ASSEMBLY THIRD READING
AB 32 (Aguiar-Curry and Robert Rivas)
As Amended May 24, 2021
Majority vote

## SUMMARY

Expands coverage of telehealth to require health plans and health insurers to cover audio only (telephone), and to reimburse for services delivered using telephone at the same payment rate as in-person visits. Continues some telehealth payment and enrollment flexibilities put in place by the Department of Health Care Services (DHCS) for the Medi-Cal program during the COVID-19 pandemic.

**Major Provisions**

1) Expands the definition of synchronous interaction for purposes of the definition of telehealth to include audio-video, audio-only, and other virtual communication.

2) Requires health plans and insurers to reimburse for audio-video, audio-only and other virtual communication on the same basis and to the same extent that the plan/insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment (referred to as "payment parity").

3) Extends payment parity to Medi-Cal managed care (MCMC) plans for telehealth (as defined under existing law) and for audio-video, audio-only, and other virtual communication, and for Medi-Cal clinic visits.

4) Requires DHCS to reimburse each federally qualified health center (FQHC) and rural health clinic (RHC) for health care services furnished through audio-only telehealth, including telephone, at the applicable prospective payment system (PPS) per-visit rate, consistent with this bill, until the earlier of January 1, 2025, or the date that the FQHC or RHC elects to participate in an alternative payment methodology (APM).

5) Requires DHCS, in consultation with affected stakeholders, to develop one or more federally permissible APM that FQHCs and RHCs may elect to participate in. Requires, to the extent that an APM includes a separate per-visit payment rate for audio-only telehealth visits, that payment rate to be less than the rate the FQHC or RHC receives for an in-person visit, except requires specified mental health services to continue to be reimbursed at the applicable PPS per-visit rate indefinitely, except if the FQHC or RHC elects an APM that covers those services.

6) Requires specified mental health services furnished through audio-only telehealth, to continue to be reimbursed at the applicable PPS per-visit rate indefinitely, except if the FQHC or RHC elects an APM that covers those services.

7) Prohibits the DHCS from restricting the ability of an enrolled clinic to provide and be reimbursed for Medi-Cal services furnished through telehealth, as specified.

8) Permits a health care provider to enroll or recertify an individual remotely through telehealth and other virtual communication modalities, including telephone, based on the current Medi-Cal program eligibility form or forms applicable to the specific program for the Family Planning, Access, Care, and Treatment (Family PACT), Presumptive Eligibility for Pregnant Women, and Every Woman Counts programs.

9) Permits a county eligibility worker to determine eligibility for, or recertify eligibility for, an individual remotely through virtual communication modalities, including telephone for the Medi-Cal Minor Consent program.

10) Requires DHCS to convene an advisory group to provide input to DHCS on the development of a revised Medi-Cal telehealth policy, and requires DHCS to complete an evaluation to assess the benefits of telehealth.

## COMMENTS

*DHCS TELEHEALTH PROPOSAL*. On February 2, 2021, DHCS released its "Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations: Public Document" which is its post-COVID telehealth policy recommendations and proposed trailer budget bill language was also posted on the Department of Finance website. The DHCS recommendations are only for Medi-Cal and not for commercial coverage. DHCS indicates it is looking to modify or expand the use of synchronous telehealth, asynchronous telehealth, telephonic/audio-only, other virtual communication systems and to add remote patient monitoring (such as continuous glucose monitors) as a Medi-Cal benefit. DHCS issued revised trailer bill language in May 2021. The main difference between this bill and the DHCS proposal is DHCS does not propose to pay for telephone visits at parity (the revised trailer bill language requires reimbursement at 65% of the equivalent office visit rate) and DHCS propose to permit FQHCs and RHC to bill for telephone services at a rate comparable to to the telephone rate for non-FQHC providers (a rate lower than the center's PPS rate). In addition, DHCS does not address payment for telephone services at parity in commercial health plan and insurance coverage.

**According to the Author**
The COVID-19 Pandemic has made abundantly clear what we have known for decades – our most vulnerable and marginalized communities continue to struggle for affordable and reliable access to healthcare. This bill will extend the telehealth flexibilities that were put in place during the COVID-19 Pandemic, which have been vital to ensuring that health centers can continue providing services. More specifically this bill will ensure that telehealth, including telephonic and video care, are available to patients regardless of who they are, their insurance, what language they speak, or the barriers they may face, such as geographic, transportation, childcare, or the ability to take time off from work.

**Arguments in Support**
This bill is jointly sponsored by the California Health+ Advocates, the California Medical Association, Essential Access Health, the California Association of Public Hospitals and Health Systems and Planned Parenthood Affiliates of California and supported by health care provider and patient advocacy groups. Generally, supporters argue telehealth has been an important way for patients to access care during the pandemic and it will be critical to post-pandemic care.

Telehealth decreases barriers, increases access to care for patients, and reduces no-show rates significantly. More importantly, telephonic (audio only) care has become a reliable modality of care. Due to inadequate broadband infrastructure and high costs of internet access and computing devices, one in eight California households lacks internet access. Many California households still rely on basic cell phones, do not have video capability, or do not have unlimited data for streaming videos. In sharing their preference for phone visits, some Medi-Cal patients and older patients have noted discomfort when required to utilize video modalities for care. Supporters argue that it is timely and necessary to update our state laws, to reflect our state values, and ensure that patients do not lose the access to care they have had during the pandemic.

