waiver amendments, State policy and operational guidance, and/or DHCS's research and evaluation agenda.

Mollow opened the discussion for comments and questions from members.

**Member Comments:**

- *Members representing Research and Policy Organizations*

Members inquired into the department's strategy to promote access, quality, and equity in telehealth, and further inquired into whether there would be a workgroup specifically focused on those issues.

Babaria noted that telehealth policy development is iterative and continuous. She asked the workgroup to reflect on what disparities in access and equity are currently known as a means of informing the department on how to be proactive in addressing access and equity concerns, while simultaneously recognizing that the process would be iterative.

- *Members representing Provider Organizations*

A member inquired into whether DHCS would provide more detail on how workgroup member feedback and engagement would be incorporated in the months after the three workgroup sessions.

Mollow noted that DHCS is committed to continuing engagement with the members of this workgroup after the third meeting.

Alice Lam transitioned the workgroup to begin discussion on potential policy approaches for consideration. Lam noted that California has been a leading state in the strength and expansiveness of its coverage and reimbursement policies for services delivered via telehealth. She reemphasized the charge of this workgroup to advise on how to pair Medi-Cal's strong policy foundation with billing, coding, and monitoring protocols and parameters, and the focus for this meeting on identifying billing and coding protocols that will provide more comprehensive and specific information about telehealth utilization as well as identifying monitoring policies to support consumer protection and program integrity. Lam highlighted that the third workgroup on October 20th, 2021 would focus on identifying other policies that will help achieve DHCS's telehealth guiding principles.

Lam reviewed the first potential policy approach of utilizing special modifiers to delineate video visits versus audio-only visits. Lam posed questions to the workgroup, including how different visits with mixed modalities should be handled (e.g., starting a visit as video and ending as audio-only); whether modifiers should be consistent across the different delivery systems in Medi-Cal; and asking generally what other policy approaches DHCS should consider to differentiate between video and audio-only

Babaria noted that DHCS recognizes the complexity of billing and wants to ensure that whatever the department implements is operationally feasible. She noted the importance of data-collection to inform policy-making decisions and that the billing and coding policies should be easily operationalized. Babaria further noted an interest in understanding the clinical situations where audio-only works better than video-only.

Lam opened the discussion for comments and questions from members.

**Member Comments:**

- *Members representing Provider Organizations*

Members noted that the telephonic evaluation and management CPT codes (99441-3) can be challenging for FQHCs to utilize because of the definitional requirements for eligible billing provider types. Additionally, the codes have other definition requirements (e.g. that they cannot be billed in the 24 hours preceding or 7 days following an in-person visit). Given those considerations, FQHCs recommend using modifiers for 'regular' CPT codes when providing audio-only services, rather than the telephonic E/M billing codes.

Members also noted their preference for billing how the visit was initiated, rather than how it ended. This would provide data on the intent of the provider which could be used to understand which services providers were intending to provide via video. Other members noted the importance of tracking asynchronous care.

Mollow confirmed that a modifier can be used to track asynchronous services.

One member noted the importance of ensuring that process requirements do not hamper patient outcomes, reminding the workgroup that regulations put in place should not be about compliance to a rule, but should be about promoting quality outcomes for patients.

- *Members representing Consumers/Consumer Organizations*

One member reemphasized the important difference in billing considerations between fee-for-service providers and managed care providers and of seeking to align requirements across fee-for-service and managed care plans.

Lam outlined another potential policy approach of documenting reasons for using audio-only instead of video in the patient record. Lam noted that during COVID-19, providers have been 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. Furthermore, Lam noted that during the PHE, for all telehealth modalities, providers are required to document verbal or written consent and provide appropriate documentation to substantiate that the appropriate service code was billed.

Lam posed several questions for the workgroup, including asking how DHCS can 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 rationale for audio-only; how specific patient consent for telehealth should be as it relates to selected modalities; what other policy approaches should DHCS consider to gain a more comprehensive understanding of reasons for audio-only use.

Babaria noted that different provider systems have different experiences and histories with telehealth, acknowledging that it's important to recognize the different starting point of providers and provider systems with regards to their technology and telehealth workflows.

Lam opened the discussion for comments and questions from members.

**Member Comments:**

- *Members representing Consumers/Consumer Organizations*

Members highlighted the importance of patient choice, recommending that consent be offered at every instance and every encounter and that patients be routinely informed – before each visit – of their rights to in-person care. One member noted that patients may not feel empowered as consumers, and thus documenting patient choice is a helpful guardrail for empowerment. Members noted consent should also include rights to technological support, if needed. Members underscored the importance of patient-centric language and access to providers and communication in the language of the patient, or else free and available translation services and interpreters, so as to ensure patients truly understand their rights and the consent process.

