Telehealth Advisory Workgroup Meeting #3

October 20, 2021

DHCS

Agenda

- Recap of Workgroup Meeting #2 Discussion and Feedback (45 min)
- Seek Workgroup Advisement on Potential Policy Approaches (75 min)
- Discuss and Seek Workgroup Input on Proposed Telehealth Research and Evaluation Agenda (30 min)
- Discuss Next Steps for Workgroup Report (10 min)
- Public Comment (15 min)
- Adjourn (5 min)

Recap of Workgroup Meeting #2

Recap: Approaches Discussed in Workgroup Meeting #2

Our goal for this section of the agenda is to review revised policy approaches following Workgroup #2 discussion and Survey #2 feedback, adjusting key considerations as necessary but not revisiting each policy conversation.

Discussed During Workgroup #2

Topic 1: Billing and Coding Protocols

- Use specific modifiers to delineate visit type
- Document reasons for using certain types of telehealth modalities

Topic 2: Monitoring Policies

- Document policies related to provider location and 'telehealth-only providers' or 'third-party telehealth providers'
- Adopt utilization review procedures for telehealth services

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach

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

Considerations Raised by Workgroup Members

- General support for adding an audio-only modifier to track audio-only visits
- Suggestion to use modality-specific modifier based on the modality used to initiate visit rather than how it ends as that will reflect provider/patient intent
- Some confusion related to coding for audio-only visits (in lieu of video or in-person) vs. telephonic evaluation and management (E/M) codes
  - Federally-qualified health centers (FQHCs) may find it challenging to bill telephonic E/M codes (99441-3); prefer billing audio-only visits using 'regular' CPT codes with audio-only modifier
- Preference for aligned approach to billing and modifier use across fee-for-service (FFS) providers and managed care providers where appropriate

Key Development:

We expect that the AMA CPT Editorial Panel will announce the approval of a new audio-only modifier in the coming weeks.

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach*

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

Considerations Raised by Workgroup Members

- Data collection is critical; open question as to whether consent, documentation, or billing/coding is the most appropriate approach to tracking rationale for different modality utilization
- Consensus on importance of patient consent, but varying perspectives on when and how consent is given
  - Some prefer consent at every encounter, citing need for patient support and empowerment
  - Others prefer less frequent consent, citing implications on workflows, provider/patient encounter time, and potential for consent regulation to affect providers' telehealth adoption
- Technological support and translation services are important in empowering patients and ensuring clear understanding during the consent process
- Patient modality preferences may change throughout visit (e.g., youths switching off video during sensitive moments)

**Policy approach amended to reflect Workgroup's feedback; policy approach discussed in Workgroup 2 read, "Document reasons for using audio-only instead of video in the patient record"*

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

New potential policy approach identified for refinement and feedback following Workgroup Meeting #2

Potential Policy Approach

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

Current State

These codes are not currently covered in FFS Medi-Cal.

Given a significant number of telephonic evaluation and management (99441-3), and assessment and management (98966-8) claims in managed care, it seems that many Medi-Cal managed care plans are covering these codes.

Discussion Questions:

- How could this policy approach support DHCS' expansive coverage of the delivery of services via audio-only?
- Is there a reason DHCS should not cover these codes?
- What are the considerations for using telephonic codes versus regular E&M codes with an audio modifier?

Topic 1: Billing and Coding Protocols | **Topic 2: Monitoring Policies** | Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach

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

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

Considerations Raised by Workgroup Members

- Out-of-state and third-party telehealth providers may help ease current and potential future workforce shortages (e.g., behavioral health and gerontologists)
- Patients close to state borders may be closer to in-person, out-of-state providers than in-person, in-state providers
- Some concerns raised regarding third party-providers, including:
  - Perceived preference for low-acuity patients
  - Fragmented information sharing
- Potential benefit of license reciprocity
- Reporting requirements may affect providers' willingness to provide telehealth services
- Data collection important for tracking and policy iteration

Key Development:

AB 457, signed by Governor Newsom on October 1, 2021, addresses third-party telehealth providers and mandates patient consent and notification requirements and health plan reporting on services delivered by third-party telehealth providers. Medi-Cal is currently exempt, but DHCS is directed to consider whether it is appropriate to adopt AB 457 requirements for Medi-Cal.

Potential Policy Approach

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

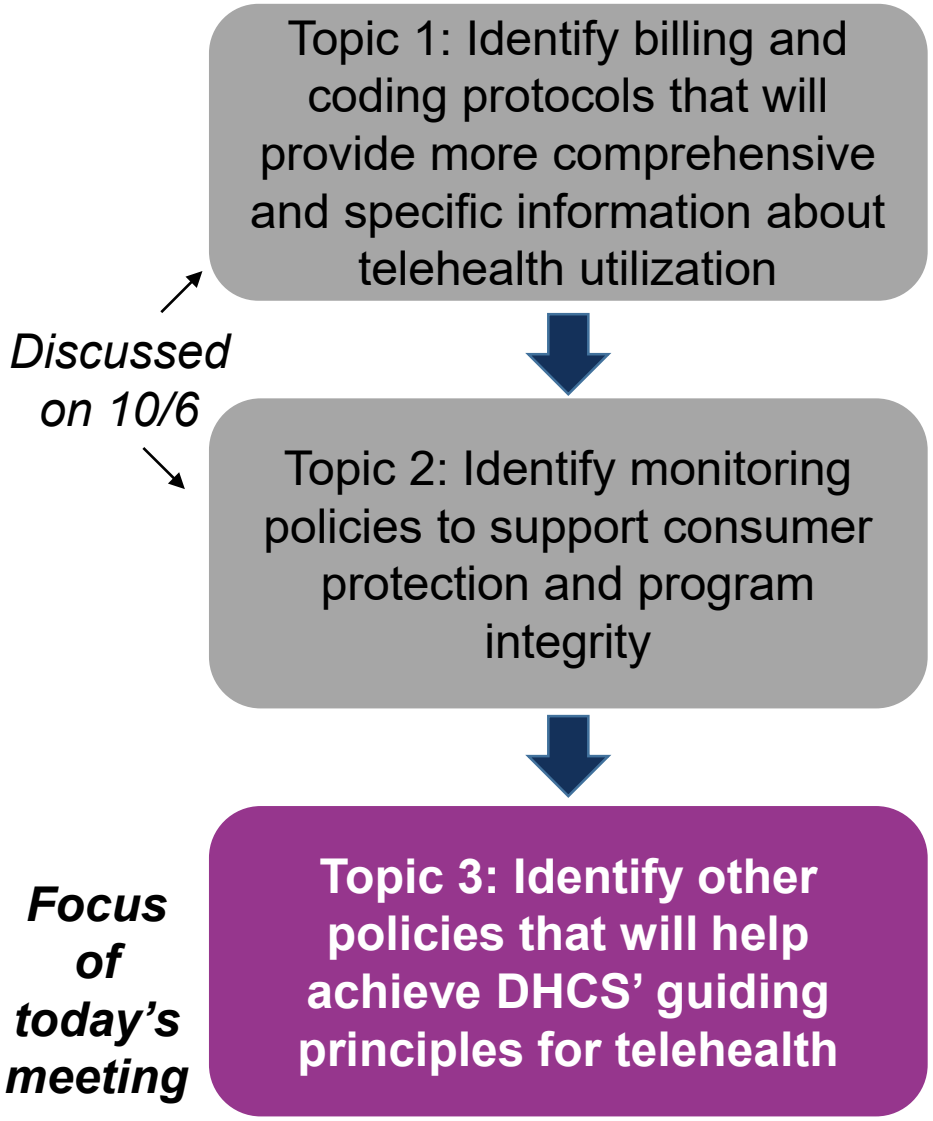
- **Time: Providers whose telehealth time exceeds hours in a week or month.**
- **Volume: Providers who bill a higher ratio of telehealth vs. in-person visits relative to others in their specialty.**
- **Time + Volume: Unexplained increase in volume; shorter appointment times that do not meet standard 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**

Considerations Raised by Workgroup Members

- Whether existing, in-person monitoring policies can be used for, or adapted to, telehealth modalities
- Tracking whether a patient is offered a full array of services across modalities may serve as indicator of access and equity
- Creating long-term policies requires creatively thinking about future uses of telehealth, beyond its uses today

Potential Policy Approaches

Topics for Workgroup Advisement



Issues to be Addressed

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

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

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

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach

Provide patients the choice of video or audio-only modalities when care is provided via telehealth, if the care can be appropriately delivered via more than one modality

Current State

DHCS' Medi-Cal telehealth policy does not require Medi-Cal providers offering services via telehealth to offer a specific set of telehealth modalities. Patient choice of telehealth modality is limited to those modalities offered by any given Medi-Cal enrolled provider.

