

CHECKLIST FOR PLANS IMPLEMENTING TELEHEALTH SERVICES

This checklist applies to Plans that wish to implement telehealth as part of their delivery of health care services in the commercial and/or Medi-Cal markets. Telehealth services may be delivered via web-based, smartphone or computer based applications and via telephone. The following are examples of telehealth modalities that a health plan may choose to use in the delivery of health care services¹:

- A **synchronous live visit** in which the provider delivers complete medical services via live, two-way video or audio between the enrollee and a remote provider;
- **Remote Patient Monitoring** in which the provider delivers services to an enrollee via remote monitoring of a enrollee with video and peripheral devices;
- An **asynchronous store and forward** consultation in which the provider delivers services to an enrollee via transmission of history and images between the enrollee and the provider for diagnosis and treatment; or,
- An **e-Consult** in which a remote, consulting provider delivers interprofessional consultation services and expert opinion to an enrollee's treating provider via asynchronous communication.

The Department of Managed Health Care (Department) encourages Plans to integrate telehealth in care delivery, and is invested in working with Plans to ensure telehealth services are consistent with the Knox-Keene Health Care Service Plan Act of 1975, as amended.² The Department created this checklist to guide Plans in describing how telehealth services are integrated in care delivery. This checklist is not intended to be all-inclusive. The Department may request additional information as necessary during its review to make a finding under the Knox-Keene Act.

Background:

Pursuant to Sections 1351(e) and 1352, the Plan must file for review its policies, procedures, and other documents adopted by the Plan to implement telehealth services.

General Filing Information:

- Plans should submit a telehealth services filing as an **Amendment** filing.
 - a. **TIMING:** If possible, submit the Amendment Filing prior to the document(s) going into effect. Amendment Filings must be submitted within 30 days of going into effect. See Rule 1300.52.4(b)(i)(A).
- Revised Exhibits:** If the Plan has revised documents previously approved by the Department, file the revised document as the proper Exhibit type, and identify in

¹ See also California Business and Professions Code section 2290.5, subdivision (a).

² California Health and Safety Code Sections 1340 et seq. (Act). References herein to "Section" are to Sections of the Health and Safety Code. References to "Rule" refer to the regulations promulgated by the Department, the California Code of Regulations, title 28.

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Exhibit E-1 the eFile number affiliated with the previously approved document. Changes to the approved document must be identified via highlight or strikeout, in accordance with Rule 1300.52(d). Also, submit a clean copy of the revised Exhibit in the filing.

- Improperly Filed Documents:** The Department will not review improperly filed Notices, Amendments, and Exhibits. The Plan will be required to re-file and/or withdraw improperly filed Notices, Amendments, and Exhibits prior to review by the Department.
- Duration of Department Review:** The duration of the Department's review will vary on a case by case basis. Duration of review depends on the quality of the documents and information provided by the Plan, and the complexity of the filing.

MINIMUM REQUIRED INFORMATION: TELEHEALTH FILING

Listed below are the most likely exhibits a Plan would submit to the Department when describing its telehealth services. This list is not exhaustive and Plans should submit all exhibits applicable to telehealth services. If the Plan chooses not to submit an exhibit listed below, please explain in Exhibit E-1 why that exhibit is not relevant to the Plan's telehealth services. Feel free to submit additional exhibits or information if it will help the Department better understand the telehealth services and the value of these services to the Plan, its providers, and its enrollees.

Exhibit E-1: eFiling Narrative

To allow the Department to conduct an effective review, the Plan must provide a summary description of the filing, covering the highlights and essential features of the information and documents provided by the Plan in the filing. See Rule 1300.51(d)(E)(1). The Plan must also provide all information necessary for the Department to make a finding under the Act that the proposed Amendment is in the public interest and consistent with the intent and purposes of the Act. See Rule 1300.52.4(a)(ii). Therefore, in the Exhibit E-1 provide a detailed narrative description of the filing including a response to each item below:

- Description of telehealth services**, including:
 1. Basics
 - a. The Plan's definition of "telehealth services."
 - b. The current status of the Plan's telehealth services. Identify whether services are currently in operation or under development. If under development, provide the date by which the Plan hopes to begin delivery of telehealth services.
 - c. The lines of business in which the Plan intends to use telehealth.
 2. Enrollee and Delivery of Telehealth Services
 - a. What medical conditions are eligible for telehealth, and who decides which conditions are eligible for telehealth. If certain criteria are used to

