Department of Health Care Services
Post-COVID-19 Public Health Emergency
Final Telehealth Policy Proposal
December 2022

Background

Medi-Cal's telehealth policy was established pursuant to the Telemedicine Development Act of 1996 (Thompson, Chapter 864, Statutes of 1996) and updated in compliance with Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. In 2019, the Department of Health Care Services (DHCS) undertook a policy review process, following extensive stakeholder engagement and public comment, to inform policy refinement. The revised 2019 policy afforded substantial flexibility to licensed providers to make clinically appropriate decisions regarding the use of synchronous and asynchronous telehealth modalities across both fee-for-service (FFS) and managed care. The finalized policy was published in the Medi-Cal provider manual and disseminated to Medi-Cal managed care plans via an All Plan Letter.

On March 13, 2020, a national public health emergency (PHE) was declared regarding the Novel Coronavirus Disease (COVID-19) outbreak. This resulted in the subsequent passage of the Families First Coronavirus Response Act (FFCRA), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and the release of numerous federal waivers and flexibilities. These collective provisions were designed to help states swiftly and appropriately respond to the PHE in an effort to control the spread of COVID-19, while helping to support the various health care delivery systems.

In response to the COVID-19 pandemic, DHCS implemented additional flexibilities via blanket waivers and Disaster Relief state plan amendments (SPAs). These changes enabled Medi-Cal's health care delivery systems to meet the health care needs of our beneficiaries in an environment where in- person encounters were not recommended and, at times, not available. DHCS' temporary policy changes during the COVID-19 PHE include:

- 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 Billing Option Program (LEA BOP) and the Targeted Case Management Program (TCM) services.
- Allowing most telehealth modalities to be provided for new and established patients.

- Allowing many covered services to be provided via audio-only for the first time.
- Allowing payment parity between services provided in-person face-to-face, by video, and by 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 to allow providers and beneficiaries to be in locations outside of the clinic.
- Allowing for expanded access to telehealth through non-public technology platforms consistent with temporary "good faith" exemptions to the Health Insurance Portability and Accountability Act (HIPAA) implemented by the federal Office of Civil Rights.

Supported by these state and federal flexibilities, Medi-Cal claims data illustrate a rapid increase in telehealth utilization in response to the pandemic, with both physical and behavioral health providers pivoting to provide services via video and audio-only modalities.

Telehealth Advisory Workgroup

Pursuant to Section 380 of Assembly Bill (AB) 133 (Committee on Budget, Chapter 143, Statutes of 2021), DHCS convened a Telehealth Advisory Workgroup for the purposes of informing the 2022-23 Governor's Budget and the development of post-PHE telehealth policies. 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.

The Workgroup met three times from September to October 2021 to advise DHCS on proposed policy options, review telehealth utilization data and insights, and discuss future telehealth research and evaluation objectives. Each Advisory Workgroup meeting was open to the public. Following each meeting, DHCS asked for additional Workgroup input via an electronic survey, and DHCS conducted a dozen one-on-one interviews with individual stakeholders representing a variety of organizations and perspectives.

In December 2021, DHCS published its Telehealth Advisory Workgroup Report that reviewed the policy approaches and workgroup deliberations. This Workgroup Report and deliberations from each Workgroup Session can be found on DHCS's Telehealth Advisory Workgroup Webpage:
https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx

A Pathway Forward

California has been a leading state in the expansiveness of its coverage and reimbursement for services delivered via telehealth. Medi-Cal has committed to continuing to enable broad telehealth coverage post-PHE, via both video and audio-only synchronous interaction, for all Medi-Cal covered benefits and services as long as the provider is able to meet the standard of care, subject to billing, reimbursement and utilization management policies developed by the Department. In addition, Medi-Cal is unique among other state Medicaid programs in regard to payment parity. Many other state Medicaid programs have implemented payment parity for video visits following the onset of the COVID-19 pandemic; however, California is one of few states to commit to reimbursing a broad array of services at parity when delivered via audio-only visits.[1]

As DHCS looks to the future, the Department is implementing broad changes that continue to allow Medi-Cal covered benefits and services to be provided via telehealth across delivery systems when clinically appropriate. All post-PHE policy changes are guided by the following DHCS principles, which were updated based on Advisory Workgroup input:

