SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: AB 32
AUTHOR: Aguiar-Curry
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SUBJECT: Telehealth

SUMMARY: Expands the definition of telehealth to include telephone and other virtual communication. Requires medical groups delegated by health plans to comply with telehealth payment parity. Extends telehealth payment parity to Medi-Cal managed care and allows remote eligibility determinations, enrollment, and recertification for Medi-Cal and specified Medi-Cal programs. Requires the Department of Health Care Services to convene a telehealth policy advisory committee and conduct an evaluation of the benefits of telehealth. Makes other policy changes related to telehealth reimbursement for federally qualified health centers, rural health centers and other Medi-Cal enrolled clinics.

Existing law:

1) Requires before the delivery of health care via telehealth, the health care provider initiating the use of telehealth to inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health, and requires the consent to be documented. [BPC §2290.5]

2) Defines "telehealth" as 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 patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. [BPC §2290.5]

3) Defines "Synchronous interaction" as a real-time interaction between a patient and a health care provider located at a distant site. [BPC §2290.5]

4) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

5) Requires a contract between a health plan/health insurer and a health care provider to specify that the health plan/health insurer 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 plan/insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment (referred to as telehealth payment parity requirements). [HSC §1374.14 and INS §10123.855]

6) Establishes the Health Care Providers' Bill of Rights, which specifies specified contract terms between health plans/insurers and health care providers, including that a plan/dental insurer does not have the authority to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan/dental insurer, as specified. [HSC §1375.7 and INS §10133.65]

7) Exempts counties contracting with DHCS for the Medi-Cal managed care expansion to rural counties from the Knox-Keene Act. [WIC §14087.95]

8) Requires a FQHC or RHC "visit" to mean a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse, and other providers, as specified. [WIC §14132.100]

9) Prohibits face-to-face contact or a patient's physical presence on the premises to be required for services provided by an enrolled community clinic to a Medi-Cal beneficiary during or immediately following a state of emergency, as described in existing law.[WIC §14132.723]

10) Requires the following services to be reimbursable when provided by an enrolled community clinic, an enrolled FFS Medi-Cal program provider, clinic, or facility approved by DHCS during or immediately following a state of emergency for any dates of service on or after the date that the department obtains federal approvals and federal matching funds to implement these provisions:
    a) Telehealth services, including services provided by the enrolled community clinic or approved enrolled provider, clinic, or facility at a distant site location, whether on or off the premises, to a Medi-Cal beneficiary located at an originating site, which includes the beneficiary's home, temporary shelter, or any other location, if the services are provided somewhere located within the boundaries of the proclamation declaring the state of emergency.
    b) Telephonic services.
    c) Covered benefit services that are otherwise reimbursable to an FQHC or RHC, but that are provided somewhere off the premises, including, but not limited to, at a temporary shelter, a Medi-Cal beneficiary's home, or any location other than the premises, but within the boundaries of the proclamation declaring the state of emergency. [WIC §14132.723]

11) Requires DHCS to ensure its reimbursement policies reflect the intent of the Legislature to authorize reimbursement for telehealth services appropriately provided by an enrolled community clinic, or, if approved by DHCS, by an enrolled FFS Medi-Cal provider, clinic, or facility, respectively, during or immediately following a state of emergency. This does not limit reimbursement for, or coverage of, or reduce access to, services provided through telehealth on or before the enactment of this section. [WIC §14132.723]

This bill:

1) Revises the definition of "synchronous interaction" to include, but not be limited to, audio-video, audio only, such as telephone, and other virtual communication.

2) Requires if a health plan/health insurer delegates responsibility to a contracted entity, including a medical group or independent practice association, then the delegated entity must

comply with telehealth payment parity requirements pursuant to existing law.

3) Requires the obligation of a health plan/health insurer to comply with telehealth payment parity requirements pursuant to existing law not to be waived if the plan/insurer delegates services or activities that the plan/insurer is required to perform to its provider or another contracting entity. Requires a plan's/insurer's implementation to be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's/insurer's contracting network providers to be considered a material change to the provider contract, as specified.

4) Requires a county contracting with DHCS for the Medi-Cal managed care expansion to rural counties, and a subcontractor of a county contracting to provide Medi-Cal services, to comply with telehealth payment parity requirements.

