BluePath HEALTH

Telehealth Policy in Medi-Cal:

Opportunities to Expand Access and Improve Care Delivery

October 2023

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I. Executive Summary

In 2021 and 2022, the California Department of Health Care Services updated the Medi-Cal telehealth policies to adapt to the expanding virtual care environment in the wake of the COVID-19 pandemic. These updates solidified many of the temporary policies allowed during the Public Health Emergency (PHE) declaration including payment parity and coverage of audio-only telehealth. However, the recent policy updates also included new changes to law and practice that are creating implementation challenges for telehealth providers in the Medi-Cal program. Work remains to be done in expanding coverage and access to telehealth services outside of the recent policy updates. In addition to addressing new implementation challenges, California has the opportunity to strengthen coverage for e-consult, advance reimbursement for remote patient monitoring, and pursue cross-state licensure reform to increase access to care in Medi-Cal through a more robust telehealth program.

II. Introduction

Prior to the COVID-19 pandemic, California's Medi-Cal telehealth policies were overhauled to expand the ability of providers to utilize telehealth, making the state one of the strongest telehealth policy environments in the country. In 2019, a Medi-Cal provider manual update expanded the ability of providers to determine clinical appropriateness for the delivery of care via telehealth, established guidelines for specialists providing electronic consultations (e-consults), and added the patient's home to the definition of originating site.[1] While the provider manual update offered guidance and clarity to many providers in the Medi-Cal program, disparities remained particularly for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). FQHCs/RHCs continued to be subject to site limitations, reimbursement exclusions, and restrictions on establishing a patient via telehealth.

The onset of the COVID-19 pandemic in 2020 and subsequent declaration of a Public Health Emergency (PHE) led to federal approval of policies increasing coverage and reimbursement flexibilities and the relaxing of prior restrictions on the provision of telehealth. The Department of Health Care Services (DHCS) allowed for Medi-Cal providers to provide all services deemed necessary via telehealth, and to deliver care via telehealth to both new and established patients, waiving limitations on where patients and providers could be located.[2] Additionally, DHCS began covering services delivered using audio-only telehealth, and implemented payment parity for services provided via telehealth, including for audio-only telehealth. Many of these allowances also applied to FQHCs/RHCs, who were able to be reimbursed for care delivered via telehealth in instances that had been prohibited previously.[3]

1 https://www.cchpca.org/2021/04/Medi-Cal-Fact-Sheet-FINAL_0-1.pdf

2 DMHC All Plan Letter 20-009: Reimbursement for Telehealth Services https://www.dmhc.ca.gov/licensingreporting/healthplanlicensing/allplanletters.aspx

3 https://www.dhcs.ca.gov/provgovpart/Documents/Telehealth-Policy-Paper.pdf

III. Post-PHE Medi-Cal Telehealth

The final state budget for Fiscal Year 2021-2022 included significant investments in strengthening telehealth in California. Signed into law under AB 133, the trailer bill language included a DHCS requirement to establish a Telehealth Stakeholder Advisory Workgroup composed of representatives from medical organizations, consumer advocacy groups, behavioral health providers, health plans, and others to inform the development of the Department's post-PHE telehealth policies.[4] The resulting Stakeholder Workgroup Report released in December 2021 outlined telehealth policy recommendations for the end of the PHE. The DHCS post-PHE telehealth policy paper, released in 2022, incorporated many of the stakeholder workgroup recommendations, such as phasing in a new video requirement to provide patients the choice of modality when receiving telehealth, and new requirements designed to monitor third-party corporate telehealth providers.[5]

Current telehealth policies maintain many of the expanded coverage policies temporarily allowed under the COVID-19 PHE, including coverage of synchronous and asynchronous telehealth for established patients, payment parity, and coverage of audio-only telehealth. Current policies maintain the PHE policy of covering virtual communications and check-ins, which were not covered in Medi-Cal prior to the pandemic. In addition, FQHCs and RHCs are able to be reimbursed at the Prospective Payment System (PPS) rate for telehealth provided via video, audio-only, and asynchronous store and forward services other than e-consult—such as in the Virtual Dental Home program, in which dental records and imaging collected at a school or other community site are transmitted to a dentist at a community clinic.[6] Audio-only visits, especially for behavioral health care, continue to make up a significant portion of health center visits into 2022.[7] Maintaining reimbursement for health centers to provide audio-only telehealth has been a critical step forward in improving access to care for many low-income Californians.

