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ASSEMBLY COMMITTEE ON HEALTH
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ASSEMBLYMEMBER, SECOND DISTRICT

Informational Hearing
Assembly Health Committee
Telehealth Policy in California Post-Pandemic
Tuesday, February 23, 2021 - 2:30 p.m.
State Capitol, Assembly Chambers

BACKGROUND

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.[1]

During the public health emergency (PHE), the state and federal governments significantly expanded the authorization for coverage of services provided through telehealth to maintain on-going patient access to health care, to sustain health care provider practices facing revenue losses from a decline of in-person visits, to help preserve personal protective equipment, and to encourage social distancing. The telehealth flexibilities and expansions during the national PHE built upon prior expansions enacted administratively by the Department of Health Care Services (DHCS) for the Medi-Cal program and through state law changes in 2019[2] and include requiring coverage for telephone visits in Medi-Cal and by state-regulated health plans, requiring reimbursement for services delivered through telehealth and telephone visits to be on the same basis and to the same extent as reimbursement for the same service through in-person (referred to as "payment parity"), and expanding the ability of clinic providers to bill Medi-Cal for telephone services during a state-declared emergency.

At the end of the 2019-20 legislative session, various health care provider associations sought to codify and make permanent many of the DHCS temporary payment and telehealth flexibilities enacted and currently in effect during the PHE. While no formal legislation was introduced in the final months of the 2019-20 legislative session, AB 32 (Aguiar-Curry) was introduced this year and recently amended to make permanent various telehealth flexibilities enacted during the PHE, including requiring commercial health plans and insurers to cover telephone calls and reimburse those visits "at parity" with in-person visits, and to require Medi-Cal managed care (MCMC) plans to pay for telehealth and telephone calls at parity with in-person visits, and to prevent restrictions currently imposed on some clinic providers.

In addition to the administrative flexibilities, legislation was passed in 2020 to allow federally qualified health centers (FQHCs) to establish a patient relationship for Medi-Cal billing purposes via telehealth on a time-limited basis (AB 2164 (Robert Rivas)). AB 2164 was vetoed by Governor Newsom, who indicated that while he was supportive of utilizing telehealth to increase access to primary and specialty care services, DHCS was in the process of evaluating its global telehealth policy to determine what temporary flexibilities should be extended beyond the COVID-19 pandemic.

The Governor also indicated that changes to FQHC and rural health clinic (RHC) telehealth is better considered within the context of a global assessment around telehealth, and the cost of these changes is also more appropriately considered alongside other policy changes in the budget process.

As part of the Governor's 2021-22 Budget, DHCS is proposing to expand Medi-Cal coverage to include remote patient monitoring (RPM) at a cost of $94.8 million ($34 million General Fund).[3] In addition, DHCS released its telehealth proposed changes on February 2, 2021[4] and associated trailer bill language, [5] a copy of which are included with the agenda and background paper.

The major provisions of AB 32 to broaden telehealth coverage are described below:

1) Require health plans and health insurers regulated by the Department of Managed Health Care (DMHC), the California Department of Insurance (CDI), and Medi-Cal to cover telephone calls;
2) Require health plans and health insurers to reimburse health care providers at parity for telephone calls (referred to as "payment parity," which currently applies to telehealth under existing law for private health plans and insurers and to MCMC plans; the requirement for MCMC plans only applies during the PHE is not codified in state law);
3) Require MCMC plans and fee-for-service (FFS) Medi-Cal to pay for telephone and telehealth at parity with in-office visits (MCMC plans were not required to pay at parity or to provide coverage for telephone calls by law but were required to do during the PHE);
4) Require reimbursement for FQHCs, RHCs, and county clinics at their in-person cost-based reimbursement rates, and to prohibit restrictions on FQHCs and RHCs that do not exist for other provider types (such as the limitation that telehealth be used for established patients, that patients be in a provider's office as part of telehealth visit, and to require the clinic provider to be within the four wall of the health center).

