December 16, 2019

Acting Director Richard Figueroa
Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

RE: CalAIM Proposal Comments

Dear Acting Director Richard Figueroa:

On behalf of the California Telehealth Policy Coalition ("Coalition"), I would like to submit these comments to the CalAIM proposal. The Coalition is a nonpartisan affiliation of nearly 70 statewide organizations and individuals who meet monthly to discuss emerging telehealth policy issues in California and cooperative means of advancing California telehealth policy. The group began meeting in 2011 when AB 415, "The Telehealth Advancement Act", was introduced and has continued to meet as telehealth becomes more integral in the delivery of health services in California. Convened by the Center for Connected Health Policy (CCHP), the diversity of organizations reflects the potential scope and reach telehealth can have on the health and wellbeing of the state's population. The Coalition and its members work to advance telehealth policy in the state to enable the ability of Californians to have access to the health services they need.

California law defines telehealth as "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…"[1] As a coalition of organizations dedicated to the advancement of telehealth service delivery and coverage in California, the Coalition thanks the Department of Health Care Services (DHCS) for the updates to the Provider Manual earlier this year that expanded the scope of reimbursement for covered services provided via telehealth. Telehealth has also been acknowledged at the federal level, with recent additions of telehealth services to the Medicare Physician Fee Schedule,[2], and a recent Office of the Inspector General report which specifically highlighted

[1] Cal. Bus. and Prof. Code 2290.5(a)(6).
[2] Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. 84 Fed. Reg. 62,567 (November 15, 2019).

telehealth as a solution to behavioral health access issues in Medicaid managed care.[3] We are grateful for the opportunity to comment and excited by the prospect CalAIM offers for innovation and efficiency across the Medi-Cal program. We think there are several areas where strong consideration of telehealth can bolster the innovative approaches to care delivery and payment contained in the proposal.

Some of the comments we are submitting are related specifically to making parties aware that telehealth is a viable option for care delivery. A significant impediment to the utilization of telehealth is an education issue on when and where telehealth can be used and the Department's policy surrounding it. Lack of awareness about the needs that telehealth can address and the extent to which it can be used cause both providers and health plans to hesitate to take advantage of telehealth opportunities, and thus limit the options Californians have to access needed services. We submit the following comments in response to DHCS' request for comment on the CalAIM proposal.

I. Require Managed Care Plan to report on telehealth activities in Population Health Management Strategies

We welcome DHCS' proposal to incorporate whole person care into its proposed Population Health Management strategies to include risk stratification and mitigation, and care coordination, particularly DHCS's stated goal of using health IT to support integrated care and care coordination.

We ask that within any DHCS plan, guidance or template for Managed Care Plan (MCP) Population Health Management strategies that DHCS include require reporting fields related to telehealth programs utilized by MCPs in risk stratification, mitigation or care coordination, and that DHCS publish such strategies for stakeholders. While telehealth may not be utilized by MCPs in all Population Health Management strategies and plans, many MCPs may do so, and collection of such targeted information from MCPs will be useful information for DHCS and stakeholders alike to understand the extent to which existing and soon-to-emerge telehealth modalities are being used to address, measure, mitigate, and care for member health needs. The Coalition is aware of many MCPs that already have telehealth programs in place to address issues related to care coordination, access to care and provide services based on condition or specialty. For example,

[3] U.S. Dept. of Health and Human Servs., Office of the Inspector General. Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care. Report OEI-02-17-00490. September 12, 2019.

Health Net has partnered with UC Davis on a Project ECHO initiative to help train its primary care providers on medication-assisted treatment for opioid use disorder.[4] By calling out telehealth as a viable population health management tool in different scenarios and by publishing these strategies online, MCPs and partner stakeholders will be aware of the opportunity to utilize these technologies and be able to better understand the current state of innovative techniques to training and care delivery.

II. Explicitly allow for telehealth services to be provided in "In Lieu of Services"

DHCS has proposed the inclusion of language that MCPs be able to provide in lieu of services to allow MCPs to integrate flexible services and supports into their population health strategies.

