Alameda County Behavioral Health Care Services MENTAL HEALTH & SUBSTANCE USE SERVICES	DocuSigned by: By: Karyn L. Tribble, PsyD, LCSW, Director BA167CA0C0D444A...
POLICY TITLE **Telehealth Policy**	**Policy No: 100-2-5** **Date of Original Approval**: 8/23/2022 **Date(s) of Revision(s):**

PURPOSE

This policy addresses the need to provide telehealth guidance for Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services that complies with federal and State regulations. Telehealth may expand and improve clinically appropriate services within the Alameda County Mental Health Plan (MHP) and Drug Medi-Cal-Organized Delivery System (DMC-ODS), inclusive of both new and existing beneficiaries.

AUTHORITY

- Business and Professions Code §2290.5
- California Code of Regulation Title 16 §1815.5: Standards of Practice for Telehealth
- DHCS Medi-Cal & Telehealth page
- DHCS BHIN 21-047 Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal
- DHCS BHIN 21-003 Telehealth for Assessment of 72-hour Involuntary Detentions (5150 and 5151 Assessments)
- DHCS Post COVID-19 Public Health Emergency Telehealth Policy Recommendations (May 2021)
- DHCS Medi-Cal Provider Manual: Telehealth (August 2020)

SCOPE

All ACBH county-operated programs and entities and individuals providing mental health services and substance use disorder services under a contract or subcontract with ACBH.

BACKGROUND

Medi-Cal's telehealth policy was originally established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. In 2019, the Department of Health Care Services (DHCS) revised the policy, which afforded substantial flexibility to licensed providers to make clinically appropriate decisions regarding the use of synchronous and asynchronous telehealth modalities across both fee-for-service (FFS) and managed care. In March 2020, a national public health emergency (PHE) was declared regarding the Novel Coronavirus Disease (COVID-19) outbreak. This resulted in federal waivers and

flexibilities, inclusive of telehealth, to support various health care delivery systems. Telehealth expansion and flexibilities during the COVID-19 PHE include:

- Expanding the ability for providers to render all applicable Medi-Cal services that can be appropriately provided via telehealth modalities—including those historically not identified or regularly provided via telehealth such as home and community-based services and Targeted Case Management (TCM) services.
- Allowing most telehealth modalities to be provided for new and established beneficiaries.
- Allowing many covered services to be provided via telephone/audio-only for the first time.
- Allowing payment parity between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/audio only when the services met the requirements of the billing code by various provider types.
- Allowing for expanded access to telehealth through non-public technology platforms. A "non-public facing" remote communication product is one that, as a default, allows only the intended parties to participate in the communication. Non-public facing remote communication products would include, for example, platforms such as Apple Facetime, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, Zoom, or Skype. This "good faith" exception was granted by the federal Office for Civil Rights, which would otherwise not be allowed under federal Health Insurance Portability and Accountability Act (HIPAA) requirements.

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

Please note: DHCS telehealth and telephone flexibilities during the COVID-19 public health emergency will continue until December 31, 2022.

DHCS POST-COVID-19 PHE TELEHEALTH POLICY RECOMMENDATIONS

For post-COVID-19 PHE, DHCS proposes to implement broad changes to continue to allow additional Medi-Cal covered benefits and services to be provided via telehealth modalities across all delivery systems, when clinically appropriate. While the recommended changes will not incorporate all flexibilities allowed during the COVID-19 PHE, DHCS believes its recommended approach is both reasonable and balanced in terms of promoting appropriate standards of care, providing access to quality health care services, and helping to advance equity in availability of modalities across the delivery systems. This will be done while maintaining beneficiary choice, preserving provider flexibility, and protecting the integrity of the Medi-Cal program (from both a quality and fiscal perspective). DHCS believes that providing health care services through various telehealth modalities can help provide beneficiaries, especially those residing in rural and underserved areas of the State, with increased access to critically needed subspecialties, and could improve access to culturally appropriate care, such as allowing care with a provider whose language, race, or culture are the same as that of the beneficiary.