To inform the discussion around AB 32 and the DHCS telehealth proposal, this Assembly Health Committee informational hearing will provide an overview of telehealth law and policy, the current state of evidence on telehealth and telephone visits, policy considerations for consideration on telehealth policy post-pandemic, and hear and evaluate recently-released DHCS telehealth policy changes for the post-PHE period.

Background

Telehealth utilization expanded during the pandemic across all payors during the first months of the PHE as virtual physician visits became an accepted part of the new normal.[6] At the peak of telehealth utilization, approximately 48% of health care visits were delivered via telehealth in April 2020, with telehealth visits compromising about 20% of healthcare visits in June 2020.

The state and federal governments made hundreds of health-related policy and fiscal changes in response to the PHE, including changes to Medicaid (Medi-Cal in California), federal changes to Medicare and changes related to state-regulated private health plan and insurers. The state and federal PHE responses also included changes to telehealth regulatory and payment policy that built upon changes enacted administratively by DHCS in 2019 and through state legislation in 2019, and federal legislation and policy changes.

State Health Plan/Insurance Law and PHE Guidance

On the state level, DMHC and CDI issued bulletins in response to the PHE. The DMHC bulletins[7] in effect accelerated the requirements in state law established pursuant to AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019, which had a delayed operative date of January 1, 2021.

AB 744, among other provisions, requires health plan and health insurer contracts with health care providers to specify that the health plan/insurer must reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health plan/insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.[8]

In the guidance, the DMHC directed plans to provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee.

The CDI notice[9] states that CDI expects that health insurers should allow all network providers to use all available and appropriate modes of telehealth delivery including, but not limited to, synchronous video, and telephone-based service delivery, and to facilitate care with physical separation, insurers should immediately implement reimbursement rates for telehealth services that mirror payment rates for an equivalent office visit, and the reimbursement should align with the requirements set forth in AB 744.

DHCS Law and PHE Guidance

DHCS' Medi-Cal telehealth policy is in state law, regulation, the State Medicaid State Plan, provider manuals, FAQs, and guidance to MCMC plans and providers. Prior to the PHE, Medi-Cal provided coverage for services via:

- Synchronous two-way interactive audio-video communications (for example, where the person and the health care provider are communicating in real-time via a computer);
- Asynchronous store and forward[10] (asynchronous store and forward is defined as the transmission of a patient's medical information from an originating site[11] where the patient is located to the health care provider at a distant site, such as an x-ray or imaging result),[12]
- E-consults (asynchronous health record consultation services that provide an assessment and management service in which the patient's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient's health care needs without patient face-to-face contact with the consultant).
- Virtual/telephonic communication includes a brief communication with another practitioner or with a patient, who in the case of COVID-19, cannot or should not be physically present (face-to-face). Reimbursement is limited to two Healthcare Common Procedure Coding System (HCPCS) for brief virtual communications (for example, remote evaluation of

recorded video or images submitted by an established patient, or a virtual check-in, not related to an evaluation and management service or procedure provided within the seven previous days).

However, reimbursement for these different telehealth modalities differed by provider type, and by Medi-Cal payor. For example, certain provider types (such as FQHCs, as described below) have more restrictive payment provisions, while county mental health plans and drug treatment systems authorize broader use of telephone visits than the two HCPCS codes described above.

State regulation and California's Medicaid State Plan authorize county mental health plans (56 county entities serving 58 counties which provide specialty mental health services to Medi-Cal beneficiaries) to provide specified services either via face-to-face or via telephone. For example, mental health services,[13] medication support services,[14] crisis intervention,[15] and targeted case management,[16] may be provided either face-to-face or by telephone with the beneficiary or significant support persons. These modes of service delivery pre-date the PHE.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a county opt-in substance use disorder (SUD) treatment benefit for Medi-Cal beneficiaries authorized in late 2014 and continued in the state's 2015 Medi-Cal waiver known as Medi-Cal 2020. The Special Terms of Conditions (STCs) of the state's Section 1115 Medicaid waiver authorize specified services to be delivered in-person, via telephone or telehealth, including outpatient services,[17] intensive outpatient treatment,[18] recovery services,[19] and case management.[20] The details of the DMC-ODS benefit are almost entirely in the STCs of the waiver. Thirty-seven counties with over 95% of the state's population reside in a DMC-ODS county. The remaining counties are referred to as State Plan Counties and have a more limited benefit.