5) Permits for the Family Planning, Access, Care, and Treatment, Presumptive Eligibility for Pregnant Women, and Every Woman Counts programs, a 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.

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

7) Permits DHCS to develop program policies and systems to support implementation of remote eligibility determination, enrollment, and recertification.

8) Permits DHCS to implement, interpret, or make specific this bill by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

9) Defines "enrolled clinic" as a licensed clinic, intermittent clinic exempt from licensure, a hospital or nonhospital-based clinic operated by the state or any of its political subdivisions, including the University of California, or a city, county, city and county, or hospital authority, and a tribal clinic exempt from licensure, or an outpatient setting conducted, maintained, or operated by a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in federal law.

10) Requires health care services furnished by a Medi-Cal enrolled clinic through telehealth to be reimbursed by Medi-Cal on the same basis, to the same extent, and at the same payment rate as those services are reimbursed if furnished in person.

11) Prohibits DHCS from restricting the ability of an enrolled clinic to provide and be reimbursed for services furnished through telehealth and having policies that require all of the clinical elements of a service to be met as a condition of reimbursement. Includes as prohibited restrictions all of the following:

    a) Requirements for face-to-face contact between an enrolled clinic provider and a patient.

    b) Requirements for a patient's or provider's physical presence at the enrolled clinic or any other location.

c) Requirements for prior in-person contacts between the enrolled clinic and a patient.

d) Requirements for documentation of a barrier to an in-person visit or a special need for a telehealth visit.

e) Policies, including reimbursement policies, that impose more stringent requirements on telehealth services than equivalent services furnished in person.

f) Limitations on the means or technologies through which telehealth services are furnished. This paragraph does not prohibit policies that require compliance with applicable federal and state health information privacy and security laws.

12) Includes in the definition of "visit" for purposes of Medi-Cal reimbursement of FQHCs and RHCs a telehealth encounter to the same extent as an in-person encounter.

13) Requires Medi-Cal managed care plans to comply with telehealth payment parity requirements. Prohibits Medi-Cal managed care plans from being required to pay FQHCs and RHCs the same amount for audio-only telehealth visits as equivalent in-person visits on or after January 1, 2025. Applies this to the extent consistent with federal Medicaid requirements that a managed care plan provide payment for services furnished by a FQHC and RHC that is not less than the level and amount of payment the managed care plan would make for the services if the services were furnished by a provider that is not a FQHC or RHC.

14) Requires DHCS to seek any necessary federal approvals and obtain federal financial participation (FFP) in implementing this bill, and this bill to be implemented only to the extent that any necessary federal approvals are obtained and FFP is available and not otherwise jeopardized.

15) Requires DHCS to reimburse each FQHC and RHC for health care services furnished through audio-only telehealth, including telephone, at the applicable prospective payment system 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) described 23) below.

16) Requires mental health services that are excluded from the benefits provided by county mental health plans under the specialty mental health services waiver, furnished through audio-only telehealth, to continue to be reimbursed at the applicable prospective payment system per-visit rate indefinitely, except if the FQHC or RHC elects an APM that covers those services.

17) Requires by January 2022, DHCS to convene an advisory group to provide input to DHCS on the development of a revised Medi-Cal telehealth policy that promotes all of the following principles:
   a) Telehealth shall be used as a means to promote timely and patient-centered access to health care.
   b) Patients, in conjunction with their providers, shall be offered their choice of service delivery mode. Patients shall retain the right to receive health care in person.
   c) Confidentiality and security of patient information shall be protected.

d) Usual standard of care requirements shall apply to services provided via telehealth, including quality, safety, and clinical effectiveness.

18) Requires the advisory group to include representatives from community health centers, designated public hospitals, Medi-Cal managed care plans, consumer groups, labor organizations, behavioral health providers, counties, health care districts, and other Medi-Cal providers. Requires DHCS to utilize any potential federal funding or other nonstate general funding that may be available to support this effort.

19) Requires DHCS to consider disparities in the utilization of, and access to, telehealth, and to support patients and providers in increasing access to the technologies needed to use telehealth.

20) Requires when the care provided during a telehealth visit is commensurate with what would have been provided in person, payment to also be commensurate.

