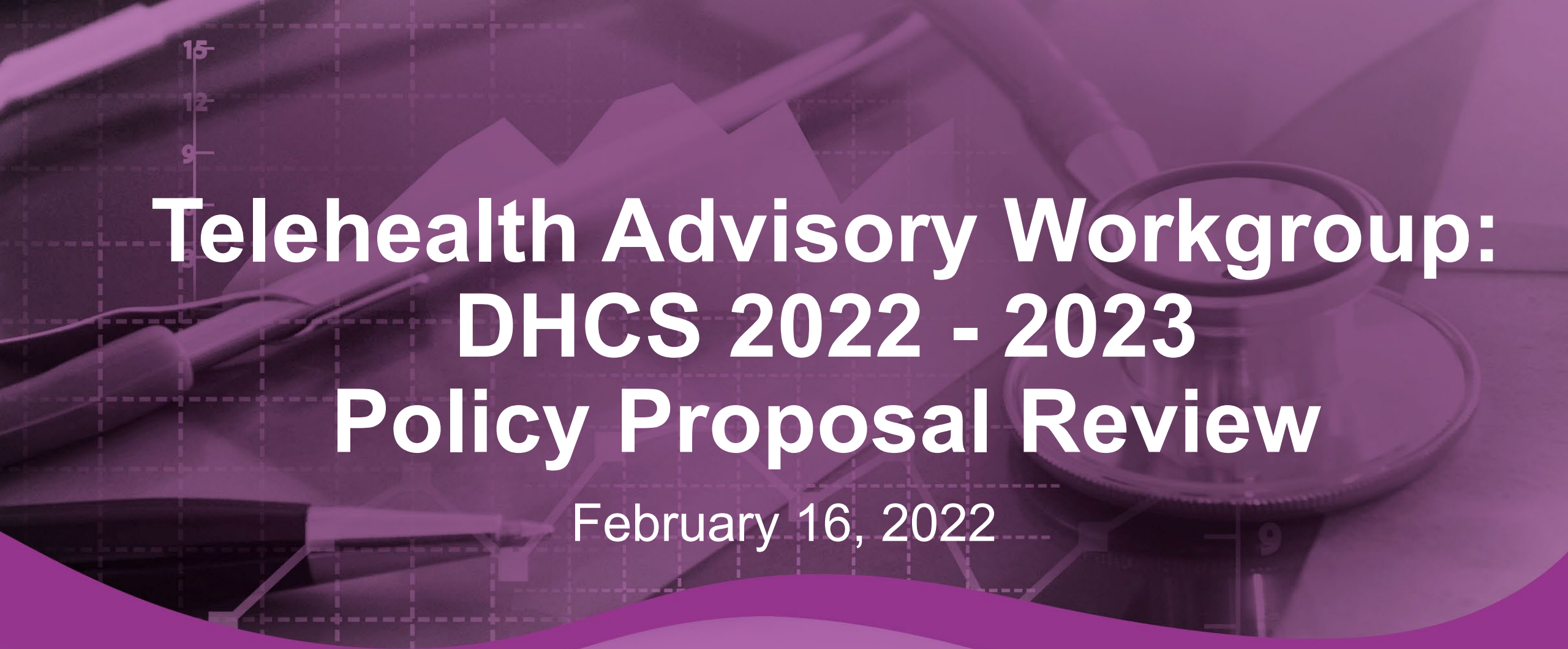


Telehealth Advisory Workgroup: DHCS 2022 - 2023 Policy Proposal Review

February 16, 2022

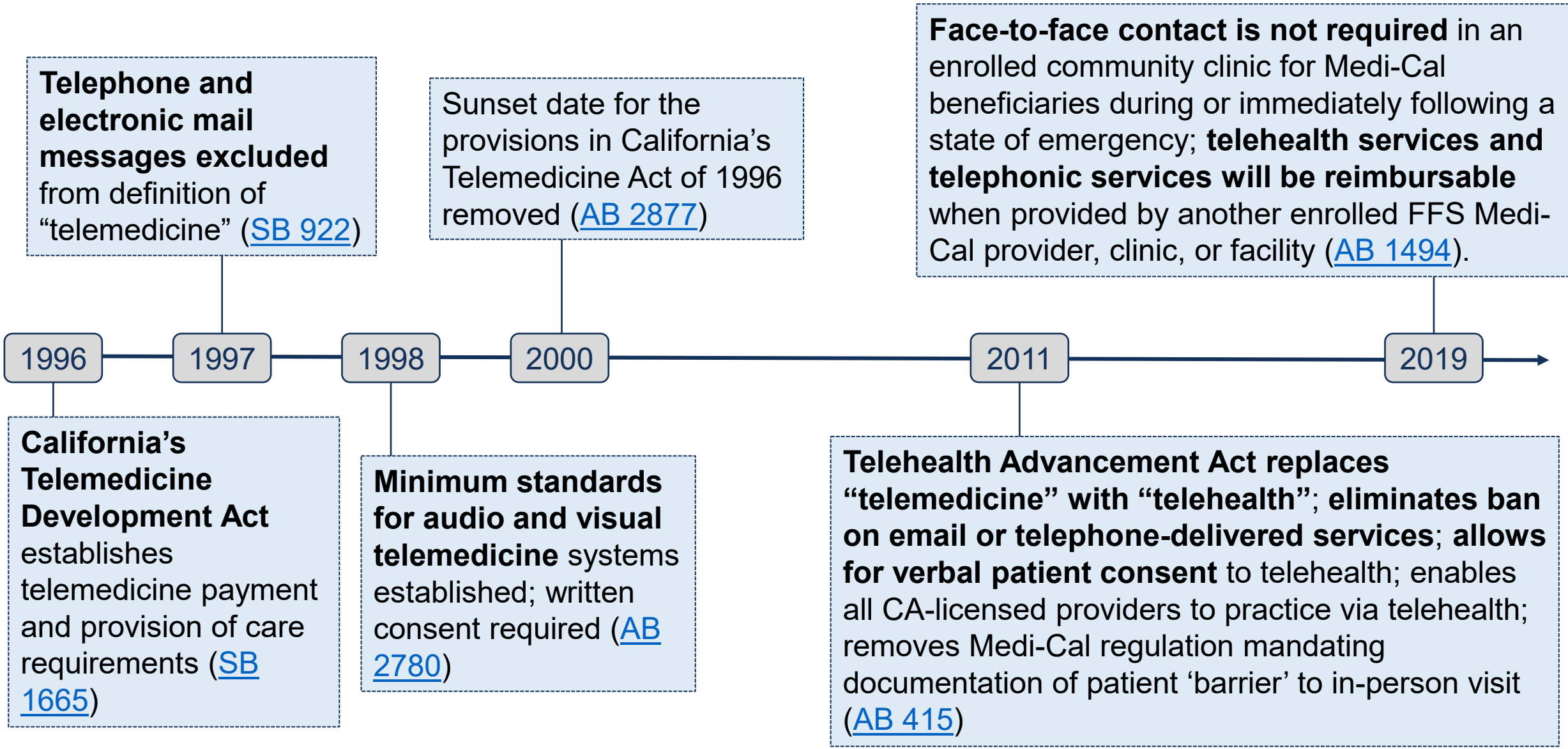
DHCS

Agenda

- Overview of History and Policy Development Process
- Discuss Proposed Policies