Discussion Questions:

- How should DHCS balance patient choice of telehealth modality with delivery of services via the most clinically appropriate modality?
- What do we know about patient choice in commercial coverage? Are we creating worsening health disparities if Medi-Cal beneficiaries have less choice?
- How might this policy approach impact access to care if some providers are unable to offer both modalities?
- Should DHCS consider implementing this policy over time to accommodate providers who haven't yet adopted video?
- What other policy approaches should DHCS consider to ensure patient choice in telehealth modalities?

Potential Policy Approach

Ensure patients have the opportunity to access in-person services

Current State

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

Discussion Questions:

- Should providers be required to offer in-person services? A referral to in-person services?
- Are there some clinical areas or specialties that should be exempt from such requirements?
- How would this policy be implemented by providers and plans? What is the optimal way for patients to be notified of the opportunity for in-person access (e.g., at visit with provider? annual member notice from plan? other?)
- How might this policy approach impact access to care and health disparities?
- What other policy approaches should DHCS consider to ensure patient choice in method of care delivery?

Topic 1: Billing and Coding Protocols

Topic 2: Monitoring Policies

Topic 3: Other Policies to Support Guiding Principles

Potential Policy Approach

Allow new patients to be established via telehealth (video or audio-only) subject to certain protections

Current State

DHCS' Medi-Cal telehealth policy does not discuss the establishment of new patients via telehealth.

Discussion Questions:

- How might this policy approach impact access to care?
- What protections or criteria should be met in order to establish a new patient via telehealth?
- Are there clinical areas or specialties where it would be clinically inappropriate to establish a new patient via video visit? Audio-only visit? Other modalities?
- How might this approach impact certain quality/outcome measures that require in-person care? Are there policy modifications that can guard against this?

Potential Policy Approach

Allow the use of synchronous telehealth to meet patient access to care standards ("network adequacy").

Current State

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

Discussion Questions:

- How should access to services via telehealth be accounted for in meeting patient access standards?
- How might this potential policy approach impact access to care and health disparities, particularly in medically underserved communities? Are there potential unintended consequences?
- Should this policy approach be limited to specific telehealth modalities? Certain specialties?
- What other policy approaches should DHCS consider to promote access to care via telehealth?

Additional Discussion Questions

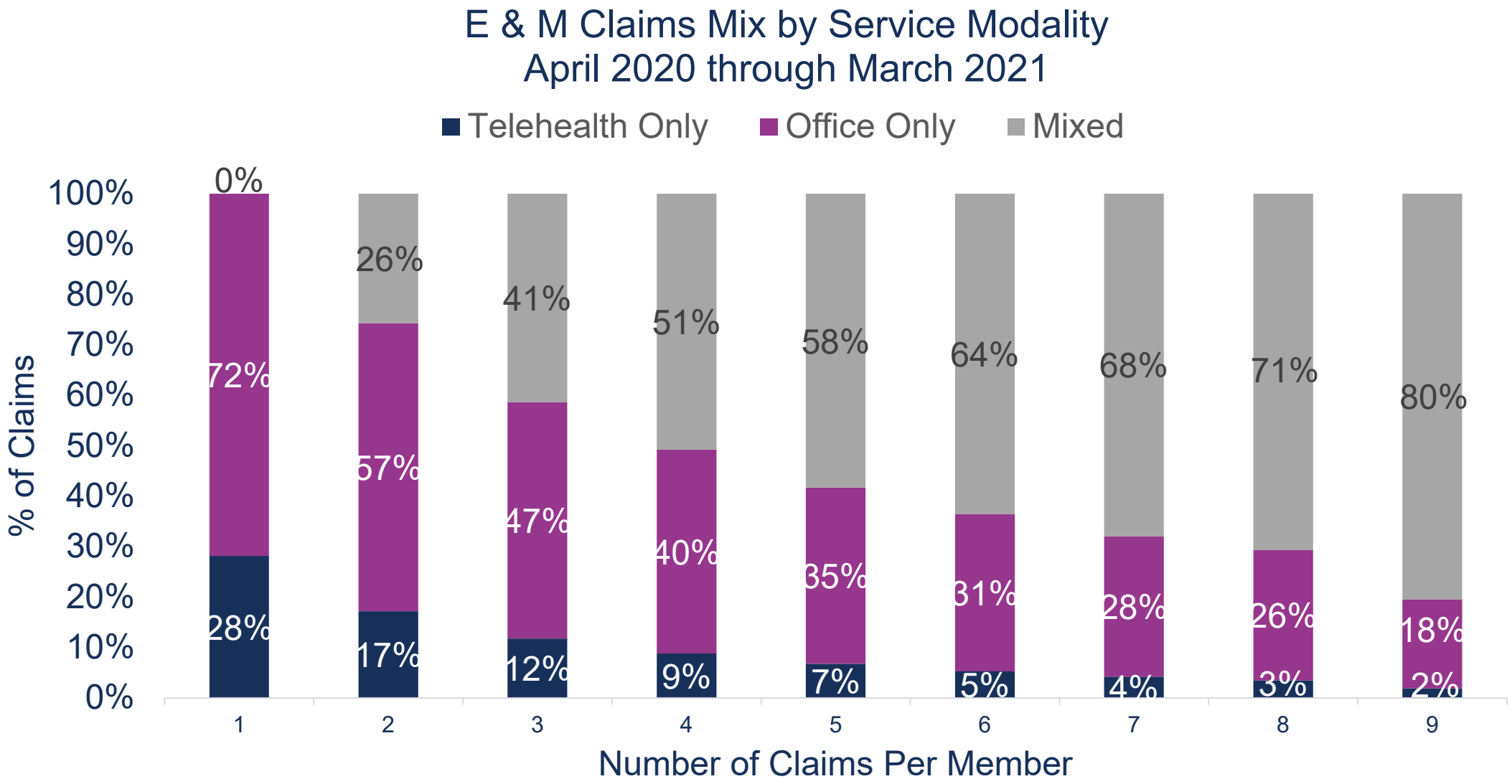
- What other policy approaches are important to consider?
- What factors should DHCS consider when weighing implementation of these policy approaches?

