DEPARTMENT OF HEALTH CARE SERVICES
Telehealth Advisory Workgroup
September 22, 2021
9:30am-11:45am PST

MEETING SUMMARY

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

Telehealth Advisory Members Not Attending:
Lisa Harris, Indian Health Council

California Department of Health Care Services (DHCS) Staff Attending (alphabetical): Autum Boylan, Mayra Cano, Bambi Cisneros, Anastasia Dodson, Carol Gallegos, Catherine Hicks, Yingjia Huang, Jacob Lam, Karen Mark, Rene Mollow, Lisa Murawski, Kelly Pfeifer, Susan Philip, Melissa Rolland, Tyler Sadwith, Linette Scott, Rachelle Weiss, Norman Williams

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

Public Attending: 146 individuals from the public attended by Zoom.

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

Telehealth Advisory Workgroup Meeting Presentation and Discussion
Slides: https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Advisory-Workgroup-Meeting1-20210922.pdf

Mollow outlined the context and charge of the Stakeholder Advisory Workgroup. In response to COVID-19, coverage and reimbursement for telehealth services were expanded in the Medi-Cal program. As directed under a telehealth-related provision of a health-related trailer-bill to the 2021-2022 Budget Act, Assembly Bill 133 (AB-133), the California Department of Health Care Services (DHCS) was directed to convene a Telehealth Advisory Workgroup to inform DHCS in establishing and adopting billing and utilization management protocols for telehealth modalities starting January 1, 2023. The charge of this workgroup is to provide recommendations to DHCS that will inform policies for telehealth modalities that preserve access, quality, and patient choice. Additionally, the workgroup is charged with discussing and assessing the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits in the past or during the COVID-19 pandemic.

Mollow reviewed the timeline for the Workgroup, noting that there will be three sessions: one on September 22nd, one on October 6th, and one on October 20th. Given the timeline of the workgroup meetings, Mollow noted that there may be 'homework' for workgroup members to conduct in-between meetings. The discussions and content of these sessions will culminate in a stakeholder recommendations report, to be developed in November, that will include a qualitative summary of the Telehealth Advisory Workgroup Meeting proceedings, key themes and feedback on policy approaches, issues and considerations, and recommendations on policy approaches and a research and evaluation agenda. This report will inform DHCS telehealth policy making for the 2022-2023 proposed Governor's Budget.

Mollow also outlined what was in and out of scope for the workgroup as well as basic ground rules for participation. Specifically, the workgroup will not focus on telehealth beyond existing covered benefits, payment parity and reimbursement rates, or additional telehealth modalities. For participation, individuals must speak one at a time, remain engaged, actively listen, be mindful of time, and not speak over others or monopolize discussion.

As a brief review of the history of telehealth coverage in California, Mollow noted the most recent policy chances in Medi-Cal, namely those enacted immediately before and in response to the COVID-19 pandemic that allowed for increased telehealth flexibilities

during Public Health Emergencies (PHE). Specifically, in today's PHE, DHCS has established payment parity between telehealth modalities (video and audio-only) and in-person services, so long as those services meet billing code requirements; allowed video and audio-only visits; removed site limitations for Federally Qualified Health Centers/Rural Health Centers (FQHCs/RHCs); expanded synchronous and audio-only telehealth to additional delivery systems and allow reimbursement for additional physical health codes; expanded virtual check-ins to additional delivery systems (e.g., 1915c waivers, LEA BOP, among others).

Mollow noted the importance of recent policy changes at DHCS, while also outlining some of the current limitations. In 2019, DHCS coding guidance for FQHCs/RHCs did not require use of telehealth modifiers, limiting the ability to track telehealth claims and resulting in underreporting of telehealth claims. Additionally, the modifiers used did not distinguish between audio-only and video-visits. Thus, DHCS had policies in place, but the lack of use and lack of distinction between audio-only and video visits make data analyses challenging.

In terms of data collection, DHCS analyzed paid claims for the total number of outpatient telehealth visits for every 100,000 beneficiaries for March 2021. The outpatient visits include outpatient medical and non-specialty mental health services, but do not include specialty mental health services.

