Stakeholder Comment/Feedback - Provider Manual	DHCS Response
General - CCHP recommends that the Department consider reimbursing for the third modality of telehealth: remote patient monitoring (RPM). RPM has been shown to be an effective and efficient manner in which to provide care particularly in the treatment of chronic conditions. Over twenty states currently offer some form of reimbursement for RPM within their Medicaid programs and current California law does provide DHCS the flexibility to reimburse for such services. Additionally, the Center for Medicare and Medicaid Services (CMS) have been expanding reimbursement policy to cover RPM technologies under chronic care management reimbursement. We believe by allowing RPM to be reimbursed, Medi-Cal will see improved access to needed services, greater efficiencies in care and costs as conditions are treated earlier on before they escalate into more serious episodes. At a minimum, CCHP suggests mirroring the Medicare policies to the extent possible in regards to chronic care management. Page 1: Under "Originating Site," although the Department is not limiting where a telehealth interaction may take place, CCHP would suggest adding a few more examples of eligible sites such as "schools, skilled nursing facilities and the workplace" to make it very clear that various locales are eligible. Page 5: Under "Asynchronous Store and Forward Telecommunications Systems: Modifier GQ," it states that the GQ modifier will be required for all services delivered asynchronously including "x-rays, and electrocardiograms." While these services are provided asynchronously, they have not been required to use the modifier because the nature of the service itself is asynchronous. Requiring the use of GQ modifier may be confusing. CCHP suggests not requiring the GQ modifier for services that are by their definition asynchronous. Page 6: For the eConsult codes, CCHP would recommend that the Department also consider reimbursing the eConsult codes that were recently approved for Medicare reimbursement. The CMS approved codes may better represent the services being delivered via eConsult and paint a more complete picture of what exact services are being provided.	**General: RPM is not part of this policy update but, as always, DHCS will continue to evaluate and assess different modalities for delivery of Medi-Cal covered benefits and services.** **Page 1: Business and Professions Code (BPC) Section 2290.5(a)(4) defines the originating site as the patient's location or where store and forward originates. DHCS' proposed policy aligns with state law and does not limit the originating site setting. The definition provides clarity that it may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.** **Page 5: For Modifier GQ, DHCS has revised the language to remove modifier GQ for those services.** **Page 6: DHCS has reviewed available procedure codes for this purpose, including those proposed by the federal Centers for Medicare and Medicaid Services (CMS) for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.**
Page 1: Under "I. Definitions: Originating Site," AARP strongly supports the addition of a patient's home to the definition. Adding this language is consistent with other states and will allow both the patient and their family caregiver(s) to benefit from telehealth services. Additionally, although the originating site definition states that the settings where services are provided are not limited to what is listed, we feel it is important to reach people at the places they frequent the most and believe clarification is needed to highlight whether senior centers and congregate meal sites for seniors are also included in the definition. Noticeably absent from the manual is a mention of reimbursement for remote patient monitoring (RPM). AARP supports RPM as an intervention to improve health outcomes, reduce unnecessary readmissions, and a tool to manage chronic illness. We recommend that the Department consider including reimbursement for services delivered via RPM. Over twenty states currently offer some form of reimbursement for RPM within their Medicaid programs and current California law does provide DHCS the flexibility to pay for such services. Page 3: Under "IV. Telehealth Reimbursable Services" there is no mention of the coverage of home health services, including but not limited to: chronic diseases management, rehabilitation, palliative care, case management, or post-surgical follow-up. The incorporation of home health services into any telehealth policy is critical to patient health, particularly seniors, people with disabilities and the home bound. It is also very important to providers to have assurance that services will be covered for home health that would otherwise be covered for in-office care. Page 4: Under "IV. Telehealth Reimbursable Services" it is unclear how medical device is defined. The definition of this term may impact how some services are delivered in a home setting. For example, would a blood pressure cuff be categorized as a "medical device?" If there is a current definition of medical device defined elsewhere in statute, rule, or manual, that information/location should be cited in this section.	**Page 1: BPC Section 2290.5(a)(4) defines the originating site as the patient's location or where store and forward originates. DHCS' proposed policy aligns with state law and does not limit the originating site setting. The definition provides clarity that it may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.** **In addition, RPM is not part of this policy update but, as always, the Department will continue to evaluate and assess different modalities for delivery of services.** **Pages 3/4: DHCS' proposed policy does not list the types of benefits or services appropriate to be provided via a telehealth modality. Instead, DHCS provides parameters around what benefits or services may be appropriate to provide via a telehealth modality, provides examples of what is not appropriate, and speaks to documentation requirements in the event of an audit. This broadness is intentional to allow the health care practitioner rendering services or benefits sufficient flexibility to make medically appropriate decisions regarding the appropriate delivery modality for a particular beneficiary. That said, DHCS will review the language referenced and make additional edits for clarity, if needed. However, DHCS will not specify whether categorically a certain service or benefit is appropriate for a particular beneficiary as that is a decision between the treating health care practitioner and the patient. By definition, services provided at the originating are not provided via telehealth.**
Question: Would asynchronous encounters include review of diabetes downloads/devices? We kindly request DHCS ensures there is alignment and coordination between the final Medi-Cal telehealth policies and California Children's Services (CCS) telehealth policies (in terms of approved codes, approved originating sites, and other key criteria.) Often, the same pediatric specialty providers deliver services under both Medi-Cal and CCS, and unaligned policies could cause confusion and frustration. Page 2: "Health care providers must also inform the patient about the use of telehealth and obtain verbal consent from the patient…" **Questions**: 1) Must it be the provider delivering the telehealth service that obtains consent, or can any clinical staff member obtain consent? 2) How often does consent need to be obtained and documented for telehealth? Is it once, once a year, or every time you have an encounter? For example, patients only sign Conditions of Admission once a year. Since telehealth is not a procedure, but a form to deliver treatment, could it be done similarly to Conditions of Admission? 3) Can telehealth consent be rolled up into other consent documents, such as Conditions of Admission? If that were the case, would the type of physician attestation/documentation needed read something like: "consent to participate in telehealth is included in our Conditions of Admission, to which this patient/family has agreed…"	**Question: DHCS' proposed policy does not list the types of benefits or services appropriate to be provided via a telehealth modality. Instead, DHCS provides parameters around what benefits or services may be appropriate to provide via a telehealth modality, provides examples of what is not appropriate, and speaks to documentation requirements in the event of an audit. This broadness is intentional to allow the health care practitioner rendering services or benefits sufficient flexibility to make medically appropriate decisions regarding the appropriate delivery modality for a particular beneficiary.** **DHCS is coordinating efforts to ensure comparability and alignment in connection with Medi-Cal telehealth policies across program lines, including CCS.** **Page 2: State law requires the health care practitioner initiating the use of telehealth to inform the beneficiary and obtain consent and maintain appropriate documentation. Documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 3: While the previous Medi-Cal provider manual contained a list of CPT4 codes approved for telehealth; this new policy does not have any such list. Question: Is it implied that all codes are authorized, provided other requirements are met? It seems section IV implies yes, that all CPT4 codes that are currently Medi-Cal covered benefits may be provided via telehealth, but we would like explicit confirmation. Page 3: Question: What remote patient monitoring codes are approved for use? Page 6: The section on E-consults lists a few documentation requirements for the distant site provider delivering an e-consults. Question: does this documentation need to go in the patient's medical record at the originating site? If the distant and originating sites use different EMRs, must the distant site provider create a new MRN and enter notes for the patient in his own EMR? Page 7: "If billing store and forward … providers at the originating site may bill the originating site fee … but may not bill for the transmission fee." Question: can you explicitly clarify if the distant site providers are allowed to bill the transmission fee in store and forward telehealth?	**Page 3: DHCS' proposed policy does not list the types of benefits or services appropriate to be provided via a telehealth modality. Instead, DHCS provides parameters around what benefits or services may be appropriate to provide via a telehealth modality, provides examples of what is not appropriate, and speaks to documentation requirements in the event of an audit. This broadness is intentional to allow the health care practitioner rendering services or benefits sufficient flexibility to make medically appropriate decisions regarding the appropriate delivery modality for a particular beneficiary.** **Page 3: RPM is not part of this policy update but, as always, DHCS will continue to evaluate and assess different modalities for delivery of services.** **Page 6: Consistent with state law, DHCS expects that any health care practitioner initiating the use of telehealth inform the beneficiary obtain consent and maintain appropriate documentation. Documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared.** **Page 7: As noted in the draft policy, neither the distant site nor originating site providers can bill the transmission fee for store and forward.**
Page 2: Documentation of consent in the medical file should not be required for asynchronous communications (eConsult, teledermatology, teleretina). Page 3: Is the "within 30 days" window to allow for in-person consultation following a virtual visit in conflict with existing time/access standards? Page 5: eConsults should be reimbursable not just for "complicated symptoms or illnesses," but for "any or all" symptoms or illnesses that necessitate a specialist's input. Page 6: Request that the "greater than 30 minutes" time duration associated with review and analysis of eConsult data be removed. Page 7: Can the eConsult originating site Provider (presumably PCP) bill the Q3014 code for each eConsult encounter initiated? Is there a time/quantity limit?	**Page 2: State law requires the health care practitioner initiating the use of telehealth, including store and forward, to inform the beneficiary and obtain and maintain appropriate documentation. This consent documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.** **Page 3: The requirement that a beneficiary may receive "interactive communication" with a dermatologist, ophthalmologist, or dentist "within 30 days" is a statutory requirement for store and forward in Welfare and Institutions Code Section 14132.725(b).** **Page 5: DHCS has reviewed the store and forward/e-consult policy and revised the language for additional clarity. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed** **Page 6: DHCS has reviewed available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier, which will allow reimbursement for e-consults longer than five minutes when all of the policy requirements are satisfied. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.** **Page 7: Yes, the originating site provider can bill Q3014 per e-consult, subject to the parameters and limitations of the policy (e.g., once per day, same recipient, same provider).**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 1: **I. Definitions** - We request that DHCS add Remote Patient Monitoring (RPM) to the definition of telehealth. There is a lack of mention of reimbursement for RPM. We recommend that the Department consider include reimbursement for services delivered via RPM particularly in the case of treating individuals with special health care needs and/or chronic conditions. Research has shown that RPM has reduced re-hospitalizations and helped control chronic conditions (See: CCHP's RPM Research Catalogues for a list of studies). Over twenty states currently offer some form of reimbursement for RPM within their Medicaid programs and current California law does provide DHCS the flexibility to pay for such services. Page 2: **III. Documentation Requirements** – The manual states that in-person contact is not required for telehealth services, "subject to reimbursement policies adopted by the Department." This language is confusing, and we are concerned it may be used to inappropriately limit access to telehealth. We ask DHCS to either clarify this language or strike it entirely. Page 2: **III. Documentation Requirements** – We recommend that DHCS remove the requirement of "informed consent" in order to align the manual with existing law in Cal. Business & Professions Code § 2290.5. Informed consent is a specific medical and legal term of art, in which a physician must explain the risks and benefits to a patient for any complex procedure. It is not appropriate or necessary for the use of telehealth. As currently required, a simple consent to the use of telehealth services is sufficient, and we recommend that DHCS modify this section accordingly. Additionally, we also recommended editing the included sentence as follows to align the manual with existing law: The consent shall be documented in the patient's medical file and be available to the Department upon request. Existing law does not specify where consent must be documented. We also do not support the language giving the Department increased access to patient records. Any patient medical records should be obtained according to existing procedures available to the Department and subject to exist privacy laws including HIPAA and CMIA. In addition, the manual states "health care providers must also inform the patient about the use of telehealth and obtain verbal consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health" (emphasis added). We recommend that the Telehealth Manual reflect the Business and Professions code language "verbal or written consent" in place of "verbal" only. Obtaining verbal consent may be impractical when asynchronous consults are performed in that a primary care provider (PCP) may request an e-consult in the days following a patient visit, requesting advice on a patient's labs or images.	**Page 1: RPM is not part of this policy update but, as always, the Department will continue to evaluate and assess different modalities for delivery of services.** **Page 2: This language refers to the reimbursement policies for the underlying covered Medi-Cal benefits and services (e.g., requirements for billing certain codes) as well as the telehealth policy requirements. DHCS will revise for additional clarity. DHCS has made clarifying edits to the final version of the language to avoid confusion.** **Page 2: DHCS has removed the word "informed" from the consent section and revised the section to allow written consent. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality.**
Page 4: IV. Telehealth Reimbursable Services, Generally – We recommend deleting the subsection "Examples of Services Not Appropriate for Telehealth" included in the both the manual and the All Plan Letter. Specifying what types of benefits or services should not be delivered via telehealth may be lead to inappropriate denials of coverage by the managed care plans. This determination is more appropriately made by the physician or other treating provider. We recommend replacing this paragraph with a statement that telehealth should be provided according to generally accepted standards of medical care and when determined appropriate by treating provider. Page 5: V. Billing Requirements – The federal regulations cited (Title 42 Code of Federal Regulations Section 410.78) do not apply here, as they only regulate telehealth in Medicare; they also contain requirements that are different from those included in this policy manual. Therefore, we recommend striking this paragraph to avoid confusion. Page 5: V. Billing Requirements - As currently drafted, the manual excludes phone, fax & email from asynchronous store and forward. We recommend including all modalities in coverage to ensure broad access to needed telehealth services. Page 6: V. Billing Requirements – The manual requires that the provider create and maintain a record of patient consent for transmission of medical information for e-consult. This separate and additional documentation should already be covered under consent to treatment or consent for use of telehealth. Creating superfluous documentation requirement will create unnecessary administrative burdens for providers. This additional consent may also be confusing to patients and create obstacles to utilizing e-consult for patient care. Additionally, this consent is unnecessary since information can be legally shared under HIPAA for treatment purposes.	**Page 4: Thank you for your comment.** **Page 5: Thank you for your comment.** **Page 6: DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality.**
Page 2: Based on the proposed coverage of telehealth using multiple modalities – including asynchronous interactions – we recommend dropping the word "verbal" from the consent requirement to better reflect that patient consent could obtained using more than one modality, including written or electronic consent: "providers must also … obtain *verbal* consent from the patient." Page 3: Nurx strongly supports DHCS 'coverage of services provided through asynchronous telemedicine, which is an important and clinically-valid tool through which practitioners can deliver beneficial healthcare services. In our experience, asynchronous telemedicine is efficient and patient-centered, allowing providers to accurately capture patient data, integrate evidence-based protocols, provide time to make informed judgments, and avoid the burdens of scheduling all parties to be at video screen at a specific time. Page 3: We strongly commend DHCS for its proposal to allow treating providers to use their professional judgment to determine whether it is clinically appropriate to deliver via telehealth. Nurx believes that providers need to be free to choose the mode of care that best suits their practice and their patients, while maintaining the standard of care. Page 4: The proposed rules indicate that services that "involve sampling of tissue or insertion/removal of medical devices" would not be expected to be appropriately delivered via telehealth. We request that DHCS confirm and clarify that results emanating from remote lab tests can appropriately be the subject of a telehealth consult or part of the diagnostic information a provider considers when delivering care through telehealth.	**Page 2: Thank you for your comment.** **Page 3: Thank you for your comments.** **Page 4: DHCS will review the language referenced and make additional edits for clarity, if needed. However, DHCS will not specify whether categorically a certain service or benefit is appropriate for a particular beneficiary as that is a decision between the treating health care practitioner and the beneficiary**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 1: **I. Definitions: Originating Site** Essential Access Health appreciates the Department's proposal to not limit the patient's location and allowing the patient's home to be an eligible originating site. Patients – especially teens - often don't seek sensitive sexual and reproductive health services due to confidentiality issues. Allowing the patient to determine the originating site will give them flexibility to access services where they feel safe and where they feel their confidentiality will be protected. For these reasons, it would be helpful to include more examples of sites that are explicitly acceptable to serve as originating sites for patients and providers. Page 2: **II. Provider Requirements** While we agree that providers delivering health services to Medi-Cal beneficiaries via telehealth modalities must be licensed in the State of California and enrolled as a Medi-Cal provider, there is no clinical reason to require that providers reside in the State to deliver services. Requiring residence in the State will limit the State's ability to expand the pool of providers available to deliver care to Medi-Cal beneficiaries in areas where California is experiencing provider shortages. Page 2: **III. Documentation Requirements** We appreciate the proposed policy allowing a Medi-Cal provider to provide patient care via telehealth without having to have a prior in-person visit. This provision will greatly expand access to sexual and reproductive health service for patients that cannot access services in traditional health care settings. Research has demonstrated the safety and efficacy of at-home HIV and STD testing kits and the dispensing of self-administered contraception without requiring an in-person medical visit or physical examination. Californians are already accessing these medical services via telehealth modalities, without an in-person provider visit. Page 3: **IV. Telehealth Reimbursable Services** Essential Access Health applauds the Department's proposal to give Medi-Cal providers discretion to determine which services are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment. Trusting Medi-Cal providers and allowing them flexibility to determine the best method to deliver care will improve health outcomes and remove barriers to care.	**Page 1: BPC Section 2290.5(a)(4) defines the originating site as the patient's location or where store and forward originates. DHCS' proposed policy aligns with state law and does not limit the originating site setting. The definition provides clarity that it may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.** **Pages 2/3: Thank you for your comments.**
General - There is a lack of mention of reimbursement for remote patient monitoring (RPM). The Coalition recommends that the Department include reimbursement for services delivered via RPM particularly in the case of treating individuals with special health care needs and/or chronic conditions. Research has shown that RPM has reduced re-hospitalizations and helped control chronic conditions (See: CCHP's RPM Research Catalogues for a list of studies). Over twenty states currently offer some form of reimbursement for RPM within their Medicaid programs and current California law does provide DHCS the flexibility to pay for such services. Page 1: Under "I. Definitions: Originating Site," the Coalition applauds the Department's proposal to not limit the patient's location and allowing such places as the home to be an eligible site. It would be helpful, that while not creating a restrictive list, to also include a few more examples of eligible sites such as "schools, child care centers, (See The Children's Partnership regarding telehealth in these locations), community centers, residential facilities and the workplace." Page 2: For informed consent when teleophthalmology, teledermatology or teledentistry services are provided via store-and-forward, it should be clarified which site, the originating or distant site, should be responsible for notifying the patient of their right to receive interactive communication with the distant specialist and shall be able to receive it upon request. Page 3: In the "Medical Record: Technical & Professional Components" section, it was unclear which health care provider, originating site or distant site should "ensure that the technical component of Medi-Cal covered benefits or services are performed at the originating site during a telehealth transmission and billed according to standard Medi-Cal policy." A distant site provider will unlikely have that oversight over the originating site. Explicit statement of the responsible party would help avoid confusion. Page 5-6: The definitions of the proposed codes to be used for eConsult appear to be misaligned with the intent of offering this service be reimbursed. There is a face-to-face component to the definition of these codes that does not exactly match with eConsult. The codes used in CMS' CY 2019 proposal for eConsult align better with the services: 99446, 99447, 99448, & 99449.	**General: RPM is not part of this policy update but, as always, DHCS will continue to evaluate and assess different modalities for delivery of services.** **Page 1: Business and Professions Code Section 2290.5(a)(4) defines the originating site as the patient's location or where store and forward originates. DHCS' proposed policy aligns with state law and does not limit the originating site setting. The definition provides clarity that it may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.** **Page 2: State law requires the health care practitioner initiating the use of telehealth, including store and forward, to inform the beneficiary and obtain and maintain appropriate documentation. This consent documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.** **Page 3: DHCS has incorporated the "Medical Record: Technical and Professional Components" requirements under the "Documentation" section and has made corresponding edits for greater clarity. These edits include clarifying that DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation to substantiate the corresponding technical/professional components of billed CPT or HCPCS codes. In addition, this documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared.**
Page 5-6: The definitions of the proposed codes to be used for eConsult appear to be misaligned with the intent of offering this service be reimbursed. There is a face-to-face component to the definition of these codes that does not exactly match with eConsult. The codes used in CMS' CY 2019 proposal for eConsult align better with the services: 99446, 99447, 99448, & 99449. Page 7: It would be helpful if DHCS could clarify whether the Originating Site and Transmission Fee Restrictions (once per day, same recipient, same provider; and maximum of 90 minutes per day (1 unit = 1 minute), same recipient, same provider) are per patient restrictions rather than per provider restrictions.	**Pages 5/6: DHCS has reviewed available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.** **Page 7: As noted in the policy, these are both per patient and per provider restrictions. Policy around the originating site and transmission fee is not changing with this Provider Manual clarification.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 1: Definitions: originating site. We commend DHCS for broadly defining “originating site” to include any number of places in an increasingly mobile society. While we recognize the definition in the revised Telehealth Policy is not exclusive, we recommend including additional illustrative examples of locations that could likewise qualify as an originating site – including, but not limited to, a residence (as opposed to the patient’s residence), schools, shelters, transitional or emergency housing, community centers, the workplace, or other locations where individuals utilizing safety net services frequently obtain assistance or that otherwise feel comfortable to a patient in need. Alternatively, the Telehealth Policy can simply state that the originating site means the location wherever an eligible patient is physically located. Page 1, 5-6: Definitions and Billing Requirements: asynchronous store and forward. The definition of “asynchronous store and forward” is very broad – and yet the billing guidance offered later in the revised Telehealth Policy states that single mode consultation such as telephone calls, fax, or emails are not considered asynchronous store/forward – nor are communications initiated directly by patients. We urge DHCS to broaden its reimbursement policy for “asynchronous store and forward” to include communications such as telephone calls, fax, or emails – including those initiated directly by patients – as we believe these telehealth practices mirror existing standard of care that takes place in brick and mortar practices; and moreover, that reimbursement for these types of communications would contribute greatly to the health care needs of patients and serve to reduce healthcare costs associated with recurrent or avoidable illness. We would also like the revised Telehealth Policy to expressly adopt the utilization of mobile or app-based modalities for the provision of healthcare. While the definition of “asynchronous store and forward” is arguably broad enough to cover mobile or app-based modalities, we think clarity of this point will be useful to providers who are otherwise hesitant to adopt newer technologies that expand access to healthcare without clear guidance from DHCS. We believe the Telehealth Policy must be expansive enough to allow for current technology in the market and remain forward looking enough to capture future technological developments; this will allow telehealth in California’s Medi-Cal program to match other advancing state telehealth initiatives and continue to grow into this important space. Finally, we would also like DHCS to clarify that “asynchronous store and forward” includes communications common in current healthcare service spaces - namely through patient portals systems and live chat modalities. We would also like DHCS to clarify whether these types of common communications are reimbursable under the revised Telehealth Policy.	**Page 1: Thank you for your comments.**
Page 2: Documentation Requirements. DHCS should revise its consent requirement in its Telehealth Policy in a manner that is consistent with Sec. 2290.5 of the Business and Professions Code, which requires health care providers to inform patients about the use of telehealth and obtain either verbal or written consent (which must be documented in the patient’s medical record) – as opposed to mandating that providers obtain verbal consent, as currently stated in the revised Telehealth Policy. Page 3: Telehealth Reimbursable Services, Generally. We would like DHCS to clarify how its revised Telehealth Policy applies to services that are coded and reimbursed under a bundled payment methodology. For example, medication abortion is billed under CPT S0199, and includes all office visits, pelvic ultrasounds, laboratory studies, urine pregnancy tests, and recipient education. To the extent that one or more of these services that are included in S0199 is provided via telehealth, how does that fact change how providers bill for medication abortion services – if at all? We recommend that clarifications like these be placed in the appropriate policy manual that relates to the services provided (e.g., clarification on how to bill for medication abortion services via telehealth should be included in the Medi-Cal Abortions manual). Page 3: Medi-Cal Record: Technical & Professional Components. We ask DHCS to clarify whether both providers at the originating site (if any) and the distant site must maintain all medical information transmitted during the delivery of Medi-Cal covered services via telehealth. The revised Telehealth Policy is particularly unclear on this point if the originating site is also the billing provider (in which case, presumably under existing law it would have a separate duty to support its claim with an adequate medical record). Page 3: Place of Service Code 02. For providers who do not use the CMS 1500 form (e.g., institutional providers), we ask DHCS to clarify how the place of service 02 requirement impacts billing practices if at all (for example, using the UB 04 form). For providers who do use the CMS 1500 form, we similarly ask DHCS to clarify whether indicating a place of service code of 02 applies to the entire claim – or whether the code be used to apply only to those services marked with a modifier as having been provided via telehealth? We are concerned that an over application of the place of service code to the entire claim, regardless of whether all services identified on the claim were in fact provided via telehealth, could result in a requirement to split claims for services provided to the same patient on the same day to more than one claim.	**Page 2: DHCS has removed the word “informed” from the consent section and revised the section to allow written consent. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality.** **Pages 2/3: Telehealth, like an in-person visit, is a modality for delivering Medi-Cal covered benefits or services and the Medi-Cal reimbursement rate is dependent to the underlying CPT-4 or HCPCS codes. Ultimately, providing a service via telehealth does not alter existing reimbursement policy. Standard Medi-Cal billing policies and procedures would continue to apply.** **Page 3: Since telehealth is a modality for delivering covered Medi-Cal benefits and services (subject to the limitations and parameters described in this policy), there is no change to current reimbursement structures in areas such as bundled payments. Standard Medi-Cal billing policies and procedures would continue to apply.** **Page 3: POS 02 does not apply to facilities using the UB-04, as noted in the Provider Manual language. For more information, please see the FQHC/RHC/IHS sections of the Provider Manual. For the CMS-1500, billing examples will be included in the final published Provider Manual.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 4 Examples of Services Not Appropriate for Telehealth. The revised Telehealth policy very broadly states, on the one hand, that nearly all existing covered Medi-Cal services are covered if provided via telehealth, provided certain restrictions are met – including that the provider at the distant site believes the services provided are clinically appropriate based on evidence-based medicine and best practices to be delivered via telehealth. However, the policy also states that in its view, there are some services that would not: "be expected to be appropriately delivered via telehealth" include those that would "otherwise require the in-person presence of the patient for any reason." This statement, while reasonable in tone, is vague and open to a great deal of interpretation. Telehealth relies on technology that, like healthcare, is advancing and changing at a rapid pace. It is foreseeable that perhaps in future years DHCS' judgment of what is or is not appropriate for telehealth may not comport with the medical judgment of those in the provider community. It is also foreseeable that evidence-based medicine may be evolving to include telehealth at a pace that is not in step with DHCS policy. We'd like DHCS to develop (if it has not done so already) a mechanism by which providers can communicate and work through potential disagreements about the appropriateness of using telehealth for certain services with DHCS and include a description of that process in the revised Telehealth policy. Page 5: Billing Requirements. The revised Telehealth Policy specifies how E/M services should be billed when provided via synchronous telehealth and if provided at the originating site. However, the policy is unclear about how to bill for these or other services when: 1. The service is provided at the distant site; 2. The service is provided via near-real time asynchronous telehealth. We recommend clarifying in the revised Telehealth Policy how to bill for E/M services that are provided at the distant site or through distant site systems (or else state that E/M can never be "provided" at the distant site); and whether E/M can be provided via near-real time asynchronous modalities. Page 5: Billing Requirements. The revised Telehealth Policy identifies specific codes for e-consult services. We would like DHCS to clarify whether the codes identified in the revised Telehealth Policy are meant to be an exhaustive list of CPT codes used with a GQ modifier to bill for e-consults, or whether other CPT codes can also be used with the GQ modifier as appropriate.	**Page 4: DHCS' proposed policy does not list the types of benefits or services appropriate to be provided via a telehealth modality. Instead, DHCS provides parameters around what benefits or services may be appropriate to provide via a telehealth modality, provides examples of what is not appropriate, and speaks to documentation requirements in the event of an audit. This broadness is intentional to allow the health care practitioner rendering services or benefits sufficient flexibility to make medically appropriate decisions regarding the appropriate delivery modality for a particular beneficiary. That said, DHCS will review the language referenced and make additional edits for clarity, if needed. However, DHCS will not specify whether categorically a certain service or benefit is appropriate for a particular beneficiary as that is a decision between the treating health care practitioner and the beneficiary.** **Page 5: The heath care provider at the distant site is the one rendering and billing for services provided via telehealth (using an applicable HCPCS or CPT-4 and modifier). If there is a health care provider also present at the originating site with the patient and s/he is providing a medically necessary service, then it would follow standard Medi-Cal policies for in-person billing.** **Page 5: Yes. Providers may only bill e-consults with the CPT-4 code that is finalized and published in the Medi-Cal Provider Manual.**
General: The manual does not list reimbursement for remote patient monitoring (RPM). PSJH recommends that the Department include reimbursement for services delivered via RPM particularly in the case of special health care needs and/or chronic conditions. PSJH recommends DHCS adopt the following CPT Codes: 99091, 99453, 99454 and 99457. Research has shown that RPM has reduced re-hospitalizations and helped control chronic conditions. Over twenty states currently offer some form of reimbursement for RPM within their Medicaid programs and current California law does provide DHCS the flexibility to pay for such services. Page 1: Under "I. Definitions: Originating Site," PSJH applauds the Department's proposal to not limit the patient's location and allowing such places as the home to be an eligible site. It would be helpful, that while not creating a restrictive list, to also include a few more examples of eligible sites such as "schools and the workplace." Page 3: In the "Medical Record" Technical & Professional Components" section, it is unclear which health care provider, originating site or distant site should "ensure that the technical component of Medi-Cal covered benefits or services are performed at the originating site during a telehealth transmission and billed according to standard Medi-Cal policy." A distant provider will unlikely have that oversight over the originating site. PSJH recommends clarifying language to make explicit the responsible party. Page 5-6: Under "V. Billing Requirements," *PSJH recommends that DHCS align the eConsult CPT codes with those used in CMS' CY 2019 proposal and existing codes for eConsult: 99446, 99447, 99448, 99449, 99451 and 99452.* *Furthermore, eConsults are meant to be under 30 minutes. DHCS should adopt CMS time-based CPT codes for a physician to properly bill for the consultation.* Page 7: PSJH recommends that the Department clarify whether the Originating Site and Transmission Fee Restrictions (e.g. once per day, same recipient, same provider; and maximum of 90 minutes per day [1 unit = 1 minute), same recipient, same provider) are per patient restrictions rather than per provider restrictions.	**General: RPM is not part of this policy update but, as always, the Department will continue to evaluate and assess different modalities for delivery of services.** **Page 1: BPC Section 2290.5(a)(4) defines the originating site as the patient's location or where store and forward originates. DHCS' proposed policy aligns with state law and does not limit the originating site setting. The definition provides clarity that it may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.** **Page 3: DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation. This documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared.** **Pages 5/6: DHCS has reviewed available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier, which will allow reimbursement for e-consults longer than five minutes when all of the policy requirements are satisfied. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.** **Page 7: As noted in the policy, these are both per patient and per provider restrictions. Policy around the originating site and transmission fee is not changing with this provider manual clarification.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 2-3: *Section III - Informed Consent*: Currently, we understand that health care providers must inform and obtain verbal consent from patients in order to deliver telehealth services. Furthermore, for teleophthalmology, teledermatology, or teledentistry services delivered via asynchronous store and forward (including eConsults), the patient must be notified of their right to receive interactive communication with the distant specialist providing consultation, and to receive such communication within 30 days of the patient's notification of the results of the consultation if requested. **We would like to request clarification if this proposed rule applies to all asynchronous telehealth services or just those services as listed (teleophthalmology, teledermatology, and teledentistry). In either case, we would strongly recommend DHCS to eliminate both 1) the need for patients to give verbal consent and 2) the ability for patients to request and receive interactive communications for asynchronous store and forward telehealth services.** Neither RubiconMD nor Safety Net Connect require patient consent for any eConsult conducted on our platforms, which gives our primary care provider users the ability to make the final decision on patient care free of external pressure from patients. By adding a mandate involving patients in the decision process, DHCS is effectively undercutting the authority of the treating physician and diluting the efficacy of a proven process. An eConsult is a modernized curbside consult, which is intended to specifically be a peer-to-peer interaction. Additionally, requiring an interactive communication with the Distant Site specialist within 30 days will place an undue burden on the consulting specialist, in terms of both time and effort spent conversing with the patient and in the additional medical responsibility such a conversation would bring upon the specialist. Such burdens would discourage specialists from participating in eConsult programs and would effectively decrease the specialist expertise available to PCPs and their patients in need. In short, this mandate to allow patients to give verbal consent and have the right to request and hold interactive communications with consulting providers would nullify the intended impact of eConsults on multiple levels and greatly diminish the proven positive impact of the technology. Page 6: *Section V - Billing Requirements - eConsults*: In the proposed update to the Telehealth Provider Manual, health care providers at the distant site must create and maintain "record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent (greater than 30 minutes)" when responding to an eConsult request. **We would recommend removing or greatly decreasing this time requirement for consulting specialists**. eConsult provider data over the past year shows that the median case response creation time for a consulting specialist was **4 minutes 37 seconds** with **~95% of all specialist responses taking 10 minutes or less** to create. Enforcing an excessive 30-minute minimum time requirement for specialist responses will either unnecessarily introduce a source of waste into an already heavily-taxed system or incentivize consulting specialists to dishonestly record the time they have spent responding to an eConsult.	**Pages 2-3: DHCS has removed the word "informed" from the consent section. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.** **Page 6: DHCS has reviewed available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier, which will allow reimbursement for e-consults longer than five minutes when all of the policy requirements are satisfied. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.**
Page 1: The E-Consult Workgroup supports DHCS's inclusion of e-consult in the Telehealth Provider Manual and its definition. We thank DHCS for supporting e-consult's role in providing patient-centered care and its role in reducing wait times for specialty care, optimizing the time spent in face-to-face appointments, strengthening relationships between providers, and enabling them to more effectively and efficiently meet the healthcare needs of low-income families and individuals across the state. Page 2: We request that DHCS remove the term "informed" from consent requirements, as the Business and Professions Code sec. 2290.5 requires obtaining verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services. Informed consent requirements were explicitly excluded by the legislature in drafting the Telehealth Advancement Act of 2011. In addition, the manual states "health care providers must also inform the patient about the use of telehealth and obtain *verbal* consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health" (emphasis added). We request that for e-consults, DHCS remove the requirement for "verbal consent", for the sharing of information when directly related to patient care is covered under HIPAA rules and in the "general consent for care" that patients sign when they join a practice. In addition, obtaining *verbal* consent for e-consult is impractical in that a PCP may request an e-consult in the days following a patient visit, seeking specialist review of a patient's labs or images.	**Page 1: Thank you for your comment.** **Page 2: DHCS has removed the word "informed" from the consent section and revised the section to allow written consent. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 6: We appreciate DHCS's efforts to reimburse e-consults through the use of CPT codes 99358 and 99359 for consulting providers' time. In addition, we request that DHCS add CMS and AMA-approved code sets that can be used for all e-consults up to the first hour. Many econsult responses provided by consulting providers take less than 30 minutes to complete. E-Consult Workgroup members have noted that the 99358 and 99359 codes may cause confusion in that they are not specific to e-consult when other codes have been specifically designated for interprofessional internet consultation (e-consult) services. Should DHCS consider other codes to recompense the consulting provider's time, we recommend adoption of CPT code 99451 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time) (Included in CMS Physician Fee Schedule for CY 2019). In addition, the E-Consult Workgroup supports the 99446-9 CPT code series if it were not to require including a "verbal and written report," as e-consults do not generally include a verbal report. We also ask that DHCS recompense treating physicians for their time spent on e-consults and recommend adoption of CPT code 99452 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes) included in the CMS Physician Fee Schedule for CY 2019. This would allow primary care providers to account for the significant amount of time in gathering and documenting patient information and corresponding with the consulting physician in order to "close the loop" on an e-consult. We request that both code sets 99446-9 and 99451, 99452 be included in the DHCS approved list of codes to create consistency with the CMS Physician Fee Schedule for 2019, noting that these codes are also supported by the American Medical Association in "CPT Changes 2019." Page 6: The manual states that "both health care providers at the originating and distant sites must clearly document all information relating to previous but related primary health care services and maintain this information in the patient's medical record." (emphasis added). The majority of e-consult providers use platforms with structured templates for creation and response to e-consults, providing the PCP with guidelines or required elements of the request in order to facilitate the specialist's response. Requiring "all information" relevant to previous care creates an undue burden on both the PCP in gathering information, and to the specialist in reviewing information that may not be pertinent to the request. The workgroup recommends replacing "all information" with "relevant information."	**Page 6: DHCS has reviewed available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.** **Page 6: DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation. This documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. DHCS will make revisions for clarity.**
CHA appreciates that DHCS has shared the revised Telehealth Provider Manual with stakeholders. CHA requests that DHCS develop a separate Telepsych Provider Manual Update as MHPs often cite lack of guidance from DHCS as a barrier to providing Medi-Cal members with telepsych services. Specifically, CHA requests that DHCS clarify that telepsych can be used in the following situations: • LPS involuntary holds, 5150 evaluations in all LPS designated and non-designated treatment settings. • Treatment initiation in all hospital settings (inpatient, outpatient and emergency department settings).	**Thank you for your comment.**
General: The organizations listed urge the Department to include remote patient monitoring (RPM) services as a reimbursable modality and category of services provided via telehealth when determined appropriate and advisable by the patient's distant site provider. Remote patient monitoring is particularly important in the case of treating children with special health care needs, who are often reliant on medical devices, making constant monitoring a necessity, and travel to health care providers a challenge. Research has shown that RPM has reduced re-hospitalizations and helped control chronic conditions (See: CCHP's RPM Research Catalogues for a list of studies). Over twenty states currently offer some form of reimbursement for RPM within their Medicaid programs, and current California law provides DHCS the flexibility to pay for such services. We ask that DHCS include RPM in the finalized telehealth policies. There is a lack of mention of reimbursement for remote patient monitoring (RPM) in the proposed changes. Page 1: Under "I. Definitions: Originating Site," the organizations listed applaud the Department's proposal to make explicit that the patient's location (originating site) is not limited. We have long advocated that the home without a health care provider present should be recognized as an eligible originating site location, when deemed appropriate by the distant site provider. We also urge the Department to include: schools, child care centers, community centers, residential facilities, and the workplace, as additional examples of eligible originating sites. Please see our August 2018 report, Advancing the Adoption of Telehealth in Child Care Centers and Schools, for evidence-based research and outcomes of school and child-care based telehealth programs in various states across the country. Including child care centers and schools as additional examples of eligible originating sites, while not exhaustive, will provide clarity and confidence for school and child care centers that want to adopt telehealth programs for their pupils, and will also align with the goals of AB 2315, which requires the Department of Education, in consultation with DHCS and stakeholders, to develop guidelines for school-based telehealth to provide mental/behavioral health services to pupils in public schools. Page 2: For informed consent, when teleophthalmology, teledermatology or teledentistry services are provided via store-and-forward, it should be clarified which site—the originating or the distant site—should be responsible for notifying the patient that she/he has the right to receive an interactive communication with the distant specialist and shall be able to receive it upon request. Page 3: In the "Medical Record: Technical & Professional Components" section, it is unclear which health care provider, originating site or distant site, should "ensure that the technical component of Medi-Cal covered benefits or services are performed at the originating site during a telehealth transmission and billed according to standard Medi-Cal policy." A distant site provider will unlikely have that oversight over the originating site. Explicit statement of the responsible party would help avoid confusion.	**General: RPM is not part of this policy update but, as always, the Department will continue to evaluate and assess different modalities for delivery of services.** **Page 1: BPC 2290.5(a)(4) defines the originating site as the patient's location or where store and forward originates. DHCS' proposed policy aligns with state law and does not limit the originating site setting. The definition provides clarity that it may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.** **Page 2: DHCS has removed the word "informed" from the consent section. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. State law requires the health care practitioner initiating the use of telehealth to inform the beneficiary and obtain and maintain appropriate documentation. This consent documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. As noted elsewhere, general consent protocols may also be sufficient.** **Page 3: DHCS has incorporated the "Medical Record: Technical and Professional Components" requirements under the "Documentation" section and has made corresponding edits for greater clarity. These edits include clarifying that DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation to substantiate the corresponding technical/professional components of billed CPT or HCPCS codes. In addition, this documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 4: In both the proposed APL and Provider Manual, DHCS lists “insertion/removal of medical devices” as an example of “types of services that cannot be appropriately delivered via telehealth.” While we agree that “certain types of services cannot be appropriately delivered via telehealth” and that the “provider must assess the appropriateness of the telehealth modality to the patient’s level of acuity at the time of the service,” we would strongly urge the Department to leave it up to the provider to determine which services cannot be delivered appropriately via telehealth in the particular circumstance and at the specific time of service. We believe that a list of examples of excluded services, determined by DHCS, may cause confusion when it comes to Medi-Cal policy on this topic. For example, for children with special health care needs, who live at home and are often connected to many medical devices, removal and insertion of G-tubes, which is very common and often done by parent/caretaker, should be allowed via telehealth at the decision and discretion of the treating distant site provider. The proposed Telehealth Provider Manual lists “insertion/removal of medical devices” as “Examples of Services Not Appropriate for Telehealth.” It is not clear whether DHCS means to exclude all insertion/removal of medical devices as services not appropriate for telehealth under Medi-Cal because the APL goes on to say, in the same paragraph, “A provider must assess the appropriateness of the telehealth modality to the patient’s level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.” We ask for clarity, if not exclusion of examples, about whether all appropriateness is left up to the treating provider. Page 4: The organizations listed urge the Department to ensure that there is alignment and coordination between the final Medi-Cal Telehealth policies proposed here and the telehealth policies for the California Children’s Services (CCS) Program (See Dec 2017 N.L. 16-1217 , Addendum Dec 2013 N.L. 14-1213 , and July 2018 N.L. 09-0718).) Most often, the same pediatric specialty providers provide services under both Medi-Cal and CCS, and unaligned policies could cause confusion and frustration among providers. As importantly, we urge that the DHCS Benefits Division work closely with the Mental Health Services Division to align telehealth policies for specialty mental health services and substance use disorder services with those proposed here, and to ensure that mental/behavioral services are eligible for delivery and reimbursement via telehealth modalities. Children enrolled in Medi-Cal are entitled to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, which includes Specialty Mental Health Services (SMHS) for those who meet medical necessity criteria. However, fewer than 5% of eligible children and youth access SMHS under the EPSDT entitlement. (DHCS tracks the percentage of Medi-Cal enrolled children under age 21 who receive SMHS each fiscal year, and it has consistently been low, though the need has grown, indicating severe access and other barriers.	**Page 4: DHCS’ proposed policy does not list the types of benefits or services appropriate to be provided via a telehealth modality. Instead, DHCS provides parameters around what benefits or services may be appropriate to provide via a telehealth modality, provides examples of what is not appropriate, and speaks to documentation requirements in the event of an audit. This broadness is intentional to allow the health care practitioner rendering services or benefits sufficient flexibility to make medically appropriate decisions regarding the appropriate delivery modality for a particular beneficiary. That said, DHCS will review the language referenced and make additional edits for clarity, if needed. However, DHCS will not specify whether categorically a certain service or benefit is appropriate for a particular beneficiary as that is a decision between the treating health care practitioner and the beneficiary.**
Page 7: It would help to avoid confusion if DHCS could clarify that the Originating Site and Transmission Fee Restrictions (once per day, same recipient, same provider; and maximum of 90 minutes per day (1 unit = 1 minute), same recipient, same provider) are per patient restrictions rather than per provider restrictions.	**Page 7. The restriction is per patient per provider.**
General: There is a lack of recognition of remote patient monitoring (RPM), which refers to the secure transmission of patient health and medical data collected at the originating site to a provider who will assess them at a distant site. At least 20 state Medicaid programs cover services offered through RPM. For example, an evaluation of Iowa’s congestive heart disease management program, provided through RPM, found that the overall costs to Medicaid shrunk because the number and length of hospital stays decreased. In the provision of prenatal care, remote patient monitoring for high-risk pregnancies has also been extremely effective. As such, NHeLP recommends reimbursement for services delivered via RPM. General: The manual needs to be corrected to state that informed consent can be either verbal or written. Business & Professions Code 2290.5(b) was amended in 2014 to permit written consent to enable the use of asynchronous telehealth. Page 4: NHeLP strongly suggests that DHCS allow the provider decide when the telehealth service will be beneficial and necessary, therefore subject to reimbursement. Therefore, we recommend that the sentence that begins with “certain types of benefits or services” only keep the language that maintains that telehealth is appropriate whenever an in-person interaction is not needed.	**General: RPM is not part of this policy update but, as always, the Department will continue to evaluate and assess different modalities for delivery of services.** **General [Page 2]: DHCS has removed the word “informed” from the consent section and revised the section to allow written consent. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation. This documentation should be maintained in the beneficiary’s medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.** **Page 4: Thank you for your comment.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 2: LHPC recommends the Department provide specific e-consult consent guidance that does not require informed consent. Page 6: LHPC recommends the Department revise its billing requirements for e-consult to include the CPT codes approved for e-consult in the PFS CY 2019.	**Page 2: DHCS has also streamlined and further clarified the consent requirement section to remove the word "informed" and apply clearly and equally across the board for the telehealth modality, including e-consults.** **Page 6: Thank you for your comment.**
Page 1: We recommend adding care transition and community-based palliative care to the definition of telehealth. These are important services that can be tailored for delivery via telehealth modality. Page 1: We recommend that the "asynchronous store and forward" definition be updated to require the use of a secured mobile application to support consultation between interdisciplinary health care teams. Page 2: For consistency purposes please also use the words "and/or" as used in the APL language, in the provider manual. See below in RED: APL Page 2: "The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment." PM, Section IV, Page 3: "The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth." Page 2: Please clarify whether certain reimbursable services (e.g. Diabetes Prevention Program) that are allowed to be provided virtually and by non-licensed providers would also be required to be based in California. Page 2: Because asynchronous communications do not involve patients directly, we request that documentation of consent in the medical file not be required (eConsult, teledermatology, teleretina, etc.). Page 3: Please clarify whether the "within 30 days" window to allow for in-person consultation following a virtual visit is in conflict with existing time/access standards. Page 3: Please clarify whether there is an appropriate modifier code for FQHCs if "POS 02" is not to be used by FQHCs for virtual visits.	**Page 1: Thank you for your comment.** **Page 1: Mobile applications are not part of this policy clarification but, as always, DHCS will continue to evaluate and assess different modalities for delivery of services.** **Page 2: DHCS revised the language in the Provider Manual to allow for "and/or best practices."** **Page 2: Under state law, asynchronous store and forward requires patient consent. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. State law requires the health care practitioner initiating the use of telehealth to inform the beneficiary and obtain and maintain appropriate documentation. This consent documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.**
Page 3: We recommend expanding Section IV, "Telehealth Reimbursed Services, Generally," to include a bullet for managed care plan providers under global risk to expand telehealth services delivered by non-practitioners. Providers such as (but not limited to) Community Health Workers, Registered Nurses, Social Workers, Care Navigators, and Health Educators provide services linked to Medi-Cal covered benefits that may not be billable using CPT-4 or HCPCS codes. Page 5: Please clarify that eConsults are reimbursable for "any and all" symptoms or illnesses that necessitate a specialist's input, not just for "complicated symptoms or illnesses." Page 6: We request that the "greater than 30 minutes" time duration associated with review and analysis of eConsult data be removed because on average, these communications take less than 30 minutes to complete Furthermore, CPT codes 99358 and 99359 are not appropriate codes to bill for e-consults as these typically take less than 30 minutes to complete. Page 6: As e-consult services do not provide direct care delivery, plans recommend that the additional patient consent requirements be removed. Page 7: Please clarify whether there are any time or quantity limits for the Q3014 code for initiated encounters.	**Page 3: The requirement that a beneficiary may receive "interactive communication" with a dermatologist, ophthalmologist, or dentist "within 30 days" is a statutory requirement for store and forward in Welfare and Institutions Code Section 14132.725(b).** **Page 5: DHCS has reviewed the store and forward/e-consult policy and revised the language for additional clarity. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.** **Page 6: DHCS has reviewed available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier, which will allow reimbursement for e-consults longer than five minutes when all of the policy requirements are satisfied. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.** **Page 6: DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for telehealth, both for synchronous and asynchronous/e-consult modalities.** **Page 7: Limits for Q3014 are listed on page 9 of the Provider Manual.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 1: The Plan suggests the definition of telehealth clearly state that the below forms of telehealth are included (without limitation), so that there is no confusion as to permitted modalities: a) Telephone visits b) Video visits c) Email exchanges d) Questionnaire based electronic visits Clarity in this definition is important to the Plan, as all of these modalities are an essential part of the care provided to the Plan's members. They are convenient for members, increase member satisfaction, and reduce time and travel expenses. In addition, all of these modalities serve to reduce the costs associated with in person visits. Along with synchronous telehealth, such as telephone and video visits, including asynchronous telehealth examples is also particularly important to the Plan. Members and providers exchange millions of secure emails annually to facilitate the diagnosis, consultation, treatment, education, care management, or self-management of a member's health care. In addition, the Plan's providers are piloting asynchronous "eVisits" for certain conditions. During these eVisits, members complete comprehensive electronic questionnaires about their symptoms; providers then review the responses and take action accordingly (e.g., the provider may email the member to let the member know a prescription has been ordered based on the member's symptoms). This innovative asynchronous approach to telehealth leads to similar outcomes as synchronous telehealth modalities, but with even more convenience than the scheduling of a telephone or video visit.	**Page 1: All telehealth services must meet the definitions in order to qualify as permissible modalities. Please refer to those definitions in making these determinations.**
Page 1: Similar to the definition of telehealth, the Plan suggests the definition of E-Consult clearly state that the below forms of E-Consults are included (without limitation), so there is no confusion as to the permitted modalities: a) Phone consults b) Video consults c) Email consults The providers within the Plan's exclusively contracted provider groups routinely perform consultations between one another given PCPs and specialists of all types are part of the same provider groups. These consultations are an integral part to Kaiser Permanente's model of care, and the high quality results delivered to the Plan's members. These consultations are also beneficial in that they reduce costs of addition in person visits with specialists (when appropriate), and thus reduce member time and travel expenses for additional visits. Given the very high frequency with which these provider consultations are occurring, it is important to the Plan that all modalities be included – both asynchronous emails and/or store and forward consults, as well as synchronous telephone or video consults among providers. All of these modalities are currently being used among providers to facilitate the diagnosis, consultation, treatment, education, care management, or self-management of a member's health care. Page 1: The Plan suggests the below word of "and" be replaced with the word "or" for the definition telehealth in both the APL and Provider Manual. Replacing "and" for "or" ensures that the definition not require that a diagnosis, consultation, treatment, education, care management, and self-management are all completed during one telehealth visit. The mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, or and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.	**Page 1: All telehealth services must meet the definitions in order to qualify as permissible modalities. Please refer to those definitions in making these determinations.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
Page 2: In addition, the Provider Manual states “health care providers must also inform the patient about the use of telehealth and obtain verbal consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health.” The Plan recommends that the Provider Manual reflect the Business and Professions code language requiring “verbal or written consent” in place of “verbal” only. Obtaining verbal consent may be impractical when asynchronous consults are performed by email or in that a PCP may request an E-Consult in the days following a patient visit, requesting advice on a member’s labs or images. Multiple Provider Manual pages: In 2017, when CMS eliminated the requirement of modifiers for telehealth billing, the Plan also removed the applicable modifiers from the Plan’s adjudication system. The modifiers were replaced with the newly created Place of Service (“POS”) 02-Telehealth. The Plan acknowledges that DHCS also uses the Telehealth POS 02 as outlined in the Provider Manual. However, adding modifiers will require substantial coding and implementation efforts. The Plan would to explore options for DHCS to receive this kind of information in alternative reporting formats while systems changes are implemented. In addition, the Plan suggests that DHCS select a code set that can be used for all E-Consults up to the first hour. Many E-Consult responses provided by consulting providers take less than 30 minutes to complete. The Plan acknowledges the importance of having a code reflecting the initial communication (e.g., up to 30 minutes) and subsequent communications (e.g., up to one hour). Codes 99358 and 99359 may cause confusion in that they are not specific to E-consults and capture other services for “prolonged evaluation and management.” Page 3: For consistency purposes, the Plan suggests that the words “and/or” in APL language also be used in the Provider Manual. See below in red: APL Page 2: "The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment." Provider Manual, Section IV, Page. 3: “The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and best practices to be delivered via telehealth.”	Page 2: DHCS has removed the word “informed” from the consent section and revised the section to allow written consent. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation. This documentation should be maintained in the beneficiary’s medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement. Thank you for your comment. In the FFS delivery system, use of modifiers will remain unchanged as this is our mechanism to identify if service was provided via telehealth. Plans may have a different mechanism for tracking telehealth visits, so please refer to the APL for additional information. Page 3: Thank you for your comment. DHCS will review and, as applicable, make clarifying edits.
Page 5: The following provision is unclear to the Plan, as it could be read to imply that telephone visits or email exchanges between providers and members, or from providers to providers, are not included in telehealth. As described in detail above, many telehealth services are provided via these modalities, so the Plan suggests that DHCS remove this language. “Asynchronous store and forward, including e-consult, does not include single mode consultations by telephone calls or images transmitted via facsimile machines or electronic mail.” Page 6: The Plan suggests replacing “all information” with “relevant information” on Page 6 of the Provider Manual. The Provider Manual states: “Both health care providers at the originating and distant sites must clearly document all information relating to previous but related primary health care services and maintain this information in the patient’s medical record.” Some PCP’s use platforms with structured templates for creation and response to E-Consults, providing the PCP with guidelines or required elements of the request in order to facilitate the specialist’s response. Requiring “all information” relevant to previous care creates an undue burden on both the PCP in gathering information, and to the specialist in reviewing information that may not be pertinent to the request.	Page 5: Thank you for your comment. DHCS will review and, as applicable, make clarifying edits. DHCS has made revisions to the “Documentation” section for greater clarity. These edits include clarifying that DHCS expects that any health care practitioners providing covered benefits or services to Medi-Cal beneficiaries maintain appropriate documentation to substantiate the corresponding technical/professional components of billed CPT or HCPCS codes. In addition, this documentation should be maintained in the beneficiary’s medical record at both the originating and distant site, in the event the health records are not shared. NOTE: Kaiser’s questions and feedback related to the APL for MCP-specific information will be responded to separately.
OCHIN Comments on the Proposed Changes to the Medi-Cal Telehealth Policy Manual I. Remote Patient Monitoring Remote patient monitoring (RPM) is absent from the reimbursed services. This service is critical for the care of those with special health needs or chronic conditions. RPM helps patients avoid readmissions, reducing healthcare costs significantly. In light of the recent CMS approval for remote patient monitoring (CPT codes 99453, 99454 and 99457) DHCS should match CMS. Also, in light of the proposed FCC Connected Care Pilot launching, and the ability to utilize remote patient monitoring, this availability to then use this service lends to the importance of its inclusion for reimbursement. II. Originating Site Definition Further, the benefit of telehealth and virtual care is allowing FPACT patients who are distant from the clinic to receive care services. Online enrollment processes are important for those who are unable to travel long distances because of transportation or time constraints. For those in desperate need of care, it is critical that they may enroll electronically to engage with a provider. It can then be left up to the discretion of the provider to determine the timeline for a physical visit based on individual circumstances.	**I: RPM is not part of this policy update but, as always, DHCS will continue to evaluate and assess different modalities for delivery of services.** **II: Thank you for your comment.**