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- determine what medical conditions are eligible for telehealth, describe those conditions.
- b. Who decides to deliver health care services via telehealth – the Plan, the provider, or the enrollee.
 - c. Whether the use of telehealth is optional for enrollees.
 - d. Whether the Plan uses telehealth only when delivering outpatient services. Is telehealth used in any of the following: inpatient services; prescription drug services; urgent care; or emergency services?
 - e. Whether enrollee eligibility is a factor for receiving telehealth or whether telehealth is purely an interaction between providers and enrollees without regard to enrollee status. If enrollee eligibility is a factor, describe any limitations or exclusions for the use of telehealth, including any age or condition restrictions.
 - f. Whether availability of telehealth services is based on where an enrollee lives (e.g., covered if an enrollee lives in a rural area but not for enrollees in urban areas).
 - g. Whether there is cost-sharing charged to the enrollee for telehealth, or any other fees for enrollees unique to services provided via telehealth. If so, describe whether the Plan offers any benefits to cover telehealth services. If enrollee is not charged cost-share, explain whether the Plan absorbs the cost. If cost-share is charged for telehealth services, affirm that it does not exceed the cost-share for the same service delivered in-person.³
 - h. Whether enrollee consent is required before proceeding with telehealth services, and if so, whether written or verbal consent is required.
 - i. Where an enrollee receives telehealth services, such as in the enrollee's home, in a provider's office, or in plan-contracted facility.
 - j. Whether an enrollee must own certain equipment to access telehealth services.
 - k. How the Plan ensures continuity of care with a telehealth provider, when applicable.
 - l. How the Plan ensures compliance with language assistance requirements while providing telehealth services.
3. Telehealth Providers
- a. Whether the Plan is contracting with a vendor or with individual telehealth providers for the provision of telehealth. If the Plan is contracting with individual telehealth providers, state whether they are the Plan's existing providers who also provide in-person services. If the Plan is contracting with a vendor, identify that vendor.
 - b. How enrollees can tell which providers offer services via telehealth, or how enrollees can identify the Plan's telehealth vendor.

³ See California Health and Safety Code section 1374.14, subdivision (c).

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- c. Whether any telehealth providers offer services only through a telehealth modality and not through in-person visits.
 - d. Whether any telehealth providers are located outside of California.
 - e. Whether all telehealth providers are licensed in California.
 - f. The Plan's process for the credentialing and re-credentialing of telehealth providers.
4. Network
 - a. Whether the Plan is intending to use its telehealth network to address provider network adequacy concerns, and, if so, how the Plan justifies using telehealth services instead of in-person services to deliver care.⁴
 5. Administration of Telehealth
 - a. The security and confidentiality standards for the Plan and its telehealth providers.
 - b. How the Plan maintains telehealth medical records.
 - c. The geographic location and length of time books and records related to telehealth services are stored.
- Previously Approved Documents:** If the Plan's filing includes changes or revisions to a document the Department approved previously, provide the eFiling number(s) associated with the most recently approved version of the document.
- Scope of Policy, Procedure, or Document:** If the Plan is providing a policy, procedure or document for review, identify the scope of the policy, procedure or document, including whether it applies to specific, or all, lines of business.
- Impact on other Plan Documents:** Explain the effect of the proposed change on any other enrollee or provider-facing documents, including, but not limited to, the evidence of coverage and/or disclosure form, or provider manual. Describe how:
- a. The change will be communicated to the affected audience;
 - b. The timing for communication of the change; and,
 - c. Whether the change will necessitate revisions to other Plan documents.

⁴ The health plan's obligation to deliver readily available and accessible care, as described in Rule 1300.67.2, encompasses an obligation to make care timely and geographically accessible to enrollees. The Act does not contemplate the use of telehealth to satisfy this requirement, therefore, the availability of telehealth services does not exempt a health plan from its obligation to deliver timely and geographically accessible in-person care. The Department will consider the availability of telehealth services to satisfy network adequacy obligations only in those circumstances where in-person care cannot be reasonably provided to enrollees. See Rule 1300.67.2.1, subd. (c) for examples of factors that may justify the use of alternative methods for the delivery of care.

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- Notice of Change:** If the Plan files a new or revised policy, procedure, or document, describe how and when the Plan will inform appropriate Plan personnel, vendors, and/or providers of the change.
- Implementation of Change:** Describe how and when the Plan will implement telehealth services.
- Use by Contracted or Subcontracted (Downstream) Entities:** Describe how the Plan will ensure downstream individuals or entities do not use or circulate any outdated Plan policy, procedure, or document.
- Name of Affected Networks:** List the names and network identifiers, if applicable, of all networks that will include the telehealth services.
- Exhibits Included in Filing:** Describe, and identify by name and Exhibit type, all documents submitted as part of the filing for consideration by the Department.
- Other Information:** Include any other information the Plan thinks would help the Department review this filing.

Exhibit H-1

- Identify the portions of the health plan's geographic service area which can access telehealth services.

Exhibit I-1 and I-3: List of Contracting Providers

- Provide all information for the "Exhibit I-1 Telehealth," available in the "Downloads" section of the eFiling web portal, as requested both in the Networks eFiling Instruction Manual and in the eFiling Network Report Form - Telehealth. This includes reporting all providers who will be delivering telehealth services and relevant provider information, including name, specialty, medical group, telehealth organization, telehealth delivery modality, location where enrollee can receive telehealth services, and any limitations on the provider's availability to treat all enrollees (e.g., geographic limitations, medical group limitations, or other eligibility requirements).
- Indicate whether the telehealth providers will also be treating enrollees in-person.

