DHCS Medi-Cal Telehealth Advisory Workgroup Report

December 2021

DEPARTMENT OF HEALTH CARE SERVICES

I. Executive Summary

Background: Pursuant to Assembly Bill 133 (AB 133), for the purposes of informing the 2022 – 2023 Governor's Budget, the Department of Health Care Services (herein 'DHCS') was directed to convene a Telehealth Advisory Workgroup. AB 133 directed the Telehealth Advisory Workgroup to consist of subject matter experts and key stakeholders to advise DHCS in establishing and adopting billing and utilization management protocols for telehealth to increase access and equity and reduce disparities in the Medi-Cal program. From September to October 2021, the Workgroup met three times to advise DHCS on proposed telehealth policy options, review telehealth utilization data and insights, and discuss future telehealth research and evaluation objectives.

Proposed Policy Options: The Workgroup deliberated and discussed three proposed topics and corresponding potential policy approaches:

Topic 1: Billing and Coding Protocols	
Potential Policy Approaches	Use specific modifiers to delineate visits by telehealth modality, including by introducing a new audio-only modifier
	Obtain and document in the patient record: (1) consent for use of specific telehealth modalities; and (2) reason for use of the modality selected
	Activate Common Procedural Terminology (CPT) codes for capture of telephonic evaluation and management and assessment and management visits in Medi-Cal
Topic 2: Monitoring Policies	
Potential Policy Approaches	Require 'third-party corporate telehealth providers' without a physical location to follow protocols to ensure community linkages and continuity of care for Medi-Cal enrollees
	Adopt utilization review procedures for telehealth services similar to those used for in-person services
Topic 3: Other Policies to Support Guiding Principles	
Potential Policy Approaches	Provide patients the choice of telehealth modality when care is provided via telehealth, if the care can be appropriately delivered via more than one modality and meets the standard of care
	Ensure patients have the right to access in-person services

	Allow new patients to establish a relationship with a provider via telehealth subject to certain protections
	Allow the use of synchronous telehealth to meet Medi-Cal managed care enrollee access to care standards (network adequacy)

Note: Details regarding workgroup feedback and degree of alignment for each policy approach can be found in the full report. Key terms related to telehealth are included in the Appendix.

Workgroup input on potential policy approaches by member type:

Workgroup members representing consumers and consumer organizations were supportive of policy approaches that seek to ensure access to care and preserve patient choice. They emphasized the importance of obtaining meaningful consent, educating patients about their in-person and telehealth care delivery options, and allowing patients to choose the modality that best suits their needs and preferences. Members highlighted the necessity of ensuring telehealth policies appropriately address patients' needs for and rights to language access and services, such as virtual interpreter services.

Workgroup members representing provider organizations noted the benefits of telehealth on patient access to clinical care during the COVID-19 pandemic. Members advised DHCS that some new guardrails may increase administrative burden and urged DHCS to allow for provider discretion when determining how best to utilize telehealth for care delivery.

Workgroup members representing health plans highlighted the benefits of aligning Medi-Cal telehealth policies with those of other payers, noting that any new requirements implemented in Medi-Cal may restrict access and/or increase burden on providers serving Medi-Cal enrollees if similar rules are not adopted by commercial plans and other coverage programs. Members also underscored the benefits of telehealth on addressing patient access challenges and provider workforce shortages, particularly for rural communities.

Workgroup members representing policy and research organizations noted the important role telehealth played in the COVID-19 pandemic, citing the need for continued analysis and policy iteration as the state better understands how to best leverage telehealth as a tool to increase health access, equity, and outcomes.

A more complete summary of the input provided by Workgroup members organized by potential policy approach is contained in Section IV of this report.

Research and evaluation plan: In addition to further developing the policy approaches noted above, DHCS is in the process of defining a research and evaluation plan to study the impact of telehealth. DHCS will consider how best to assess telehealth utilization and its impact on access, quality and outcomes, and on provider and enrollee experiences. Equity is a cross-cutting component of DHCS' future research and evaluation approach. To that end, DHCS will seek to assess variations and disparities in telehealth access and utilization, quality and outcomes of care, and provider and enrollee experiences data by race/ethnicity, primary language spoken, sex, age, aid code, geographic region, and disability status (where feasible). The development of the DHCS research and evaluation plan is ongoing and as such is not available to inform the policy that will be recommended in the 2022-2023 Governor's Budget. The research and evaluation plan will be informed by feedback provided by the Workgroup and will build upon the telehealth data management and analytic work already undertaken by DHCS and the analyses presented to the Workgroup.

Next steps: DHCS is committed to crafting telehealth policies that reflect DHCS's guiding principles of access, standard of care, patient choice, equity, stewardship, confidentiality, and payment appropriateness. As DHCS continues to refine its telehealth policy approaches and research and evaluation plan, there are several immediate and longer-term steps DHCS will take to ensure its policy appropriately reflects Workgroup sentiment and Department goals. DHCS will:

- Prepare a budget proposal policy paper and policy and operational guidance for the 2022-2023 Governor's budget;
- Develop a telehealth research and evaluation plan that will outline key telehealth considerations as well as a roadmap for gathering and analyzing those data;
- Host webinars to review the 2022-2023 Governor's proposed budget policies, at which time DHCS will seek further Workgroup member and other stakeholder feedback.

II. Introduction to the DHCS Telehealth Advisory Workgroup

Pursuant to Assembly Bill 133 (AB 133), for the purposes of informing the 2022 – 2023 Governor's Budget, the Department of Health Care Services (herein 'DHCS') was directed to convene a Telehealth Advisory Workgroup. AB 133 directed the Telehealth Advisory

Workgroup to consist of subject matter experts and key stakeholders to advise DHCS in establishing and adopting billing and utilization management protocols for telehealth to increase access and equity and reduce disparities in the Medi-Cal program. From September to October 2021, DHCS convened a Telehealth Advisory Workgroup to advise DHCS on proposed telehealth policy options, review telehealth utilization data and insights, and discuss future telehealth research and evaluation objectives.

The Workgroup included representatives from seven legislatively-mandated organizations as well as dozens of DHCS-identified organizations and individuals that represent a diverse cross-sector of stakeholders. AB 133 mandated the advisory group include representatives from: the California Association of Public Hospitals, California Medical Association, California Primary Care Association, Essential Access Health, Local Health Plans of California, California Behavioral Health Directors Association (represented by Los Angeles County Department of Mental Health), and Planned Parenthood Affiliates of California. For DHCS-identified organizations, DHCS issued a solicitation and received approximately 90 responses, selecting organizations and individuals that represented a diverse cross-section of stakeholders. The full list of Workgroup members can be found in the Appendix.

The Workgroup met three times – on September 22, October 6 and October 20 – to advise DHCS on proposed policy options, review telehealth utilization data and insights, and discuss future telehealth research and evaluation objectives.[1] Workgroup discussions were guided by the charge set forth in AB 133. Members discussed issues related to a range of telehealth modalities, and in many cases discussions and policy approaches focused on modalities that experienced significant growth during the pandemic, such as synchronous telehealth and audio-only visits. Telehealth beyond existing Medi-Cal covered benefits, payment parity and reimbursement rates, and additional telehealth modalities (e.g., store and forward, remote patient monitoring) were considered out of scope for the Workgroup. Each Telehealth Advisory Workgroup meeting was open to the public with the public provided the opportunity to comment during a designated 15-minute public comment period. Following each meeting, DHCS

[1] Telehealth Advisory Workgroup meeting materials and summaries are available at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx

asked for additional Workgroup input via an electronic survey. Advisory Workgroup input from each survey was reviewed and synthesized, and directly informed refinements to policy approaches and areas for Workgroup discussion. In addition, throughout the Workgroup process, DHCS conducted a dozen one-on-one interviews with individual stakeholders representing a variety of organizations and perspectives. This report reflects the output of these Workgroup meetings, survey responses, DHCS data analyses, one-on-one interviews, and Workgroup member feedback on an initial report draft.

Workgroup members received a preliminary draft and had the opportunity to submit comments on how to improve the clarity and comprehensiveness on the issues and considerations discussed in the report.

Overall Report

Commenters suggested the report further detail the Workgroup's charge and scope, clarify telehealth terminology, and reframe references to other states' audio-only policies. We appreciate the importance of clarity in communication on Workgroup deliberations and telehealth policy, and included additional details to address these comments.

Commenters requested an acknowledgement of the report's focus on synchronous and audio-only telehealth over asynchronous telehealth. We acknowledge the policies discussed herein significantly focus on synchronous and audio-only telehealth.

Commenters recommended small grammatical adjustments throughout and these have been incorporated.

Section III – Current State of Medi-Cal Telehealth Policy and Utilization

Commenters were concerned with the perspective that telehealth may lead to over utilization and/or cost increases and requested clarification between 'telehealth' and 'telefraud.' We have adjusted language, outlined limitations of the sources cited, and noted that we will continue to monitor Medi-Cal and national trends.

A few comments suggested adjustments to the explanation of Medi-Cal's pre-PHE policies, included observations on PHE telehealth utilization trends, and recommended edits to Guiding Principle considerations. We did not adjust the report in response to

these considerations, because we believe this report appropriately reflects DHCS policies, utilization trends, and guiding principles.

Section IV – Proposed DHCS Telehealth Policy Approaches

Comments were received and addressed across all policy approaches. Commenters requested that their perspectives raised during workgroup discussion be included more specifically, suggested areas where previous and current DHCS policies be clarified, and/or recommended that the limitations of cited sources be considered. We amended the report to reflect members' perspectives, DHCS policies, and current research considerations where applicable.

Several comments were received regarding DHCS's proposed policy approach on consent requirements, requesting DHCS reference additional current policies and update discussion on when and why consent is obtained. New additions to this report reflect DHCS's prioritization of and commitment to obtaining meaningful consent.

Multiple comments on patient choice of modality highlighted the importance of understanding this policy's effect on health systems, other proposed policies, and DHCS's guiding principles. We appreciate the considerations from members and amended language to reflect additional details from Workgroup discussion.

Several commenters provided additional perspectives beyond what was discussed in the Workgroup's three sessions. We appreciate this reflection, recognize telehealth is an evolving field, and look forward to continued discussion.

Section V – Considerations for Telehealth Research and Evaluation

Commenters recommended variables for further data stratification and potential research questions. We agree that data stratification can be used to progress our aim of advancing equity by understanding variations and disparities across different populations, with a shorter-term focus on telehealth utilization and longer-term focus on additional domains. We were able to incorporate some of the requested additions within this report (e.g., disability status, geographic region), but are unable to commit to future data stratifications by sexual orientation and gender identity due to insufficient data at this time to support this stratification.

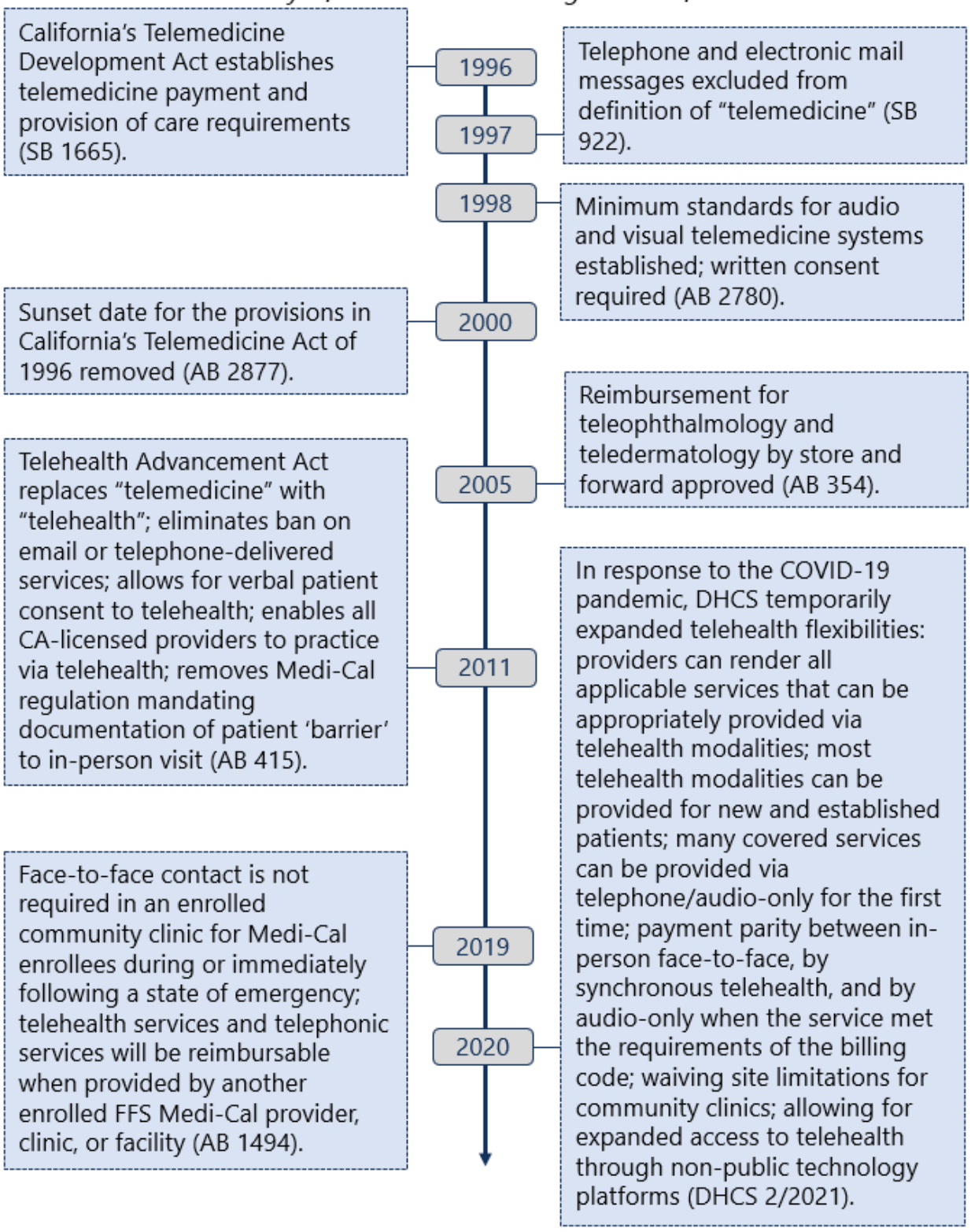
III. Current State of Medi-Cal Telehealth Policy and Utilization