Stakeholder Comment/Feedback - Provider Manual	DHCS Response
IV. Store-and-Forward & eConsults OCHIN strongly supports standardization of networks and reimbursement rates for eConsults for both the originating and distant sites. Physicians' time is extremely valuable, whether it is being utilized during face-to-face or virtual services. To decrease the rate of provider burnout, it is important to make sure payers apply the necessary level of value to the services they provide, and that this level is the same across all networks. Documentation in an EHR for consent should not be required for eConsults, or asynchronous communication. Documentation for other telehealth activities creates barriers and potential administrative overhead. Further, 10 or 14 business days is the recommended time span for a distant provider to follow up after the consultation. OCHIN recommends changing the word "complicated" on page 5 to "any or all." This arbitrary restriction is difficult to define and restricts the use of eConsults, when the goal is to expand the capabilities of and access to eConsults. Similarly, any time restrictions or limits on eConsults should be removed. The time should be documented accurately for reimbursement.	**IV – Documentation & Consent: State law requires the health care practitioner initiating the use of telehealth, which includes synchronous and asynchronous, to inform the beneficiary and obtain consent and maintain appropriate documentation. DHCS has also streamlined and further clarified the consent requirement section to apply clearly and equally across the board for the telehealth modality. In addition, documentation should be maintained in the beneficiary's medical record at both the originating and distant site, in the event the health records are not shared. If a health care practitioner or health care group/organization has a general consent protocol that specifically references use of telehealth as a modality, then this would satisfy the consent requirement.** **IV – E-Consults: Consistent with DHCS' policy for store and forward writ large, only the distant site provider may bill for e-consults under the policy. In addition, DHCS has reviewed the proposed policies and available procedure codes for this purpose, including those proposed by CMS for the Medicare program. DHCS has revised the store and forward/e-consult policy for additional clarity and selected a single and more appropriate CPT-4 code for billing with the GQ modifier, which will allow reimbursement for e-consults longer than five minutes when all of the policy requirements are satisfied. DHCS believes that these revisions more closely align the store and forward/e-consult policy with current industry practices while still meeting the needs of the Department and our beneficiary population. Moving forward, DHCS will continue to have ongoing discussions around telehealth modalities and will also continue to evaluate, assess, and modify its policy, as needed.**
Page 2: Provider Requirements The SPA is limited to "licensed providers". Under California law, a qualified autism provider who is eligible for Medicaid reimbursement includes a person who is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism. Certified Behavior Analysts provide the most recognized form of behavioral treatment for autism, applied behavior analysis (ABA). In California ABA providers are recognized in the Health and Safety Code, Insurance Code, and Medicaid State Plan Amendment, but are not licensed by the State. Request amending draft language as follows: The health care provider billing for Medi-Cal covered benefits or services provided via a telehealth modality and who has the ultimate responsibility for the care of the patient must be licensed in the State of California *or one authorized to provide behavioral health treatment by an approved Medicaid state plan amendment and* enrolled as a Medi-Cal provider.	**BPC Section 2290.5(a)(3) authorizes only licensed providers and marriage and family therapist interns (associate marriage and family therapists) for services delivered via telehealth. California considers certified behavior analysts to be licensed, so they may provide services via telehealth when appropriate. However, qualified autism service paraprofessionals are not certified by the Behavior Analyst Certification Board and are therefore not considered licensed by the State. We have updated the Provider Manual to reference the licensing requirement in the Business and Professions Code.**

