CENTER FOR CONNECTED HEALTH POLICY (CCHP)

is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.
Disclaimers & Friendly Reminders

• Any information provided in today’s webinar is not to be regarded as legal advice. Today’s talk is purely for informational and educational purposes.
• Always consult with your organization’s legal counsel.
• CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.
• Today’s webinar will be recorded and slides presented here will be made publicly available as resources at cchpca.org.
• Closed captioning is available.
• Please refrain from political statements or advertising commercial products or services during this webinar.
ABOUT CCHP

• Established in 2009 as a program under the Public Health Institute
• Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
• Work with a variety of funders and partners on the state and federal levels
• Administrator National Consortium of Telehealth Resource Centers
• Convener for California Telehealth Policy Coalition
NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org

© Center for Connected Health Policy/Public Health Institute
May 21, 2021: Telemental & Behavioral Health

This webinar series was made possible by grant number GA5RH37470 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, U.S. Department of Health & Human Services.
TODAY’S WEBINAR

Connecticut Department of Social Services
Kate McEvoy, JD, Director of Health Services, Connecticut Department of Social Services

California Department of Health Care Services
Rene Mollow, MSN, RN, Deputy Director, California Department of Health Care Services, Health Care Benefits and Eligibility
Connecticut Strategies to Enable Access for Older Adults and People with Disabilities
Center for Connecticut Health Policy Webinar
May 14, 2021
Connecticut, which had no applied experience with telehealth prior to the initial declaration of the Public Health Emergency, joined sister states in rapidly deploying, and iteratively expanding, an expansive portfolio of telehealth coverage, at parity with in-person rates, and via audio-visual conferencing and telephone. With respect to older adults and people with disabilities:

- some of this coverage (e.g. authority for remote assessments and various services under home and community-based waivers) was directly targeted; and
- other coverage (e.g. remote provision of skilled therapies, hospice and customized wheelchair assessment) was not specifically targeted but had substantial benefit
Content:

- Public health emergency declarations and authorities
- Member supports
- Provider supports
- Telehealth services, utilization and satisfaction survey data
Public Health Emergency Authorities
HUSKY Health has used three federal authorities to flexibly respond to needs of members and providers during the PHE.

<table>
<thead>
<tr>
<th>Authority Type</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid and Children’s Health Insurance Program (CHIP) 1135 waiver</td>
<td>Increasing Access-to-Care Flexibilities by removing prior authorization requirements, expanding the ability to serve members in alternate settings such as a shelter or vehicle, waiving or adding flexibilities (settings, signatures, assessments, other) to various requirements for home and community-based 1915(c), 1915(i), and 1915(k) programs, and suspending various provider enrollment requirements to enable enrollment of new providers</td>
<td>CMS has approved many of Connecticut’s requests via letters of 3/27/20, 5/12/20, 6/17/20, 8/21/20, and 3/12/21. The approved 1135 authorities expire at the end of the PHE</td>
</tr>
</tbody>
</table>
HUSKY Health has used three federal authorities to flexibly respond to needs of members and providers during the PHE.

<table>
<thead>
<tr>
<th>Authority Type</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid &amp; CHIP Disaster Relief State Plan Amendments (SPAs)</td>
<td>• <strong>Eligibility</strong> (election of the new Medicaid testing group)</td>
<td>Medicaid SPAs were approved on 8/13/20 and 2/22/21; CHIP SPA was approved on 8/27/20</td>
</tr>
<tr>
<td></td>
<td>• <strong>Coverage</strong> (add flexibility for telehealth, home health, Community First Choice (CFC), and 1915(i) state plan services)</td>
<td>The disaster SPAs expire at the end of the PHE</td>
</tr>
<tr>
<td></td>
<td>• <strong>Reimbursement</strong> (specified temporary rate increases, COVID-19 lab fee codes, telehealth audio-only codes, other)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Cost sharing</strong> (waiver of HUSKY B copayments for most medical services and prescription drugs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Coverage of vaccines</strong></td>
<td></td>
</tr>
</tbody>
</table>
HUSKY Health has used three federal authorities to flexibly respond to needs of members and providers during the PHE.