Medi-Cal Telehealth Policy Pre-COVID-19 Pandemic

Medi-Cal's telehealth coverage began in 1996 with the passage of the California Telemedicine Advancement Act (SB 1665), which established telemedicine payment and provision of care requirements. Other legislation, as outlined in the figure below, continued to expand access to services through the 2000s. The passage of the Telehealth Advancement Act (AB 415) in 2011 laid the foundation for Medi-Cal to drastically expand coverage of telehealth in Medi-Cal, eliminating the ban on email and telephone-delivered services, permitting patients to verbally consent to telehealth, and enabling all California-licensed and Medi-Cal enrolled providers to practice via telehealth. Prior to the COVID-19 pandemic, many behavioral health services covered by Medi-Cal were available through telehealth.[2,3]

[2] California Department of Health Care Services, TN No 12-025, Approved 12/18/2012.
[3] Special Terms and Conditions to DMC-ODS letter of approval from the Centers for Medicare and Medicaid Services, 12/29/2020

History of Telehealth Coverage in California



Temporary COVID-19 Telehealth Policy Flexibilities

In response to the onset of the COVID-19 pandemic in 2020, DHCS implemented several flexibilities in order to meet the needs of Medi-Cal enrollees and ensure they could continue to receive necessary care. These included:

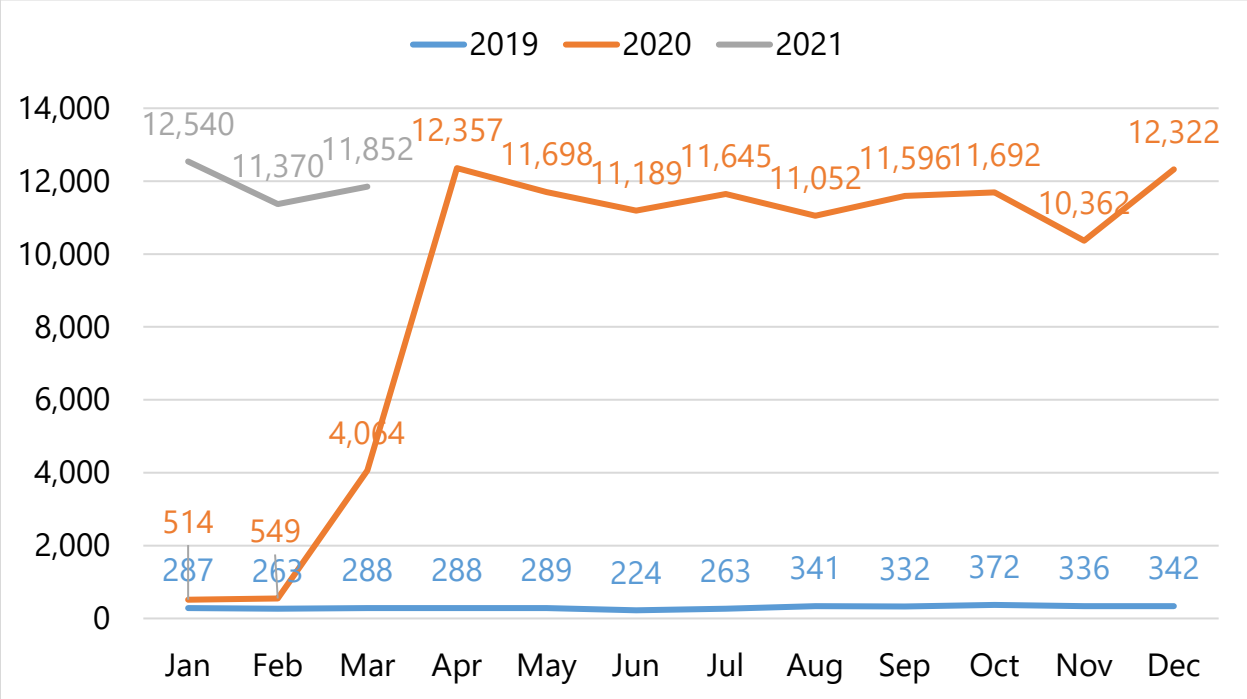
- Expanding the ability for providers to render all applicable Medi-Cal services that can be appropriately provided via telehealth modalities, including those historically not identified or regularly provided via telehealth such as home and community-based services, Local Education Agency (LEA) and Targeted Case Management (TCM) services;
- Allowing most telehealth modalities to be provided for new and established patients;
- Allowing many covered services to be provided via telephone/audio-only for the first time;
- Allowing payment parity between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/audio only when the services met the requirements of the billing code by various provider types, including Federally Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) in both FFS and managed care;
- Waiving site limitations for both providers and patients for FQHC/RHCs, which allows providers and/or patients to be in locations outside of the clinic to render and/or receive care, respectively; and,
- Allowing for expanded access to telehealth through non-public technology platforms.

Telehealth Utilization During the COVID-19 Pandemic

Medi-Cal claims data illustrate the rapid increase in telehealth utilization in response to the pandemic. As shown in the figure below, in February 2020, prior to the onset of the COVID-19 pandemic, telehealth represented only 549 claims per 100,000 Medi-Cal

enrollees.[4] By April 2020, telehealth claims increased significantly to over 12,000 claims per 100,000 enrollees and remained relatively stable through March 2021.

Telehealth Claims per 100,000 Enrollees, January 2019 – March 2021



To inform discussions by the Workgroup, DHCS analyzed telehealth claims data from April 2020 to March 2021 to understand utilization during the COVID-19 pandemic period. These detailed analyses are available in the meeting materials posted to the Telehealth Advisory Workgroup website.[5] To assess utilization and variation in utilization, these data analyses were stratified by enrollee demographics, types of modality use (e.g., telehealth visits, office visits), managed care plan and other factors. Visualizations were developed to graphically present variation in utilization.

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[4] California Department of Health Care Services. COVID-19 Impact on Medi-Cal Utilization. Preliminary data reported through April 2021; based on data extracted August 2021. Report date: September 21, 2021. https://www.dhcs.ca.gov/dataandstats/reports/Documents/COVID-19_Impact_Reports/Covid19-Impact-on-Medi-Cal-Utilization.pdf

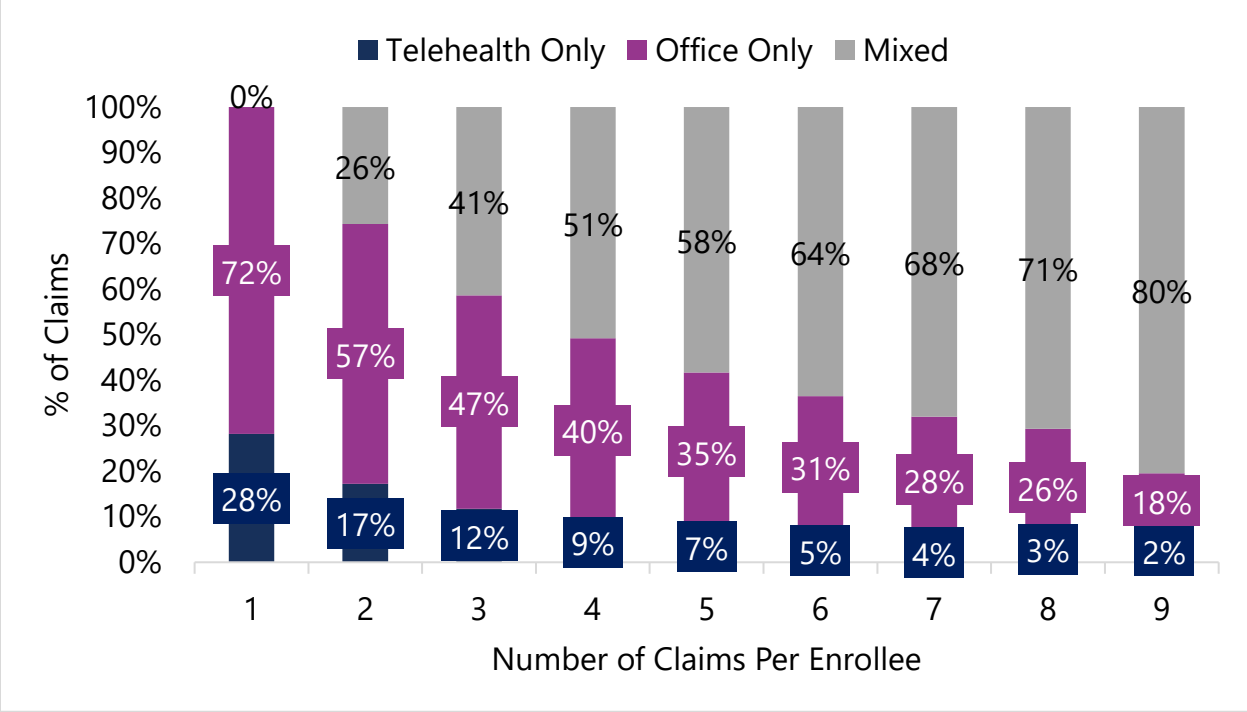
[5] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx

There are several limitations with the data and analyses. The data included only outpatient medical and non-specialty mental health claims, and did not differentiate between audio-only and video telehealth claims. In addition, FQHC or Indian Health Memorandum of Understanding (IHS-MOA) 638 clinic billing guidance did not require telehealth modifiers and as such, FQHC/IHS-MOA telehealth utilization is likely underrepresented.

The most common types of services delivered via telehealth were primarily evaluation and management (E&M) services and psychiatric and mental health services (see tables and figures in the Appendix). Between April 2020 and March 2021, about 18% of new patient E&M claims were via telehealth while 33% of established patient E&M claims were via telehealth.

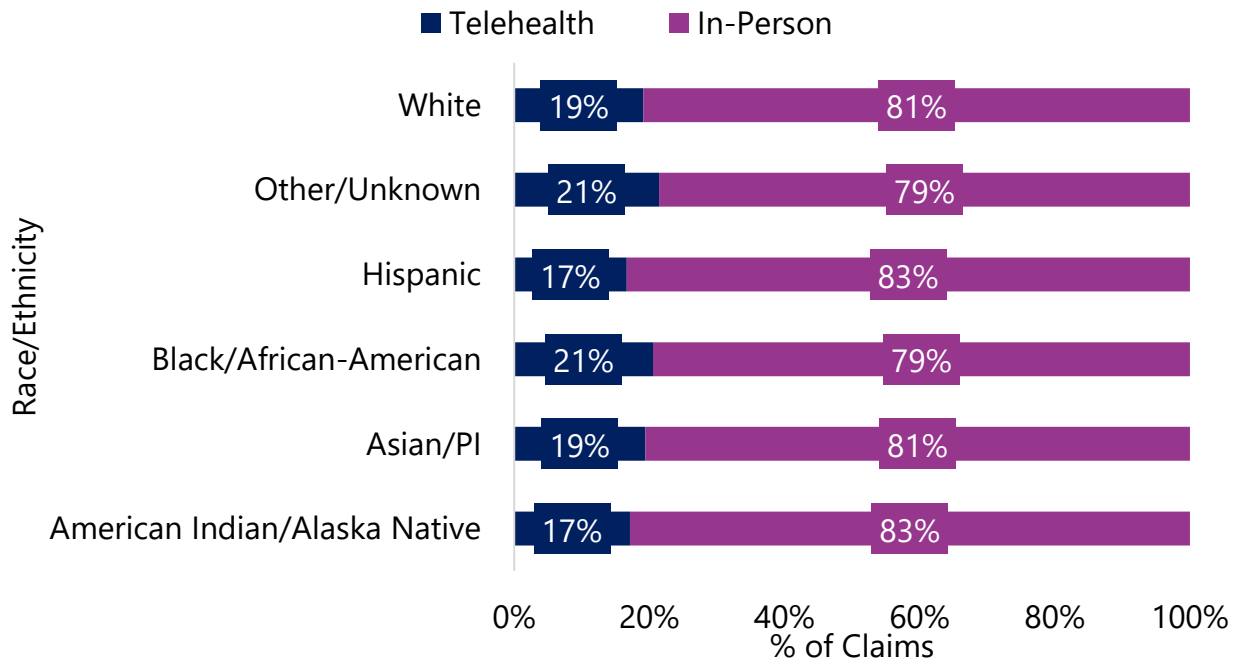
To further understand Medi-Cal enrollees' service use, a focused analysis assessed the number of claims by service modality – telehealth, office and mixed modality. 'Mixed' modality refers to enrollees using a mix of discrete telehealth and office services across multiple claims. At all levels of overall utilization, it was much more common to have 'office-only utilizers' than 'telehealth-only utilizers'. Of enrollees with three or fewer total claims, about half were 'office-only utilizers'. As the number of claims per enrollee increased, the percent via telehealth only and office only decreased while the percent of mixed modality visits became predominant. Additional analysis assessed the number of claims by service modality – telehealth, office and mixed modality – by primary language spoken as well as E&M claims for new and established patients by primary language spoken (See the Appendix).