Stakeholder Comment/Feedback - Provider Enrollment	DHCS Response
Page 2: Under “II. Provider Requirements,” it was unclear if there are three separate categories a provider may fall into to qualify as an eligible Medi-Cal provider. CCHP suggests that language be added clarifying the intent in this section. Page 2: Under “II. Provider Requirements,” it was unclear what is meant by “A health care provider rendering to a group may be located outside of California.” Does “a group” mean a hospital? Clinic? Group therapy? Or is there some other meaning? In discussions with various parties, CCHP found each party interpreted the phrase different and have concerns that if the language isn’t clarified there will be different interpretations by providers. CCHP suggests more explicit language to explain the intent. Page 2: Under “II. Provider Requirements,” a provider must be licensed in order to be eligible to provide telehealth delivered services. However, there are currently some Medi-Cal enrolled providers who may provide services in-person and receive reimbursement who could use telehealth to deliver services, such as behavioral analysts. We recommend that the terminology used should be “qualified health care provider” as enrollment as an eligible Medi-Cal provider should address any licensing or certification requirements without having it be repeated here. Page 2: Under “II. Provider Requirements,” CCHP believes that it is not necessary to require the physical location of the provider to be within the borders of California. Other states’ Medicaid programs are eliminating such a requirement, if it exists, as telehealth is becoming more common place as a way to deliver care. Additionally, out-of-state providers help fill a gap for some needed specialty care where there may be a shortage of California providers or those willing to accept Medi-Cal patients. Out-of-state providers would still need to meet other qualifications to be an eligible Medi-Cal provider such as licensing or certification requirements and those should provide adequate avenues checks on these providers.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page2: “A billing health care provider delivering services via telehealth must be located in and licensed in California…” Question: does the provider need to be located in CA at the time of the telehealth encounter? If the answer is no, we would suggest removing the words “be located in.” The revised sentence would read: “A billing health care provider delivering services via telehealth must be licensed in California…”	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page 2: Please remove the requirement that a telehealth provider must reside in California and consider the allowance of interstate licensing agreements.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**

