§ 1374.14. Telehealth services reimbursement

(a)(1) A contract between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(b)(1) A health care service plan contract shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan

to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

HISTORY:

Added Stats 2019 ch 867 § 3 (AB 744), effective January 1, 2020. Amended Stats 2021 ch 439 § 4 (AB 457), effective January 1, 2022.

§ 1374.141. Conditions for third-party telehealth service offer by health care service plan

(a) If a health care service plan offers a service via telehealth to an enrollee through a third-party corporate telehealth provider, all of the following conditions shall be met:

(1) The health care service plan shall disclose to the enrollee in any promotion or coordination of the service both of the following:

(A) The availability of receiving the service on an in-person basis or via telehealth, if available, from the enrollee's primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards in Sections 1367 and 1367.03 and regulations promulgated thereunder.

(B) If the enrollee has coverage for out-of-network benefits, a reminder of the availability of receiving the service either via telehealth or on an in-person basis using the enrollee's out-of-network benefits, and the cost sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted providers.

(2) After being notified pursuant to paragraph (1), the enrollee chooses to

receive the service via telehealth through a third-party corporate telehealth provider.

(3) The enrollee consents to the service consistent with Section 2290.5 of the Business and Professions Code.

(4) If the enrollee is currently receiving specialty telehealth services for a mental or behavioral health condition, the enrollee is given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.

(b) For purposes of this section, the following definitions apply:

(1) "Contracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services, including mental and behavioral health services, and who is contracted with or employed by the enrollee's health care service plan as a network provider. A "contracting individual health professional" shall not include a dentist licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a contracting individual health professional's affiliation with a group.

(2) "Contracting clinic" means a clinic, as defined in Section 1200, that is contracted with or owned by the enrollee's health care service plan and as a network provider.

(3) "Contracting health facility" means a health facility, as defined in Section 1250 and paragraph (1) of subdivision (f) of Section 1371.9, that is contracted with or operated by the enrollee's health care service plan and serves as a network provider.

(4) "Third-party corporate telehealth provider" means a corporation directly contracted with a health care service plan that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

(c) If services are provided to an enrollee through a third-party corporate telehealth provider, a health care service plan shall comply with all of the following:

(1) Notify the enrollee of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.

(2) Notify the enrollee that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their primary care provider, unless the enrollee objects.

(3) Ensure that the records are entered into a patient record system shared with the enrollee's primary care provider or are otherwise provided to the enrollee's primary care provider, unless the enrollee objects, in a manner consistent with state and federal law.

(4) Notify the enrollee that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

(d) A health care service plan shall include in its reports submitted to the department pursuant to Section 1367.035 and regulations adopted pursuant to that section, in a manner specified by the department, all of the following for each product type:

(1) By specialty, the total number of services delivered via telehealth by third-party corporate telehealth providers.

(2) The names of each third-party corporate telehealth provider contracted with the plan and, for each, the number of services provided by specialty.

(3) For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party corporate telehealth provider's contracted providers available to the plan's enrollees that are also contracting individual health professionals.

(4) For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by enrollees, including frequency of use, gender, age, and any other information as determined by the department.

(5) For each enrollee that has accessed services for a third-party corporate telehealth provider, enrollee demographic data, including gender and age, and any other information as determined by the department.

(e) The director shall investigate and take enforcement action, as appropriate, against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and third-party corporate telehealth providers to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(f) If a health care service plan delegates responsibilities under this section to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(g) This section shall not apply when an enrollee seeks services directly from a third-party corporate telehealth provider.

(h) This section shall not apply to a health care service plan contract or a Medi-Cal managed care plan contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall consider the appropriateness of applying the requirements of this section, in whole or in part, to the Medi-Cal program pursuant to the advisory group process described in paragraph (2) of subdivision (f) of Section 14124.12 of the Welfare and Institutions Code.

HISTORY:

Added Stats 2021 ch 439 § 5 (AB 457), effective January 1, 2022.