



State of California—Health and Human Services Agency
Department of Health Care Services



Post-COVID-19 Public Health Emergency
Telehealth Policy Recommendations: Public Document
February 2, 2021

Background

Medi-Cal's telehealth policy was originally established pursuant to 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 our Medi-Cal provider manuals 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 a myriad of 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.

While Medi-Cal had an existing robust telehealth policy given the changes implemented in 2019, as a result of the COVID-19 PHE, DHCS implemented additional broad flexibilities relative to telehealth modalities via blanket waivers and Disaster Relief state plan amendments (SPAs). This has 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 (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 Federal 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. This “good faith” exemption was granted by the federal Office for Civil Rights, which would otherwise not be allowed under federal Health Insurance Portability and Accountability Act (HIPAA) requirements.

Both physical and behavioral health providers responded rapidly to the COVID-19 PHE and widely pivoted to provide services via synchronous telehealth and telephonic/audio-only modalities. While telehealth has been available for decades as a promising solution to reduce barriers to care, utilization and adoption of these modalities has been historically slow. Prior to the PHE, very few providers had opted to adopt the use of various telehealth modalities, and, thus, it remained unavailable as a widespread option for most Medi-Cal beneficiaries. The COVID-19 PHE has led to the adoption of the use of telehealth modalities at an accelerated pace that had been unthinkable prior to the PHE. Providers quickly learned how to deliver a variety of services through new technology platforms, and Medi-Cal managed care plans learned how to reimburse those services.

A Pathway Forward

For post-COVID-19 PHE, DHCS is proposing to implement broad changes to continue to allow additional Medi-Cal covered benefits and services to be provided via telehealth modalities across all delivery systems, when clinically appropriate. While the recommended changes will not incorporate all of the flexibilities allowed for during the COVID-19 PHE, DHCS believes its recommended approach is both reasonable and balanced in terms of

promoting appropriate standards of care, providing access to quality health care services, and helping to advance equity in availability of modalities across the delivery systems. This will be done while maintaining beneficiary choice, preserving provider flexibility, and protecting the integrity of the Medi-Cal program (from both a quality and fiscal perspective). DHCS believes that providing health care services through various telehealth modalities can help provide beneficiaries, especially those residing in rural and underserved areas of the State, with increased access to critically needed subspecialties, and could improve access to culturally appropriate care, such as allowing care with a provider whose language, race, or culture are the same as that of the beneficiary.

DHCS has heard from providers, Medi-Cal managed care plans, and professional associations that no show rates for appointments have significantly decreased as a result of the ability to provide health care services utilizing various telehealth modalities. This could be due to the flexible nature of the services being provided from the beneficiary's home or community. Reduced no-show rates indicate that the existing telehealth flexibilities are helping Medi-Cal beneficiaries to access services in ways that work for their individual circumstances. DHCS has also heard anecdotally that many beneficiaries prefer receiving health care services through various telehealth modalities because it reduces long travel distance on public transportation, prevents having to take time off work, reduces wait times to see a provider, and/or avoids parents having to arrange for child care. All of those factors can be obstacles to in-person visits, reducing access to care.

All of the post-COVID-19 PHE policy changes envisioned and recommended by DHCS were guided by the following principles:

1. **Equity:** Use of an equity framework, focusing on improving equitable access to providers, and addressing inequities and disparities in care to every member, regardless of race, ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location. Telehealth services will 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.
2. **Access:** Telehealth should be used as a means to promote adequate, culturally responsive, patient-centered, equitable access to health care, and to strengthen provider network adequacy.

3. **Standard of Care:** Require the use of evidence-based strategies for the delivery of quality and culturally responsive care. Standard of care requirements shall apply to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.
4. **Patient choice:** Patients, in conjunction with their providers, should be offered their choice of service delivery mode. Patients should retain the right to receive health care in person.
5. **Confidentiality:** Patient confidentiality should be protected. Patients must provide informed consent verbally or in writing in their primary or preferred language about both care and the specific technology used to provide it.
6. **Stewardship:** As stewards of public resources, steps will continue to be taken to mitigate and address fraud, waste, discriminatory barriers, and abuse.
7. **Payment Appropriateness:** Reimbursement for services provided via telehealth modalities will be considered in the context of various methods of reimbursement, nature of service, type of care provider, and the health system payment policies and goals.