Stakeholder Comment/Feedback - Provider Enrollment	DHCS Response
Page 2: Certain reimbursable services (e.g., Diabetes Prevention Program) are both allowed to be provided virtually and are provided by non-licensed providers (health coaches). Do non-licensed providers of virtual services also need to be based in California? This requirement would be burdensome. Page 2: II. Provider Requirements – We request that DHCS clarify that both a billing provider rendering services via telehealth and a rendering provider must be licensed in the State of California. Page 2: Please remove the requirement that a telehealth provider must reside in California and consider the allowance of interstate licensing agreements. Page 2: “A health care provider rending services to a group...” Please clarify if this refers to a group receiving services (i.e., therapy) or a provider group rendering services outside of California. Page 2: Please remove the requirement that a telehealth provider must reside in California and consider the allowance of interstate licensing agreements.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page 2: We recommend deleting the confusing geographic requirements for MediCal providers as follows: “A billing health care provider delivering services via telehealth must be located in and licensed in California or reside in a border community and be enrolled as a Medi-Cal provider. If the medical standards of care deem it safe to provide particular services via telehealth, it should not matter where the provider is located. Including residency requirements for MediCal providers contradicts the spirit of the sanctioned telemedicine model elsewhere in the guidelines.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page 2: II. Provider Requirements While we agree that providers delivering health services to Medi-Cal beneficiaries via telehealth modalities must be licensed in the State of California and enrolled as a Medi-Cal provider, there is no clinical reason to require that providers reside in the State to deliver services. Requiring residence in the State will limit the State’s ability to expand the pool of providers available to deliver care to Medi-Cal beneficiaries in areas where California is experiencing provider shortages.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page 2: Under “II. Provider Requirements,” it was unclear if there were three separate categories a provider may fall into to qualify as an eligible Medi-Cal provider. Clarification of this would eliminate confusion. Page 2: Under “II. Provider Requirements,” it was unclear what is meant by “A health care provider rendering to a group may be located outside of California.” Does “a group” mean a hospital? Clinic? Group therapy? Clarification of this would eliminate confusion. Page 2: Under “II. Provider Requirements,” a provider must be licensed in California in order to be eligible to provide telehealth delivered services under Medi-Cal. However, there are currently some Medi-Cal enrolled providers who may provide services in-person and receive reimbursement who could use telehealth to deliver services, such as behavioral analysts. We recommend that the terminology used should be “qualified health care provider.”	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**