DHCS has heard from providers, Medi-Cal managed care plans, and professional associations that no show rates for appointments have significantly decreased as a result of the ability to

provide health care services utilizing various telehealth modalities. This could be due to the flexible nature of the services being provided from the beneficiary's home or community. Reduced no-show rates indicate that the existing telehealth flexibilities are helping Medi-Cal beneficiaries to access services in ways that work for their beneficiary circumstances. DHCS has also heard anecdotally that many beneficiaries prefer receiving health care services through various telehealth modalities because it reduces long travel distance on public transportation, prevents having to take time off work, reduces wait times to see a provider, and/or avoids parents having to arrange for child care. All of those factors can be obstacles to in-person visits, reducing access to care. All of the post-COVID-19 PHE policy changes envisioned and recommended by DHCS were guided by the following principles:

- ***Equity:*** Use of an equity framework, focusing on improving equitable access to providers, and addressing inequities and disparities in care to every beneficiary, regardless of race, ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location. Telehealth services will comply with civil rights law, including non-discrimination, accessibility under the Americans with Disabilities Act, access to qualified language interpreters, and accurate, culturally responsive translation.
- ***Access:*** Telehealth should be used as a means to promote adequate, culturally responsive, beneficiary-centered, equitable access to health care, and to strengthen provider network adequacy.
- ***Standard of Care:*** Require the use of evidence-based strategies for the delivery of quality and culturally responsive care. Standard of care requirements shall apply to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.
  Beneficiary choice: Beneficiaries, in conjunction with their providers, should be offered their choice of service delivery mode. Beneficiaries should retain the right to receive health care in person.
- ***Confidentiality***: Beneficiary confidentiality should be protected. Beneficiaries must provide informed consent verbally or in writing in their primary or preferred language about both care and the specific technology used to provide it.
- ***Stewardship***: As stewards of public resources, steps will continue to be taken to mitigate and address fraud, waste, discriminatory barriers, and abuse.
- ***Payment Appropriateness***: Reimbursement for services provided via telehealth modalities will be considered in the context of various methods of reimbursement, nature of service, type of care provider, and the health system payment policies and goals

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

DHCS is <u>not recommending</u> continuation of the following temporary COVID-19 PHE flexibilities:

- Telephonic/audio-only modalities to establish a new beneficiary for delivery systems allowed to bill such services.
- Payment parity for telephonic/audio-only modalities and virtual communications for delivery systems allowed to bill such services.

POLICY

Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. Providers determine if a benefit or service is clinically appropriate to be provided via a telehealth modality, subject to beneficiary consent. Beneficiary choice must be preserved: beneficiaries have the right to request in-person services. The standard of care is the same whether the beneficiary is seen in-person, via telehealth (synchronous audio and video) or via telephone (audio-only).

Medi-Cal covered services delivered via telehealth and telephone modalities are reimbursable in Medi-Cal fee-for-service, managed care (physical health care), Mental Health Plan (MHP), and the Drug Medi-Cal Organized Delivery System (DMC-ODS), including initial assessments.

PROCEDURE

Network Adequacy

DHCS allows Medi-Cal managed care plans, county Mental Health Plans and county Drug Medi-Cal Organized Delivery System plans to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the network adequacy time or distance standards.

Compliance and Documentation

Clinical Appropriateness
Providers should use clinical judgment about the safety of using telehealth or telephone appointments with each beneficiary. In accordance with HIPAA, for disclosures, providers must make reasonable efforts to limit the information disclosed to that which is the "minimum necessary" to accomplish the purpose.

Telehealth Location
Providers should always use private locations and beneficiaries should not receive telehealth services in public or semi-public settings, without the beneficiary's consent or urgent circumstances. Providers should implement reasonable safeguards to limit incidental disclosures of protected health information (PHI). This could include using lowered voices, refraining from using speakerphone, and encouraging the beneficiary move a distance away from others when discussing PHI. DHCS does not restrict the location of the provider while providing services via telehealth or telephone or of the beneficiary receiving the services. Providers may deliver services via telehealth or telephone from anywhere in the community, including outside a clinic or other provider site and beneficiaries may receive services via telehealth or telephone in their home or in other locations.