E&M Claims Mix by Service Modality, April 2020 – March 2021

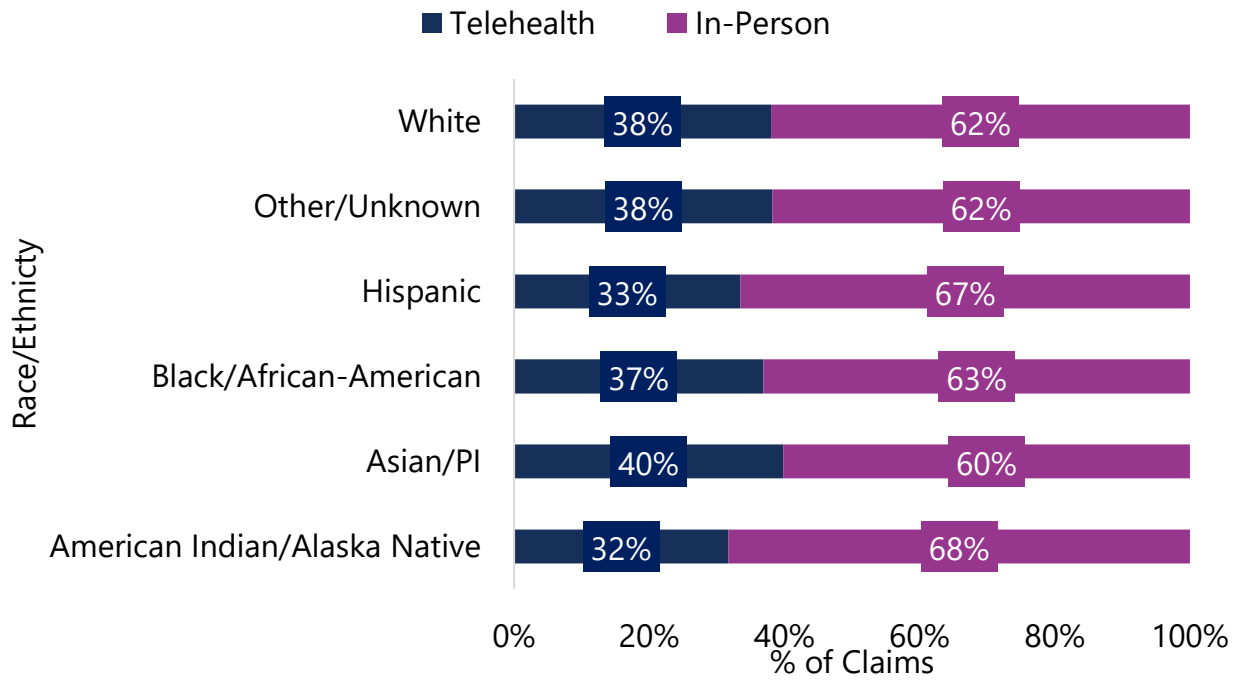


In terms of race/ethnicity, the DHCS reviewed the percent of in-person and telehealth E&M claims by race/ethnicity among both new and established patients. Across all race/ethnicity groups, new patient E&M claims via telehealth were around 20% or less of all claims. Asian/Pacific Islander established patients had the highest percentage of new and established patient telehealth E&M claims; American Indian/Alaska Native had the lowest; all racial/ethnic groups had about 33% or higher established patient telehealth claims.

New Patient E&M Claims Mix by Race/Ethnicity, April 2020 - March 2021



Established Patient E&M Claims Mix by Race/Ethnicity, April 2020 - March 2021



These and other data presented to the workgroup informed discussions on the impact of telehealth on access to care, the quality and outcomes of care, and if there were observable disparities in these data. The data presentations also informed Workgroup discussions of the proposed telehealth policies. Finally, these data generated many recommendations from the workgroup for how to approach research and evaluation going forward.

Future Telehealth Policy Commitments

DHCS is in the process of developing its future telehealth policy and weighing which temporary flexibilities enabled during the COVID-19 pandemic may continue on a permanent basis. AB 133 required DHCS to seek federal approval to continue flexibilities put in place during the PHE to continue through December 31, 2022. As communicated to the Workgroup, DHCS intends for many policies to be continued on a permanent basis after 2022. Specifically, DHCS has explained the current state of telehealth coverage in Medi-Cal and committed to continuing and expanding telehealth coverage, as follows:

Policy Area	Details
Baseline coverage of synchronous telehealth	• Synchronous video and audio-only telehealth covered across multiple services and delivery systems, including physical health, dental, non-specialty and specialty mental health, and SUD services (Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System / DMC-ODS) • DHCS intends to continue coverage of synchronous video and audio-only telehealth coverage put in place during the PHE State Plan Drug Medi-Cal, 1915(c) waivers, Targeted Case Management (TCM) Program and Local Education 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)

Policy Area	Details
	• DHCS intends to continue the current coverage of asynchronous telehealth put in place during the PHE 1915(c) waivers, TCM and LEA-BOP
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), so long as those services meet billing code requirements • DHCS intends to continue the use of cost-based reimbursement for TCM and LEA BOP telehealth services • Payment parity excludes virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, etc.) • All county-administered behavioral health reimbursements will be cost-based until BH Payment Reform via CalAIM (anticipated July 2023)
Virtual communications & check-ins	• Brief virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, etc.) are covered by Medi-Cal for non-physician practitioners in physical health • DHCS intends to expand coverage of virtual communications (specifically e-visits) to 1915(c) waivers, TCM and LEA-BOP
Telehealth in FQHCs & RHCs	• FQHCs/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 patient or provider
Remote patient monitoring (RPM)	• RPM is covered by Medi-Cal for dates of service on or after July 1, 2021; request for federal approval is under development

Policy Area	Details
Telephonic enrollment for minor consent	• Telephonic enrollment for minor consent will continue after the PHE • This will be done through the Medi-Cal Eligibility Procedures Manual Updates as permanent policy and MEDIL I21-09 has been issued to reflect the policy
Key terms and definitions included in Appendix.	

DHCS Telehealth Guiding Principles

DHCS has committed to these future telehealth policies because DHCS recognizes the inherent value and benefit to enabling greater access to care via telehealth. Providers, Medi-Cal managed care plans, and professional associations have attested that telehealth has contributed to significant declines in no show rates. The California Health Care Foundation (CHCF) has reported that 83% of safety net providers in California are currently using telehealth and consider it "very" or "somewhat" effective, and 88% intend to continue offering telehealth in the future as long as payment for in-person and telehealth services are comparable. [6] DHCS also acknowledges that telehealth can be a powerful tool in combating provider workforce shortages and geographic disparities in access to care, particularly among underserved populations such as those living in rural areas where traveling to an in-person visit may be burdensome and patients may have limited access to in-person care.[7]

Enrollees are also satisfied with the ability to receive care remotely. DHCS recognizes that many enrollees prefer the opportunity to receive services through a range of telehealth modalities because it reduces travel time on public transportation, prevents

[6] CHCF Infographic - "Patients with Low Incomes and Their Providers Agree: Continue Telehealth"

[7] D Jaffe, L Lee, S Huynh, T Haskell, "Health Inequalities in the Use of Telehealth in the United States in the Lens of COVID-19," Population Health Management, Vol. 23, No. 5.

having to take time off work, reduces wait times to see a providers, and/or avoids parents having to arrange for child care. CHCF findings substantiate these sentiments; CHCF found that 64% of California patients with low income said they had an easier time keeping their appointment for a phone or video visit than they did keeping an in-person visit in the past.[8] However, as noted in a poll recently conducted by NPR, the Robert Wood Johnson Foundation, and the T.H. Chan School of Public Health at Harvard, the majority of patients surveyed still prefer to see their provider in-person.[9]

In light of the expansive policy commitments outlined above, DHCS is determining how to integrate guardrails to manage the delivery of services via telehealth in order to:

- Ensure all patients have equitable access to care
- Ensure that patients are getting the highest quality and safest care at the right time, in the right setting, and in the patient's preferred modality
- Ensure Medi-Cal enrollees are able to receive in-person care when desired and as clinically appropriate
- Ensure appropriate use of all covered telehealth modalities
- Avoid fraud and maintain program integrity for covered services

The post-PHE policy changes envisioned and recommended by DHCS will be guided by the following principles, which have been refined based on feedback from Workgroup members:

Guiding Principle	Details from Feb. 2021 DHCS Policy Proposal[10]	Current Details Refined to Reflect Workgroup Input
Equity	Use of an equity framework, focusing on improving	Use an equity framework, focus on improving equitable access to

[8] CHCF Infographic - "Patients with Low Incomes and Their Providers Agree: Continue Telehealth"
[9] NPR, the Robert Wood Johnson Foundation, and the T.H. Chan School of Public Health at Harvard, "Household Experiences During the Delta Variant Outbreak" (October 2021)
[10] DHCS Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations: Public Document (February 2021)

Guiding Principle	Details from Feb. 2021 DHCS Policy Proposal[10]	Current Details Refined to Reflect Workgroup Input
	equitable access to providers, and addressing inequities and disparities in care to every enrollee, regardless of race, ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location. Telehealth services will comply with civil rights law, including non-discrimination, accessibility under the Americans with Disabilities Act, access to qualified language interpreters, and accurate, culturally responsive translation.	providers and addressing inequities and disparities in care to every enrollee, regardless of race, ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location. Services delivered by telehealth must comply with civil rights law, including non-discrimination, accessibility under the Americans with Disabilities Act, access to qualified language interpreters, and accurate, culturally responsive translation. Enrollees and providers should have access to culturally and linguistically appropriate education regarding care delivery via telehealth that is informed by demographically inclusive consumer user experience research and with consumer input.
Access	Telehealth should be used as a means to promote adequate, culturally responsive, patient-centered, equitable access to health care, and to strengthen provider network adequacy.	Leverage telehealth modalities as a means to expand access to adequate, culturally responsive, patient-centered, equitable and convenient health care, and to strengthen patient access care standards (network adequacy). Medi-Cal enrollees should have convenient access to telehealth similar to Californians enrolled in other types of coverage (e.g.,

Guiding Principle	Details from Feb. 2021 DHCS Policy Proposal[10]	Current Details Refined to Reflect Workgroup Input
		Covered California, CalPERS, Medicare, commercial.)
Standard of Care	Require the use of evidence-based strategies for the delivery of quality and culturally responsive care. Standard of care requirements shall apply to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.	Use evidence-based strategies for the delivery of quality and culturally responsive care via telehealth. Standard of care requirements should apply to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.
Patient Choice	Patients, in conjunction with their providers, should be offered their choice of service delivery mode. Patients should retain the right to receive health care in person.	Patients, in conjunction with their providers, should be offered their choice of service delivery mode via telehealth or in-person care. Patients should retain the right to receive health care in person.
Confidentiality	Patient confidentiality should be protected. Patients must provide informed consent verbally or in writing in their primary or preferred language about both care and the specific technology used to provide it.	Patient confidentiality must be protected. Patients should provide informed consent verbally or in writing in their primary or preferred language about both care and the specific technology used to provide it.
Stewardship	As stewards of public resources, steps will continue to be taken to mitigate and address fraud, waste, discriminatory barriers, and abuse.	Exercise responsible stewardship of public resources, including mitigating and addressing fraud, waste, discriminatory barriers, and abuse.
Payment Appropriateness	Reimbursement for services provided via telehealth modalities will be considered in the context of various	Consider reimbursement for services provided via telehealth modalities in the context of various methods of

Guiding Principle	Details from Feb. 2021 DHCS Policy Proposal[10]	Current Details Refined to Reflect Workgroup Input
Note: This guiding principle was not discussed during the Workgroup meetings because DHCS has already committed to implementing payment parity for video and audio-only visits and appropriate payment for other modalities.	methods of reimbursement, nature of service, type of care provider, and the health system payment policies and goals.	reimbursement, nature of services, type of care providers, and the health system payment policies and goals.

Inherent Trade-Offs in Enabling Care Via Telehealth

There are many benefits to enabling widespread use of both video and audio-only visits for Medi-Cal enrollees. A large body of research supports the use of telehealth for a range of health care services; telehealth has been found to be particularly beneficial for patients with chronic conditions and behavioral health needs.[11] From the patient perspective, telehealth can improve access to care and enhance patient satisfaction by making care more convenient and reducing some of the burdens of seeking in-person care (e.g., time away from work or school, arranging for childcare, seeking

[11] Totten AM, McDonagh MS, Wagner JH. The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic. White Paper Commentary. AHRQ Publication No. 20-EHC015. Rockville, MD: Agency for Healthcare Research and Quality. May 2020.

transportation). It is important, however, to weigh these benefits with the potential risks to expanding coverage and reimbursement for services delivered via telehealth without appropriate consumer protections and monitoring mechanisms.

» Expanded access to telehealth is beneficial for some patient populations but may perpetuate health inequities and disparities for others: Research suggests that simply expanding access to telehealth does not necessarily benefit the whole population, but often a subset (often younger people in urban settings with lower acuity conditions) who can easily access care via telehealth.[12]

- Older adults, lower-income individuals, communities of color, and patients who visit a community health center are less likely to have the technology or broadband access necessary to conduct a video visit. These populations may be better positioned to access care via audio-only visits, however not all services can be delivered over the phone in a clinically appropriate manner.[13]
- Patients with low levels of digital literacy or who require interpreter services or other accommodations may not be able to access care via video or audio-only.[14]

» Research suggests telehealth demonstrates equal or improved quality of care as compared to in-person care, yet there is limited evidence regarding the quality of care for individuals who receive both telehealth and in-person care: Several studies and reports suggest equivalency in quality of care delivered via

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[12] A Mehrotra, B Wang, G Snyder, "Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?" The Commonwealth Fund, Issue Brief (August 2020).
[13] A Mehrotra, B Wang, G Snyder, "Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?" The Commonwealth Fund, Issue Brief (August 2020).
[14] D Velasquez, A Mehrotra, "Ensuring the Growth of Telehealth During COVID-19 Does Not Exacerbate Disparities in Care" Health Affairs (May 2020).

telehealth vs. in-person,[15,16,17] however such findings may not be generalizable because: 1) the equivalency research that does exist is limited and tends to focus on older adults and those with mental health or chronic conditions; and, 2) the vast majority of patients who receive telehealth care also receive in-person care. There is not yet sufficient evidence that examines the quality or cost impact for patients who receive both in-person and telehealth care (i.e., hybrid care).[18] It should be noted that, the research on the quality and experience of care for behavioral health is more robust, especially for telepsychiatry.[19]

» For patients with conditions that require in-person interventions, the inability of telehealth providers to conduct physical exams or diagnostic testing could pose quality and patient safety risks without appropriate guardrails: While many conditions can be appropriately diagnosed and treated via telehealth, video and audio-only visits are limited by their inability to complete a full physical exam. For example, a provider connecting with a patient who has an ear infection is unable to examine the inner ear and may resort to prescribing antibiotics without confirming an infection. Inappropriate use of telehealth for conditions that require a physical exam could risk patient safety and result in

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[15] Richard O'Reilly et al., "Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results from a Randomized Controlled Equivalence Trial.," Psychiatric Services 58, no. 6 (2007): 836–43

[16] Totten AM, Womack DM, Eden KB, et al. "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews.," Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2016. Technical Briefs, No. 26

[17] "Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis," AHRQ, August 2020.

[18] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2021.

[19] American Psychiatric Association. "American Psychiatric Association: Telepsychiatry Toolkit."

lower quality care.[20,21] As above, this is less of a risk for behavioral health, since physical exams are rarely needed.