21) Requires by July 2024, DHCS to complete an evaluation to assess the benefits of telehealth in Medi-Cal. Requires the evaluation to analyze improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth, and DHCS to utilize any potential federal funding or other nonstate general funding that may be available to support the implementation of this effort.

22) Requires DHCS to provide data and information to the evaluator, as appropriate, and report its findings and recommendations on the evaluation to the appropriate policy and fiscal committees of the Legislature no later than October 31, 2024.

23) Requires DHCS, in consultation with affected stakeholders, including, but not limited to, the California Association of Public Hospitals and Health Systems and the California Primary Care Association, to develop one or more federally permissible APM, consistent with federal law, that FQHCs and RHCs may elect to participate in.

24) Requires the APMs to be designed to enable the continued provision of high-quality health care, while furthering the goals of the Medi-Cal program to improve access and equity, and incentivize and support clinic infrastructure improvements.

25) 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 and RHC receives for an in-person visit. Exempts mental health services furnished through audio-only telehealth that are excluded from the benefits provided by county mental health plans under the specialty mental health services waiver.

26) Requires DHCS to submit and seek federal approval of the state plan amendment necessary for the implementation to be effective no later than January 1, 2025, and this to be implemented only to the extent that any necessary federal approvals are obtained and FFP is available and not otherwise jeopardized.

FISCAL EFFECT: 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 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 (FFS).

   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)

PRIOR VOTES:

Assembly Floor:	78 - 0
Assembly Appropriations Committee:	16 - 0
Assembly Health Committee:	13 - 0

COMMENTS:

1) *Author's statement.* 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.

2) *COVID-19 emergency.* On March 11, 2020 the novel Coronavirus (COVID-19) was declared a global pandemic which set in motion declared public health emergencies across the United States. The COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020). On March 16, 2020 Governor Gavin Newsom announced that the state asked federal officials to make it easier for California to quickly and effectively provide care to about 13 million Medi-Cal beneficiaries as California works to protect the public from COVID-19. Specifically, the letter requested to ease certain federal rules governing doctors and other health care providers who treat people covered through Medi-Cal, and loosen rules regarding the use of telehealth and where care can be provided, making it simpler to protect seniors and other populations at high risk for harm if exposed to the virus. The DHCS letter to the federal Centers for Medicare & Medicaid Services (CMS) asked that the rules be waived under Section 1135 of the Social Security Act. The March 13th declared national emergency over COVID-19 allowed DHCS to seek the waiver. Under this authority and also through a California Medicaid State Plan amendment (SPA # 20-0024) was approved by CMS in May of 2020.

3) *DHCS Telehealth Policy.* According to DHCS, temporary policy changes during the COVID-19 public health emergency include:
   a) 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, Local Education Agency and Targeted Case Management services;
   b) Allowing most telehealth modalities to be provided for new and established patients
   c) Allowing many covered services to be provided via telephone/audio-only for the first time;
   d) 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, including FQHCs and RHCs in both FFS and managed care;

e) Waiving site limitations for both providers and patients for FQHC and RHCs, which allows providers and/or beneficiaries to be in locations outside of the clinic to render and/or receive care, respectively; and,

f) Allowing for expanded access to telehealth through non-public technology platforms. This "good faith" exemption was granted by the federal Office for Civil Rights, which would otherwise not be allowed under federal Health Insurance Portability and Accountability Act requirements.

Both physical and behavioral health providers responded rapidly to the COVID-19 public health emergency and widely pivoted to provide services via synchronous telehealth and telephonic/audio-only modalities. 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. The COVID-19 public health emergency has led to the adoption of the use of telehealth modalities at an accelerated pace that had been unthinkable prior to the public health emergency. 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

4) *California Health Benefits Review Program (CHBRP) analysis.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. Key findings include:

   a) *Coverage impacts and enrollees covered*. At baseline, 100% of enrollees with commercial or CalPERS health insurance that would be subject to this bill have coverage for live video telehealth services, whereas 80.4% of enrollees have coverage for telephone services. Approximately 7% of enrollees in CalPERS HMOs do not have benefit coverage for telehealth delivered via telephone. This bill would require commercial and CalPERS health plans and policies to provide new benefit coverage for telephone telehealth services for 19.6% of enrollees. At baseline, 100% of Medi-Cal managed care beneficiaries have existing benefit coverage for live video services. However, 73.5% of beneficiaries in DMHC-regulated Medi-Cal managed care plans have coverage for synchronous telephone services. This bill would require Medi-Cal managed care plans, County Organized Health Systems (COHS), and the FFS program to provide new benefit coverage for synchronous telephone services for 26.5% of beneficiaries.