Telehealth Communication Products
The U.S. Department of Health and Human Services Office of Civil Rights (HHS-OCR) guidance states that providers can use various non-public facing remote communication products that are available to communicate with new and existing beneficiaries, as long as it is used in good faith during the period of the COVID-19 PHE. However, public facing applications such as Facebook Live, Twitch, TikTok, and similar video communication applications should not be used in the provision of telehealth. DHCS does not impose requirements about which video chat applications can be used to provide services via telehealth beyond the guidance established by HHS-OCR.

Please note that after the national PHE declaration expires, HHS-OCR may resume enforcement of regulatory requirements related to telehealth, including those that pertain to video chat applications. Additional guidance regarding HHS-OCR's HIPAA enforcement during the COVID-19 public health emergency can be found on HHS-OCR webpage: Telehealth.

As previously noted, DHCS recommends providers use HIPAA compliant video communication products and enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products.

Beneficiary Consent

DHCS' telehealth policy already allows for both verbal and written consent, consistent with state law. While this requirement is currently waived in light of the COVID-19 public health emergency, where practicable and as a matter of best practice, DHCS recommends providers continue to document verbal beneficiary consent for services provided via telehealth and other virtual/telephonic communication modalities.

Telehealth Documentation

Providers are required to complete service documentation in the beneficiary record in the same manner as in-person visit. Verbal or written consent for telehealth or telephone services shall be documented in the beneficiary record. The fact that a service was performed by telehealth or telephone must be clearly documented in the chart and, if applicable, the appropriate service location (e.g. Telehealth Synchronous Video & Audio, Telephone Audio-Only) selected in an electronic health record (EHR). Please note, effective November 2021, County MHP and DMC-ODS are required to submit Medi-Cal claims with modifiers (i.e. Telehealth synchronous audio and video service: GT, Telephone (audio-only) service: SC, Store and forward (e-consult in DMC ODS): GQ) for improved State telehealth data collection, analysis and findings.

If a beneficiary is receiving services via telehealth or via telephone, and a beneficiary signature on the treatment/beneficiary plan is required, electronic signatures are allowable. If it is not possible to obtain an electronic signature, a written explanation in the beneficiary record is sufficient. It is not necessary to obtain a signature when the beneficiary returns for an in-person visit.

Drug Medi-Cal Organized Delivery System:

- The initial clinical assessment, including any determination of diagnosis, medical necessity, and/or level of care may be conducted by synchronous video telehealth visits, or in-person.
- Licensed providers and non-licensed staff may provide services via telehealth and telephone, as long as the service is within their scope of practice.
- Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telephone for a beneficiary quarantined in their room in a residential facility due to illness).
- DMC-ODS beneficiary and group counseling services that a provider determines to be clinically appropriate can also be provided via telehealth and telephone, (examples include beneficiary education, crisis intervention, case management, medication support services).
- DHCS supports the use of telehealth and telephone for DMC-ODS services when it is appropriate, and all relevant federal and state requirements are met. Additionally, DHCS

supports the use of store and forward communications for DMC-ODS physician consultation services (e-consults).

- DHCS does not impose any limitations regarding telehealth flexibilities for the provision of medications for treating substance use disorder, commonly referred to as medication-assisted treatment, above and beyond applicable federal guidance. For example, SAMHSA has issued guidance describing how waivered buprenorphine prescribers working outside of the Narcotic Treatment Program (NTP) setting may prescribe buprenorphine to new and existing beneficiaries via telehealth (including telephone). The SAMHSA guidance also outlines telehealth flexibilities available to NTPs, including the ability to treat new buprenorphine beneficiaries via telehealth, to treat existing buprenorphine and methadone beneficiaries via telehealth, and to dispense take home medications with new flexibilities. Please refer to DHCS COVID-19 Frequently Asked Questions: Narcotic Treatment Programs for additional information regarding these COVID-related flexibilities for NTPs.