Lastly, for its post-COVID-19 PHE telehealth policy, DHCS will continue to take into consideration and follow the HIPAA Privacy Rule which protects the privacy of patients' health information (protected health information) but is balanced to provide that appropriate uses and disclosures of information still may be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes. To this end, covered health care providers that use video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. For most disclosures, covered health care providers must make reasonable efforts to limit the information disclosed to that which is the "minimum necessary" to accomplish the purpose.

Post COVID-19 PHE Telehealth Policy Recommendations

DHCS is looking to modify or expand the use of synchronous telehealth, asynchronous telehealth, telephonic/audio-only, other virtual communication systems and to add remote patient monitoring to create greater alignment and standardization across delivery systems. This would include advancing the following telehealth policy recommendations effective July 1, 2021 (or in accordance with federal approvals):

- Allow specified FQHC and RHC providers to establish a new patient, located within its federal designated service area, through synchronous telehealth.
- Make permanent the removal of the site limitations on FQHCs and RHCs, for example, allowing them to provide services to beneficiaries in the beneficiary's home.
- Expand synchronous and asynchronous telehealth services to 1915(c) waivers, the TCM Program and the LEA Medi-Cal Billing Option Program (LEA BOP).
- Add synchronous telehealth and telephonic/audio-only services to State Plan Drug Medi-Cal.
- Require payment parity between in-person face-to-face visits and synchronous telehealth modalities, when those services meet all of the associated requirements of the underlying billing code(s), including for FQHC/RHCs. Payment parity is required in both FFS and managed care delivery systems, unless a managed care plan and a network provider mutually agree to another reimbursement methodology.
- Expand the use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients. These modalities would be subject to a separate fee schedule and not be billable by FQHC/RHCs.
- Provides that the TCM Program and the LEA BOP will follow traditional certified public expenditure (CPE) cost-based reimbursement methodology when rendering services via applicable telehealth modalities.

COVID-19 PHE Flexibilities Not Recommended for Continuation

As noted above, DHCS' recommended changes will not incorporate all of the flexibilities allowed for during the COVID-19 PHE. Specifically, for FQHC/RHC services, federal requirements necessitate payment parity using the Prospective Payment System (PPS) for covered services rendered by FQHC/RHCs, regardless of the telehealth modality used. This would therefore require DHCS to pay the PPS rate for telephonic/audio-only services, if allowed for FQHCs/RHCs. Given the underlying intent of and level of care provided, DHCS does not believe it is appropriate to pay FQHC/RHC and/or non-clinic providers for less involved and less costly modalities, such as a telephonic/audio-only visits, e-consults, or e-visits, at the same rate as a visit conducted in-person or through synchronous telehealth modalities.

DHCS is not recommending continuation of the following temporary COVID-19 PHE flexibilities:

- Telephonic/audio-only modalities as a billable visit for FQHC/RHCs reimbursed at PPS rate
- Telephonic/audio-only modalities to establish a new patient for delivery systems allowed to bill such services
- Payment parity for telephonic/audio-only modalities and virtual communications for delivery systems allowed to bill such services
- Various temporary COVID PHE flexibilities for Tribal 638 clinics as the federal government sets policy for Indian Health Services. DHCS will revert to pre-PHE policies.

However, DHCS would like to engage in future discussions with interested FQHC/RHC stakeholders regarding the use of telephonic/audio-only modalities, e-consults, virtual communication modalities (e.g., e-visits), and/or remote patient monitoring services in the context of an Alternative Payment Methodology. DHCS recognizes the value of being flexible in the use of telehealth across the health care safety net, while protecting the integrity of the Medi-Cal program from a health care quality and fiscal perspective.

Pre- and Post-COVID-19 PHE Telehealth Framework

The chart presented in this section represents, at a high-level, the pre- and post-COVID-19 PHE telehealth framework that DHCS is seeking to maintain and advance, as described above. For purposes of this chart, the following assumptions apply to the policies:

- Applies to Medi-Cal covered benefits and services provided across the FFS and managed care delivery systems.
- Maintains alignment with Welfare and Institutions Code Sections 14132.72 and 14132.725 (Telehealth Advancement Act of 2011), as well as Business and Professions Code (BPC) Section 2290.5, and removes most limitations on the setting in which Medi-Cal services are provided to the patient or by the health care provider.
- Tribal FQHCs (with a targeted implementation date of January 1, 2021, pending federal approvals) will follow the FQHC/RHC telehealth policy.
- Caveats that any needed SPA or waivers will include any limitations to billable providers or services, including utilization management protocols or services where telehealth modalities are not allowed.