<table>
<thead>
<tr>
<th>Authority Type</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915(c) Appendix K waivers</td>
<td><strong>Requests for flexibilities around remote assessments and reassessments</strong>, additional services, staffing of services, and retainer payments for home and community-based providers</td>
<td>CMS first approved Connecticut’s Appendix K submissions on 3/27/20 and approved renewal on 3/24/21</td>
</tr>
</tbody>
</table>
Member Supports
To support members during the PHE, HUSKY Health:

- Covers COVID-19 testing, treatment and vaccinations with no cost share
- Extended coverage to 90-day periods for prescription drugs, medical surgical supplies, hearing aid batteries, parenteral/enteral supplies, respiratory equipment and supplies
- Implemented a broad portfolio of telehealth options in support of primary care, behavioral health services, birth to three, physical/occupational/speech therapy, rehab clinics, autism spectrum disorder services, school-based child health, our long-term services and supports waivers, evaluation in support of customized wheelchairs, speech and language pathology, respiratory care, and dental

Please note that extended coverage and telehealth flexibilities are authorized by Executive Order and are subject to legislative/executive review.
Through CHNCT, DSS’ medical administrative services organization (ASO), is maintaining a 24/7 nurse care line, supporting referrals to providers, and using data to identify people in need of intensive care management.

Through Beacon Health Options, DSS’ behavioral health ASO, has implemented a peer staff warm line.

Expanded long-term services and supports under the waivers.

Is ordering and distributing Personal Protective Equipment (PPE) to consumer employers who participate in self-directed care under Community First Choice.

Implemented a specialized Non-Emergency Medical Transportation (NEMT) service for COVID-positive people.

Partnered with DPH, the ASOs and Veyo on vaccine education, outreach, warm reservation line, NEMT for appointments and equity efforts.
Provider Supports
<table>
<thead>
<tr>
<th>HUSKY Health has supported providers by . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implementing coverage for telemedicine at the same rates that are paid for in-person visits</td>
</tr>
<tr>
<td>• Providing administrative flexibilities (e.g. removal of prior authorization) in where and how care can be provided</td>
</tr>
<tr>
<td>• Continuing to pay 100% of clean claims on a timely, bi-weekly basis</td>
</tr>
<tr>
<td>• Making payment advances and provider relief payments</td>
</tr>
<tr>
<td>• Advocating at the federal level for further financial relief</td>
</tr>
</tbody>
</table>
Telehealth
Permitted specified physical therapy (PT), occupational therapy (OT) and speech & language pathology (SLP) services to established patients via synchronized telemedicine (real time live audio and video technology) Provider Bulletin 2020-23

For various 1915(c) home and community-based services (HCBS) waivers:

- Allowed virtual assessments and reassessments
- Waived the face-to-face requirement
- Permitted various services (adult day programs, mental health counseling, services for individuals with intellectual disabilities including day supports and group supported employment) to be provided electronically and in some cases telephonically  Provider Bulletin 2020-27
Permitted hospice agencies to provide services via telemedicine or audio-only telephone Provider Bulletin 2020-28

Permitted behavioral assessments of individuals with Autism Spectrum Disorder to be rendered via synchronized telemedicine (audio and video) Provider Bulletin 2020-47

Permitted physical therapists, occupational therapists, and assistive technology professionals to conduct customized wheelchair evaluations via synchronized audio and visual telemedicine, so long as one of the licensed professionals is in the member’s home while the certified ATP is present by synchronized telemedicine during the evaluation, or vice-versa Provider Bulletin 2020-46
## Telehealth Claims Analysis