- **Equity**: Using an equity framework, focus on improving 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 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. Beneficiaries 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**: 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 to care standards (network adequacy). Medi-Cal beneficiaries should have convenient access to telehealth similar to Californians enrolled in other types of coverage (e.g., Covered California, CalPERS, Medicare, commercial).
- **Standard of Care**: Use evidence-based strategies for the delivery of quality and culturally responsive care via telehealth. Standard of care requirements

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

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 via telehealth or in-person care. Patients should retain the right to receive health care in person, with the understanding there may be a future PHE or natural disasters that affect the availability of in-person care.
- **Confidentiality**: 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**: Exercise responsible stewardship of public resources, including mitigating and addressing fraud, waste, discriminatory barriers, and abuse.
- **Payment Appropriateness**: Consider reimbursement for services provided via telehealth modalities in the context of various methods of reimbursement, nature of services, type of care providers, and the health system payment policies and goals.

There are many benefits to enabling widespread use of both synchronous video and audio-only visits for Medi-Cal beneficiaries. 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 individuals with chronic conditions and behavioral health needs.[2] From the beneficiary perspective, telehealth can improve access to care and enhance 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 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 populations but may perpetuate health inequities and disparities for others.[3, 4, 5]

---

[2] 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.

[3] 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).

[4] 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).

[5] D Velasquez, A Mehrotra, "Ensuring the Growth of Telehealth During COVID-19 Does Not Exacerbate Disparities in Care" Health Affairs (May 2020).

- Research suggests that telehealth demonstrates equal or improved quality of care as compared to in-person care for certain care services, yet there is limited evidence regarding the quality of care for individuals who receive both telehealth and in-person care.[6, 7, 8, 9, 10]
- For individuals with conditions that require in-person interventions, the inability of telehealth providers to conduct physical exams or diagnostic testing could pose quality and safety risks without appropriate guardrails.[11, 12]
- Improved access and convenience could potentially lead to overutilization and increase health care costs.
- More expansive coverage of telehealth could increase risk for fraud.[13, 14]

DHCS Telehealth Policies

The following Telehealth Policies reflect deliberations and considerations from the Telehealth Advisory Workgroup discussions, public comments, internal DHCS deliberation, and statutory provisions.

In September and October 2021, DHCS hosted the Telehealth Advisory Workgroups and welcomed feedback from members and the public on the proposed policies. Those deliberations resulted in a Telehealth Policy Recommendations package that was shared by the Department in February 2022, and trailer bill language that was published in March 2022.

---

[6] 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

[7] 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.

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

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

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

[11] 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.

[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] 2020 National Health Care Fraud Takedown | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (hhs.gov)

[14] HHS OIG, "Medicaid – Telehealth Expansion During COVID-19 Emergency"

Those proposed policies were further vetted by the Telehealth Advisory Workgroup and the public in Spring 2022. In February, a reconvening of the Telehealth Advisory Workgroup discussed the proposed policies, and the Department welcomed additional feedback on the proposed policies and TBL throughout the Spring.

As part of the Budget Act of 2022, trailer bill language establishing telehealth policies was enacted through SB 184 (Chapter 47, Statutes of 2022). SB 184 expands and further details DHCS's statutory authority related to coverage of telehealth in Medi-Cal. This language were subsequently amended by a legislative bill, AB 32 (Chapter 515, Statutes of 2022). AB 32 further amended the trailer bill language to add specificity about establishment of new patients via telehealth and exceptions to the requirement that providers offer video telehealth.

Below is an outline of the final policies DHCS will be implementing.