- Next Steps
- Public Comment
- Adjourn

Overview of History and Policy Development Process

History of Telehealth Coverage in California



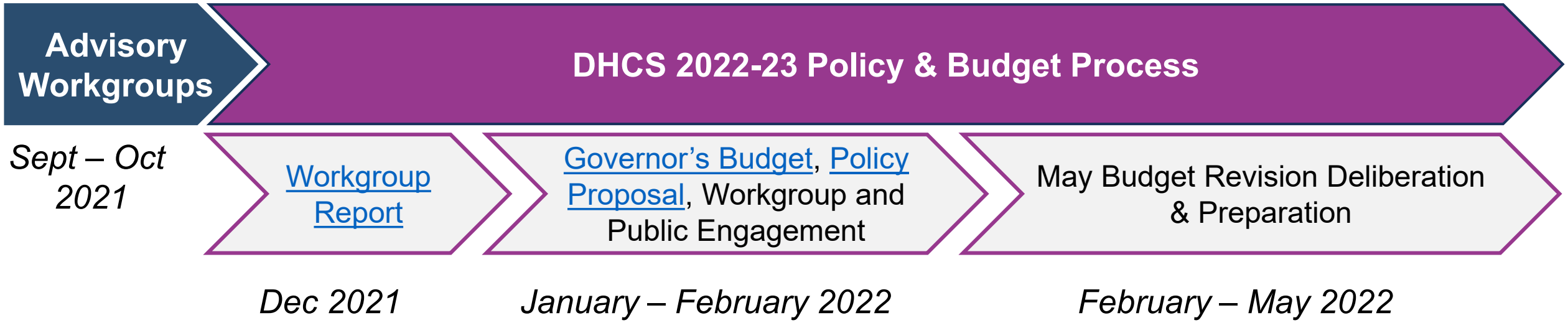
COVID-19 Public Health Emergency (PHE) Telehealth Flexibilities