   b) *Medical effectiveness.* Most studies pertinent to this analysis examine the use of telehealth modalities as a substitute for in-person care. In these cases, the relevant studies evaluated whether care provided via these technologies resulted in equal or better outcomes and processes of care than care delivered in person, and whether use of these technologies improved access to care. Some studies assessed the effects of telehealth as a supplement to in-person care; these studies evaluated whether adding these technologies improves processes of care and health outcomes relative to receiving in-person care alone. To examine whether services delivered via telehealth are of the same quality as in-person services, CHBRP examined three sets of outcomes: 1) health outcomes, including both physiological measures and patient-reported outcomes; 2) process of care outcomes,

including treatment adherence and accuracy of diagnoses and treatment plans; and 3) access to care and utilization outcomes, such as wait time for specialty care, or number of outpatient visits, emergency department visits, and hospitalizations. CHBRP found that evidence regarding whether telehealth modalities and services result in equal or better outcomes than care delivered in person is mixed, depending on the disease and condition, telehealth modality, and type of outcome studied: health outcomes, process of care, or use of other services. Because telehealth studies have only focused on a limited number of diseases and conditions, the findings may not be generalizable outside of the specific diseases and conditions studied.

i) For Live Video: There is preponderance of evidence that care delivered by live video is at least as effective as in-person care for health outcomes for several conditions and health care settings, including infectious disease, obesity, diabetes, and abortion. There is clear and convincing evidence that mental health services for attention deficit/hyperactivity disorder (ADHD) depression, and posttraumatic stress disorder (PTSD) delivered by live video are at least as effective as in-person care for processes of care and health outcomes. There is clear and convincing evidence that dermatology diagnoses made via live video are as accurate as diagnoses made during in-person visits. There is a preponderance of evidence that scores on neurocognitive tests administered via live video are similar to scores obtained when tests are administered in person. Studies have also found diagnostic concordance between live video and in-person examination for shoulder disorders, otolaryngology, and fetal alcohol syndrome. There is a limited evidence that care delivered by live video is at least as effective as in-person care for access to care and utilization.

ii) For Telephone: For the diseases and conditions studied, the preponderance of evidence from studies of the effect of telephone consultations suggests that telephone consultations were at least as effective as in-person consultations on health outcomes. For the diseases and conditions studied, findings from studies of the effect of telephone consultations on processes of care and access to care and utilization are inconsistent; therefore, the evidence that medical care provided by telephone compared to medical care provided in person is inconclusive.

iii) Comparing Live Video to Telephone: There is a preponderance of evidence that behavioral health services delivered by live video are comparable to services delivered by telephone consultation on health outcomes. CHBRP found no studies that compared live video to telephone consultation on outcomes for processes of care and access to care and utilization of health services.

c) *Utilization*. Of the new telehealth visits provided postmandate, CHBRP estimates that supplemental services will represent 50% of additional telehealth services and 50% will replace in-person care due to the ongoing effects of the pandemic and reticence by patients to seek in-person care.

d) *Medi-Cal*. In addition to the estimated $136,534,000 increase in premiums for the 8.05 million Medi-Cal beneficiaries enrolled in DMHC-regulated Medi-Cal managed care plans, a proportional increase of $42.62 million is estimated to occur for the beneficiaries enrolled in COHS managed care and the FFS program. CHBRP assumes the two populations to be relatively similar and to have relatively similar benefit coverage. Of the $136,534,000 increase in Medi-Cal managed care expenditures, $134,005,000 would be due to parity requirements and $2,529,000 would be due to new coverage of telehealth services. Additionally, of the $136,534,000 increase in expenditures, $24,450,000

(0.10%) would be due to the increase in coverage and parity requirements for telehealth services provided by FQHCs/RHCs.