Mollow discussed some preliminary data findings:

- Adults 18-64 years old were more likely to have a telehealth visit than children, youths, or seniors;
- Female beneficiaries were more likely to have a telehealth visit than males;
- Hispanic beneficiaries had the lowest rate of telehealth visits; White race/ethnicity had the highest rate;
- Age, blind and disabled beneficiaries were among the most likely to use telehealth; former foster youth were among the least likely;
- The rate of telehealth visits in managed care was far higher than in fee-for-service;
- The rate of telehealth visits per 100,000 beneficiaries was highest at Blue Shield Promise and Kaiser North and South.

Mollow noted the importance of stakeholder feedback and input on what data analyses DHCS should prepare for discussion in future workgroups.

In discussing the benefits of telehealth – access, patient satisfaction, quality – Mollow noted that there are some inherent trade-offs in enabling care via telehealth:

- Expanded access to telehealth could perpetuate health inequities and disparities;
- Improved access could lead to unnecessary or duplicative care;
- Inability of telehealth providers to conduct physical exams or diagnostic testing could pose quality and patient safety risks without appropriate guardrails;
- Expansive coverage of telehealth could increase risks of fraud and abuse;

- Limited research exists regarding the quality of care for individuals who receive telehealth and in-person care.

Mollow highlighted the critical importance of DHCS Telehealth Guiding Principles in the decision-making of DHCS, noting that these principles have been the foundation for policy recommendations to the Governor. There are six guiding principles: Access, Standard of Care, Patient Choice, Equity, Stewardship, and Confidentiality.

Mollow introduced Alice Lam and Jared Augenstein from Manatt Health to explain policy approaches and lead discussion.

Alice Lam highlighted the importance of stakeholder feedback and keeping DHCS guiding principles at the forefront of conversation and decision-making. Lam noted that the goal of the first workgroup is to discuss a range of potential policy approaches and that subsequent workgroups would allow for prioritization and deeper reflection on specific policies. Lam outlined that the first guiding principle to discuss was access, with the policy approach for consideration whether DHCS should allow the use of synchronous telehealth to meet network adequacy standards for Medi-Cal managed care health plans, County Mental Health Plans, Dental Managed Care plans and Drug Medi-Cal-Organized Delivery Systems (DMC-ODS). Lam noted Medicare's policy that states, "to encourage and account for telehealth providers in contracted networks, we provide MA plans a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers" for a variety of specialties; Lam also noted Colorado's 2015 bill which allows insurers to offer access to specialty services via telehealth as a way of meeting the state's network adequacy requirements. Augenstein followed Lam's comments, posing questions for workgroup members about whether telehealth providers should be accounted for in meeting network adequacy standards or requirements, whether telehealth can be used to meet network adequacy standards or requirements, and what guardrails should be put in place to ensure that beneficiaries still have appropriate access to in-person care.

Member Comments:
Workgroup members commented that telehealth should be incorporated into Medi-Cal managed care network adequacy standards so long as access to in-person care was not jeopardized.

Members noted the benefit of telehealth flexibilities on improving California's workforce shortages by not only allowing for more providers to contribute within California, but also allowing out of state providers to contribute to an otherwise short-staffed system. Yet other members noted concerns that fully out-of-state telehealth providers may create further fragmentation of care and that this should be considered in the development of network adequacy standards.

Members noted that telehealth during the COVID-19 pandemic has transformed the delivery system, and thereby fundamentally shifted how individuals,

providers, and systems think about adequacy and networks. Given that fundamental shift, several members noted the need for leveraging data from the past two years to better understand the value of telehealth on increased utilization, access, and outcomes as a means of understanding if network adequacy standards were appropriately or inappropriately met throughout COVID-19.

Lam discussed DHCS's guiding principle Standard of Care, outlining the policy approach for discussion of whether DHCS should allow new patients to be established via telehealth subject to certain guardrails, and noted examples of relevant telehealth regulations in Medicare, North Carolina, and Tennessee. Augenstein opened for discussion, inquiring into what circumstances – if any – Medi-Cal should allow audio-only services for new patient visits, and whether audio-only services should be allowed if a patient has not had an in-person visits with the rendering telehealth provider within a given timeframe.