As a result of the COVID-19 PHE, DHCS implemented broad flexibilities relative to telehealth modalities via blanket waivers and Disaster Relief state plan amendments (SPAs).

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 (LEA) and Targeted Case Management (TCM) services.
- Allowing most telehealth modalities to be provided for **new and established patients**.
- Allowing many covered services to be provided via **telephone/audio-only for the first time**.
- Allowing **payment parity** between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/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**, which allows providers and/or beneficiaries to be in locations outside of the clinic to render and/or receive care, respectively.
- Allowing for expanded access to telehealth through **non-public technology platforms**.

Post-PHE Policy Development Processes & Timeline



DHCS Guiding Principles *(1 of 2)*


Equity


Access


Standard of Care


Patient Choice


Confidentiality


Stewardship


Payment Appropriateness

Equity	Use 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 proficiency 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 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).

DHCS Guiding Principles *(2 of 2)*


Equity


Access


Standard of Care


Patient Choice


Confidentiality


Stewardship


Payment Appropriateness

Standard of Care	Use evidence-based strategies for the delivery of quality and culturally responsive care via telehealth. Standard of care requirements 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.

Proposed Policies

Policy Categories

Policy Category	*Policy Area*
Broad-Based Policies First Introduced During COVID-19 PHE	➢ Baseline coverage of video, audio-only, and asynchronous telehealth* ➢ Payment Parity ➢ Virtual Communications & Check-ins ➢ Telehealth in FQHCs & RHCs ➢ Establish New Patients via Telehealth
Billing and Coding Protocols	➢ Telehealth Modifiers ➢ Patient Consent ➢ Telephone Evaluation and Management (E&M) and Assessment and Management (A&M) CPT Codes
Monitoring Policies	➢ Third Party Corporate Telehealth Providers ➢ Utilization Review
Other Policies to Support DHCS's Guiding Principles	➢ Patient Choice of Telehealth Modality ➢ Right to In-Person Services ➢ Network Adequacy

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Policy Area: Baseline coverage of synchronous telehealth

Proposed Approach

- Continue coverage of video and audio-only telehealth coverage across multiple services and delivery systems, as covered during the PHE.
- Additional policies will be implemented to encourage appropriate use of 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.

Current State

- 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
- 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).

Policy Area: Baseline coverage of asynchronous telehealth

Proposed 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.

Current State

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).

Policy Area: Payment Parity

Proposed Approach

- Continue parity in reimbursement levels between in-person services and select telehealth modalities (video, 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

Current State

- DHCS has implemented parity in reimbursement levels between in-person services and telehealth modalities (video, 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.

Policy Area: Virtual Communications & Check-ins

Proposed 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 the use of different modalities when clinically beneficial.

Current State

- Brief virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, etc.) are covered by Medi-Cal in physical health.*

**Medi-Cal providers may be reimbursed using the Healthcare Common Procedure Coding Systems (HCPCS) codes G2010 and G2012 for brief virtual communications. For more detail, please see: https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf*

Policy Area: Telehealth in FQHCs & RHCs

Proposed Approach

- Continue to reimburse FQHCs/RHCs at Prospective Payment System (PPS) rate for otherwise billable visits delivered via telehealth, including visits delivered via (1) video, (2) audio-only, and (3) store and forward.
- Continue exemption from site limitations for patient or provider.

Rationale

More closely **aligns reimbursement policy** across provider systems and **augments access to care**.

Current State

FQHCs/RHCs are reimbursed at the Prospective Payment System (PPS) rate for video, audio-only, and store and forward, and are not subject to site limitations for either patient or provider.