e) *Impact on expenditures*. This bill would increase total net annual expenditures by $240,827,000, or 0.18%, for enrollees with DMHC-regulated plans, CDI-regulated policies, and DMHC-regulated Medi-Cal managed care plans. This is due to an increase in total health insurance premiums paid by DMHC-regulated large-group plans ($0.29 per member per month [PMPM]), small-group plans ($0.77 PMPM), individual market plans ($0.20 PMPM), CalPERS HMOs ($0.13 PMPM), Medi-Cal managed care plans for age under 65 years ($1.42 PMPM), Medi-Cal managed care for ages 65 and over ($1.41 PMPM), CDI-regulated large-group ($1.32 PMPM), and CDI-regulated individual market ($0.95 PMPM) policies. The largest increases in expenditures were in Medi-Cal managed care for age under 65 (0.63%), Medi-Cal managed care for age 65+ (0.30%), and CDI-regulated large group (0.26%). CHBRP does not project any cost offsets or savings in expenditures that would result because of the enactment of provisions in this bill.

f) *Public health*. This bill would increase access to health care by reducing transportation barriers to in-person care by covering telephone (audio only) visits. This bill would also increase health care options and reduce travel costs and travel time for those enrollees who use the newly covered telephonic visits or reimbursable live video visits with FQHC/RHC providers. These enrollees and Medi-Cal beneficiaries may have equivalent or better outcomes (compared with in-person care) because they would no longer delay or avoid in-person visits because of travel difficulties. For those rural (and some urban) enrollees and Medi-Cal beneficiaries who have no broadband connectivity (due to lack of infrastructure in remote areas or cost of service or devices), a landline telephone would remain a viable telehealth modality, resulting in equivalent or better outcomes (compared with in-person care).

5) *FQHC and RHC APM Pilot*. SB 147 (Hernandez, Chapter 760, Statutes of 2015) authorized a three-year APM pilot program for county and community-based FQHCs willing to participate in the pilot program. The purpose of SB 147 to incentivize delivery system and practice transformation at FQHCs through flexibilities available under a capitated model which would move the clinics away from the traditional volume-based, PPS, to a payment methodology that better aligns the evolving financing and delivery of health services. The proposed APM structure provides participating FQHCs the flexibility to deliver care in the most effective manner, without having to worry about the more restrictive traditional billing structure that is in place today. With the flexibility of payment reform, FQHCs will begin to provide and/or expand upon the innovative forms of care which are not reimbursed under traditional volume-based PPS. This pilot has not been implemented.

6) *Budget Act of 2021-22*. As part of the budget, DHCS requested trailer bill language to extend permanent flexibilities for the delivery of certain Medi-Cal benefits through telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities, to establish a rate for audio-only telehealth services at 65% of the FFS rate, and a comparable alternative to the prospective payment system rates for clinics to maintain an incentive for in-person care. This issue was rejected by the Senate Budget Health and Human Services Subcommittee #3 and instead the subcommittee adopted modified placeholder trailer bill language to align with the provisions of this bill.

7) *Related legislation.* AB 133 (Assembly Committee on Budget), *pending in the Senate Committee on Budget and Fiscal Review,* and SB 133 (Senate Committee on Budget and Fiscal Review), *pending in the Assembly Committee on Budget,* are omnibus health trailer bills, that include a requirement that DHCS seek federal approvals to extend the Public Health Emergency-approved flexibilities related to the delivery and reimbursement of services via telehealth modalities until December 31, 2022, and convene an advisory group to provide recommendations to inform DHCS on establishing and adopting billing and utilization management protocols for telehealth modalities. AB 133/SB 133 also authorize DHCS to enter into contracts or amend existing contracts, for purposes of implementing these provisions and exempts those contracts from specified provisions of law.