» Improved access could potentially lead to overutilization and drive up healthcare costs: Telehealth can improve access to care and make care more convenient for patients, providing greater access to preventive care that can help patients avoid complications from untreated conditions. However, more expansive and convenient access to telehealth can also result in additive, rather than substitutive care, which could increase costs for payers and patients.[22,23]

» More expansive coverage of telehealth could increase risk for fraud: Expanded coverage of telehealth services may open up the potential for fraud. Since 2016, HHS-OIG has seen a significant increase in "telefraud": scams that leverage aggressive marketing and misrepresent services as telehealth.[24] More recently, the HHS- OIG has announced plans to audit whether State Medicaid agencies and providers complied with Federal and State requirements for telehealth services under the COVID-19 PHE, and whether States provided adequate guidance to providers regarding telehealth requirements.[25] HHS-OIG is expected to issue its findings next year.

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[20] Lori Uscher-Pines et al., "Access and Quality of Care in Direct-to-Consumer Telemedicine," Telemedicine and E-Health 22, no. 4 (2016): 282–87.
[21] A Mehrotra, B Wang, G Snyder, "Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?" The Commonwealth Fund, Issue Brief (August 2020),
[22] J S Ashwood, A Mehrotra, D Cowling, L Uscher-Pines, "Direct-to-Consumer Telehealth May Increase Access to Care But Does Not Decrease Spending," HEALTH AFFAIRS 36, NO. 3 (2017), pp: 485–491, doi: 10.1377/hlthaff.2016.1130.
[23] DHCS acknowledges the limitations of the study cited here, including that it is four years old and pertains to direct-to-consumer telehealth. However, this is a commonly cited study regarding the financial impact of telehealth services.
24 2020 National Health Care Fraud Takedown | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (hhs.gov)
[25] HHS OIG, "Medicaid – Telehealth Expansion During COVID-19 Emergency"

IV. Proposed DHCS Telehealth Policy Approaches Considered by the Advisory Workgroup

Overview of Telehealth Policy Topics and Approaches

California has been a leading state in the expansiveness of its coverage and reimbursement for services delivered via telehealth. Unlike most other state Medicaid programs that limit telehealth to specific clinical areas or services, Medi-Cal has committed to permanently enabling broad telehealth coverage, via both video and audio-only services, for all Medi-Cal covered benefits and services as long as the provider is able to meet the standard of care. In addition, Medi-Cal is unique among other state Medicaid programs in regards to payment parity. Many other state Medicaid programs have made permanent payment parity for video visits following the onset of the COVID-19 pandemic, however California is one of few states to permanently commit to reimbursing a broad array of services at parity when delivered via audio-only visits.[26]

As DHCS looks to the future, DHCS proposed potential policy approaches, organized across three major topics, to the Telehealth Advisory Workgroup for discussion and deliberation. These topics, listed below, are core to the charge of the workgroup defined under AB 133 and consistent with DHCS's guiding principles.

Topic 1: Billing and Coding Protocols	
Potential Policy Approaches	Use specific modifiers to delineate visits by telehealth modality, including by introducing a new audio-only modifier
	Obtain and document in the patient record: (1) consent for use of specific telehealth modalities; and (2) reason for use of the modality selected
	Activate Common Procedural Terminology (CPT) codes for capture of telephonic evaluation and management and assessment and management visits in Medi-Cal

[26] Manatt on Health: Tracking Telehealth Changes State-by-State in Response to COVID-19

Topic 2: Monitoring Policies	
Potential Policy Approaches	Require 'third-party corporate telehealth providers' without a physical location to follow protocols to ensure community linkages and continuity of care for Medi-Cal enrollees
	Adopt utilization review procedures for telehealth services similar to those used for in-person services
Topic 3: Other Policies to Support Guiding Principles	
Potential Policy Approaches	Provide patients the choice of telehealth modality when care is provided via telehealth, if the care can be appropriately delivered via more than one modality and meet the standard of care
	Ensure patients have the right to access in-person services
	Allow new patients to establish a relationship with a provider via telehealth subject to certain protections
	Allow the use of synchronous telehealth to meet Medi-Cal managed care enrollee access to care standards (network adequacy)

Topic 1: Billing and Coding Protocols

Use specific modifiers to delineate visits by telehealth modality, including by introducing a new audio-only modifier

Supporting detail and current state: Modifiers are often appended to billing claims to provide additional information regarding a service to improve accuracy or specificity regarding the services rendered or the manner in which they were delivered. Different payors (e.g., Medi-Cal, Medicare, commercial payors) require the use of modifiers on claims or encounters for payment purposes but also to track specific services and modalities rendered by the provider.

Use of audio-only modalities has proliferated during the COVID-19 pandemic and is expected to continue for the foreseeable future, especially since Medi-Cal has committed to covering audio-only modality on a permanent basis. However, there is not yet a commonly accepted modifier to allow providers to delineate between video and audio-only synchronous interactions – the GT modifier, used to identify synchronous telehealth services, could apply to either video or audio-only, and the 95 modifier only applies to synchronous video visits.

Telehealth Modality	Modifiers Providers Are Currently Directed to Use by DHCS by Delivery System
Video Visits	Physical Health and Dental: 95 Specialty mental health, Drug Medi-Cal, and DMC-ODS: GT
Audio-Only Visits	Physical Health and Dental: None Specialty mental health, Drug Medi-Cal, and DMC-ODS: SC
Asynchronous	All delivery systems: GQ

In Medi-Cal today, all providers are instructed to bill asynchronous encounters with the GQ modifier, however guidance related to modifier use for video and audio-only visits differs by delivery system. Specialty mental health, Drug Medi-Cal, and DMC-ODS counties and providers recently received guidance instructing them to bill for services delivered via video visit using the GT modifier, and audio-only visits using the SC modifier starting November 1, 2021.[27] Providers who offer physical health and dental services via telehealth are directed to bill for video visits with the 95 modifier, but the DHCS Medi-Cal telehealth policy provides no distinct modifier guidance for audio-only encounters. [28] Without an audio-only modifier for physical health and dental services, DHCS is currently unable to track and analyze use of audio-only telehealth across Medi-Cal enrollees.

DHCS has proposed utilizing specific modifiers to delineate visits by telehealth modality, including by adopting an audio-only modifier, in order to enable DHCS to understand telehealth utilization by modality going forward. In addition, DHCS proposed to seek alignment of modifier requirements across delivery systems.

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[27] DHCS Behavioral Health Information Notice No: 21-047, October 6, 2021. In subsequent communication, DHCS strongly encouraged counties to meet the November 1, 2022 effective date for telehealth modifiers and also provided a blanket waiver until January 1, 2022 to accommodate counties facing systemic challenges.

[28] DHCS Medi-Cal Telehealth Policy

Issues raised by workgroup:

Members representing provider organizations:

Members noted the importance of utilizing modifiers to track use of telehealth modalities accurately and were supportive of the addition of a specific audio-only modifier.

Several members raised the issue of mixed modality telehealth encounters, or visits that start via one modality and conclude using a different modality. Members cited examples of providers starting an encounter via video but needing to transition to a phone call due to poor internet connectivity. When discussing the best approach for appending modifiers to mixed modality encounters, many members of the group noted their preference for billing how the visit was initiated, rather than how it ended, in order to provide data on the intent of the provider. Other members preferred giving providers discretion to append modifiers based on the primary modality used to deliver a service.

Members noted the importance of using modifiers to track all telehealth modalities, including asynchronous care. One member raised concerns about the administrative burden on provider practices to update their billing systems to accommodate new modifiers, and requested that DHCS use a phased-in approach if adopting new modifiers so providers have time to adapt their billing and practice management systems. Many members noted the importance of DHCS providing Medi-Cal providers with clear guidance and protocols if new modifiers are adopted and current protocols are adjusted.

Members representing consumers/consumer organizations:

One member emphasized the important difference in billing considerations between fee-for-service providers and managed care providers and urged DHCS to align telehealth modifier requirements across Medi-Cal fee-for-service and managed care delivery systems.

Degree of workgroup alignment and DHCS implementation considerations: There was broad support among the Workgroup for adding an audio-only modifier. When implementing this policy approach, DHCS will consider utilizing the new audio-only

modifier approved by the American Medical Association (AMA) CPT Editorial Panel.[29] DHCS will seek to provide clear guidance on the use of modifiers, and align telehealth modifier guidance across all Medi-Cal delivery systems where appropriate; however, it may take time to fully realize this alignment due to systems limitations. DHCS will also consider how to best ensure accuracy and billing for different telehealth modalities and will assess adding new modifiers, as needed, to delineate other telehealth modalities and align with national standards when possible.

Obtain and document in the patient record: (1) consent for use of specific telehealth modalities; and (2) reason for use of the modality selected

Supporting detail and current state: Patient consent is a critical component of care delivery, and it is especially important with the introduction of new care delivery modalities, such as telehealth. Documenting the purpose of selecting one modality over another has been used as a tool during the COVID-19 pandemic to validate the use of telehealth for a service that might otherwise not be covered in a non-pandemic environment, and evaluate health access and equity across telehealth modalities and Medi-Cal populations.

A temporary Medi-Cal policy bulletin regarding payment for telehealth and telephonic communications mandates that providers 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. [30] Additionally, on a permanent basis 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. [31]

DHCS has proposed expanding upon its permanent consent policy to obtain and document in the patient record consent for use of specific telehealth modalities and the

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[29] CPT® Editorial Summary of Panel Actions September-October 2021.
[30] DHCS Bulletin: Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19) (January 5, 2021)
[31] DHCS Medi-Cal Telehealth Policy

reason for use of the modality selected as a means of ensuring equitable access to care and patient choice.

Issues raised by workgroup:

Members representing consumers/consumer organizations:

Members highlighted the critical importance of patient choice, with some members recommending that consent be confirmed at every clinical encounter and that patients be routinely informed – before each visit – of their right to in-person care. One member commented that documenting patient choice supports patient empowerment throughout the clinical process.

Members underscored the importance of patient-centric language and access to providers and communication in the preferred language of the patient – or free and available translation services and interpreters – so as to ensure patients truly understand their rights. Additionally, members suggested that access to technological support and translation services are important to empowering patients and ensuring clear understanding during the consent process.

Members representing payer organizations:

One member indicated that they opposed adding new requirements of documenting consent, particularly as the DHCS seeks to streamline documentation protocols across delivery systems.

Members representing provider organizations:

Members commented that while obtaining informed patient consent is paramount, there were concerns that telehealth modality-specific consent processes could impact operations and access. For example, requiring consent at every visit may interfere with the time allotted for a clinical appointment. One member noted that in the past, consent processes perceived as overly-burdensome have reduced provider willingness to adopt telehealth, thereby reducing access to telehealth services for patients. Some members requested that DHCS maintain its current consent protocols.

Members were curious to understand how clinical practices would bill for the time taken to obtain consent. One member questioned whether the consent process is the most effective method for understanding patient modality preference.

Degree of workgroup alignment and DHCS implementation considerations: There was broad agreement among the Workgroup that meaningful consent is critical and that understanding patient modality preferences (through consent or otherwise) is important to better understand telehealth utilization across the Medi-Cal population; however, there were concerns about capturing consent for specific modalities, and varying perspectives on whether requiring consent documentation at every visit is the best method for collecting these data. DHCS recognizes that obtaining meaningful consent is central to ensuring patient choice. DHCS acknowledges and is evaluating concerns raised by members regarding the potential workflow impacts and burden associated with obtaining repeated and more detailed consent, including information on the reason for use of a telehealth modality. When implementing this policy approach, approach, DHCS will consider and seek to balance the importance of patient consent on patients' right to access and choice with the impact that obtaining repeated consents may have on provider workflows. DHCS will also consider what information must be shared with patients during the process of obtaining consent for use of telehealth, such as the right to access in-person services. Finally, DHCS will ensure that its policy on obtaining consent for telehealth is consistent with existing statutory and regulatory requirements related to obtaining consent.[32]

Activate Common Procedural Terminology (CPT) codes for capture of telephonic evaluation and management and assessment and management visits in Medi-Cal

Supporting detail and current state: In 2020 during the COVID-19 PHE, Medicare and many other payers temporarily added coverage of telephonic E&M codes that may be billed by physicians, nurse practitioners, and physician assistants (99441-3) as well as telephonic assessment and management (A&M) codes (98966-8) that may be billed by qualified non-physician health care professionals. These codes:

- may only be billed to an established patient (although some payers have waived this requirement during the PHE),

[32] For example, California Welfare and Institutions Code 14132.72(d) and Business and Professions Code 2290.5, which outline conditions within Medi-Cal related to obtaining and documenting consent for patients who receive care via telehealth.

- cannot originate from a related visit within the previous 7 days, and
- cannot result in a related service or procedure within the following 24 hours.

Currently, these codes are not covered in Medi-Cal. However, given a significant number of telephonic E&M, and A&M claims in managed care, it appears that some Medi-Cal managed care plans may be covering these codes at their discretion. Without coverage for telephonic E&M and A&M codes, Medi-Cal providers delivering care via audio-only are currently billing other CPT codes with telehealth modifiers for services delivered over the telephone.

Telephonic E&M and A&M Codes	
CPT Code	**Definition**
99441	**Telephone evaluation and management service** provided by a physician, nurse practitioner or physician assistant; **5-10 minutes**
99442	Same as above; **11-20 minutes**
99443	Same as above; **21 or more minutes**
98966	**Telephone assessment and management service** provided by qualified non-physician; 5-10 minutes
98967	Same as above; **11-20 minutes**
98968	Same as above; **21 or more minutes**

Telephonic E&M and A&M codes provide an additional and more accurate option to capture brief telephone check-ins with patients. These codes do not require use of a modifier since the CPT definition denotes the modality as telephonic.

Outpatient office E&M codes are available for visits that meet the criteria set forth in the CPT manual – including the three key components of patient history, clinical examination, and medical decision-making – and can be appended with a video or audio-only modifier.

Issues raised by workgroup:

Members representing provider organizations:

Given the unique nature of FQHC billing procedures (i.e., prospective payment system (PPS) billing), members noted that it may be challenging for FQHCs to utilize telephonic

E&M and A&M codes. In addition, the definitional requirements for these codes, such as eligible billing provider types and other requirements (e.g., that they cannot be billed in the 24 hours preceding or 7 days following an in-person visit) create significant restrictions on when and how the codes can be billed.

One member commented that providers believe Medicare currently values these codes at a low relative value unit (RVU),[33] suggested that DHCS provide adequate level of reimbursement to incentivize providers to use them when appropriate, rather than bill outpatient office E&M codes with an audio-only modifier which would likely result in higher reimbursement.