Stakeholder Comment/Feedback - Provider Enrollment	DHCS Response
Page 2: Provider Requirements. The revised Telehealth policy generally limits billing providers to just those who reside in and who are licensed in the state of California (or who reside in a border community), and who are enrolled in Medi-Cal. However, an exception is made for a provider who is rendering to a group, if the provider is located outside of California. Aspects of this policy are ambiguous. It is unclear what qualifies as a border community, or what DHCS means by “group” in this context. To the extent “group” means physician group, we note that primary care clinics often offer the same services provided by physician groups that practice primary care – leading us to question why the exception does not apply to all outpatient settings where similar services are provided. It is also unclear what is meant by requiring a provider to “reside” in California; does this mean the provider must physically be in California when services are provided, must live in this state, or must do business in this state? Either way, the residing requirement seems unnecessary so long as the other requirements (licensed in California and enrolled in Medi-Cal) are met. We urge DHCS to: (1) Specify exactly which towns/regions qualify as a border community under this policy; (2) expressly extend the exception for providers rendering to a “group” from outside of California to primary care clinics in addition to just “groups;” and (3) delete the requirement for providers to “reside” in California. Page 2: Provider Requirements. The revised Telehealth Policy specifies that a provider must be licensed in the State of California and enrolled as a Medi-Cal provider. However, some services are currently covered by Medi-Cal even if provided by a health care provider who is unlicensed or who is not enrolled in Medi-Cal because the provider does not appear on a claim and is employed by an enrolled community clinic that bills for the provider’s services. We recommend that the terminology used in this section instead refer to “qualified health care provider” as opposed to a provider who is licensed and enrolled.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."** **Title 22 of the California Code of Regulations Section 51006 allows for Medi-Cal beneficiaries to be treated "when it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State."**
Page 2: Under “II. Provider Requirements,” it is unclear if there are three separate categories a provider may fall into to qualify as an eligible Medi-Cal provider. Clarification of this would eliminate confusion. Page 2: Under “II. Provider Requirements,” it was unclear what is meant by “A health care provider rendering to a group may be located outside of California.” Does “a group” mean a hospital? Clinic? Group therapy? PSJH requests clarification from DHCS. Page 2: Under “II. Provider Requirements,” a provider must be licensed in California in order to be eligible to provide telehealth delivered services under Medi-Cal. However, there are currently some Medi-Cal enrolled providers who may provide services in-person and receive reimbursement who could use telehealth to deliver services, such as behavioral analysts. We recommend that the terminology used should be “qualified health care provider.”	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page 2: Section II – Provider Requirements: We would like to ask for clarification around the following: “A health care provider rendering to a group may be located outside California.” Specifically, we would like further definition of the terms “rendering” and “group” to better understand the exact meaning of this exception.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Page 2: We ask that DHCS consider modifying the enrollment-related provisions requiring that the “provider delivering services via telehealth must be located and licensed in California, or reside in a border community…” (emphasis added). APL 17-019, the California Code of Regulations and the Welfare and Institutions Code do not state that providers must be physically located in California in order to be reimbursed by the Medi-Cal program. We request that enrollment and licensing policy be clarified to allow for out-of-state, California licensed providers to be reimbursed for telehealth services, recommending striking the language “must be located” to reflect that due to the shortage of specialists able to see Medi-Cal patients, telehealth programs should be able to leverage the use of not only “border community” but all out-of-state providers licensed in California.	**DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**