Current Medi-Cal telehealth policies also include several new policies not in place pre-pandemic or under the PHE flexibilities that aim to ensure Medi-Cal beneficiaries have choice in telehealth modality and access to in-person care should they prefer it. These include new additions regarding obtaining patient consent, offering video and audio-only telehealth, providing in-person care or facilitating warm hand-offs, and network adequacy.[8] The new Medi-Cal requirements also pose some complications for the telehealth landscape in California, as they do not align with requirements across other payer types. For example, the warm hand-off requirement requires Medi-Cal providers furnishing services through live video or audio-only telehealth to arrange for referrals and facilitate in-person care to receive reimbursement. This requirement is not otherwise a standard of practice, and other payers like Medicare and commercial health plans do not impose similar requirements on providers to receive reimbursement for telehealth services.

4 AB 133: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133
5 https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Advisory-Workgroup-Report-2021-12-02.pdf
6 https://dental.pacific.edu/sites/default/files/users/user244/VirtualDentalHome_PolicyBrief_Aug_2014_HD_ForPrintOnly.pdf
7 https://jamanetwork.com/journals/jama/article-abstract/2803527
8 https://www.dhcs.ca.gov/provgovpart/Documents/Telehealth-Policy-Paper.pdf

IV. Remaining Challenges

By adopting the flexibilities deemed necessary during the PHE, California has addressed many of the telehealth issues that limited the ability of patients and providers to utilize telehealth to its fullest extent pre-pandemic. However, work remains. As outlined above, the post-PHE policies related to establishing patients via asynchronous telehealth, consent, video requirements, and the facilitation of in-person services create new challenges for Medi-Cal providers and patients, such as designing new workflows for obtaining consent for telehealth services. In a March 2023 meeting of the California Telehealth Policy Coalition, members shared the difficulties in implementing the new Medi-Cal telehealth consent language because it is payor-specific: it is difficult to integrate a new requirement that only applies to Medi-Cal patients accessing care via telehealth, and not other patients.[9]

In addition to addressing these Medi-Cal policy implementation challenges, California should look to models in other states to advance reimbursement for e-consult and remote patient monitoring, and advance licensure reform. By continuing to limit the ability of providers in California's safety net to provide e-consults and remote patient monitoring, Medi-Cal policies are creating inequitable barriers that prevent patients and providers from fully realizing the benefits of telehealth. Additionally, licensure policies for providers delivering care via telehealth across state lines remains an area of concern in California state policy. The state's hesitancy to adopt licensing reforms or join interstate licensing compacts limits the flexibility available to patients and providers to access the care they need when they need it.

A. Implementation challenges related to post-PHE Medi-Cal telehealth policies

Establishing Patients via Asynchronous Telehealth

Current policies do not allow for providers to establish patients via asynchronous telehealth in most instances—although the Medi-Cal program has clarified that patients can be established via asynchronous telehealth in teledentistry. For other specialties that use asynchronous telehealth, such as dermatology in which patients may submit photos of a rash or skin condition virtually, the provider-patient relationship cannot be established for purposes of Medi-Cal reimbursement. Establishing patients via asynchronous telehealth has been an ongoing issue for Medi-Cal providers, and the Department's decision creates challenges specific to Medi-Cal. The requirement that a new patient relationship can only be established through synchronous telehealth counters existing laws related to provider practice. This includes the current legal ability to provide an appropriate prior examination for purposes of prescribing via questionnaire and other store-and-forward technologies and California Medical Board guidelines that specify that telehealth is subject to the same standard of care as in-person services—not a higher or lower standard.[10] The Medi-Cal policy requiring the establishment of a new patient through synchronous telehealth creates new telehealth practice requirements on providers for Medi-Cal patients that are not consistent across payer types.

9 March 17, 2023. California Telehealth Policy Coalition monthly meeting.

10 AB 1264 (Petrie-Norris), 2019.

Additionally, the policy does not mirror those of other states. Several states, including Massachusetts, Oregon, and Texas, reimburse for asynchronous store-and-forward telehealth under their state Medicaid programs with no additional policies limiting services to established patients.[11] As Medi-Cal has established exceptions for teledentistry, a model already exists for how this could be expanded across the Medi-Cal program.