Telehealth Data

Telehealth Claims Utilization Analysis

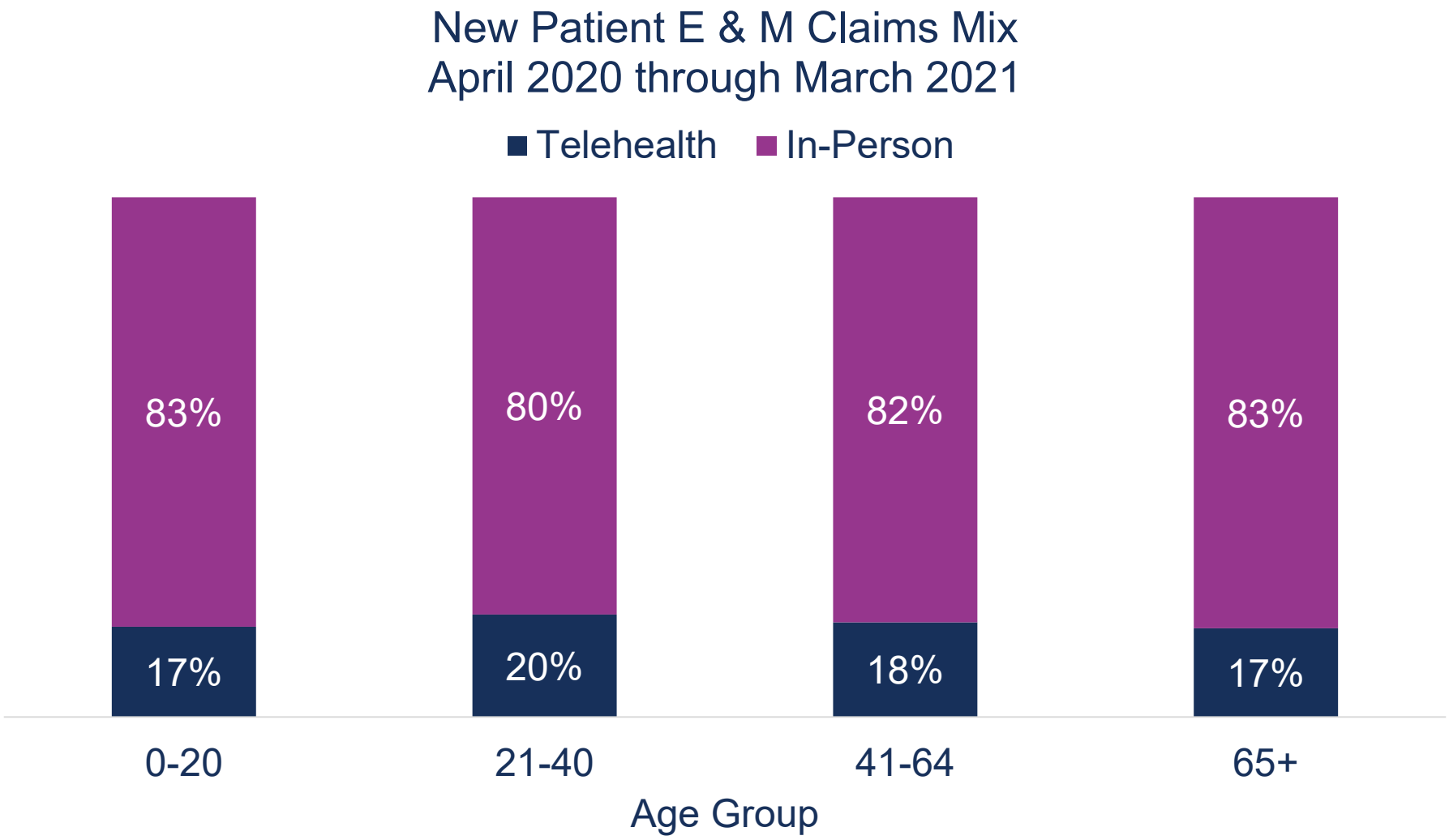
- DHCS analyzed paid claims for the 20 most commonly-used CPT codes for outpatient telehealth visits from April 2020 through March 2021
- The claims include FFS and managed care
- These outpatient visits include outpatient medical and non-specialty mental health services. These data do not include specialty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

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



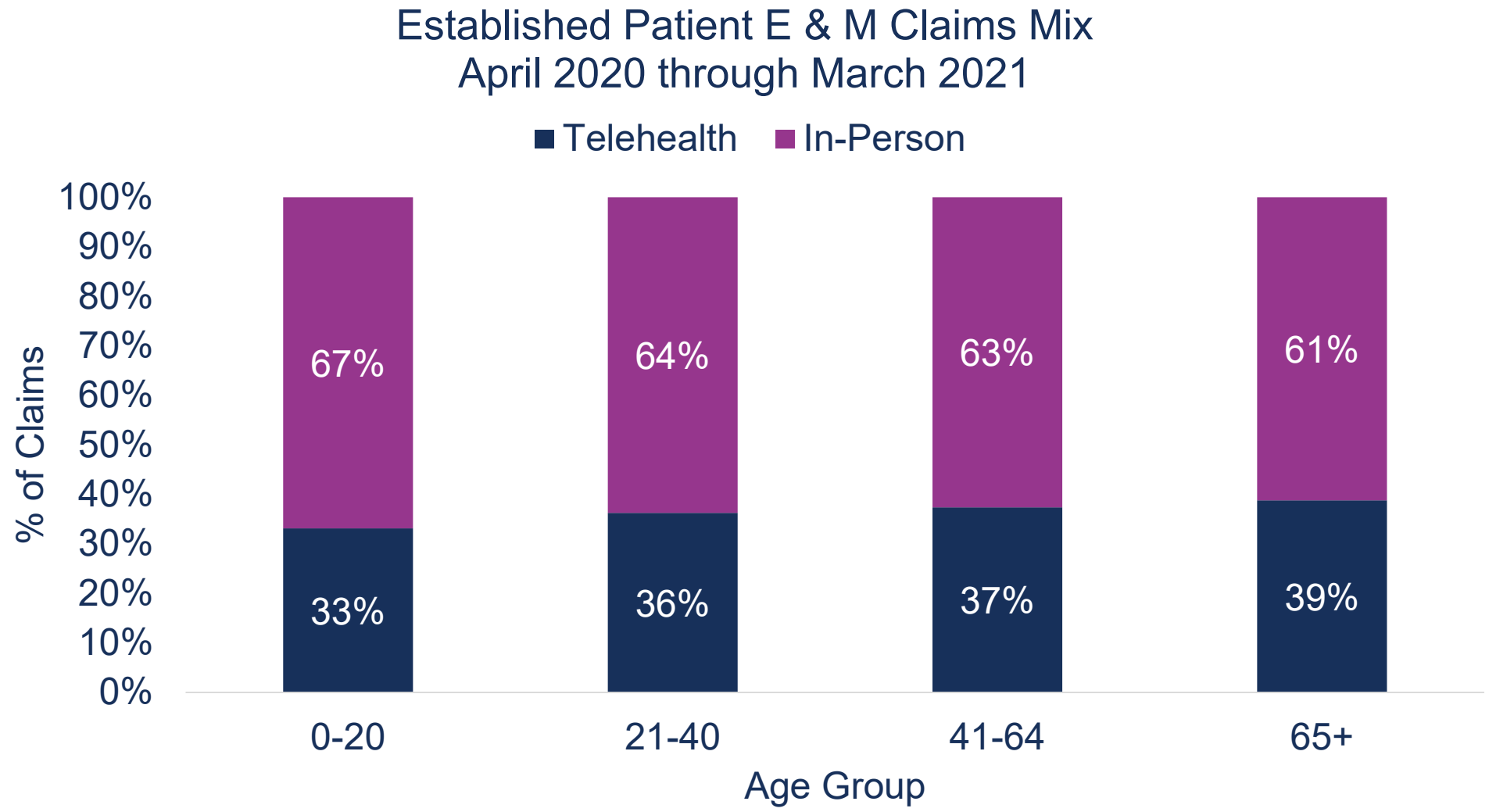
Preliminary analyses

About one in five of new patient Evaluation & Management (E&M) claims were via telehealth across age groups