Broad-Based Policies First Introduced During the COVID-19 PHE

A. Policy Area: Baseline coverage of synchronous telehealth

- **Current State During PHE:** Synchronous video and audio-only telehealth are covered across multiple services and delivery systems, including physical health, dental, non-specialty and specialty mental health, and SUD services (State Plan Drug Medi-Cal and Drug Medi-Cal Organized Delivery System / DMC-ODS). Services may also be delivered through telehealth in 1915(c) waiver programs, Targeted Case Management (TCM) Program and Local Education Agency Medi- Cal Billing Option Program (LEA-BOP).
- **Final Approach:** Continue coverage of synchronous video and audio-only telehealth coverage across multiple services and delivery systems, as covered during the PHE. Additional policies described below will be implemented to encourage appropriate use of synchronous video and audio-only telehealth.
- **Rationale:** Increases access to care and coordination of care and allows for the use of different modalities when clinically beneficial; reduces the need for unnecessary office visits for non-complex cases that are clinically appropriate to be triaged and/or addressed via audio-only modalities.

B. Policy Area: Baseline coverage of asynchronous telehealth

- **Current State During PHE:** 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).
- **Final Approach:** Continue coverage of asynchronous telehealth across

many services and delivery systems. Continue, post-PHE, coverage of asynchronous telehealth to 1915(c) waivers, TCM and LEA-BOP.

- **Rationale:** Promotes and further supports flexibility in terms of the types of Medi- Cal covered benefits and services able to be provided via asynchronous telehealth modalities.

C. Policy Area: Payment Parity

- **Current State During PHE:** 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 the standard of care and billing code requirements that apply to in-person services. Payment parity excludes virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, e-consult, etc.).
- **Final Approach:**
  - Continue parity in reimbursement levels between in-person services and select telehealth modalities (synchronous video, synchronous audio-only, or asynchronous store and forward, as applicable) across delivery systems. Payment parity will continue to exclude virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, e- consult, etc.).
  - Continue the use of cost-based reimbursement for TCM and LEA BOP telehealth services. All county-administered behavioral health reimbursements will be cost-based until BH Payment Reform via CalAIM (anticipated July 2023).
- **Rationale:** Aligns reimbursement for services and supports commitment to stakeholders to not differentiate between telehealth modalities for reimbursement purposes.

D. Policy Area: Virtual Communications & Check-Ins

- **Current State During PHE:** Brief virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, etc.) are covered by Medi- Cal in physical health.[15]
- **Final Approach:** Continue coverage of brief virtual communications in physical health. Add coverage of virtual communications (specifically e-visits) to 1915(c) waivers, TCM and LEA-BOP.
- **Rationale:** Increases access to care and coordination of care and allows for

[15] Medi-Cal providers may be reimbursed using the Healthcare Common Procedure Coding Systems (HCPCS) codes G2010 and G2012 for brief virtual communications.

the use of different modalities when clinically beneficial.

E. Policy Area: Telehealth in FQHCs & RHCs

- **Current State During PHE:** FQHCs/RHCs are reimbursed at the Prospective Payment System (PPS) rate for (1) synchronous video, (2) synchronous audio- only, and (3) store and forward, and are not subject to site limitations for either patient or provider. Virtual communications are covered.
- **Final Approach:** Continue to reimburse FQHCs/RHCs at PPS rate for otherwise billable visits delivered via telehealth, including visits delivered via (1) synchronous video, (2) synchronous audio-only, and (3) store and forward. Continue exemption from site limitations for patient or provider. Virtual communications continue to be covered.
- **Rationale:** More closely aligns reimbursement policy across provider systems and augments access to care.

F. Policy Area: Establish New Patients via Telehealth

- **Current State During PHE:** During the PHE, DHCS allows providers to use synchronous and asynchronous telehealth for new and established patients in Medi-Cal (including patients served by FQHCs/RHCs).
- **Final Approach:**
    - Providers may establish a relationship with new patients in- person or via synchronous video telehealth visits, subject to certain protections.
        - In specialty mental health services, the establishment of care for a new patient refers to the mental health assessment done by a licensed clinician.
        - For the purpose of substance use treatment in Drug Medi-Cal and Drug Medi-Cal Organized Delivery System, the establishment of care for a new patient refers to the American Society of Addiction Medicine Criteria Assessment.