Additional Consent Requirements

Under the new policy requirements, providers are required to obtain consent before the initial delivery of telehealth services and share new, additional information related to the right to in-person services, the voluntary nature of consent, transportation, the relevant limitations or risks of receiving care via telehealth, and notifications of the complaint process.[12] These additional consent requirements have created confusion among many providers in California and may impose barriers to accessing care as providers face difficulties in streamlining the new requirements into existing workflows and processes when the new requirement only applies to Medi-Cal, and not other payor types. The requirement as outlined by DHCS requires providers to apprise patients of certain rights they are entitled to in the Medi-Cal program, including transportation to in-person services. California law already requires consent prior to the use of telehealth, and telehealth stakeholders have raised concerns that creating different standards specific to Medi-Cal may limit telehealth adoption. No similar requirement is in place for in-person services.

In 2013, AB 809 sought to finalize the issue of telehealth consent in California after the passage of AB 415 (2011), which also removed a Medi-Cal requirement mandating documentation of barriers to in-person visits, a requirement that is prohibited in state law.[13, 14] The purpose of AB 809 was to ensure that consent did not become a barrier to telehealth utilization, and the bill intentionally made the law broad to accommodate different providers and workflows. Similar to the provider-patient relationship establishment proposal addressed above, DHCS's consent policy has increased requirements specific to Medi-Cal, and for California compared to other state Medicaid programs. No other state Medicaid program imposes this same consent requirement on telehealth providers. DHCS should consider lifting the new consent policy, or offer further clarification to providers regarding workflow integration, to ensure it does not become a barrier that impacts patient access to care.

Video Requirement

The post-PHE policy includes a requirement for Medi-Cal providers to "phase in" the option of video services to promote patient choice between telehealth delivered via video and audio-only.[15] At some point in the future–no sooner than January 2024–all Medi-Cal providers will be required to provide telehealth via live video as an option. As of fall 2023, DHCS has indicated that they are drafting provisions for this requirement which may include exceptions. Expanding audio-only access has benefited many Medi-Cal providers and patients that lack access to high-speed, affordable broadband necessary to use video.[16] Despite

11 CCHP "Store and Forward" State Comparison: https://www.cchpca.org/topic/store-and-forward/

12 https://www.dhcs.ca.gov/provgovpart/Documents/Telehealth-Policy-Paper.pdf

13 http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0801-0850/ab_809_cfa_20130419_161645_asm_comm.html

14 California Welfare and Institutions Code 14132.72 (d).

15 https://www.dhcs.ca.gov/provgovpart/Documents/Telehealth-Policy-Paper.pdf

16 Uscher-Pines, et.al. "Changes in In-person, Audio-only, and video visits in California's Federally-Qualified Health Centers, 2019-2022." https://www.rand.org/pubs/external_publications/EP70041.html.

recent and substantial investments in broadband by the state, the digital divide will not be closed by January 2024, including for those Medi-Cal providers who reside in areas of the state that do not have sufficient broadband access to support video telehealth. If these providers are unable to continue offering telehealth services because of the requirement, health care access is likely to worsen for the low-income communities already experiencing disparate access to care.

In-Person Requirement and Facilitation of Warm Hand-offs

DHCS policy requires FQHCs, RHCs and other Medi-Cal providers furnishing services through live video or audio-only telehealth to arrange for referrals and facilitation of in-person care. This requirement is unique to Medi-Cal providers and requires implementing new workflows and procedures that differ from required standard of practice for providers rendering in-person services, creating additional burdens that further distinctions in care between Medi-Cal and commercial insurance. This provision may lead to fewer providers willing to serve Medi-Cal patients, only further limiting Medi-Cal enrollee's access to services. A mandate to provide "warm hand-offs" to other providers is not currently a standard of practice and should not be a prerequisite to reimbursement.

In addition to addressing the challenges presented by the recent DHCS Medi-Cal policy update, California can further strengthen its telehealth program in three key areas: e-consult reimbursement, remote patient monitoring, and cross-state licensure. For each of these areas, California should look to other states that have implemented policies to expand access to care.