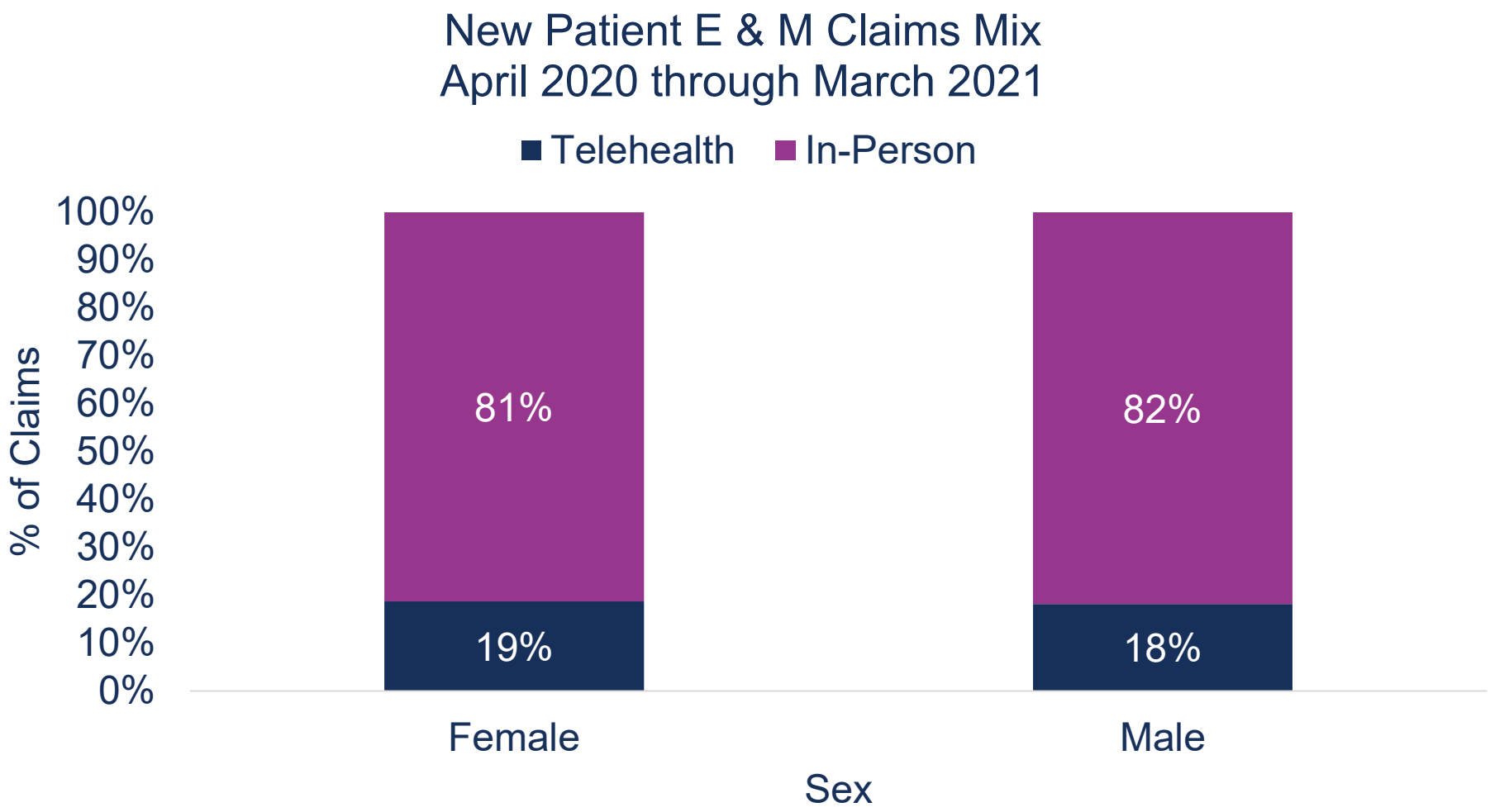
Preliminary analyses

For established patient E&M claims, telehealth represented one-third or more of all claims for each age group; older patients were more likely to have telehealth claims