Stakeholder Comment/Feedback - Family PACT	DHCS Response
Page 6: **Medicine: Telehealth** The Department's proposed policy states that a Family PACT provider must determine client eligibility at the site of clinical service delivery. To make the promise of the new telehealth policies a reality for individuals that continue to face barriers obtaining family planning services at a health setting, it is essential for Family PACT eligibility determination to be able to be processed remotely. Allowing Family PACT patients to enroll remotely will expand access and create greater equity and alignment among California's public programs. According to the Guttmacher Institute, over 3,000,000 low-income individuals in California remain in need of publicly funded family planning services. Online eligibility and enrollment processes are already available for Covered California and Medi-Cal and should also be made available to Family PACT patients. Essential Access Health welcomes the opportunity to explore and support strategies to implement online Family PACT eligibility determination in an effective manner at an upcoming Office of Family Planning stakeholder meeting or at a separate meeting.	**Thank you for your comments. The intent of the telehealth policy is from a service delivery perspective not client eligibility and enrollment. DHCS will take under advisement exploring different modalities for client enrollment.**
General - Allowing FPACT patients to enroll remotely will expand access and create greater equity and alignment among California's public programs. According to the Guttmacher Institute, over 3,000,000 low-income individuals in California remain in need of publicly funded family planning services. To make the promise of the new telehealth policies a reality for individuals that continue to face barriers obtaining family planning services at a health setting due to confidentiality concerns and/or barriers related to transportation, child care and time off work, it is essential for FPACT eligibility determination to be able to be processed remotely. Online eligibility and enrollment processes are already available for Covered California and Medi-Cal and should also be made available to Family PACT patients.	**Thank you for your comments. The intent of the telehealth policy is from a service delivery perspective not client eligibility and enrollment. DHCS will take under advisement exploring different modalities for client enrollment.**
Page 6: We recommend DHCS clarify how the use of telehealth can be used to facilitate the enrollment and immediate provision of Family PACT services to a new patient enrolling into Family PACT via a telehealth modality. The revised Family PACT provider manual states that "[a]n enrolled Family PACT provider must determine client eligibility at the site of clinical service delivery." We'd like DHCS to clarify what this means for patients receiving care via synchronous modalities while at a place of the patient's choosing (or any site other than where the Family PACT provider is located). As part of this clarification, please confirm if new patients can be determined eligible for Family PACT when the Family PACT provider is located at a distant site. If new patients cannot be deemed qualified for Family PACT from home (or another originating site where a Family PACT provider is not located), we strongly urge DHCS to permit online enrollment into Family PACT from any originating site– similar to the online enrollment process used for PE4PW. This will drastically increase access to Family PACT services and reduce operating costs for providers who can provide family planning services to patients via telehealth modalities.	**Thank you for your comments. Client eligibility cannot be done via telehealth. The intent of the telehealth policy is from a service delivery perspective not client eligibility and enrollment. DHCS will take under advisement exploring different modalities for client enrollment.**
General: The E-Consult Workgroup applauds DHCS's blanket inclusion of all telehealth services listed in the Telehealth Provider Manual, including e-consult, in the payment policies for FQHCs, the Indian Health Service, and Family PACT providers.	**Thank you for your comment.**

Stakeholder Comment/Feedback - Family PACT	DHCS Response
Allowing FPACT patients to enroll remotely will expand access and create greater equity and alignment among California's public programs. According to the Guttmacher Institute, over 3,000,000 low-income individuals in California remain in need of publicly funded family planning services. To make the promise of the new telehealth policies a reality for individuals that continue to face barriers obtaining family planning services at a health setting due to confidentiality concerns and/or barriers related to transportation, child care and time off work, it is essential for FPACT eligibility determination to be able to be processed remotely. Online eligibility and enrollment processes are already available for Covered California and Medi-Cal and should also be made available to Family PACT patients.	**Thank you for your comments. The intent of the telehealth policy is from a service delivery perspective not client eligibility and enrollment. DHCS will take under advisement exploring different modalities for client enrollment.**
Following the sentence that says, "If a non-covered service is recommended for a Family PACT client, the client must be informed of the medical necessity of the service and that it is not reimbursed by the program," NHeLP suggests requiring the provider to communicate to the patient that Medi-Cal may cover other types of reproductive health services and the provider should refer the client to a Medi-Cal provider who offers the sought service. Allowing FPACT patients to enroll remotely, including at their originating site, will expand access and create greater equity and alignment among California's public programs. According to the Guttmacher Institute, over 3,000,000 low-income individuals in California remain in need of publicly funded family planning services. To make the promise of the new telehealth policies a reality for individuals that continue to face barriers obtaining family planning services at a health setting due to confidentiality concerns and/or barriers related to transportation, child care and time off work, it is essential for FPACT eligibility determination to be able to be processed remotely. Online eligibility and enrollment processes are already available for Covered California and Medi-Cal and should be made available to Family PACT patients.	**Thank you for your comments. DHCS will consider the suggested revision to the "Excluded Services" language (not part of the Telehealth draft policy).** **The intent of the telehealth policy is from a service delivery perspective not client eligibility and enrollment. DHCS will take under advisement exploring different modalities for client enrollment.**

Stakeholder Comment/Feedback - All-Plan Letter
We would appreciate the Department clarifying whether a nurse, physician or therapist who is either employed or under contract with a licensed home health agency that is enrolled as a Medi-Cal provider can bill for telehealth services when the patient resides at home and is currently receiving Medi-Cal home health services. The individual clinicians meet the definition of health care provider under Chapter 547; however, the services would be billed through the licensed Medi-Cal enrolled home health agency which is licensed under the Health & Safety Code that is not referenced in Chapter 547. It is important that the Department's All Plan Letter to the Managed Care Plans is very clear on the specific entities that may bill for this service.
Page 3: Please define "reasonable attempts" to contract a non-virtual Provider. Page 3: The APL reads "…regardless of Member assignment in any Independent Physician Association…" – does this mean that all virtual care services are a health plan benefit? Are delegated entities also allowed to provide virtual visits per the revised policy?
Page 2: **IV. Telehealth Reimbursable Services, Generally** – We recommend deleting the subsection "Examples of Services Not Appropriate for Telehealth" included in the both the manual and the All Plan Letter. Specifying what types of benefits or services should not be delivered via telehealth may be lead to inappropriate denials of coverage by the managed care plans. This determination is more appropriately made by the physician or other treating provider. We recommend replacing this paragraph with a statement that telehealth should be provided according to generally accepted standards of medical care and when determined appropriate by treating provider.
Page 2: For the reasons outlined above, we also recommend deleting the geographic provider requirements in the APL as follows: "Each telehealth provider must be licensed in the State of California, enrolled as a MediCal provider, *and must reside in California (or a border community)*.
General: To the extent any of the policies suggested above are incorporated into the Telehealth Provider Health Manual, those same policies should be expressly incorporated into the APL. This would include, but should not be limited to, our suggested policy clarifications and changes regarding (1) single mode consultations, live-chat communications, and the use of mobile and app-based modalities; (2) payment parity; and (3) how Medi-Cal managed care plans determine what services cannot be "appropriately" provided via telehealth, and the process for effective provider communication when disagreements over "appropriateness" arise. General: We recommend the APL expressly state that plans are not permitted to: (1) set conditions that limit access to services provided via telehealth in a manner that conflicts with the Telehealth Provider Manual; or (2) limit coverage to services provided via telehealth based on a particular technology platform or vendor used in the telehealth transmission. General: DHCS has previously published several policies for Medi-Cal managed care plans that are unique to reproductive health care (see, e.g., APL 15-020 [abortion services]; APL 10-003 [augmented reimbursement for family planning services; PL 98-011 [family planning services in Medi-Cal Managed Care]). Although these policies may exist in other APLs or DHCS publications, experience has shown that payors are often unaware or misunderstand rules such as the out-of-plan "freedom of choice" guarantee (MMCD Policy Letter 98-11) or the requirement for contracted plans to ensure delegated payors adhere to all applicable rules regarding coverage and payment. We recommend DHCS document in this APL how its revised telehealth guidance interplays with MMCD APL 98-11 and other APLs governing family planning and reproductive health services covered by Medi-Cal managed care plans. In particular, we would like the APL to expressly state that even if MCPs are approved to use telehealth to meet network adequacy rules, MCPs and their delegated payors are still required to cover all abortion, family planning, and family planning-related services provided by a Medi-Cal beneficiary's provider of choice – even if the provider is out-of-plan, and as always, without prior authorization.