In response to concerns that the in-person requirement created barriers specific to the Medi-Cal program, AB 124l was introduced in early 2023, which would amend the policy to clarify that telehealth providers must maintain protocols to either offer services in-person or arrange for a referral to in-person services.[17] AB 124l would specify that the facilitation or referral arrangement does not require the telehealth provider to schedule an appointment on behalf of the Medi-Cal patient. AB 124l was signed into law by the Governor, easing some concerns regarding burdens placed on the Medi-Cal program. However, a different standard is likely to remain between in-person care and telehealth services because providers will be required to integrate new protocols and workflows to meet the referral requirement. It will be critical to monitor telehealth participation among providers in the Medi-Cal program beyond 2024 to measure the impact of new policies such as the in-person requirement, and ensure it is not further shrinking the Medi-Cal provider pool.

17 https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB124l.

B. Additional challenges for California and opportunities to learn from other states

In addition to opportunities to improve existing, post-PHE Medi-Cal telehealth policies, other opportunities exist to improve other aspects of Medi-Cal policy and California law to support telehealth's expansion in the California safety net. Below are several areas where California policymakers can take action, and how they can look to examples from other states.

E-Consult Reimbursement

In January 2023, the Centers for Medicare and Medicaid Services released a State Health Official (SHO) letter clarifying that interprofessional electronic consultation (e-consult) is a distinct service that can be covered by state Medicaid programs.[18] As of 2019, California DHCS telehealth guidance has covered e-consults only for the consulting provider.[19] There is currently no coverage for the coordinating primary care physician's time and effort. Additionally, FQHCs are entirely excluded from reimbursement for e-consults under current policy. The January 2023 letter outlines that payment can be made directly to consulting providers, clarifies for states how to add e-consult services to Medicaid programs, and establishes parity with services that are covered and reimbursed in the Medicare program. However, as of publication, DHCS has not indicated that they are pursuing a State Plan Amendment to cover e-consults in California—in particular for FQHCs/RHCs that currently cannot bill for e-consults. This SHO letter presents an opportunity for California to pursue e-consult coverage that benefits patients and providers statewide. E-consults are proven, effective strategies to connect primary care providers with specialists to ensure patients can receive high-quality, timely care.[20]

In April 2023, DHCS released an All Plan Letter regarding telehealth stating that "all Providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs)" can be reimbursed for interprofessional consultations.[21] A recent analysis of e-consults being conducted across the Medi-Cal program demonstrates that health centers are in fact leading the way in e-consult utilization. Preliminary data from the UCSF Center for Innovation in Access and Quality, reported by Medi-Cal managed care plans, shows that more than 160,000 e-consults were conducted by over 600 FQHCs, RHCs, and Indian Health Centers across California between 2020-2022.[22] As California's community clinics and health centers provided care to more than 7 million low-income Californians in 2022, ensuring FQHCs/RHCs have the tools necessary to provide care to their patients should be of highest priority to DHCS.[23]

As of writing, CMS has not approved any State Plan Amendments to enact coverage and payment for e-consults since the SHO letter. However, New York State is pursuing the option, and has submitted a proposed State Plan Amendment to CMS that would

18 https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf

19 DHCS All Plan Letter 2019-009 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-009.pdf

20 https://jamanetwork.com/journals/jama-health-forum/fullarticle/2780298

21 Draft APL 23-XXX "Telehealth Services Policy." Distributed by DHCS to managed care plans via email January 2023.

22 https://public.tableau.com/app/profile/bluepath.health/viz/CIAQeConsultEvaluationDashboards/EquityDashboard

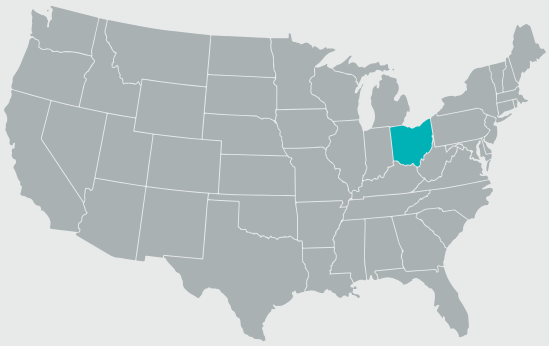
23 California Primary Care Association "California State Profile of Community Clinics and Health Centers." https://www.dropbox.com/s/lso9f8m87f7yra3/2022_CPCA_FINAL_CA_Statewide_Profile.pdf?dl=0

enact coverage and reimbursement for the treating and consulting provider.[24] California has the opportunity to lead the nation in e-consult coverage and reimbursement by joining New York in pursuing a State Plan Amendment.