Exhibit I-4: Calculation of Provider-to-Enrollee Ratios

- Identify, by county, the PCP- and Specialist-to-enrollee ratios based only on all providers who see enrollees in-person. If the Plan has internal ratio standards based on individual provider types, please break the data down accordingly.
- Identify, by county, the PCP- and Specialist-to-enrollee ratios based on all available providers, including in-person providers and telehealth providers. If the

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Plan has internal ratio standards based on individual provider types, please break the data down accordingly.

Exhibit I-5: Standards of Accessibility

- Describe the full extent of telehealth services available to enrollees.
- Provide all policies and procedures that describe how the telehealth is accessed both by enrollees and providers.
- Include any access policies and procedures related to the telehealth program.
- Describe under what circumstances telehealth is used as a substitute for an in-person visit with a provider.
- Describe the Plan's appointment timeframes for accessing telehealth services.
- If the Plan is utilizing telehealth services to meet the timely access standards for an initial appointment, please describe how the Plan believes the use of telehealth meets the timely access standards for initial appointments. This information should also be filed in Exhibit J-13.

Exhibit I-6: Referral Process

- Describe the process for how an enrollee is referred to a telehealth provider.
- If, after a telehealth visit with an enrollee or between providers (e-consult), a provider decides to refer an enrollee to another provider, please describe the timing of when a referral is made.
- Describe the impact of the telehealth program on an enrollee's ability to obtain a referral to a provider for an in-person visit (e.g., telehealth is required before an in-person specialist visit).

Exhibit J-1 through J-5: Internal Quality of Care Review System

- Explain the clinical standards applied by the Plan when determining whether an enrollee's condition can be appropriately treated via telehealth.
- Describe the Plan's system for reviewing the quality of care delivered through telehealth to identify, evaluate and remedy problems relating to access, continuity, quality of care, and utilization.
- Specify the key persons and committees responsible for ensuring quality of care delivered through telehealth.
- Describe the standards and norms used by key persons and committees to evaluate quality of care delivered through telehealth and how those standards

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and norms will be communicated directly to contracted providers or vendors delivering telehealth.

- Describe the frequency and scope of Plan's audits and how the Plan will enforce standards and norms for care delivered through telehealth.
- Describe the contractual arrangements enabling the Plan to monitor and require compliance with its standards and norms for telehealth.

Exhibit J-9: Utilization Management Policies and Procedures

- Submit utilization management policies and procedures with revisions to address telehealth services. If no revisions were made to the Plan's utilization management policies and procedures, affirm that no revisions are necessary to specifically address telehealth services.

Exhibit K-1, K-2, K-3: Provider Contracts

- Submit template agreements between the Plan and individual providers, provider groups, hospitals, and facilities, which address telehealth services. If the Plan has not revised its template provider agreement for this filing, provide the filing number in which the provider agreement was last reviewed and approved, and identify the page(s) and paragraph(s) that address telehealth services.
- Describe compliance with statutory and regulatory requirements specified in Rule 1300.51(d)-Item K-2.
- Submit template provision in provider contract regarding provider compensation.

Exhibit N-1, N-2: Administrative Service Agreements

- Submit the Plan's written contract(s) with a vendor for telehealth services.
- Describe Plan monitoring of the vendor in the delivery of telehealth services to protect Plan, its Plan business, its enrollees, and its providers in the event there is a failure of performance from the telehealth vendor or the telehealth ASA is terminated.

Exhibit Q-7/Q-8: Contracts with Government Agencies/MOU with Government Agencies

- File these contracts or MOUs if Plan has contracted with a county or Federally Qualified Health Center (FQHC) for that government agency to provide health care services and those services might be delivered to Medi-Cal enrollees via telehealth.

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Exhibit S or P: Subscriber Contracts

- Submit any statements of benefits in the Plan's subscriber contracts that address telehealth services.

Exhibit U-1/Q-1/T-1: EOCs and Disclosure documents

- Submit disclosure to enrollees of the use of telehealth in the delivery of health care services.
- Submit disclosure to enrollees regarding cost-sharing for services provided through telehealth.

Exhibit V: Advertisements

- Submit advertisements regarding the availability of telehealth services.

Exhibit W-1: Grievance Policy and Procedure

- Submit the Plan's present grievance policies and procedures with revisions addressing how enrollees submit, and the Plan resolves, grievances involving telehealth. If the Plan has not revised its grievance policies and procedures for this filing, affirm that grievances involving telehealth services are subject to the Plan's approved grievance policy, and provide the filing number in which the grievance policy was last reviewed and approved.