Claims Service Dates Between 3/1/2020 and 4/29/2021
Claims Paid Thru 4/29/2021

### Telehealth Claims by COE

<table>
<thead>
<tr>
<th>COE</th>
<th>COE Description</th>
<th>Members*</th>
<th>Claims</th>
<th>Paid Amount</th>
<th>Billing Providers</th>
<th>Performing Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Medicare Crossover</td>
<td>27,593</td>
<td>119,801</td>
<td>$3,822,026.87</td>
<td>1,609</td>
<td>6,404</td>
</tr>
<tr>
<td>120</td>
<td>Hospital Outpatient – Emergency Room</td>
<td>160</td>
<td>168</td>
<td>$60,891.68</td>
<td>14</td>
<td>87</td>
</tr>
<tr>
<td>122</td>
<td>Hospital Outpatient – All Other</td>
<td>12,839</td>
<td>52,070</td>
<td>$9,908,031.15</td>
<td>43</td>
<td>1,705</td>
</tr>
<tr>
<td>130</td>
<td>Physician Services – All</td>
<td>200,318</td>
<td>491,149</td>
<td>$37,810,507.29</td>
<td>1,294</td>
<td>7,068</td>
</tr>
<tr>
<td>131</td>
<td>Other Practitioner</td>
<td>113,068</td>
<td>943,843</td>
<td>$98,397,077.51</td>
<td>4,082</td>
<td>6,209</td>
</tr>
<tr>
<td>145</td>
<td>Home Health Services</td>
<td>343</td>
<td>2,894</td>
<td>$670,081.02</td>
<td>8</td>
<td>183</td>
</tr>
<tr>
<td>150</td>
<td>FQHC – Medical</td>
<td>140,236</td>
<td>410,525</td>
<td>$0.00</td>
<td>19</td>
<td>858</td>
</tr>
<tr>
<td>152</td>
<td>FQHC – Mental Health</td>
<td>38,578</td>
<td>452,286</td>
<td>$0.00</td>
<td>18</td>
<td>755</td>
</tr>
<tr>
<td>160</td>
<td>Dental</td>
<td>11</td>
<td>11</td>
<td>$274.56</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>161</td>
<td>Vision</td>
<td>247</td>
<td>403</td>
<td>$16,076.68</td>
<td>34</td>
<td>55</td>
</tr>
<tr>
<td>162</td>
<td>Clinic Services</td>
<td>61,092</td>
<td>696,392</td>
<td>$71,903,606.70</td>
<td>240</td>
<td>1,178</td>
</tr>
<tr>
<td>999</td>
<td>All Other</td>
<td>16,580</td>
<td>242,457</td>
<td>$24,494,286.95</td>
<td>184</td>
<td>528</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>439,455</td>
<td>3,411,999</td>
<td>$247,082,860.41</td>
<td>6,068</td>
<td>16,851</td>
</tr>
</tbody>
</table>

### Telehealth Claims by Call Type

<table>
<thead>
<tr>
<th>Call Type</th>
<th>Members*</th>
<th>Claims</th>
<th>Paid Amount</th>
<th>Billing Providers</th>
<th>Performing Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio Only</td>
<td>205,134</td>
<td>576,677</td>
<td>$11,332,952.18</td>
<td>1,643</td>
<td>8,151</td>
</tr>
<tr>
<td>Audio/Video</td>
<td>356,295</td>
<td>2,846,274</td>
<td>$23,749,908.23</td>
<td>5,967</td>
<td>16,214</td>
</tr>
<tr>
<td>Total</td>
<td>439,455</td>
<td>3,411,999</td>
<td>$247,082,860.41</td>
<td>6,068</td>
<td>16,851</td>
</tr>
</tbody>
</table>

* Distinct members per category might include duplicates when aggregated. Distinct members are shown in the Totals.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other/Multiple Races/Unknown</td>
<td>30.39%</td>
<td>29.90%</td>
<td>32.21%</td>
<td>31.12%</td>
<td>29.81%</td>
<td>29.20%</td>
<td>29.34%</td>
<td>45.88%</td>
</tr>
<tr>
<td>Asian Non-Hispanic</td>
<td>2.77%</td>
<td>2.67%</td>
<td>2.80%</td>
<td>2.61%</td>
<td>2.17%</td>
<td>1.95%</td>
<td>2.07%</td>
<td>42.26%</td>
</tr>
<tr>
<td>Black/African American Non-Hispanic</td>
<td>14.66%</td>
<td>14.55%</td>
<td>14.30%</td>
<td>14.04%</td>
<td>13.56%</td>
<td>14.84%</td>
<td>12.85%</td>
<td>51.28%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.36%</td>
<td>22.07%</td>
<td>20.56%</td>
<td>21.47%</td>
<td>22.37%</td>
<td>26.70%</td>
<td>20.72%</td>
<td>55.91%</td>
</tr>
<tr>
<td>White/Caucasian Non-Hispanic</td>
<td>30.82%</td>
<td>30.81%</td>
<td>30.12%</td>
<td>30.76%</td>
<td>32.10%</td>
<td>27.31%</td>
<td>35.02%</td>
<td>39.85%</td>
</tr>
</tbody>
</table>

The 2\textsuperscript{nd} and 4\textsuperscript{th} columns reflect the overall incidence of each group as a segment of the HUSKY Health membership, comparing 2019 and 2020.