Remote Patient Monitoring for FQHCs/RHCs

Remote patient monitoring (RPM) refers to the collection of patient data–such as blood pressure, weight, glucose levels–from a patient using home health devices and monitored by a treating provider. RPM has been increasingly adopted for chronic disease management, particularly for patients with diabetes and heart disease. In Medi-Cal, RPM is covered in instances for patients experiencing "one complex chronic condition expected to last at least three months."[25] Similar to e-consult, RPM is "not a reimbursable telehealth service for FQHCs/RHCs" in California presently, as it is deemed to not meet the visit requirements outlined in the provider manual.[26]

As FQHCs/RHCs provide care to the low-income communities and communities of color across California which experience higher rates of diabetes and heart disease compared to the population as a whole, RPM has the potential to improve health outcomes.[27] By establishing a reimbursement model for FQHCs/RHCs to provide RPM—potentially through a Fee for Service model as is underway in Ohio (see call-out box) or through an Alternative Payment Methodology (APM) in which FQHC/RHCs are paid a monthly per member rate—California can take proactive steps to enable safety-net providers to utilize life-saving information about the patients they serve.



State Example: Ohio

In 2022, Ohio updated its telehealth billing guidelines for providers after House Bill 122 unanimously passed the Ohio House and Senate.[28] In the Ohio Medicaid program policy update, the state clarified that FQHCs and RHCs will be paid for RPM on a Fee for Service basis as a covered non-FQHC/RHC service under the Ambulatory Health Care Clinic provider type.[29] Under this model, RPM is being reimbursed at the Medicare rate.[30]

24 New York State Medicaid Bureau of Health Access, Policy, and Innovation. Personal communication with authors, August 10, 2023.

25 https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval.pdf

26 https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/rural.pdf

27 CDPH, "Burden of Diabetes in California." https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/2019%20Diabetes%20Burden%20Report%20(SCOTT_9JUNE2020).pdf

28 https://www.legislature.ohio.gov/legislation/134/hb122

29 https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/Telehealth-Billing-Guidelines.pdf

30 https://www.chcf.org/wp-content/uploads/2021/01/ReimbursingFQHCsTelehealthPostCOVID19Pandemic.pdf

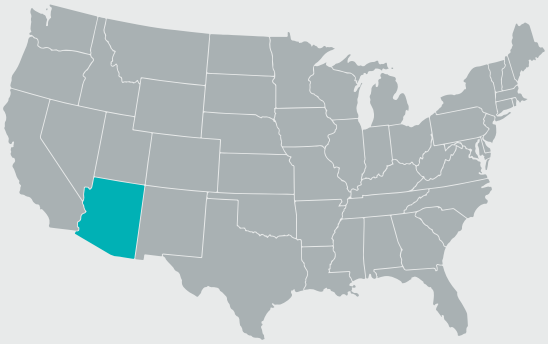
Licensure

The dramatic increase in telehealth utilization during the pandemic also led to an increased focus on licensing providers across state lines to allow for out-of-state providers to see patients via telehealth. While California has not adopted licensure reform policies in recent years, other states across the country have embraced removing practice restrictions, particularly to address shortages of behavioral health providers. Thirty-eight states in the nation have now joined the Interstate Medical Licensure Compact, easing processes for physicians to practice across state lines; however, California is not one of them.[31] While researchers have posited that the Interstate Medical Licensure Compact and other licensure reforms could ease provider shortages, there is a lack of conclusive data on the impacts of these policy changes.[32]

Two pieces of California legislation introduced in 2023 are related to licensure. AB 232 (Aguiar-Curry), signed into law by the Governor, creates a 30-day temporary practice allowance for social workers, therapists, and clinical counselors who meet certain conditions to provide care to patients located in California.[33] For individuals visiting California temporarily or relocating to the state, the 30-day period allows for continuity of care. While the bill is narrow in focus, it implements changes to licensing practices in California that have thus far been unsuccessful. Licensure exceptions for those visiting or relocating to California would enable providers to support continuity of care for certain patients that cross state lines, including college students, patients receiving complex procedures in other states, and those who reside in communities along state borders.