One member stated that not all managed care plans use the codes described, nor are they currently in alignment on code definitions and usage.

Another member noted that these codes are not on the list of codes eligible for Proposition 56 Supplemental Payments through Family Planning Access Care Treatment (Family PACT, FPACT) and that DHCS should consider adding the codes to this list if they are covered in Medi-Cal.

Degree of workgroup alignment and DHCS implementation considerations: Workgroup members were generally supportive of the idea that telephonic E&M and A&M codes should be covered. When considering this policy approach, DHCS will assess appropriate reimbursement levels for telephonic E&M and A&M Codes and consider the development of clear guidance on when providers should bill telephonic E&M and A&M codes and outpatient office E&M codes, and feasibility of

[33] Note: This perception may be related to past Medicare reimbursement policy, but Medicare has recently increased reimbursement for these codes. In 2020, CMS increased Medicare payment for telephonic evaluation and management codes 99441-3 to be equivalent to the similar in-person codes, office or other outpatient evaluation and management codes for established patients 99212-4. As a result of this change, payment for telephonic evaluation and management services increased from a range of about $14-41 to about $46-110. Medicare implemented telephonic E&M and A&M codes as a way of temporarily enabling providers to bill for audio-only services, and is ending coverage for these codes at the end of the PHE.

operationalizing these codes at FQHCs. DHCS intends to continue to maintain payment parity for outpatient office E&M visits billed with audio-only modifiers.

Topic 2: Monitoring Policies

Require 'third-party corporate telehealth providers' without a physical location to follow protocols to ensure community linkages and continuity of care for Medi-Cal enrollees

Note: This policy approach previously focused on both out-of-state providers and third-party corporate telehealth providers and was adjusted following the final Workgroup meeting to focus on "third-party corporate telehealth providers," as defined in state law.[34] *Nothing about this policy approach would change the existing state licensure and Medi-Cal provider enrollment requirements. In addition, the adjusted policy approach seeks to align, where appropriate, with recently passed Assembly Bill 457.*

Supporting detail and current state: Currently, Medi-Cal policy mandates that providers who offer services via telehealth to Medi-Cal enrollees and are located out-of state 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 meets all Medi-Cal program enrollment requirements.[35] There are exceptions to this provision: 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. Also, providers in border communities, including groups and solo practitioners are eligible for enrollment.

There are currently no special requirements in place for third-party corporate telehealth providers without a physical location in California. As a result, DHCS is unable to track or monitor telehealth care delivery among third-party corporate telehealth providers.

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[34] AB 457 amended sections of California's Health and Safety Code and Insurance Code to include definitions for third-party corporate telehealth providers.
[35] DHCS Medi-Cal: Telehealth FAQs for Providers

DHCS is considering placing special requirements on the Medi-Cal program and contracted managed care plans when enrollees access care from third-party corporate telehealth providers, such as:

- Disclosing the availability of receiving the service on an in-person basis or via telehealth, if available, from the Medi-Cal enrollee's primary care provider, treating specialist, or from another contracting individual health professional;
- Ensuring that medical records from an encounter are shared with the Medi-Cal enrollee's primary care provider and notifying enrollees that their medical records will be shared with their primary care provider, unless they object;
- Informing Medi-Cal enrollees that all services received through the third-party corporate telehealth provider are available and can be accessed in-person; and,
- Collecting and reporting data regarding telehealth services delivered to Medi-Cal enrollees by third-party corporate telehealth providers, including:
    - Contracted providers and number of services provided by specialty; and,
    - Enrollee information including frequency of use, gender, age, demographic data, and any other information as determined by DHCS.
- Adding conditions regarding when and to what extent third-party corporate telehealth providers are allowable in Medi-Cal.

Issues raised by workgroup:

Members representing consumers/consumer organizations:

Members had varying perspectives on what parameters would be appropriate for third-party corporate telehealth providers. Some members argued that enabling access to third-party corporate telehealth providers could expand access and alleviate workforce shortages, especially in the event of a future state-wide emergency.

A member commented that in-state plans and providers who contracted with third-party corporate telehealth providers should be responsible for ensuring that these providers are making appropriate referrals and sharing relevant medical records from the appointment, as appropriate.

Some members felt that third-party corporate telehealth providers should follow certain protocols, such as having an ability to refer to a local in-person provider, in order to ensure patient choice and access.

Members representing research and policy organizations:

Members noted the benefit of third-party corporate telehealth providers on alleviating workforce shortages, agreeing with others that connections to local providers is important to ensuring high-quality care coordination and reducing the likelihood that enrollees are referred to high-cost in-person care (e.g., urgent care and/or the emergency room).

Members representing provider organizations:

Members reiterated the benefit of third-party corporate telehealth providers on alleviating workforce shortages. A few members highlighted concerns about third-party corporate telehealth providers, including the belief that such providers only treat low-acuity patients, and that they are disconnected from a patient's traditional care systems resulting in clinical fragmentation.

One member noted the importance of clear policies, policy education, and information sharing, adding that obtaining buy-in from managed care plans would be important in the roll-out and acceptance of these policies. Another member requested that the policy be crafted to consider circumstances where a patient may purposefully seek out a third-party corporate telehealth provider because they do not want to receive those services from or have medical information shared with their primary care provider.

Members representing payer organizations:

Members emphasized the importance of thinking about rural communities in designing this policy, noting that an increase in telehealth options may limit providers' willingness to provide rural, in-person services.

Members noted that imposing requirements on third-party corporate telehealth providers may limit these providers' willingness to offer services and thus decrease access to care.

Members also emphasized that registration and submitting data reporting would be an additional administrative burden on third-party corporate telehealth providers.

Degree of workgroup alignment and DHCS implementation considerations: The Workgroup was in general agreement that enabling enrollees to access third-party corporate telehealth providers could help alleviate workforce shortages, especially for specialty providers, and that it would be beneficial for such providers to have

connections with – or the ability to refer enrollees to – local in-person services. When refining this policy approach, DHCS will consider how best to align with parameters set forth in Assembly Bill 457 where applicable, including disclosing the availability of receiving services in person; ensuring that medical records from an encounter are shared with the Medi-Cal enrollee's primary care provider when applicable, while considering state and federal privacy regulations in regards to record-sharing; informing Medi-Cal enrollees of service availability in-network and in-person; and collecting and reporting data on telehealth service utilization. DHCS seeks to address concerns that third-party corporate telehealth providers may reduce continuity of care, and seeks to balance increasing access to care while not limiting patient access to in-person care.

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, recognizing some providers may only provide telehealth services.
>
> Time + volume: Unexplained increase in volume; 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, including TTY and sign language interpretation.

Supporting detail and current state: It is standard practice for Medi-Cal and other payers to conduct utilization reviews to monitor and assess care delivery across their enrollee population. Currently, DHCS conducts reviews of in-person care delivery based on fraud complaints, statutorily required reviews, and other reviews as needed to ensure Medi-Cal program integrity.

DHCS is considering adopting utilization review procedures for telehealth services similar to those used for in-person services, including the targeted review of outliers

based on certain criteria such a time, volume, standard of care, and consumer complaints. DHCS's goal in proposing and adopting utilization review procedures is to ensure delivery of high quality of care and consumer protections.

Issues raised by workgroup:

Members representing payer organizations:

Members commented that these policies are challenging to monitor at the individual level. For example, it would be difficult for an individual provider to know if they were conducting too many telehealth visits. In addition, one member noted that if third-party corporate telehealth providers would be by default, reported as high utilizers of telehealth and be flagged as outliers.

One member noted the importance of recognizing provider preference in modality delivery, noting that some providers (e.g., behavioral health providers) are choosing to practice solely through telehealth and they should not be disincentivized via a monitoring policy from delivering care via their preferred modality.

Additionally, members noted the importance of considering monitoring policies within the context of overall policy decisions (e.g., application to third-party corporate telehealth providers, who by definition would report high telehealth volume).

Members representing provider organizations:

Members had varying opinions on how to define time and volume parameters. Some members expressed that the industry does not yet have baseline telehealth information post-PHE and thus it would be premature to define time and volume parameters based on PHE data. Other members argued that the future of telehealth likely looks different than current utilization patterns, and thus DHCS should consider policies that will recognize current and future utilization patterns. One member advised the DHCS conduct telehealth time and volume utilization reviews at the clinic, practice or health system level rather than reviewing telehealth utilization among individual providers. Another member noted that time and volume parameters should not be set universally, citing the fact that time and volume parameters vary across patient populations, service types, and specialty needs.

One member highlighted the importance of tracking what modalities and services an enrollee is being offered.

One member raised concerns about implementing a utilization review policy that monitors utilization of care delivered via telehealth differently than in-person care. Another member noted that it would be no easier to engage in clinically inappropriate behavior over telehealth than in-person, reaffirming the idea that telehealth monitoring policies should align with those of in-person care.

Degree of workgroup alignment and DHCS implementation considerations: There was alignment among Workgroup members in adopting telehealth utilization review procedures that mirrored those used for in-person care, acknowledging DHCS should be flexible in setting specific targets/flags given how much is unknown about post-PHE telehealth utilization. When implementing this policy approach, DHCS will consider the challenge of setting utilization review parameters based on telehealth utilization during the COVID-19 PHE, consider how to utilize existing in-person utilization review procedures to monitor telehealth service delivery, and regularly review the experience base in determining specific targets/flags.

Topic 3: Other Policies to Support Guiding Principles

Provide patients the choice of telehealth modality when care is provided via telehealth, if the care can be appropriately delivered via more than one modality and meet the standard of care

Supporting detail and current state: Supporting patient choice is a central focus for DHCS in developing its future telehealth policy. During COVID-19, DHCS expanded its telehealth policy temporarily to allow enrollees to receive care in-person or via video or audio-only visits. [36] A CHCF study conducted in the summer of 2020 found that among California survey respondents, 71% of low income individuals and 68% of people of color agreed with the statement that "in the future, whenever possible, I would always

[36] DHCS Bulletin: Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19) (January 5, 2021)

like the option for phone or video visits."[37] Current Medi-Cal telehealth policy, however, does not require Medi-Cal providers to offer services via specific telehealth modalities – it simply allows Medi-Cal providers the option to offer a range of covered modalities.[38] Thus, patient choice of telehealth modality is limited to those modalities offered by any given Medi-Cal provider.

DHCS is considering adapting its policy to provide enrollees their choice of telehealth modality, if the care can be appropriately delivered via more than one modality while meeting standard of care, as a means of promoting patient choice, access, and equity.

Issues raised by workgroup:

Members representing consumers/consumer organizations:

One member noted that policymakers 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 expressed concern that this policy may unintentionally reduce telehealth access, as some providers may not be able to – or be interested in – providing care via all telehealth modalities and thus would not offer any services via telehealth. One member noted the risk of prematurely restricting access to care when the industry does not fully understand the ramifications of telehealth on outcomes. One member highlighted how a patient's access to broadband internet can impact their ability to connect with providers over different telehealth modalities, and urged DHCS to consider current broadband limitations while promoting access to the full range of telehealth modalities. Another member noted that DHCS should include asynchronous telehealth in its policies.

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[37] CHCF, "Listening to Californians with Low Incomes: Health Care Access, Experiences, and Concerns Since COVID-19" (October 2020)
[38] DHCS Medi-Cal Telehealth Policy

One member noted the importance of offering providers resources and accommodations to allow providers to adopt technology infrastructure necessary to offer patients a choice of telehealth modalities. Another member indicated that clear guidance and reasonable implementation guidelines will be necessary to implement this policy approach.

Members were in general agreement that restricting access to services is disadvantageous to patients. Furthermore, what patients or providers deem "clinically advantageous" may differ based on a beneficiary's location or other needs.

Members representing payer organizations:

Members emphasized the importance of ensuring that implementation of this policy approach does not exacerbate existing access disparities between commercial and Medi-Cal enrollees. One member encouraged the Workgroup and DHCS not to think about telehealth as a replacement of in-person services, but an extension of service.

Degree of workgroup alignment and DHCS implementation considerations: Workgroup members aligned around the idea that patients should have choice in telehealth care delivery, but emphasized that DHCS should consider how requiring providers to offer multiple telehealth modalities may impact access to care. As DHCS considers the policy of providing patients the choice of telehealth modalities, DHCS will evaluate the potential unintended consequences this policy may have on overall access to care and existing health care disparities. DHCS will also consider how to phase-in such a policy over time to allow sufficient time for providers to adopt technologies necessary to offer patients a choice of modality. Finally, DHCS will seek to coordinate with other state and federal efforts that provide resources for broadband availability, telehealth adoption, and provider support.

Ensure patients have the right to access in-person services

Supporting detail and current state: Patient choice is a guiding principle for the development of DHCS's future telehealth policy design, highlighting DHCS's belief that patients should have the ability to choose the mode of care delivery that best meets their clinical and personal needs. A recent national poll conducted during the pandemic by NPR, the Robert Wood Johnson Foundation, and the T.H. Chan School of Public Health at Harvard found that while 82% of respondents who had a telehealth visit

reported satisfaction, nearly two-thirds (64%) would have preferred an in-person visit.[39] The degree to which patient preferences for telehealth vs. in-person care may differ outside of a pandemic remains topic for further study.

Currently, DHCS Medi-Cal telehealth policy gives providers flexibility to use telehealth as a modality for delivering medically necessary services to their patients.[40] DHCS does not require providers to offer in-person services if they also offer services via telehealth.

DHCS is considering adjusting its policy to ensure patients have the right to access services in-person or via telehealth in an effort to support patient choice and equity. This may be implemented through a requirement that providers are able to refer patients to appropriate in-person care, provide a warm hand-off to an in-person provider, or offer an in-person option themselves. There may be exceptions to this policy for certain types of providers.

Issues raised by workgroup:

Members representing consumers/consumer organizations:

Members noted the importance of access to in-person visits, emphasizing that enrollees should be routinely reminded (through annual notices, at the time of appointment booking, as well as throughout an enrollee's clinical journey) of their right to in-person services. Members highlighted the benefits of in-person services as an opportunity for providers to engage with patients in ways that may elicit more subtle insight into a patient's experience and circumstances.

Members representing payer organizations:

Members noted that in-person visits help providers identify certain aspects of a patient's history and health status, but that providers offering services via telehealth can ask questions to elicit information that they may otherwise gather in-person.