8) *Prior legislation.* AB 2164 (Robert Rivas of 2020) would have required a "visit" for purposes of reimbursement by Medi-Cal to include a visit by an FQHC/RHC patient and a health care provider using telehealth through synchronous interaction (face to face over video) or asynchronous store and forward (the sending of images such as x-rays to a health care provider), and would have authorized a FQHCs and RHCs to establish a patient, located within the federal designated service area of the FQHC and RHC, through synchronous interaction or asynchronous store and forward as of the date of service. Would have permitted DHCS to implement, interpret, and make specific the Medi-Cal telehealth provisions of this bill by means of all-county letters, provider bulletins, and similar instructions, and required the adoption of regulations by July 1, 2022. AB 2164 would have sunset 180 days after the state of emergency for the COVID-19 pandemic has been terminated by proclamation of the Governor or by concurrent resolution of the Legislature. AB 2164 was vetoed by the Governor. In his veto message, the Governor writes:

   > *While I am supportive of utilizing telehealth to increase access to primary and specialty care services, DHCS is currently in the process of evaluating its global telehealth policy to determine what temporary flexibilities should be extended beyond the COVID-19 pandemic. Changes to FQHC and RHC telehealth is better considered within the context of a global assessment around telehealth in the state of California. Further, the cost of these changes is also more appropriately considered alongside other policy changes in the budget process next year.*

   AB 744 (Aguiar-Curry, Chapter 867, Statutes of 2019) requires health care contracts after January 1, 2021, to specify that the health plan or insurer is required to cover and reimburse diagnosis, consultation, or treatment delivered through telehealth on the same basis and to the same extent that the plan or insurer is responsible for coverage and reimbursement for the same service provided through in-person diagnosis, consultation, or treatment. Revises Medi-Cal telehealth requirements so that the law prohibits face-to-face contact between a health care provider and a Medi-Cal patient for health care services that are appropriately provided by store and forward, to the extent that FFP is available, subject to billing and reimbursement policies developed by DHCS.

   AB 1494 (Aquiar-Curry, Chapter 829, Statutes of 2019) prohibits face-to-face contact or a patient's physical presence on the premises of an enrolled community clinic, as specified, to be required for services provided to a Medi-Cal beneficiary during or immediately following a state of emergency. Requires DHCS on or before July 1, 2020, to issue and publish on its Website guidance to facilitate reimbursement for services provided by enrolled community clinics to a Medi-Cal beneficiary during or immediately following a state of emergency.

AB 1174 (Bocanegra, Chapter 662, Statutes of 2014) expands the scope of practice for a registered dental assistant in extended functions, registered dental hygienist, and registered dental hygienist in alternative practice to better enable the practice of teledentistry in accordance with the findings of a Health Workforce Pilot Program, and authorizes Medi-Cal payments for teledentistry services provided to individuals participating in the Medi-Cal program.

AB 415 (Logue, Chapter 547, Statutes of 2011) establishes the Telehealth Advancement Act of 2011 to revise and update existing law to facilitate the advancement of telehealth as a service delivery mode in managed care and the Medi-Cal Program.

6) *Support if amended.* Health Access California writes that while they support ongoing expansion of telehealth modalities, they have emphasized the need to proceed in a manner that centers consumer interests with a data-driven approach. Health Access California suggests additional amendments as follow to ensure consumer choice is not sacrificed as a result of telehealth expansions, and to ensure strong data evaluation requirements:
   a) Add language to Health and Safety Code and Insurance Code to specify that consumers may always opt for in-person care, even if previously that elected to receive services via telehealth.
   b) Apply evaluation requirements for telehealth services delivered to consumers in the commercial market as well as those in Medi-Cal managed care plans, and 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.

   The Center for Autism and Related Disorders (CARD) writes existing law allows for telehealth to be provided by qualified autism providers and qualified autism service professionals. However, 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, and we respectfully urge an amendment to continue the flexibility that permits qualified autism service paraprofessionals to deliver services via telehealth.

   The Los Angeles Unified School District Los Angeles Unified seeks an amendment that would clarify that school districts can also take advantage of the policy this bill seeks to accomplish.

7) *Support*. Essential Access Health, a cosponsor of this bill writes, telehealth has become a crucial pathway for patients to access care during the pandemic and will remain so beyond the public health emergency period. Access to telehealth decreases barriers, increases access to care for patients, and reduces no-show rates significantly. Telephonic care in particular has become a reliable modality of care. Recent surveys conducted by the California HealthCare Foundation found that most patients would like the option of a telephone or video visit and would likely choose a phone or video visit over an in-person visit whenever possible. Essential Access Health conducted a survey of Title X provider network last fall and respondents reported that on average, nearly 60% of their remote sexual and reproductive health visits were conducted by telephone. A majority said that more than half of their patients are expected to choose telehealth visits over in-person appointments by April 2021. Over 40% of California teen respondents reported that they would prefer telehealth visits by phone. Nearly 60% of California teen respondents indicated they would be much more or somewhat more likely to get health care using telehealth than if they had to go to a clinic.