Unlike state regulated health plans and insurers, existing law does not require Medi-Cal or MCMC plans to pay health care providers at parity with in-office visits. DHCS indicates there is no policy prohibition on MCMC plans choosing to utilize telephone visits within their respective provider networks. DHCS indicates it is aware that, pre-PHE, MCMC plans and their provider networks were utilizing telephonic/audio only modalities to deliver care but the approaches varied among plans. However, DHCS indicates MCMC plans would still be prohibited from paying FQHCs for telephonic visits because this would not comport with DHCS policy, and the plans must, at minimum, meet the requirements outlined in the Medi-Cal Provider Manual. DHCS indicates, to the extent a MCMC plan incurred costs for telephone visits and reported them to DHCS as costs for covered services, they would be recognized and considered in the rate setting process. In addition, Medi-Cal does not currently reimburse for RPM[21] (although this is proposed in the Governor's 2021-22 Budget). RPM enables communication and counseling or remote monitoring of chronic conditions such as cardiovascular and respiratory disease including hardware and web-based software to track health care data typically from the patient's home.

On March 24, 2020, April 30, 2020, June 23, 2020 and January 5, 2021,[22] DHCS issued guidance expanding and clarifying the scope of Medi-Cal coverage of telehealth, including requiring MCMC plans to pay for telehealth visits and telephone visits to be the same as in person visits (MCMC plans were exempt from the provisions of AB 744) and clarified the scope of coverage.

Under the DHCS PHE guidance, and unless otherwise agreed to by the MCMC plan and provider, DHCS and MCMC plans must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. DHCS and MCMC plans must provide the same amount of reimbursement for a service rendered via telephone or virtual communication, as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.[23]

For Medi-Cal covered benefits and services provided via traditional telehealth (synchronous, two-way interactive, audio-visual communication, or asynchronous store and forward), DHCS proposed to waive its existing restrictions/requirements relative to "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements for FQHCs, RHCs and Tribal clinics. Those restrictions limited the use of telehealth by FQHCs and RHCs to:

- Established patients of the clinic (seen within the last three years or assigned to the clinic by a MCMC plan);
- Limited services outside of the four walls to the clinic to only certain populations (migrant/seasonal workers, homeless individuals and homebound individuals); and,
- Prohibited these clinics from billing for telephonic communication visits.

DHCS indicated waiving these limitations will allow FQHCs, RHCs, and Tribal Clinics greater flexibility under DHCS' existing telehealth policy, which is described above. These waiver requests parallel state law provisions enacted following the fires of 2018 (AB 1494 (Aguiar-Curry), Chapter 829, Statutes of 2019). AB 1494 required telehealth, telephone and services outside of the four walls to be Medi-Cal reimbursable when provided by an enrolled community clinic, an enrolled FFS Medi-Cal program provider, clinic, or facility approved by DHCS during or immediately following a state of emergency to a Medi-Cal beneficiary who was not at another health care provider location (including at the patient's home).

DHCS "Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations: Public Document"

On February 2, 2021, DHCS released its post-COVID telehealth policy recommendations[24] and proposed trailer bill language was posted on the Department of Finance website. DHCS indicates it is looking to modify or expand the use of synchronous telehealth, asynchronous telehealth, telephonic/audio-only, other virtual communication systems and to add RPM to create greater alignment and standardization across delivery systems. DHCS indicates this would include advancing the following telehealth policy recommendations effective July 1, 2021 (or in accordance with federal approvals):

- Allow specified FQHCs and RHCs providers to establish a new patient, located within its federal designated service area, through synchronous telehealth (as previously indicated, DHCS policy pre-PHE limits FQHCs and RHCs ability to use telehealth to "established patients" who have been in at the clinic within the last year or who are assigned to the clinic by a MCMC plan) ;

- 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 (DHCS policy pre-PHE required most patients to be in a health care provider's office to receive telehealth services from a remote provider);
- 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 (existing law exempts MCMC plans from the payment parity requirement); and,
- Expand the use of clinically appropriate telephonic/audio-only, other virtual communication, and RPM for established patients. These modalities would be subject to a separate fee schedule and not be billable by FQHC/RHCs.