Members representing provider organizations:

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[39] NPR, the Robert Wood Johnson Foundation, and the T.H. Chan School of Public Health at Harvard, "Household Experiences During the Delta Variant Outbreak" (October 2021)

[40] DHCS Medi-Cal Telehealth Policy

Members generally agreed that the need for in-person services varies by specialty; behavioral health was cited as an example of a specialty that will likely permanently shift to increased telehealth post-PHE.

Members disagreed on how often in-person care should be offered to patients, with some members believing that patients should be reminded consistently throughout their clinical experience (e.g., at the time of scheduling, via text or patient portal message), while others thought less frequent reminders were necessary.

Members discussed the exact definition of "access to in-person services"; one member rhetorically asked whether an in-person visit that is booked four months in the future qualifies as appropriate access to in-person care. This member further questioned whether being offered an in-person visit with a provider the patient has never seen before would be considered access to in-person services.

One member emphasized the dramatic provider shortages across specialties, even in the commercial context, and reinforced the importance of optimizing choices patients have for timely and clinically appropriate care.

Degree of workgroup alignment and DHCS implementation considerations: Workgroup members agreed that patients should have access to services both in-person and via telehealth but noted concerns that this policy should not be implemented in a way that reduces access to telehealth services. Most members agreed that the need for availability of in-person services varies based on patient needs and clinical specialty.

When implementing this policy approach, DHCS will consider how to ensure that guaranteeing access to in-person services does not exacerbate current disparities in access to in-person care or create disparities in access to telehealth services.

Allow new patients to establish a relationship with a provider via telehealth subject to certain protections

Supporting detail and current state: A new patient typically establishes a relationship with a provider by attending their first visit in which the providers may review the patient's medical history, conduct a physical exam if necessary, and discuss their current clinical needs or questions.

The current DHCS Medi-Cal telehealth policy does not discuss the establishment of new patients via telehealth; however, the DHCS FQHC/RHC provider manual prohibits the establishment of a new patient/provider relationship via asynchronous telehealth.[41, 42]

Issues raised by workgroup:

Members representing consumers/consumer organizations:

Members emphasized the importance of evaluating this policy proposal from the patient perspective, focusing on what would support patient access and outcomes. Members cited certain Medi-Cal populations that DHCS should consider in their evaluation of this policy approach, including enrollees with home health needs, rural patients, and the unhoused. A member noted that while CalAIM initiatives are supporting some of these populations, they have a hard time accessing care and being able to establish a patient relationship via telehealth would be critical for access to care. In addition, members noted the importance of understanding how this policy might impact access to telehealth services for children and adolescents.

Members were not fully aligned, as some members noted it may not always be clinically appropriate for patients to establish a relationship with a provider via telehealth.

Members representing provider organizations:

Most members representing provider organizations strongly supported the ability to establish new provider-patient relationships via telehealth. Members noted 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 easily access services (due to transportation issues, childcare issues, challenge getting time off work, etc.) were able to do so, and thus it is essential that any future telehealth policy not increase 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

[41] DHCS Medi-Cal Telehealth Policy
[42] DHCS RHC/FQHC Provider Manual

telehealth must ensure that access to in-person services can be provided, including the provision of transportation services.

Members also expressed that DHCS should consider allowing providers to establish a new patient through asynchronous as well as synchronous telehealth, noting the importance of asynchronous telehealth for certain specialties (e.g., teledentistry) and certain provider types (e.g., FQHCs/RHCs).

Members representing payer organizations:

One member noted that establishing a patient via telehealth should be allowed as long as the telehealth modality is appropriate for the type of service being delivered and that, depending on the condition, it may be applicable for the patient to be seen in-person as a follow up.

Degree of Workgroup Alignment and DHCS Implementation Considerations: There was a unified perspective that new patient-provider relationships should be able to be established via telehealth, but there were mixed opinions in regards to whether there should be limitations related to specific services or modalities. In addition, there was alignment among members around updating the FQHC and RHC provider manual to allow for the establishment of new patient/provider relationships via asynchronous telehealth when certain conditions are met. When implementing this policy approach, it is essential for DHCS to consider circumstances where it may not be clinically appropriate to establish a new patient/provider relationship via telehealth and the nuances of different telehealth modalities.

In addition, as it relates to the use of asynchronous telehealth for certain services (e.g., teledentistry) DHCS will consider concepts advanced during stakeholder discussions to inform the potential conditions upon which a patient may be able to establish a relationship with a provider at a FQHC or RHC via asynchronous telehealth (e.g., requiring that a billable provider in the Medi-Cal program who is employed by the FQHC or RHC supervises or provides the telehealth service, or that the billing provider is also an employee of the FQHC or RHC).

Allow the use of synchronous telehealth to meet Medi-Cal managed care enrollee access to care standards (network adequacy)

Supporting detail and current state: Traditionally, Medi-Cal managed care enrollee access to care standards (i.e., network adequacy) set the baseline requirements related to a health plan's ability to deliver covered in-person benefits and services.

Under current Medi-Cal managed care plan rules, if plans are unable to meet time or distance standards 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.[43] Currently five out of twenty-six Medi-Cal managed care plans have requested an alternative access standard to utilize telehealth to count towards their Medi-Cal managed care enrollee access to care standards; twenty-nine Specialty Mental Health Plans and twenty-four Drug Medi-Cal Organized Delivery Systems use telehealth to count towards network adequacy access to care standards. DHCS is considering allowing Medi-Cal plans to meet the managed care enrollee access to care standard for certain types of providers via telehealth rather than having to utilize an alternative access standard. The Centers for Medicare and Medicaid Services (CMS) codified policy in 2020 to enable Medicare Advantage (MA) plans to account for certain telehealth providers in their networks.[44] In general, MA plans must ensure that 85% of enrollees in rural areas and 90% of enrollees in non-rural areas reside within the maximum travel time and distance standards from providers. In addition, CMS provides MA plans a 10% credit towards the percentage of enrollees that must reside within required time and distance standards when the plan contracts with telehealth providers for dermatology, psychiatry, cardiology, otolaryngology, neurology, ophthalmology, allergy and immunology, nephrology, primary care, obstetrics & gynecology, endocrinology, and infectious diseases. DHCS is also considering allowing a higher percentage credit related to access via telehealth for non-specialty and specialty mental health, DMC-ODS and DMC.

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[43] DHCS Medi-Cal Managed Care All-Plan Letter 21-006

[44] Contract Year 2021 Medicare Advantage and Part D Final Rule

Issues raised by workgroup:

Members representing consumers/consumer organizations:

Members were generally cautious about the role that telehealth might play in in Medi-Cal managed care enrollee access to care standards. Members noted that California's provider workforce shortages should be considered in crafting this policy, noting that improving access to telehealth should not come at the expense of access to in-person care.

Members representing provider organizations:

Members acknowledged that telehealth can play an important role in providing access to care in underserved areas. However, they also suggested that telehealth providers should be able to provide a full spectrum of care – prescriptions, specialty referrals, appropriate follow-up care, etc. – either directly or through connections with brick and mortar practices.

Members representing payer organizations:

Members acknowledged the comments of other workgroup members who expressed concern about the role of telehealth within Medi-Cal managed care enrollee access to care standards, noting that plans do not view telehealth as a replacement of in-person visits, but as an additional clinical tool for providers. Members suggested that Medi-Cal managed care enrollee access to care standards must ensure sufficient and appropriate access to in-person services, and that inclusion of telehealth services may need to be specialty-specific.

One member presented a slightly different perspective, noting that future Medi-Cal enrollees may prefer telehealth to in-person care (e.g., younger generations who have grown up in the digital era) and these preferences should be recognized in the patient access standards.

Degree of workgroup alignment and DHCS implementation considerations:
Members were in general agreement that accounting for telehealth within Medi-Cal managed care enrollee access to care standards is complex, as the policies must balance the goals of increasing access to telehealth services without limiting access to in-person services or reducing patient choice. As DHCS considers implementation of this policy approach, it will seek to promote access to care via telehealth without unintentionally

limiting in-person care and will take into consideration that there are different considerations for different specialties, delivery systems and geographies.

V. Considerations for Telehealth Research and Evaluation

During the PHE, telehealth became a vital modality for the delivery of many outpatient services to Medi-Cal enrollees. As telehealth now becomes a mainstream method of care delivery, DHCS will consider how to study telehealth utilization and its impact on access, quality and outcomes, and on provider and enrollee experiences. Future research and evaluation approaches will also assess telehealth utilization through the lens of health equity by assessing variations and disparities in telehealth utilization and quality of care by race/ethnicity, primary language spoken, sex, age, aid code, geographic region, and disability status (where feasible). In considering a future research and evaluation plan, DHCS will draw from feedback provided by the Workgroup and will build upon the telehealth data management and analytic work already undertaken by DHCS and the analyses presented to the Telehealth Advisory Workgroup. DHCS will also consider whether additional data collection will be needed, how billing/coding requirements will support research, and what resources and timeframes will be necessary to undertake this work.

Potential Research Questions

During the final Workgroup meeting on October 20, DHCS presented a set of potential research questions in several broad domains that DHCS is considering as a guide for future research and evaluation. The Workgroup discussed these questions and recommended others, many of which are incorporated in the domains below: access and utilization; quality and outcomes of care; equity; provider and enrollee experiences, and equity.

Access and Utilization

DHCS approaches to telehealth research and evaluation will be informed by these questions on access to care and overall utilization for Medi-Cal enrollees:

- How does telehealth contribute to access to care for different populations and types of services? For enrollees who haven't historically sought services?

- What are the most common types of telehealth visits and how has access to those visits changed over time?
- What is the baseline of telehealth utilization post-PHE?
- How is the mix of service modalities (telehealth, in-person) changing over time?

Quality and Outcomes of Care

Potential areas of inquiry related to quality and outcomes may include:

- How does telehealth impact clinical outcomes for specific conditions? This might include disease-specific outcome measures such as Hemoglobin A1C rate or percent of patients with controlled hypertension and utilization measures such as hospitalizations and emergency department visits. This would require examining telehealth as part of a suite of care management services and not a stand-alone intervention.
- How does telehealth impact preventive care quality measures? This might include commonly utilized preventive care quality measures such as breast cancer screening rate, colon cancer screening rate and cervical cancer screening rate, among others. This would require examining telehealth as part of population health management efforts (since the actual preventive service would not be appropriately delivered remotely via telehealth modalities).
- How do quality and outcomes differ by telehealth modality (e.g., video, audio-only, asynchronous, remote patient monitoring)? (Note: dependency on implementation of an audio-only modifier to allow comparative data).
- How does telehealth contribute to meeting CalAIM goals of improved access and quality of care for particular populations of focus?
- How does DHCS approach quality and program integrity assessments differently with telehealth now playing a more prominent role in care?

Provider and Enrollee Experiences

DHCS will also assess how telehealth is impacting providers and Medi-Cal enrollees. DHCS will consider the avenues by which to collect and analyze data, including questions added to existing quality surveys (e.g., Consumer Assessment of Healthcare Providers and Systems or CAHPS), annual external quality reviews of managed care plans, and other potential methods. The evaluations would aim to potentially address these questions:

- What are provider experiences with using telehealth?
- How has the use of telehealth affected provider and enrollee satisfaction?
- What are Medi-Cal enrollees' experiences with using telehealth, particularly for non-English speaking enrollees?
- How are enrollees informing the research and evaluation agendas?
- In what ways do provider/patient needs set policy agendas and care standards in low-income health care settings?
- How can DHCS promote learning about telehealth and sharing of best practices among providers?

Equity

Equity is a cross-cutting component of DHCS' future research and evaluation efforts. Where possible based on available data and resources, DHCS will seek to assess variations and disparities in telehealth access and utilization, quality and outcomes of care, and provider and enrollee experiences for all of the questions listed in the prior domains by race/ethnicity, primary language spoken, sex, age, aid code, and disability status (where feasible). In addition, these questions would also be assessed by provider type, managed care plan and geographic region, including an examination of telehealth utilization by geography (e.g., county, urban/rural) and areas with limited broadband access. Finally, DHCS would aim to assess these questions for specific populations of focus (e.g., California Children's Services, dually eligible, persons with disabilities). Research questions specific to equity may include:

- Compared to in-person visits, how is telehealth used for different enrollee populations, looking at usage by race/ethnicity, primary language spoken, location (urban vs rural), and age?
    - For age, the analysis should be broken down into smaller age groupings, particularly for children and adolescents.
    - For race/ethnicity, seek to break down analysis by more focused subgroups, such as among the Asian/Pacific Islander populations.

Research and Evaluation Workplan

From November 2021 to March 2022, DHCS will develop short-term evaluation and long-term evaluation plans. This will involve developing frameworks and methodological approaches with which to address the research questions, identifying data collection

requirements, assessing how billing/coding requirements will support evaluation, identifying specific measures, and considering reporting timeframes and channels.

Workgroup members offered their perspectives on DHCS's approach to research and evaluation during Workgroup meetings and via surveys fielded by DHCS. This feedback will inform has DHCS develops its evaluation plans. DHCS will also continue to seek stakeholder, provider and Medi-Cal enrollee input into the research and evaluation plans, the analytic results and how to meaningfully understand and use these results.

VI. Next Steps for DHCS Telehealth Policy Development

DHCS is committed to crafting a telehealth policy that reflects its guiding principles of equity, access, standard of care, patient choice, confidentiality, stewardship, and payment appropriateness. As DHCS continues to refine its policy approach, there are several immediate and longer-term steps DHCS will take to ensure its policy appropriately reflects Workgroup advisement and perspectives and DHCS goals.

DHCS will work to prepare a budget policy paper as an input into the 2022-2023 Governor's budget proposal process, as well as to prepare policy and operational guidance. This policy paper will be informed by Workgroup member feedback through the Workgroup comments as well as survey submission comments. DHCS will also develop a telehealth research agenda that will outline key telehealth considerations as well as a roadmap for gathering and analyzing that data. Additionally, in early 2022, DHCS will host webinars to review the 2022-2023 Governor's proposed budget policies, at which time DHCS will seek further Workgroup member and other stakeholder feedback. DHCS welcomes Workgroup member feedback, and encourages Workgroup members and others to provide feedback throughout the regular budget development process, submitting comments and input through traditional channels.