Policy Area: Establish New Patients via Telehealth

Proposed Approach

- Clarify providers may only establish a relationship with new patients in-person or via video telehealth visits, subject to certain protections.
- "Establishment of care for a new patient" for behavioral health refers to:
  - Mental health assessment done by a licensed clinician in Specialty Mental Health Services
  - American Society of Addiction Medicine Criteria Assessment for substance use treatment in DMC and DMC-ODS
- Prohibit establishment of a new patient relationship using telehealth modalities other than video interaction and allow the Department to provide for specific exceptions to this prohibition, which shall be developed in consultation with stakeholders.
- Allow FQHCs and RHCs to establish new patient/provider relationships via asynchronous telehealth when certain conditions are met (based on requirements of the Virtual Dental Home model).

Rationale

Increases access to care by establishing new patients via telehealth while supporting consumer protections.

Current State

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.

Policy Categories

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Policy Area: Telehealth Modifiers

Proposed Approach

Use specific modifiers to delineate visits by telehealth modality, with alignment of requirements across delivery systems. Adopt new nationally-recognized audio-only visit 93 modifier announced by the American Medical Association's (AMA) Common Procedural Terminology (CPT) Editorial Board as soon as possible.*

Rationale

Enables **understanding of telehealth utilization** by audio-only or audio-video modality to support evaluation, **tracking of quality outcomes** and future program decisions. Aligns and **streamlines modifier use** across all delivery systems.

Current State

Providers who offer physical health services via telehealth are directed to bill for video visits with the 95 modifier and asynchronous store and forward encounters with the GQ modifier, but the DHCS Medi-Cal telehealth policy provides no distinct modifier guidance for audio-only encounters. As of November 1, 2021, specialty mental health, Drug Medi-Cal, and DMC-ODS counties are required to bill for services delivered via video and audio-only using specific modifiers.

** 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".*

Policy Area: Behavioral Health Telehealth Modifiers

Proposed Approach

Align with use of audio-only visit modifier 93* with CPT Codes while retaining additional modifier SC for use with HCPCS codes.

Rationale

While licensed providers will transition to use of CPT codes during the CalAIM payment reform initiative, other types of behavioral health providers will retain use of HCPCS codes. This action support the goals of **understanding of telehealth utilization** by audio-only or video modality while acknowledging limitations of HCPCS coding.

Current State

Behavioral health providers are able to utilize HCPCS code modifier GT for synchronous audio and video, SC for audio-only and GQ for store and forward (e-consult only) in DMC-ODS counties.

** 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".*

Policy Area: Patient Consent

Proposed Approach

Enhance existing consent requirements to require a provider to share all the following information at least once with patients before initiating services through telehealth: (i) Right to in-person services; (ii) Voluntary nature of consent; (iii) Availability of transportation to access in-person services when other available resources have been reasonably exhausted; (iv) Limitations/risks of receiving services via telehealth, if applicable; (v) availability of translation services.

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.

Current State

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. 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.

Policy Area: Telephonic E&M and A&M CPT Codes

Proposed 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 telephone check-ins** with patients.

Current State

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.

**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.*

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Policy Area: Third Party Corporate Telehealth Providers (1/2)

Proposed Approach

- Consider methods to identify and monitor third-party corporate telehealth providers to further examine data related to services provided by these providers.
- Further evaluate requirements set forth by AB 457 to determine potential benefit in light of complimentary policy approaches in Medi-Cal, level of effort needed to apply to Medi-Cal, necessity for alignment with commercial plans and across Medi-Cal delivery systems, and potential implementation design applicable to providers outside of Knox-Keene licensed plan networks.
- Complementary approaches that may mitigate need for additional requirements include: requirement for in-person services or warm hand-off linkage to in-person care, A&I utilization reviews for program integrity, informed consent, beneficiary education about the right to in-person services.

Rationale

- Access to third-party corporate telehealth providers could help **alleviate acute workforce shortages**, particularly for specialty providers.
- DHCS has a different reporting and oversight infrastructure than the Department of Managed Health Care, which oversees implementation of AB 457 for Knox-Keene licensed plans.

Policy Area: Third Party Corporate Telehealth Providers (2/2)

Current State

- 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 Jan 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.

Policy Area: Utilization Review

Proposed Approach

Continue to apply risk-based approach by expanding analytics and algorithm development to effectively identify suspect telehealth activity to be audited or investigated. Identified risks include, but are not limited to, the following: (1) Up-coding time and complexity of services provided; (ii) Misrepresenting the virtual service provided; (iii) Billing for services not rendered; (iv) 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.