The 3\textsuperscript{rd} and 5\textsuperscript{th} columns use a denominator reflecting the total of members receiving “telehealth eligible services” (i.e. services were permitted to be billed as telehealth in 2020 with the telehealth modifier) and reflect the racial breakout of members with those services in 2019 and 2020. Again, totals are 100%.

The 6\textsuperscript{th} column reflects use of telehealth eligible services that were billed with the telehealth modifier, by each group, for 2020.

The 7\textsuperscript{th} (audio only 2020) and 8\textsuperscript{th} (a/v 2020) columns use a denominator reflecting the total membership receiving that type of service, and reflects the racial breakdown of those services.

The 9\textsuperscript{th} column represents the % of each racial group that used audio-only services (note that this does not equal 100%).
HUSKY Health medical administrative services organization CHNCT conducted surveys to seek feedback on use of telehealth

Key results of the survey of **801 members** showed the following:

- 58.2% of respondents reported using “video with audio/telephone” for their appointment, compared to 47.2% of respondents who utilized “audio-only” 79.6% of respondents either “strongly agree/agree” that “overall, [they] liked using telehealth” and 72.0% reported they either “strongly agree/agree” that “telehealth worked just as good for as an in-person appointment”
- When asked to identify features that members **liked**, 76.0% indicated that they “did not have to travel to the office” and another 42.9% reported having “less time waiting for the appointment to start”
- When asked to indicate features they **did not like**, 64.2% indicated “nothing,” 12.4% noted they “found it too hard to talk to the doctor/felt less personal,” and another 8.4% reported “it was hard to use/had problems connecting”
Key results of 203 provider respondents showed the following:

- 69.6% of providers used video with audio; 27.0% audio only; and 3.3% advised they didn’t offer telehealth
- 45.8% of providers noticed a decrease in missed appointments
- 66.0% of providers did not experience any technical difficulty when visiting with their patient during a telehealth visit
- 73.9% of providers surveyed indicated they found telehealth an adequate replacement for an in-person visit
- 83.3% said they would continue to use telehealth after the COVID-19 crisis

Member listening sessions have also been held by Medicaid member advisory bodies including the behavioral health-focused Child & Family Advisory Council
Questions?
Telehealth Medicaid Policies for Seniors

René Mollow, MSN, RN
Deputy Director
Health Care Benefits & Eligibility
Telehealth Brief History

• Pre-COVID Telehealth Policy
  o Medi-Cal’s telehealth policy was originally established pursuant to Assembly Bill 415, known as the Telehealth Advancement Act of 2011.
  o In 2019 DHCS, following extensive stakeholder engagement and public comment, introduced revised telehealth 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.

• Temporary COVID-19 PHE flexibilities:
  o Expand the ability for providers to render all applicable Medi-Cal services that could be appropriately provided by via telehealth modalities – including those historically not identified or regularly provided via telehealth such as home and community-based services, Local Education Agency (LEA) and Targeted Case Management (TCM) services.
  o Allow most telehealth modalities to be provided for new and established patients.
  o Allow many covered services to be provided telephonic/audio only services for the first time.
  o Allow payment parity between in-person, synchronous telehealth, and telephonic services including FQHC/RHCs in both FFS and managed care.
  o Waive site limitations for both providers and patients for FQHC/RHCs.
  o Allow expanded access to good-faith provision of telehealth through non-public technology platforms that would otherwise not be allowed under HIPAA requirements.
Telehealth Visits

- Telehealth visits were identified based on the presence of a modifier on the claim or encounter (modifiers 95, GQ and GT)
- Telehealth visits include phone and video healthcare visits
- Telehealth Visits are outpatient visits in fee-for-service or managed care – mental health visits are not included in this chart
- Source of data:
  - MIS/DSS Claims and Eligibility
Telehealth Visits
Per 100,000 beneficiaries