Pre-COVID-19 PHE Policy	Proposed Post-COVID-19 PHE Changes	Rationale/ Considerations
Synchronous telehealth: This includes a real-time live interaction (two-way, audio-visual communication) ¹		
Medi-Cal covers in the following delivery systems: <ul style="list-style-type: none"> • Physical health² - New and established patients • FQHC/RHC – Established patients • Specialty mental health (SMH) for most services • Dental • DMC-Organized Delivery System (DMC-ODS) • LEA BOP speech therapy only • 1915(c) waivers - case management and indirect caregiver support 	Add for the following delivery systems: <ul style="list-style-type: none"> • FQHC/RHC – within the service area of the clinic, will allow the ability to establish new patients, removes site limitations for the location of clinic providers and allows patients to remain in their home or community. • State Plan Drug Medi-Cal (DMC) – allow for all covered services • 1915(c) waivers – allow modality for waiver intake, ongoing re-assessments, direct care services (align with physical health) • LEA BOP– allow modality for all services provided by licensed practitioners who are acting within their scope of practice (with the exception of services that are not amenable to a telehealth modality such as specialized medical transportation) • TCM – allow for all covered services • Additional SMH services, such as services by a remote provider while a patient is in residential or inpatient settings 	<ul style="list-style-type: none"> • Support payment parity for all Medi-Cal covered benefits and services provided via synchronous telehealth modalities since the quality and complexity of those visits are expected to be identical under Medi-Cal policy in terms of the professional and technical components that providers must satisfy relative to quality of services, documentation, and billing.

¹ BPC Section 2290.5(a)(5)

² Physical health includes but is not limited to primary care, specialty care, family planning, non-FQHC/RHC community clinics, mild to moderate mental health, non-county substance use disorder services (e.g. MAT, SBIRT), California Children’s Services (CCS), and Genetically Handicapped Persons Program (GHPP).

Pre-COVID-19 PHE Policy	Proposed Post-COVID-19 PHE Changes	Rationale/ Considerations
	<p>Reimbursement:</p> <ul style="list-style-type: none"> Requires payment parity between in-person face-to-face visits and synchronous telehealth, when those services meet all of the associated requirements of the underlying billing code(s), including for FQHC/RHCs. Payment parity is required in both FFS and managed care delivery systems, unless a plan and a network provider mutually agree to another reimbursement methodology. For LEA BOP and TCM services, reimbursement will be via the CPE cost-based reimbursement methodology. 	
<p>Asynchronous telehealth³ [e.g., store and forward and e-consults]: The transmission of a patient’s medical information from an originating site to the health care provider at a distant site.</p>		
<p>Medi-Cal covers in the following delivery systems:</p> <ul style="list-style-type: none"> Physical health (store and forward, e-consult) FQHC/RHC – Only for ophthalmology, dermatology, and dentistry 	<p>Add for the following delivery systems:</p> <ul style="list-style-type: none"> 1915(c) waivers – applies to case management and direct care (where allowable in physical health policy) LEA BOP - provided by licensed practitioners who are acting within their scope of practice (with the exception of services that are not amenable to a telehealth modality such as specialized medical transportation) 	<ul style="list-style-type: none"> Promote and further support flexibility in terms of the types of Medi-Cal covered benefits and services able to be provided via asynchronous telehealth modalities.

³ BPC Section 2290.5(a)(1)

Pre-COVID-19 PHE Policy	Proposed Post-COVID-19 PHE Changes	Rationale/ Considerations
<ul style="list-style-type: none"> Dental DMC-ODS (e-consults) 	<ul style="list-style-type: none"> TCM – all services Reimbursement: <ul style="list-style-type: none"> Reimbursement for asynchronous telehealth will be subject to a separate fee schedule. For LEA BOP and TCM services, reimbursement will be CPE cost-based reimbursement methodology. 	
Telephonic (Audio-Only): Telephonic communication includes audio-only modalities		
Medi-Cal covers in the following delivery systems: <ul style="list-style-type: none"> Physical health – Healthcare Common Procedural Coding System (HCPCS) Code G2021 – virtual check-in via telephone 1915(c) waivers - case management and indirect caregiver support SMH, most services DMC-ODS 	Add for the following delivery systems: <ul style="list-style-type: none"> For all delivery systems, providers are not able to establish a patient using telephonic/audio-only modalities Physical health (Evaluation and Management (E&M) codes, other Current Procedural Terminology (CPT) codes) State Plan DMC – allow for all services except initial assessment All 1915(c) waivers – align direct care services with physical health policy Developmentally Disabled waiver – allow for waiver intake, ongoing re-assessments LEA BOP – provided by licensed practitioners who are acting within their scope of practice (with the exception of services that are not amenable to a telehealth modality such as specialized medical transportation) 	<ul style="list-style-type: none"> Reduce the need for unnecessary office visits, for non-complex cases that are clinically appropriate to be triaged and/or addressed via telephonic/audio-only modalities. Allow for initial assessments to see if a follow-up, face-to-face, in-person visit is required, which could be particularly beneficial and help reduce access issues relative to certain high-demand sub-specialties. In general, given the underlying intent of and level of care provided via telephonic/audio