Stakeholder Comment/Feedback - All-Plan Letter
Page 2: As we currently understand, in order to practice telehealth and/or provide telehealth services in the state of California, a provider must be licensed and live in the state of California and also be enrolled as a Medi-Cal provider. **We would strongly recommend that requesting providers in California be able send eConsult requests to consulting specialists located and licensed outside of California**. Restricting eConsults to be entirely in-state great undercuts the potential of the technology and would significantly limit the ability for California patients to access the specialty care they need. In CMS' recently passed Physician Fee Schedule, **there is no mention of geographic restrictions of any kind** when outlining criteria necessary for providers to reimbursement completed eConsults. Please note that we are not advocating for out-of-state specialists to be eligible for Medi-Cal reimbursements, as we understand this would place an undue financial burden on the state. We only propose that California providers should be able to interact with out-of-state specialists when necessary in order to provide care for their patients.
Page 1: CHA appreciates DHCS' providing clarification to Medi-Cal managed care health plans (MCPs) on DHCS' policy on telehealth services as outlined in the Medicine: Telehealth section of the Medi-Cal provider manual, including clarification regarding the services that are covered and the expectations related to documentation. CHA believes this clarification will promote the use of the telehealth modality, thereby increasing access to health care for California's most vulnerable populations. Page 1: CHA requests that in addition to this APL, DHCS develop clarifying guidance for specialty mental health plans (MHPs) through an MHSUDS Information Notice and share the draft guidance with stakeholders for review.
General: The organizations listed urge the Department to ensure that there is alignment and coordination between the final Medi-Cal Telehealth policies proposed here and the telehealth policies for the California Children's Services (CCS) Program (See Dec 2017 N.L. 16-1217 , Addendum Dec 2013 N.L. 14-1213 , and July 2018 N.L. 09-0718).) Most often, the same pediatric specialty providers provide services under both Medi-Cal and CCS, and unaligned policies could cause confusion and frustration among providers. As importantly, we urge that the DHCS Benefits Division work closely with the Mental Health Services Division to align telehealth policies for specialty mental health services and substance use disorder services with those proposed here, and to ensure that mental/behavioral services are eligible for delivery and reimbursement via telehealth modalities. Children enrolled in Medi-Cal are entitled to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, which includes Specialty Mental Health Services (SMHS) for those who meet medical necessity criteria. However, fewer than 5% of eligible children and youth access SMHS under the EPSDT entitlement. (DHCS tracks the percentage of Medi-Cal enrolled children under age 21 who receive SMHS each fiscal year, and it has consistently been low, though the need has grown, indicating severe access and other barriers. Page 2: In both the proposed APL Provider Manual, DHCS lists "insertion/removal of medical devices" as an example of "types of services that cannot be appropriately delivered via telehealth." While we agree that "certain types of services cannot be appropriately delivered via telehealth" and that the "provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service," we would strongly urge the Department to leave it up to the provider to determine which services cannot be delivered appropriately via telehealth in the particular circumstance and at the specific time of service. We believe that a list of examples of excluded services, determined by DHCS, may cause confusion when it comes to Medi-Cal policy on this topic. For example, for children with special health care needs, who live at home and are often connected to many medical devices, removal and insertion of G-tubes, which is very common and often done by parent/caretaker, should be allowed via telehealth at the decision and discretion of the treating distant site provider. The proposed Telehealth Provider Manual lists "insertion/removal of medical devices" as "Examples of Services Not Appropriate for Telehealth." It is not clear whether DHCS means to exclude all insertion/removal of medical devices as services not appropriate for telehealth under Medi-Cal because the APL goes on to say, in the same paragraph, "A provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site." We ask for clarity, if not exclusion of examples, about whether all appropriateness is left up to the treating provider.

Stakeholder Comment/Feedback - All-Plan Letter
Page 2: While we agree that telehealth providers providing services to Medi-Cal beneficiaries be licensed in the State of California and become enrolled as a Medi-Cal providers, there is no clinical reason to require that providers reside in the State to deliver services. Requiring residence in the State defeats the purpose for seeking telehealth services, and will limit the State's ability to expand the pool of providers available to deliver care to Medi-Cal beneficiaries in areas where California is experiencing provider shortages. The proposed policy also contradicts the Telehealth Provider Manual that says rendering providers can be located outside of California and contradicts the Medical Board's own pronouncements that the provider need only be licensed in California. Therefore, we suggest deleting the requirement that providers reside in California or provide services while they are in California. Furthermore, we are aware that enrollment as a Medi-Cal provider is a process that may take time. As such, we recommend that DHCS speed up the processing time of enrollment. Lastly, we strongly suggest that all offices within DHCS, including the Enrollment Division, work in coordination with the Benefits Division and others to successfully implement this new telehealth policy. Page 2: The sentence that states, "certain types of services cannot be appropriately delivered via telehealth," could be confusing when other sections of the Plan Letter as well other accompanying documents establish that the responsibility falls on the provider to determine when telehealth services can be delivered for reimbursement. Therefore, we suggest replacing this section with the following wording, "Providers are responsible for determining whether a particular service can be appropriately delivered by telehealth. Services that may not be suitable for telehealth delivery include...."
Page 2: LHPC recommends the Department remove the requirement that providers be located in California or a border community. Page 2: LHPC recommends the Department develop exception criteria to permit providers without California licensure to deliver telehealth services under specified circumstances. Page 2: LHPC recommends the Department use the term "qualified health care provider" in addition to "licensed in California" when defining provider requirements.
Page 1: We request that the scheduling of a visit via telehealth by a member be sufficient documentation of consent. We request that the Department allow the maximum flexibility to have the member choose the virtual visit option without having to go through a formal consent process that may delay care. Members are always provided with both an in-person and a virtual visit option, and the virtual visit is only activated when initiated by the patient, which should indicate member consent. Page 2: In 2017, when CMS eliminated the requirement of modifiers for Telehealth billing, plans replaced the modifiers with the newly created Place of Service ("POS") 02-Telehealth. Pans request that only the POS 02, and not an additional modifier, be required for Telehealth billing purposes. Page 2: Plans request that the Medi-Cal enrollment requirements and in-state residency requirements be removed for e-consult providers. The purpose of e-consults is to increase PCP and specialist capacity by supporting the PCP with clinical advice and provider education to avoid unnecessary specialty referrals. Requiring e-consult specialists to practice and be licensed in California, as well as being Medi-Cal certified, undermines the goal of increasing California provider capacity. Since e-consults offer physician-to-physician advice and there is no direct relationship between the member and e-consult physician, it does not benefit the member to require California licensure or practice location. If it is the Departments intent to enact this regulation to include e-consult providers, the Plan requests that the Department reconsider this requirement. Page 2: We request clarification that site or origination fees are not required as part of a telehealth visit and that this be included in the final APL. Behavioral health services do not require that the provider have an actual office or site for the telehealth visit. Providers and members have access to HIPAA compliant platforms that can be accessed from any location. This provides flexibility for behavioral health providers to be available from various locations and for members to use the service from home or any other convenient location.

Stakeholder Comment/Feedback - All-Plan Letter
Page 3: The APL states: “The telehealth provider must be available to provide telehealth services to assigned members in the defined service area regardless of member assignment in any Individual Physician Association (IPA) or physician group.” This language is confusing to the plans. Is the intent to state that if a plan’s member is assigned to an IPA, the member should be able to access telehealth services through the plan’s network, even if the IPA does not offer telehealth? Or is it stating that a telehealth provider in an IPA must offer plan members telehealth services regardless of the member’s assignment in the IPA? We would like to better understand the Department’s intent to better evaluate this provision. We are concerned about potential stifling of innovation in telehealth. Some IPAs may decide to build telehealth networks in their IPA for their members, which would differentiate that IPA and add a valuable service to members to increase access. Plans and IPAs should be able to build networks to best fit market and demographic needs. Page 3: The APL stipulates that telehealth providers must be available to provide telehealth services to assigned members in the defined service area regardless of member assignment in any IPA or physician group. Please clarify whether all virtual care services would be considered health plan benefits, and whether delegated entities are also permitted to provide virtual visits. Page 4: We recommend adding care transition and palliative care to the definition of telehealth. These are important services that can be tailored for delivery via telehealth modality. Page 4: Please replace the word “and” with the word “or” for the definition Telehealth in both the APL and PM. Replacing “and” for “or” ensures that the definition not assume that a diagnosis, consultation, treatment, education, care management, and self-management are all completed during one Telehealth visit. The mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, or and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers Page 4: We suggest that the definition of Telehealth clearly state that the below forms of Telehealth are included, but not limited to, so there is no confusion: a) Phone visits b) Video visit c) Email visit
General: While the Plan’s providers are very experienced with telehealth, telehealth may not always be available for a member for all services, even when telehealth would otherwise be clinically appropriate (e.g., certain specialties may not yet offer telehealth, or offer all telehealth modalities). As such, the Plan suggests that DHCS add clarifying language to the APL that explains that the coverage of services via telehealth is permissible, but not required. Page 1: The Plan suggests that DHCS add a sentence to the APL that clarifies that the scheduling of a telehealth visit is sufficient for documentation of consent. A telehealth visit would not be scheduled (i) electronically by the member unless the member was consenting to such modality, or (ii) via the Plan’s booking representatives, unless the member had verbally consented to such modality. In addition, the Provider Manual states “health care providers must also inform the patient about the use of telehealth and obtain verbal consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health.” The Plan recommends that the Provider Manual reflect the Business and Professions code language requiring “verbal or written consent” in place of “verbal” only. Obtaining verbal consent may be impractical when asynchronous consults are performed by email or in that a PCP may request an E-Consult in the days following a patient visit, requesting advice on a member’s labs or images. Page 2: The Plan suggests that DHCS consider removing the requirement that a telehealth provider must reside in California or a border community: “Each telehealth provider must be licensed in the State of California, enrolled as a Medi-Cal provider, and **must reside in California (or a border community)**.” In the world of telehealth, the Plan strives to be innovative in using providers that may reside outside of California. This residency requirement would eliminate the ability of licensed California providers to add capacity to the Plan’s network (when necessary), to provide rare, highly specialized services, or to perform E-Consults with other providers – only because the otherwise qualified provider was not residing in California. This seems contrary to the goal of expanding access to services through the provision of telehealth, and would be a significant restriction on the availability of telehealth services. Along similar lines, the Providers Manual provides that a “health care provider rending to a group may be located outside California.” It is unclear if this is in the context of E-Consults, and if so, why this only applies when rending *to a group* vs. consulting with a provider who doesn’t practice within a group. For the reasons described above, the Plan suggests that DHCS remove “to a group.”