VII. Appendix

Acronyms

AMA – American Medical Association

A&M – Assessment and Management

CalAIM – California Advancing and Innovating Medi-Cal

CPT – Current Procedural Terminology

DHCS – Department of Health Care Services

DMC – Drug Medi-Cal

DMC-ODS – Drug Medi-Cal Organized Delivery System

E&M – Evaluation and Management

FPACT – Family Planning Access Care and Treatment

FQHC – Federally Qualified Health Center

HCPCS – Healthcare Common Procedure Coding System

LEA-BOP – Local Education Agency Medi-Cal Billing Option Program

PHE – Public Health Emergency

RHC – Rural Health Clinic

SUD – Substance Use Disorder

TCM – Targeted Case Management

Key Terms

Telehealth: The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.[45]

Telemedicine: Two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.[46]

Asynchronous store and forward: The transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.[47]

Synchronous interaction: A real-time interaction between a patient and a health care provider located at a distant site.[48]

Interactive telecommunications system: Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.[49]

Virtual communications and check-ins: Virtual communication services consists of at least five minutes of technology-based communication or remote evaluation services to conduct e-visits (e.g., web-based modalities, such as web-based interfaces, live chats, etc.) furnished by an applicable provider. Virtual check-ins (or brief communication technology-based services) are for patients to communicate with their physicians, health care practitioners, or other skilled and trained individuals such as Community Health Workers.[50]

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[45] Business and Professions Code section 2290.5(a)(6)
[46] Centers for Medicare and Medicaid Telemedicine Definitions.
[47] Business and Professions Code section 2290.5(a)(1)
[48] Business and Professions Code section 2290.5(a)(5)
[49] Title 42 of the Code of Federal Regulations, Part 410.78 (a)(3)
[50] DHCS Post-COVID-19 PHE Policy Recommendations, June 10, 2021

E-consult: Asynchronous health record consultation services that provide an assessment and management service in which the patient's treating health care practitioner (i.e., attending or primary) requests the opinion and/or treatment advice of another health care practitioner (i.e., consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient's health care needs without patient face-to-face contact with the consultant. E-consults between health care providers are designed to offer a coordinated multidisciplinary case reviews, advisory opinions, and recommendations of care.[51]

Remote patient monitoring (RPM): RPM enables communication and counseling or remote monitoring of chronic conditions such as cardiovascular and respiratory disease. RPM includes hardware and web-based software to track health care data typically from the patient's home.[52]

Telehealth Advisory Workgroup Membership List

Name	Organization / Entity
Per Assembly Bill 133	
Amy Moy	Essential Health Access
Beth Malinowski	California Primary Care Association
David Ford	California Medical Association
Linnea Koopmans	Local Health Plans of California
Lisa Matsubara	Planned Parenthood Affiliates of California
Sarah Hesketh	California Association of Public Hospitals and Health Systems
Yvette Willock	California Behavioral Health Directors Associations (represented by Los Angeles County Department of Mental Health)
Selected by DHCS	
Anna Gorman	County of Los Angeles Department of Health Services
Anna Leach-Proffer	Disability Rights of California
Anne Frunk	Shasta Community Health Center
Anthony Magit	Rady Children's Hospital & Children's Specialty Care Coalition

[51] DHCS Telehealth Definitions

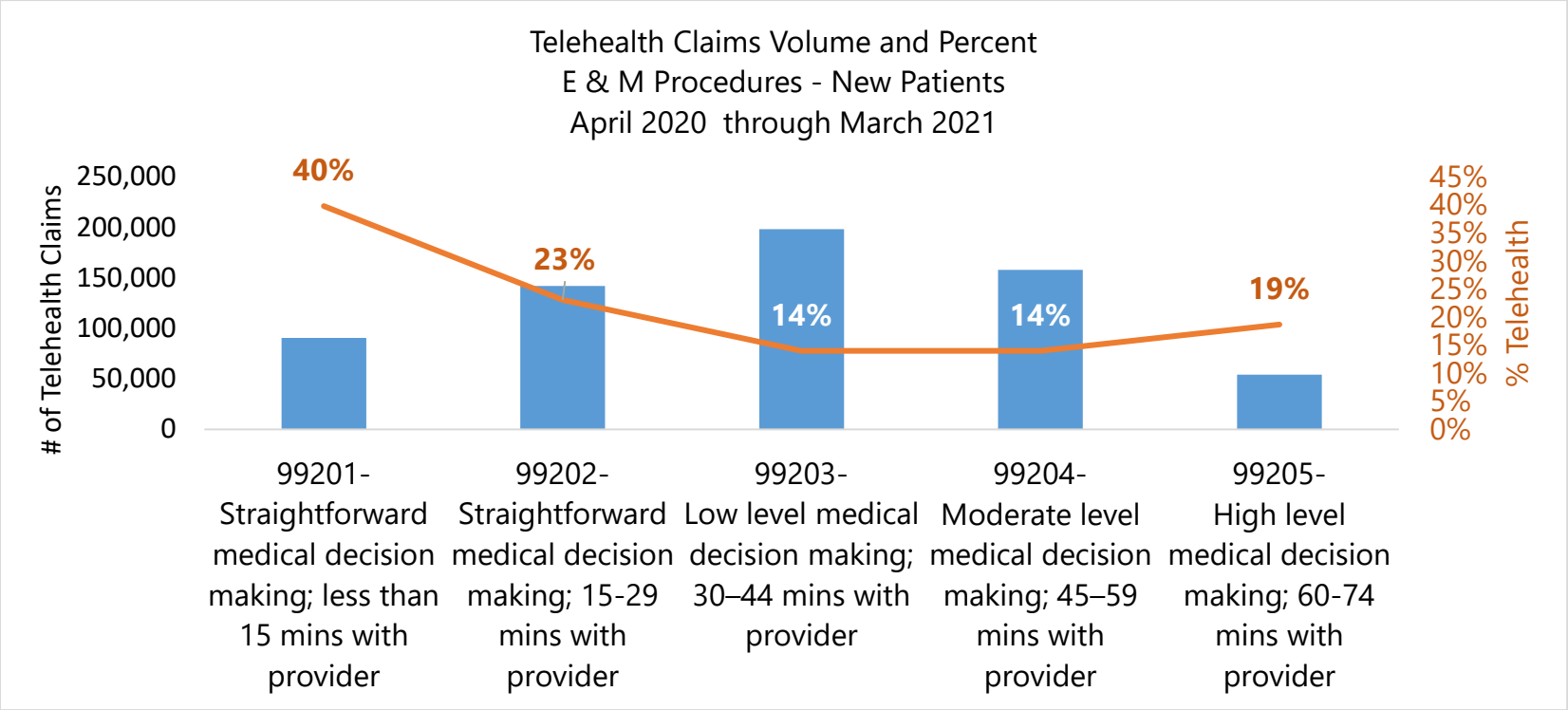
[52] DHCS Post-COVID-19 PHE Policy Recommendations, June 10, 2021

Name	Organization / Entity
Carol Yarbrough	University of California San Francisco Medical Center
Cary Sanders	California Pan-Ethnic Health Network
Tiffany Huyenh-Cho	Justice in Aging
Claudia Page	California Children's Trust
Fabiola Carrion	National Health Law Program
Farid Hassanpour	CenCal Health
Flora Haus	American Association of Retired Persons (AARP) California
James Marcin	University of California, Davis Health
Jen Raymond	Children's Hospital Los Angeles
Katie Heidorn	Insure the Uninsured Project
Leticia Alejandrez	California Emerging Technology Fund
Leticia Galyean	Seneca Family of Agencies
Lisa Harris	Indian Health Council
Lisa Moore	University of California Health
Mandi Najera	Promesa Behavioral Health
Matt Lege	Service Employees International Union, California State Council
Mei Wa Kwong	Center for Connected Health Policy
Nancy Netherland	Kids and Caregivers
Paul Glassman	California Northstate University College of Dental Medicine
Rajiv Pramanik	Contra Costa Health Plan
Rebecca Picasso	Blue Shield of California
Reynaldo Vargas-Carvajal Jr	Downey Unified School District
Sarah Bridge	Association of California Healthcare Districts
Sylvia Trujillo	Oregon Community Health Information Network

Supplementary Telehealth Utilization Analyses

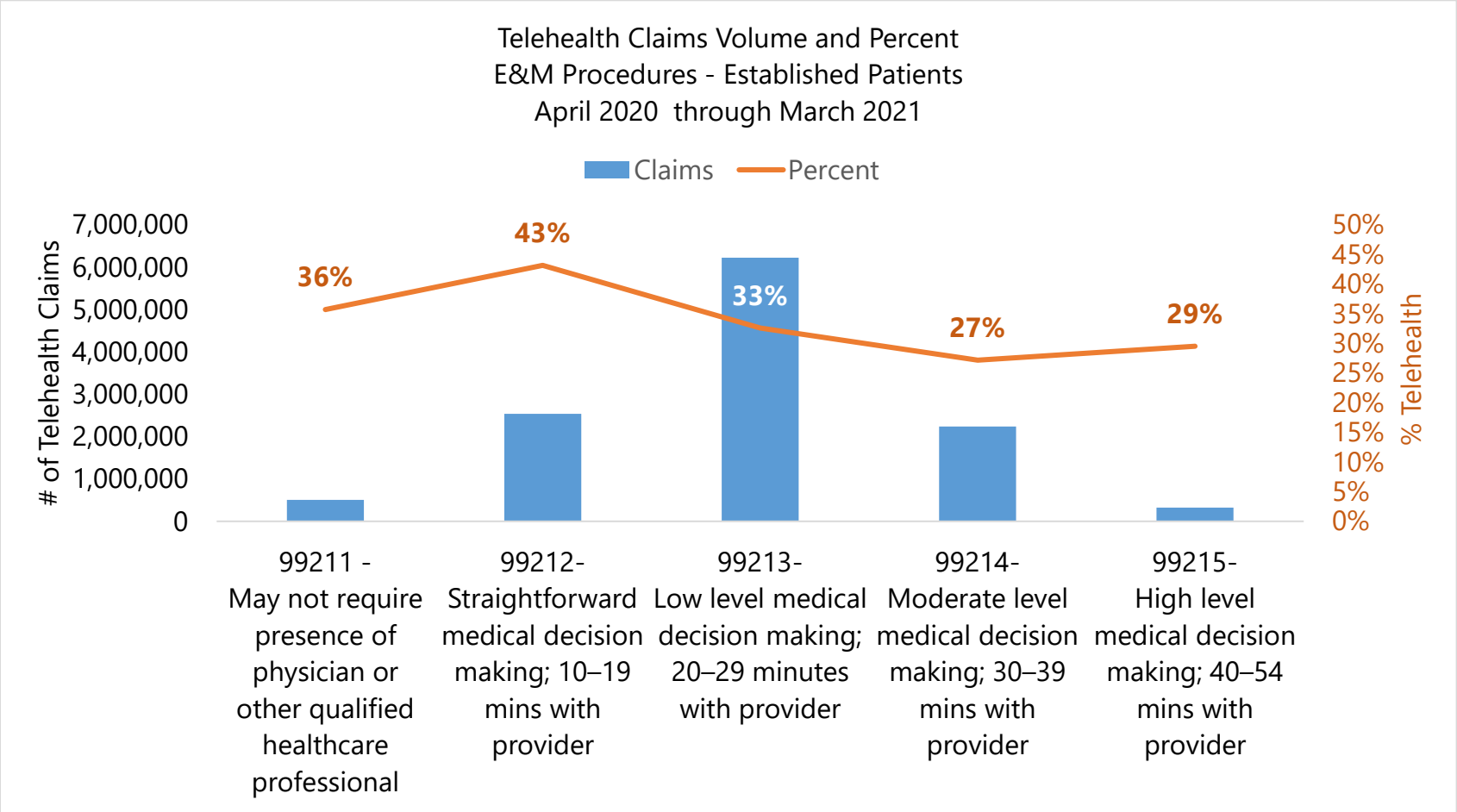
Below is a selection of the telehealth utilization analyses produced for Workgroup consideration. More detailed analyses are available in the meeting materials posted to the Telehealth Advisory Workgroup website.[53]

