Department of Health Care Services
Post-COVID-19 Public Health Emergency
Telehealth Policy Recommendations

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 myriad 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 expansive 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 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, 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.

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 – 2023 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 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. Unlike most other state Medicaid programs that limit telehealth to specific clinical areas or services, 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 regards 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 proposing the implementation of broad changes that continue to allow additional Medi-Cal covered benefits and services to be provided via telehealth across delivery systems when clinically appropriate. All post-PHE policy changes envisioned and recommended by DHCS were guided by the following principles, which were also updated to reflect Advisory Workgroup input:

- **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 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 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

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

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]
- 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

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[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).

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]

Telehealth Policy Proposals

DHCS has been developing its future telehealth policy. DHCS intends for many policies first introduced during the COVID-19 pandemic to be continued after 2022. DHCS has also developed and refined proposed policy approaches for establishing and adopting billing and utilization management protocols for telehealth as part of the process of working with the Telehealth Advisory Workgroup established pursuant to AB 133, as discussed above.

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

A. Policy Area: Baseline coverage of synchronous telehealth

[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. 26

[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"

- **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).
- **Proposed 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).
- **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.

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.).
- **Proposed 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]
- **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.

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.
- **Proposed 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.
- **Rationale:** More closely aligns reimbursement policy across provider systems and augments access to care.

[15] 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

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).
- **Proposed Approach:**
    - Clarify providers may only 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.
    - Prohibit establishment of a new patient relationship using telehealth modalities other than video, and allow the Department to provide for specific exceptions to this prohibition, which shall be developed in consultation with stakeholders.
        - For FQHCs and RHCs, an exception to this prohibition will allow FQHCs and RHCs to establish new patient/provider relationships via asynchronous telehealth when certain conditions are met, including that the patient is present at an originating site that is a licensed or intermittent site of the FQHC or RHC. For example the Virtual Dental Home, a unique model that can provide dental care to underserved communities.
- **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:** Providers who offer physical health services and nonspecialty mental health services via telehealth are 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 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 audio-only using a specific modifier.

- **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.[16]
- **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. 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.
- **Proposed Approach:** 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
    - 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.

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

[16] 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

- **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.
- **Proposed Approach:** Activate CPT codes for capture of telephonic evaluation and management and assessment and management visits in Medi-Cal by July 1, 2022. 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 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.
- **Proposed Approach:**
    - Consider methods to identify third-party corporate telehealth providers and 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.

- **Rationale:** Promote continuity of care and care coordination between third-party corporate telehealth providers and patient's local in-person care teams. Monitor provision of services provided by third-party corporate telehealth providers.

K. Policy Area: Utilization 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.
- **Proposed 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.
- **Proposed 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.

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

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.
- **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 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 brochure 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.
- **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 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.

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 is now developing a plan to study telehealth utilization and its impact on access, quality and outcomes, and on provider and enrollee experiences. The 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 framework that DHCS is seeking to maintain and advance, as described above, DHCS will take a number of actions, which include but are not limited to:

- **Trailer Bill Language (TBL):** As part of the Fiscal Year 2022-23 Governor's Budget, DHCS proposes TBL. However, COVID-19 PHE flexibilities will continue for the duration of the PHE and until December 31, 2022. For information related to the TBL, please see the TBL Fact Sheet.
- **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.
- **Promulgating Regulations:** DHCS will promulgate state regulations as needed.
- **Developing and Issuing Policy Guidance:** Through calendar year 2022, 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, as well as materials informing beneficiaries of their right to access in-person care.
- **Legislative and Stakeholder Engagement:** DHCS will conduct legislative briefings, participate in legislative hearings, and conduct stakeholder engagement efforts through its regular distribution channels and dedicated forums.