Member Comments:
Member comments reinforced the importance of standard of care, noting that high quality and sophisticated standards of care are possible in all modalities (in-person, audio-only, video visits). Members commented that DHCS should avoid creating limitations by specialty or practice type because modalities are changing rapidly and thus regulations need to be flexible enough to reflect the pace of change in the use of telehealth. There were several comments on the importance of appropriate coding to track outcomes based on modality.

Lam highlighted that patient choice is an important pillar to DHCS, outlining a proposed policy approach of requiring all telehealth providers that furnish health care services via video or audio-only modalities to offer both modalities. Lam noted that Medicare proposes requiring coverage of audio-only services if "the patient is not capable of, does not wish to use, or does not have bandwidth/access to use interactive audio-video modality", further noting that Vermont enables Medicaid providers to deliver services via audio-only if the patient elects to receive services via that modality. Augenstein opened for discussion, inquiring into what guidelines Members believe are helpful in ensuring audio-only preserves quality of care, whether there are services where audio-only does not meet standard of care, and whether the default telehealth modality for providers should be video, with audio-only available upon patient request.

Member Comments:
Several members reiterated the value of audio-only visits in increasing access and patient choice overall, noting that many constituents and beneficiaries would often chose audio-only visits over video-visits because of preference and/or technological limitations.

A few members noted that modalities are not always interchangeable or equivalent, and that it is important for patients to use the appropriate modality for his/her given situation. Members also commented that the appropriate use of one

modality over another for the same clinical need may vary depending on a patient's own situation (e.g., life events, location).

Members expressed interest in identifying either qualitative or quantitative data that reflects patients' preference choices for in-person vs. telehealth modalities. Members noted it would be helpful to understand beneficiary preferences as it relates to longer-term use of telehealth modalities, given that telehealth utilization data from the past eighteen months was predominantly collected during the COVID-19 pandemic. A few members expressed caution about using data collected during the COVID-19 pandemic to make decisions on frequency limits, noting that it is challenging to extrapolate from the pandemic experience.

One member noted that the framing of the conversation suggested a superiority of in-person or video visits over audio visits, commenting that the workgroup should not think of telehealth as an alternative to in-person, or a trade-off between audio and video, but rather an additional modality that coexists with in-person care.

Lam and Augenstein discussed the importance of DHCS's guiding principle Equity and outlined the proposed policy approach of requiring all telehealth providers to offer services via in-person with face-to-face contact. Lam noted that DHCS believes telehealth should offer an additional option for care and all Medi-Cal beneficiaries should retain the choice to have access to in-person care if they choose to do so. Lam explained North Carolina's Medicaid Program policy that states "beneficiaries are not required to seek services through telehealth, virtual communications, or remote patient monitoring, and shall be allowed access to in-person services, if the beneficiary requests". Augenstein opened discussion, prompting workgroup members to reflect on whether there are instances where 'telehealth only' providers might be able to meet the proposed policy through a referral, whether there are instances where a provider should not be required to offer in-person services, and whether there are other guardrails or considerations that DHCS could put in place to ensure beneficiaries are not inappropriately steered towards telehealth as opposed to in-person services.

Member Comments:
Member perspectives on requiring telehealth providers to also offer such services via in-person, face-to-face contact differed.

Members noted that telehealth services increase access to care and flexibility of care, but also expressed concern that steering a patient towards telehealth could be inappropriate.

One member noted that the workgroup's conversation referenced Medicare's high use of audio-only, noting that audio-only services in Medicare are often a way to break down technological barriers and increase access.

There was general agreement that the workgroup would benefit from defining 'steering'.

The final guiding principle discussed was stewardship, with a two-fold proposed policy approach: require telehealth providers to be located in California (with limited exception for specialty care), and require the implementation of post-visit monitoring protocols to facilitate oversight of telehealth services. Augenstein noted a recent MedPAC report detailing practical approaches to address program integrity concerns, including auditing providers who are outliers in terms of the volume of telehealth services they bill relative to other providers, auditing providers who are outliers in terms of the time spent delivering care via telehealth, and other red flags that would be important to consider, including more than a certain percentage threshold of audio-only visits, or a regular pattern of high-cost diagnostic tests following a telehealth visit. Questions posed for discussion included what guardrails should be put in place for out-of-state providers who deliver services via telehealth to Medi-Cal beneficiaries, and what monitoring protocols should DHCS consider adopting to facilitate oversight of telehealth services.