We ask that DHCS make explicit in its final guidance on in lieu of services that MCPs will be allowed to utilize telehealth to provide in lieu of services, when clinically appropriate. For example, remote patient monitoring (RPM) may be a critical part of home modifications for respite care to allow greater independence in the home coupled with continuous monitoring of a beneficiary's health status. Remote patient monitoring for home health has been associated with reduced hospital admissions,[5] improved clinical outcomes,[6] and decreasing program costs over time.[7] CMS has recognized RPM's promise by adding several CPT codes to the Medicare Physician Fee Schedule for 2019.[8] Even more, some existing Whole Person Care Pilots, such as that in Santa Cruz County, have included RPM telehealth in their pilots, and we hope that by highlighting telehealth,[9] DHCS is able to encourage MCPs to think of creative and innovative ways of provide enhanced care to their members.

III. Consider telehealth investments in MCP rate setting

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[4] UC Davis Health, Center for Advancing Pain Relief. UC Davis ECHO Pain Management TeleMonitoring. Accessed December 11, 2019. Available at https://health.ucdavis.edu/advancingpainrelief/Projects/ECHO.html

[5] Mierdel S and Owen K. Telehomecare reduces ER use and hospitalizations at William Osler health system. Stud Health Technol Inform. 2015;209:102-108. doi: 10.3233/978-1-61499-505-0-102.

[6] Bowles KH et al. Clinical effectiveness, access to, and satisfaction with care using a telehomecare substitution intervention: a randomized controlled trial. Int J Telemed Appl. 2011;2011:540138. doi: 10.1155/2011/540138. Epub 2011 Dec 1.

[7] Peretz D, Arnaert A and Ponzoni NN. Determining the cost of implementing and operating a remote patient monitoring programme for the elderly with chronic conditions: A systematic review of economic evaluations. J Telemed Telecare. 2018;24(1):13-21. Doi: 10.1177/1357633X16669239.

[8]

[9] Santa Cruz County. Whole Person Care Background. July 12, 2018. Available at http://caph.org/wp-content/uploads/2018/07/santa-cruz-wpc-pilot-7.12.18.pdf.

DHCS intends to move to regional rate-setting for MCPs to incentivize cost efficiencies and support innovations within the Medi-Cal program. As such, we strongly suggest that DHCS consider including financial investments in telehealth in its rate-setting methodology for MCPs.

Coalition members recognize that many MCPs have made significant investments in various telehealth programs over the past decade, even when those services were not reimbursed or otherwise captured by CPT codes and reimbursed by DHCS. Initial costs to start a telehealth program include procurement, software licensing, implementation management, workflow redesign and personnel for both an organization and its clinic partners, including FQHCs and public hospitals that serve Medi-Cal enrollees. Medi-Cal's current rate-setting methodology does not account for these investments in rate adjustment, and we recommend DHCS consider the California Health Care Foundation's 2019 report which specifically recommends that DHCS adopt a rate adjustment criterion that MCPs make health-related investments as a condition of qualifying for a rate adjustment.[10] Accounting for such investments in rate-setting may also spur further MCP-provider collaborations on innovation care delivery projects, which will help our safety net system achieve CalAIM's goal of integration.

IV. Establish a 'connected care coordinator' to guide health IT activities

DHCS notes that as part of its Institutions of Mental Disease (IMD) demonstration, it must develop a health IT plan that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability. DHCS has also proposed launching the Enhanced Care Management benefit option, scaling Whole Person Care through "in lieu of" Services, and MCP Population Health Management strategies, initiatives that all require data exchange between multiple entities.

We ask that DHCS work with CHHS and other health agencies under its umbrella to take the opportunity to create the position of "coordinator for connected care" to oversee all health IT efforts within CalAIM and DHCS. While DHCS currently has the Information Management Division, there is not a current staff member who is tasked with such coordination efforts, especially to provide guidance to payers and providers on how to navigate the myriad billing, health records and other IT systems that are in place both among and often within organizations. Moreover, collaboration among agencies under a coordinator would strengthen the ability to streamline health IT and technology efforts for all California health projects. The Coalition notes a need for guidance on how to securely share data among entities in a way that complies with the law, especially given the complex integration of system involved with telehealth programs, such as EHRs, billing, eligibility and the telehealth platform itself.