- *Members representing Provider Organizations*

Members commented that although patient consent is paramount, there are aspects of the consent process that would affect operations or access. One member noted that in the past, consent processes and other policies to ensure consent have acted as barriers by reducing providers' adoption of telehealth services, and thus reducing access to services for patients. Members noted that consent processes take time, and wanted to better understand how that time would be incorporated into a visit and billed for. One member noted the importance of keeping data collection in mind, and encouraged the workgroup to reflect on the end goal of the data (e.g., is the data purported to capture rationale for audio-only) and which approach – consent, documentation, billing/coding – would most appropriately track those data goals.

Lam posed a general question of what other billing and coding protocols are important to consider in this process, and what factors DHCS should consider when weighing implementation of billing and coding protocols. Lam opened the discussion for comments and questions from members.

**Member Comments:**

- *Members representing Research and Policy Organizations*

Members noted the importance of educational content for – and training of – providers to ensure providers know how to appropriately bill. One member noted that provider understanding and compliance is a key input into robust data.

One member noted that their research suggested audio-only patients were much most likely to face transportation, language, and technological barriers.

Jared Augenstein discussed an additional potential policy approach, posing to the workgroup whether providers who offer telehealth must be located in California (with some exceptions for specialty care). Augenstein noted that in current policy, an out of state provider who offers telehealth to Medi-Cal beneficiaries must be licensed in California, be enrolled as a Medi-Cal rendering provider, and be affiliated with an

enrolled Medi-Cal group that is located in California or a border community and meets all Medi-Cal program enrollment requirements.

Augenstein posed a few question for workgroup members, including: how might this potential policy approach impact access to, and continuity of, care; what principles or considerations should drive exceptions to this policy approach; and, what other policy approaches should DHCS consider putting in place for out-of-state providers.

Augenstein opened the discussion for comments and questions from members.

**Member Comments**

- *Members representing Consumers/Consumer Organizations*

One member noted the importance of thinking expansively about who touches a patient, particularly in a primary care setting (e.g., community health workers), and whether that should inform who is eligible for telehealth services. Another member noted the importance of access to out-of-state providers in the event of a state-wide emergency that disallows patients from accessing normal caregivers, and noted the potentially valuable role of license reciprocity.

- *Members representing Research and Policy Organizations*

One member noted research that demonstrated a high need for gerontologists, emphasizing that telehealth could be a beneficial way of increasing access to that needed specialty.

- *Members representing Provider Organizations*

Member noted the diversity of challenges that exist around networks, including the nuances of geographic challenges. For example, a patient located in northern California may be physically closer to a specialist in Oregon than their in-state specialist in the Bay area, and thus could see that out-of-state specialist in-person more easily than an in-state specialist in-person.

Additionally, a member noted that while behavioral health is not considered a specialty, lack of access to behavioral health providers in the state would benefit from out-of-state care. This member also noted the importance of clear policies and information sharing, as well as obtaining buy-in from managed care plans and behavioralists.

- *Members representing Payer Organizations*

A member reemphasized the need for thinking about rural border communities whose closest in-person options might be out of state. The member inquired into whether DHCS is considering applying policies to out of state providers that also offer in person services.

Mollow noted that DHCS has policies to permit out of state care when that care is not available in rural communities. A member noted the difficulty in enforcing that

rule, noting that limitations placed on out of state providers because they offer telehealth may limit their willingness to offer those services.

Augenstein moved discussion to the subsequent potential policy approach: whether telehealth-only providers or third-party telehealth providers without a physical location would register with DHCS and submit annual reports showing utilization and encounter among Medi-Cal beneficiaries. Currently policy dictates that 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. He noted that because of current-state policy, DHCS does not have information to delineate telehealth-only or third-party telehealth providers from other providers.

Augenstein posed a few questions for the workgroup, including: how this proposed policy would impact patient choice for in-person visits; how would third party telehealth providers add value and integrate into the delivery system; what other policies should be considered to encourage integration and coordination.

Babaria further posed for the workgroup the question of whether DHCS needs to think about telehealth-only providers depending on their specialty. She further noted the importance of data, and the potential for future national metrics to include telehealth quality.

Augenstein opened the discussion for comments and questions from members.

**Member Comments**

- *Members representing Provider Organizations*

One member noted two primary concerns of third party telehealth providers: first, a concern that third party providers only see low acuity patients. Second, a concern that encounters with these providers would not be documented with the patient's primary care physician, thereby creating increased fragmentation of clinical care.

- *Members representing Consumers/Consumer Organizations*

One member noted the importance of thinking about adolescents and youths when discussing modality, consent, and choice; for example, during a video visit, patients may switch off the video during sensitive moments. Additionally, a member noted the importance of capturing data on third party vendors, especially given the potential for third party vendors to be working with schools.

- *Members representing Payer Organizations*

One member noted that registration and submitting data reporting is an additional administrative burden on telehealth providers and may have unintended consequences, including affecting providers' willingness to provide care via telehealth.