    - Providers may establish a relationship with new patients via audio-only synchronous interaction (including patients served by FQHCs/RHCs) in the following instances, when established in accordance with department specific requirements and consistent with federal and state laws, regulations, and guidance:
        - When the visit is related to sensitive services as defined in subsection (n) of Section 56.06 of the Civil Code.[16]

[16] "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code,

- When the patient requests an audio-only modality or attests they do not have access to video.
- When the visit is designated by the department to meet another exception developed by the department in consultation with stakeholders.

- **Rationale**: Increases access to care by establishing new patients via telehealth while supporting consumer protections.

Billing and Coding Protocols

G. Policy Area: Telehealth Modifiers

- Current State During PHE: Prior to July 2022, providers who offer physical health services and nonspecialty mental health services via telehealth were directed to bill for synchronous video visits with the 95 modifier and asynchronous store-and- forward encounters with the GQ modifier, but the DHCS Medi-Cal telehealth policy previously provided no distinct modifier guidance for audio-only encounters. As of July 2022, DHCS updated the telehealth provider manual to include Modifier 93 to designate audio-only services. [17] As of November 1, 2021, specialty mental health, Drug Medi-Cal, and DMC-ODS counties are required to bill for services delivered via audio-only using a specific modifier.
- **Final Approach:** Continue use of audio-only modifiers across Medi-Cal delivery systems.
- **Rationale:** Enables understanding of telehealth utilization by audio-only or video modality to support evaluation, tracking of quality outcomes and future program decisions. Aligns and streamlines modifier use across all delivery systems.

H. Policy Area: Patient Consent

- **Current State During PHE:** 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.

---

obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV§ionNum=56.05.

[17] Effective January 1, 2022, AMA's CPT Editorial Panel released 93 as the modifier for "synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system". https://www.ama-assn.org/practice- management/cpt/cpt-appendix-audio-only-modifier-93-reporting-medical-services

Temporarily during PHE, providers are required to 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.

- **Final Approach:** Require providers to obtain consent once before the initial delivery of telehealth services. Enhance existing consent requirements to require additional information be shared with beneficiaries regarding:
  - Right to in-person services.
  - Voluntary nature of consent.
  - Availability of transportation to access in-person services when other available resources have been reasonably exhausted.
  - Limitations/risks of receiving services via telehealth, if applicable.
  - Notification of the beneficiary's right to make complaints about the offer of telehealth services in lieu of in-person care or about the quality of care delivered through telehealth.
- **Rationale:** Supports patient choice and equitable access to care by ensuring patients receive necessary information regarding care delivery via telehealth to make an informed choice on service delivery modality.

I. Policy Area: Telephonic Evaluation & Management (E&M) and Assessment & Management (A&M) CPT Codes

- **Current State During PHE:** Telephonic E&M (99441-3) and Telephonic A&M (98966-8) CPT codes are not currently covered in FFS Medi-Cal. Providers delivering E&M or A&M services via audio-only currently bill outpatient office E&M codes with a telehealth modifier.
- **Final Approach:** Activate CPT codes for capture of telephonic evaluation and management and assessment and management visits in Medi-Cal. Add use of telephonic E&M codes (99441-3) and A&M codes (98966-8).
- **Rationale:** Offers providers an additional and more accurate option to capture brief audio-only check-ins with patients.

(Note: These codes are defined as brief telephonic check-ins. Providers can bill either of these codes if the service is a brief telephonic check-in. If the service is not a brief check-in and is instead an E&M or A&M visit provided via audio-only, providers will not use these codes but will bill the appropriate code to describe the visit and use the applicable modifier. Additional detail will be provided in the provider manual.)

Monitoring Policies

J. Policy Area: Third Party Corporate Telehealth Providers

- **Current State During PHE:** Out-of-state providers who offer telehealth to

Medi-Cal beneficiaries must 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 meet all Medi-Cal program enrollment requirements. Third-party corporate telehealth providers without a physical location in California are not required to designate their status as such with DHCS, if they subcontract with a Medi-Cal provider, and therefore DHCS is currently unable to monitor or evaluate services provided to Medi-Cal enrollees by third-party corporate telehealth providers. Recently enacted AB 457 (Chapter 439, Statutes of 2021), effective January 1, 2022, requires health plans to comply with specific requirements if telehealth services are offered to enrollees through a third-party corporate telehealth provider. Medi-Cal is exempt from AB 457, but the law directs DHCS to consider applying these requirements.