Preliminary Data as of 01/2021
Telehealth Visits
By Sex per 100,000 beneficiaries through 2020

Preliminary Data as of 03/2021
Telehealth Visits
By Age Group per 100,000 beneficiaries through 2020

Preliminary Data as of 03/2021
Telehealth Visits
By Race/Ethnicity per 100,000 beneficiaries through 2020

Preliminary Data as of 03/2021
Telehealth Visits New
By Location per 100,000 beneficiaries through 2020

Preliminary Data as of 03/2021
Telehealth Visits
By Delivery System per 100,000 beneficiaries through 2020

Preliminary Data as of 03/2021
Post COVID-19, DHCS is recommending broad changes to allow the continuation of additional Medi-Cal covered benefits and services to be provided via telehealth modalities.

- Approach is both reasonable and balanced to ensure equity in availability of modalities across the delivery systems while protecting the integrity of the Medi-Cal program.

- Use of the various telehealth modalities continue to provide beneficiaries with increased access to critically needed subspecialties and could improve access to culturally appropriate care.

- Ensure adherence to HIPAA Privacy Rule for appropriate uses and disclosures of information.
Telehealth Post COVID-19

- Recommend to allow the following for all 1915(c) waivers via traditional two way interactive audio-visual telehealth
  - Waiver intake (e.g., initial assessments, level of care determinations, care plan development, home environmental assessments)
  - Case management / Care Coordination
  - Ongoing re-assessments (e.g., scheduled and ad hoc re-assessments, LOC re-determinations, care plan updates, home environmental re-assessments)

- Recommend to allow the following for all 1915(c) waivers via store and forward/e-consults and audio-only telehealth
  - Case management / Care Coordination
Telehealth Post COVID-19 (cont.)

- Allow specified FQHC and RHC providers to establish a new patient, located within its federal designated service area, through synchronous telehealth and make permanent the removal of the site limitation.

- Expand synchronous and asynchronous telehealth services to 1915(c) waivers, the TCM Program and the LEA Medi-Cal Billing Option Program (LEA BOP) and add synchronous telehealth and telephone services to Drug Medi-Cal.

- Require payment parity between in-person, face-to-face visits and synchronous telehealth modalities, when those services meet all of the associated requirements of the underlying billing code(s), including for FQHC/RHCs.
  - Payment parity is required in both FFS and managed care delivery systems, unless plan and network provider mutually agree to another reimbursement methodology.
• Expand the use of clinically appropriate telephonic/audio-only, other virtual communication and remote patient monitoring for established patients only.
  – These modalities would be subject to a separate fee schedule and not billable by FQHC/RHCs.

• Provides that the TCM Program and the LEA BOP will follow traditional certified public expenditure (CPE) cost-based reimbursement methodology when rendering services via applicable telehealth modalities.
Telehealth Post COVID-19 (cont.)

Flexibilities DHCS is **not** recommending:

- Telephonic/audio-only modalities as a billable visit for FQHC/RHCs reimbursed at the Prospective Payment System rate.
- Telephonic/audio-only modalities to establish a new patient.
- Payment parity for telephonic/audio-only modalities, virtual communications for delivery systems allowed to bill such services.
- Continuing COVID-19 PHE telehealth policies for Tribal 638 clinics as the federal government sets policy for Indian Health Services.

DHCS would like to engage with interested FQHC/RHC stakeholders relative to using telephonic/audio-only modalities, e-consults, virtual communication modalities (e.g., e-visits) and/or RPM in the context of an Alternative Payment Methodology.
CMS Guidance on Medicare during COVID 19

• CMS has added 144 telehealth services covered through the end of the PHE such as
  o Initial inpatient and nursing facility visits
  o Discharge day management services,
  o Medicare telehealth services at renal dialysis facilities and at home.
  o Medicare telehealth services for certain emergency department visits at home.
  o Medicare telehealth services for certain physical and occupational therapy services at home.
  o Some services delivered via audio only devices.
  o Virtual check-ins and E-visits.
Critical, medically necessary services can be delivered by the PACE Organizations (POs) via an in-person visit or via telehealth.