Stakeholder Comment/Feedback - All-Plan Letter
Page 2: As shown below, the Plan suggests clarifying that provider enrollment is only required “to the extent possible”. The Fee-for-Service (“FFS”) pathway for enrollment of out-of-state providers is very limited in scope and would not be available to many out-of-state providers, creating significant barriers to the use of out-of-state telehealth providers. However, per DHCS’s provider enrollment FAQs, only providers with an existing FFS pathway are required to enroll. The Plan believes that adding the clarification below will align with DHCS’s FAQs, and also remove any unintended barriers to the provision of telehealth by out-of-state providers (assuming residency requirements are also removed). “Each telehealth provider must be licensed in the State of California, enrolled as a Medi-Cal provider (to the extent possible), and must reside in California (or a border community).” Page 2: In 2017, when CMS eliminated the requirement of modifiers for telehealth billing, the Plan also removed the applicable modifiers from the Plan’s adjudication system. The modifiers were replaced with the newly created Place of Service (“POS”) 02-Telehealth. The Plan acknowledges that DHCS also uses the Telehealth POS 02 as outlined in the Provider Manual. However, adding modifiers will require substantial coding and implementation efforts. The Plan would to explore options for DHCS to receive this kind of information in alternative reporting formats while systems changes are implemented. In addition, the Plan suggests that DHCS select a code set that can be used for all E-Consults up to the first hour. Many E-Consult responses provided by consulting providers take less than 30 minutes to complete. The Plan acknowledges the importance of having a code reflecting the initial communication (e.g., up to 30 minutes) and subsequent communications (e.g., up to one hour). Codes 99358 and 99359 may cause confusion in that they are not specific to E-consults and capture other services for “prolonged evaluation and management.” Page 2: For consistency purposes, the Plan suggests that the words “and/or” in APL language also be used in the Provider Manual. See below in red: APL Page 2: "The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment." Provider Manual, Section IV, Page. 3: “The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and best practices to be delivered via telehealth.”
Page 4: The Plan suggests the definition of telehealth clearly state that the below forms of telehealth are included (without limitation), so that there is no confusion as to permitted modalities: a) Telephone visits b) Video visits c) Email exchanges d) Questionnaire based electronic visits Clarity in this definition is important to the Plan, as all of these modalities are an essential part of the care provided to the Plan’s members. They are convenient for members, increase member satisfaction, and reduce time and travel expenses. In addition, all of these modalities serve to reduce the costs associated with in person visits. Along with synchronous telehealth, such as telephone and video visits, including asynchronous telehealth examples is also particularly important to the Plan. Members and providers exchange millions of secure emails annually to facilitate the diagnosis, consultation, treatment, education, care management, or self-management of a member’s health care. In addition, the Plan’s providers are piloting asynchronous “eVisits” for certain conditions. During these eVisits, members complete comprehensive electronic questionnaires about their symptoms; providers then review the responses and take action accordingly (e.g., the provider may email the member to let the member know a prescription has been ordered based on the member’s symptoms). This innovative asynchronous approach to telehealth leads to similar outcomes as synchronous telehealth modalities, but with even more convenience than the scheduling of a telephone or video visit.

Stakeholder Comment/Feedback - All-Plan Letter
Page 4: Similar to the definition of telehealth, the Plan suggests the definition of E-Consult clearly state that the below forms of E-Consults are included (without limitation), so there is no confusion as to the permitted modalities: a) Phone consults b) Video consults c) Email consults The providers within the Plan's exclusively contracted provider groups routinely perform consultations between one another given PCPs and specialists of all types are part of the same provider groups. These consultations are an integral part to Kaiser Permanente's model of care, and the high quality results delivered to the Plan's members. These consultations are also beneficial in that they reduce costs of addition in person visits with specialists (when appropriate), and thus reduce member time and travel expenses for additional visits. Given the very high frequency with which these provider consultations are occurring, it is important to the Plan that all modalities be included – both asynchronous emails and/or store and forward consults, as well as synchronous telephone or video consults among providers. All of these modalities are currently being used among providers to facilitate the diagnosis, consultation, treatment, education, care management, or self-management of a member's health care. Page 4: The Plan suggests the below word of "and" be replaced with the word "or" for the definition telehealth in both the APL and Provider Manual. Replacing "and" for "or" ensures that the definition not require that a diagnosis, consultation, treatment, education, care management, and self-management are all completed during one telehealth visit. The mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, or and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.
Comments arising from All Plan Letter 18-XXX The DHCS policy does not address who is responsible – the patient, the managed care plan (MCP) provider, or the MCP – for providing the electronic or other equipment necessary for the patient to participate in a synchronous interaction between the patient and a health care provider located at a distance site. We suggest clarifying this issue in the most appropriate of the DHCS's telehealth policy documents. It appears from the APL that a "Medi-Cal provider" must be an individual provider who meets the DHCS's requirements as discussed in the APL. Please clarify whether DHCS would consider designating a telehealth vendor such as Teladoc or MD Live a "Medi-Cal provider," if the vendor's employees or consultants meet the requirements for telehealth providers specified in the APL page 2, and if the vendor contracts with an MCP. At page 3 of the APL, in regards to network adequacy, the APL seems to require the telehealth provider be available to all members in the service area, not just members assigned to a particular medical group. This would seem to create an incentive for a Plan to use a telehealth vendor, unless each medical group can provide telehealth to all members in the service area, even those not assigned to their medical group. We suggest clarifying how this policy would work in the delegated model where a beneficiary's care has been delegated to a medical group and the group has received a capitation to arrange all care for the beneficiary.
Page 2 - Policy: The APL is limited to "licensed providers". Under California law, a qualified autism provider who is eligible for Medicaid reimbursement includes a person who is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism. Certified Behavior Analysts provide the most recognized form of behavioral treatment for autism, applied behavior analysis (ABA). In California ABA providers are recognized in the Health and Safety Code, Insurance Code, and Medicaid State Plan Amendment, but are not licensed by the State. Request amending draft language as follows: Each telehealth provider must be licensed in the State of California *or one authorized to provide behavioral health treatment by an approved Medicaid state plan amendment*, enrolled as a Medi-Cal provider, and must reside in California (or a border community).
Does this also apply to FFS reimbursements? Directly Observed Therapy (DOT) for tuberculosis is a carve-out from managed care plans. The service is only reimbursable, per Title 22, when provided by trained local public health department staff. Local health departments submit claims through FFS.

DHCS Response
Benefits Division added Business and Professions Code citation to the policy to address this concern. We will align the APL with any changes made to the BD Telehealth Policy.
"Reasonable" requirements are defined according to Welfare and Institions Code Section 14197. The IPA language is only within the context of network adequacy determination - this is just stating that if telehealth providers are being used to fulfill network adequacy reqs in a given geographic area, telehealth services must be available to all beneficiaries in that specified area. There is nothing in the APL that precludes delegated entities from being able to provide telehealth services. Thank you for your feedback, we will make the appropriate revisions to the network adequacy section.
This is language from the Benefits policy and APL language is written to be in alignment with that policy. However, this is language that has been reviewed by medical staff across multiple divisions at DHCS, who agree there are certain services that would not be approriately provided via telehealth with current medical technology.
This is language from the Benefits policy and APL language is written to be in alignment with that policy.
The APL will be revised to reflect any changes to the Telehealth Policy made by the Benefits Division. The MCPs already understand that they cannot be more restrictive than the benefits outlined in the Provider Manual and this probably does not need to be duplicated in the APL. Making requirements regarding use of specific telehealth platforms or vendors is outside of the scope of the APL. Unless there is a direct conflict between the Telehealth APL and past APLs, it is typically not practice to address all past APLs that could be relevant. The division will consider all reasonable revisions should any issues arise in the future. The "freedom of choice" requirements have been communicated to the MCPs previously in other ways.

DHCS Response
DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."
This feedback should be shared with the Mental Health Division who would make the decision about the publication of an information notice.
The Integrated Systems of Care Division reviewed the policy and APL along with other stakeholders and their feedback will be incorporated.

DHCS Response
DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."
This is language from the Benefits policy and APL language is written to be in alignment with that policy. Permitting providers without California licensure would also be against Medical Board of California policy, and it is not clear under what circumstance that would be necessary. "Qualified health care provider" might be redundant with "Medi-Cal enrolled" provider, which is already used in the policy and APL.
Acquiring verbal or written consent is required by law. The APL does not currently make any requirements on originating site, and the beneficiary may access services from their home if desired, and does not require the provider to be located in any particular location to provide telehealth services (as long as they fulfill the other requirements for providers). Regarding the two comments from Page 3: The IPA language is only within the context of network adequacy determination - this is just stating that if telehealth providers are being used to fulfill network adequacy reqs in a given geographic area, telehealth services must be available to all beneficiaries in that specified area. Thank you for your feedback, we will make the appropriate revisions to the network adequacy section. There is nothing in the APL that precludes delegated entities from being able to provide telehealth services. Actual provision of telehealth services is not subject to any restrictions related to IPAs or geographic area. Care management and palliative care services are already existing Medi-Cal benefits, and would therefore be able to be provided via telehealth. Regarding any revisions to wording in the policy, this is language from the Benefits policy and APL language is written to be in alignment with that policy, so any changes would be initiated with Benefits first. DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."

DHCS Response
Acquiring verbal or written consent is required by law. The APL does not currently make any requirements on originating site, and the beneficiary may access services from their home if desired, and does not require the provider to be located in any particular location to provide telehealth services (as long as they fulfill the other requirements for providers). Regarding the two comments from Page 3: The IPA language is only within the context of network adequacy determination - this is just stating that if telehealth providers are being used to fulfill network adequacy reqs in a given geographic area, telehealth services must be available to all beneficiaries in that specified area. Thank you for your feedback, we will make the appropriate revisions to the network adequacy section. There is nothing in the APL that precludes delegated entities from being able to provide telehealth services. Actual provision of telehealth services is not subject to any restrictions related to IPAs or geographic area. Care management and palliative care services are already existing Medi-Cal benefits, and would therefore be able to be provided via telehealth. Regarding any revisions to wording in the policy, this is language from the Benefits policy and APL language is written to be in alignment with that policy, so any changes would be initiated with Benefits first. DHCS has revised the Provider Manual to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."
Acquiring verbal or written consent is required by law, so it is unclear that scheduling alone would be sufficient. Regarding any revisions to wording in the policy, this is language from the Benefits policy and APL language is written to be in alignment with that policy, so any changes would be initiated with Benefits first. DHCS has revised the policy to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."

DHCS Response
Acquiring verbal or written consent is required by law, so it is unclear that scheduling alone would be sufficient. Regarding any revisions to wording in the policy, this is language from the Benefits policy and APL language is written to be in alignment with that policy, so any changes would be initiated with Benefits first. **DHCS has revised the policy to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Acquiring verbal or written consent is required by law, so it is unclear that scheduling alone would be sufficient. Regarding any revisions to wording in the policy, this is language from the Benefits policy and APL language is written to be in alignment with that policy, so any changes would be initiated with Benefits first. **DHCS has revised the policy to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**

DHCS Response
Acquiring verbal or written consent is required by law, so it is unclear that scheduling alone would be sufficient. Regarding any revisions to wording in the policy, this is language from the Benefits policy and APL language is written to be in alignment with that policy, so any changes would be initiated with Benefits first. **DHCS has revised the policy to state, "The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community."**
Making specific requirements on the technological equipment needed and who would be providing that equipment would be outside of the scope of the APL. Defer discussion of telehealth vendors as being considered as an entity for Medi-Cal enrollment to Provider Enrollment Division. Thank you for your feedback; we will make the appropriate revisions to the network adequacy section.
BPC Section 2290.5(a)(3) authorizes only licensed providers and marriage and family therapist interns (associate marriage and family therapists) for services delivered via telehealth. California considers certified behavior analysts to be licensed, so they may provide services via telehealth when appropriate. However, qualified autism service paraprofessionals are not certified by the Behavior Analyst Certification Board and are therefore not considered licensed by the State. We have updated the Provider Manual to reference the licensing requirement in the Business and Professions Code.
The telehealth policy applies to both FFS and Managed Care Medi-Cal. Since this is a service billed to FFS, it is recommended that the proposed billing codes to be used for DOT adhere to all the requirements outlined in the Provider Manual Telehealth policy.

Stakeholder Comment/Feedback - Teledentistry	DHCS Response
Page 1: Under “Informed Consent: Synchronous or Live Transmissions” the language states that “live transmissions are only to be used at the beneficiary’s request.” A dental provider’s professional judgement should also be a consideration when it comes to live transmissions requests. We suggest the language be amended to allow provider discretion as well as the patient’s ability to request this transmission. We suggest the following, “live transmissions may be provided at the beneficiary’s request or if the health care provider believes the service is clinically appropriate.” Note: This is the same language that is in the provider manual, page 3, “IV: Telehealth Reimbursable Services, Generally” and changes made here should be made there as well.	**MDSD agrees with the suggested language.**
Page 4-14: Is the “within 30 days” window to allow for in-person consultation following a virtual visit in conflict with existing time/access standards? Page 4-15: Is the “within 30 days” window to allow for in-person consultation following a virtual visit in conflict with existing time/access standards?	**The Teledentistry timeframe does not conflict with existing time/access standards.** **The 30 day noted on page 4-14 and 4-15 of the dental provider handbook applies to how long the member has to request for a real-time communication (not in person) with the distant dentist at the time of the consultation or within 30 days of the original consultation. If requested, communication with the distant dentist may occur either at the time of the consultation, or within 30 days of the member's notification of the results of the consultation.** **The time/access standards in both FFS and managed care for scheduled dental appointments depends on the type of service that is needed (emergency, routine, or urgent). The existing time/access standards would also apply to teledentistry, therefore, there is no conflict.**