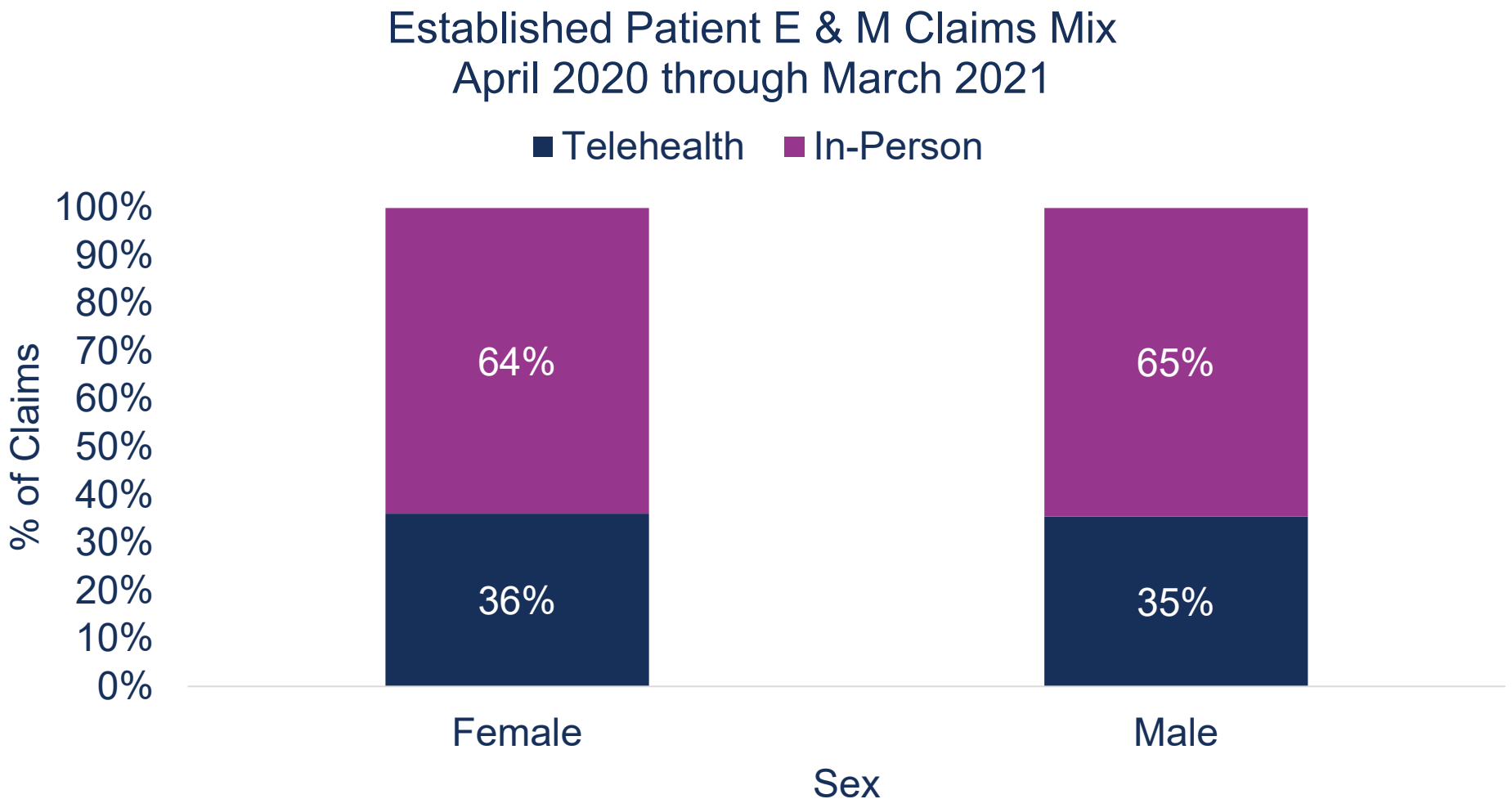
Preliminary analyses

Fewer than one in five new patient E&M claims were via telehealth for both sexes



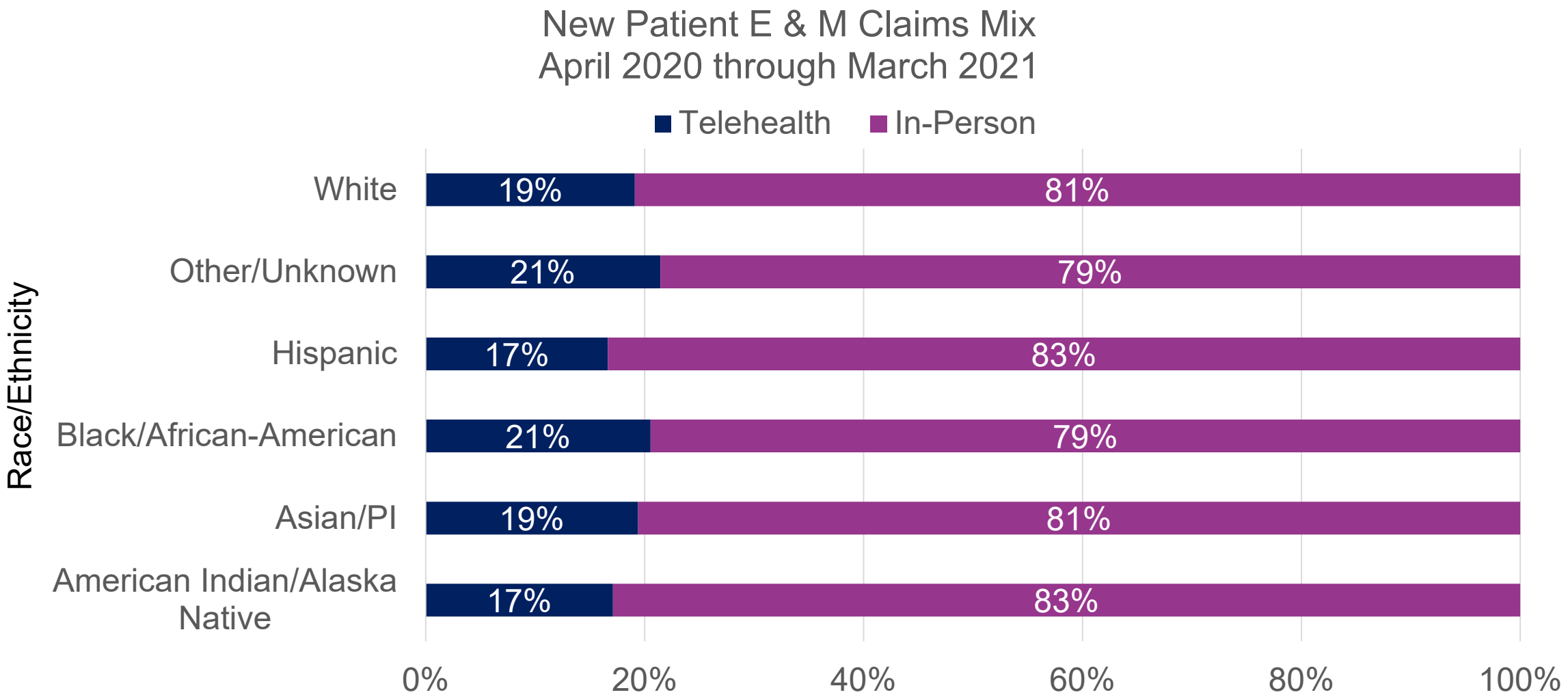
Preliminary analyses

Just over one-third of established patient E&M claims for both female and male members were via telehealth



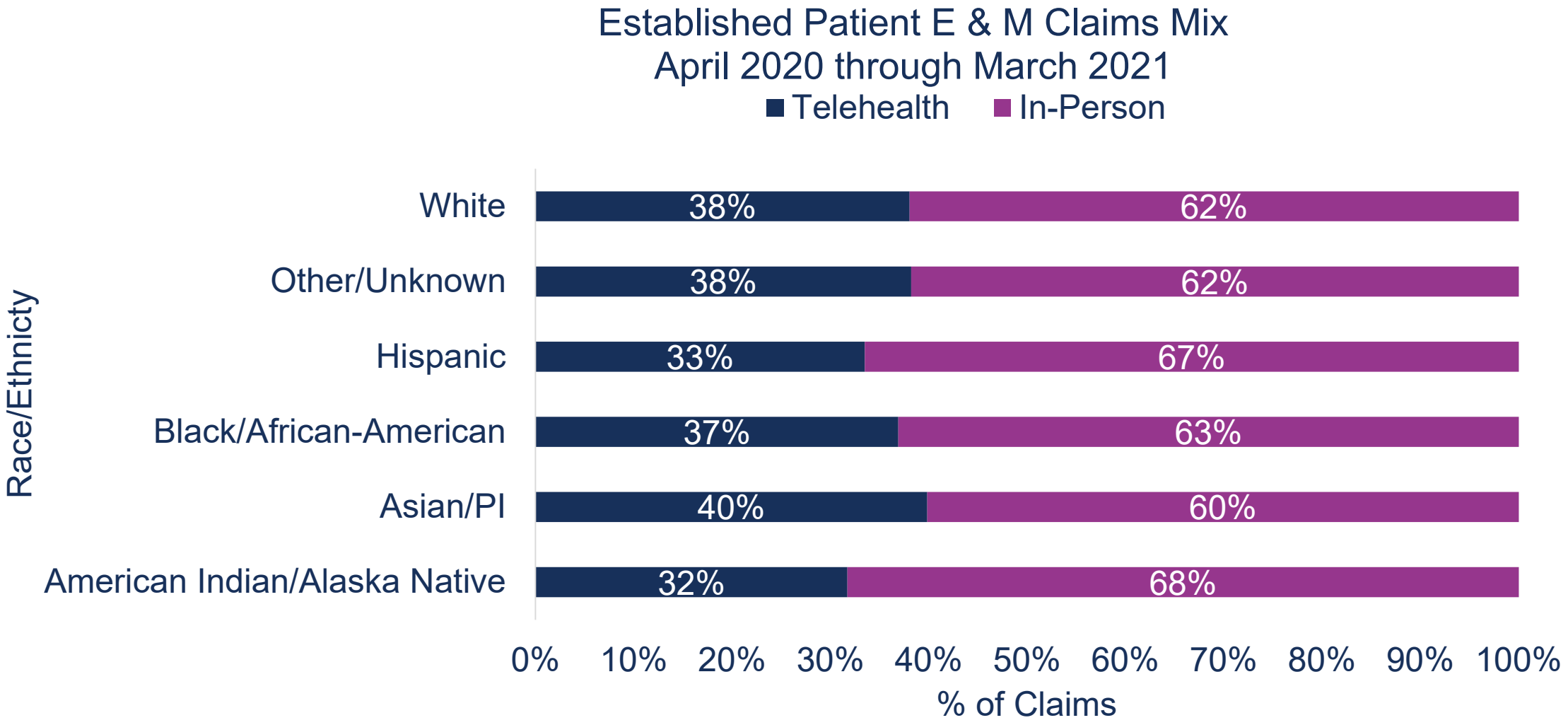
Preliminary analyses

Across all race/ethnicity groups, new patient E&M claims via telehealth were around 20% or less of all claims