The California Medical Association, another cosponsor, writes the provisions of this bill guarantee that Medi-Cal patients will have the same access to telehealth services as commercially-insured patients. This is a key change, as Medi-Cal patients are most likely to have transportation challenges, child care issues, or other challenges that make it difficult to get to an in-person visit. California Health+ Advocates, another cosponsor, writes community health centers are leveraging telehealth technology to improve access to care and meet increased patient demands. Telehealth has been an important way for patients to access care during the pandemic and it will be critical to providing post-pandemic care, and telephonic (audio only) care has become a reliable modality of care. Another sponsor, Planned Parenthood, writes centers now provide about 25% of their visits through telehealth – which includes both video and audio-only visits. The majority of Planned Parenthood's telehealth visits are for birth control, sexually transmitted infections screening and treatment, pregnancy counselling, gender affirming care, PrEP and PEP follow-ups, and UTI screenings. All visits, regardless of modality, meet the time, medical decision-making, and documentation requirements of billing codes to be reimbursed. The California Public Hospitals and Health Systems, another cosponsor, writes Telehealth has opened up new options for patients who struggle with traditional visits, thereby expanding access to ensure their needs are met and helping to prevent the devastating consequences of delayed and avoided care. Increasing take-up of primary, preventive and chronic disease care via telehealth will likely result in better health outcomes and lower total costs to Medi-Cal over the long term. Telehealth is not a substitute for all types of in person care and all situations, but when it is appropriate, we must ensure the option is available. California's public health care systems are successfully using telehealth to provide a broad array of care, including primary and specialty care, chronic disease management, bedside consults for patients in the hospital, behavioral health care, and the support of care coordinators and social workers.

9) *Concerns.* The Service Employees International Union, California (SEIU) writes that the COVID-19 pandemic has disrupted our healthcare delivery system, and telehealth is an important modality for the delivery of healthcare during the emergency and moving forward. As this effort moves forward, it is vital that California understands the impact of this modality on the workforce, just like the introduction of other invocations like x-rays, election health records or cardiac catheterization. SEIU requests that the evaluation process described in this bill are expanded to include the impact on the healthcare workforce. Below is sample of language that expands the evaluation section of this bill, to help understand the impact of telehealth on the workforce.

    The impact of telehealth on the healthcare workforce, including types of positions or roles, expansion or reduction in types of workers, and skills or certifications that are needed to prepare workers and providers to effectively provide care through telehealth. Best telehealth workforce practices or models for delivering high-quality care as they relate to outcomes in the bill.

    The current language of this bill creates a stakeholder process that calls out employers to develop APMs for payment of telehealth services. The types of services and level of reimbursement have a significant impact on SEIU members, and that process would be incomplete without their perspective. If this provision moves forward, SEIU requests to be included in that stakeholder process.

10) *Opposition.* The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans write to oppose this bill because it is one of the fourteen health insurance mandate will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state

regulation by seeking alternative coverage options. Large employers, unions, small businesses and hard-working families value their ability to shop for the right health plan, at the right price, that best fits their needs. Benefit mandates impose a one-size-fits-all approach to medical care and benefit design driven by the Legislature, rather than consumer choice. The California Chamber of Commerce (Chamber) believes 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 indicates 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, and states without this guardrail, the bill could potentially place even the simplest and shortest patient-provider telephone interactions at parity with in-person presentations.

11) *Policy comment.* Policy comment.
12) *Amendments.*
   a) The amendments to the Insurance Code are unnecessary as health insurers do not delegate services to medical groups and other entities.
   b) Does the committee wish to adopt amendments requested by SEIU, Health Access California, CARD or Los Angeles Unified?