- **Final Approach:** Monitor and assess implementation of current policies prior to implementing new requirements. Specifically:
    - Monitor the implementation of AB 457 reporting requirements by plans to the Department of Managed Health Care.
    - Monitor the implementation of complimentary policy approaches in Medi-Cal that promote continuity and quality of patient care and program integrity, including the requirements listed below in (K), Utilization Monitoring and Review; (L), Patient Choice of Telehealth Modality; and (M), Right to In-Person Services.
- **Rationale:** Promote continuity of care and care coordination between telehealth providers and patient's local in-person care teams. Monitor provision of services provided by all telehealth providers.

K. Policy Area: Utilization Monitoring and Review

- **Current State During PHE:** DHCS currently conducts reviews of in-person care delivery based on fraud complaints, results of fraud data analytics, statutorily required reviews, and other reviews as needed to ensure Medi-Cal program integrity. Similarly, DHCS conducts targeted reviews of outlier and high-risk telehealth provider activity and service claims identified from fraud complaints and data analytics.
- **Final Approach:** Continue to expand analytics and algorithm development to effectively identify suspect telehealth activity to be investigated. Potential risks include, but are not limited to, the following:
    - Up-coding time and complexity of services provided.
    - Misrepresenting the virtual service provided.
    - Billing for services not rendered.
    - Kickbacks.
- **Rationale:** Ongoing telehealth utilization monitoring and targeted reviews enhance program integrity; deter fraud, waste and abuse; and promote high

quality of care and consumer protections.

Other Policies to Support DHCS's Guiding Principles

L. Policy Area: Patient Choice of Telehealth Modality

- **Current State During PHE:** Medi-Cal does not require providers offering services via telehealth to offer a specific set of telehealth modalities (e.g. video and audio-only). Patient choice of telehealth modality is limited to those modalities offered by any given Medi-Cal enrolled provider.
- **Final Approach:** Over time, but no sooner than January 1, 2024, phase in an approach that provides patients the choice of a video telehealth modality when care is provided via telehealth. Specifically, if a provider offers audio-only telehealth services, the provider will also be required to provide the option for video services to preserve beneficiary choice. The Department will develop an exceptions process and outline exceptions to this requirement based on providers' access to requisite technologies.
- **Rationale:** Supports patient choice, access, and equity. Grants providers time to acquire infrastructure necessary to offer additional telehealth modalities and allows for exceptions based on providers' access to certain necessary technologies (e.g., broadband).

M. Policy Area: Right to In-Person Services

- **Current State During PHE:** DHCS's 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.
- **Final Approach:** Over time, but no sooner than January 1, 2024, phase in an approach that requires any provider furnishing services through telehealth to also either offer services via in-person face-to-face contact, or link the beneficiary to in-person care. If the provider chooses to link the beneficiary to in-person care to satisfy this requirement, they must provide for a referral to and a facilitation of in-person care that does not require a patient to independently contact a different provider to arrange for such care. DHCS will consider stakeholder recommendations on ways to ensure access to in-person services and telehealth services without restricting access to either, and work with stakeholders to develop a consumer-friendly informational notice to inform enrollees about right to in-person care.
- **Rationale:** Ensures patients are aware of their right to access in-person services without adversely impacting access to either in-person or telehealth services.

N. Policy Area: Network Adequacy

- **Current State During PHE:** Managed care plans that are unable to meet time or distance requirements for patient access to care in their provider networks may request an Alternative Access Standard for greater distance or travel time than the access to care standard. Currently five out of twenty-six Medi-Cal managed care plans have utilized telehealth as an alternative access standard; 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.
- **Final Approach:** Allow Medi-Cal managed care plans, county Mental Health Plans and county Drug Medi-Cal Organized Delivery System plans to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the network adequacy time or distance standards. DHCS will develop policies for granting credit in the determination of compliance with time or distance standards.
- **Rationale:** Increases access to care while balancing patients' right to access in- person services.