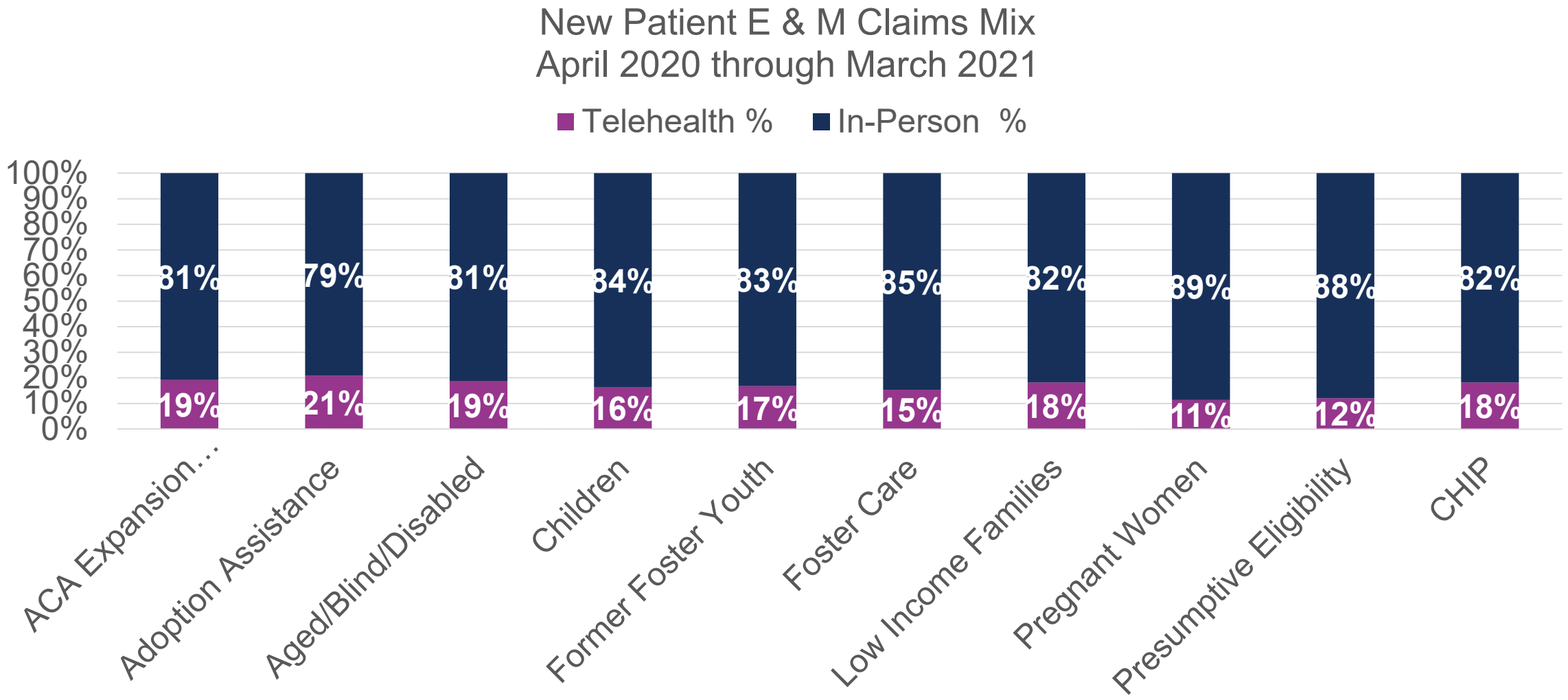
Preliminary analyses

Asian/Pacific Islander established patients had the highest % of telehealth E&M claims; American Indian/Alaska Native had the lowest; all racial/ethnic groups had about 33% or higher telehealth claims



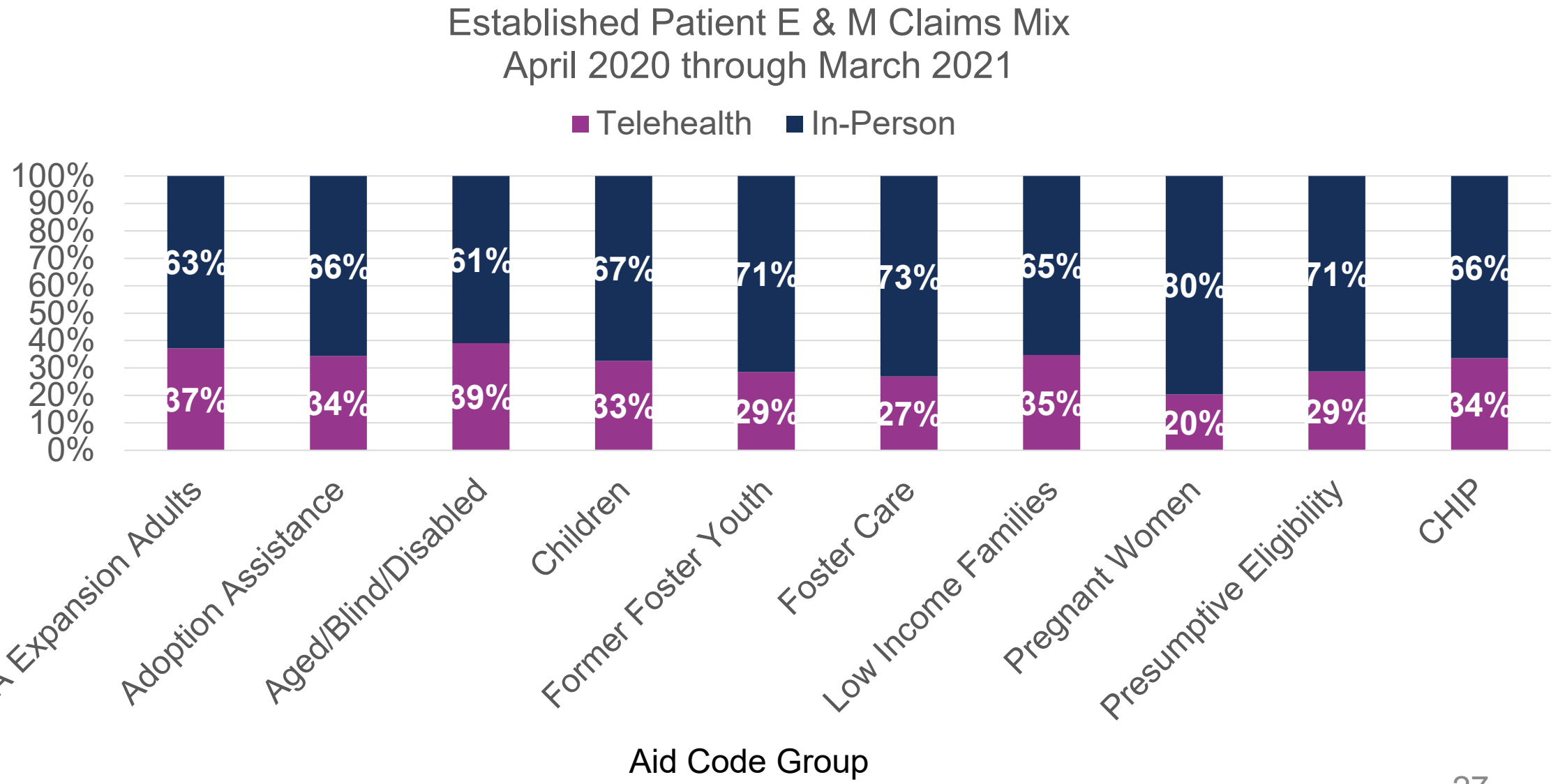
Preliminary analyses

For new patient E&M claims, telehealth represented around 20% of visits across aid codes; pregnant and presumptive eligibility aid codes had the lowest % of telehealth claims