Member Comments:

Workgroup members highlighted the importance of telehealth for increasing the number of specialists (in state and out-of-state) available to California beneficiaries (e.g., gerontologists).

One member noted the potential operational and logistical complications of allowing out-of-state providers to provide services in-state. Another member noted that solely out-of-state providers may disrupt the in-state referral networks and potentially disrupt continuity of care.

Lam opened discussion to public comment.

Public Comment:

Individuals from the public highlighted the unique challenges of rural communities, in particular labor shortages and infrastructure (e.g., wireless internal connectivity). Individuals echoed workgroup members' comments on the importance of modalities outside synchronous telehealth and emphasized the importance of framing telehealth as way to increase efficiency and efficacy of care through triaging patients and supporting patient decision-making. There was also discussion on the Department's updated policy, effective November 1st, 2021, that will require modifiers for Special Mental Health Services provided via telehealth.

Additional Member Comments:

Several members emphasized the importance of asynchronous telehealth services to equity, access, and standard of care. Additionally, several members emphasized that telehealth should not be considered a separate clinical practice, but rather an extension of current practices that must meet similar clinical standards and processes.

Additional Resources Members Shared:

- Center for Connected Health Policy
  - Telehealth in California: Legislative History, 2019 https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/CA%20Telehealth%20Timeline%202019%20Update%20FINAL.pdf
  - Telehealth Policy Update California Presentation, 2/16/2021 https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/1%20KWONG%20CA%20TELEHEALTH%20POLICY%20DECK%20FEB%2016%202021_3.pdf

- California Health Benefits Review Program (CHBRP)
  - A Brief to the 2021-2022 California State Legislature, 2/11/2016 https://www.chbrp.org/Telehealth%20Background%20Brief-%20FINAL.pdf
  - What is the Current State of the Evidence on Telehealth, 2/13/2021 https://www.chbrp.org/2021%20CHBRP%20Presentation%20to%20Health%20Committee%20Info%20Hearing%20Telehealth%2002232021%20final.pdf

- OCHIN
  - Letter from OCHIN to Honorable Gavin Newsom, 3/25/2021 https://static1.squarespace.com/static/5ade0eb85cfd79247926399a/t/60639b9159387e284b4b5a16/1617140625412/CA+Governor+Newsom%2BMediCal%2BTelehealth%2BEquity+Final+%281%29.pdf

- California Health Care Foundation
  - Webinar – Making Telehealth Work: Key Insights from the California Safety Net, 8/30/2021 https://www.chcf.org/event/webinar-making-telehealth-work-key-insights-safety-net/
  - Californians with Low Incomes Report High Satisfaction with Telehealth, 10/22/2020 https://www.chcf.org/blog/californians-low-incomes-report-high-satisfaction-telehealth/

- Insure the Uninsured Project
  - Broadband for Health Basics, 5/2021 https://www.itup.org/wp-content/uploads/2021/05/Broadband-and-Health-Basics-FINAL-V1.pdf

- Health Law
  - Medicaid Principles on Telehealth https://healthlaw.org/resource/medicaid-principles-on-telehealth/

- California Children's Trust
    - Snapshot: Youth Share Their Thoughts About Telemental Health During COVID and Beyond, 4/2021 https://cachildrenstrust.org/wp-content/uploads/2021/05/NoGoingBack_snapshot.pdf
    - No Going Back: Providing Telemental Health Services to California Children and Youth After the Pandemic, 1/2021 https://cachildrenstrust.org/wp-content/uploads/2021/01/NoGoingBack_final.pdf

- California Pan-Ethnic Telehealth Network
    - Equity in the Age of Telehealth: Considerations for California Policymakers, 12/2020 https://cpehn.org/assets/uploads/2020/12/telehealthfactsheet-12420-d-1.pdf