Follow-Up Items from February 11, 2021, BH-SAC Webinar

COVID-19 and Behavioral Health Services; COVID-19 Dashboard

1. *Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program*: Can you share more about efforts to collect data on sexual orientation and gender identity during COVID and in general for the dashboard?

   DHCS Response: *Jacey Cooper, DHCS*: I will get back to you.

   DHCS Follow-Up: DHCS only collects Sexual Orientation Gender Identity (SOGI) information on the CalHEERS application. There is not sufficient data collection to report on these categories. We are also working to incorporate the SOGI questions into the Medi-Cal application, which will require federal approval. We will continue to engage with stakeholders on this effort and future efforts around reporting.

2. *Kiran Savage-Sangwan, California Pan-Ethnic Health Network*: Have you looked at the comparison in race and ethnicity between 2019 and 2020? Were there trends in that data? If we have an uptick in mild-to-moderate, is that contributing to closing racial disparities?

   DHCS Response: *Jacey Cooper, DHCS*: We will get back to you.

   DHCS Follow-Up: DHCS has not done this analysis yet but will consider doing so in the future.

3. *Catherine Teare, California HealthCare Foundation*: The rate of 8 to 9 percent for adult specialty mental health via telehealth is striking. Do you have thoughts on why?

   DHCS Response: *Jacey Cooper, DHCS*: We are looking at the data to make sure the modifier is not the issue, meaning it was data quality as opposed to a service difference.

DHCS Follow-Up: When the COVID-19 public health emergency (PHE) began, DHCS had a permissive telehealth policy, allowing services to be delivered via telehealth and telephone in the Specialty Mental Health Services (SMHS) program and Drug Medi-Cal Organized Delivery System (DMC-ODS). We require telehealth modifiers to be used for SMHS, but telehealth was rarely used, so our billing system would not have rejected a telehealth claim that was missing a modifier (the system would not know the difference between an in-person visit and a telehealth visit, so it could not reject the claim). Also, DHCS does not require modifiers for DMC-ODS, and the Short Doyle claiming system would reject a claim if the modifier was attached. During the first week of the PHE, DHCS was alerted that some counties were not allowing telehealth because their systems were not designed to accept the modifier. Therefore, in the interest of maintaining appropriate access to beneficiaries, we quickly issued guidance allowing providers to offer telehealth services without using the modifier (we encouraged its use in SMHS, but didn't require it).

We are currently implementing a system change to accept modifiers in DMC-ODS and DMC so we can implement a mandate for all behavioral health services to include a modifier when done via telehealth. We would then amend our audit practices to ensure providers were using the modifier when appropriate. However, we must build (this) in time for providers to update their electronic health records and for counties to update their billing systems. Once we issue our guidance, we anticipate it will take several months for providers to submit telehealth data accurately. Therefore, we will be unable to accurately report behavioral health telehealth use until 2022, at the earliest.

4. *Rosemary Veniegas, California Community Foundation*: In reviewing the data on utilization and emergency department visits, I am thinking about the long-term consequences of having COVID. The beneficiaries of 2020 will continue in 2021. Are there plans to understand the implications for patients in the first year when there were fewer medical interventions versus this year with more options available? I imagine there may be long-term cost implications as we look ahead to value-based payment approaches.

   DHCS Response: *Jacey Cooper, DHCS*: That is a great reflection on the data. We will take that back and think about it. Teams are doing a lot of thinking about the impact of COVID on the health care delivery system and what it will mean for the future for those who were COVID positive. You raise a good point about the difference for those who tested positive early in the pandemic. I imagine there will be many research projects we can learn from. And, absolutely as those members age, we may see co-morbidities early and we do often see co-morbidities at younger ages in Medi-Cal than other populations.

DHCS Follow-Up: DHCS has not done this analysis yet but will consider doing so in the future.

5. *Hector Ramirez, Consumer Los Angeles County*: These data allow me to conduct better advocacy. I see that intersectionality is missing and there is not much on co-morbidities in populations, which is important to me as a stakeholder. Is there data on co-morbidities, and can you speak to the benefits of integrating this into the dashboards as we advance principles of equity?

   DHCS Response: *Jacey Cooper, DHCS*: Thanks. We will take that back to the data team to see what we can produce in the future.

   DHCS Follow-Up: DHCS has not done this analysis yet but will consider doing so in the future.