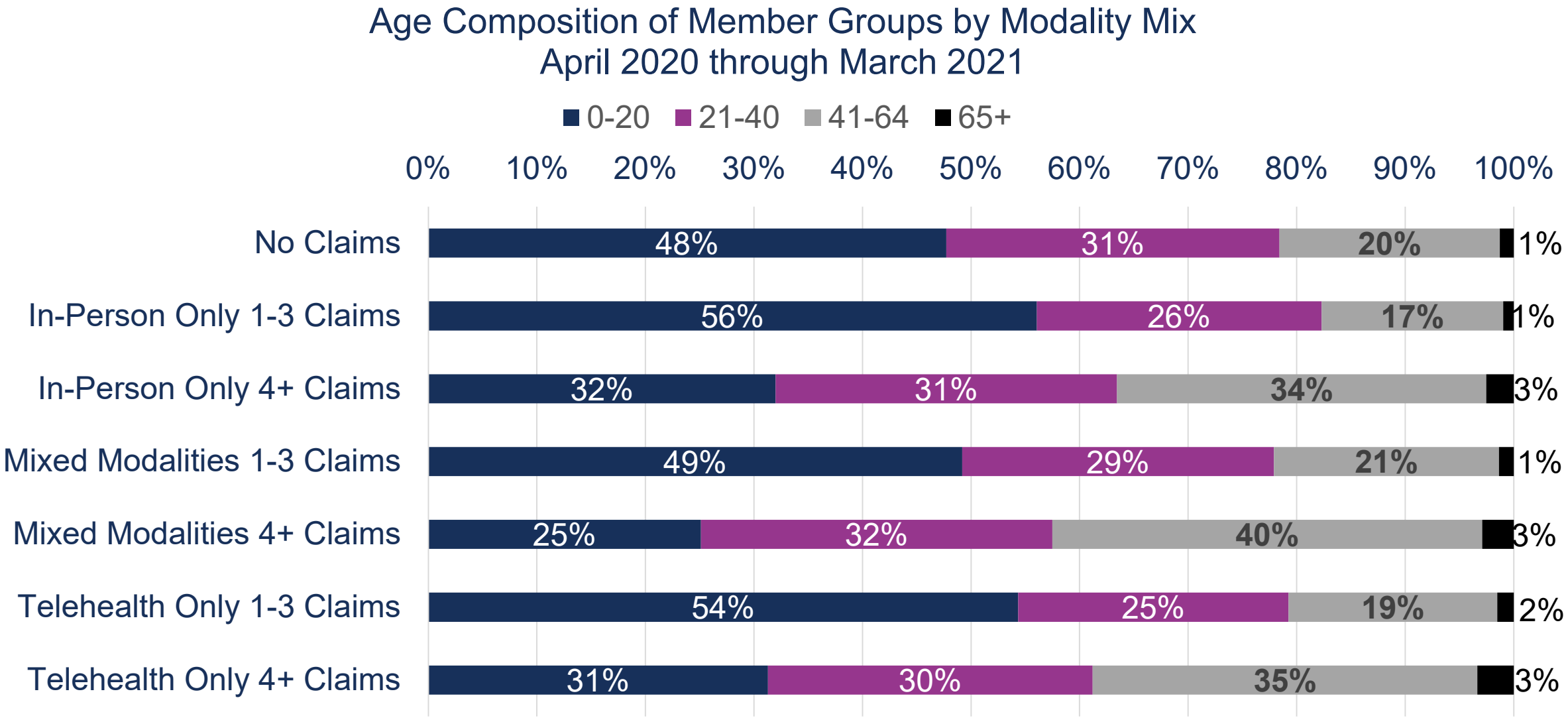
Preliminary analyses

Pregnant members had the lowest % of telehealth visits for established patient E&M claims; for most aid codes, telehealth claims were about one-third of claims



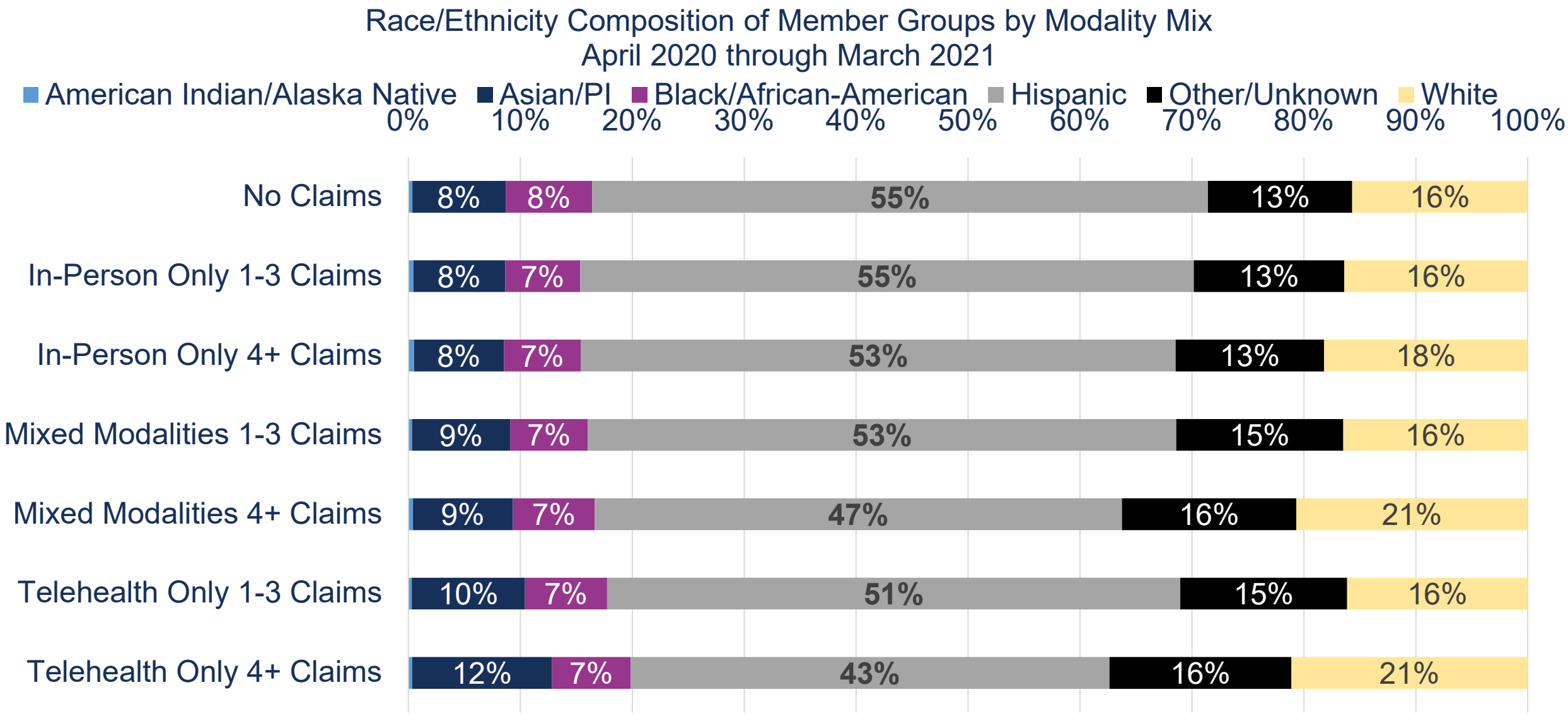
Preliminary analyses

As utilization increases, adult age groups represent an increasing share of utilization; a trend that holds across modalities (in-person-only, mixed, and telehealth-only)



Preliminary analyses

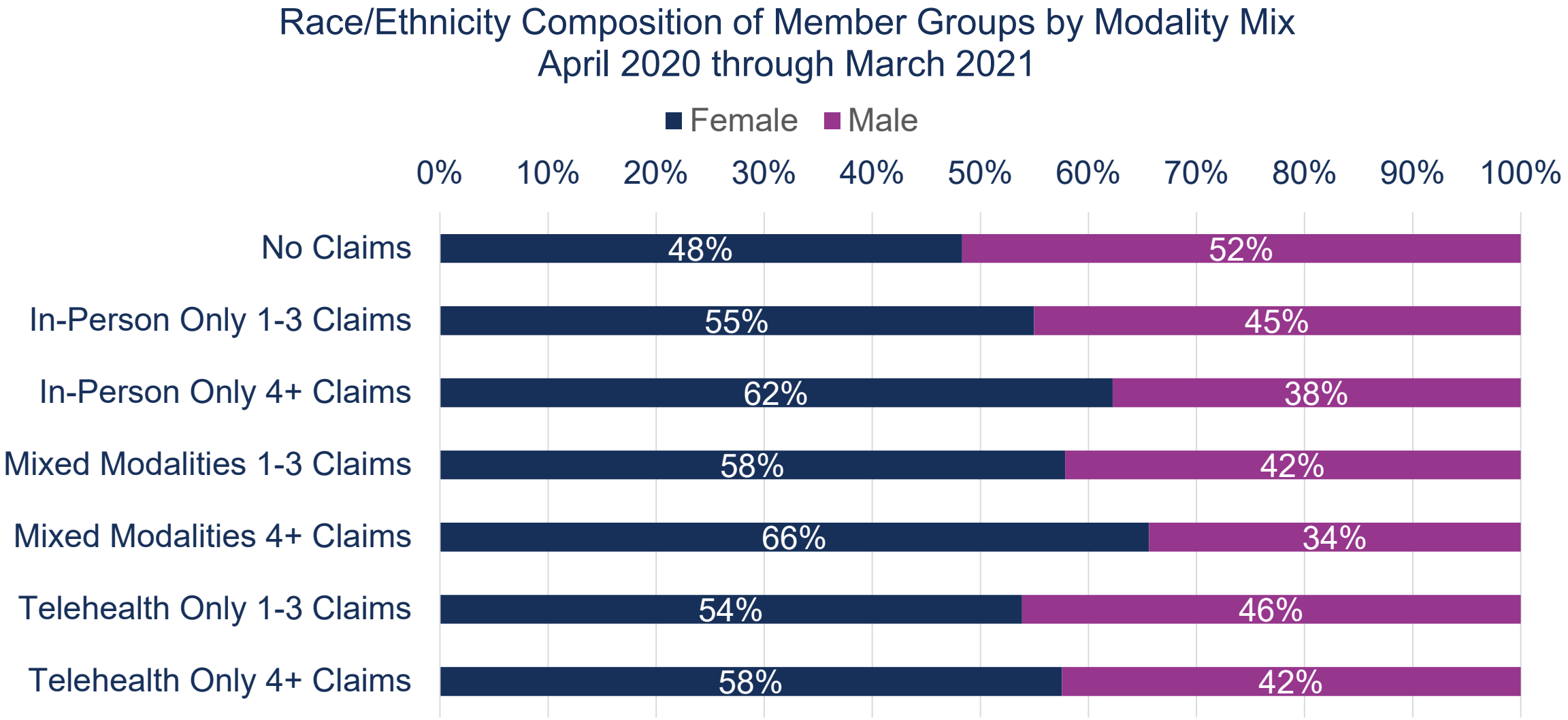
Hispanics represent 50% of Medi-Cal members, 52% of members with a least 1 E&M claim, and 43% of members with 4+ telehealth only claims