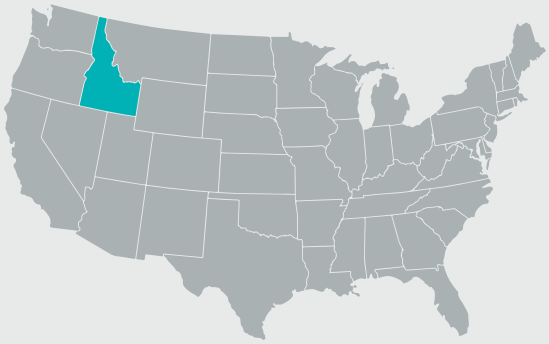
AB 1369 (Bauer-Kahan), on the Governor's desk at the time of writing, would allow a licensed physician or surgeon from out of state to provide care via telehealth to a patient located in California without a license if the patient has a disease or condition that is "immediately life-threatening."[34] Depending on the final legislative decisions of the 2023-2024 session, these two bills have the potential to make the most dramatic reforms to California licensing policies in years.

31 https://www.imlcc.org/
32 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8654457/
33 https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB232
34 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1369



State Example: Arizona

Arizona allows providers from out-of-state to practice telehealth in multiple scenarios. A provider can register with the applicable licensing board if they are licensed and in good standing in their home state. In addition, there are exceptions to the registration requirement when: the service is delivered in consultation with a healthcare provider in Arizona with ultimate authority over the patients' diagnosis; to provide after-care for a patient who received a medical procedure in another state; and when the patient is traveling to Arizona and seeing their primary care provider or behavioral health provider while visiting. As a bordering state, California policymakers should look to align licensing efforts with Arizona to support residents who travel back and forth between the two states.



State Example: Idaho

In Idaho, recent licensing policy was adopted with an emphasis on addressing the behavioral health professional shortage. In the recently passed House Bill 6l, the Idaho legislature established the ability of patients to access mental and behavioral health care from providers located outside of Idaho via telehealth.[35] College students, for example, who may have a provider in their home state are now able to continue receiving care via telehealth while located in Idaho.

35 https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2023/legislation/H006l.pdf

V. Additional Opportunities

A. DHCS Research & Evaluation Plan

With the release of the permanent post-PHE telehealth policies based on the Telehealth Advisory Workgroup recommendations, DHCS also announced their 2023 Telehealth Research and Evaluation Plan. The plan outlines how DHCS will study "telehealth utilization and its impact on access, quality and outcomes, and on provider and enrollee experiences."[36] Access and equity concerns remain top of mind for telehealth proponents, particularly in assessing barriers in access for Californians who do not speak English as their first language. DHCS' Research & Evaluation Plan has the potential to advance the evidence-base for telehealth policies that center historically disadvantaged communities. Measurement should include utilization trends and demographic data to help policymakers and telehealth stakeholders understand where telehealth is most effectively used and identify the populations where additional investment should be focused.

To strengthen California's telehealth program, DHCS should continue to convene the Telehealth Advisory Workgroup or other ongoing advisory committee to provide input on telehealth research, evaluation, and policy development. It is critical not to lose the momentum established during the COVID-19 pandemic to address barriers to widespread telehealth utilization.

B. Broadband Access

Access to high-speed, affordable broadband remains unequal across California – and without access to high-speed internet and devices, the potential of telehealth is not fully realized. Inequities in broadband access contribute to inconsistent experiences with telehealth. Many individuals do not have the capability to attend a video visit, and patients may not have a private and quiet location for their appointment if they must access broadband outside of their homes. While California is in the midst of major broadband infrastructure investments, it is not likely to close the digital divide in the next few years. The California Broadband Council, the Middle Mile Advisory Committee and the Department of Technology's State Digital Equity Plan are all meeting currently to monitor and inform the state's advancements of high-speed broadband access. As these efforts progress, it will be essential to ensure that DHCS, health plans, providers, consumer advocacy groups, telehealth experts, and other stakeholders engage and demonstrate leadership in tackling the issue of broadband access as one that is critical to improving health outcomes in California.