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 require DHCS to pay the PPS rate for telephonic/audio-only services, if allowed for FQHCs/RHCs. DHCS states that, given the underlying intent of and level of care provided, it does not believe it is appropriate to pay FQHC/RHC and 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 states it 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; and,
- Various temporary COVID PHE flexibilities for Tribal clinics as the federal government sets policy for Indian Health Services. DHCS will revert to pre-PHE policies.

However, DHCS indicates it 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 RPM services in the context of an Alternative Payment Methodology (federal Medicaid law authorizes states to pay an FQHC or RHC an APM if the methodology is agreed to by the State and the center or clinic, and results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under the PPS requirements[25]). 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.

Post-PHE Regulatory and Payment Policy

As a result of the COVID-19 pandemic, what was once a little-used alternative mode of delivery to in-person visits became essential as telehealth maintained health care access for patients while providing social distancing for patients and providers and reducing the need for personal protective equipment for health care providers and patients. Prior to the PHE, there were multiple arguments for telehealth coverage, including that it:

- Provides timely access to health care;
- Results in patients needing less time to arrange transportation, miss work, and arrange child and elder caregiver assistance;
- Expands access to health care providers in rural and underserved areas as over seven million Californians live in a health professional shortage area;
- Reduces patient "no show" rates (missed appointments with health care providers);
- Reduces reliance on emergency departments (EDs) and urgent care, and reduces the use of EDs as a usual source of care for Medi-Cal beneficiaries;
- Increases access to specialists as one in four Medi-Cal beneficiaries report have difficulty finding specialty care;
- Eliminates transportation barriers due to distance, road closures due to weather, winter conditions, construction or fire;
- Reduces patient travel time;
- Reduces use of and expenditures on non-emergency medical transportation and emergency transportation;
- Provides patients with greater flexibility in making appointments to access care;
- Has shown to be popular in patient satisfaction surveys; and,
- Provides flexibility in accessing care by expanding the appointment times.

The expansion of coverage to include telephone calls – and to pay for telephone calls at parity with or equivalent to an in-office visit during the PHE is one of several policy issues that pose trade-offs between ease of access to health care services and a likely increase in utilization and the overall cost of care to payors and patients. Many of the arguments for telehealth apply to coverage of telephone visits, but telephone visits differ in several aspects, including the inability of a health care provider to view the patient, the equipment needed, greater ability to use and ease of access for telephone for patients and providers, the lack of long-term data on quality on utilization, and the reduced need for payment for transmission costs for telephone visits.

The chart below shows some of the arguments made in policy and medical journals, briefing papers, and by stakeholders in support and opposition for requiring coverage of telephone calls, and paying for those calls at parity:

Arguments in Support	Arguments in Opposition
Required Coverage of Telephone Calls in Commercial Coverage and Medi-Cal	
▪ Easier and more convenient for patients to use telephone as compared to telehealth; ▪ Available for patient without broadband access (connectivity) for whom telehealth is not an option; ▪ More patients have telephones as compared to individuals with a computer or tablet; ▪ Patient satisfaction, including some patient preferring telephone to telehealth when discussing sensitive services away from a home or work computer; ▪ County mental health plans (which provide specialty mental health services to Medi-Cal beneficiaries) and DMC-ODS (for SUD services) are already authorized to provide services via telephone under existing regulation; ▪ Reduces 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; and, ▪ Most of the telehealth primary care and behavioral health visits at more than 500 clinics in California that serve low-income patients have been audio-only visits.	▪ Health care cost impact resulting from ease and convenience of telephone visits results in overuse and/or additional visits (as opposed to a one-to-one replacement for in-person visits); ▪ Health care providers are unable to assess a patient's skin tone, gait, facial expressions and nonverbal cues or otherwise conduct a physical exam during a telephone call; ▪ Telephone calls are clinically inappropriate for certain patient populations (for example, infants, adults with hearing loss or a cognitive disorders). ▪ Requiring coverage of telephone calls builds off of FFS payment model, which incentivizes low-intensity services provided at volume; ▪ Telephone coverage should only be required as part of APM or capitated payment arrangement; and, ▪ Unknown impact on utilization and health care costs in out years as widespread coverage of telephone visits is a more recent delivery modality during the PHE.
Mandatory Payment Parity for of Telephone Calls in Commercial Coverage	
▪ Reimbursement should be equivalent to reflect a health care provider's time, irrespective of the modality by which the service is delivered (telephone, telehealth or in-person); ▪ Payment parity incentivizes the availability of telephone services, thereby increasing access to care after hours and offering an alternative to after-hours urgent care or emergency department usage; ▪ Payment parity ensures access to "brick and mortar" providers currently serving the patient, instead of providing an incentive for plans and insurers to use telehealth vendors to provide telehealth services; and, ▪ Payment parity increases provider revenue and sustains provider practices when in-person visits are not possible during a PHE that require social distancing.	▪ Payment rates between health plans and health care providers should be left to the market, similar to other non-telehealth payment arrangements in the commercial market (state law should not establish a "rate setting floor" for commercial payments); ▪ Payment parity increases patient cost-sharing for patients with deductible or co-insurance plan or policy; ▪ Payment parity incentivizes reduced in-office availability by providing equivalent revenue to in-person visits; ▪ Payment parity for telephone visits is inappropriate as these visits do not include clinical elements common to an in-person exam (such as blood pressure, weight, temperature, oxygen levels) and can be provided at a lower cost; ▪ Payment parity is inappropriate because less administrative work is required of the health care provider's office and staff because the patient is not physically present; and,

Arguments in Support	Arguments in Opposition
	▪ Payment parity increases premiums costs and overall health care costs as commercial telehealth vendors can provide telehealth and telephone visits for a lower per visit price than many office visits;
Mandatory Payment Parity for Telephone and Telehealth in Medi-Cal	
▪ Payment parity applies to state-regulated health plans and insurers for commercial coverage for telehealth under existing law; ▪ Payment parity ensures access to "brick and mortar" providers currently serving the Medi-Cal population.	▪ The cost-based reimbursement required for FQHCs and RHCs (under PPS), and certain county clinics is excessive for a telehealth visit or telephone call; ▪ Reimbursement rates between MCMC plans and their contracting providers should be subject to negotiation and not mandated by state law; ▪ Telephone services are likely to be shorter and for less intensive conditions than in-person visits;

One significant issue is whether telephone visits are best and appropriately reimbursed through FFS payment, and if value-based payment should be the long-term goal. One commentator – in an article entitled "The Mismatch of Telehealth and Fee-for-Service Payment"[26] about Medicare payments during the PHE - described how the fixed billing costs to providers for low levels of reimbursement made no financial sense for providers to provide the service, but that increasing the payment raised other issues, including that reimbursing at a higher rate for a lower cost service would result in an increase in volume, as quoted below:

> The pandemic has reinforced that FFS is particularly inappropriate for many low-cost services, including many telehealth services. Within a few weeks of adoption during the PHE, CMS (for Medicare) raised the 5- to 10-minute phone call fee from $15 to $46—the rate for a level 2 office visit, better supporting financially strapped practices. As a temporary policy in the midst of the COVID-19 crisis, "overpaying" for high-frequency, low-cost services makes good policy sense. Post–COVID-19, however, we can expect a proliferation of telehealth services if Medicare continues to overpay for such communications. Policy makers face a dilemma. Using standard, relative cost calculations, they could establish "correct" fees, which primary care practices would rarely bill for or provide. Alternatively, Medicare could pay a rate far higher than the resource cost calculations would establish, making the services highly profitable and provided at high volume.
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> Policy makers similarly face unpalatable choices in setting rates for telehealth visits that are substitutes for in-person visits. Patients face substantial time costs in travel, waiting room, and, finally, time with their practitioner. Time costs are a major constraint on the volume of office visits but would mostly disappear if patients' homes become routinely accepted as the originating telehealth site, as COVID-19 PHE policy permits. As permanent policy, then, there would likely be a massive increase of telehealth visits, especially if Medicare Physician Fee Schedule payments equaled office visit payments, despite the substantially lower production cost.

The author proposed instead to pay primary care practices lump sum payments to cover the cost of virtual telehealth care when there is an established, ongoing patient relationship. A pool of money rather than FFS payments for telehealth communications would allow practices to determine how best to provide care outside of in-person visits while also reducing exorbitant billing costs.

The FFS payment methodology is particularly relevant to the telehealth and telephone payment parity discussion for Medi-Cal payments because of the way and amounts FQHCs, RHCs and Los Angeles County cost-based clinics are reimbursed under Medi-Cal. FQHCs are a core component of the primary care delivery system in Medi-Cal that are projected to cover nearly 19 million visits in 2021. Under federal law, FQHCs and RHCs are reimbursed by Medi-Cal on a per-visit rate through what is known as PPS. Under PPS, payments to FQHCs and RHCs must be reasonable and related to the cost of furnishing services, be calculated on a per visit basis. Each FQHC and RHC has a specific PPS Medi-Cal rate for each face-to-face encounter, irrespective of the reason or intensity of the visit or whether the patient is new or an established patient.

The PPS rates vary significantly by FQHC (from a low of $63.69 per visit to a high of $718.67) and the average ($214.60) and median ($203.01) FQHC rates under PPS exceed the most commonly billed primary care codes in Medi-Cal FFS and managed care (as shown in the chart below) and which raises questions as to whether these payment amounts are appropriate, particularly because the estimated monthly rate paid to Medi-Cal plans for the entire scope of services the plan is responsible for is $84 for a child and $264 for a non-disabled adult.

The most commonly billed primary care codes in Medi-Cal FFS and MCMC include the following (the total payment is the base rate plus the Proposition 56 supplemental payment amount):

Primary Care Procedure Code	Procedure Code Description	Base Rate	Prop 56 Rate
99211	Office/outpatient visit established	$12.00	$10.00
99212	Office/outpatient visit established	$18.10	$23.00
99213	Office/outpatient visit established	$24.00	$44.00
99214	Office/outpatient visit established	$37.50	$62.00
99215	Office/outpatient visit established	$57.20	$76.00
99201	Office/outpatient visit new	N/A	$18.00
99202	Office/outpatient visit new	$34.30	$35.00
99203	Office/outpatient visit new	$57.20	$43.00
99204	Office/outpatient visit new	$68.90	$83.00
99205	Office/outpatient visit new	$82.70	$107.00
99391	Preventive visit established infant	$34.69	$75.00
99392	Preventive visit established age 1-4	$37.39	$79.00
99393	Preventive visit established age 5-11	$43.85	$72.00
99394	Preventive visit established age 12-17	$54.83	$72.00
99395	Preventive visit established age 18-39	$102.90	$27.00
99401	Preventive counseling individual	$12.94	N/A

States have policy options under Medicaid to address telehealth utilization and costs, but these approaches would require federal approval and some would require a waiver of federal law. These include:

- Limiting coverage to certain areas (for example, rural areas);
- Limiting telephone coverage to certain services (such as behavioral health, where utilization is below estimated prevalence rates and where same day visit billing restrictions exist for FQHC);
- Limiting telehealth coverage to only services provided through a MCMC plan or when a provider is capitated;
- Tying the extension of PHE payment authorities to a specific date certain requirement, after which coverage would be limited to an APM or value-based payment arrangement;
- Limiting coverage to a certain number of visits (Medi-Cal has this policy for specified optional benefits, which limit beneficiaries to no more than two visits a month from a list of specified services[27]);
- Limiting telehealth or telephone coverage to only established patients (not for an initial visit, a policy in effect pre-PHE for FQHCs); and,
- Extending some PHE payment authorities on a time-limited basis through a sunset date and gather data and evaluate the expansion because the expansion of telehealth and telephone is recent phenomena.