Pre-COVID-19 PHE Policy	Proposed Post-COVID-19 PHE Changes	Rationale/ Considerations
	<ul style="list-style-type: none"> • TCM – all services • Additional SMH services, such as services by a remote provider while a patient is in residential or inpatient settings <p>Reimbursement:</p> <ul style="list-style-type: none"> • Telephonic/audio-only services would be subject to a separate fee-schedule and reimbursed at a rate appropriate to the service provided. • Telephonic/audio-only services are not billable by FQHC/RHCs 	<p>only modalities, inclusive of the types/quality services rendered, the level of complexity, and associated documentation, these interactions are not typically viewed equivalent to face-to-face in-person visits and therefore should be reimbursed at a rate appropriate to the service provided.</p>
<p>Virtual communications⁴: “Virtual check-ins” (or brief communication technology-based services) are for patients to communicate with their physicians, health care practitioners, or other skilled and trained individuals such as Community Health Workers. Virtual communication services consists of at least five minutes of technology-based communication or remote evaluation services to conduct e-visits (e.g., web-based modalities, such as web-based interfaces, live chats, etc.) furnished by an applicable provider.</p>		
<p>Medi-Cal covers in the following delivery systems:</p> <ul style="list-style-type: none"> • Physical Health – e-visits <p>Note: HCPCS code G2010 and code G2012 are currently</p>	<p>Add for the following delivery systems:</p> <ul style="list-style-type: none"> • Physical health – add select HCPCS and CPT codes • 1915(c) waivers – allow the use of e-visits and mobile apps • LEA BOP– may be used by licensed practitioners who are acting within their scope of practice (with the exception of services that are not amenable to a telehealth modality 	<ul style="list-style-type: none"> • Similar to the rationale above for telephonic/ audio only modalities, given the underlying intent of and level of care provided via virtual communication modalities, these interactions are not typically viewed as

⁴ Generally, these virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners/skilled and trained individuals; where the communication is not related to a medical visit within the previous seven days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).

Pre-COVID-19 PHE Policy	Proposed Post-COVID-19 PHE Changes	Rationale/ Considerations
billable for established patients.	such as specialized medical transportation.) <ul style="list-style-type: none"> • TCM – all services Reimbursement: <ul style="list-style-type: none"> • Services would be subject to separate fee schedule, using specific codes. • E-visits allowed with HCPCS G2061-G2063 and CPT 99421-99423. 	being equivalent to face-to-face in-person visits and therefore will be reimbursed using specific codes with separate rates.
Remote Patient Monitoring (RPM): RPM enables communication and counseling or remote monitoring of chronic conditions such as cardiovascular and respiratory disease. RPM includes hardware and web-based software to track health care data typically from the patient’s home.		
Medi-Cal does not cover RPM today.	Add for the following delivery systems <ul style="list-style-type: none"> • Physical health for specific procedure codes, (one-time set-up and education, device, remote monitoring of physiological parameters- billable 30 days; and interpretation and communication back to patient). • Home Health (align policy with Medicare in terms of making this a covered home health benefit; See Federal Rule) • All 1915(c) waivers – align direct care services with physical health policy Reimbursement: <ul style="list-style-type: none"> • Services would be subject to a separate fee schedule, using specific codes and allowable for use by Home Health Agencies. 	<ul style="list-style-type: none"> • Promote and further support flexibility in terms of the types of Medi-Cal covered benefits and services able to be provided via RPM. • Support high-quality health care services across delivery systems • Provide improvement in outcomes such as reduced mortality, improved quality of life, and reduced hospital and nursing facility admissions • Similar to the rationales above for telephonic/audio-only and virtual

Pre-COVID-19 PHE Policy	Proposed Post-COVID-19 PHE Changes	Rationale/ Considerations
		<p>communication modalities, given the underlying intent of and level of care provided via RPM, these interactions are not typically viewed equivalent to face-to-face, in-person visits and therefore will be reimbursed using specific codes with separate rates.</p> <ul style="list-style-type: none"> • This modality has the ability to help individuals remain safely in their home and/or to be discharged early from inpatient or skilled nursing facility care.