O. New Policy Area: Video Visits for PACE Eligibility Assessments

- **Current State During PHE:** During the PHE, enabled by federal flexibilities, DHCS has allowed PACE organizations to conduct initial assessments and annual re-assessments via telehealth.
- **Final Approach:** Allow PACE organizations to remotely conduct initial eligibility assessments and annual reassessments via video, subject to federal approval.
- **Rationale:** This policy change enables PACE organizations to complete initial eligibility assessments and re-assessments via video, as it has done during the PHE, aligning with the general Medi-Cal policy which allows for new patient establishment via video.

P. New Policy Area: Telehealth in Correctional Settings

- **Current State During PHE:** Telehealth is widely used in state prisons, county jails and youth correctional facilities and continued through the pandemic. People who are incarcerated can opt out of receiving health services altogether but do not consent to the modality of service (e.g. in-person, video/audio telehealth) if they chose to receive health services.
- **Final Approach:** Exempt correctional settings from certain proposed policies to align telehealth policies with current clinical operations of correctional settings.

- **Rationale:** Currently, individuals who are incarcerated are not granted the same consent or modality options as individuals who are not incarcerated. Exceptions for correctional settings are needed to ensure new telehealth policy does not contradict existing clinical operations for populations who are incarcerated.

Telehealth Research and Evaluation Plan

In addition to policy proposals, DHCS is committed to understanding how telehealth utilization is evolving relative to other modalities of care and its impact on beneficiaries. The Telehealth Advisory Workgroup recommended specific research questions for DHCS to pursue, including how telehealth contributes to access to care for different populations, how telehealth impacts clinical outcomes for specific conditions, and how telehealth use compares to in-person visits for specific populations. DHCS has conducted a literature review of telehealth research and methodologies, assessed existing claims and encounter data for use in telehealth research, and has developed a plan to study telehealth utilization and its impact on access, quality and outcomes, and on provider and enrollee experiences. The Telehealth Research and Evaluation Plan will lay out how DHCS will monitor and report on telehealth utilization, assess provider and plan compliance with telehealth policies, and evaluate the impact of telehealth on access, quality and specific populations of interest. DHCS will leverage existing internal capacity for telehealth monitoring, reporting and compliance assessment. In addition, DHCS will collaborate with external research partners, such as UCLA for the California Health Interview Survey, and the California Health Care Foundation on their interests in Californians' experiences with telehealth.

Next Steps and Associated Action Items

To effectuate the telehealth policies DHCS has described above, DHCS has taken or will take a number of actions, which include but are not limited to:

- **Trailer Bill Language:** As noted above, trailer bill language was enacted through SB 184 (Chapter 47, Statutes of 2022) as a part of the Budget Act of 2022, and this language was subsequently amended by AB 32 (Chapter 515, Statutes of 2022).
- **State Plan Amendments (SPAs):** As necessary, DHCS will submit SPAs to CMS for necessary federal approvals, which will have an effective date of no later than the day after the PHE ends.
- **1915(c) Home and Community Based Services (HCBS) Waivers:** DHCS will amend existing 1915(c) HCBS waivers to allow for telehealth and other virtual communication modalities and amendment waiver contracts, as necessary.
- **Federal PACE Waiver:** Federal PACE regulations require PACE

assessments to be conducted in-person. DHCS will seek a waiver from CMS to allow PACE organizations to conduct initial eligibility assessments and annual reassessments remotely.

- **Promulgating Regulations:** DHCS will promulgate state regulations as needed.
- **Developing and Issuing Policy Guidance:** DHCS will develop and issue clear policy guidance for Medi-Cal plans and providers across delivery systems, which may include, but not be limited to, the following:
  - Updates to various sections of the Medi-Cal Provider Manual.
  - All-Plan Letters.
  - Policy Letters.
  - Behavioral Health Information Notices.
- **Informing Materials:** DHCS will produce Medi-Cal provider and beneficiary informational materials related to billing for, providing, and seeking services through telehealth, including model language for patient consent and an informational notice for beneficiaries related to telehealth and right to access in-person services.
- **Legislative and Stakeholder Engagement:** DHCS will participate in legislative hearings and conduct stakeholder engagement efforts through its regular distribution channels and dedicated forums.