[10] California Health Care Foundation. Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs. March 2018.

V. Ensure that MCPs and other entities participating in full integration plans are made aware of telehealth as an acceptable modality for providing care.

DHCS has proposed creating full integration plans that will capture physical health, mental health and substance use services within a single MCP, working in tandem with county and other provider partners.

Such a proposal is both ambitious and exciting to see and we are certain that the myriad of policies to ensure integration will be carefully studied and addressed. We ask that as the planning and execution of that plan for integration happens, the Department carefully consider how telehealth can be used and made available and how potentially conflicting policies might inhibit its use. Many existing policies exists in a multitude of programs that have been in place or were formulated without taking into consideration the use of telehealth. As such, some of these policies may inadvertently prohibit the use of telehealth in some way. For example, prior to 2018, Medi-Cal had a definition for group therapy services that required they take place "in-person." This in-person requirement eliminated the opportunity to use telehealth when those services take place from a distance. Although this type of policy was not meant to exclude telehealth it had the unintended consequence of doing so. The Coalition requests that as the plans are being formulated for the various aspects of CalAIM to keep in mind the role telehealth can play and ensure that language does not create any new barriers to the use of telehealth.

Thank you once again for this opportunity to provide comments. Should you have any question or need further information, please do not hesitate to contact me at meik@cchpca.org or 916-993-6179.

Respectfully,

Mei Wa Kwong, JD
Executive Director, Center for Connected Health Policy

TELEHEALTH POLICY COALITION MEMBERS:

2020 Mom
AARP
Adventist Health
Essential Access Health
Family Voices of California
For Hims/For Hers
Granite Wellness Centers

Advocates for Health, Economics and Development
America's Physician Groups
Asian Americans Advancing Justice - Los Angeles
Association of California Healthcare Districts
Association of Independent California Colleges and Universities
Beacon Health Options
BKY Consulting
Blue Shield California
BluePath Health
CalHIPSO
California Academy of PAs
California Chronic Care Coalition
California Commission on Aging
California Dental Hygienists' Association
California Department of Public Health
California Health and Wellness
California Health Care Foundation
California Health Collaborative
California Health Information Association
California Hospital Association
California Long-Term Care Ombudsman Association
California Medical Association
California Northstate University – College of Dental Medicine
California Pan-Ethnic Health Network
California Primary Care Association
California School Based Health Alliance
California State University Chico
California Telehealth Network
Camicia
Center for Autism
Center for Connected Health Policy
Center for Health and Technology
Center for Technology and Aging
Central California Alliance for Health
Children's Partnership
Children's Specialty Care Coalition
Health Access
Health Care Interpreter Network
Health Plan of San Joaquin
Hooper, Lundy & Bookman, PC
KP Public Affairs
LA Children's Trust
Latino Coalition for a Health California
LeadingAge California
Local Health Plans of California
Loma Linda University Health
Maven Project
mPulse
Multi-state Licensure for California Nurses Taskforce
MVM Strategy Group
National Association of Community Health Centers
National Health Law Program
National Multiple Sclerosis Society
Noteware Government Relations
Oakland USD
OCHIN
Pacific Business Group on Health
Partnership Health Plan
Planned Parenthood Affiliates of California
Presence Learning
Providence
Public Health Institute
Rady Children's Hospital - San Diego
Sacramento Case Management Society of America
San Francisco Health Plan
Scripps Health
Sharp HealthCare
Stanford Children's Health
Stanford Health Care
Steinberg Institute
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Citizen Advocacy Center
Clinical Informatics, LLC
Coalition for Compassionate Care of California
Coalition for Multi-State Licensure in California Nurses Taskforce
Cognivive
Community Health Center Network
Connecting to Care
DirectDerm
Doctor On Demand
Tusk Strategies
UC Davis
UC Davis Medical Center
Union of American Physicians and Dentists
University of California Office of the President
University of California San Francisco
West Health
Western Center on Law & Poverty
Wildflower Health