DHCS POST-PHE TELEHEALTH PROPOSALS

FACT SHEET I March 2022

Introduction

The California Department of Health Care Services (DHCS) that oversees the state Medicaid program (Medi-Cal) recently released their permanent telehealth proposals for the program beginning in 2023. In 2021, given concerns raised by stakeholders and policymakers related to uncertainty around post-public health emergency (PHE) telehealth policies, through AB 133 the Administration temporarily extended the state's Medi-Cal telehealth policies that were put in place in response to COVID-19 until December 31, 2022. In the meantime, the legislation also called upon the Department to convene a stakeholder advisory group to discuss new billing proposals they wished to incorporate into permanent post-2022 policies. The group met over a series of three meetings in the fall of 2021 and DHCS issued a report in December 2021 summarizing those meetings and stakeholder feedback, including member concerns around DHCS' newly suggested approaches.

On February 4, 2022, DHCS released their permanent telehealth policy proposals. While overarching policies related to maintaining audio-only coverage and payment parity for all telehealth modalities appear to be continuing, a few additional policies proposed may create new barriers to the utilization of telehealth within the Medi-Cal program.

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Synchronous Telehealth

(Includes Live Video and Audio-Only)

DHCS proposes to continue the coverage for synchronous telehealth, both live video and audio-only, that existed before and during the pandemic. This would include services in Targeted Case Management (TCM) Program and Local Education Agency Medi-Cal Billing Option Program (LEA BOP) that were temporarily allowed during COVID-19. For audio-only, the modifier "93" will need to be used. DHCS also proposes to add to the available services list audio-only codes 99441-3 (E&M) and 98966-8 (A&M) by July 1, 2022. These codes appear to be in addition to codes providers can bill for when providing services via audio-only and appended with the modifier "93".

Payment parity will continue for live video and audio-only as long as the services meet the same standard of care and billing requirements as in-person services, although different rates may apply to the 99441-3 and 98966-8 code series. New patients will primarily only be allowed to be established via live video as well.

Asynchronous Telehealth

(Includes Store-and-Forward and eConsult)

DHCS' proposal would continue asynchronous telehealth that was seen before and during the pandemic including asynchronous coverage for TCM and LEA-BOP. Payment parity will continue for asynchronous as long as the services meet the same standard of care and billing requirements as in-person services. Limited exceptions for the establishment of patients via store-and-forward will apply to certain provider services within FQHCs and RHCs.

Virtual Communications & Check-Ins

(Brief communications, live chats, web-based interfaces)

Brief virtual communications were allowed during the PHE for physical health. DHCS proposes to continue this coverage and allow e-visits for TCM and LEA-BOP. These would be separate from general telehealth policies and rates.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

FQHCs and RHCs were allowed during the pandemic to provide services via audio-only, and pre-pandemic, were able to receive reimbursement for services provided via live video and some services provided via store-and-forward. Additionally, during the pandemic, site limitations on the patient and provider were lifted and FQHCs were also allowed to use synchronous and asynchronous telehealth for new and established patients. FQHCs and RHCs were paid their prospective payment rate (PPS).

DHCS is proposing to continue many of these policies including payment of the PPS rate for live video, audio-only, and asynchronous services as well as lifting the site limitations. However, DHCS is proposing to limit establishment of a relationship with new patients to in-person or synchronous visits. Establishing relationships through other modalities will be prohibited with only certain exceptions such as asynchronous can be used to establish a new relationship if the patient is at an originating site that is licensed or an intermittent site of the FQHC/RHC.

Other Proposals

The foregoing proposals were expected items as they were policy issues that were touched upon in previous proposals and were the focus of the COVID-19 waivers. However, DHCS included several other proposals that had not been raised during COVID-19 and stakeholders only learned of the Department's interest in these issues this past fall at the stakeholder advisory group meetings.

Patient Consent

Current law allows consent to the use of telehealth to be obtained either written or orally (BPC 2290.5). Very few details were listed as to what needed to be included in the consent. DHCS is proposing the addition of specific information that would need to be captured:

- 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 receive services via telehealth, if applicable
- Availability of translation services

Third Party Corporate Telehealth Providers

As DHCS currently does not have a way to monitor or evaluate third party corporate telehealth providers, DHCS will consider methods to identify and examine data related to the services these entities provide. DHCS will also consider the recently implemented AB 457 (Santiago, 2021) which requires health plans to comply with specific requirements if third party corporate telehealth providers are offered to their enrollees when exploring potential methods of identifying and examining data.

Fraud

DHCS will continue to work on expanding monitoring for fraudulent activities related to telehealth.

Video/In-Person Requirements & Other Proposals

DHCS is proposing that over time it will phase in an approach that if a provider is offering audio-only telehealth, they will need to also provide an option for live video as well. They would not phase in the approach before January 1, 2024.

In that same vein, DHCS is also proposing a phased-in approach that would require providers offering services via telehealth to also offer services in-person or link the beneficiary to in-person care. If the latter, the telehealth provider will need to facilitate that link and the patient would not be required to independently contact a different provider to arrange for care.

DHCS also proposes to allow Medi-Cal Managed care plans, county Mental Health Plans and county Drug Medi-Cal Organized Delivery System plans to use live video as a means of demonstrating compliance with network adequacy time and distance standards.

DHCS is developing a plan to study telehealth utilization and its impact on access, quality and outcomes as well as provider and enrollee experiences.

Analysis

Overall, many of the general concerns raised in 2021 over DHCS' initial set of proposals were addressed by the 2022 version, such as maintaining audio-only coverage and payment parity for all telehealth modalities. Many of the COVID-19 flexibilities remain and it appears the pre-pandemic level of coverage is mostly intact though more details on how these additional billing policies will be implemented will need to be known to be certain. Additionally, it should be noted that according to the DHCS Telehealth Advisory Group Report, p. 15 and a December 2021 provider bulletin, remote physiological monitoring is covered by Medi-Cal for dates of service on or after July 1, 2021.

However, the unexpected proposals on additional consent requirements and phasing in a requirement that all providers delivering care via audio-only will eventually need video capacity are new. Requiring telehealth providers to also offer in-person (or facilitate in-person services for the enrollee) is also new. The latter is possibly related to concerns regarding the ability to fully monitor and regulate a third-party corporate telehealth provider. During the stakeholder process, some members raised concerns that all these newly proposed actions may set up a different and more restrictive standard that may result in less access to telehealth for the Medi-Cal population when compared to those covered by commercial payers. Preventing the ability to establish a patient via all telehealth modalities, as determined appropriate by a provider, is also a new and distinctly Medi-Cal requirement. Although the DHCS proposal does suggest that they look to develop specific exceptions to the prohibition in consultation with stakeholders.

During the Advisory Group process, members did raise questions about these issues, including why consent was being revisited as it had been addressed several years prior through multiple pieces of telehealth legislation (AB 415 and AB 809) and previous stakeholder negotiations. It should be noted, that some of the concerns in this regard raised by Advisory Group members had centered on requiring an explanation as to why telehealth was used, which conflicted with AB 415 from 2011 that eliminated that administrative step.

At this time, these remain proposals only and as of the writing of this fact sheet, the trailer bill language, which will likely contain more details, is not yet available. DHCS noted that it will be conducting briefings, hearings and engaging stakeholders throughout the legislative budget process, which will go into the summer and be the vehicle for vetting and finalizing any permanent changes.

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