Preliminary analyses

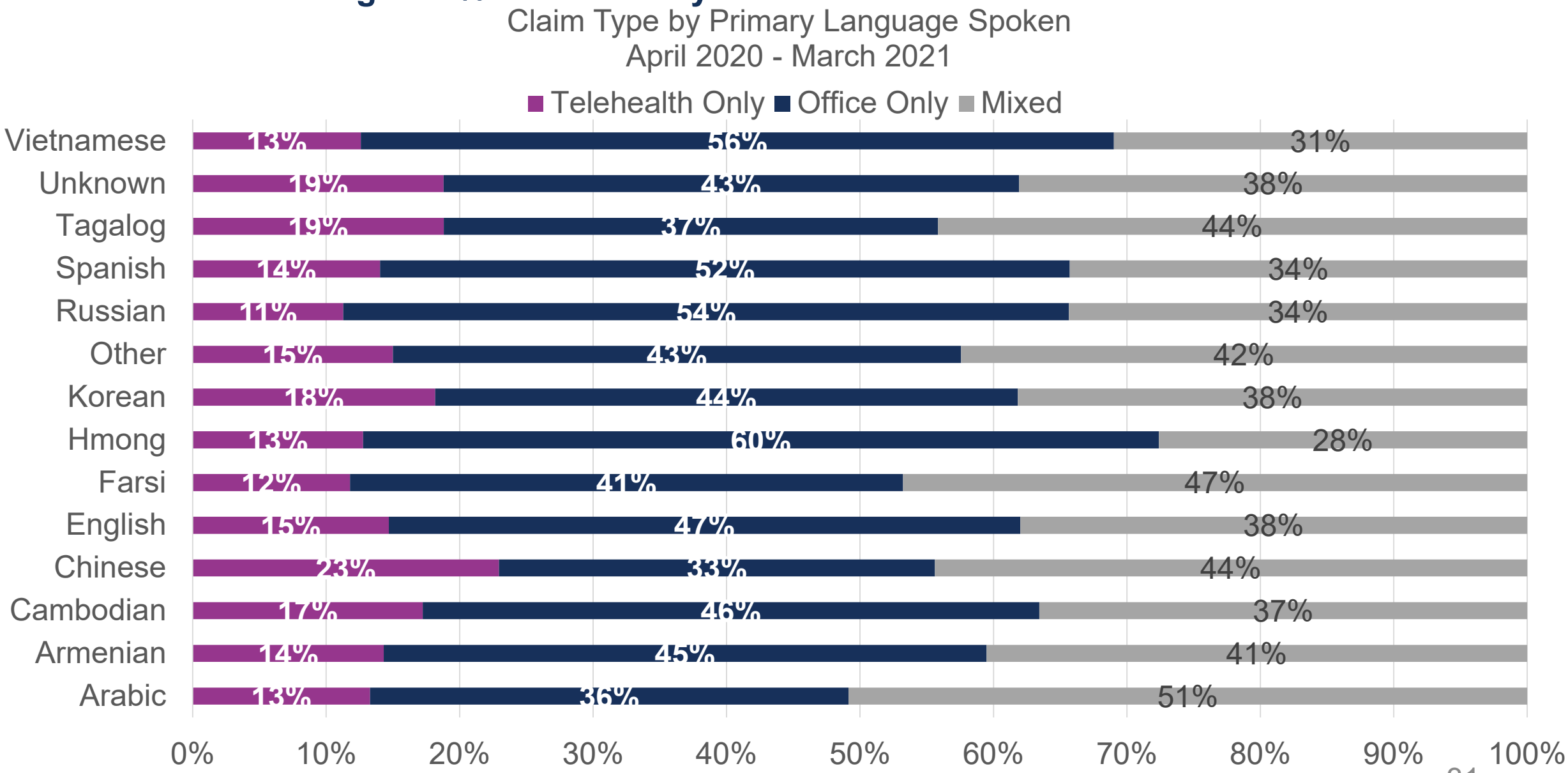
Note - American Indian/Alaska Native had 1% or less in each modality

Females represent 50% of Medi-Cal members, 60% of members with a least 1 E&M claim, and 58-66% of members with 4+ claims across service modalities.



Preliminary analyses

Chinese-speaking members had the highest % of telehealth-only claims; Hmong-speaking members had the highest % of office-only claims



Preliminary analyses *Chinese* includes Cantonese, Mandarin and Other Chinese. *Other* includes ASL

Research and Evaluation Plan Timeline and Research Questions

Research and Evaluation Plan Development

- Research and evaluation framework development
- Assess billing/coding components of research and evaluation
- Expert input – Telehealth researchers, workgroup input via survey
- Methodological approaches developed
- Final research and evaluation plan

Potential High Level Research Questions for Monitoring, Research and Evaluation

- How is telehealth utilization evolving over time?
- How is the mix of service modalities (telehealth, in-person) changing over time?
- How does telehealth contribute to access to care?
- How does telehealth contribute to the quality of care?
- How is the use of telehealth impacting the total cost of care?
- What are provider experiences with using telehealth?
- What are Medi-Cal members experiences with using telehealth?

These questions would be stratified by race/ethnicity, aid code, sex, age groups, region, and specific vulnerable populations or those with special health care needs (e.g., California Children's Services, duals, disabled)

Next Steps for Workgroup Report

Looking Ahead: Continued Stakeholder Engagement

Telehealth Advisory Workgroup

September – October 2021

- Interviews
- Three workgroup meetings
- Post-meeting surveys
- Input submitted through DHCS mailbox

Workgroup Recommendations Report

November – December 2021

- DHCS to draft workgroup recommendations report
- Workgroup members to provide feedback during open review period
- DHCS to incorporate feedback and finalize report

DHCS Policy & Budget Process

December 2021 – June 2022

- Drawing from Workgroup Recommendations Report, DHCS to prepare 2022 – 2023 Governor's proposed budget policy paper and policy and operational guidance
- DHCS to host webinars to review 2022-2023 Governor’s proposed budget policies, and seek workgroup member and other stakeholder feedback
- Stakeholders to provide feedback through regular budget development process

Public Comment

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

Additional Comments & Next Steps

Should you have additional questions or comments, please email **Medi-Cal_Telehealth@dhcs.ca.gov**.