Current State

DHCS currently conducts reviews of all provider types and modalities of service based on risks assessments, fraud complaints, results of fraud data analytics, statutorily required reviews, and other as-needed reviews to ensure Medi-Cal program integrity. Program integrity approaches for auditing health care services being rendered in-person versus telehealth only differ in the performance of an “on-site” review of a physical location.

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Policy Area: Patient Choice of Telehealth Modality

Proposed Approach

Over time, but no sooner than January 1, 2024, phase in an approach that provides patients the choice of an audio-video telehealth modality when care is provided via telehealth. Specifically, if a provider offers audio-only telehealth services, the provider should also provide the option for audio-video services to preserve beneficiary choice.

Rationale

Supports **patient choice, access, and equity**, while allowing providers time to acquire infrastructure necessary to offer additional telehealth modalities.

Current State

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.

Policy Area: Right to In-Person Services

Proposed 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: **(1)** offer services via in-person face-to-face contact, **or (2)** 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 consumer-friendly communications 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.

Current State

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.

Policy Area: Network Adequacy

Proposed 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 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

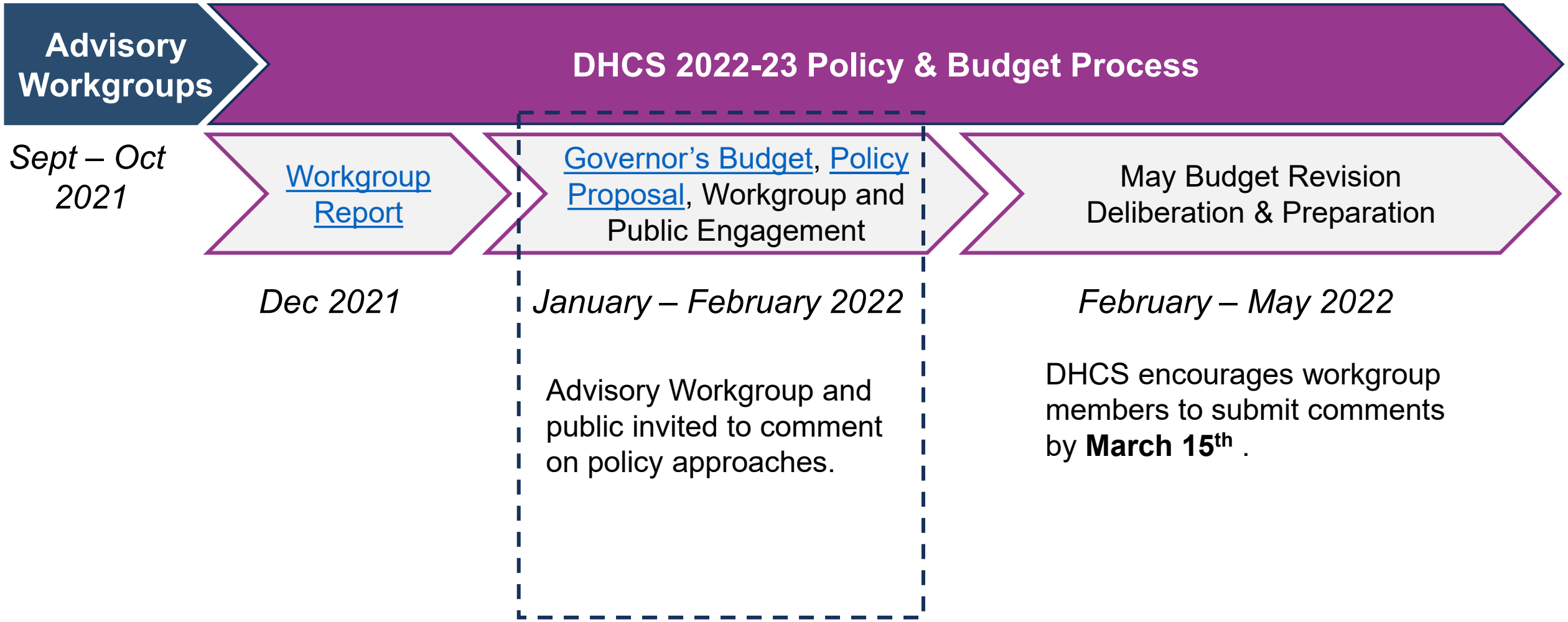
Increases access to care while balancing patients' **right to access in-person services.**

Current State

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.

Next Steps

Looking Ahead: Workgroup Member Engagement & Budget 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**.