Conclusion

California, like other states and the federal government, has enacted many temporary policies in response to the COVID-19 pandemic to encourage telehealth and telephone use. Expanded telehealth and telephone coverage, and requiring the payment of those services at parity, would likely increase the availability of those services. However, other policy considerations– such as not incentivizing overuse, ensuring payments are appropriate for the service delivered, and responsibly managing the cost of health care, must be balanced against the goal of increasing access to care.

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[1] Business and Professions Code Section 2290.5(a)(6) defines "telehealth" to mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

[2] AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019 and AB 1494 (Aguiar-Curry), Chapter 829, Statutes of 2019.

[3] "2021-22 Governor's Budget Department of Health Care Services Highlights, January 8, 2021" available at: https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2021-22-Governors-Budget-Highlights.pdf.

[4] "Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations: Public Document, February 2, 2021" available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Policy-Proposal-2-1-21.pdf.

[5] The proposed Medi-Cal telehealth trailer bill language posted is RN 21 08394 dated January 29, 2021 at: https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/332

[6] The Rand Blog, "What Telemedicine Needs to Succeed Beyond COVID-19" by Doug Irving, dated September 2, 2020
[7] Department of Managed Health Care All Plan Letter 20-009, dated March 18, 2020 and available at: https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2020-009%20(OPL)%20-%20Reimbursement%20for%20Telehealth%20Services%20(3_18_20).pdf?ver=2020-03-18-105612-547 and APL 20-013 dated April 7, 2020 and available at: https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2020-013%20-%20Telehealth%20Services%20(4_7_2020).pdf
[8] Health and Safety Code Section 1374.14.
[9] California Department of Insurance Notice re: Telehealth During COVID-19 State of Emergency dated March 30, 2020 and available at: http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/upload/nr034TelehealthCOVID-19-03302020.pdf
[10] Welfare and Institutions Code Section 14132.725.
[11] Business and Professions Section 2290.5(a)(4) defines the "originating site" to mean a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.
[12] Business and Professions Section 2290.5.
[13] Title 9, Section 1840.324.
[14] Title 9, Section 1840.326.
[15] Title 9, Section 1840.336.
[16] Title 9, Section 1840.342.
[17] "Medi-Cal 2020" (Project Number 11-W-00193/9) Special Terms and Conditions No. 135 available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf.
[18] Medi-Cal 2020" (Project Number 11-W-00193/9) Special Terms and Conditions No. 136 available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf.
[19] Medi-Cal 2020" (Project Number 11-W-00193/9) Special Terms and Conditions No. 142 available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf.
[20] Medi-Cal 2020" (Project Number 11-W-00193/9) Special Terms and Conditions No. 143 available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf.
[21] DHCS Coverage Questions available at: https://www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telethealth-Service.aspx.
[22] DHCS "Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19), dated January 5, 2021 (supersedes June 23, 2020, April 30, 2020 and March 24, 2020 guidance) available at: https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf.
[23] DHCS "Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19), dated January 5, 2021 (supersedes June 23, 2020, April 30, 2020 and March 24, 2020 guidance) available at: https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf.
[24] Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations: Public Document" dated February 2, 2021 and available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Policy-Proposal-2-1-21.pdf.
[25] Section 1902(bb)(6) of the federal Social Security Act.
[26] Berenson R, Shartzer A. The Mismatch of Telehealth and Fee-for-Service Payment. *JAMA Health Forum.* Published online October 2, 2020. doi:10.1001/jamahealthforum.2020.1183.
[27] Title 22 of the California Code of Regulations, Section 51304.