**Arguments in Support if Amended**
The Los Angeles Unified School District seeks an amendment that would clarify that school districts can also take advantage of the policy this bill seeks to accomplish. The Centers for Autism and Related Disorders (CARD) writes that, during the public health emergency, flexibilities have been granted to allow services by qualified autism service paraprofessionals who often provide direct one-on-one treatment. CARD requests this bill be amended to continue the flexibility that permit qualified autism service paraprofessionals to deliver services via telehealth.

Health Access California (HAC) writes that, while it supports ongoing expansion of telehealth modalities, is has have emphasized the need to proceed in a manner that centers consumer interests and a data-driven approach as we move forward. HAC suggests additional amendments to ensure consumer choice is not sacrificed as a result of telehealth expansions, and to ensure strong data evaluation requirements. Specifically, HAC requests language to specify that consumers may always opt for in-person care, even if previously they elected to receive services via telehealth, to apply evaluation requirements for telehealth services delivered to consumers in the commercial market as well as those in MCMC plans, and to strengthen requirements to include full evaluation of the impact telehealth has had on delivery, access, and quality of healthcare, including health outcomes, and how telehealth has impact diverse communities.

**Arguments in Opposition**
The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC) and America's Health Insurances Plans (AHIP) write in opposition to this bill and 13 other bills. CAHP, ACLHIC and AHIP write that these 14 bills will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage. The opponents argue that now is not the time to inhibit competition with proscriptive mandates that reduce choice and increase costs, and conclude that California needs to protect the coverage gains we've made and stay focused on the stability and long-term affordability of our health care system.

**Arguments in Opposition Unless Amended**
The California Chamber of Commerce (Chamber) writes that it is opposed to the bill unless it is amended. The Chamber writes that telehealth is rapidly expanding due to its convenience, safety, accessibility, and affordability, and that employers, health plans and insurers collaborate to design innovative solutions that increase access to care, improve the quality of care, and reduce the cost of care delivery. Unfortunately, this bill's current definition of telehealth will increase the cost of care delivery since it places no parameters on the telephone-only parity provision. The

Chamber argues a clear definition is needed for exactly which virtual/remote services will be placed at parity with in-person presentations and to what extent they will be at parity. Without this guardrail, the Chamber argues this bill will come with an unmanageable price tag for struggling businesses and consumers.

## FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) The California Health Benefits Review Program (CHBRP) states that some telehealth services replace existing in-person visits, while others are new supplemental visits that would not have taken place in the absence of telehealth coverage. As the supplemental visits increase overall utilization of health care services, this bill increases health care costs as follows:

    a) Total state costs as follows:

        i) $136.5 million total funds ($49 million General Fund (GF)) to Medi-Cal managed care. $24.5 million of this total funds cost ($9 million GF) is attributable to the increase in coverage and payment parity requirements for telehealth services provided by FQHCs and RHCs. The General Fund calculation assumes a federal financial participation (FFP, or federal matching percentage) of 64%, the same as that calculated for the Remote Patient Monitoring proposal in the Medi-Cal November 2020 Local Assistance Estimate.

        ii) $42.6 million ($15 million GF) for services delivered to beneficiaries enrolled in Medi-Cal County Organized Health Systems and Medi-Cal fee-for-service.

        iii) $1.1 million to The California Public Employees' Retirement System (CalPERS) for premium increases, $624,000 of which would be borne by the General Fund, federal funds and various special funds, with the remainder borne by local funds.

    b) Total non-state costs as follows:

        i) $39.6 million in commercial health care premium increases paid by non-CalPERS employers.

        ii) $21.9 million in premium increases, and $41.7 million in increased cost-sharing, paid by individuals and employees.

    c) CHBRP does not identify cost offsets or savings as a result of this bill because it requires payment parity with in-person services and results in increased utilization. CHBRP notes it is unlikely the actual cost of staff, technology and resources used to deliver services via telehealth are less expensive than in-person care.

2) There is a significant amount of uncertainty related to cost estimates. Costs may be higher or lower than estimated by CHBRP. In particular, DHCS estimates potential costs due to the

payment parity requirement are indeterminate but could be as high as $300 million total funds annually (about $100 million GF annually), higher than CHBRP estimates.

3) Administrative costs to DHCS to develop an alternative payment methodology for clinics, likely in the hundreds of thousands of dollars (GF and federal funds). To implement SB 147 (Hernandez), Chapter 760, Statutes of 2015, a prior bill that authorized a pilot project to deploy an alternative payment methodology for FQHCs, DHCS requested three-year limited-term positions and spending authority of $240,000 per year for three years and a $300,000 contract for evaluation

4) One-time staff or contract costs to DHCS of $50,000 (GF and federal funds) to support facilitation of an advisory board to provide input to telehealth policies. Costs would be higher if the facilitator was asked to draft recommendations or policies.

5) Unknown potential Medi-Cal costs for increased number of beneficiaries associated with the option for remote eligibility determinations and recertifications, which should reduce the frictional costs of gaining and retaining Medi-Cal eligibility (GF and federal funds).

## VOTES

**ASM HEALTH: 13-0-2**
**YES:** Wood, Aguiar-Curry, Bigelow, Burke, Carrillo, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago, Waldron, Calderon
**ABS, ABST OR NV:** Mayes, Flora

**ASM APPROPRIATIONS: 16-0-0**
**YES:** Lorena Gonzalez, Bigelow, Calderon, Carrillo, Chau, Megan Dahle, Davies, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Holden, Luz Rivas

## UPDATED

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