Adult Day Health Care (ADHC) can provide basic services to participants through telehealth or other remote services:
- Basic services include: occupational therapy, physical therapy, speech therapy, medical services, nursing services, nutrition services, psychiatric or psychological services, social services, and recreation or planned social activities.

When using telehealth flexibility DHCS requested POs send notification to the PACE Policy Unit for tracking purposes.
Home and Community-Based Alternatives Waiver
COVID 19 Flexibilities

• Temporarily modify licensure or other settings requirements allowing telehealth as an alternative option to face-to-face interactions for medically necessary services by waiver service providers and waiver agencies.

• A covered health care provider can use any non-public facing remote communication product that is available to communicate with patients.
Assisted Living Waiver
COVID 19 Flexibilities

• Medically necessary services can be delivered by home health agency (HHA) providers and CCAs via telehealth, as deemed appropriate by the HHA provider or Care Coordination Agencies (CCA).
• The Office of Civil Rights (OCR) exercises enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth.
DHCS Next Steps

• **Budget Proposal**: The budget includes $94.8 million total funds ($34.0 million General Fund) to implement remote patient monitoring services as an allowable telehealth modality in fee-for-service (FFS) and managed care delivery systems.

• **Advancing Trailer Bill Language (TBL)**: The TBL, with an effective date of July 1, 2021, which includes the following:
  o Add virtual communication, telephonic/audio-only and RPM as allowable modalities under Medi-Cal
  o Allow DMC providers to deliver all allowable SUD services via synchronous and telephonic/audio only modalities
  o Expand the definition of a FQHC and RHC visit to include synchronous interaction and include the ability of these providers to establish patients through synchronous telehealth.
  o Use of telehealth to meet network adequacy standards in Medi-Cal managed care health plans, County mental health plans, dental managed care plans and DMC-ODS
  o Revise Alternate Access Standards submission and review process and to postpone the network adequacy sunset provision until 2026
• **Submission of State Plan Amendments (SPAs):** as necessary, submit any needed SPAs for necessary federal approvals, with an effective date of July 1, 2021.

• **Submission of 1915(c) Home and Community Based Services (HCBS) Waivers:** will amend existing 1915(c) HCBS waivers, with an effective date of July 1, 2021, to allow for telehealth and other virtual communication modalities and amendment waiver contracts, as necessary.

• **Promulgating CA Regulations:**
  - TCM
  - SMH
  - DMC
DHCS Next Steps (cont.)

• **Developing and Issuing Policy Guidance:** Through calendar year 2021, develop and issue clear policy guidance for Medi-Cal providers across delivery systems.
  o Updates to various sections of the Medi-Cal Provider Manual and other policy/procedure documents.
  o Creation of new and amendments to existing provider and patient education materials.
  o Execution of contract amendments, as appropriate across various delivery systems

• **Initiating Stakeholder Engagement**
DHCS Telehealth Links

• Medi-Cal and Telehealth website: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx

• DHCS Telehealth Trailer Bill and Fact Sheet: https://www.dhcs.ca.gov/Pages/LGA.aspx

Thank you!
Panel Q&A

Please submit questions using the Q&A function.
Thank You!

Connecticut Department of Social Services
Kate McEvoy, JD, Director of Health Services, Connecticut Department of Social Services

California Department of Health Care Services
Rene Mollow, MSN, RN, Deputy Director, California Department of Health Care Services, Health Care Benefits and Eligibility
Subscribe to CCHP’s email listserv or stay tuned to CCHP’s resources page for recordings of this webinar and presentation slide decks!
Kansas Department of Health and Environment, Division of Health Care Finance
Fran Seymour-Hunter, Interagency Liaison

Massachusetts
Clara Filice, MD, MPH, MHS, Deputy Chief Medical Officer, MassHealth

Texas Health and Human Services Commission
Erin McManus, MPAff, Senior Policy Advisor, Medical Benefits, Medicaid/CHIP Services Department
Tamra Boyd-Ostrout, LMSW, Behavioral Health Policy Analyst for Medical Benefits, Medicaid/CHIP Services Department
Thank You!

www.cchpca.org
info@cchpca.org