C. Children and Youth Behavioral Health Initiative

In 2019, California launched the Children and Youth Behavioral Health Initiative (CYBHI), a partnership between DHCS, the Department of Health Care Access and Information, Department of Managed Health Care, the California Department of Public Health, and the Office of the Surgeon General. This five-year, cross-departmental initiative includes a virtual services platform and e-consult platform with the goal of providing accessible and equitable behavioral health services to children and youth ages 0-25, particularly critical in the wake of the Public Health Emergency and its impacts on

36 https://www.dhcs.ca.gov/provgovpart/Documents/Telehealth-Policy-Paper.pdf

behavioral health needs of youth.[37] The Department has selected a vendor that will provide behavioral health resources to children and youth and their families starting January 2024.[38] DHCS has indicated that they will be launching a provider engagement campaign to recruit participating providers to an accompanying e-consult program that provides for asynchronous provider-to-provider connections. This investment in behavioral health for children and youth has the potential to strengthen e-consult adoption across the state, and the CYBHI should leverage and advance sustainable funding for the e-consult programs already in place. By optimizing the existing solutions and programs in place for primary care, the e-consult program can strengthen the network of behavioral health providers and limit the need for new workflows and major operational changes.

D. Reproductive Health

In the wake of the *Dobbs* Supreme Court decision in summer 2022, increased attention has turned to reproductive health care provided via telehealth across the nation. As dozens of states have passed legislation or issued executive orders restricting access to abortion and punishing providers who perform or assist abortions, many have looked to telehealth as a strategy for providing medication abortion despite legal obstacles. Additionally, patients in states where abortion remains legal and accessible have also increased utilization of telehealth for medication abortion, as it can provide additional confidentiality and reduce the burdens of traveling to a clinic or provider. While California is currently a national leader in enacting reproductive health protections for both patients and providers, the state legislature is currently hearing multiple bills related to protecting patients and providers from potential legal action and requests for information from entities in other states regarding abortion care delivered by providers in California, including those services provided via telehealth.[39] As states with restrictive abortion laws see reproductive health providers leaving out of fear of punishment and retaliation, provider protections are important for workforce development and retention.[40] If this package of reproductive health-focused bills is signed into law, California would join Massachusetts and New York in protecting providers from legal actions originating out of state.[41]

E. Data Exchange Framework

The California Health and Human Services agency's Data Exchange Framework (DxF) is the first ever statewide data sharing agreement to advance secure exchange of health and social services information between providers.[42] Statewide data sharing supports coordination of care, particularly for individuals with chronic conditions and complex health care needs—many of whom may receive care via telehealth. As DxF implementation progresses, it will be critical to monitor how telehealth-only providers participate in the framework and collaborate with other health care and social service entities across the state. The DxF presents the opportunity to bring telehealth vendors further into the statewide Health Information Exchange (HIE) landscape. For example, as innovative RPM models expand

37 https://doi.org/10.1016/j.psychres.2023.115082

38 https://www.dhcs.ca.gov/cybh

39 SB 345 (Skinner) https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB345; AB 352 (Bauer-Kahan) https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB352

40 https://www.npr.org/sections/health-shots/2023/05/23/1177542605/abortion-bans-drive-off-doctors-and-put-other-health-care-at-risk

41 https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter127

42 https://www.cdii.ca.gov/wp-content/uploads/2023/01/2_CalHHS-DxF_Guiding-Principles_Final_v1_07-01-2022.pdf

across the state, the data collected should inform decisions made by the patient's primary care providers and others on the care team. Supporting telehealth providers in the Medi-Cal program to share patient data among health and social service entities can improve care coordination, and ultimately, lead to better health outcomes.

VI. Conclusion

California's current telehealth landscape reflects many advancements to expand services in Medi-Cal during the COVID-I9 public health emergency, yet the state must continue to address continued challenges and barriers to equitable telehealth adoption. By creating new policies that only apply to the Medi-Cal program, California may further disparities in access between low-income residents enrolled in Medi-Cal and those enrolled in commercial insurance or Medicare. Additionally, addressing reimbursement for e-consults and remote patient monitoring, and taking opportunities to advance licensure reform will support the state's goals of equitable access to timely, high-quality care for all Californians.

Acknowledgements

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