New Patient E&M Claims, April 2020 – March 2021

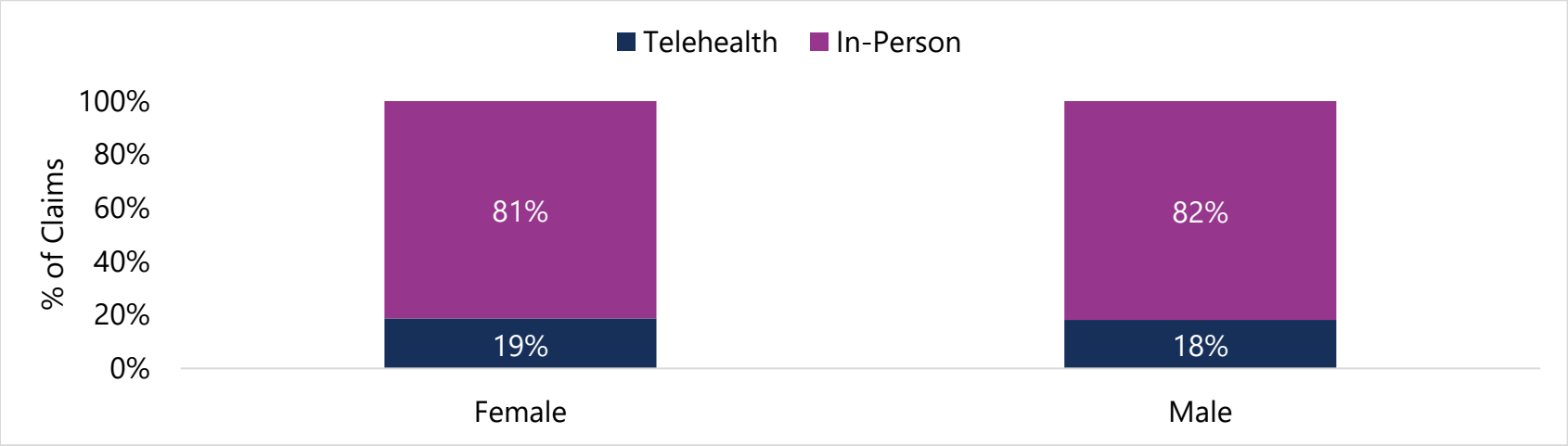


[53] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx

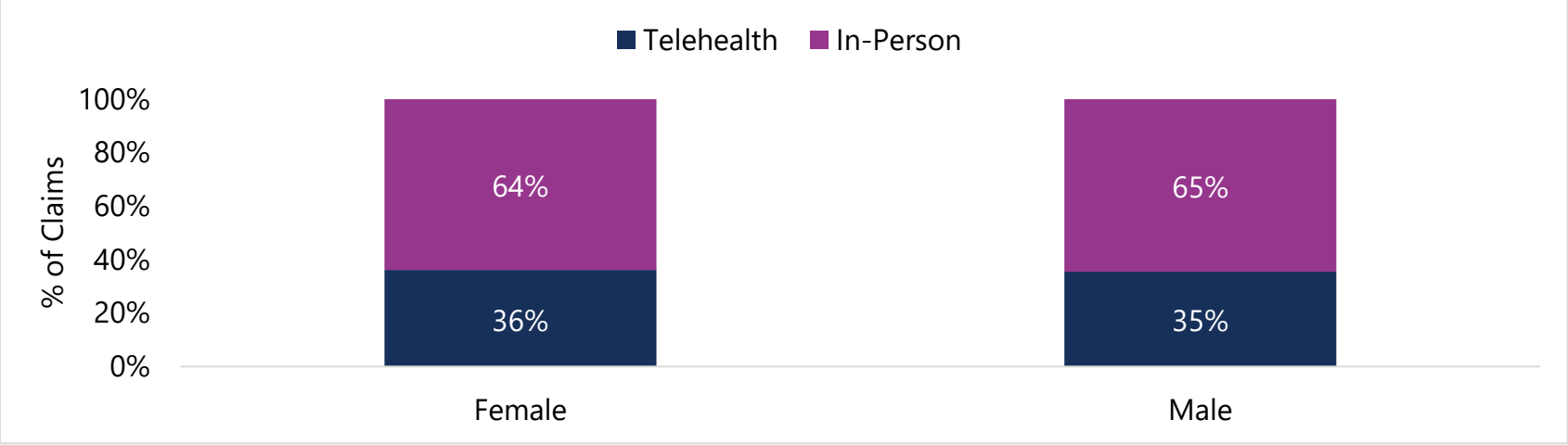
Established Patient E&M Claims, April 2020 – March 2021



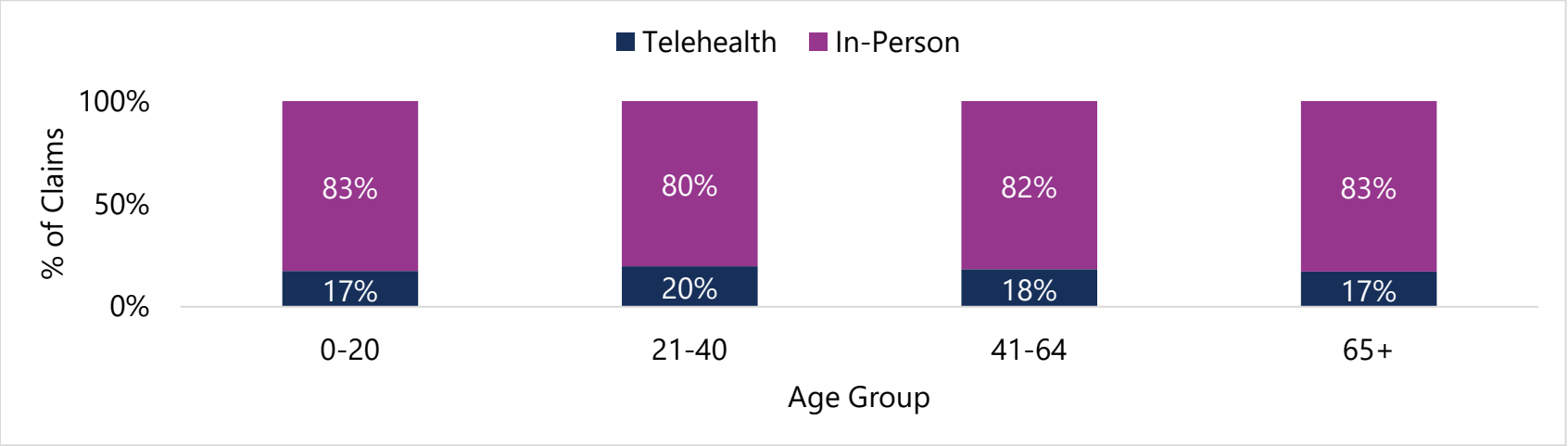
New Patient E&M Claims by Sex, April 2020 – March 2021



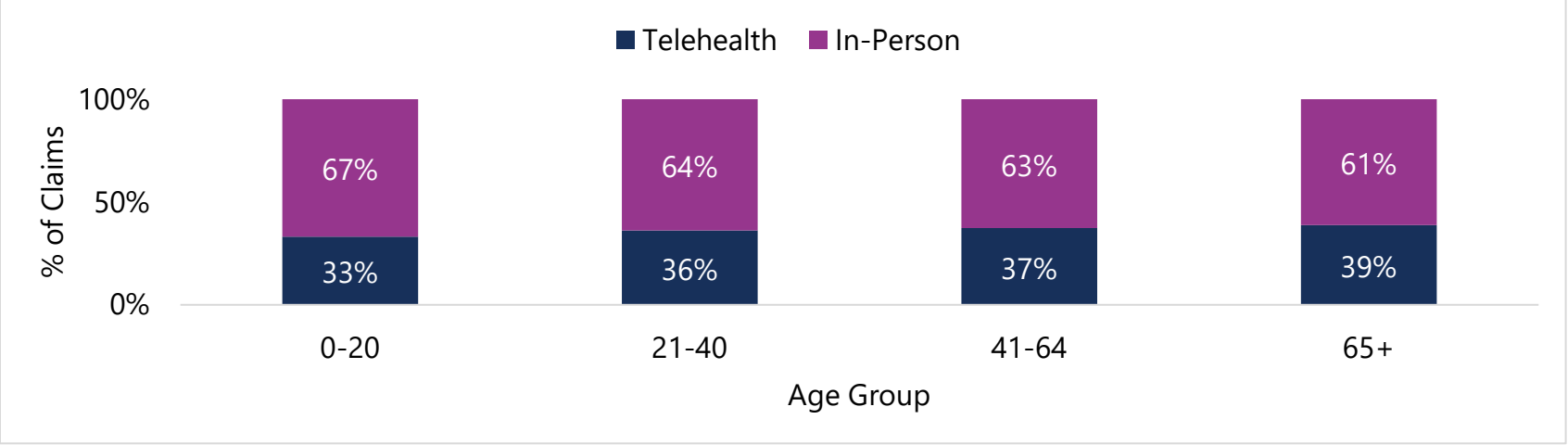
Established Patient E&M Claims by Sex, April 2020 – March 2021



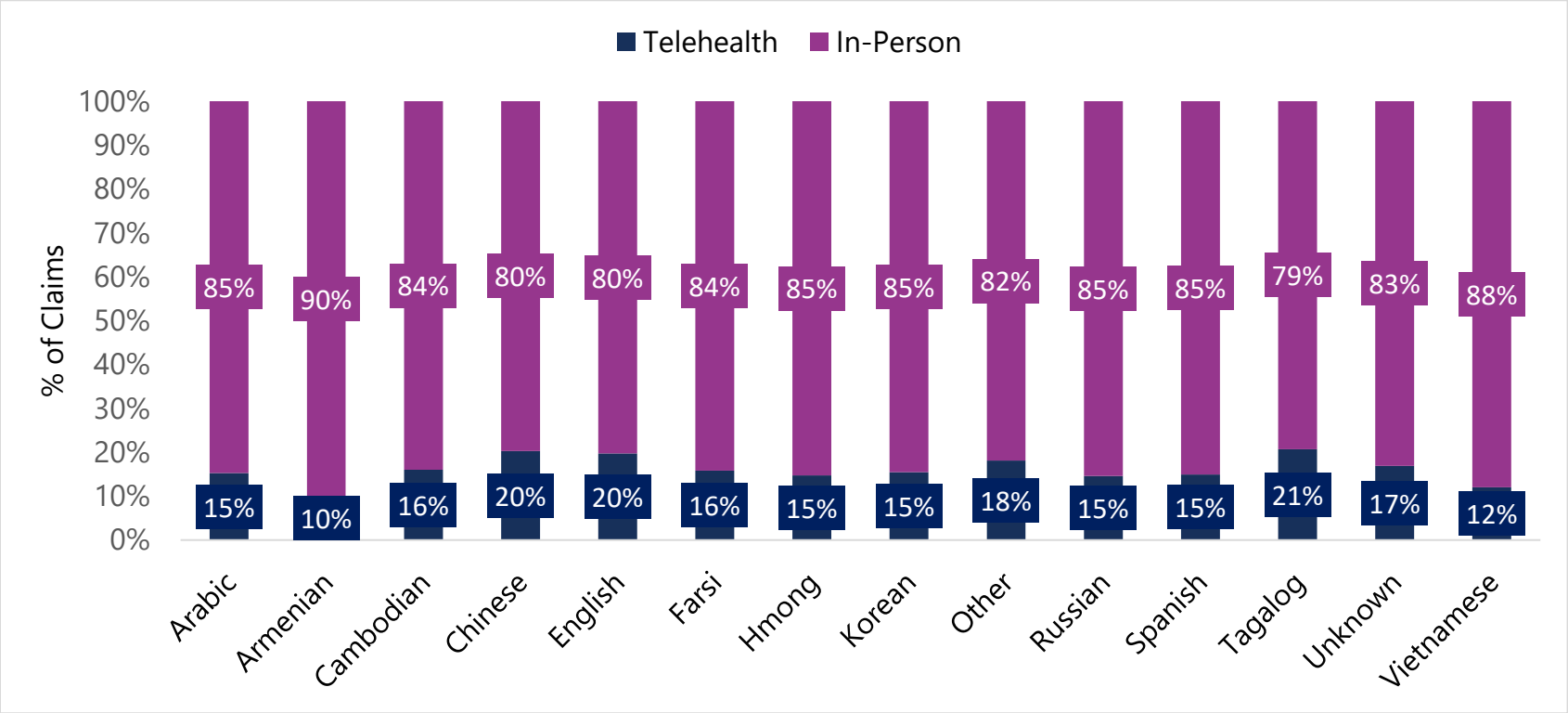
New Patient E&M Claims by Age, April 2020 – March 2021



Established Patient E&M Claims by Age, April 2020 – March 2021

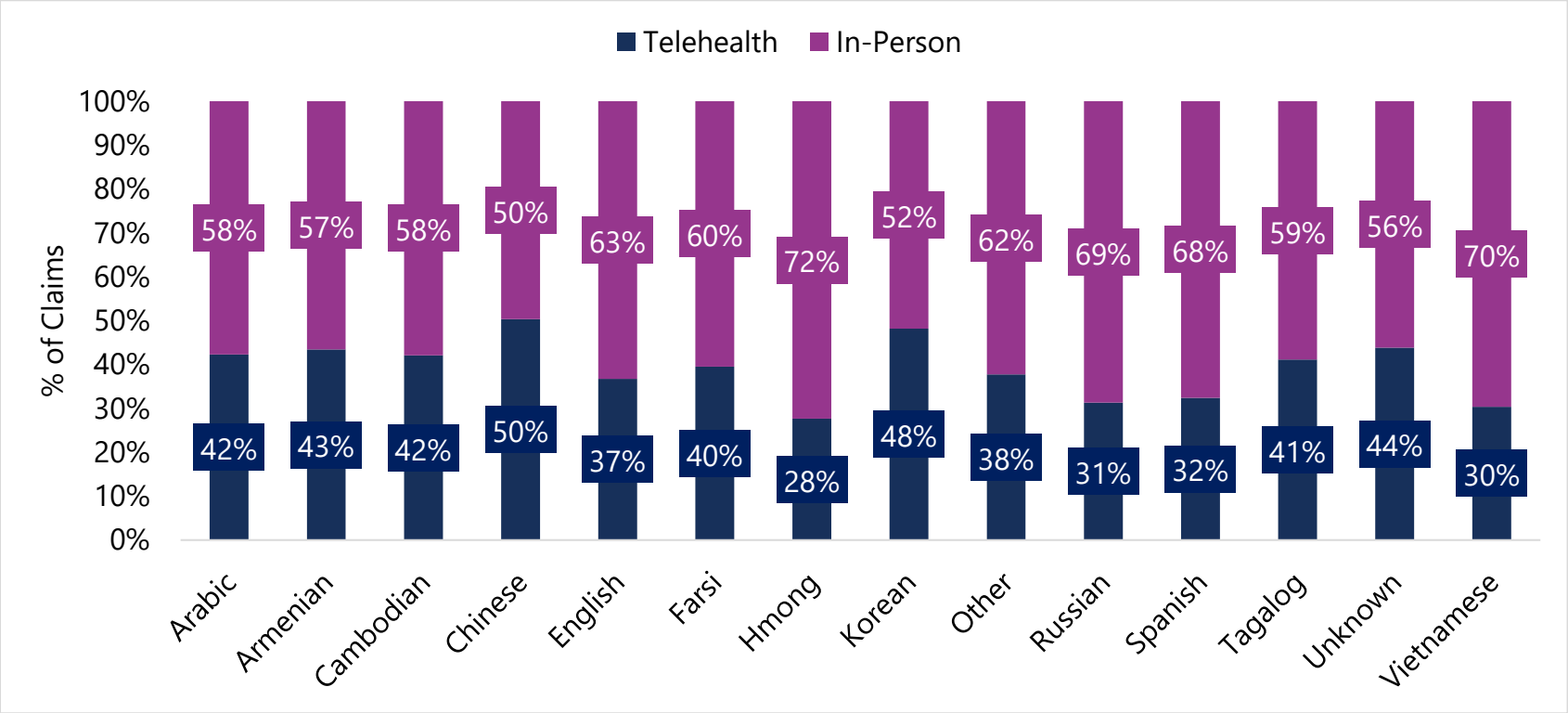


New Patient E&M Claims by Primary Language Spoken, April 2020 – March 2021



Note - Other includes ASL. Chinese includes Cantonese, Mandarin and Other Chinese

Established Patient E&M Claims by Primary Language Spoken, April 2020 – March 2021



Note: Other includes ASL. Chinese includes Cantonese, Mandarin and Other Chinese