Augenstein outlined a third potential policy approach under monitoring policies: whether DHCS should adopt utilization review procedures for telehealth services similar to those used for in-person services. This utilization review may include such criteria as: time, volume, time and volume, standard of care, and consumer complaints. Augenstein noted that DHCS currently conducts reviews based on fraud complaints, statutorily required reviews, and other reviews as needed to ensure Medi-Cal program integrity.

Augenstein outlined a number of questions for stakeholder consideration, including: 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.

Babaria noted that the goal of targeted reviews it to ensure equity and quality. She asked the workgroup to reflect on how DHCS can stratify audits by demographic variables to track disparities more regularly.

Augenstein opened the discussion for comments and questions from members.

**Member Comments**

- *Members representing Payer Organizations*
  One member noted that fraud, waste, and abuse monitoring policies already exist, hypothesizing that outliers for telehealth would probably be the same as those for in-person care and thus commenting that additional policies may not be needed.

- *Members representing Provider Organizations*
  One member noted that for tracking purposes, it would be important to know whether a patient is being offered a full array of services across modalities. This member noted that they didn't believe it would be easier to do anything clinically inappropriate over telehealth than in-person, but encouraged the workgroup to think creatively beyond how telehealth is being used today to how it could be used – and therefore how it should be monitored – in the future.

Dr. Linette Scott, Deputy Director and Chief Data Officer, Enterprise Data Information Management, introduced herself and provided an overview of the latest telehealth data. She noted that DHCS analyzed paid claims for the 20 most commonly used CPT code for outpatient telehealth visits from April 2020 to March 2021, including fee-for-service and management care claims. She noted that the data on outpatient visits included outpatient medical and non-specialty mental health services, further noting that the data do not include specialty mental health services.

Scott discussed preliminary data findings:

- The most commonly used procedure codes for telehealth services are Evaluation and Management services and psychiatric and mental health services;

- Established patient visits had twice the telehealth utilization of new patient visits;
- ~18% of new patient Evaluation and Management claims were telehealth during the time period;
- ~33% of established patient Evaluation and Management claims were telehealth during the time period;
- 50-60% of claims for treatment of speech, language, or hearing disorders were telehealth during this time period;
- About half of psychotherapy claims were telehealth and about 25-45% of mental health related services claims were telehealth;
- Nearly 75% of Medi-Cal members had no telehealth claims; 4% of Medi-Cal members had 9 or more telehealth claims during the time period.

Scott opened the discussion for comments and questions from members.

**Member Questions and Comments Regarding Data**

- One member inquired into whether there are codes beyond Evaluation and Management codes that are commonly used for telehealth, and also inquired into whether it would be possible to stratify data based on demographics.
    - Scott noted that the top 20 codes included mental health and treatment of auditory processing disorders. Scott further noted that there are patient privacy concerns with detailed stratifications, but if stratifications by demographic would be helpful, her team can work towards that data.

- One member inquired into how to benchmark telehealth utilization with in-person data, specifically inquiring into the context for what percent of the 75% of Medi-Cal beneficiaries that did not receive telehealth care received in-person care. They noted that higher utilizers of telehealth could prefer the telehealth modality, or those individuals could be higher acuity and thus need access to care in whichever form is most readily available.
    - Scott acknowledged the importance of better understanding what percent of non-telehealth users sought in-person care, and noted her team would look into that data more closely. She agreed that higher utilizers of care could be higher acuity or patients who prefer that modality.

- One member inquired into whether DHCS Data Team overlayed the decline in outpatient visits with the increase in telehealth visits.
    - Scott noted that there was a decrease in overall outpatient visits due to the COVID-19 pandemic, and that some areas of health saw no dip in overall visits and potentially even an increase in visits (e.g., mental health). Scott further noted that dental, and emergency care had a large decrease, but has since returned to relatively pre-PHE levels.

- One member inquired into whether the data included FQHC information, noting that it would be helpful to see FQHC data.
    - Scott noted that the data presented included FQHC information when FQHC data was coded with an appropriate telehealth modifier.

Augenstein discussed areas for further data analysis and research, including research into a broader set of CPT codes, demographics of high telehealth utilizers, claims requiring in-person evaluation but with telehealth modifier, outlier telehealth volumes, disaggregating 0-20 age data into smaller age groupings. He also noted that the data teams would incorporate today and future suggestions from workgroup members.

Augenstein outlined that DHCS would develop a research and evaluation agenda that would include when and how to conduct a more detailed assessment of Medi-Cal telehealth claims/encounter data, a consideration on how billing protocol design would inform future data collection and analytic possibilities, and short-term (1 year) and longer term (2-3 years) research agendas to understand the impact of telehealth utilization and access, quality of care and disparities, and utilization management and billing protocols.

Lam opened the discussion to public comment.

**Public Comment**

There were no public comments.

**Closing Remarks**

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