Specialty Mental Health Services:

- The initial clinical assessment, including any determination of diagnosis and/or medical necessity for outpatient services can be conducted by synchronous video telehealth visits, or in-person.
- Beneficiary or group services that can be provided by telehealth or telephone are reimbursable in all counties (For example, include mental health services, crisis intervention services, targeted case management, intensive care coordination, and medication support services can be provided via telehealth, telephone, or in-person).
- Licensed providers and non-licensed staff may provide services via telehealth or telephone, as long as the service is within their scope of practice.
- Certain services, such as crisis stabilization, day rehabilitation, day treatment intensive, crisis residential treatment services, and adult residential treatment services, require a clearly established site for services and require some in-person contact between facility staff and a beneficiary to be claimed. However, California's State Plan does not require that all components of these services be provided in-person (For example, services can be provided via telephone for a beneficiary quarantined in their room due to illness).

5150 Evaluations and 5151 Assessments:

Welfare and Institutions Code Sections (W&I) 5150 evaluations and 5151 assessments may be performed by authorized providers face-to-face via telehealth as per W&I 5008(a) and W&I 5151(b). This may include releases from involuntary holds for evaluation and treatment, as appropriate. These services are billable to Medi-Cal regardless of whether they are provided in person or through telehealth as long as the beneficiary has Medi-Cal coverage for the service and all Medi-Cal requirements are met. This assessment shall be made face-to-face either in person or by synchronous interaction through a mode of telehealth that utilizes both audio and visual components.

NON-COMPLIANCE

I. Definition of non-compliance: Any failure to abide by the stated policy.

II. The U.S. Department of Health and Human Services Office of Civil Rights (HHS-OCR) has clarified that they will use enforcement discretion and will not impose penalties for

noncompliance with the regulatory requirements under the HIPAA Rules when providers use telehealth in good faith during the federal COVID-19 public health emergency.

III. Failure to comply with federal and/or State HIPAA and telehealth policy may result in penalties.

IV. Reports of non-compliance can be made in writing or verbally to supervisors, and staff shall not face retribution for reporting non-compliance.

V. Reports of non-compliance shall be communicated to supervisors and the appropriate ACBH System of Care within 72 hours to ensure timely response and corrective action.

VI. Any communication that contains protected health information or otherwise confidential information should be sent through secure methods such as email with secure encryption.

VII. Should an emergency situation arise where conformance with this policy is impractical, the supervisor(s) and Division Director will be notified immediately.

CONTACT

ACBH Office	Current Date	Email/Phone
Office of Quality Management/ Quality Improvement	7/14/2022	QITeam@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

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Original Date of Approval: 8/23/2022 by Karyn L. Tribble, PsyD, LCSW, Behavioral Health Director

Revision Author	Reason for Revision	Date of Approval by (Name, Title)

DEFINITIONS

Term	Definition
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a beneficiary's health care while the beneficiary is at the originating site and the health care provider is at a distant site. Telehealth facilitates beneficiary self-management and caregiver support for beneficiaries and includes synchronous (video and audio) interactions and asynchronous store and forward transfers.
Asynchronous Store and Forward	Transmission of a beneficiary's medical information from an originating site to the health care provider at a distant site. Consultations via asynchronous electronic transmission initiated directly by beneficiaries, including through mobile phone applications, are not covered.
E-Consults	Fall under the auspice of store and forward. Asynchronous health record consultation services that provide an assessment and management service in which the beneficiary's treating health care practitioner (attending or primary) requests the opinion and/or treatment advise of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the beneficiary's health care needs without beneficiary face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers.
E-Visits	Communications between a beneficiary and their provider through an online beneficiary portal.
Synchronous Interaction	Real-time interaction between a beneficiary and a health care provider located at a distant site.
Distant Site	Site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Originating Site	Site where a beneficiary is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the beneficiary or the health care provider is not limited. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the beneficiary's home.

APPENDICES

NONE