CONCURRENCE IN SENATE AMENDMENTS
AB 688 (Mark González)
As Amended July 7, 2025
Majority vote

SUMMARY

Requires the Department of Health Care Services (DHCS), commencing in 2028 and every two years thereafter, to use Medi-Cal data and other data sources available to DHCS to produce analyses in a publicly available Medi-Cal telehealth utilization report, as specified. States it is the intent of the Legislature to advance the use of telehealth and increase access to health care by establishing state policy that optimizes the use of telehealth to improve health, as specified.

Senate Amendments
Strike the requirement that DHCS include specified updates to the analyses and add a coauthor.

COMMENTS

Telehealth in Medi-Cal. Telehealth is a mode of delivering health care services remotely using information technology. The three primary modalities are video, audio (including telephone), and asynchronous store and forward, which can be used when a real-time interaction is not needed.

Telehealth utilization increased rapidly in response to the COVID-19 pandemic. According to data published by DHCS, prior to the onset of the COVID-19 pandemic, telehealth represented around 300 claims per 100,000 Medi-Cal member months. By April 2020, telehealth claims increased dramatically to over 12,000 claims per 100,000 member months and remained relatively stable through March 2021. Following March 2021, telehealth claims remained significantly higher than pre-COVID-19 pandemic levels but declined from the peak.

Medi-Cal Telehealth Policy. Prior to the COVID-19 pandemic, DHCS had expanded the availability of telehealth in Medi-Cal by allowing most clinically appropriate services to be provided through telehealth. During the COVID-19 pandemic, DHCS implemented additional telehealth flexibilities to allow Medi-Cal providers to meet the health care needs of enrollees. After significant stakeholder and legislative engagement, post-pandemic Medi-Cal telehealth policies were codified through the 2022-23 health trailer bill, SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, with minor and clarifying changes made through subsequent legislation.

According to DHCS, California has been a leading state in the expansiveness of its coverage and reimbursement for services delivered via telehealth. DHCS has committed to continuing to enable broad telehealth coverage for all Medi-Cal covered benefits and services, as long as the provider is able to meet the standard of care, subject to billing, reimbursement, and utilization management policies developed by DHCS. In addition, DHCS notes Medi-Cal is unique among other state Medicaid programs in that the state reimburses audio-only visits at parity with in-person visits.

Utilization. In addition to Medi-Cal utilization data, the California Health Interview Survey (CHIS) has been a key data source for statewide telehealth data. According to an October 2023 analysis of CHIS data by the UCLA Center for Health Policy Research, *"Telehealth and the Future of Health Care Access in California*," in 2021, about half (49%) of California adults

reported using telehealth to seek care and telehealth use decreased to 46.7% in 2022. The report notes telehealth remained a popular way to access care even after declining from record-high utilization levels seen during the pandemic. However, the use of telehealth varied. For instance, Latinx and Asian adults were less likely to use telehealth compared with white adults.

Currently Available Medi-Cal Data.

1) *Administrative Data.* DHCS has access to claims data that DHCS pays directly through the fee-for-service Medi-Cal program, as well as encounter data provided to DHCS by managed care plans that pay providers for Medi-Cal services. Claims and encounter data include a large number of data elements about each medical service provided, for instance, type of service (often called a service or billing code), procedures, diagnoses, rendering provider, and dates of service. Fee-for-Service (FFS) claims data also includes provider charges and payment data. DHCS also has other administrative data, such as age and race/ethnicity, which it links with claims data to provide a fuller picture of the health status and service utilization of different Medi-Cal populations.

2) *Telehealth Data.* DHCS has produced telehealth data reports by analyzing a subset of claims and encounters that include a telehealth ″modifier,″ which is a two-letter code appended to a service code to designate the service was delivered via telehealth.

   DHCS has produced public reports on telehealth visits per 100,000 beneficiaries by age group, sex, race/ethnicity, aid code (which designates a beneficiary′s category of Medi-Cal eligibility), delivery system (FFS or managed care), and managed care plan. Additionally, DHCS analyses examined the claims volume and percent of telehealth office visits for various types of services, and for new and established patients.

   DHCS has also developed a public-facing interactive telehealth dashboard, which displays a large number of data fields and allows public users to further refine data displays through drop-down menus. Dashboard data from 2019 to 2022 generally confirms the rapid growth in the use of telehealth during the COVID-19 pandemic, then a slightly decrease and plateau in utilization by 2022. The most common services provided through telehealth are medical office visits and psychotherapy visits.

3) *2022 Medi-Cal Telehealth Research and Evaluation Plan (R&E Plan)*. Pursuant to a statutory requirement included in SB 184, DHCS issued the R&E plan in December 2022. The R&E Plan described DHCS′ state of telehealth data collection processes and capabilities, as well as opportunities to support more comprehensive data collection and analyses in the future. DHCS describes the R&E Plan as a path to assess the impact of telehealth on utilization, access, quality, outcomes, equity, and provider and enrollee experience, which could then inform future telehealth policy development. The plan presented telehealth R&E Plan questions that have been proposed by DHCS and stakeholders across key domains, and proposed both near-term and longer-term R&E Plan questions.

   According to the R&E Plan, the most pressing need in the near term is to better understand the impact of all telehealth modalities on access and utilization of care among Medi-Cal enrollees. This is done by collecting data, analyzing and reporting findings on baseline telehealth utilization and access to care among Medi-Cal enrollees. This bill appears to align with the R&E Plan′s access and utilization reporting goals.

According to the Author
California faces a significant challenge in understanding the usage and effectiveness of telehealth, especially among those enrolled in Medi-Cal. The author asserts the use of telehealth must be optimized in California by establishing state policy for all residents, beginning with prioritizing Medi-Cal data collection. The author states the purpose of this policy is to increase access to health care and behavioral health by maximizing the use of telehealth in order to augment and enhance health and medical care for those who are medically underserved, ultimately improving individual patient outcomes and overall population health.

This bill is sponsored by the California Emerging Technology Fund (CETF), a non-profit corporation focused on closing the digital divide that was established pursuant to orders from the California Public Utilities Commission as a condition of approving a telecommunications merger.

Arguments in Support
This bill′s sponsor, CETF, indicates this bill is a critical link in the quest for health equity in California. The sponsor indicates it is important to measure to what extent access to telehealth—including specialty care through remote patient visits and expert consultations—can reduce adverse health outcomes for residents who are both economically and medically disadvantaged. The sponsor further notes that last session, AB 1943 (Weber) of 2024, a similar bill, passed unanimously with a recommendation to the consent calendar in both the Assembly and Senate, and states this bill builds upon AB 1943 and incorporates technical amendments provided by DHCS to that bill last session. AARP asserts this bill will help increase access to care by identifying populations and areas of the state that are underserved.

Arguments in Opposition
None.

FISCAL COMMENTS

According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

VOTES:

ASM HEALTH: 15-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Arambula, Carrillo, Flora, Mark González, Krell, Patel, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 14-0-1
YES: Wicks, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Hart, Pacheco, Pellerin, Solache, Ta, Tangipa
ABS, ABST OR NV: Sanchez

ASSEMBLY FLOOR: 79-0-0
YES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas

SENATE FLOOR: 37-0-3
YES: Allen, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Jones, Laird, Limón, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Reyes, Richardson, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Alvarado-Gil, Hurtado, Rubio

UPDATED

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CONSULTANT: Lisa Murawski / HEALTH / (916) 319-2097 FN: 0001264