SUPPORT AND OPPOSITION:

Support:

California Association of Public Hospitals and Health Systems (cosponsor)
California Medical Association (cosponsor)
CommunityHealth+ Advocates (cosponsor)
Essential Access Health (cosponsor)
Planned Parenthood Affiliates of California (cosponsor)
AARP California
AIDS Healthcare Foundation
Alameda Health Consortium
Alameda Health System
All Inclusive Community Health Center
Alliance Medical Center
AltaMed Health Services
American College of Obstetricians and Gynecologists District IX
Ampla Health
APLA Health
Arnold & Associates
Arroyo Vista Family Health Center
Asian Health Services
Asian Pacific Health Care Venture, Inc.
Association for Clinical Oncology
Association of California Healthcare Districts
Bartz-Altadonna Community Health Centers
Behavioral Health Services, Inc.
Borrego Health
Business & Professional Women of Nevada County
California Academy of Family Physicians
California Association of Health Facilities
California Association of Social Rehabilitation Agencies
California Behavioral Health Planning Council

California Board of Psychology
California Chapter of the American College of Emergency Physicians
California Chronic Care Coalition
California Commission on Aging
California Commission on the Status of Women and Girls
California Consortium for Urban Indian Health
California Dialysis Council
California Hospital Association
California Primary Care Association
California Podiatric Medical Association
California Psychological Association
California School-based Health Alliance
California Solar & Storage Association
California State Association of Psychiatrists
California Telehealth Network
California Telehealth Policy Coalition
Center for Family Health & Education
Central California Partnership for Health
Central Valley Health Network
ChapCare Medical and Dental Health Center
CHE Behavioral Services
Children Now
Children's Specialty Care Coalition
Chinatown Service Center
Citizens for Choice
City of San Francisco
Coalition of Orange County Community Health Centers
CommuniCare Health Centers
Community Clinic Association of Los Angeles County
Community Health Councils
Community Health Partnership
Community Medical Wellness Centers
County Health Executives Association of California
County of Contra Costa
County of San Diego
County of San Francisco
County of Santa Barbara
County of Santa Clara
County Welfare Directors Association of California
Desert Aids Project
District Hospital Leadership Forum
Eisner Health
El Proyecto Del Barrio, Inc.
Family Health Care Centers of Greater Los Angeles, Inc.
Father Joe's Villages
First 5 Association of California
Golden Valley Health Centers
Governmental Advocates, Inc.
Health Access California
Health Alliance of Northern California

Health Care LA
Health Center Partners of Southern California
Health Improvement Partnership of Santa Cruz
Kheir Clinic
Kheir Health Services
LA Clinica De LA Raza, INC.
Lifelong Medical Care
Los Angeles Homeless Services Authority
Los Angeles LGBT Center
Mission City Community Network
Morongo Basin Healthcare District
MPact Global Action for Gay Men's Health and Human Rights
NARAL Pro-Choice California
National Association of Social Workers, California Chapter
National Multiple Sclerosis Society
Natividad Medical Center - County of Monterey
Neighborhood Healthcare
North Coast Clinics Network
North East Medical Services
Northeast Valley Health Corporation
Occupational Therapy Association of California
OCHIN
Ole Health
ParkTree Community Health Centers
Petaluma Health Center
Queens Care Health Centers
Redwood Community Health Coalition
Rural County Representatives of California
Saban Community Clinic
Salud Para La Gente
San Fernando Community Health Center
San Francisco Department of Public Health
San Mateo County Board of Supervisors
San Ysidro Health
Santa Barbara Women's Political Committee
Santa Barbara; County of
Santa Cruz Community Health Centers
Santa Rosa Community Health
Shasta Community Health Center
Solano County Board of Supervisors
South Bay Family Health Center
South Central Family Health Center
St. John’s Well Child and Family Center
Steinberg Institute
Sutter Health
TCC Family Health
Tenet Healthcare Corporation
The Achievable Foundation
The California Association of Local Behavioral Health Boards and Commissions
The Los Angeles Trust for Children's Health

Triple P America Inc.
TrueCare
UMMA Community Clinic
Unicare Community Health Center
Universal Community Health Center
Urban Counties of California
Venice Family Clinic
WellSpace Health
Western Center on Law & Poverty
Westside Family Health Center
Women's Health Specialists

Oppose: America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce (unless amended)

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