Next Steps and Associated Action Items

To effectuate the post-COVID-19 PHE telehealth framework that DHCS is seeking to maintain and advance, as described above, DHCS will need to take certain next steps and engage in the following actions, which include but are not limited to:

- **Budget Proposal:** As part of the Governor’s Budget, the Department proposes to make permanent and expand certain telehealth flexibilities put in place during the COVID-19 pandemic focusing on improving equitable access to providers, and addressing inequities and disparities in care to every member. Among the telehealth proposals, the budget includes \$94.8 million total funds (\$34.0 million General Fund) to implement

remote patient monitoring services as an allowable telehealth modality in fee-for-service (FFS) and managed care delivery systems.

- **Advancing Trailer Bill Language (TBL):** As part of the Fiscal Year 2021-22 Governor's Budget, DHCS proposes TBL, which would be effective July 1, 2021,. However, would note that all COVID flexibilities will continue for the duration of the PHE, even if beyond July 1, 2021. TBL includes the following components:
 - Add virtual communication, telephonic/audio-only and RPM as allowable modalities under Medi-Cal.
 - Allow State Plan DMC providers to deliver all allowable substance use disorder (SUD) services via synchronous telehealth and telephonic modalities.
 - All reimbursable services provided through various telehealth modalities shall comply with privacy and security requirements.
 - Expand the definition of an FQHC and RHC visit to include synchronous interaction.
 - Allow FQHC and RHC providers to establish new patients through synchronous telehealth.
 - Reimbursement changes: in-person and synchronous telehealth payment parity in FFS and managed care (unless alternate agreements are in place with network providers).
 - Allow the use of telehealth to meet network adequacy standards in Medi-Cal managed care health plans, County Mental Health Plans, Dental Managed Care plans and DMC-ODS.
 - Revise Alternate Access Standards submission and review process and to postpone the network adequacy sunset provision until 2026.
- **State Plan Amendments (SPAs):** As necessary, DHCS will submit SPAs to CMS for necessary federal approvals, which will have an effective date of July 1, 2021.
- **1915(c) Home and Community Based Services (HCBS) Waivers:** DHCS will amend existing 1915(c) HCBS waivers, which will be effective July 1, 2021, and allow for telehealth and other virtual communication modalities and amendment waiver contracts, as necessary.
- **Promulgating CA Regulations:** DHCS will promulgate state regulations, which will include the following components:

- TCM: Modify Title 22 of the California Code of Regulations (CCR) Section 51185 to expand the definition of an “encounter” to include additional telehealth modalities.
- SMH: Revise Chapter 11 of Division 1 of Title 9 of the CCR to comply with any SPAs that include synchronous telehealth and telephonic/audio-only modalities to clarify additional SMH services are eligible for these modalities.
- State Plan DMC: Modify Title 22 of the CCR, Section 51341.1 to allow State Plan DMC providers to deliver all allowable SUD services via synchronous telehealth and telephone/audio-only modalities.

- **Developing and Issuing Policy Guidance:** Through calendar year 2021, DHCS will develop and issue clear policy guidance for Medi-Cal providers across delivery systems, which will include, but not be limited to, the following:
 - Updates to various sections of the Medi-Cal Provider Manual and other policy/procedure documents, such as:
 - LEA BOP (inclusive of updates such as the expanded definitions of a “school site” to include home learning)
 - TCM (inclusive of cost report instructions and time survey methodology)
 - All Plan Letters, Policy Letters and/or Behavioral Health Information Notices
 - Creation of new and amendments to existing provider and patient education materials, as follows:
 - Providers: Informing and providing educational materials on how to bill for telehealth, including best practices and how to promote use of telehealth modalities in practice. In addition, guidelines on the appropriate distribution of in-person versus telehealth services, including models of care, evidence based practices and utilization management protocols that would be deployed.
 - Patients: Informing and providing educational materials regarding the availability of various telehealth modalities in Medi-Cal and how to access those modalities.
 - Execution of contract amendments, as appropriate across various delivery systems

- **Initiating Stakeholder Engagement:** DHCS, like with prior updates to its telehealth policies, will begin stakeholder engagement efforts through its regular distribution channels and dedicated forums. DHCS will provide more information as it becomes available relative to the nature, extent, and scheduling of this engagement.